

After Sontag: Reclaiming Metaphor

MARTHA STODDARD HOLMES,
CALIFORNIA STATE UNIVERSITY, SAN MARCOS

When I first studied human biology, I was overwhelmed by the idea that the inside of my body was in continual vertiginous motion, aswarm with physiological processes. It still makes me awestruck and queasy to think about the heart muscle pumping, or peristalsis, or necrosis. I need frequent anesthesia—a respite from sensing the pervasive workings of the body—to get through the day. As cognitive neuroscientist Antonio Damasio describes it,

sometimes we use our minds not to discover facts but to hide them. We use part of the mind as a screen to prevent another part of it from sensing what goes on elsewhere. . . . One of the things the screen hides most effectively is the body, our own body, by which I mean the ins of it, its interiors. Like a veil thrown over the skin to secure its modesty, but not too well, the screen partially removes from the mind the inner states of the body, those that constitute the flow of life as it wanders in the journey of each day. (1999, 28–29)

Thinking about metaphor is a little like thinking about the inner life of the body. *Pace* George Lakoff and Mark Johnson (1982), we live *within* metaphoric constructions at least as often as we live *by* them. Just as we often use them as appliances to make sense of our lives to ourselves and others, metaphors ply us. Just as evocative sensory images can produce a “moment of being” that changes the direction of a poem or short story, metaphors can shape and propel our life narratives with resonant, defining images of our embodied experiences. (Virginia Woolf theorizes and describes “moments of being” versus “this cotton wool, this non-being” in her essay “A Sketch of the Past” [1985, 70, 71].) Learning more how metaphor powers the engine of life narratives enables us to shift that dynamic so that we can live by metaphors rather than in their thrall.

Two other touchstones for an analysis of how metaphors both propel narratives and provide their residual meanings are Susan Sontag's *Illness as Metaphor* and *AIDS and Its Metaphors*, polemical essays that shaped body studies scholarship in the humanities through their critique of the dangers of metaphorical thinking about illness. Sontag argues that "the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphorical thinking" (1990, 3). She particularly critiques militaristic metaphors that characterize cancer and AIDS as invading aliens, and resistance to such cellular invasions as battles—constructions that inform both vehicle and tenor in negative ways and, above all, stigmatize and thus increase the suffering of sick people.

Sontag's work was a key foundation for my own work in disability studies. My book *Fictions of Affliction: Physical Disability in Victorian Culture* (Holmes 2004) argues that the persistent meanings of disability—particularly blindness, deafness, and mobility impairments—in the popular imagination are guided by affect-based (usually melodramatic) narratives and resonant metaphorical constructions more than they are by the materiality of impairment or the social, political, and/or economic facts of disabled people's lives. To offer a small example, if verbal shorthand for lacking awareness is that a person "was blind to that reality," then daily linguistic practices inscribe and reinscribe visually impaired people as lacking awareness, just as these practices invisibly and implicitly brand deaf and hard-of-hearing people as individuals who (sometimes willfully) fail to recognize what is before them. If wheelchairs are things we are "bound" to, then those who *use* wheelchairs (the preferred construction) are restricted, rigid, ironically immobilized in others' imaginations even as they actually wheel and zoom about their daily lives. (The children's book *Mama Zooms* is a rare counterexample [Cowan-Fletcher 1996].) Further, temporarily nondisabled people—enculturated into the idea that blindness is groping in the dark or having a veil drop between oneself and the material world, or into the idea that using a wheelchair is (bizarrely) a form of paralysis—are surely set up for trauma when they join that metaphorically scripted group of "the disabled," as we all will, if we live long enough. How we imagine the body—its distinctions, diversity and similarity across the human community, variations over time—dictates policy and practice; as all the essays in this collection argue, metaphors—and the narratives they mobilize—matter. Similarly, if saying that a person who uses a brace is "a bird with a broken wing" or describing a person who signs is "dumb" generates a narrative of striving and flight followed by injury, loss, and frailty, or a backstory

of ignorance or lack of response, then the same story leaves behind a residue of pathos, like sediment in a wineglass: we are left perceiving loss and sadness as the dominant tones of this person's life narrative. Sontag's polemic fueled and justified my work to locate a partial genealogy of deeply engraved beliefs about disability in nineteenth-century literary, medical, social work, educational, biographical, and autobiographical texts, as it did the work of many other scholars in disability studies and medical humanities. A later experience with ovarian cancer, however, led me to reflect on a serious problem, not so much with Sontag's argument but with my own overzealous and undernuanced adoption of it.

