

## Reading Minds and Telling Tales in a Cultural Borderland

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**Abstract** In this article I consider “narrative mind reading,” the practical capability of inferring the motives that precipitate and underlie the actions of others. Following Jerome Bruner, I argue that this everyday capacity depends on our ability to place action within unfolding narrative contexts. While Bruner has focused on narrative mind reading as a within-culture affair, I look to border situations that cross race and class lines where there is a strong presumption among participants that they do not, in fact, share a cultural framework. Instead, interactions often reinforce actors’ perceptions of mutual misunderstanding and cultural difference. Drawing on a longitudinal study of African American families who have children with severe illnesses, I examine narrative mind reading and misreading in one mother’s interactions with the clinicians who treat her child. I further explore how narrative misreadings are supported through chart notes and “familiar stranger” stories. The focus on miscommunication grounds a theory of the reproduction of cultural difference in interactive dynamics and brings Bruner’s emphasis on narrative into dialogue with contemporary anthropology of cultural borderlands. [narrative, culture, African Americans, health disparities, border zones]

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The first time I saw Jerome Bruner was in the early 1980s at MIT when I was a graduate student. He was lecturing to a crowded room, speaking about the social intelligence of young humans. The topic was interesting enough, but I was no developmental psychologist. What gripped me was the drama Bruner enacted: a playful moment between an infant and mother, a kind of “this is not a hat” game using a kitchen colander that the infant donned for his mother. In this wonderfully ordinary moment, a child puts on his “hat.” Mother responds, “Oh what a wonderful hat,” and they laugh together. That is the whole exchange. But how revealing of the subtleties of mind reading even at such a tender age. Child knows this is not a hat. Mother knows that child knows that this is not a hat. Child knows that Mother knows that child knows that this is not a hat. Bruner presents us with the smallest joke as it turns on, and creates, meanings at once personal, intersubjective, and cultural. In retrospect, I cannot really believe that Professor Bruner (as I thought of him then) had an actual colander on his head when he told this story, but to this day, I can *see* that colander, and a mother and child in the thick of just pretend.

In one sense, this article can be read as a reflection on Brunerian insights about narrative thinking that stem from such ubiquitous games as “this is not a hat.” For Bruner’s exploration

into, among other things, the social brilliance of the very young, has led him to construct an understanding of narrative that goes well beyond storytelling. In Bruner's hands, narrative emerges not simply as a mode of discourse but as a fundamental form of human sense making. As Bruner treats it, narrative is interwoven into the very fabric of our sociability; it is that cognitive capacity that allows us to become culture learners and culture makers. In the intimate space of parent and child, culture emerges not as a *fait accompli* but as a drama of young humans in their early encounters as they learn to share the world of their elders. He offers a compelling reading of the way humans are introduced into a place of public meanings, symbols, scripts, a cultural world in fact.

Narrative is connected to our capacity to read other minds—what I call, somewhat awkwardly, “narrative mind reading.” I mean by this, that practical capability of inferring (rightly or wrongly) the motives that precipitate and underlie the actions of another. I follow Bruner's suggestion that this everyday capacity depends on narrative. It is not only that a story is, in some basic sense about motives, dealing as it does with “the vicissitudes of human intentions” (Bruner 1986:16). More radically, deciphering intentions depends on our ability to place action within unfolding narrative contexts. That is, our interpretive capacity to infer motives requires placing an act within the context of an unfolding story.

This suggestion has been theorized in philosophy as well. Paul Ricoeur links narrative to the ongoing work of interpreting action, what he calls “practical understanding.” Actions, he says, belong to a “network” that includes goals, motives, and agents who can be held responsible. As such, actions offer “temporal structures that call for narration” (1984:59). Narrative mind reading as tacit practical understanding has strong kinship with the speech act of storytelling in which a narrator explicitly links actors, motives, acts, and consequences in a causal chain—often precisely for the purpose of determining who is responsible for the results. Alisdair MacIntyre has argued that to ascertain what someone is doing, we have to place their action in a context that makes it intelligible to us. This is, above all, a narrative context. “An action,” he writes, “is a moment in a possible or actual history or in a number of such histories” (1981:199). For an action to be intelligible to us at all, we must place it within some sort of “possible or actual history”: we must see it as an episode in a story. Such a story need not be one that is completed. This narrative sensibility, this kind of mind reading, is part of the ongoing work of interpreting the meaning of actions as they take place (see also Carr 1986; Olafson 1979; Ricoeur 1981, 1984, 1985, 1987, 1992).

What Bruner adds to these philosophical arguments is the connection between a narratively shaped mind reading and the work of culture. He is not alone in linking narrative, mind, and culture, although he has been instrumental in shaping many of the current discussions. In both anthropology and psychology, several notable scholars, including some of the contributors to this special issue, have also been exploring narrative as a mode of cultural thinking. For my purposes, I concentrate on Bruner's work; examples of others whose work points in similar directions include Elinor Ochs and Lisa Capps 2001; James Wertsch 2002, this issue; Linda Garro 2000; Dorothy Holland et al. 1998. Indeed, Bruner draws heavily on

work in anthropology and psychology, as well as philosophy and literary theory, to make his case. Despite these affinities and borrowings, there is no question that Bruner has been a pioneer in the investigation of narrative as a form of cultural thinking (Amsterdam and Bruner 2000; Bruner 1986, 1990, 1996, 2002).

Drawing on and synthesizing a broad range of theoretical work and research, Bruner portrays a loosely interlocked set of practices in which narrative, thought, and culture are connected. In his work, narrative is variously: (1) a prelinguistic apprehension of the intentions of others; (2) a culturally acquired set of scenarios guiding how members carry out ordinary acts; (3) a discourse supremely designed for the interpretation of exceptional instances, allowing us to “read the minds” of actors who operate in violation of canonical schema; (4) a noetic space in which possible worlds are imagined. This is not an exhaustive list—he examines the connection between narrative and the construction of the cultural self, for example—but it is sufficient to display how richly and creatively Bruner has played with the power of narrative in the practical work of reading other minds, recognizing and finding one’s way in familiar situations, explaining surprises and deviations from the expected, and dreaming up new ways to live.

