MAKARION, ELENA Ph.D. Resisting Triumph and Embracing Uncertainty in Narratives of Mental Health. (2024)
Directed by Dr. Risa Applegarth. 188 pp.

A mental health diagnosis can impact one’s ethos, self-understanding, and whether or not one is listened to and believed by others. This is especially true of uncertain and ongoing mental health conditions that are difficult to diagnose or cure. In this dissertation, I take an interdisciplinary approach, using rhetorical, disability, and literary theory to consider practical implications for a wide array of audiences, including the narrative medicine and mental health rhetoric fields. Through an analysis of case studies, patient stories, and patient handbooks, I establish the pervasive impact of the cultural story of triumph. Within this dominant cultural story, I decode expectations in triumph scripts, focusing on cause-and-effect plots and metaphors of brokenness that can be dismissive of painful experiences or make the person who doesn’t “overcome” culpable for their illness/disability. By bringing attention to the foreclosing power of triumph scripts and medical identifications, I call for an expansion of narrative forms that allow for ambiguity, agency, and singularities in narrating experiences. These divergent narratives can be found in the formal structures of literature. In subsequent chapters, I cluster novels—defined as Gothic and Transient narratives—that offer rhetorical strategies, like fresh plots and metaphors, which allow for accepting instead of overcoming embodied differences. Through literature, I describe the affordances of narratives to create inroads to a fuller engagement with the severities of suffering while also inviting identification with difference for both the listeners and tellers of experiences of illness/disabilities.

RESISTING TRIUMPH AND EMBRACING UNCERTAINTY IN NARRATIVES OF MENTAL HEALTH

by

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A Dissertation
Submitted to
the Faculty of The Graduate School at
The University of North Carolina at Greensboro
in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

Greensboro

2024

Approved by

Dr. Risa Applegarth
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DEDICATION

I dedicate this dissertation to my husband and best friend, Steven Makarion, who was my partner every step of the way and never for a moment doubted I could do this. Thank you for moving across country twice, giving me the gift of time, and devoting your last decade with me to this dream. I hope to make you proud.

APPROVAL PAGE

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May 17, 2024
Date of Acceptance by Committee

May 17, 2024
Date of Final Oral Examination

ACKNOWLEDGEMENTS

I want to thank my incredible committee, Risa Applegarth, Anthony Cuda, and Heather Adams; thank you for allowing me to take the wandering path, to cross disciplines, and to arrive at work I find worthwhile. To my brilliant daughter: thank you for bringing me so much joy and for sharing your mom’s time so generously this last decade. This project could not have been possible without my parents, Julie and Rick Carter, my first, best, and continued teachers. I especially thank my sister, Rachel Carter, for reading 1,000+ pages this last decade and being ready within 5 minutes notice to jump into my project as if it were your own; your insight and diligence has helped me develop each of these ideas. To my brother, Benjamin Carter, thank you for helping me parse through a chaos of content to make something cohesive. Boundless gratitude to Kye Flannery for doing the narrative medicine work that has shown me why this subject matters; there are so many hoops you jumped through with me to make this degree happen. Thank you, also, to Craig Nova, who first convinced me I could write. Lastly, thank you to the best of friends and readers, Anne Elizabeth Chacon, Jeni Smith, Scott Guild, Brie Goumaz, Jessie Van Rheenan, Hiala Witt, Jonathan Carter, Kris Brunelli, and Cory MacPherson for the generative conversations and encouragement. Where would I be without you all?

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CHAPTER I: MEDICAL IDENTIFICATION AND DIVERGENT LITERATURE

"My heart is moved by all I cannot save:
so much has been destroyed
I have to cast my lot with those
who age after age, perversely,
with no extraordinary power,
reconstitute the world." – Adrienne Rich

While this is a project using the tools of rhetoric, I will take an interdisciplinary approach, to take advantage of the possibilities rhetorician Peter Khost, in his book *Rhetor Response,* names as "literary affordances." "Affordances" he defines as "the ways in which readers 'use' and integrate literature into their own writing or lives. Unconcerned with authorial intent, interpretive meaning, or critical reception, "affordance" signifies a shift in focus from what literary texts mean and do to *what one can do with them*" (ii). I take seriously the notion that literature can open new possibilities to storytellers as they describe their unique embodied experiences; and, additionally, that literature can open new possibilities for listening and understanding these stories. Literature, with its focus on the embodied, contextual, and singular, offers rhetorical possibilities for resisting dominant scripts and for reimagining depictions and responses to divergent agency.

Unlike traditional literary approaches, I am less concerned with authorial intention, but rather examine novels to extract divergent narrative strategies that can be taken up and used in authoring and listening to illness narratives. I use this rhetorical approach to literature, locating two narrative devices: plot and metaphor that writers like Virginia Woolf, Paul Harding, Charlotte Perkins Gilman, and Shirley Jackson employ.