Sontag herself had mixed feelings about metaphor. The healthier, more truthful perspective on illness she demands is one "purified of . . . resistant to, metaphoric thinking"—a statement laden with implied metaphors equating metaphoric thinking with an impurity or pollutant or virus, a substance that corrupts the truth or makes thinking sick. In fact, in *AIDS and Its Metaphors*, Sontag looks back to characterize this earlier passage as "a brief, hectic flourish of metaphor, in mock-exorcism of the seductiveness of metaphoric thinking." Seeming to retrospectively bracket her judgment against metaphor, she reaffirms it in the next sentence: "Of course, one cannot think without metaphors. But . . . some metaphors we might well abstain from or try to retire" (1990, 93).

Illness as Metaphor is hugely important as a space-clearing move—a statement that elbows out the walls that constrain our thought and slaps us awake to the meanings in too-familiar words. Sontag's argument against metaphors is itself dangerous, however, as a stopping place. A desire to retire certain metaphors is all too easily translated into a "metaphors are bad" or "good metaphor/bad metaphor" policy, and once we start scrutinizing "negative images," it's all too easy to slip into a ban on all images, all representation, because of the inherent potential that our figures will do harm. And, of course, stopping metaphors is like ceasing to eat or to breathe.

The more crucial questions, then, are which metaphors matter and *whose* metaphors determine our imaginative course (the story that unfolds in our minds, arguably an important aspect of the clinical experience, as Catherine Belling argues elsewhere in this issue) and all the material and practical effects that narrative produces. We construct an imaginary narrative around diagnosis in response to questions: What is it? What is it like? Where has it come from? When did it get here? Where might it go—and when? Howard Brody's notion of a story being "broken" and collaboratively repaired by doctors and patients to build a new

narrative elides the point that whoever offers a defining metaphor for that story generates its leitmotif. Naming the metaphor is like laying the first brick that determines the shape of the house. So the first questions answered—“What is it and what is it *like*?”—powerfully determine the others, as metaphor determines narrative. Sontag’s critique of metaphoric thinking about the body and illness has had an uneven impact on the discursive power of patients and doctors (and by doctors, I mean a much wider range of health professionals who themselves have different degrees of control over the ways of speaking and other practices that provide meaning and direction to patients’ bodies and lives). Patients have always had limited influence on the (also limited) stock of public metaphors that shape their own care. In calling for an end to metaphoric thinking about illness, Sontag may have unwittingly lessened patients’ already marginal power. Our task, after Sontag, is to rethink metaphor as a site of self-direction rather than one of interpellation by medical discourse.

When I was diagnosed with cancer in 2003, six weeks into a Literature and Medicine class—and barely two weeks after teaching *Illness as Metaphor* and *AIDS and Its Metaphors*—I told my students the news and exhorted them to “Remember Sontag!” I privately cringed at the kind, concerned e-mails from students, family, and friends that began, “I heard that you’re battling cancer.” Truly, I did not feel that this metaphor helped my apprehension of my illness. Battling? It felt inauthentic. I was crawling. Or rather: sometimes I was trundled from hospital to home in a stunned state; sometimes feeling well enough to be curious about and fascinated by the unfamiliar experiences; sometimes flushed with grateful relief in a moment of comfort; sometimes feeling wildly uncomfortable with pain or frantic with awkwardness—the shame of asking for pain meds, the embarrassment of looking awful when visitors came, or the combined shame and awkwardness of being too preoccupied with bone pain or GI misery to pass as my usual self. And sometimes, wonderfully, I was just asleep. It’s not that battling was distasteful or reprehensible to me (as it seems to have been to Sontag); it just didn’t fit. But without a fitting metaphor, I had no story.