In all of these uses, to talk about narrative as a practice of reading minds is to speak of it as an interpretive strategy that pays special attention to the motives, beliefs, and emotions of actors, a practice of ascertaining what is in the minds and hearts of others. Narrative mind reading is necessary for practical action; part and parcel of the most ordinary sense making. And it is a both culturally shaped and critical to the production of cultural knowledge. Cultures provide resources for sense making because they allow the invention of plausible narrative scenarios; they help place actions within possible histories. They support one’s ability to construct or envision stories that others are living out. It is these imagined, unfolding stories that allow one to see any particular actions as actions of a given sort. When life runs smoothly, mind reading (or “good enough” mind reading) is nearly effortless. Narrative reasoning feels less like deliberation than immediate perception. The child just knows that the mother knows that this is not a hat.

But life need not run smoothly. We sometimes find ourselves in situations where it is not clear what is going on, or why people are doing what they are doing. It may not even be clear what people are doing when they are doing it in front of our very eyes. The stories we choose to tell, or feel compelled to tell, often concern precisely those situations where we were not, in fact, able to sort out what story we were in and came to grief because of it. Or, where someone else was inept at “reading the situation” and bungled things. This turns out to be of special salience in the cultivated space I attend to here.

In the argument I outline below, I work to build on, but also depart from, Bruner’s treatment of narrative and cultural thought. While Bruner focuses on narrative mind reading as a within-culture affair, I look to situations where there is a strong presumption among participants that they do not share a cultural framework, situations where interactions very often

reinforce participants' experiences of "cultural difference." In border zones it becomes unclear whether one should even speak of a culture that is shared, although it is equally problematic to speak of vastly different cultural worlds because people and cultural objects move across borders with regularity. What does narrative mind reading look like when culture is more a form of encounter than a form of life? The sort of encounter I have in mind is one in which actors perceive their interlocutors (or some of them) as "Other" in capital letters. In such a cultural borderland people find themselves struggling to bridge cultural divides, to make themselves interpretable, readable (and readable in the right way) to those they regard as foreigners. They also work as detectives, trying to discern the cultural meanings behind the behaviors of others. In such cross-cultural encounters, individuals are continually engaged in creating plausible narratives to make sense of the exotic actions of others. The border zone I explore is contemporary health care, more specifically, the urban hospital in North America.

### **When Culture Is a Borderland: The Urban Clinic**

The border zone is currently perhaps anthropology's dominant trope, one that has emerged as part of the refiguration of culture. Anthropologists have pondered how to think about culture in the face of globalizing forces (Appadurai 1996; Gupta and Ferguson 1997; Marcus 1999; Olwig and Hastrup 1997; Tsing 2005). In their work, culture emerges more vividly as a space of encounter than of enclosure. Culture has become identified with a key activity common to border life, the social work of making different. Here, cultural meanings are tied primarily to a group's efforts to distinguish themselves from salient others with whom they have some commerce. If there is something real about culture, many argue, it is the name for a relational practice (Fischer 2001), a practice in which cultural identity is produced only in the moment of cultural differentiation. Cultures, Hommi Bhabha declares, "recognize themselves through their projections of 'otherness'" (1994:12). Lila Abu-Lughod suggests that culture is not a localized substance but a "volatile form of difference" (1990). Culture emerges as a "contested category and . . . site of ideological and political struggle" (Mahon 2000: 469–470).

The trope of the politically fraught borderland joins with another powerful trope, culture as a scene of travel with its attendant experiences of estrangement, displacement, and creative discovery (Appadurai 1988, 1996; Clifford 1988, 1992; Jackson 1995; Mattingly 2006; Olwig and Hastrup 1997; Paerregaard 1997). Culture has come to be the name of a land one travels through as much as lives in, a land characterized by hybridity. In this hybrid place, especially as depicted by postcolonial theorists, cultural identities are reinvented in unexpected ways and belonging is marked by liminality and contestation rather than any uncomplicated citizenship (Bhabha 1994).

This rethinking of culture has produced a new kind of anthropological common sense, one that abandons "old ideas of territorially fixed communities and stable, localized cultures" in

favor of “apprehend[ing] an interconnected world in which people, objects, and ideas are rapidly shifting and refuse to stay in place” (Gupta and Ferguson 1997:4). Cultures are, in Tsing’s telling phrase, produced through “friction”: “the awkward, unequal, unstable, and creative qualities of interconnection across difference” (Tsing 2005:4). Reconstructed through a host of new spatial metaphors, culture—or cultural spaces—are ones in which motion is as important as dwelling. This is not to say, Arjun Appadurai explains, that there are no “relatively stable communities and networks of kinship” but “the warp of these stabilities is everywhere shot through with the woof of human motion” (1996:34). If taken seriously, this rethinking of culture complicates a culturally based notion of mind reading. It challenges the assumption that mind reading can be presupposed on a preexisting shared, comparatively stable world of public meanings. In what follows, I consider how a notion of narrative mind reading might function in a cultural world rather more like the one these anthropologists and culture theorists describe—cosmopolitan, contested, and characterized by politically charged, difference-making exchanges among actors living in a border space (Mattingly 1998, 2000; Mattingly and Lawlor 2001).

In medical anthropology, the clinical world has often been recognized as contested terrain. But the figure of clinic as border zone takes on a decidedly less familiar cast when situated within recent debates about culture, place, and space that have arisen among scholars far removed from anything clinical, those who have been delivering, or responding to, challenges concerning the location of culture in the face of a globalizing and decolonizing world. Cultural studies and subaltern studies offer intriguing vantage points for examining the border activities of health care practices.