Here, too, I will examine how dominant narratives like the cultural story of triumph employ literary devices—particularly cause-and-effect plots and metaphors of brokenness—

that encode a set of cultured expectations for bodies of difference. A triumphal script, built upon assumptions around what health and rhetoricity ought to entail, forecloses the uncertainties, possibilities, and ongoingness of chronic mental health conditions. In this project, I take a rhetorical listening approach, informed by Krista Ratcliffe and Kyle Jensen's *Rhetorical Listening in Action*. Ratcliffe and Jensen offer a method for understanding the power of cultural scripts: "If …rhetoric has a socializing function that moves people to adopt certain 'attitudes and actions,' then cultural logics may be imagined as discursive formations comprised of three elements: 1) a dominant trope, 2) associated beliefs, and 3) cultural scripts" (29). Accepting their challenge to "listen across difference," I will identify the dominant narrative tropes of Triumph in medicalized cultural understandings of illness and disability. I will show how such scripts can constrain and foreclose a speaker/rhetor's rhetorical agency and authorship, while failing to challenge our rhetorical listening capacities as we do when we listen deeply to difficult stories.

When a person with an illness is uncertain about the nature of their condition—say, perhaps, no definitive diagnosis has been found—they enter then into a space which is well-traversed by any member of a disability community: what it is to be pressed to "adopt certain attitudes and actions" which may not apply, and may even cause harm. Here, I will identify rhetorical tactics, such as plots and metaphors used in the triumph narrative, which deny an "honest engagement with the body and its pain" as well as the "full humanity" and affordances of illness/disability (Adams, Reiss 9).

When one authors an experience which does not follow a triumph script, listeners may *overwrite* the meaning of the teller's story. This is especially true of painful stories of ongoing uncertainty and suffering, which may create in the empathetic listener some degree of pain. A popular recent video created from a talk by Brené Brown, a shame researcher and doctor of social work, depicts a person at the bottom of a hole, with a well-meaning person shouting from above, trying to think of silver linings to paint on the cloud. “Rarely,” Brown says, “does an empathetic response begin with ‘at least…’” (3). In the waxing and waning of a crisis of ongoing illness, it is tempting to apply a familiar script which promises an end and purpose to the suffering. Yet, listeners who are only familiar or comfortable with scripts of certainty and cure may ignore or deny the presence of another’s invisible suffering — an approach which honors neither the rational thought nor the feelings and embodied experience as part of exploring and interpreting the world we live in, oblivious to the postmodern attention to shifting and layered realities (Nealon). The expectation that triumph is the appropriate storyline can silence and estrange, in effect cutting off the voices of those who would communicate ongoing suffering, or the rich affordances of embodied differences. We need new scripts.

And we can find some of these scripts in literature. My goal in offering new scripts is to further shift our engagement with disability and illness, moving toward a radical acceptance of a person’s embodied realities which acknowledges each person’s right to author their own experiences. To have our experiences believed and heard—in the fullness of their spaciousness and difficulty—is an extension of agency. By bringing attention to the foreclosing capacity of medicalized identification, we make space for including literature in fields such as Rhetoric of Health and Medicine (RHM) to increase narrative agency. We may begin to center thinkers in the field of Narrative Medicine, whose founder Rita Charon, MD, sought to improve the practice of medicine through an integrative understanding of the value of stories:

> Narrative medicine proposes that health professionals, as a matter of routine, be equipped with the skills that allow them to absorb, recognize, interpret, and comprehend the value of all that patients tell competently, actually. Through training in reading, in writing, in reflecting, in decoding these many gestures of life-writing, health professionals can

> readily become dutiful and powerful readers to their patients' illness narrative… Through their own powers of reflection and clinical imagination, they can recognize the plights of patients sometimes more clearly than can the patients. They can, then, with deep empathy, name the suffering they see, offer themselves humbly as one who recognizes, who listens, who cares (Charon 103).

The teller, she points out, is competent. The listener, trained in medicine but not storytelling, must build skills in order to catch up. In closely attending to literature that allows for ambiguous and complex representations of illness through literary *forms,* I am able to offer practical alternative narrative strategies to the tellers/authors who must rescript a new identity in the wake of a sudden illness or diagnosis that "shatters" their previous "cohesive" sense of self (Frank 4). Unlike in the field of Narrative Medicine, however, which often focuses on "understanding" representations of illness (as a way to become a more empathetic listener), this project more closely aligns with RHM's concerns of patient agency, advocacy, and identification (which I will discuss more fully in the following section).

In order to increase agency by allowing resistance to the dominant scripts that may cause harm, I will rely on what I define as Gothic and Transient narratives, which offer a set of associated beliefs and scripts that allows for complexity, identification, rhetoricity, and agency through narrative strategies. Particularly, I will examine novels, short stories, memoirs, and patient narratives that intentionally resist dominant narrative structures and, through their innovative forms, reconstitute the meanings made of embodied differences. I frame these alternatives as "divergent narratives," a term Rhetoric of Health and Medicine scholar Catherine Gouge develops in her essay "No Single Path: Desire Lines and Divergent Pathographies in Health and Medicine." Catherine Gouge encourages a shift away from static ideas of agency rooted in generalized values held by many in the medical community and by culture at large. Gouge argues that listeners can benefit from recognizing patients' "desires" as a way to understand the underlying values which determine what agency looks like *for them* (125). Gouge explains:

> Divergent pathographies are valuable to the study of health and medicine because they can help us elaborate on this acknowledgment that agency, like doing, is both rhetorical and storied. The emphasis on agency as agile, situated, and emergent can help form the basis of a more nuanced—and, perhaps, honest—understanding of divergent behaviors as rhetorical acts of becoming; of the limitations of narrow, oversimplified ideas of agentic action; and of the ableist, mastery-and-control models of agency to which complicated? expectations are bound…. In so doing, divergent pathographies explore the many ways that agency is embodied, oriented, produced, and distributed" (Gouge 127).

