

“Uncanny Rounds”

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What does it mean to say something is uncanny? In Freud's view, the uncanny involves the familiar becoming strange. Sitting in an ordinary place where one is apparently safe – such as a cozy house -- one feels exposed to inexplicable terror, about to witness the appearance of things felt to be "too terrible to bring fully to light."ⁱ The uncanny is something which ought to have remained hidden but has come to light. In this essay, I will describe the intrusion of things felt to be "too terrible to bring fully to light" in the context of racial and class distancing in a medical setting. Here, the work of repression and distancing happens not only in the psyche but also– hidden in plain sight – in observable social interactions.

I will compare two incidents I observed in a major East Coast teaching hospital, in clinical Rounds for affective disorders.ⁱⁱ Rounds provides a kind of living classroom for small groups of medical students and doctors interested in affective disorders like depression and bipolar disorder. In Rounds, a patient is interviewed and asked questions by a small group of medical researchers and students. Bear in mind that these events are part of the normal activity of a large teaching hospital, and that they are usually attended by doctors, medical students and medical residents. The patients have all been admitted as inpatients on one ward or another.

In the first incident, a resident presented the case as usual, before the patient came

in.

Mr. Anderson is an economics professor at a university in a nearby state. He is Bipolar I, not presently controlled by medication [because the lithium he was taking affected his kidneys. He was sexually inappropriate with students at a party while drinking, and experienced a general decrease of his social inhibitions He has tried Depakote, Neurontin, Seroquel, and Tegretol.

His teaching became poor, he was nasty in class and pushed at the desk in anger, which students found intimidating. He would break into song in the middle of lecturing (and he teaches one of the core courses). There were student complaints. As of this January, he was relieved of his teaching duties. He is a renowned economist, and he has written textbooks. When he was up, he experienced higher spending than usual, low impulsivity, irritability, and pressured speech. When he was down, he needed increased sleep and he experienced anhedonia [the absence of pleasure from activities that usually do bring pleasure]. The cycles were every 4-5 months to hourly.

Mr. Anderson came in looking drawn and grey, with a shaggy beard. Wearing a casual plaid shirt, jeans, and a cardigan, he walked with a shambling, erratic gait and jerky limbs. A senior physician conducted the interview.

[how are you today?]

I am where I want to be – I am getting better so I can function in a productive way. I went off lithium in 1996. Since then, things have been erratic, I have had trouble sleeping, I've been waking early and feeling irritable, talking fast, with

slurred speech; I've been making mistakes, getting mixed up at the blackboard, but I have great energy and I think I am superman. I am committing myself to grand research projects and big research problems.

My department upgraded the curriculum, and this put my courses out of date. My math is not good enough to handle the newer techniques, and this causes me great anxiety. One of the students complained I put a question on the exam I myself had not been able to answer during class, but I thought that was OK, that students should figure things out for themselves. This happened when I was manic. When I am depressed, I sleep a lot, and come to class unprepared. I talk slowly and I don't meet my duties.

[Do you feel normal?]

No, not since stopping the lithium. Since being off the lithium, I would say I have been more manic.

[Do you have any delusions?]

That I am competent to do what I can't, to work with mathematical models I don't have training for. I put articles on the syllabus I don't understand.

[This is not a delusion, but overconfidence.]

When I got the letter from the department saying I was out of the classroom. I had lost my job, and was really down.

[Dr. Dean: Do you experience rapid cycling?]

[Mr. Anderson describes in some detail the variation in the lengths of his moods.]

[Dr. Dean: Do you go through a normal state there for a minute in between?]

That would be the smallest time, and it is the only time I feel normal.

[Can you bring the moods on? Can you change your mood?]

Mr. Anderson launched into a long and involved but coherent narrative about his experiences working in industry and his decision to move to academia. Dr. Dean tried unsuccessfully to interrupt him a couple of times. After the interview ended, Dr. Dean turned to the group:

Was this an easy diagnosis to make?