Urban health care provides an excellent site in which to explore mind reading as a fraught and fragile act. Mistakes can have disastrous consequences for health outcomes. There are, of course, political and economic reasons why health care is often ineffectual and access to decent care is hard to come by when one is poor in America. But these structural conditions and discoveries are routinely produced and embodied through the cultural stories and scripts that so influence how professionals and various client groups understand one another. When clinical interchanges do not go well, it is often because of misreadings. These charged moments can lead to a spate of aggrieved storytelling by all concerned. More subtly, when things go well in a clinical interaction, patients, clinicians, and even family caregivers are able “read” one another effectively enough to create a shared narrative. That is, they are able to participate as actors in an unfolding story they mutually construct, one for which they have real commitment and one that embodies or suggests healing possibilities (Mattingly 1998, 2000; Mattingly and Lawlor 2001).

In the following case, I explore key events in one parent’s encounters with the healthcare world as these illuminate the clinic as site of difference making. I look at the role of narrative mind reading in constructing difference. I should note that, border zones are not just places in which conflict and cultural “Othering” take place. They are also places in which actors sometimes find common ground (Mattingly 2004, 2006).

## The Tale of Two Travelers

For the past decade, I, along with several colleagues, have been following a group of about 30 African American families in Los Angeles and Chicago whose young children have serious illnesses or chronic disabilities. Many of these families are poor. It is well documented that race and class play a prominent role in creating communicable difficulties and contribute to health disparities for African Americans. I turn to one of these families we have known since 1997, Barbara and her daughter Rhonda. I focus primarily on two highly charged events centering on the drama of diagnosis. In policy language, these are dramas of health care access. The first concerns a conflict between Barbara and a Euro-American doctor in a hospital emergency room. The second concerns a visit one week later to the same hospital (but a day unit), where Barbara is finally able to get the attention of another doctor who listens to her. An accurate diagnosis of her extremely ill three-year-old child quickly follows. I compare the story that Barbara tells of these two moments with notes from the hospital's medical chart about the same encounters.

Drawing on this rich material, and on the multiple—and dramatically conflicting—perspectives of these clinical encounters, I explore how these actors “read” the minds of their interlocutors, the kind of narrative framings that informed this mind reading, and how this served to produce misunderstandings.

### Barbara's Story: Learning to Fight for Care

I met Barbara and Rhonda in October 1997, just a month after Rhonda, four and a half at the time, had been diagnosed with brain cancer. During our first official interview, Barbara wasted no time but launched, almost immediately and with very little prompting from me, into a harrowing story about her long journey for a diagnosis, an entire year in which she took her very sick daughter repeatedly to emergency rooms in hospitals all over the city only to hear that there was nothing seriously wrong with Rhonda. A central drama of her story was her mounting fear and frustration as she witnessed her daughter becoming increasingly ill (with violent vomiting and headaches) while she was sent home again and again after long waits at emergency rooms and other outpatient treatment facilities. Health professionals offered a wide range of advice and possible diagnoses, improper diet or allergies were frequent suspects. Barbara followed the suggestions but nothing helped.

Barbara was at her wits end. One night, after a particular violent spate of vomiting—“It was like in *The Exorcist!*” Barbara recalled with a shudder—she rushed Rhonda to the emergency room. She recounts the acerbic exchange that followed when her daughter was finally seen by the on-call doctor. “I had a little confrontation with the lady in there, okay?” she tells me. I ask her to describe what happened. Here is the story she tells.

**Barbara:** That evening, when I brought her um—the doctor down there in the emergency, she um, came and checked [Rhonda], and I was telling her, “She’s really, she’s constantly vomiting and having headaches really bad.” And she did her little checking,

and she said, “Well, I don’t see anything.” And we did her urine and, “I don’t see anything.” I said, “But I’m not leaving here unless you guys tell me to do something because—” and then she started, like, getting a little smart on me.

**Cheryl:** Yeah, like what did she say? Just go—just please go through this.

**Barbara:** Okay. She was, like, saying, “Well, if you don’t think that I’m doing my job, then you could just take her to the, um—I’m gonna make you an appointment and you can take her to the day hospital.” I said, “Oh, it’s not that I don’t think you’re doing your job, I just want my daughter to get help.” You know, as you understand, I’ve been taking her everywhere and she still be doing the same thing constantly, over and over. And so then, she, um—she got a little upset, so she left out—

**Cheryl:** What did she say?

**Barbara:** And she went across the hall and—where her little office was—when all that time, the door was open, you know, all the time she was seeing patients. But when she left out of there from talking to me, she went over there and she closed her door, and I guess she was telling the social worker—because the social worker came down and came in there and talked to me and was asking me, “What’s going on? Is there something wrong?” I said, “Yes, there’s something wrong.” She said, “Well, the doctor feels that you don’t think she’s doing her job.” I said, “So, but why does she have to call the social worker on me?” You know? And then I started feeling like they was, um—I felt like she thought that I was, like, kind of crazy or did something to my daughter myself. That’s the kind of feeling I had got. I felt kinda—very uncomfortable. I said, “Do you guys call the social worker on all people?” You know? And she—and I was letting the social worker explain. “No, it’s not on all people. It’s just when the parents feel that you’re not happy with your doctor, and the doctor will call.” You know, but then, she kinda calmed me down. You know, I wasn’t arguing or I wasn’t saying any, you know, bad—anything—I just wanted my baby to get help, you know? I didn’t want to take her home again and be like she was. You know, she’d done been through it too much.

In clinic encounters that cross race and class lines, worries over being misread constitute major threats. Here, narrative mind reading is connected to the problem of being in places where one must “partner-up” with foreigners to get one’s job done (Lawlor and Mattingly 1998). In Barbara’s story, the doctor’s fear of Barbara plays a part in preventing her from listening in detail to Barbara’s description of Rhonda’s worsening symptoms. Barbara herself said that by the time she got to the emergency room on this visit, she “was going crazy” with worry. It is not difficult to imagine that an emergency room doctor could attribute Barbara’s panic and refusal to accept her diagnosis (nothing is wrong) to a mother’s precarious mental state, or worse, to an abusive parent. City emergency rooms in the middle of the night get their quota of the mentally unstable and health professionals, like everyone else in contemporary America, are on the alert for parent–child abuse.

