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The Doctor, the Breath and Thomas Bernhard

Using Novels in Health Psychology

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Abstract

The use of literature in medical education has increased greatly in recent years, as attested to by growth in the medical humanities field. In this article we argue that literary texts may be beneficial for use in health psychology, illustrated by an analysis of patient–physician interaction in the novel *Breath* by Thomas Bernhard. Reading novels can impact on people's health-related behaviours. Using novels in our teaching and training can illustrate that there are alternative, useful ways of gaining health-related knowledge beyond objective, scientific rationality. Novels are able to show health, illness, disability and suffering in their full human, social and spiritual contexts, and therefore should be considered seriously in our health psychology endeavours.

Keywords

- *medical humanities*
- *narratives*
- *patient–physician communication*
- *qualitative research*
- *respiratory illness*

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PSYCHOLOGISTS and other behavioural scientists who teach medical students are faced with a fascinating, albeit sometimes difficult and disappointing, task. Given various objectives in medical education and guidelines on professional behaviour, medical students have been required to develop their communication and counselling skills. While this training was initially resisted (and sometimes loathed) by students, in recent decades these negative reactions appear to have diminished somewhat (Millar, 2004).

Observing clinical encounters, role-playing and teaching small groups are methods often used in these communication training programmes. In recent years, an additional method has gained in popularity among psychologists, physicians and other health care providers: teaching courses on literature and medicine (Powley & Higson, 2005). In this approach, novels and poems are used as sources for teaching about crucial themes such as coping, stress, adherence, social support and patient–physician communication. For example, *The black swan* by Mann (1990) was used in a medical humanities class in Finland to teach trainee gynaecologists about symptom perception, illness behaviour and sexuality. In this book, a 50-year-old postmenopausal woman falls in love with a much younger man. In the first few weeks of their encounter, she begins menstruating again, perceived by her as a sign of rejuvenation. It is, however, a sign of ovarian cancer. The teachers of the class asked the students to write a free-form essay about the book, and were rather shocked to learn that the students focused on biomedical rather than on biopsychosocial issues: 'whether oestrogen was the cause or the effect of Rosalie's condition was the most common question the students asked' (Lahtinen & Torppa, 2007, p. 46).

The use of literature in medical training has become much more widespread, as attested to by the growth of the field of medical humanities. Essentially, the medical humanities employ perspectives derived from wide-ranging disciplines such as history, philosophy, literature, art and music to further our understandings of health, illness and medicine (Gordon, 2005). A number of journals focus specifically on this topic (e.g. *Academic Medicine*, *Literature and Medicine*, *Medical Humanities*) or have weekly poems and/or patient pages (e.g. *BMJ*, *Chest*, *JAMA*), while websites from universities where medical humanities are taught list hundreds of books that can be used for teaching and research purposes (e.g. www.medhum.nyu.edu). Recent books outline curricula and teaching formats with teaching materials (Powley & Higson, 2005), and interest in the use of literature in medical education continues to increase (Calman, 2005). Medical humanities have become part of mainstream medical education in many western countries (Gordon, 2005). Yet even more generally, the arts and humanities 'have become increasingly important in the treatment practices of health professionals' (Furman, 2006, p. 560).

Short stories, novels and poetry can illustrate a range of social and health problems from the perspective of the writer (Calman, 2005). Further, such writings can portray illness in particular ways (e.g. chronic illness, psychiatric illness) that allow people to be seen as whole persons, with thoughts, worries and feelings (Calman, 2005). Examination of literary texts has provided a wealth of knowledge about patients' experiences of illness. Indeed, Bolton (2005) has argued that literature is vital in medicine and health care, providing knowledge and offering crucial understandings of the narrative nature of human lives. More recently, Charon (2006a, p. 191) points out that doctors have,

> turned to literary texts and ways of thinking that help us to enter the worlds of patients, see other's experience from their perspectives, greet the metaphorical as well as the factual power of words, and be moved by what we hear.

For example, the short story *The Yellow Wallpaper* (by Charlotte Perkins Gilman, 1997) has been posited as a useful tool in helping health care practitioners and students understand postpartum psychosis and reactions to drug therapies (Frye, 1998; Tucker, Crow, Cuccio, Schleifer, & Vannatta, 2004).