[The first two students he called on hesitated and could offer no answers.]

We need some help for our friends here. How would we describe his speech?

What is pressured speech?

[Student: The person can't get the words out?]

No, it is the opposite, you cannot interrupt. You can't get a word in. He qualifies.

He goes off on tangents, and doesn't answer the question. You could use the word circumlocution if he eventually gets back, but I despaired of him ever getting back several times. Is it a thought disorder? We look at his syntax and semantics. Is the syntax loose, is he distracted? And his semantics -- is he appropriate?

Students had trouble answering these questions, but Dr Dean summed up the consensus that Mr. Anderson did not have thought disorder:

Maybe he is a normal variant. His condition is especially common among professors. This is a grey zone.

[Dr. Jones added: It is not clear-cut. His pattern is not at all uncommon, especially among writers and artists.]

In this case, since several criteria of schizophrenia or schizoaffective disorder were lacking (delusions and thought disorders), the physicians in the room focused on the

diagnosis of bipolar disorder. Since Mr. Anderson had many positive signs of manic depression, the treatment recommended at the end of Rounds was restarting a low dose of lithium, in hopes that the renal problems would not recur. Nonetheless, Mr. Anderson was placed in a “grey zone” between mental illness and mental health, perhaps because the doctors identified with the patient and his brilliant youth, followed by his faltering middle age. His moodiness, his occasional over-reaching of his knowledge, and his travails moving between academia and industry might have been all too familiar. A certain generosity might also have been flowing from Mr. Anderson’s gratitude for the medical treatment he received at this hospital and his open expression of insight into the pathological features of his condition.

In the second incident, a resident again presented the case.

This is a 20-year-old African-American male admitted in the emergency room at Riverside Hospital [pseudonym for a recently built medical complex] with a strong suicidal gesture: he said he wanted to blow off his head with a gun, and he actually did have a gun. . . . Two years ago he was admitted to State College, in the business program. He kept very busy, often staying up until 2 am, during his first year. Now he is home for the summer and has a summer job as an intern at an investment bank, the first job of any substance he has ever had. . .

One week before admission, he had a dose of Angel Dust [PCP]: unknown to him it was in the marijuana he smoked. In college for the first two years he was on the Dean’s list. Then there was a down-turn because he felt his family didn’t visit him and therefore must not love him. After that he only got C’s. He has also been anxious and overactive. . . .

On admission here, I saw someone who was clearly manic. I assessed him as a 20-year-old with underlying illness who had become floridly manic with all these stressors.

Complaining of pain, he was examined and diagnosed with severe testicular torsion, and so he had to have a testicle removed.

Mr. Burton came in, accompanied by his mother and grandmother. As he entered the room, he looked around at all the people sitting there in white coats, and said, "Hello, I am Keith Burton." Sitting down, mother on one side and grandmother on the other, he said, "I'm a 20-year-old college student with a 3.75 GPA and I am not crazy." Without missing a beat, a senior physician began the interview.

[How are you feeling today?]

Great.

[How did it happen that you called 911?]

I loved my family and I missed them in Florida, so I came back north. After I got here, my grandmother kicked me out. She said I was crazy to drop out of college, so I told her next time you speak to me I will be calling from a mental institution.

[Do you remember the question I just asked you?]

I came to Baltimore, saw my friend, and called 911 emergency. They took me to Riverside Hospital where they injected me with three needles, because they said I had to be calmed down, but I was terrified, I didn't know what it was.

[Were you scared?]

No, it was really that I was terrified. I wanted to call my mother, because no one even knew where I was, and I didn't know what the needle was. Now I have

needle marks all over and I don't even shoot drugs. After the 4th needle, I again wanted to call my mother and father, but they wouldn't let me, so I ran. I was terrified. They called security on me, restrained me. But I still got shot.

Now I am back to my old self.

[Is anything not quite back?]

Well, my testicle is gone. But I feel great, great.

[How is your energy?]

Great, I have like an extra little boost.

