

CODES AND COPING: A NURSING TRIBUTE TO NORTHROP FRYE

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In this essay I will outline features of Northrop Frye's (1982) work *The Great Code: The Bible and Literature* which are of vital interest to nurses and nursing. It is my belief that nursing as a healing art is ever involved in drama, live performance with real-life actors. Images in combination bring forth birth and death, comedy and tragedy, suffering and sorrow, comfort and joy, and are all conceived and interpreted from within one's heritage or tradition. What Frye does in *The Great Code* is elaborate and illuminate the Western tradition upon which Judeo-Christian society and culture, and healing, adapting, and coping, are based. He brings to consciousness what for most of us remains in the unconscious, hidden, realms of our behaviour, our body language and our speech acts. He exposes the vehicles of meaning we use in the production of our art of nursing. Each practitioner has in common with Shakespeare, Milton, Dante, Blake, etc. (admittedly, along with all our ancestors and everyone alive today) that the reality he creates and participates in, draws from the images of our heritage. Frye shows how the poignant and significant images appearing in literature down through the ages of Western culture are coded (i.e., have their blueprint) in the Bible.

Drawing from Frye, I will advocate a basis for interpretation, one of the fundamental arts in nursing: attending to the actual images that people express in what nurses call coping, to the structure of the meaning implicit in situations and experience (insofar as that is possible) that is, to the codes or symbolic logic of the images, and to the potential transformations or reformulations embodied in the social and political context, which is usually referenced in the images, and which nurses and patients are a part of.

It may be useful to recall here that when Frye began his career in literary criticism, the field was not well developed. There was no agreed nomenclature, there were no ground rules for what constituted the science and art of the discipline. In his polemical introduction to *Anatomy of Criticism*, Frye (1957) makes some distinguishing remarks

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regarding the development of the discipline of literary criticism which have relevance, I believe, for the development of nursing: "There is a place for classification in criticism, as in any other discipline which is more important than an elegant accomplishment of some Mandarin caste. The strong emotional repugnance felt by many critics toward any form of schematization in poetics is again the result of a failure to distinguish criticism as a body of knowledge from the direct experience of literature, where every act is unique, and classification has no place" (p. 29).

I have expressed my own repugnance at the tendency for the schematization inherent in nursing diagnoses (one of the current attempts to establish a discipline with its own nomenclature and discourse) to violate the direct experience of caring for patients (Hagey & McDonough, 1984). So I am here attempting to begin to outline what I believe to be relevant to nursing. In the critique of nursing diagnoses referred to above I tentatively called interpretation, translation, reconstruction of meaning and symbolic action elements of nursing. For the purposes of this paper, I will be referring only to interpretation. I believe interpretation to be a more modest and humanistic approach to the development of discourse in nursing than that of diagnosis, and more compatible with the phenomenon of caring.

Frye has given me the insight that each endeavour in an art is rooted in the Judeo-Christian tradition of the LOGOS or WORD. Frye (1982) points out that in literature, Goethe's Faust divides the Logos into reason and *praxis* or creative act (Note 1). I view nursing (since much of it involves dramatic performance which unfolds in time) as being like the generation of narrative, i.e., a creative putting together of images in action, but not excluding reason and knowledge. The patients receiving nursing services are "readers" of this narrative, which for them, is not just the output of a single nurse but an entire dramatic whole, transcending multiple subscripts. The community of patients and their families and friends form an audience. They find themselves in plays in which they thought they were supposed to be the central characters. A process of communication ensues in which nurses, in turn, interpret the symbols in the environment of characters and audience and behave symbolically to make meaning.

Frye is attempting to outline his field, which he says is a sub-set of cultural history-making needing delimiting from psychology on the one hand, and anthropology in the extended sense on the other. I am attempting to delimit the critical discipline of nursing, which draws from psychology, anthropology and a host of other fields such as

sociology, physiology, socio-linguistics and the therapies of medicine, pharmacy, nutrition and so on. In *The Critical Path*, Frye (1971) sets out a vision of what must be done to develop his field:

Criticism must develop a sense of history within literature to complement the historical criticism that relates literature to its non-literary historical background. Similarly, it must develop its own form of historical overview, on the basis of what is inside literature rather than outside it. Instead of fitting literature into a prefabricated scheme of history, the critic should see literature as a coherent structure, historically conditioned but shaping its own history, responding to, but not determined in its form, by an external historical process. The total body of literature can be studied through its larger structural principles, which I have just described as conventions, genres, and recurring image-groups or archetypes. (p. 24)

I am certainly not the first to suggest that nursing ought to look within itself, to ascertain its own historical overview, to evaluate what is really inside of nursing (Schlotfeldt, 1971; Stevens, 1979). I am responding here to the challenge of contributing to the development of the larger structural principles in what has yet to become the critical discipline of nursing. Again, taking from Frye, I believe it is this critical discipline of nursing which should rightly be thought of as a science. But the *praxis* — reasoned, creative caring, i.e., attending to meaning for the people we serve, — should be conceived of as art.