According to Gouge, if there is a script limiting what health and agency looks like, then it becomes impossible to recognize actions that diverge from norms in health. Divergent narratives can move into the realm of ambiguity by resisting closure, mastery, and cure. Thereby, they allow for singular and embodied realities of suffering or difference to be depicted in their fullness, rather than as reductive medicalized versions. In applying a rhetorical approach to literature, we will look for glimpses of possibility, a method that "attempts to suggest that which is possible…striving to attain a place in that of potentiality" (Poulakos 36). I search for inroads of singular, embodied experiences that can offer new narrative and rhetorical potentialities.

Identification with a Medical Identity and the Risks to One's Rhetoricity

There are many risks to identifying with a medical diagnosis. In the introduction to a special issue of RHM "Interrogating the Past and Shaping the Future of Mental Health Rhetoric Research," Cathryn Molloy, Drew Holladay and Lisa Melonçon invite interdisciplinary scholars to consider the stakes of mental health discourses through rhetorical approaches. These scholars situate RHM as a "dwelling place" and point toward a shared exigence sensed by participants in this field that public representations and discursive behaviors surrounding diagnoses (especially the stigma of a mental health diagnoses) can infringe upon patients' agency and self-narration. The introduction generates many potential directions for the newly developing field, but one possibility they suggest is for rhetorical scholars to identify the impacts that medical labels and discourses can have for patient identification. My dissertation takes up several questions related to Mental Health Rhetoric Research (MHRR)'s overall interest in patient identification, storied representations, and socially constructed diagnoses. The first question I explore from the field of MHRR is: "What are the exigencies and consequences of labeling a set of behaviors as illness? Disorders? Disabilities?" (Molloy ii). Specifically, how does constituting difficult lived experiences *as* illness shape, through narrative elements like metaphors, one's personal story? Further, how does adopting these stories intersect with one's ethos and self-authorship? The second central question I take up is "Where can MHRR make connections between discourses of mental health and its representations in popular media such as fiction, television, film, and social media?" (Molloy iv). I will explore how constituting an illness identity often overwrites other identities, brings into question a person's credibility as the narrator of their body, and forecloses alternative ways of making meaning of embodied differences. Additionally, I consider the affordances of alternative narrative representations to resist stigmatized identifications and reshape rhetorical possibilities.

In my alignment with the field of RHM, I share this community's concern with the implications of diagnostic definitional power in the lives of doctors, patients, friends, and family members who have stakes in medical narratives and identity uptake. In each chapter, I begin with a call to action from doctor and patient narratives that articulate a problem (like demanding certainty or cure through plot.) Next, I turn to disability and critical rhetoric theories that frame how these depictions circulate and are sustained in cultural narratives of mental illness and disability. Then, I turn to fictional representations that further elucidate these problems and respond with divergent narrative strategies. Finally, using rhetorical theories of identification and Métis, I describe rhetorical possibilities of agentic narrative alternatives for reconstituting embodied differences that allow for the rich affordances of embodied difference, the severity of ongoing suffering, mystery and uncertainty, chaos and lack of cohesion, and other central aspects of chronic disabilities and mental health conditions that cannot be "cured."

While this is, in many ways, an interdisciplinary project, I situate this dissertation within the subfield of MHRR (Mental Health Rhetoric Research). Fortunately, the field of RHM identifies itself as an "emergent multi-and interdisciplinary field" in its methodologies, audiences, and objects of analysis (Meloncon i). My approach is largely narrative based and draws from narratology scholarship in fields such as sociology, sociolinguistics, psychology, psychiatry, cultural studies, medicine, and literature to set the rhetorical situation and exigence. Foremost however, this dissertation centers a critical rhetoric approach with its consideration of how vulnerable rhetors navigate their rhetoricity.[1] Particularly, I look at how dominant narratives foreclose rhetorical listening. My arguments about ways mental illness narratives restrict rhetoricity are buoyed by disability theories that embrace embodied differences and critiques of norms. I explore how discourses of illness often serve certain portions of the population (for example, the able-bodied or the medical-industrial complex that insists on "cure" and an ideal state of health) but negate stories told by those with embodied differences as the "other." As medical sociologist Peter Conrad explains in "Medicalization and Social Control," those who have *definitional* power over certain persons also have control over the

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[1] Remi Yergeau, Jay Dolmage, Eli Clare, Jennell Johnson, Cathryn Molloy, and Scott Blake.

meanings made of illness (210). The critiques my project offers are supported by branches of health rhetoric such as normative rhetoric, medical rhetorics, and disability rhetoric, that describe how these discourses are constructed and function across cultures.