Recurrent failures at mind reading (esp. the health professionals’ erroneous perceptions of Barbara) point toward the limitations of social attunement posed by a cosmopolitan situation in which each participant has a very partial understanding of the other. This is

a narrative failure, an inability to recognize the story one is in. The emergency room doctor believes she is faced with a demanding, possibly abusive mother and a child who is not ill. She responds to this imagined storyline, and furthers it, by disappearing into the safety of the doctor's quarters and asking a social worker to meet with the mother. While Barbara recognizes this erroneous plot, she cannot find a way—during this hospital visit at least—to break out of the role into which she has been cast. In frustration and helplessness, she sees no choice but to take her sick daughter home again, undiagnosed and untreated.

The inaccurate storyline is not the result of a doctor's simple misinterpretation. Rather, the doctor is almost irresistibly drawn into this plot because of a number of circumstances, especially institutional and economic ones. She is "doing hospital" of a particular kind—urban emergency room hospital. Increasingly, because of the paucity of affordable health care for the poor, those without health insurance must make use of emergency rooms for routine health care. This means that harried emergency room staff in urban hospitals are continually confronted by "nonemergencies," as they call them. If someone is black and from the inner city, they are quickly classed into the group who, lacking health insurance, will use the hospital for routine problems. The staff's mandate, both from a medical perspective and from the hospital's tightening economic one, is to sort out these "nonemergencies," spending as little time on them as possible, to leave room for those in serious need of medical treatment. A poor African American mother who brings in a child with vague symptoms is playing a part in a common script; if she protests too strongly at being got rid of, she is quickly cast in a well-known "problem parent" story.

From Barbara's standpoint, the exchange with the emergency room doctor was a turning point. In her tale, it figures as a key episode in a plot that underscores the moral necessity of noncompliance. Access sometimes even requires trespassing, she discovers. A week later, as she went on to tell me in her story, she returned to the hospital with an even sicker child. The hospital receptionist told her to come back a month later at her appointed date. This time she resisted in a more active way. She looked past the reception desk to a door that, Barbara said, had a sign "The Administrator." (In actual fact, there is no such sign.) Behind this door was a suite of doctors offices and secretarial staff, for she had often seen them coming and going through it. This space was off limits to patients and families. Barbara picked Rhonda up in her arms, marched past the protesting receptionist and through the suite of rooms, declaring to the startled secretaries: "My baby is sick. She needs help and I'm not leaving until somebody sees my baby." A doctor was summoned. He asked Rhonda to tell him where it hurt. Rhonda pointed to the back of her head. He asked her to walk. She did, wobbling to one side. He ran for another doctor and they asked her to walk again. Again she wove, listing to her right. Two days later, Rhonda had a CAT scan and a subsequent diagnosis of a malignant brain tumor that had grown, Barbara recounts, to "the size of an egg." The tumor, Barbara was told, had been growing unchecked for at least a year. Prognosis was poor.

### Diagnostic Puzzles: The View from the Medical Record

I now turn to Rhonda's medical record to glean something of the health professionals' perspectives on these events. Although sketchy, the chart notes are remarkably telling. They corroborate Barbara's version of events and, yet, suppress the moral connections made in Barbara's account. Here is an excerpt from the emergency room doctor's notes about their charged interaction. "Vague history of complaint . . . normal gait . . . social problems . . . ref to social work. . .Diagnosis: vomiting, psychosocial concerns, parent-child conflict." We hear nothing of a confrontation, but there is a foreboding suggestion about Barbara's emotional state and her possible fitness as a mother. Intriguingly, a conflict is reported, but it is portrayed as occurring between parent and child rather than between parent and doctor. There is also a note by the social worker, the one "called on," who notes, in more sympathetic tones, the mother's "frustration and fear."

Barbara's story of her confrontation with the emergency room doctor, coupled with the doctor's notes in the medical chart, offer an eloquent instance of Barbara's "narrative mind reading." Just as Barbara feared, the doctor saw her as a possibly abusive mother. Barbara "read" the doctor's mind with acuteness. She told me, "And then I started feeling like they was, I felt like she thought that I was, like, kind of crazy or did something to my daughter myself." Her capacity to do such mind reading is, as Bruner often points out, a matter of reading public symbols. The social worker, the doctor's closing her office door that had been open earlier, these overt behaviors are accurately read by Barbara as signs that her protests have placed her in the dangerous category of "problem parent," perhaps even "abusive parent." Or, as the emergency doctor wrote in the medical chart, Barbara's behavior indicates the presence of "psychosocial concerns" and "parent-child conflict."

The very next entry in the medical chart comes six days later, written by the doctor Rhonda sees after Barbara has carried her into the administrative offices, the one who recognized that Rhonda was probably seriously ill. In this doctor's report, no mention is made of this unorthodox trespass into the doctors' quarters. Instead, his entry indicates, along with some general description of the symptoms described by Barbara, that there is possibility of a brain tumor. He notes that a CAT scan has been ordered: "Phys Exam: looks well but wobbly . . . has me concerned about mass in head, will schedule CT." A further entry, three days later, notes Rhonda has had surgery. The neurosurgeon reports in the record that they did a "partial resection with VP shunt placement." There is also a note by the hospital chaplain from that same day, stating he has met with the family to offer "spiritual support."

The most important feature of these terse notes is what is missing. This is a genre of narrative (if one wishes to call it that) notable for its significant absences. To follow Aristotle's (1970) idea that stories offer moral arguments through the organizing function of the plot, the medical chart "narrative" denies the moral that Barbara's story makes. It does so not by offering a counterargument, a counterplot, but by a kind of refusal of narrative itself. It organizes events as a series, a chronicle in Hayden White's (1980, 1987) terms. A chronicle places events in a chronology; it is structured as a series, not "one thing because of another"

(the logical structure of narrative proper) but, rather, “one thing after another” (sheer chronology). In an emplotted narrative, stories link acts to motives and intentions as well as to consequences. Ochs and Capps, following Shirley Brice Heath, speak of such chronological accounts of actions as “recasts,” as distinct from narratives engrained around a plot. “Recasts are logically simple in that they do not center around a breach of expectations nor do they link events into a plot structure” (2001:85). Referring to oral discourse, they note that recasts “tend to be grammatically, lexically, and phonologically relatively flat” (2001:85). This is also an apt description of written medical records.