The production of nursing care is no less the production of images than is the creation of literature. The concretists may say in opposition to this view that nursing is not just dealing with images. It utilizes hardware, harsh medicine, observational tools and management techniques, all of which are real and consequential, in addition to being images. It uses crucial diagnostic categories which must be treated concretely and denotatively. They must be plugged into the appropriate treatment in the same way, say, a cardiac monitor must be plugged into some concrete electrical source.

I would look at it more holistically. All of the concrete paraphernalia and hard facts considered to be the tools of nursing, are laden with images. Furthermore, images are utilized in organized ways which are culturally constituted according to convention. It is the archetypes of cultural meaning and values, so invisible to nurses, which demand the presence or absence of concrete paraphernalia and facts

and which encode the behaviours of each of the actors in the live dramas we participate in. (See Goodenough (1971) for the concept of DNA-like codes in culture and language).

Frye (1982) makes a similar argument in the introduction to *The Great Code*. He suggests, I think, that Biblical scholars and practitioners of Christianity whose primary concern is historical fact and theological consensus, to the exclusion of the significant coded imagery and dramatic structure of the Bible (which has been a formidable resource for generation upon generation) have been misled. They have missed great opportunities for literary insight and understanding of our cultural heritage and the power of particular works of art. I turn now to highlight selections from *The Great Code* which may lead to interpretive insight on the part of nurses regarding the settings we work in and the dramas we are party to. All references to Frye's work are to this 1982 publication, except where otherwise stated.

CONSIDERATIONS ON THE NATURE OF 'LANGAGE'

Taking from Vico, Frye outlines three phases of 'langage', the French idea of the basis for mutual intelligibility in human language development, which have changed from those he set down in *The Anatomy of Criticism*; hieroglyphic, hieratic and demotic. He elaborates upon the three types as being primarily metaphoric, metonymic (in a specific sense) and descriptive, respectively. As to chronology, one sees much metaphoric or poetic writing in the Bible. Here, subject is not separate from object and words have magical powers. When something sacrosanct is said or read on a sacred occasion, words are used as a powerful force (Frye, p. 6). I believe such sacrosanct contexts have not disappeared with advancement of technology. There are many instances in health care settings where words carry a magic — either positive, soothing and healing or despicable and unspeakably devastating — such as when someone is receiving diagnosis or prognosis, or coming to, from unconsciousness or shock. It behooves nursing to investigate the magical power of words and the rituals they are part of. Furthermore, there are many segments of today's world where altered states of consciousness constitute important ways of coping and the ritual use of words and related symbols has been well documented. The medical anthropology literature is replete with examples of this in nonwestern cultures as well as those influenced by Christianity. (Lambek, 1981, and Hagey, 1980, respectively.)

The hieratic or second phase of 'langage' development is exemplified in Plato, where subject and object show separation, where a dialectic emerges, where a separate form of reality (thought) exists

alongside experience (Frye, p. 8). Also, in this phase allegory gains prominence, where there is a metaphorical paralleling twined in with the conceptual prose. Syllogistic reasoning is evident, where conclusions are already contained in the premises; "I think, therefore I am" was distinctive of this phase. Frye points out that this type of language formulation is useful in maintaining authority. It is my observation that much explanation to patients in medical settings is coded in this phase of '*langage*': "Your kidneys seem to want to shut down." "It will heal when it's good and ready to." "You've been under a great deal of stress." (Note 2)

Each of these statements makes use of a sort of personification of causality where the effect is syllogistically related to the culprit with whom the professional has limited personal knowledge, and therefore limited influential ability. What is interesting in the implied relations of such statements is the partial separation of I from thou. There is no signal that nurse and patient are divided and opposed as subject and object. Rather, what may be opposed is one aspect of the patient to another, e.g. his kidneys to his body. Such explanations, frowned on in scientific circles as childish and inaccurate, are perhaps deliberate attempts on the part of practitioners to be of some authority and yet, not to be too distant.