The stakes of adopting a diagnosis as a way of rescripting oneself are high. For, a diagnosis is more than just a medical definition; it is also an identity that is highly storied in discourses that circulate in popular culture. Therefore, taking up a diagnosis often means taking up a self-identification shaped by medical discourses and popular representations of illness and disability. Among the most important RHM scholarship on medical discourses is Kimberly Emmons' research on mental disabilities and "identity uptake" (32). Emmons describes how the intersections of metaphors in discourses (the Diagnostic Statistical Manual [DSM], movies, pharmaceutical ads, family narratives, celebrity posts) create a dominant narrative and that through repeated exposure to these medical and popular representations, individuals come to "inhabit healthy and ill subjectivities, taking on dispositions and subjective orientations as they take up the available genres and discourses" (35). While there is nothing inherently problematic about accepting a medicalized narrative of the self, it is important to attend to the ways that medical discourses can shape identity. For, the risk of receiving a diagnosis is that "in the process they [patients] alter themselves to accommodate the expectations and images encoded by the discourse" (Emmons 57). In fact, recent embodiment theory has gone as far as to say that one's bodily experiences are shaped through discourses of the body.[2] Thus, the stakes of identification with specific narratives that circulate in conjunction with illness, disease, or disability are high since they have the power to rescript understandings of the self.

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[2] See Amy Koerber, and Abby Knoblauch *Bodies of Knowledge: Embodied Rhetorics in Theory and Practice*.

One of the ways that medical identities are imposed on individuals is through the socially constructed narratives surrounding diagnoses. As medical rhetorical scholar Peter Conrad explains, society is increasingly moving toward “medicalization” as a way of making sense of embodied differences and suffering (9). When experiences of illness or disability are “framed and filtered by medical prose” they often take a tone that presents its framework for experience as factual and unbiased, if not the absolute and definitive guide for understanding difference (Conrad 10). Additionally, because of the authoritative power of a text like the DSM, the discursive and narrative aspects of diagnostic identities often become invisible (Holladay 4). And considering that a person struggling with mental health symptoms must first be given a diagnosis (for access, insurance, medication, protocol and treatment purposes), it is vital to consider how accessing treatment often leads to taking up a new identity. As Kimberly Emmons explains, medicalized narratives “draw on the ideological power of genres as a means of imposing subjectivities and subsequently disposing individuals toward biomedical interventions in their lives” (Emmons 76). For this reason, scholars in MHRR prioritize making visible the social-constructedness of the DSM as not a definitive but rather as a narratively and socially constructed text (Patty 49). There is a mutuality of the DSM with cultural narratives; for each shapes the other. This discursive relationship between the DSM and cultural knowledge is an important dimension of my critique; here I want to make explicit that my aim is not to critique the process of diagnosis or to critique the validity of the DSM, but rather I bring attention to how the DSM is shaped by cultural metaphors and stigma of difference and how this in turn shapes the narratives and identities it offers up.

As scholars in disability studies have shown[3], taking up a mental health diagnosis is an especially fraught situation since the DSM works *against* an established idea of what "normal" and "healthy" looks like. In order to receive treatment, one must first be interpreted as a being who is the "other": abnormal versus normal, disabled versus able-bodied, disordered instead of orderly. A diagnosis, then, is constructed through ideas of what normal and healthy ought to look like in ways that often render differences as problematic, morally wrong, and in need of cure and fixing. In chapters 2, 3, and 4 I discuss how diagnostic narratives often rescript the person as the problem and as the one responsible for not overcoming one's illness or disability. I critique the underlying logics embedded in metaphors and narratives of disability that write disability as a "problem in need of fixing" (Kessler). I explore Dolmage's questions on how metaphors shape understandings of disability and illness, asking, "Why have definitions of disability been based upon discourse (largely scientific) that represents itself as objective and "natural"? Why do metaphors of disability often function to hide an individual's humanity and highlight a deficit?" (114). As Lennard Davis explains in his article "Constructing Normalcy," to frame illness as the consequence of an ill society—to frame it as a consequence and to give it a purpose *at all*, instead of accepting it as merely the reality of the human condition—is to create bodies of difference as necessitating cure in dehumanizing ways.

For many, the terror of a diagnosis derives from a fear of giving up one's unique, singular, embodied sense of self for a universal stigmatized story (Showalter 9). Many fear that they will no longer be able to author oneself to oneself or to others; or that one will no longer be oneself at all. It is no wonder, given the way discourses of illness and disability have been

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[3] See Lennard Davis, Jonathan Metzl, and Catherine Prendergast.

constructed, that there is often resistance and terror around accepting a mental health diagnosis.[4] The fears of not being listened to or believed, of having one's embodied differences denied or belittled; of not having one's perceptions of reality acknowledged as valid, and of not being seen as fully agentic are at the root of many people's resistance to seeking treatment for mental health.

A major contributor to my understanding of medical identification are Indigenous theories that describe the *constituting* power of diagnostic labels that shapes and forecloses one's subjectivity. Renee Linklater, a scholar whose work centers Indigenous and First Nations communities, critiques the impacts of Western medical interventions upon Indigenous self-understandings, in particular the constitutive impacts of receiving medical diagnoses. In one of the interviews with a tribe member, Linklater explains that:

> The impact of diagnoses on identity is a particularly important issue… An elder expressed concern about the impact of labeling on the formation of identity and the subsequent harm that comes from negative identity development and self-image, noting "in our traditional way we never label anybody." Ed is concerned that for some people, "it becomes a part of who they are." He indicates, "When it becomes the core of who they are, I don't know how we manage to get them into a state of healthiness because they're trapped, I think, in a state of illness (112).