In psychology, there has been a strong emphasis on narrative analysis of texts in the area of health, illness and medicine. For example, Sarbin (1997, p. 67), in his article 'The poetics of identity', makes the case that 'imaginings influence the construction of identity … that imaginings stimulated by stories read or stories heard can provide the plot structures for one's own self-narratives'. Patients' illness stories can also be used as the empirical data with which their narratives can be analysed (Haidet, Kroll, & Sharf, 2006). Paintings, plays, operas, movies and music are other sources of empirical material that have also been used in examining patients' narratives on illness (Heaton, 2006, for plays; Powley & Higson, 2005, for movies and music; Willich, 2006, for operas). Furthermore, autopathography, 'the patient's tale' (Kearney, 2006, p. 111), offers health psychologists opportunities to analyse themes in these patients' tales, for example, 'warning', 'denial', 'diagnosis', 'family' and 'hospital staff'.

In summary, therefore, novels and other literature have been employed in medicine and psychology for teaching medical students (in line with developments in medical humanities), understanding people's experiences of illness (e.g. Frank, 2002) and also for enabling an examination of patients' own illness stories. However, we believe that health psychology could benefit further from other uses of novels and literature in ways that may enable a more humane health psychology. Specifically, novels in health psychology could be used to: (1) provide further insight into health psychology theories and models, particularly for teaching purposes; (2) explore and understand psychological and/or health-related concepts; (3) examine how they may impact on the health and behaviour of readers; and finally (4) teach our students that there are various ways of gaining health-related knowledge beyond objective, scientific rationality (see also Charon, 2006b). In the following sections we outline each of these arguments, emphasizing the first with examples from Thomas Bernhard's writing.

Novels may provide further insight into health psychology theories, particularly for teaching purposes

The use of novels containing patients' narratives may be beneficial in teaching both psychology and medical students about self-management and shared decision making in medical contexts. Further, concepts such as patient–physician communication can be analysed by using a novel. Here we use the book *Breath, a decision* by Thomas Bernhard to examine how the author describes doctors and other health care providers, what this may mean for teaching students and what it means for concepts of health professional–patient relationships.

Many of the books by Bernhard are autobiographical. Bernhard was the son of an Austrian woman, and was born out of wedlock in the Netherlands in 1931. Soon after, his mother and Thomas Bernhard settled in Austria where they endured the Second World War. Probably induced by the appalling conditions during and immediately after the war, Bernhard fell ill with respiratory problems, which would haunt him for the rest of his life. He died when he was 58. He was a prolific writer of novels and plays, frequently fiercely criticizing (Austrian) bourgeois society and authorities, including physicians. He is considered to be one of the most important European authors of the 20th century (Honegger, 2001). *Breath* certainly is inspired by autobiographical elements; however, in a literary sense it is also a work of fiction. Bernhard was no friend of doctors; he is extremely critical of the profession. In many of his other books (e.g. *In the cold* [1981] or *Wittgenstein's nephew* [1987]), psychiatrists and respiratory specialists are heavily criticized. *Breath, a decision* is a mere 60 pages in length. There are neither chapters nor paragraphs, and it takes the reader some time to get used to the rhythm of the writing. However once there, the book reads like a train—albeit a train that appears to be heading 'on a journey towards the end of the night' (cf. *Voyage au bout de la nuit* [*Voyage towards the end of the night*], Céline, 1952, written by a doctor with a similar hatred of bourgeois society).

In the following sections we provide specific quotations (*in italic*) from *Breath, a decision* to provide support for our argument, but also to provide a sense of the directness and clarity of Bernhard's writing style.

> *But it was impossible to speak to them … The doctors on the ward-round never did anything to enlighten their patients in the death ward, and in consequence all three patients were effectively abandoned, both medically and morally.* (p. 241)

Breath, a decision is about the sojourn of an 18-year-old Thomas Bernhard in a hospital and a sanatorium. It describes the days before his admission, the admission itself, his stay in the room where the dead are laid out, the death of his grandfather in the very same hospital during his admission, his recovery, discharge from hospital and the beginning of his stay in the sanatorium. The patient-author diagnoses himself with 'wet pleurisy'. When he starts to show signs of recovery, his mother dies—mainly due to poor medical care, according to Bernhard. He is then diagnosed with tuberculosis. The medical insurers send him a 'certificate of admission to Grafenhof Sanatorium' (in German, 'Grafen' means graves) where he begins his journey towards his next illness-episode in the next medical institution.