The demotic, or descriptive, third phase of '*langage*' according to Frye appears in English literature with Francis Bacon and John Locke. Subject and object are clearly separated. Frye says, "Hence this approach treats language as primarily descriptive of an objective natural order. The ideal to be achieved by words is framed on the model of truth by correspondence. A verbal structure is set up beside what it describes, and is called 'true' if it seems to provide a satisfactory correspondence to it" (p. 13). It is to this model of parallel accuracy between the description of the observer and what is observed that schools of nursing aspire. Here the nurse and the patient are completely separated as subject and object. The nurse is the one to diagnose objectively clinical entities observed in the patient. The crusade in the nursing diagnosis movement is to be able to produce a descriptive set of nomenclatures which accurately represent the realities any clinician might encounter, from constipation to poor coping strategies. (See the list of nursing diagnoses used at the University of Toronto, Faculty of Nursing, developed by Jones and Jakob, 1982.)

Frye points out that this third phase is now being superseded since Einstein has shown that matter ("the great bastion of the objectivity of the world") is an illusion of energy (p. 14), and "we seem now to be confronted once again with an energy common to subject and object which can be expressed verbally, only through some form of

metaphor" (p. 15). Already, nurses are joining linguistic philosophers in studying the implications of the metaphoric basis of language expression which may bring forth the new fourth phase. (See, for example, my study, 1984, on metaphors surrounding diabetes where I use the framework of Lakoff and Johnson, 1980, who hold that language, indeed our entire conceptual system, is metaphorically constructed.)

MYTH AS THE ORGANIZING PRINCIPLE OF CULTURAL MEANING

For Frye the word myth does not have the popular connotation of falsehood. It means for him "first of all, mythos, plot, narrative, or in general the sequential ordering of words" (p. 31). There is a secondary sense too in which he uses the term: "It means being charged with special seriousness or importance. Sacred stories illustrate a specific social concern" (p. 33); thirdly, "A myth takes its place in mythology [as] an interconnected group of myths" (p. 33). Chronologically, Frye sees myths as evolving in pre-discursive phases of society and "what follows is that mythical structures continue to give shape to the metaphors and rhetoric of later types of structure" (p. 35). So, for example, the Exodus myth in the Bible which narrates the deliverance of Israel from Egypt was used by American Negroes to appeal to Christians in the cause of overriding slavery. Frye quotes the well-known southern spiritual as evidence:

Go down, Moses,
Way down in Egypt land
Tell old Pharaoh
Let my people go. (p. 49)

Frye suggests that mythology "is a powerful instrument of social authority and coercion, and is accordingly used as such . . . Marxism makes a similar appeal today as a unifying instrument of authority" (p. 51). For Frye, Marxist ideology is founded on the Exodus myth. The Bible itself is a set of myths whose overall structure is deliverance.

It therefore provides underlying (structural) meaning to so many specialities in health care: the medical model, the problem solving approach, the helping process, self-help and self-care; all are constructs intended to effect "deliverance" in the sense of coming through, perhaps even prevailing or surviving. Any useful comparison of these models would not be complete without consideration of their mythic origins. Leaving aside that immense undertaking, I will only note the contrast of the word "deliverance" with the word "delivery" which is used in the literature of the health professions as denoting action of the persons trading a service — bringing it to a client, thus taking the credit for any "deliverance" which may result.

METAPHORS AS VEHICLES OF MEANING CONSTRUCTION

Frye claims that "metaphor is, not an incidental ornament of Biblical language, but one of its controlling modes of thought" (p. 54). He even argues that "spiritually" (pneumatikos) in the Bible, continually means metaphorically; that Christianity as an experience can not rely on metaphoric expression (p. 56). Frye argues that myth and metaphors are the true literal basis of narrative of the Bible whose purpose by its own account is revelation to effect deliverance. Many codes for our belief and behaviour and for drama in literature are contained in the Biblical metaphors and the myths which organize them.

Let me give you an example of Biblical metaphors structuring the meaning of drama in a health care setting. A prominent medical centre in a major Canadian city conducted an assessment program for patients with chronic health problems and nurses were actively involved. The assumption was that this population of patients was "out there coping" one way or another and it would be prudent to conduct research to develop an appropriate taxonomy which could be used to describe the problems they have and evolve some sort of assessment tool which could be used to evaluate and measure the efficacy and cost of the services used to maintain them. For this research then, the patient informant had to be verbally competent. The case I am about to present involves a patient who was eliminated from the study as "verbally incompetent." However no eliminations were made until after each patient had been admitted to the hospital and had undergone a complete physical assessment.