Barbara’s story is much richer, narratively speaking, than the chart. Notably, it contains the kind of causal argument that comes with a narrative plot. In a story, actions suggest motives and intentions and, these actions, carried out in particular circumstances, lead to consequences. In her tale, doctors will not take her seriously, thus resulting in repeated misdiagnoses of her daughter’s condition, and when a diagnosis is finally made—only after she has caused what Kenneth Burke would call “trouble”—her daughter is very ill with advanced cancer. Barbara wonders to this day whether her daughter would still be alive if she had been able to get the attention of the doctors sooner. By contrast, the clinic gaze, as instantiated through the medical charts, reveals another kind of narrative strategy, an institutionalized insistence on chronicle rather than narrative proper. Here, Barbara’s charged encounter with the emergency room doctor is reduced to an isolated instance that (evidently) has no bearing on, and does not bear on, the events that are later recorded. No clinician narrator returns to the medical record to emplot the earlier episodes in an unfolding history, to reread the past in light of what later unfolds.

### **Narrative Strategies That Enforce Cultural Difference: Familiar Stranger Stories and the Construction of “Flat” Characters**

Stories can help to further Self–Other contrasts. All full narratives, that is, narratives characterized by breaches, plots, and the like, paint pictures of the agents who perform them. In stories, characters are created. Or, as Aristotle put it, narratives concern “men in action.” They are as much about the “men” as about the action. For it is through their acts that their characters are revealed. What kind of characters are created in stories like Barbara’s? In narratives like hers that recount dramatic clinical encounters across racial, class, and professional divides, narrative trouble is not precipitated by the mysteriousness of the foreigner. Rather, the trouble on which the plot turns comes from the problematic actions of a familiar stranger. A troublesome familiar stranger is the sort of character whose actions are predictable but unreasonable, unaccountable, deeply flawed, possibly immoral. Bruner’s insistence on the connection between narrative and culture is evident in just these border situations with the (paradoxically) “known exotic.” As he suggests, narrative mind reading is possible because actors draw on a familiar stock of stories and scripts that inform them about what story they are in across a vast range of situations. In familiar stranger encounters, actors depend on well-developed culturally based notions of what various kinds

of Others are likely to be up to, and what their motivations (however unreasonable, flawed, etc.) probably are. One mark of familiar stranger stories is the anonymity assigned to the Other. In Barbara's story, for instance, we have "the doctor" rather than a doctor with a particular name. Characters in the story (social workers, receptionists, nurses, and doctors) are depicted in stereotypical terms.

Most compelling, however, is the way Barbara's story reveals how she sees herself as designated by the doctor. When Barbara realizes that the doctor has not only left but also closed her door, a door that "all that time . . . was open," the doctor is represented as not only hostile but fearful of Barbara. When she does not return, but sends out a social worker instead, this only confirms to Barbara that she has come to be seen as possibly dangerous. Calling on a social worker has a very special meaning in such a context. For many poor, African American families, social workers connote trouble. Operating as a kind of hospital police force, they signal a particular reading of the client's character. Barbara's account communicates her own double bind. If she is to try to get care for her daughter, she is forced to act in such a way that she appears to the (predominantly white and overwhelmingly middle class) doctors as a menacing person.

Despite the marked difference in narrative style and genre between Barbara's rich narrative and the chart notes, there is an important similarity between the two accounts in that both offer "familiar stranger stories." What Barbara's account shares with the medical record is a flat rendering of the Other. The distinction in literary theory between "flat" characters and round ones is helpful here. E. M. Forster tells us that flat characters, in their purest form, are "constructed round a single idea or quality" (1927:67). Round characters, by contrast, possess multiple qualities, shadowy ambiguities, outright contradictions. Most important, they are capable of change. Flat characters, once they are identified, never surprise us, never waver. They do exactly what they are supposed to do, no more and no less. Forster gives an example. A flat character, he notes, can be described in a single sentence. "I will never desert Mr. Micawber.' There is Mrs. Micawber—she says she won't desert Mr. Micawber, she doesn't, and there she is" (1927:68).

The genre of "stories" told in clinical charts supports a flat rendering of characters through their selectivity as well as the comparative absence of plot. As clinicians say, to decipher stories in a medical chart you must learn to "read between the lines." Medical charts recount small moments here and there. These highly abbreviated short stories, multiply authored, are strung along, one after the other, as separate entries in the record without being woven into a coherent plot. Chart reporting supports an episodic structure in which events take their place and have their meaning as a succession of "nows" rather than the complex temporality that characterizes narrative proper. This manner of speaking fits a "manner of operating," as Michel de Certeau (1984) puts it. It assists in keeping the professional clinical gaze in place, an objective gaze that does not leave official room for guilt because it does not draw connections between earlier actions and subsequent consequences. In Barbara's case, this means that the chart record does not support any recognition of the unending

misdiagnoses she and her daughter have endured. Because of this, it does not provide a “reading” of Barbara’s mind that facilitates accurate interpretations of Barbara’s subsequent behavior with health professionals, including her wariness of what health professionals tell her, and her minor acts of resistance.

Cultural borderlands as zones of friction are narratively furthered by storytelling strategies that paint characters in this flat way. Stories peopled with flat characters help to make predictable certain kinds of relationships, even those stabilized around conflict. Such characters can be just as useful to the everyday storyteller (a clinician, a patient, a family caregiver) as they are to the novelist for they do not confuse the “point” of the story by introducing moral complexities and unexpected turns of the plot.