In his later novel, *In the cold*, Bernhard (1981) subsequently documents his stay in the Grafenhof, where he was treated for tuberculosis. He was discharged from the hospital in a reasonable condition but continued to have respiratory problems for the remainder of his life, dying in 1989, aged 58 years, possibly partly due to Besnier-Boeck syndrome (sarcoidosis; a respiratory disorder) (Höller, 1993).

Much research has been undertaken on how patients cope with a chronic illness, as well as how

patients' coping influences the course of their illness, and how doctors can influence this coping for the best possible outcome. In patients with chronic obstructive pulmonary disease (COPD), for example, anxiety, depression and shame have been shown to be common responses to the diagnosis of COPD. A poor prognosis is associated with above average levels of anxiety, depression and shame. Medical care that promotes better (= more active, more assertive) coping with illness is associated with shorter admissions, fewer complications and a better quality of life for the patient. Therefore, doctors who incorporate good medical care with good psychosocial care help to ensure the optimal course of the respiratory illness (Kaptein & Rabe, 2007).

Respiratory rehabilitation programmes and patient information attempt to teach patients how best to cope with their COPD, as do doctors, respiratory nurses, physiotherapists, ex-patients and sometimes the patients' partners. These programmes appear to be relatively effective in achieving their goal. The role of the doctor is to help the patient take responsibility for his/her future (illness) behaviour (as far as possible). Thus, an attempt is made to incorporate the chronic illness into the patient's daily life in a way that minimizes limitations to their daily activities and limits the impact of the illness. This all requires what American researchers call 'collaborative care' or shared care (Bodenheimer, Lorig, Holman, & Grumbach, 2002). The doctor no longer takes the leading role and instead teaches the patient to manage their illness. Such care is dependent upon the doctor–patient relationship. However, Bernhard describes almost the opposite of this relationship in his novel: '*From the doctors I could learn virtually nothing, and the sisters were incorruptibly taciturn*' (p. 243).

Models of communication between doctors and patients have been well investigated in medical psychology and medicine (e.g. de Haes, 2006; Emanuel & Emanuel, 1992). Emanuel and Emanuel describe four different models of the doctor–patient relationship, and these provide a useful framework in which to order and analyse the experiences of Bernhard as a patient in *Breath*.

1. *The paternalistic model*. Here the doctor determines what the patient needs, in both a diagnostic and therapeutic sense. The doctor is dominant and authoritative, while the patient is (expected to be) passive and agreeable. This model appears to work well in the case of acute, serious illnesses: in the Accident and Emergency department a great amount of deliberation is unnecessary for the seriously ill patient when, for example, the appendix is rupturing. However for people who have a chronic illness the use of this approach can be irritating, especially among outspoken patients (such as Bernhard) who think that they know at least as well as the doctors how they should manage their illness.
2. *The informative model*. Here the doctor provides the patient with all the relevant information about their symptoms, illness and treatment. The patient has the freedom to choose a course of action, and the doctor carries out the patients' wishes. Here, the patient lacks knowledge, and the doctor provides that knowledge. The patient is the boss; the doctor is the competent technical expert.
3. *The interpretative model*. In this model the doctor helps the patient to clarify what the patient wants from his/her medical care. The doctor is a kind of guide who stimulates the patient and helps them discover what they may want or need. This results in the patient making decisions regarding their illness and treatment. Here, the doctor is an adviser or supervisor.
4. *The deliberative model*. Here the patient and doctor discuss the role that beliefs play in making choices with regards to health and illness. The doctor helps the patient to come to a decision, almost as a friend as well as a doctor.

The four models can be conceptualized as ranging from 'doctor as dominant' to 'patient as dominant'. They can also be conceptualized as ranging from 'acute' to 'chronic' care. Although Bernhard faced both acute and chronic illness, the model he describes is clearly paternalistic, problematic, and causes conflict: '*Every day they appeared in front of my bed, a white wall of unconcern in which no trace of humanity was discernible*' (p. 240).