[What's that like?]

I have more insight now. My mind goes faster than I can articulate it. That Riverside Hospital, I will never go back there again.

[How do you feel about your self?]

Great! My whole self has had a boost. I have a job at the bank, I am going to invest in Phillip Morris, quit my job and just watch my stock rise. I took the job to learn stocks, and I have learned them in a month. The head of the company says just invest in this stock, you will see. Like you were asking me if I remember the question you asked me, of course I remembered it, I just had to start back a little bit so I could make it clear.

[So you are feeling pretty good?]

My future's so bright you gotta wear shades!

[When else do you feel like this?]

When I come home from college to my family. I am so happy to see my mother, grandmother. [He gives them each a hug and a kiss]. . .

The physician asked the mother and grandmother whether he seemed normal.

They said, *he has all this stress on him. He had too much responsibility as a child. With all that he had on his head when he was younger, then he gets to college and it is overload.*

The interview came to a close, and Mr. Burton went around the room on his way out, making eye contact and shaking hands with each one of us.

Dr. Paulson began the discussion: *His speech was tangential and circumstantial. I think he would have gone on and on if I had not redirected.* Turning to the medical students, the senior physician asked, *was he manic?*

[A student: He was overly dramatic, making himself known to us like that.]

[A second student: Also making such a point of kissing his mother and grandmother.]

The doctor: Does he have manic syndrome?

[Another student: He seemed contrived.]

[At this Dr. Jones interjected: He had a gun!!]

Let's see, are there any other students here...how about you?

[I am in occupational health.]

That counts! What do you see? Was he manic?

[I know how he feels, he worries about grades and the rest of college, he is homesick, and with all that stress on him . . .]

No one responded directly to this, so the senior physician stated, "I think he has bipolar disorder."

In striking contrast to Mr. Anderson, Mr. Burton did not end up in an unclear grey zone as a "normal variant," a person whose behavior is typical of creative researchers,

writers, and artists. In Mr. Burton's Rounds, his family wanted recognition of his difficult childhood and the responsibilities he had had to bear early on, his intelligence and success in college, his promising job, and his love for his family. His “craziness” consisted in his leaving college out of stress and homesickness. All these issues are contained to a greater or lesser extent in the resident’s initial presentation, which makes the important point that the medical case history and the patient's narrative do share common ground.

The medical students saw him as overly dramatic, contriving to demonstrate his affection toward his relatives and his collegial status with respect to the doctors. The occupational health student identified with his life as a college student far from home and saw a normal reaction to stress. The doctors looked past these descriptions and saw him as under stress, to be sure, but more importantly, they saw him clearly experiencing by turns suicidal depression and florid mania. Medication, which could be life saving, would be required at all costs. One might say the medical students reacted to him as a peer, competitively; the occupational health student reacted to him as a peer, sympathetically, and the doctors reacted to him as a patient, one who, despite his denials, must be protected from the consequences of his extreme states. The professionalization of the students required, however, that they learned to think of Mr. Burton as a patient with an illness, if doing so would help him.

From the Rounds physicians' point of view, there was agreement that Mr. Burton's case and Mr. Anderson's were distinctly different, the one a clear case of bipolar disorder and the other in a grey area. I would not want to debate the medical wisdom of this distinction, but I do want to turn to some less obvious aspects of Mr. Burton's case that

complicate his clear diagnosis. The term repression comes to mind here, not only in the sense that Freud used it, referring to something internal to the psyche, but also in a social sense, referring to something that is repressed from one social setting in particular. For example, Mr. Burton's testicle – which caused him great pain and had to be surgically removed – was dramatically absent in Rounds. As Mr. Burton says, it was missing: not only from his body but also from the conversation. Since there surely would be other contexts, equally social, where the profound loss of a testicle could be *discussed*, why was it not discussed in Rounds?