During those times in which I was blessed with the mental and physical liberty to even begin conceptualizing my disease, I would have welcomed a spur to transform it, and myself, through a change in language: the comfort of seeing cancer as a presence, an anchor, an infant, a bubble, a lover, a mosaic, a seedpod, an energy—each metaphor generating a different complement of stories. Or, if not comfort, metaphors could have offered the gifts of distraction and curios-

ity: *what is most like this?* From metaphor might spring story: if cancer were a visitor, a stranger who might change my life in valuable as well as terrifying ways, a host of possible narratives of visitors and strangers—dynamic in time, unstuck—could unfold. As anyone who has read a well-written short story can attest, short fiction shares the emotional and verbal dynamic of poetry, only slightly less compressed: a resonant central image, whether the pink ribbons in Hawthorne’s “Young Goodman Brown” or the vase in Ann Beattie’s “Janus,” often determines the affective map of narrative. An unusual ovarian tumor filled with teeth and nails becomes a resonant image in Margaret Atwood’s story “Hairball.” The protagonist names and talks to the tumor, envisioning it as “her warped child, taking its revenge”—even after the physician discounts her speculative narrative of its origin as a “child, a fertilized egg that escaped somehow and got to the wrong place” (1991, 45). Later, she reshapes the tumor-as-metaphor when she mails it to her married lover in a chocolate box, with a note saying, “This is all the rage” (47). As Atwood’s story demonstrates, narrative can as easily grow from a metaphor as the reverse: from “what is like this” comes “what most likely happened” (and “what may happen next”), a material and emotional backstory building itself to support the important image, just as each narrative we try on changes the meaning of a metaphor.

In part because of Sontag’s substantial power as a public intellectual and her texts’ impact on my own intellectual products, however, I didn’t make metaphors or spin out narratives. I internalized her rhetorical position as a powerful prohibition against metaphorical thinking about my own illness, and remained subject to whatever metaphors—and narratives—were available to me from others. It wasn’t until quite a bit later (during and after chemo) that my metaphor-making capacity returned. Even before my hair sprang out from my bald pate, my creative writing returned. Both were bizarrely recursive to my early teens: one exploded in curls; the other recorded dreams and overheard conversations, filling journals with poem fragments and metaphors. My cancer experience generated some form of creative renewal, bringing with it not only the expression-killing pain that Elaine Scarry (1995) writes about, but also a surge of words, a period of accelerated growth in my imagination, and a spike in my hunger to articulate what this strange experience was like. I had longed for sensory images to match my inner landscape and evoke its distinctive weather—not just to share it, but to know it—to claim this place I would inhabit for the foreseeable future as a named, if unpleasant, location. Over time, I regained the habit of trying on words to find

the match for my illness experience: words to say what it was like, even before I could imagine what might happen next. I look back at this as a season of verbal neoplasms and am struck by how thinking of my cancer and my writing in terms of each other dislodges each one's familiar affect.

All this may sound very psychotherapeutic and inspirational, and it was, but I believe my experience carries a broader clinical implication: not in the value of creative writing as therapy for the cancer patient, but in the suggestion that the somnolence, repression, neglect, or postponement of my capacity for thinking metaphorically about my body—its absence before my doctor diagnosed me with cancer—may have muffled my symptoms and slowed their diagnosis and treatment. In other words, I had not only cancer but also a multilayered representational problem.

We often accept or generate a simplified story of our illness's origins: "I smoked for too many years"; "It was my doctor's fault for giving me that medicine." Central to the comfort of such stories is being able to deposit causality or even blame and, in that attribution, settle the question of "why me" that seems to be a stereotype of cancer narratives. I have never asked "why me" about cancer because I had a clear and logical, if not definite, cause: multiple courses of fertility drugs. What bothered me was quite different. If what the diagnostic ultrasound found was "a very large, complex mass"—or, in my translation, two sturdy grapefruits, fused in the center, hanging out in my belly—why didn't I go to the doctor for several months after the onset of what looked in retrospect like symptoms? For—in retrospect—there *were* symptoms. I had a recurrent sense that I had just missed someone's presence in the room; I read this as my dead (of multiple myeloma) father trying to contact me. I also had a sensation beyond the functional reality of difficulty zipping my jeans—there was a ledge inside my abdomen. It felt like pressing your body up against the edge of a kitchen countertop or a table, but the pressure came from inside, like a countertop growing inside my belly, pushing out to tighten and tauten the skin of my pelvis. It was like being pregnant—that sense of an alien life form inhabiting your body, with purposes of its own. I could not see, but expected to see, a new ridge emerge from the surface of my belly.