The patient in question was an elderly woman. It was never ascertained why she agreed to cooperate in the study or what she had hoped to get out of it. The following is an account (in paraphrase) of her reactions after the admission procedure, told to rationalize why she was classified as verbally incompetent:

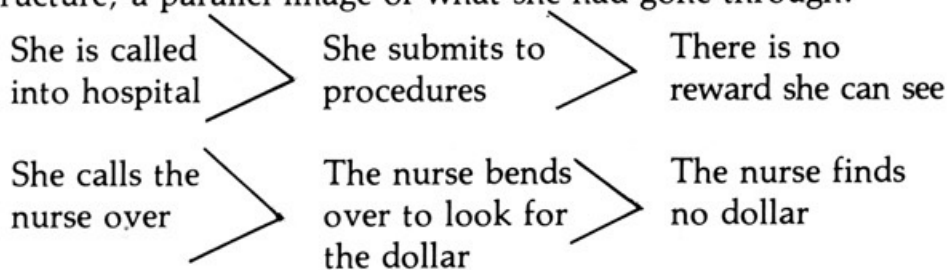
She was in a large open ward and even the other patients recognized that she was "out to lunch." She was sitting off by herself in her chair and she would call over nurses who entered, and direct them to pick a dollar up off the floor. When they got over there they found there was no dollar on the floor.

Remember that this woman had agreed to be in a study interested in finding out about how people cope with their chronic health problems. Note that the woman would be classified by a linguist as verbally competent. Her grammar was acceptable, her vocabulary was adequate. Note that the real reason, i.e., "she was out to lunch" was a category taken from folk culture, that is, it was said to be validated by

the other patients. If we attempt to understand rather than dismiss the drama displayed by this woman, we shall see a bit of Biblical logic, an old cultural code. The dramatic expression of this woman in my opinion is the manifestation of her vitality, her aliveness, her will for social communion. When it ceases she will be culturally dead and physical death will follow. Disaffection from one's culture is a main cause of death. (See for example, Turnbull's, 1961, *Forest People* for an account of how cultural breakdown leads to doom for entire populations.)

The analysis of the drama described above illuminates three principles: (a) dramatic communication is a mirroring of images, (b) dramatic sequences always reveal power hierarchies and political relationships, and (c) dramatic forms have their precursors or blueprints or codes to give them significance.

To illustrate the first principle, that dramatic communication is a mirroring of images, it can be seen that this woman gave some of herself by submitting to examination and admission to hospital (she did not come to hospital because she was ill) and she had reason to be disappointed, as there was no apparent reward as might have been expected for her participation. The drama that she expresses duplicates a structure, a parallel image of what she had gone through:

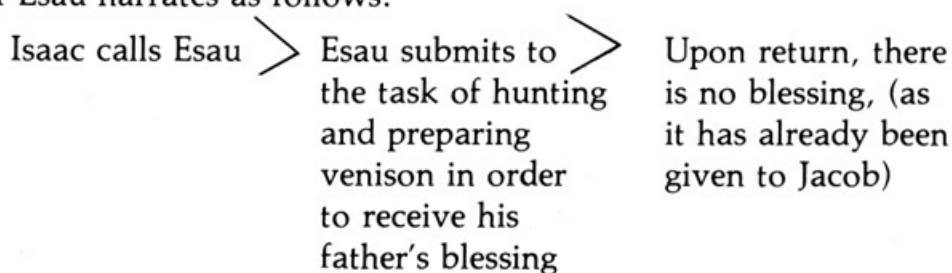


To examine the second principle, that dramatic sequences reveal hierarchies and political relationships, it can be seen that the dramatic display is a way for this woman to duplicate or have equivalent power of those who called her into the hospital. Practitioners interested in reality orientation might have hypothesized that this client had a drastic feeling of lack of power leading her to resort to such an appeal. It is ironic that her appeal itself was the very clue precipitating the decision that she was not a valid source of information about problems people have in chronic illness — such as feelings of powerlessness.

To illustrate the third principle, that dramatic forms are coded in culture, I will reference a Biblical code which has a similar structure. Frye points out that the Bible's "approach to victim figures tends to be ironic only" (p. 181) in that it avoids the Greek conception of the larger-than-life hero. (This approach encodes my perception above of irony in this woman's case.) Frye suggests that the underlying mythic

structure for such themes can be found with the following figures: “in Cain’s bewilderment at the non-acceptance of his (so far) bloodless sacrifice; in Ishmael’s near-starvation with his mother in the desert, and his father’s lament: ‘O that Ishmael might live before thee!’ (Genesis 17:18); in Esau’s bitter cry when he discovers how callously he has been cheated: ‘Bless me, even me also, O my father’ (Genesis 27:34)” (p. 181).