To move toward an answer, I turn to Mr. Burton's physical gestures of affection to his mother and grandmother. The doctors and medical students did not see this behavior as evidence of Mr. Burton's ability to function socially. Still less did they see his direct eye contact, firm handshake, and respectful personal greeting as a part of polite behavior for persons of substance in African-American culture. Rather, his behavior clearly made them uncomfortable and provided evidence that Mr. Burton was "overly dramatic." These signs of affection were an intrusion into the effort to describe in medical terms what was wrong with Mr. Burton as an individual. But Mr. Burton broke out of the silence and away from the carefully controlled answers he was supposed to make to questions. A young black man who survived urban crime and drugs was now in college with a job headed for Wall street, his future so bright he had to wear shades. The doctors, all white, might have been experiencing estrangement from his racial identity and his history, but they might also have been experiencing fear of his energy and power. He seemed to contain both too much life and too much death; his presence was disquieting.

Comparing Mr. Anderson and Mr. Burton, there were certainly legitimate medical

reasons for giving Mr. Burton the unambiguous diagnosis of bipolar disorder -- his possession of guns not least among them. But the two cases shared elements too. Both men struggled with mood as well as motivation. For both, motivation soared stratispherically and then faltered when self-doubt and depression struck. For both, mood cycles led to difficulty functioning well. (Recall that Mr. Anderson was relieved of his teaching duties!) In contemporary US culture, when a man with white identity displays mania, he can be seen as a potent force, a creative entrepreneur; when a man with black identity displays mania, he is much more likely to be seen as dangerously out of control. Mr. Anderson can be seen as a successful (white) professor with foibles: his exuberance is overconfidence rather than mania. Mr. Burton can only be seen as a faltering (black) student: his exuberance can only be seen as manic in a disordered and "mentally ill" sense, not in an effective and powerful sense. Mr. Anderson, being white, can be manic, potent, and rational at the same time. The disallowed combination is to be manic, powerful, and black all at once. Returning to Mr. Burton's lost testicle, this literal wound -- no doubt a topic of fear and horror to all the men in the room -- was evidently unspeakable. There is no way of knowing for sure, but it is possible that the silence over this loss, the quintessence of an emasculating loss, came about because this wound lay too close to the other forms of emasculation going on in Rounds at the same time.

Building on Mary Weismantel's analysis of the uncanniness of the "*chola*," the Andean market woman feared by whites as an dark racial other, I turn to the "ghostly" aspects of social processes, things that cannot be acknowledged in conventional social discourse -- they are unspeakable -- but that seethe underneath the surface, haunting social life nonetheless.ⁱⁱⁱ In his analysis of photography, Roland Barthes explores the ghostly

aspects of the photograph. He divides the analysis into two steps. First, by way of the *studium*, the photograph politely educates us about the historically specific scene the photograph depicts.^{iv} Second, by way of the *punctum*, (a Latin word that means "trauma"), we experience the puncturing or breaking of the *studium*. The *punctum* is what "rises from the scene, shoots out of it like an arrow, and pierces." The *punctum* is a wound, a prick, an off center detail that draws us past our polite engagement with the historically interesting *studium* and leads us into frightening territory.^v In an 1863 photo of Queen Victoria, the queen of England is perched on top of an enormous horse. A single groom holding its bridle supervises the horse. Barthes asks: what if the horse began to rear? What would happen to the queen's skirt, i.e. to her majesty! In raising these questions, the *punctum* points to the "blind field" that is never named in the photograph: in reality the queen's authority is tenuous and impermanent.^{vi}

Does the *punctum* help us understand Mr. Burton's case? We could see Keith Burton's lost testicle as a *punctum*, something that points to a "blind field," and that therefore could not be discussed at all in this psychiatric context. This literal wound – no doubt a topic of fear and horror to all the men in the room -- was evidently unspeakable. The uncanniness of the situation lies in the combination of the familiar and the dangerous. What if the uneasy power relationships seething beneath the surface of medical diagnostics were to break forth? What if, so to speak, using the terms of Barthes' example, the horse began to rear?