Bernhard is admitted to hospital with tuberculosis, which he attributes to carrying sacks of potatoes in a snowstorm from a wagon to the grocery store where he worked. Almost immediately after admission, he undergoes a procedure to remove fluid from his chest. The patient/author is able to describe clearly the journey he took through this unknown hospital to the treatment room where this procedure took place; a description that is amazingly fast paced and detailed. The patient is too acutely ill to be able to experience the situation according to any other model than the paternalistic model. As if in a dream, in a state of reduced consciousness that occurs with

many serious illnesses, the patient undergoes invasive medical treatments as a passive object (which he attributes to medication): '*I had resigned myself to everything—they could have done whatever they liked with me. As a result of the medication I had been given I no longer had any will-power*' (p. 220).

The patient succumbs to the medical diagnosis and treatment, the doctor determines what needs to happen, the patient is too ill to be involved in the medical care. In spite of this however, Bernhard still manages to sketch an image of the doctor: '*But for a very long time I had the impression that I had been deposited in an outpatient ward and forgotten: I thought no one was concerned about me, since everybody walked past*' (p. 219).

The patient gradually conforms to the routine in the hospital but verbally protests against the regime: 'the disaster machine of hospital life' (p. 263), 'this *hell*' (p. 237, emphasis in original) and the chilliness (of the place). These are signs in Bernhard that he is recovering and heading towards a healthier phase in which he can stand up for his own wishes (more consistent with models 2, 3 and 4 above). He continues to observe the doctors and the nurses, during the ward-rounds:

> *The ward-round had always struck me as little more than a preliminary inspection of the dead. It took place daily at about half past ten or eleven, more or less in silence. The doctors no longer used any of their medical skills on the patients, because from their point of view they were virtually dead already and clearly of no further interest to them. Everything about the doctors betokened a total passivity in the face of all-prevailing death, a passivity which had become engrained and was little more than a cold routine parading through the ward every day in a posse of white coats. My impression was that they no longer had anything to do with these lost human beings in their iron beds, who as far as they were concerned were already dead but for me still existed—and existed, moreover in the most pitiful manner, in the most distressing and degrading circumstances. … During this progress the sisters probably had nothing on their minds but the problems of space. It seemed as though they were simply waiting for beds to be vacated. Their faces were as hardened as their hands, betraying not the least trace of feeling*. (p. 239)

In Bernhard's book there are no illustrations of the informative, interpretative or deliberative models of care between health professionals and patients. The paternalistic model is the only one that is drawn on, and Bernhard remains angry at the doctors and nurses throughout his entire stay at the hospital. At the end of the book he writes that the doctors suspect him to have been exposed to the tuberculosis due to his own idiocy and indifference, and that this was the reason he caught the infection. The disdain and hatred towards doctors is formed: '*I was never able to make any real contact with them, any attempt in this direction being immediately rebuffed*' (p. 240).

Other conceptualizations of doctors are offered in other novels. In *Der Zauberberg* [*The magic mountain*] by Mann (1979), doctors are presented in quite a different manner to those in *Breath, a decision*. The patients are also different, despite the fact that tuberculosis is the shared diagnosis of the patients in both sanatoriums and books. Social circumstances are perhaps the most important determinants of these differences. Bernhard stayed in a hospital for working class patients directly after the Second World War, whereas Hans Castorp, the protagonist in *The magic mountain*, stayed in a splendid sanatorium for patients of much wealthier backgrounds (Der Schatzalp, now a five-star hotel) in the then already posh Davos (Gesler, 2000).

The history of the sanatoriums and hospitals for patients who suffered from tuberculosis is fascinating in itself (Murken, 1982; Pohland, 1984). Sanatoriums for tuberculosis patients were also set up in North America. Around 1900 there was a hospital built in the fresh air of the Rocky Mountains, Denver, Colorado, where people with long term tuberculosis were treated. Just as in Denver, Davos is also situated a 'mile high'. Once combating tuberculosis became relatively efficient, tuberculosis was replaced by asthma as the reason for long duration hospital admissions in both locations (van der Schoot & Kaptein, 1990). In both locations psychologists researched the determinants of hospital stay, re-admission and quality of life (Staudenmayer & Lefkowitz, 1981).