It is a convenience for an author when he can strike with his full force at once, and flat characters are very useful to him, since they never need reintroducing, never run away, have not to be watched for development, and provide their own atmosphere—little luminous disks of a pre-arranged size, pushed hither and thither like counters across the void or between the stars; most satisfactory. [Forster 1927:69]

When health professionals and their clients portray one another as flat characters, they have much more control over the plot and the moral of the story; characters need not be “watched for development.” Once narratively fixed, their actions and motives gain transparency, and they can be predictably reckoned with as causes for outcomes. Because actual humans are not flat, narratives that portray them in this way can only be told if there are discursive strategies that allow “real life” storytellers to ignore a great deal of what is actually done and said.

### **Telling Stories and Producing Zones of Friction**

Stories are more than texts and they do more than reconstruct past events; they shape the meaning of the present and anticipate the future. Barbara has retold her story a half dozen times during subsequent interviews. It has plainly haunted her. It has played a pivotal role in her ongoing construction of the clinical world as a treacherous place, necessary for survival but filled with danger. Barbara’s story, or part of it, traveled to other parents in the clinic. In the past several years, I have heard Barbara tell versions of it not only to me but also to other parents and family caregivers who have ill children. After Rhonda had surgery, Barbara stayed with her in the hospital. There she got to know other parents whose children also had cancer. They shared stories of their struggle to get a diagnosis with repeated trips to emergency rooms. Some told stories like Barbara’s. Swapping “horror stories” takes on a political dimension, binding together families whose troubled experiences with health care emerge as shared rather than idiosyncratic. It has also brought some relief to Barbara, for if she is not alone, then the delayed diagnosis was not so clearly her fault. She need not shoulder so much blame for her compliance, that is, for allowing herself to obey the “doctor’s orders” for an entire year while her daughter’s tumor grew unchecked. This storytelling, coupled with her own experience, reinforced Barbara’s conviction that it was

important to learn how to be noncompliant, a “just right noncompliance” that was a difficult skill to learn. It required the cultivation of numerous deceptions and devious maneuvers, what James Scott (1985) and de Certeau (1984) have famously labeled “weapons of the weak.”

A different version of her story circulated among some of the clinical staff that treated Rhonda. As I came to interview Rhonda’s rehabilitation therapists, I also discovered that Barbara had told truncated versions of this story to some of them for when I asked them how Rhonda had entered treatment, a few noted that Barbara had told them it had taken many months to get a proper diagnosis. None ever mentioned the defiant act that had finally produced a new “clinical gaze,” and from there, a new diagnosis. Perhaps Barbara never told them. The clinicians I interviewed consistently narrated a history of Barbara’s repeated and frustrated visits to doctors and emergency rooms without obtaining a diagnosis. They mentioned that this had been a long process. But they never recounted the two key events in the story Barbara told, the confrontation with the emergency room doctor of their hospital, and the drama of her trespass through the doors of “The Administration,” which finally led to a diagnosis. Their stories, like Barbara’s, portray Barbara as a victim of a long process of delayed diagnosis but lack an account of the events that brought about the delays or those that led to treatment. That is, in their versions, Barbara’s actions never linked troubled access to health care with noncompliance, precisely the moral that Barbara’s story highlights.

There were other differences in the stories the clinicians told. While Barbara recounted her story with fervor, the therapists repeated it furtively, lowering their voices uneasily as they told me what they had heard. The agonizing year of waiting with a sicker and sicker child while given repeated misdiagnoses was inevitably foreshortened in their versions to “several months.” This was not a story they were fond of telling; narrations were cursory and vague. “I think she said maybe four or five months before she got a diagnosis.” “It must have been pretty hard for her.”

Barbara’s story offers a hard lesson about what it means to be the parent of a seriously ill child, namely that compliance can be a terrible thing. Clinicians do not participate in this storyline. Her subsequent minor acts of insurrection are not episodes within a clinical “horror story” in which noncompliance is necessary to get health care. Instead, their version supports a view that Barbara is not a very compliant parent. They turn to another familiar story to explain this: the “home problems” narrative. For they attribute her behavior not to hard-won wisdom but to being “overwhelmed.” This, in turn, they ascribe to problem issues “at home,” especially the breakup of her marriage. They “read” Barbara’s mind in ways that emplot her actions as episodes in an often-told stereotyped tale concerning poor, African American women. Barbara becomes a protagonist in a story of family struggles, missing husbands, poverty, and other social ills that confront her with immense challenges and make it difficult for her to collaborate properly with health professionals. This prototypical tale is, in some respects, perfectly accurate. It is indeed true that women like Barbara routinely face enormous economic and social problems while trying to care for their ill children.

Husbands often are not there for them. But this story misses the most important events that have shaped Barbara's response to the health professionals who treat Rhonda. For this narrative of a difficult home life is disconnected in the professionals' stories from the role of health care practice in compounding her troubles. The "home problems" narrative provides a script for the emergency room doctor who is unable to find something medically wrong with Rhonda in her cursory examination. The nurses Barbara argues with rely on it, especially when they find Barbara has too many visitors in Rhonda's hospital room or does not sufficiently discipline her daughter. And it is employed by the occupational and physical therapists who are continually dismayed to find that Barbara does not sit in the waiting room during outpatient physical and occupational therapy appointments but, instead, "disappears" until the sessions are over.

### **Narrative Mind Reading and the Construction of Cultural Difference**

How do Bruner's three key notions of narrative thinking (perceiving behavior as motivated, locating actions within culturally shaped narrative scripts, and generating stories to interpret breaches from norm) figure into an understanding of the conflicted exchanges between Barbara and the clinicians? All of these notions of narrative thinking play a part in their contentious relationship. First, in the stories told, and even the more cryptic chart notes, the texts link observed behavior to motive. Second, these discourses rely on narrative schemas that govern how one is expected to "do hospital" as clinician or as parent. The emergency room doctor, in particular, as portrayed both through Barbara's story and her own chart notes, defines Barbara in a particular way because Barbara has violated the script for doing hospital properly, as a good parent should. More complexly, these accounts reveal that in border zones like American emergency rooms, there are also scripts that govern breaches. The doctor effortlessly (if erroneously) interprets Barbara's intentions because she possesses an array of scripts that govern common situations in which patients and families violate the way emergency room is supposed to be done.