Taking the latter example, it becomes plausible to consider that this woman may have been feeling betrayal even as Esau did when Isaac blessed Jacob instead of him. Parallel to the structure above, the story of Esau narrates as follows:



Hence, the dramatic expression by the woman who was admitted for assessment of her chronic illness, is parallel to that of the Biblical account of Esau, although some might discount it because the woman played the part of Isaac in calling the nurses over to get a dollar. The neo-Freudian structuralist, Jacques Lacan, would not discount this. He would argue, I believe, that, indeed, it is through such interchangeability of roles in dramatic structures that family patterns are reduplicated one generation after another. Further, it is his contention that the kinship paradigm is one of the central most important meaning codes in all of culture, to which most other meaning structures are linked (Lacan, Note 3). That is, it does matter whether the woman in the example above had any siblings, the betrayal she felt in her chronic illness and the powerlessness it has caused her, are akin to the jealousy and anger felt by Esau when Jacob got his father’s blessing but he did not and when, furthermore, he had to live as a slave unto Jacob. To put it another way, the chronic illness stands in relationship to this woman (metaphorically) as Jacob stood to Esau. It is depriving her of her birthright (to live a normal, healthy, long life) and she is a servant to her illness, if not a slave.

Another example (this one almost too obvious to be stated) of metaphor actively structuring reality in health care settings, is the notion of hell which Frye says is “a hopelessly mixed metaphor meaning (a) the human life created by human evil, (b) the world of eternal death which is the abyss or deep of nothingness, (c) a world of externally applied torture going on endlessly in time. This last aspect proved to be a very powerful political lever: as a friend of mine once remarked, good news will not sell in a mass market until it is perverted into bad news” (pp. 73-74).

Correspondingly: (a) every practitioner can identify the turmoil of blame confided by patients who associate their plight with human evil, in themselves, in others or both; (b) each of us has known patients who have experienced a sort of eternal death, an empty suffering; (c) all of us can recognize, as well, the image of risk we inject into our explanations to motivate patients toward compliance or adherence with regimens. Like mass market advertising, effective health teaching is really embedded in some ideology which implies risk in not changing behaviours or not learning some healthy technique. (See Hagey & Buller, 1983, for a contrast of the Christian notion of hell with the Ojibway idea of out-of-balance and Hagey, 1984, for a comparison of Ojibway and professional risk ideologies.)

TYPOLOGY AS FORM IN EVOLVING MEANING CATEGORIES

I have already indicated the view of constant "structures" prevailing through the ages in myth and metaphor as put forth by Frye. Here I am going to qualify that, because he also implies there is a change and change occurs in a particular way which provides for increments of significance being added to the cultural legacy. Each symbol changes when an antitype of it emerges. Frye argues that the New Testament is filled with antitypes of symbols in the Old Testament, for example, the Christian baptism is the antitype of the flood of Noah (p. 79). In both cases water serves as a propitious sort of purge and implies certain responsibilities, so the structure is similar but the emergent form is different.

Frye sees typology as a kind of compelling rhetoric analogous to that of causality (p. 81). Both follow a retrospective procedure which is reversed to a forward-looking direction. Whereas causality relates to the past and is "based on reason, observation and knowledge, . . . typology relates to the future and is . . . related primarily to faith, hope and vision" (p. 82). Causality (especially descriptive phase) tends to be in the same time plane whereas typology can transcend time. Frye argues that it is the typological structuring of Biblical myth that makes it diachronic and in a sense repeatable (pp. 83-84).

An example can illustrate. The fashion trend in North America in the 1960s to long hair, even in men, could be seen as a new form of spiritual strength, making reference to Samson (Judges 13-16). Today the fad has shifted to a long wisp of hair making visible contrast to an otherwise short haircut. With this cultural backdrop, cancer victims who lose their hair as a result of chemotherapy, have to contend with old meaning codes. Their own weakness and dismay can be seen as typologically similar to that felt by Samson after he let down his guard to Delilah, who had his head shaved; whereupon he lost his strength and was taken prisoner by the Philistines who put out his eyes (Judges 16: 17-21). The

anxiety confided by these patients about their hair growing back is not just some preoccupation with vanity and cosmetics but rather is a manifestation of their battle with cancer. Often their concern is that the chemotherapy treatment itself can betray them (just as Delilah betrayed Samson, although at first she represented something positive after the cruel killing of his wife and son at the hands of the Philistines).