The research-group in Denver demonstrated that respiratory specialists' 'sensitivity for the emotions of the patient being treated' affects the health outcomes of the patients (Staudenmayer & Lefkowitz, 1981). Insensitive doctors determined the type and dose of medication based on the objective test results of the patient, usually lung function: '*Again and again he was confronted with the inhumanity of the medical profession and rebuffed by its overwhelming self-importance, its positively perverted need to impress*' (p. 240). Sensitive doctors, however, appeared to be less concerned with the objective data when it came to prescribing medication. These doctors were more concerned with the level of anxiety and worry the patient displayed during ward-rounds when the

doctors were prescribing medication. Surprisingly, the patients of these sensitive doctors improved to a greater extent compared to patients treated by doctors who had based their medication decisions on objective criteria. This phenomenon remains a focus of modern research in medical psychology (e.g. Petrie, Cameron, Ellis, Buick, & Weinman, 2002).

Bernhard's literary work has been extensively analysed in the past decade. In the medical world, many feel wronged by Bernhard's characterization of doctors and nurses (e.g. Amm, 1996, a physician herself: 'disqualification of physicians' p. 478). In literary circles, scholars have emphasized how Bernhard, in his work about illness, uses a biopsychosocial model to make sense of the illness in his life (e.g. Mittermayer, 1985). In health psychology, this example demonstrates that it is feasible and potentially fruitful to apply a theoretical model from the area of patient–physician communication to a novel about physical illness.

Novels can assist in exploring and understanding psychological and/or health-related concepts

Novels can be used as a source of data to explore how we understand and make sense of a particular illness, psychological construct or health-related behaviour. In Bernhard's writings, therefore, as outlined in the previous section, we gain understanding into the processes of hospitalization and 'becoming a patient'. We also learn about the reality of living with a serious respiratory disorder that disrupts normal life. Marshall (2006) has argued that literature can show us our cultural perceptions of particular realities, which is important in the context of illness and disease given that these are particularly ambiguous realities.

In another sphere, Nilsson, Lindström and Nåden (2006) were interested in the phenomenon of loneliness, particularly because it has health correlates and consequences. To explore and gain further insight into this concept, these researchers examined how various forms of literature (scientific research articles and books) have treated the phenomenon of loneliness, as well as how it is discussed in research articles in nursing and caring science, psychology and psychiatry. They concluded that:

> Through the survey of the theoretical material, loneliness may be understood as a structural dimension of existence and not as an illness. The deep dimension of loneliness, however, can entail suffering that is possibly so intolerable that it may turn towards becoming an illness … loneliness can ... be turned into suffering as well as into health. (p. 93)

We would argue that this study could be extended further to explore how novels have treated the phenomenon of loneliness, and such an analysis could provide a powerful and more complex insight into this phenomenon, particularly as it relates to health, illness and medicine.

Novels can be employed as a means of impacting on the health and behaviour of readers

Surprisingly very little research has examined how the act of reading novels can have an effect on behaviours that are related to health. One study investigated how women's reading of romance novels influenced their attitudes towards condoms (negatively) and reduced intention to use condoms in the future (Diekman, McDonald, & Gardner, 2000). In this research an experimental study was also conducted, in which safe sex elements were included in romance stories. This increased participants' positive attitudes towards condoms. The researchers argue that 'fiction's narrative form and its ability to transport the reader into a vivid and involving fictional world are powerful persuasive tools in and of themselves' (2000, p. 180). Indeed, previous research shows that the more people feel 'transported' by their reading, the more likely they are to be persuaded by it (Green & Brock, 1996). Even when stories are fictional, novels help readers to form beliefs and expectations around their reading (Diekman et al., 2000), suggesting that fiction may be an influential mechanism for change currently overlooked by health psychologists.

In a powerful recent article, Ngoshi and Pasi (2007) have argued that incorporating fiction about HIV/AIDS into Zimbabwean schools would be an effective and important way to help young children cope with the realities of this disease. The HIV/AIDS pandemic in Sub-Saharan Africa is such that it is not possible to quantify or describe the extent of suffering it causes in Zimbabwe, and it is particularly devastating for women's and children's health and welfare. While there are school programmes in place that provide education about HIV/AIDS to schoolchildren (produced by the Ministry of Education in Zimbabwe in conjunction with UNICEF), these are fact-based and aim to develop knowledge, attitudes and emotional support. They are also focused more on preventative behaviour than the human experience dimension of HIV/AIDS. The authors argue that exploring the human dimension is crucial for any holistic intervention for it to help