Third, in Barbara's story, "narrative proper," we have breaches within breaches. Her own breach of proper "emergency room" behavior is nested within a moral tale about contemporary health care as a violation of ethical medical behavior. This is a violation of the canonical dramatic tropes that are supposed to govern everyday practice. The canonical clinical tropes share the (utopian) assumption that hospitals exist for clinicians to diagnose and treat sick people rather than turn them away or compel parents to break rules to get care for their children. Families, too, share these canonical healing tropes and believe they ought to be entitled to care when their children are very sick and must be taken to the emergency room. When, in actuality, this dramatic expectation fails so utterly, such failure serves as fertile ground for stories that document the inhumanity of care. In her account, we (as audience) are allowed into Barbara's mind as she depicts her own impossible position as a person who must choose between not being a good mother by obeying the doctor (and, therefore, taking a sick child home, again) or not being a good mother in the eyes of the hospital staff and, thus, possibly jeopardizing future health care for her child at one of the

best hospitals in the city. By telling this story in rich detail, Barbara points toward another moral: a breach at a societal level. She exposes a breach of expectations surrounding the claims of the American health care system, namely that a hospital is supposed to offer care when one is very sick and goes to the emergency room.

Barbara's experience hints at the way cultural scripts are invented. Her experience of the emergency room, coupled with other experiences she has had in trying to seek care for her daughter—especially the full year of fruitless trips to emergency rooms in hospitals throughout the city—are narrated and renarrated to other parents, who have similar stories of their own. For Barbara and many other parents, such powerful experiences, meriting powerful stories, are pivotal to the development of new scripts. In this case, Barbara and other parents develop scripts about uncaring, inattentive, or incompetent health professionals and how to deal with them. They devise scripts about how to act out a “just right” noncompliance as part of their responsibility to get care for their children.

In addition, failure at narrative mind reading, that is, at constructing the appropriate story to make sense of another's actions, has important practical as well as interpretive consequences. Narrative mind reading reflects received cultural identities, often in a manner that only intensifies stigmatized and racialized portraits of the “Other.” The ongoing production of cultural difference, in turn, affects the course of diagnosis and treatment.

### **Bruner and the Border Zone Theorists: Concluding Remarks**

Classic anthropological treatments of culture have been built on the presumption that social groups share beliefs, values, language, and scripts that govern daily life. Bruner notes the regrettable tendency of classic anthropology to overread the shared nature of culture, to create elegant cultural pictures and excise the ambiguous or slipshod from the cultural scene.

Bruner's treatment of narrative, particularly his emphasis on narrative's articulation of breaches of the canonical, provides him an avenue for moving away from cultural holism without relinquishing the culture concept altogether. Narratives, he declares, offer conventional strategies and scenarios for handling breaches that we inevitably encounter in pluralistic societies. More important, narratives (including a culture's available narrative scenarios or scripts) provide ways for people to negotiate differences of values and beliefs so that they can come to shared, agreed on ways of proceeding communally. It is on this last point that the sharpest divergence between Bruner and many “border zone” culture theorists arises. In simple terms, Bruner paints a more optimistic picture of the multivocal, pluralist society than they do (e.g., Amsterdam and Bruner 2000), one that—despite conflicts, misunderstandings, and practices of cultural Othering, it is still possible to talk about “a culture” because there exist some shared means—including narrative means—to negotiate.

In sum, while Bruner poses a more complex reading of social life than that characterized by classic anthropological holism, his conceptions of narrative mind reading require that members

of a society or other social groups share cultural frames. From the simple perception of intention, to the acquisition of cultural schemas for getting about in the world, to the ability to tell and understand complex stories that explore breaches and sometimes even portray new possibilities for social life, all of these interrelated modes of narrative thinking still rest largely on a classic notion of a “shared world.” Indeed, it would be impossible to accept Bruner’s notions of narrative reasoning without relying on some view of a group’s shared beliefs and scripts. Although he is critical of anthropology’s classic culture constructs and offers a picture that valorizes pluralism and its resources for inventing newly imaged possible worlds, he does not embrace the more radical positions of those anthropologists and culture theorists who either reject the culture concept altogether or use it sparingly, skeptically.

I have tried to bring Bruner’s ideas of narrative thinking to the border zone, and to place his ideas in conversation with anthropology’s contemporary culture theorists who have emphasized the cosmopolitan nature of cultural life. Bringing Bruner into conversation with anthropology’s work on culture is not simply an intellectual exercise. It is also a matter of some importance if one wants to consider narrative as a social tool, a fundamental form of thinking, but do so in social situations characterized not by seamless webs of meaning but, instead, something much more like border negotiations. Drawing on a single case of one mother, her child, and the health professionals who treat her, I have asked how Bruner’s idea of narrative mind reading illuminates the narrative work of actors operating in one kind of border zone. Conversely, how does the portrayal of culture as border zone offer new possibilities and puzzles for understanding narrative mind reading, in its various forms?

When taken to the border zone, narrative mind reading becomes intimately tied to the work of cultural Othering, an othering that depends, in part, on shared scripts. In border sites, even at their most conflicted, the problem is not that others cannot be understood. Rather, these spaces engender the construction of numerous scripts of typical violations that can make it difficult for actors to transcend their assigned roles. Even breaches become conventionalized. Such breaches may, in turn, beget narratives proper, like the one Barbara tells, that circulate among other families she meets at the hospital. Similarly, health professionals may circulate stories of their own about pivotal charged episodes with patients and family caregivers. And, as in the case of the events Barbara recounts, clinicians may selectively excise certain problematic encounters from their narratives. Although it would be overly simple to say that Barbara, her daughter, and the health professionals belong to a single, shared culture, it would be equally wrong to speak of them as operating in discontinuous worlds. Rather, they do sometimes draw on an array of commonly shared cultural scripts, such as what constitutes a medical emergency. However in virtue of their mutual positions as “familiar strangers,” this commonly shared script does not obviate the immensely consequential misreadings that ensue.