This new antitype of symbolic form forced on patients by their chemotherapy is celebrated by today's punk rockers with their shaven heads (but with some hair growth shown) and their purple markings mimicking radiation technology in cancer treatment. Susan Sontag (1979) elaborates upon the metaphors surrounding such cancer imagery: "so charged with the fantasy of inescapable fatality — a vehicle for the large insufficiencies of this culture, for our shallow attitude toward death, for our anxieties about feeling, for our reckless improvident responses to our inability to construct an advanced industrial society which properly regulates consumption and for our justified fears of the increasingly violent course of history" (pp. 84-85). In this example, the antitype and type both symbolize relations with an invasive enemy, cancer and the Philistines respectively, yet the antitype claims added associations reflecting the times and compelling metaphoric relations it references.

PHASES OF REVELATION

There are certain Biblical themes that keep repeating themselves in our culture and it may be useful for nurses to reflect on the origins and archetypes of meaning which pervade and invade our discipline. The seven phases of revelation Frye discusses are creation, revolution, law, wisdom, prophecy, gospel and apocalypse. Each holds significant blueprints for illuminating the conceptions and affective ordeals in the process of deliverance, which in part constitutes the Western cultural repertoire for coping behaviours and the facilitation of adaptation. For lack of space I will make reference only to the first phase.

In the creation myth there is the importance of the WORD. Frye points out, "The forms of life are spoken into existence" (p. 106), and comments "Genesis presents the Creation as a sudden coming into being of a world through articulate speech (another aspect of logos), conscious perception, light and stability (p. 108). "The metaphor underlying beginning" Frye says, "is not really birth at all, it is rather the moment of waking from sleep when one world disappears and another comes into being" (p. 108). I contrast the cultural implication of this with those of another tradition, for example, Ojibway. By comparison, Judeo-Christians inherited an inordinate bias toward cognitive articulation, verbal performance, awakening through receiving information. The teacher, preacher and Rabbi are cast in a different mythical mold from Nanabush, the "teacher" figure in Ojibway culture, who is a trickster and bumbler.

I have participated in Ojibway health educational workshops in which the spiritual leader in essence becomes Nanabush and plays a lot of tricks and struggles with staying in balance. Health problems are presented as problems of imbalance and the individual is left to decide how balance can be restored. So, for example, instead of saying obesity is *the* major factor in Type II Diabetes, he says, "Thin or fat can get diabetes, maybe more often somebody could get it if they are overweight." This "imprecision" is very disturbing to health professionals who are often resource people committed to the WORD, to *accurate health information*. Even when informed of the cultural context of the workshops, these professionals often have a hard time containing themselves, as they are to save the bodies of the Natives from ignorance in the same way the missionaries of old were there to save their souls from sin, through spreading the Word.

The codes reviewed in each phase of Biblical revelation provide basic meaning constructs for secular life today. Frye constantly emphasizes the interchange between sacred and secular knowledge, that is, hidden roots of today's cultural conceptions in the sacred past.

READING THE COPING PROCESS

There are several principles I wish to discuss in relation to caring for people, taken from Frye's basic question which I understand to be: How does one read, interpret and make sense of the Bible? By an admittedly remote analogy, I am asking: How does the nurse "read," interpret and make sense of coping processes in Western culture? I have found useful some of Frye's concerns which are outlined briefly here.

1. *Non-literal interpretation is appropriate.* Frye makes an appeal for the Bible to be read non-literally as a sort of mythic poetry. He claims (p. 174) myth and metaphor are not the basis for rationality, strictly defined (Note 4). I find this appeal relevant for interpretation in nursing. An instance is seen in the following example.

An elderly woman was admitted to the hospital with a severe respiratory infection approximately one week after she had been placed in a nursing home. Although she had fever which diminished her lucidity, in her encounters with her, the student working on her case, found her rational and oriented. However, despite her difficult laboured breathing, this woman would call out to the nurses as they passed her room: "Open the door, please open the door." One by one the nurses would enter the room and admonish her with abrupt tones "Your door, here, is open," "Can't you see? Look, the door is open."

In this case the nurses, uneducated about meaning and how it structures our language and expression, made literal, denotative reference to the door of the room, which already being open led them to discount the woman's concern. Yet, the concept of door can serve a multitude of metaphors and can even operate mythically as it allows for passage, transformation, narrative shifts and so on. The student in her care and concern for this woman indeed found a gold mine of "meaning." The door in this case led back to the patient's daughter's home and to the office of the nursing home administrator and, as might be expected, into eternity. Even these explicit references are mere pinpoints in comparison to the complex webs of meaning occupying this woman's consciousness and being, which were sabotaged, indeed violated by literal interpretation, as this brief example shows.