The affect associated with the ledge was thus confusing—fear of a bad growth merged with remembered excitement about the good growth of pregnancy—and I didn't know whether I was expecting death or a wonderful surprise. It was like the feeling after surgery, when you suddenly know you are made

of flesh, tissue that can be folded or stitched, only there had been no surgery yet. I would check to see if the ledge was still there, lying on my back and adjusting my position until I relocated the oddness—like searching with my tongue for a loose tooth. I never dared to press it from outside. Even the idea of palpating this strangeness brought on the other sense of “ledge,” feeling suddenly poised on the windowsill, at the edge of an unfathomable space. But these symptoms remained secret, even to myself, until after the doctor’s words pronounced them real and I began to write the metaphors that might have brought me to consult her sooner had I used them to materialize my symptoms in language.

Despite my absolute refusal to locate the causes of cancer in anything beyond fertility drugs, my slowness in seeking diagnosis, I became convinced, was closely related to my lack of active and verbal imagination about the inner realms of my own body and my dearth of metaphors to express and thus identify the unfamiliar sensations that would later be diagnosed as cancer. If I was to blame at all in the timing of my diagnosis—and I was very fortunate that it was relatively early—it was through *a failure of imagination* exacerbated by a paucity of public metaphors for the inner life of the body, and particularly for ovaries or ovarian cancer.

As I detail elsewhere, representations of the ovaries, repulsively gendered and laden with disease as they are throughout cultural history, tend to inspire one to detach oneself from these female organs. The public culture of pink ribbons and yellow bracelets—metonyms for breast cancer, testicular cancer, and cancers more generally—was (purposefully) too far removed from any apprehension of these already frightening inner organs to provide me any help in imagining ovarian growth, and the public service campaigns, which used synesthesia (silent killer/turn up the volume) and fashion as figurative vehicles to carry this problematic tenor, were no better (Holmes 2006).

Metaphor in the context of embodiment has a panoply of functions, a limited set of which Sontag emphasized for the purposes of argument. Yes, the yoking of vehicle (the resonant image) and the tenor (its concept or idea) inflects both in important ways, and the metaphoric use of cancer shapes both cancer (as vehicle) and whatever is its tenor; similarly, using military language as the vehicle (guns and tanks and missiles, as it were) to represent an engagement with illness both identifies illness as an alien enemy and, depending on your politics, lends dignity and/or horror to the process of treating illness. But there are many more ways to use metaphors, and some of them decrease suffering rather than add to it. We can

use figurative language to approach the body, as verbal pincers to get at the thing itself (or somewhere close to it) and express our own embodiment. Figurative language can even give us a better shot at proprioception, by materializing what increasingly feels immaterial and disembodied as it is reinforced by the multiple immaterialities of the contemporary world. Scarry writes that while to experience pain is to feel certainty, to hear of another's pain exemplifies doubt:

The events happening within the interior of that person's body may seem to have the remote character of some deep subterranean fact, belonging to an invisible geography that, however portentous, has no reality because it has not yet manifested itself on the visible surface of the earth. Or . . . it may seem as distant as the interstellar events referred to by scientists. . . . Vaguely alarming yet unreal, laden with consequence yet evaporating before the mind because not available to sensory confirmation, unseeable classes of objects such as subterranean plates, Seyfert galaxies, and the pains occurring in other people's bodies flicker before the mind, then disappear. (1985, 3–4)

Without metaphors for bodily experiences—our own, as well as those of other people—our viscera remain as strangely inaccessible as the Milky Way, a fact commemorated by science fiction narratives about fantastic voyages inside the body.

From another perspective, metaphors function as verbal tongs, tools for holding our own or another's embodiment away from us until a better time comes for right engagement, as Damasio argues. Thus metaphor has a prosthetic function, with all the nuances of prosthesis: it extends our sense of touch, getting us closer to those things we cannot palpate ourselves or see without technology—but also covers up what can't be handled, as some prosthetic limbs function to accommodate the needs of nondisabled lookers rather than those of the person who wears them. Prosthesis can be enabling or deeply problematic, depending on who directs its use.

As well as regulating the distance to the outsides and, even more, the insides of our bodies, metaphors—the ones Scarry (1995) and Damasio (1999) use, for example—create relationships. They are inherently relational constructions. (This is not, of course, my insight; Lakoff and Johnson [1982] articulate in detail systematic relationships in metaphor usage.) This does not mean that metaphors are good, any more than all relationships are good. They have the potential to become relationships of hierarchy or exploitation: perhaps the tenor drives the vehicle (imagine Pavarotti in a Maserati); he is simply using it. But not always: at the same time, the vehicle may carry the tenor where it wants. There is the potential for mutuality, as well, and the potential for ethical consequences.