This passage demonstrates how a label in the form of a diagnosis forms more than one's identity but can go much deeper and can become "a state" that one inhabits. These elders recognized that the labels not only invite one to enter a state of illness but that this understanding of the self also forecloses alternative imaginaries of what it means to be healthy and other possibilities for identification.

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[4] See Sarah Wasson and Elinor Cleghorn for new psychiatric and diagnostic approaches needed to address the resistance to treatment and diagnosis resulting from stigma and "fear."

Several other decolonial theories likewise highlight how dominant narratives, medical labels, and the values and priorities they communicate can overwrite an individual's agency and/or self-determination. In *Therapeutic Nations*, Dione Million describes how medical interventions offered by the West to First-Nations and Indigenous populations can impose stories along with treatments. Consequently, these stories carry and communicate the values of a medical system that are often at odds with cultural and personal values and meanings of experiences of difference. The risk of adopting these medical meanings is that individuals often exchange previous narratives for medical ones. Million argues that "the danger of such a frame disbursed at local levels is that it can foreclose on other kinds of storytelling, other tropes, other kinds of knowledge that the community can and wishes to produce" (77). The foreclosure that Million warns of is closely tied to narrative elements. Million usefully points out that medical language is not just an identity, it also delivers a story with its own tropes and kinds of knowledge that is only one of countless possible narratives and possibilities and yet, because of the ideological power and weight of the diagnostic narrative, these other narrative possibilities are often lost. I offer in subsequent chapters "other kinds of storytelling" through narratives that resist typical medicalized narrative tropes and allow for the complexity and possibilities of meanings people can make of experiences of illness and disability.

Within the allowances of medicalized discourses most encounter, the performances of self are limited. As RHM scholar Kimberly Emmons explains, "The shorthand of clinical diagnoses assures common ground and allows for other kinds of performances of the self, but it also forecloses additional descriptions of health and illness" (56). Emmons describes how diagnoses can challenge one's agency since pathologized stories are generally single-storied and rather flat, emphasizing a faulty mind. Thin stories are scripted through static labels instead of an ever shifting and contextually contingent identity. When a patient adopts a story like "I am a schizophrenic," this is a thin description and leads to "thin conclusions drawn from problem-saturated stories, which disempower people as they are regularly based in terms of weakness, disabilities, dysfunctions or inadequacies" (Morgan 13). The narrative of a diagnosis is often a particularly thin story, given that people are scripted based on their shortcomings/ otherness/mental deficiencies rather than their strengths. Instead of rich agentic meanings, people in thin stories are scripted through their problems alone: problems that must be overcome. I, like Rita Charon, encourage moving towards "thick stories," which I imagine to be sites rich in possibilities that allow for responsiveness, contingencies, ambiguity, and the complexity required for navigating a vulnerable rhetoricity and therefore can offer more varied story elements people can choose from (12).

Importantly, dominant narratives like the triumph narrative comingle with medical diagnosis and foreclose or overwrite the more nuanced and ambiguous realities of illness and disabilities and cause listeners/tellers to dismiss the difficult realities of ongoing conditions and states of being. Frequent exposure to medical narratives that construe health as a static and achievable state (especially considering the authoritative power they have over many people as the absolute truth) can foreclose other narrative possibilities and attitudes toward illness and disability. The possibilities of stories of difference as *just* difference—stories of being human and complicated and singular—can be oversimplified by medicalized narratives that label differences as problematic. These structures toward closure can lead to impatience or complete disregard for stories that do not fit within the health/illness or the able-bodied/disabled story model and assume that those living in an ongoing state of ill-health choose "not to get better" and to remain in an ill state. This assumption is seen in many of the novels I examine, such as when Jane in "The Yellow Wallpaper" is interpreted as indulging her depression or when Septimus in *Mrs. Dalloway* is told to choose to shift his focus away from his negative fancies. The pervasiveness of the triumph narrative can void stories from those who experience ongoing suffering that are outside of their control. Thus, diagnostic labels that are closely tied with the triumph narratives can foreclose possibilities of identification with ongoing disability and illness that need not be overcome or cured.

I want to emphasize that what is at risk for the person who has just received a mental health diagnosis is their sense of self; the fear that they have been "taken over" by the illness and that their perceptions can no longer be trusted. Since being rational and intentional are often equated with being rhetorical, to be constituted as an irrational being because one has an "unstable" mind can also mean to be constituted as non-rhetorical. The novels exemplify what one of the most prominent rhetorical theorists of the last few years on neurodivergence; M. Remi Yergeau, who is autistic and writes about autism, makes a powerful case that those with autism are often considered to be "rhetorically suspect" and "victim-captives of a faulty neurology" (3). The problem of authoring the self, when one's "self" is deemed unstable, faulty, or unable to "coherently" communicate, is complicated when one's story or claims to suffering cannot be proved, as is the case of describing an invisible bodily or mental illness (Yergeau 7).