2. *Dangers of solidarity and ostracism are generated by metaphor and myth.* I mentioned previously that the political is referenced in images. I do not mean this in the minimal sense of personal power of an individual to mobilize resources but rather in the transcendental sense of a whole polity, with sovereignty, solidarity, unity and governance of territory. Frye documents how metaphor operates to achieve this. For example, he stresses the powerful metaphors associated with the body of the Messiah (p. 224), compelling the growth of the early Christian church. We have its equivalent as a basis for unity today in "the body of nursing knowledge."

Myth too achieves and serves shifts in management of resources (Note 5). Frye (p. 150) points out that the story of Jacob and Esau, alluded to above, marked a change from a food-gathering economy to a ranching one (Esau, the foodgatherer, did not get the birthright). Myth serves the purpose of legitimizing such change. It is this aspect of mythic function which facilitated the dramatic response of dismissal of the "verbally incompetent" chronically ill woman mentioned earlier. Mythically, her irrelevance is encoded through metaphoric equivalence to Esau's irrelevance.

Again, I believe this insight could improve responses to patients in health care settings by forcing a selection of more humanitarian myths to organize our care. For example, a woman in her mid-fifties with a cancer which has metastasized to the brain had some pain for which she required narcotic injections to keep in check. The nurses observed that the woman seemed to be asking for the shots far more often than she needed them and a power struggle ensued in which exchanges of nasty names were made and the woman was labelled a "problem patient" (Note 6). In confidence, the woman talking about her pain used the image of Joan of Arc. She admitted to trying to increase the availability of the shots now while her pain was not too severe to avoid a time in which she would be

"burning at the stake" and a shot would not be forthcoming, either because the nurses had plotted against her, or because the order did not permit it. Her history of her relations with the nurses, she said, conjured the image, since she was made to wait for her shot as punishment for rebelling against some of the goings-on on the ward by expressing her disapproval.

This example suggests that the bureaucracies nurses work in can be experienced by patients as territorial units or policies with all the robust drama of militancy, intrigue, retaliation, etc. To nurses, the disease can be the enemy and so can the patient. This state of affairs raises serious questions about the position of nurses as interpreters where patients are literally at the mercy of cultural codes: collective and sovereign metaphors and mythic frameworks which structure unconscious interpretation and render patients ostracized.

3. *Causality and typology are used rhetorically.* Frye has marvelled, along with Whitehead, that causality is still permitted as a legitimate form of rhetoric, given Hume's succinct critique of it (Frye, 1982, p. 81; Whitehead, 1967). Critics of the relations in health care settings manifested in capitalist societies (e.g., Taussig, 1980) have lamented the imposition and implementation of causal models which violate the patient's own experience and deter healing and well-being. Taussig even implies that if serious attention is paid to interpretation of individual needs, then contingencies in the organization of care will preclude the sort of spontaneous reciprocity necessary to healing (Taussig, 1980, p. 10). I believe he has raised an important question worthy of empirical investigation. However, I believe there is a prior question which needs addressing. Do practitioners have an adequate model of interpretive procedures and of the nature of language and non-verbal behaviour in the dramatic settings we work in from which to conduct interpretation? Indeed, is interpretation part of the repertoire of skills of the average practitioner or do most practitioners make assumptions and unconsciously occupy some mythic mold to respond, however inappropriately, or interpret literally, as we saw in examples above? Can organizational changes be made which deter the use of some types of mythic frameworks, to improve "care"? Should nurses be organizing to make conditions of work more amenable to well-being which comes through attention to meaning and interpretation?

It is my belief that Frye's concepts offer a new outlook for the task of interpretation. Perceptions are not articulate representations of a single value of thought, but rather they are tied to deep narrative structures coded in our culture. In this view, interpretation is not a matter of "pinpointing" the correct value but rather a matter of decoding entire gestalts of interlinked values, entire rhetorical sequences. I believe it is this process of checking with patients, attempting to interpret the meanings

they have evoked in us, which is part of the process of caring. Caring is attending to meaning, individually specific and culturally specific, and the process itself has to vary with individuals and cultures despite there perhaps being something like universal invariant features in interpretive procedures (Cicourel, 1974). Frye's view that both causality and typology are forms of rhetoric is an important contribution to the performance of interpretation in nursing care. The results of our data gathering and observations in health care settings produce rhetorical versions of the so-called "real world" of our patients' physical and social being. There is always the danger that the myths, metaphors and typologies intuited by the nurse will be converted into "applied knowledge" representing inappropriate causal models which alienate patients and deter healing, growth or maintenance.