In articulating and processing the experience of cancer, in particular, the relational qualities of metaphor are crucial. Sontag notes that militaristic metaphors of illness ultimately circulate stories of blame: “The move from the demonization of the illness to the attribution of fault to the patient is an inevitable one, no matter if patients are thought of as victims. Victims suggest innocence. And innocence, by the inexorable logic that governs all relational terms, suggests guilt” (Sontag 1990, 99). Militaristic metaphors produce stories of valiant soldiers (overlaid, like transfers, onto bodies of elders or infants) or of wounded victims, thwarted by an insidious fiend. The narratives tend toward the Manichean or melodramatic rather than the nuanced. But this is not the only way to imagine the illness relationship, especially when we shift from metaphor to simile—from “what is it?” to “what is it like?”

Julie Carlson writes about the ethical potential of the relational qualities of similes, taking as her illustration Percy Bysshe Shelley’s distinctive strings of similes in his poems, including “To a Skylark.” Whereas metaphors, in equating two things, have the potential for colonization through conceptualization, “Shelley’s deployment of simile interrupts the conceptualizing features of metaphor” (Carlson 2009, 3), because it both makes a connection between two things and retains a “requisite individuation of both source and target entities” (4). In other words, simile teaches us “to perceive in relation not to ‘is,’ which conflates identities, but ‘likeness’” (4), which leaves both vehicle and tenor visible and distinct, neither incorporated into the other (4). The person with an illness may be *like* a soldier or a wounded bird or a china doll or a luminous grape—but *is* still him- or herself.

Carlson’s characterization of Shelley’s use of simile as a *dynamic* and *ethical* encounter with the unfamiliar is especially pertinent to embodied experiences such as illness and sudden disablement. As she notes, “What any person or thing (or life itself) is, we know not; at best, we apprehend it through perceiving what it is like. Perceiving how little we know or can know is already ‘progress’ in the Shelleyan sense” (4). Rather than a simple duality, there is an expectation for an evolving range of possible relationships and identities—each enabling a new set of potential stories.

Such flexibility is important to healthy ways of narrating the self in sickness. A cascade of changing stories, the dynamic illness narrative can generate any number of nuanced metaphors to fit the experience of an individual, as opposed to producing a predictable, reified metaphoric nugget (a hero, a victim, a villain).

As Jane Schultz argues, the encounter with the unknown, physically altered self may generate a crucial need to incorporate one's own radically othered body as *both alien and oneself*: "If one's image is unrecognizable, one must find one's way back to a notion of the self that can be accepted" (2009, 371–72). Simulating one's precancer self-image in the effort to return to it (wearing a wig over chemo-induced baldness, for example) may not be the most successful approach to the process of incorporation, much as it may be more comfortable for others. The process of simile-production, on the other hand, seems well suited to the dynamic of incorporation. Carlson sees simile as "providing a crucial workout for the aesthetic and moral functions of the imagination," which surely lends it to the context of illness (2009, 4). An encounter with illness, particularly one preinscribed by received cultural narratives and metaphors as an alien invader, would be productively remobilized not by using bad metaphors but by sparking new metaphors and similes, unfreezing "frozen" ones and renewing "used" ones (see Periyakoil 2008; Lakoff and Johnson 1982). I think that the promise Carlson recognizes in the simile can be activated in metaphors as well, provided they are one's own metaphors rather than "used" or "frozen" ones.

As we consider how to generate or regenerate figurative language for the promotion of health, we might also consider visual culture as part of the landscape of medicine and metaphor. The instantaneous, synchronic quality of the visual metaphor, which can tell us in two frames of a graphic narrative that a tumor is a constellation in a distant galaxy, is wonderfully appropriate to rendering and expressing certain embodied experiences, as I have argued elsewhere (see Holmes 2008).