In the Gothic novels I examine such as *Jane Eyre* and *Mexican Gothic*, the characters are often told that the horrors they are facing are "all in their head" and that since they are mad, their experiences are not real. This same language, "all in your head" is used across patient cases I examine at length in the Gothic chapter. For example, in a case study on Morgellons disease, which I will look at in length in the Gothic chapter, even though the illness is "imaginary" the suffering is real; and the experience of suffering begs for articulation and a listener (Jamisen). The intersection of psychosomatic illnesses, vulnerable rhetoricity, embodied realities and how they affect one's persuasive potential offers an important tension for rhetorical scholars working in either disability, narrative, or embodiment studies. And, importantly, this tension is the primary theme explored in the Gothic novels I track, even the language often parallels across the novels and non-fiction stories. As Jane says in "The Yellow Wallpaper," one of the Gothic texts I examine, "If a physician of high standing, and one's own husband, assures friends and relatives that there is really nothing the matter with one but temporary nervous depression—a slight hysterical tendency—what is one to do?" (19). The plot tension relies on the isolation and rejection of one's experiences by those who are supposed to protect and care for the protagonists. The readers know that not only will the validity of their suffering be denied, but it will be used against them: they will be labeled as crazy, or perhaps locked away forever, trapped alone in a room with the mental affliction that so torments them. The narratives' endings are marked by the estrangement the characters feel at having no one to communicate their torment with who will not call them crazy. Over time, as medical authorities continue to insist that nothing is happening to the protagonists, they begin to doubt their own lived experiences, to wonder if the doctors are correct, if perhaps the effects they are experiencing are not real. Thus, their self-authorship, not only their rhetorical communications of it to others, becomes threatened.

Given the extensive research in MHRR on the impact of mental health stigma on a patient's rhetoricity[5], this dissertation operates under the premise that to be labeled with an

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[5] See Cathryn Molloy, Molly Kessler, Renuka Uthappa, and Remi Yergeau.

illness and disability is to have one's version of reality, especially the validity of invisible pain and suffering, questioned. The disability field has long established how limited and troubling the most widely circulated representations of mental illness and disabilities are[6]. And while there is substantial research on how one's intersecting identities can lead to having one's pain discredited, what has been less referenced is how a mental health condition intersecting with invisible illnesses and disabilities undermines a person's reliability as a credible expert on the experiencers of their own body (Molloy). As Jennell Johnson establishes in "The Skeleton on the Couch: The Eagleton Affair, Rhetorical Disability, and the Stigma of Mental Illness," stigma is "a constitutive rhetorical act that also produces a disabling rhetorical effect" (461). She relates this concept to the rhetorical effect of "kakoethos," or bad character, to explain how a diagnosis can constitute a person's ethos. Johnson explains that in Greek, "stigma" meant to be visibly marked as a threat and that, although "contemporary stigmas may not be literally imprinted on the body," the mark of stigma remains (464). Yet in the contexts of medical care—in physician examining rooms, clinics, hospitals, and other spaces where diagnoses are plumbed and confirmed—a mental health condition *is* imprinted, in the form of a patient's chart. Once a patient has been given a diagnosis like schizophrenia, anxiety, or bipolar disorder, this label is imprinted on a medical record that may, in shorthand, identify them as an unreliable narrator of their body/mind (Park). For example, in the second chapter on Gothic Uncertainty, I turn to patients like Brian Teare who lived with chronic health conditions. Brian Teare went to dozens of doctors to try and get help for his symptoms but were, early on in the process, given a diagnosis of "anxiety." This diagnoses, put on his permanent chart, caused

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[6] See Jay Dolmage, Catherine Prendergast, and Eli Clare.

nearly all subsequent doctors to deny his bodily symptoms and to tell him that what he was physically experiencing (what later turned out to be a severe autoimmune disease) was merely "all in his head," symptoms of anxiety. The impact of this diagnostic labeling increases when a patient has been institutionalized: a mark that will permanently remain on a patient's medical record and that may impact a person's ability to pursue certain fields of study, receive certain professional credentials, and more (Østerud 91). Consequently, as many scholars have noted, the stigma around a mental health diagnosis that appears on a chart often shows up in the language written and ultimately impacts diagnosis and the patient's credibility in other illnesses.

If, according to the logic of involuntariness, an unstable mind cannot be trusted and lacks intentionality, then it follows that one's narrative cannot be trusted- especially when this narrative seems to contradict dominant narratives that the listener has previously encountered. Yergeau explains how "the neurodivergent are often storied into (non) rhetoricity. We are conditioned to believe that our selves are not really selves, for they are eternally mitigated by disability, in all of its fluctuations" (Yergeau 14). Given the uncertainty and difficulty of proving invisible illnesses this rhetorical susceptibility is especially problematic. For, how is one supposed to insist on the realities of invisible suffering when every dominant narrative says the suffering can be overcome and when, additionally, one has no proof that the suffering exists other than that one is living it and that one's mind tells one it is so?