The implication of Frye's perspective which I have outlined, I believe, is that the interpretation of dramatic narrative must be preserved in nursing for problem identification. The handy lists of nursing diagnoses (Note 7) and coping strategies (Note 8) sanction working conditions which strip away narrative dialogue and reciprocity. This mechanical application threatens to promote inattention to meaning and promulgate a non-caring praxis, thus contributing to alienation in health care settings.

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REFERENCE NOTES

1. The term *praxis* has gained recent popularity due to the work of Marxist scholars. Marx himself undoubtedly read Goethe and of course his mentor Hegel wrote a lot on the topic of praxis. A commonplace usage of the term today implies the synthesis of theory and practice or the incorporation of consciousness and insight into action . . . which we all know has its limits.
2. See Allan Young's argument (1980) showing the similarity in logical structure of the modern stress concept to many 'primitive' explanatory models of illness in non-industrial societies.
3. Lacan (1966, 1977) credits Ernest Jones (1918) with great insight into the theory of symbolism. See especially sections from *Écrits* entitled "Le stade du miroir comme formateur de la fonction du Je" (The mirror stage as formative of the function of the I) and "Fonction et champ de la parole et du langage en psychanalyse" (The function and field of speech and language in psychoanalysis) and "L'instance de la lettre dans l'inconscient ou la raison depuis Freud" (The agency of the letter in the unconscious or reason since Freud).
4. As an anthropologist, I am committed to the view that rationality is culturally and historically specific. Therefore, I define sub-cultures as holding to sub-sets of meaning and symbols which have their own "rationality." It is the job of the anthropologist to illuminate the logical coherence in a sub-cultural context that may appear irrational to outsiders. Frye's definition is more restricted than this in that it implies specific standards for cognitive operations which we value in the Western tradition.

5. This view of Frye's is consistent with those of French structuralist anthropologists such as Claude Lévi-Strauss, as I have learned it from Valerio Valeri (1976-77).
6. See Kelly and May (1982) for a recent review of bad patients, problem patients, etc., reported in the professional nursing literature in which an interactional approach is advocated to avoid or solve problems. However, such an approach does not provide the practitioner with the codes or blueprints for negative interactions.
7. See Gordon and Sweeney (1979) for their method of having trained clinician raters to generate the permanent set nursing diagnosis categories. These, I have argued in Hagey and McDonough (1984), acknowledge only the clinicians' view (and not the patients') of the social context from which categories are generated. Furthermore, the possibility of infinite interpretation of meaning in ever-evolving social contexts is ignored by this method.
8. See, for example, Craig and Edwards (1983) for effective and ineffective coping strategies to be determined by the nurse.

RÉSUMÉ

Codes et façons de composer: un hommage à Northrop Frye

La présente communication propose une perspective théorique pour la démarche infirmière face à l'adaptation humaine. La *praxis* y est envisagée tel un art à la fois créateur et réfléchi des soins infirmiers; elle est opposée à la *discipline critique* ou la Science qui cherche à élaborer une nomenclature et un discours. *L'interprétation* apparaît comme une autre option au diagnostic infirmier, plus compatible avec les soins dans la perspective des façons de composer (*coping*). *The Great Code: The Bible and Literature*, un ouvrage de Northrop Frye, est utilisé comme cadre de référence de l'expérience et du drame humains ainsi que des codes qui permettent à l'individu de composer avec la situation, codes dérivés de l'héritage culturel occidental. Les concepts de Frye, empruntés pour favoriser l'interprétation des drames littéraires et poétiques, sont examinés; ce sont: le mythe, la métaphore et la typologie.

L'insistance de Frye sur les images, le langage, et le pouvoir des mots et des gestes symboliques est soulignée afin de mettre en valeur l'art de dispenser les soins infirmiers en jetant une certaine lumière sur l'interprétation, la traduction, la reconstruction du sens et de l'action symbolique. Cet article nous met en présence de préoccupations d'interprétation dans le contexte infirmier. Les questions soulevées au sujet de la compréhension et de la création face au processus de *coping* sont: (a) l'interprétation rigoureuse et l'interprétation libre, (b) les dangers de la solidarité sociale et de l'ostracisme soulevés par les métaphores et le mythe, (c) l'utilisation rhétorique de la causalité et de la typologie en soins infirmiers.