For one way of understanding where the uncanny comes from, I turn to Harry Stack Sullivan, an early American psychiatrist known for what he called "interpersonal psychiatry." Sullivan's way of expressing the meaning of the uncanny was to tie it to

specific emotional states. These emotional states were related to early infancy and to the loss of the all-embracing "mother" who, in fantasy, could fulfill all the child's needs, but who, in refusing to answer the infant's cry, leaves him with cosmic emptiness.^{vii} In Sullivan's words, what he calls "uncanny emotion" arises later in life in the form of "sudden severe anxiety" -- "chilly crawling sensations, and the like, often meant by the words 'awe,' 'dread,' 'loathing,' and 'horror.'"^{viii} The experience of uncanny emotion warns of an "approach to a threshold." Across this threshold is a "nightmarish personification, [the] Not-Me." "One is always warned against [an approach to this threshold] by uncanny emotion."^{ix} For Sullivan, as for Freud, uncanniness is ". . . the fundamental propensity to become defamiliarized, derealized, as if in a dream."^x This is fear of losing who I am, of facing that it is I who might not be real.

For the Rounds incidents I described – Mr. Anderson and Mr. Burton – I would argue that the force of the uncanny comes from something like Sullivan's Not-Me; from the approach to the threshold of the utterly nightmarish, repressed but powerful Other. In Rounds, the line between Me and Not-Me borrows from an insistence that is now pervasive in Euro-American societies, the insistence that values people on economically "rational" grounds. Neoliberal forms of governance allow legal, economic, and political institutions to deny personhood to certain kinds of people, making them the Not-Me, and to divide people by economic merit, when it suits the relentless upward accumulation of capital. These forms of governance make it possible to imagine Mr. Anderson as a successful and creative professor and Mr. Burton as a failed student and deluded entrepreneur. Such comparative valuations are made on the "rational" grounds that market value determines worth. What ought to have remained hidden but nevertheless

comes to light is the completely "irrational" division of people by race.

One final point. Sullivan's discussion of uncanny emotion includes some ideas about its interactional consequences. He says that one consequence can be a feeling of apathy. It would be interesting to explore situations that give rise to uncanny emotion, which are then followed by apathy. If Sullivan is right about the link between uncanny emotion and feeling apathetic, we might be looking at a mechanism that perpetuates racial discrimination by deadening sentiments that otherwise might link people empathically. Perhaps this is one reason why the Rounds physicians and students did not take up the pain and grief that must have been caused when Mr. Burton lost his testicle.

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ⁱ Weismantel, Cholas and Pishtacos p. 8.

ⁱⁱ I was allowed to be present, occupying the same role as the medical students: I could listen and take notes, and could try to answer if I were called on. For reasons of confidentiality, I could not follow the patients into the ward or beyond.

ⁱⁱⁱ Gordon, Ghostly matters: Haunting and the sociological imagination. I have been greatly helped in this account by Lorna Rhodes' paper "Diagnostic Entanglements," given at the Conference on Medicine, Culture Power, University of Minnesota, 2002. Further descriptions of this setting are in {Martin, 2007, forthcoming #3412}

^{iv} Roland Barthes, Writing Degree Zero (Boston: Beacon Press, 1968) p. 106.

^v Gordon, Ghostly matters: Haunting and the sociological imagination p. 107.

^{vi} p. 107

^{vii} This [uncanny] emotion leads back to the "personification of the Bad Mother of the developmental stage of infancy – an uncanny being of relatively cosmic if rather nebulous proportions, possessed of the nuclear essence of transcendental evil power, against the manifestations of which the infant's magic tool, the cry, had proved of no avail." Harry Stack Sullivan, The fusion of psychiatry and social science, The collected works of Harry Stack Sullivan, Vol. 2, ed. Helen Swick Perry (New York: Norton, 1964) p. 309.

^{viii} Ibid. p. 249.

^{ix} Ibid. p. 309.

^x Vidler, The Architectural Uncanny: Essays in Modern Unhomely.