To offer a concrete example of the high stakes of attending to the credibility of the patient as the narrator of their own bodies, I offer the case of the Galvin brothers, three of whom had schizophrenia and all of whom, at separate times in their lives, visited the emergency room with complaints about their hearts and had their symptoms immediately discredited. The recent book about the Galvin brothers, *Hidden Valley Road: Inside the Mind of an American Family,* attributes the dismissal of their bodily symptoms to their schizophrenia diagnosis and the long histories of hospitalizations for "delusions" that were pulled up on their charts when they checked into the ER. The family members claim that the brothers' heart failure symptoms were ignored because the doctors figured them to be the imaginings of an unstable mind. Thus, the brothers were not given the routine checks that may have prevented heart complications, which led to their death several weeks after being dismissed. These brothers' parallel experiences, in different hospitals in different states, are more than a coincidence; they highlight the dangers of attributing a person's physical symptoms to their mental diagnosis. Unfortunately, most invisible illnesses cannot be confirmed with a test and a diagnosis. A treatment plan is entirely dependent on whether or not the patient is deemed a credible source as the narrator of their bodies.

Importantly, I want to add the caveat that I do not find medical identification to be problematic in itself. In fact, I believe that for many, choosing a medicalized screen is not to choose a thin and problematic story, but rather, identifying with a medical self-understanding can provide relief, an explanation for suffering, a sense of community with others who have similar lived experiences, a means of communication, or for contexts like work, a form of currency to legitimize necessary accommodations. This is especially the case when a diagnostic story does not contradict or threaten one's previous sense of self and cultural values. In fact, in chapter 2 on Gothic Uncertainty, I describe the problems of not being believed that something is wrong and the *inability* to receive a diagnosis that would be beneficial. Given the necessities of a diagnosis for many areas in life, I am not suggesting that diagnostic stories are problematic but rather that their totalizing power carries risks. Single stories that pose as representations of what illness always looks like or ought to look like can create harm for stories that do not fit within these models. But in the case of the medical narrative, not only does a diagnostic story foreclose alternatives in the way that picking up any narrative frame does, because of the authoritative power of the narrative, there is increased risk that the narrative can be totalizing; supplanting all other narrative possibilities.

While there are certainly many applied medical implications, like the case I just described the primary intervention I make is not to change stigmatized representations but rather to identify how particular diagnoses can alter one's sense of rhetoricity and credibility as the narrator of one's subjective reality. I argue that the triumph narrative can overscript one's sense of narrative agency by foreclosing one's singular, subjective, embodied reality, offering in its place a universal diagnostic self-understanding. I'm invested in how "stigma variously produces and reproduces mental health realities," causing one's reality to seem less-than when it is deemed "irrational" (Reynolds 2). There is already a large body of rhetorical research on the impacts of stigma, but less so on the narrative elements that make up these stigmatized narratives. My contribution to understanding the impact of stigma stories is not primarily to redefine what it means to be rhetorical.

I am, instead, looking for ways that perceived non-rhetoricity get embedded in stories surrounding a diagnosis and how they are circulated and taken up. I particularly offer counter narrative elements that center characters who navigate their perceived non-rhetoricity through divergent narrative choices. Thus, I am invested in the crises of disability as a crises of the loss of self-narration.

I particularly seek out narratives whose characters resist scripts that would write them as non-rhetorical. For example, in *Tinkers*, following a health crisis, the protagonist leaves his family to maintain his sense of humanity rather than accept the new story of him they take up that renders him pathetic and untrustworthy. I locate stories of characters whose crises lie not in the fact that they have a disability, but in the restrictions that their disability creates. For, the tension of the novels I am concerned with is not a coming to terms with disability as much as coming to terms with the crises of storying oneself; the tension is in the reclaiming the right to author one's reality—despite one's disability. The protagonist (or likewise a patient with a diagnosis), may think: my diagnosis means that I can no longer trust my mind, my perceptions, and my reality, and thus my diagnosis will supplant my sense of self. In this way, just like in how the triumph narrative threatened to circumscribe experiences of ongoing suffering, a diagnosis of mental illness threatens to circumscribe one's ability to self-narrate through perceived non-rhetoricity. This reclamation of self-authorship is evident in patient accounts I analyze in chapter one, such as memoirs by Kate Bowler, Joan Didion, and Lisa Olstein, whose narratives describe the difficulties of accepting a diagnosis and detail the extensive grappling to integrate their diagnosis and the risks the diagnostic stories pose to their sense of who/what they are.