All this points to one more set of gifts that the humanities, particularly creative writing and literary criticism, have to offer medical culture, a landscape inhabited by both doctors and patients and doctors-as-patients. Alongside the narrative competence proposed by Rita Charon (2001, 1897–98) and other proponents of narrative medicine, we need to continue teaching the skill of metaphoric literacy, and not only to medical students but also to the children in our school systems. Then, faced with any embodied experience, visible or invisible, we will all be better equipped to articulate for ourselves and others "what it is like" and "what it is." Despite fears to the contrary, the ability to articulate one's embodied experience, and particularly changes to the unseen viscera, will not necessarily obstruct the doctor's diagnostic prowess and process: I am not saying that patient's metaphors and similes should dominate the diagnosis, only that

they should never be disregarded or discounted. Again, if we are metaphorically literate, we can learn to be critical readers of metaphors, metonyms, and symbols outside us and inside us; we can learn to see that metaphors, like aesthetics in general, are always “interested,” as Matthew Arnold would say, that is, inextricably bound to politics and social relations. This doesn’t mean we need to cleanse them from our medical culture, but that we need to give a wider constituency access to metaphor-making.

So, while it was always time to move on from Sontag’s argument, I want to suggest, in particular, that we need to carry forward—along with Sontag’s important critique of received metaphor—a much wider access to metaphor-making and metaphor-reading, as a way to complement our attention to narratives as meaningful currency in the culture of medicine and in the experience of living, healthy and ill. More people need training to read metaphors critically; we need to provide, as teachers, greater access to that capacity for originating metaphors, and encourage the generation of a more varied palette of bodily metaphors (and particularly a more balanced storehouse: verbal metaphors that appeal to tactility and other senses beyond the visual; metaphors made in visual and plastic media rather than solely those made of words).

We should also expand the reach of existing cultural sites that can build scaffolding for our imagining of the body, in sickness and in health. William H. Parker’s *A Gynecologist’s Second Opinion* offers a rare set of details about the look and size of the ovaries through the life cycle: in young girls, they are “off-white . . . walnut-sized lumps of tissue” that start out smooth but after many ovulations develop a “pitted and irregular” surface. After menopause, ovaries become smaller, the size of almonds, and change to pale white. The language of medical culture itself is necessarily evocative so that those who witness—pathologists, for example—can render body parts and growths unimaginable to future medical professionals, who will make judgments based on word-pictures that are not always accompanied by color photographs. This rich sensory description needs to move beyond these texts and out into public culture, as it does in Shelley Jackson’s hypertext novel *Patchwork Girl* (2001), in which “ovaries hang like kumquats from delicate vines,” or in David Hellerstein’s essay on medical education, “Touching” (1986, 70), in which ovaries are described as “those small elusive olives.” We also need more first-person writing that works with tactility and also with other modes of self-perception (my experience of feeling as if a ledge were inside my abdomen, for example) to discuss all kinds of cancer experiences.

Finally, it is crucial that, in this particular discussion of medicine and metaphor, we urge not simply that health care professionals learn to be imaginative creators, critical users, and attentive readers of metaphor, but also that they encourage, listen to, allow, and consider their patients' metaphors, just as they listen and attend to their patients' stories. One recent article analyzing the frequency and type of metaphors used in oncologist-patient communications focused on what doctors said and their tendency to use more metaphors than analogies; the authors noted that some types of metaphor were especially prevalent, including agricultural (32 percent), militaristic (22 percent), mechanical (19 percent), and sport-related (9 percent). The study also found that "physicians who used analogies elicited higher (better) patient ratings of communication" and that "patients reported less trouble understanding physicians who used metaphors . . . and analogies" (Casarett et al. 2010, 258).

What, though, do patients have to say about what a sensation or illness *is like*—(simile)—what part, for them, stands in for the whole (synecdoche) or otherwise stands in for (metonymy) the embodied condition? Doctors must listen not simply to correct and realign the metaphors, as one piece suggested (see Periyakoil 2008)—offering as an example a patient whose capacity for metaphoric constructions seemed quite limited—but rather to engage in shared learning, as co-owners of the capacity for metaphor, codirectors of the operative metaphors for a particular illness experience, and equally, if differently, informed participants in the culture of medicine (see Jain 2010). When we expand access, encouraging a more democratic nurturing of the capacity for figurative thinking about the body—and when we become more inclusive in considering whose metaphors will resonate in the story of the body—there are important implications for communication around illness and healing. Metaphors are transformative magic with the potential to change patients' and doctors' attitudes toward embodiment and illness, to influence self-diagnosis and the timing of diagnosis, and potentially to change the course of illness and health. The principle of self-determination—a cornerstone of biomedical ethics—needs to be applied to the discourse that frames a person's illness. Especially when we lack many other choices, we should always have the power and ability to consider "what is most like thee."

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