children 'combat the pain, the stigma and the discrimination and develop the courage to live positively with the harsh realities of the disease' (Ngoshi & Pasi, 2007, p. 245). They continue on to say that this could be achieved through the use of fictional literature and creative texts, and indeed identify three such texts that would be extremely beneficial. These texts are fictional and semi-autobiographical, are situated in Zimbabwe and articulate intimate human experiences of HIV/AIDS in ways that also tackle the silence and culture of denial surrounding this disease. The key argument developed is that literature is a potentially creative approach to social change 'by reorienting widespread fear, denial and misconception about the disease' (2007, p. 248). Literature is a powerful way for children to learn and make sense of their communities and their worlds (Ngoshi & Pasi, 2007).

Taking this idea a step further, novels could be written by psychologists as a way of having an impact on people's lives. In a recent article Moreno (2006, p. 210) has argued that more psychologists should write fiction to make a difference in people's lives:

> Exacting change in patients, students, supervisees, and other parties need not be limited to the classroom, consulting room, self-help books, or psychological texts. Authors may also educate and impact others through fiction. Specifically, the literary or commercial novel affords psychologists the opportunity to enlighten, empower, or otherwise touch the lives of those not normally privy to our expertise.

Health psychologists could use such an approach for numerous areas of health behaviours. As with Ngoshi and Pasi's (2007) argument, such writing may be particularly relevant and useful for children and young people, but would certainly not be limited to these groups.

Novels can teach us and our students that objective, scientific rationality is not the only way to gain knowledge about health, illness and caregiving

Knowledge about health, illness, disability, sickness and so on can be gained through novels and other artistic forms. These are said to be expressive forms of research, which 'seek to expand understanding, present subtle ideas that might even be paradoxical or dialectic, and lend themselves to the study of that which is difficult to reduce' (Furman, 2006, p. 561). On the other hand, objective, scientific knowledge is obtained by reducing information down to numerical data, and important contextual meanings and experiences are stripped away (Furman, 2006; Willis, 2002). Knowledge that is derived from research exploring and examining sources of fiction, novels, autobiographies and so on illuminates experience, and can complement knowledge that is derived from research that is based within a scientific, empirical paradigm (Hawkins & McEntyre, 2000).

Wear (2000) provides an insightful account of how the arts may teach (medical) students that ways of gaining knowledge other than the objective, scientific way may be more useful for particular things, particular areas and in particular contexts. As she succinctly outlines:

> Students, then, look by default to scientific domains as the only keys to unlock the secrets of the body—how it works, how it is maintained, how it breaks down, and how it is fixed (the mechanical metaphor is deliberate)—and to explain their patients' responses to illness. This idolatry of science and monogamous love affair with its methods are pernicious, leaking into areas of medicine for which understandings and appreciations may be far better served through other domains of knowledge, other ways to inquire, and other sources of understanding in which context, provisionality, subjectivity, and narrative figure prominently and in which the lived experiences of illness are addressed and illuminated in all their rich complexities. (2006, p. 281).

While Wear focuses on medical students, her arguments are easily translated to psychology students. She argues that students' thinking does not move beyond simple dualisms, and qualitative data and research are positioned as in opposition to quantitative data and research; just in the same way that art is positioned in opposition to science, and subjectivity positioned in opposition to objectivity. However, subjectivity (and art, it can be argued) has much to do with the experience of illness, even though subjectivity is viewed as having 'no place in the making of scientific knowledge' (Wear, 2000, p. 279). Wear draws on Gadamer (1996) to argue that subjective knowledge is knowledge that science cannot ignore.

In the field of social epidemiology, Kawachi and Howden Chapman (2004) have presented a strong case for the use of literature. They chart five American novelists from across two decades (1885–1905; Henry James, William Dean Howells, Frank Norris, Theodore Dreiser and Edith Wharton) and highlight how their classic novels can teach us a wealth of information and knowledge regarding the links between wealth and power, inequality and corruption, poverty and illness.

Indeed, these researchers state that 'a student of social epidemiology will profit as much from a close reading of these classics as consulting a half dozen textbooks on social stratification' (2004, p. 738). This article raises questions for us: which are the classic novels for health psychology? Which would we choose to recommend to our students, to provide them with a wealth of knowledge about people's choices in everyday behaviour, their experiences of illness, the taken-for-grantedness of health, the process of becoming a patient? Disease and illness are never just physical phenomena, they are also and always social, psychic and spiritual, and utterly human (von Engelhardt, 2004). Selected classic novels can teach us this in a much more engaging and resonant manner than any number of scientific research articles (e.g. Posen, 2005).