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## References Cited

Abu-Lughod, Lila

1990 Romance of Resistance: Tracing Transformations of Power through Bedouin Women. *American Ethnologist* 17(1): 41–55.

Amsterdam, Anthony, and Jerome S. Bruner

2000 *Minding the Law*. Cambridge, MA: Harvard University Press.

Appadurai, Arjun

1988 *The Social Life of Things: Commodities in Cultural Perspective*. Cambridge: Cambridge University Press.

1996 *Modernity at Large: Cultural Dimensions of Globalization*. Minneapolis: University of Minnesota Press.

Aristotle

1970 *Poetics*. G. Else, trans. Ann Arbor: University of Michigan Press.

Bhabha, Hommi

1994 *The Location of Culture*. London: Routledge.

Bruner, Jerome S.

1986 *Actual Minds, Possible Worlds*. Cambridge, MA: Harvard University Press.

1990 *Acts of Meaning*. Cambridge, MA: Harvard University Press.

1996 *The Culture of Education*. Cambridge, MA: Harvard University Press.

2002 *Making Stories: Law, Literature, Life*. New York: Farrar Straus and Giroux.

Carr, David

1986 *Time, Narrative, and History*. Bloomington: Indiana University Press.

Clifford, James

1988 *The Predicament of Culture*. Cambridge, MA: Harvard University Press.

1992 *Traveling Cultures*. In *Cultural Studies*. Larry Grossberg, ed. Pp. 96–116. London: Routledge.

De Certeau, Michel

1984 *The Practice of Everyday Life*. S. Rendall, trans. Berkeley: University of California Press.

Fischer, Michael M.J.

2001 Ethnographic Critique and Technoscientific Narratives: The Old Mole, Ethical Plateaux, and the Governance of Emergent Biosocial Polities. *Culture, Medicine, and Psychiatry* 25(4): 355–393.

Forster, Edward Morgan

1927 *Aspects of the Novel*. New York: Harcourt Brace Jovanovich.

Garro, Linda C.

2000 Cultural Knowledge as Resource in Illness Narratives: Remembering through Accounts of Illness. *Narrative and the Cultural Construction of Illness and Healing*. Berkeley: University of California Press.

- Gupta, Akhil, and James Ferguson  
1997 *Anthropological Locations: Boundaries and Grounds of a Field Science*. Berkeley: University of California Press.
- Holland, Dorothy, William Lachiocotte, Debra Skinner, and Carole Cain  
1998 *Identity and Agency in Cultural Worlds*. Cambridge, MA: Harvard University Press.
- Jackson, Michael  
1995 *At Home in the World*. Durham, NC: Duke University Press.
- Lawlor, Mary, and Cheryl Mattingly  
1998 The Complexities Embodied in Family-Centered Care. *American Journal of Occupational Therapy* 52(4): 259–267.
- MacIntyre, Alisdair  
1981 *After Virtue: A Study in Moral Theory*. Notre Dame, IN: University of Notre Dame Press.
- Mahon, Maureen  
2000 The Visible Evidence of Cultural Producers. *Annual Review of Anthropology* 29: 467–492.
- Marcus, George  
1999 *Critical Anthropology Now: Unexpected Contexts, Shifting Constituencies, Changing Agendas*. Santa Fe: School of American Research Press.
- Mattingly, Cheryl  
1998 *Healing Dramas and Clinical Plots: The Narrative Construction of Experience*. Cambridge: Cambridge University Press.  
2000 Emergent Narratives. In *Narrative and the Cultural Construction of Illness and Healing*. Cheryl Mattingly and Linda Garro, eds. Pp. 181–211. Berkeley: University of California Press.  
2004 Performance Narratives in Clinical Practice. In *Narrative Research in Health and Illness*. B. Hurwitz, T. Greenhalgh and V. Skultans, eds. Pp. 73–94. London: Blackwell.  
2006 Pocahontas Goes to the Clinic: Popular Culture as Lingua Franca in a Cultural Borderland. *American Anthropologist* 108(3): 494–501.
- Mattingly, Cheryl, and Mary Lawlor  
2001 Fragility of Healing. *Ethos* 29(1): 30–57.
- Ochs, Elinor, and Lisa Capps  
2001 *Living Narrative: Creating Lives in Everyday Storytelling*. Cambridge, MA: Harvard University Press.
- Olafson, Frederick A.  
1979 *The Dialectic of Action: Philosophical Interpretation of History and Humanities*. Chicago: University of Chicago Press.
- Olwig, Karen, and Kirsten Hastrup  
1997 *Siting Culture: The Shifting Anthropological Object*. London: Routledge.
- Paerregaard, Karsten  
1997 *Linking Separate Worlds: Urban Migrants and Rural Lives in Peru*. Oxford; New York: Berg.
- Ricoeur, Paul  
1981 *The Rule of Metaphor: Multidisciplinary Studies of the Creation of Meaning in Language*. Toronto: University of Toronto Press.  
1984 *Time and Narrative*, vol. 1. Kathleen McLaughlin and David Pellauer, trans. Chicago: University of Chicago Press.  
1985 *Time and Narrative*, vol. 2. David Pellauer, trans. Chicago: University of Chicago Press.  
1987 *Time and Narrative*, vol. 3. Kathleen Blamey and David Pellauer, trans. Chicago: University of Chicago Press.  
1992 *Oneself as Another*. Kathleen Blamey, trans. Chicago: University of Chicago Press.

Scott, James

1985 *Weapons of the Weak: Everyday Forms of Peasant Resistance*. New Haven, CT: Yale University Press.

Tsing, Anna Lowenhaupt

2005 *Friction: An Ethnography of Global Connection*. Princeton, NJ: Princeton University Press.

Wertsch, James V.

2002 *Voices of Collective Remembering*. Cambridge, MA: Cambridge University Press.

White, Hayden

1980 The Value of Narrativity in the Representation of Reality. *In* *On Narrative*. W. J. Thomas Mitchell, ed. Pp. 1–23. Chicago: University of Chicago Press.

1987 *The Content of Form: Narrative Discourse and Historical Representation*. Baltimore, MD: Johns Hopkins University Press.