Conclusions

In this article we explored ways in which health psychology may be informed by novels, but the same arguments can be applied to various forms of cultural expression, including operas, poems and plays. We illustrated how these forms may impact on: (a) understanding patients' behaviour; (b) exploring psychological and/or health-related concepts; (c) the health and behaviour of readers; and (d) teaching the value of diverse forms of knowledge gathering when learning about health, illness and caregiving. Our exploration illustrates the many opportunities that the area of literature (or more broadly, human artistic endeavours) and medicine offers researchers and teachers in a (health) psychology setting.

Health psychology journals are usually strong on theoretical models (although not necessarily theory per se). We maintain that this may imply a weakness at the same time, in that the ecological validity of the articles in these journals may be questionable. Close reading of *Breath, a decision* will teach a student of clinical health psychology as much about compliance or self-management as consulting textbooks on clinical health psychology (cf. Kawachi & Howden Chapman, 2004, on reading novels about poverty and socio-economic status and health).

Pennebaker (1997) and Smyth, Stone, Hurewitz and Kaell (1999) present empirical data on the beneficial effects of expressive writing on quality of life in patients with various chronic somatic conditions. Theories on symptom perception, psychoneuroimmunology and self-management may be helpful in doing further research into the area of literature and medicine. Novels, poems and even operas may be new and exciting sources of data in this respect (Jones, 2006). Combining various areas of theory and research may be instrumental in helping patients with chronic somatic (and psychiatric) illnesses: many breakthroughs in science were helped by combining theories and methods from widely divergent fields. It is exciting to see whether combining theories and methods from literary science, (health) psychology and art, will produce knowledge that is fascinating in itself, and that may be helpful in patient care.

In the first section of this article, a novel by Bernhard was employed to illustrate aspects of an influential model on patient–physician interaction, and was useful for this purpose. However, there may be other novels that could be employed to illustrate the limitations of this influential patient–physician interaction model—novels that may be able to inform health psychologists that such models might need expanding, or even rejecting outright (conceivably for specific marginal groups, or in specific local, cultural contexts, such as in poverty stricken countries where simply seeing a doctor is a privilege). Identifying such novels would be an excellent way to develop further work in this area, and would inform future research.

As it stands, the suggestions provided in this article regarding the use of novels in health psychology research and teaching have not been especially challenging of health psychology theories, models or knowledge. Indeed, our examples assume that mainstream health psychology knowledge (and the way it is derived) is straightforward and unproblematic, providing us with 'truth' and 'facts' about health, illness and disease. However, our meanings and our understandings of these concepts stem from our social and cultural worlds, and people who experience different social and cultural worlds (from the mainstream) have different meanings and understandings of health, illness and disease and the medical world (Lyons and Chamberlain, 2006). Novels are one medium that could demonstrate these differences in forceful and immediate ways. Novels offer vast potential for exploring the ways in which health, illness and specific behaviours are understood by groups outside of the (adult, white, western) mainstream, such as people from ethnic minorities; indigenous populations; people who are gay, lesbian, bisexual and/or transgendered; people with disabilities; children; people living in poverty and people from lower socio-economic groups. For example, in New Zealand, a novel may forcefully show how a Māori protagonist struggles to think about health, illness and disease in the dominant Pakeha, western way, without consideration of

Whanau (family) or Wairua (spirit) (see Durie, 1998). These are important issues for health psychology, and novels have huge potential to help to broaden its individualistic focus, to challenge mainstream views and to question theories and assumptions. While not the focus of the present article (and it would take another article to argue these views fully), we do call upon others to develop such ideas further in the future.

In conclusion, Bolton (2005) has noted that in medicine, and in health care, there is a large and increasing gap between what gets measured and what actually matters. We need to be wary, as health psychologists, of falling into the same trap. This wariness would involve engagement with alternative forms of knowing, and new ways of teaching and training. Novels and other creative endeavours offer potentially rich sources of knowledge, empowerment and enlightenment, and their use in health psychology could be invaluable.

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