The Foreclosing Power of the Triumph Narrative and the Call for Divergence

Since the possibilities for self-narration are largely determined by the narrative materials one has had frequent exposure to, it is vital to attend to the limitations and possibilities of story elements individuals can select from. As Ratcliff and Jensen explain, "Listeners must learn to identify the discourses they encounter… conventions include, for example, what can be said (topics) and not said (silences) as well as how something may be said and not said (tone and word choice) and how something may be delivered (platform, genre, formatting, sentence style)" (64). Importantly, one's narrative identity is always a socialized and discursive collection of narrative elements gathered from the story materials with which one is most familiar. It may seem that one has full agency over one's self-story, but, according to narrative identity psychologists, one selects (whether consciously or not) from the stories one has previously encountered (McLean 237). As one of the founders of the field of Narrative Identity, Dan McAdams, explains, "It would seem that different cultures offer different menus of images, themes, and plots for the construction of narrative identity, and individuals within these cultures appropriate, sustain, and modify these narrative forms as they tell their own stories" (McAdams 237). I find this metaphor—of the *menu* of available narrative means for taking up an identity—to be useful in thinking about how narrating one's story does not have endless possibilities and one can never start from "scratch." Rather, in one's self-narration, these stories are extremely limited. Given the relational aspects of self-narration, one's identity is never fully autonomous or outside of prevalent cultural stories. Consequently, the menu of narrative elements that one chooses can never be "neutral" and, in the case of illness, disease, or disability, the selection of narrative elements for constituting one's identity is constrained by the most pervasive narratives (Ratcliffe and Jensen 18). Therefore, I argue that a taking a critical eye to the menu of narrative elements one has been served—like the plots and metaphors I address in this project—can allow greater choice in whether to continue to use those narrative elements, or, to take up divergent narrative elements (which I identify in the latter half of this chapter) for scripting one's self-understanding.

Many script illness and rescript their sense of self through the Triumph Narrative not only because it is available, but also because it seems to restore a sense of order and control to often chaotic experiences of illness. Rita Charon calls humans "sensemaking" and narrative-making creatures, a facet I will explore in Chapter 1 where I talk about the triumph narrative.

This impulse to story as a way of regaining agency over the uncertain. But for now, I assert that the shock of an illness creates a narrative exigency. Arthur Frank, disability scholar, calls illness "a call to story" since illness often functions as the dissolution of one's previous life's story that the unexpected illness has disrupted (Frank 13). Many who have suffered from a sudden trauma or illness describe these experiences as "ruptures" in one's "previously coherent" life's story (McLean). In the wake of an illness that seems to come from nowhere, has seemingly no purpose, and is all but impossible to describe given the body's resistance to language, many turn to stories and metaphors to reestablish a cohesion in one's life (Charon). The triumph narrative readily provides what a person in shock and horror may want most. At least, nearly all health-related marketing materials sell triumph as the solution to the narrative problem caused by illness. Given the state of uncertainty and terror of sudden illness, a triumphant story is often readily embraced. As Kaethe Weingarten, a prominent Narrative Sociologist on illness narratives explains in "Making sense of illness narratives: Braiding theory, practice and the embodied life," mental illness "threatens the way we know ourselves and how others know us also. Anything that helps put illness in its place, that allows us to feel that we are who we are despite it, is welcome" (Weingarten 198). People are, generally, untrained and inexperienced in listening to stories of chaos. An impulse toward narration is a powerful force. This desire for cohesion and making sense, often takes the form of giving purpose to suffering and, for this reason, I found it to be the most common.

Of the cultural narratives that intersect with mental health diagnosis and foreclose a rich engagement with embodied differences, I've chosen to focus on the Triumph Narrative—the most prevalent dominant narrative I identified across the genre of Healing Handbooks, Narrative Medicine discourses, Self-care and health discourses, popular film representations, and, most importantly, patient stories. The patient stories, especially, provided the exigency for addressing the triumph narrative. While the triumph narrative goes by many names across disability studies: the Supercrip myth (Dolmage), The Hero's Journey (Joseph Campbell), the Quest Narrative (Arthur Frank), the story of Overcoming (Eli Clare) or the myth of Enhancement (Colleen Derkatch), I ultimately chose Kathlyn Conway's definition of triumph from her book *Illness and the Limits of Expression*, as the definitional framework to locate pervasive dominant narratives that have a directional push toward cure. While I will define the triumph narrative at length in chapter two, to give a brief description, Kathlyn Conway explains the triumph narrative is a "cultural story of triumph that suggests any adversity can be managed or overcome" (Conway 134). This story aligns perfectly with American myths of the self-made man and if you work/believe/strive hard enough, anything is achievable. Using the Healing Handbooks and patient stories, I explore how ideals built around norms come to dictate expectations surrounding health that demand cure and penalize bodies of difference that do not get better.

The Triumph narrative is a valuable site of analysis because it demonstrates how the constraints of narrative elements can foreclose full engagements with suffering. In the triumph story, when one does not overcome the problem of difference and return to a previous state, the responsibility shifts to the individual, assuming that illness/disability (an *un*natural state) must be the consequence of a lack of willpower or punishment for wrongdoing. This triumph narrative invites an affective response of either pity or a moral lessons about fortitude or growth; suffering either must be overcome or must serve some larger purpose. Staying in one's suffering is not an option. Through my analyses of these illness-to-health trajectories, I identify two narrative elements—plots and metaphors that push toward cure—in Healing Handbooks written by medical professionals and how they enforce imperatives toward an imaginary ideal health. In my analysis, I aim to make visible the hidden encoded narrative expectations and the norms they are built upon. I particularly critique who these narrative configurations serve, and who they harm, using a traditionalist critical rhetoric approach.[7] I draw upon a wide body of disability scholarship to do so and weave the theories through my critiques in each chapter. In doing so, I locate two triumph tropes—metaphors of brokenness and cause-and-effect plots—that work in conjunction with popular and medical discourses to push people toward cure and an idealized version of a presumed normal body.

One of the reasons that the triumph narrative as totalizing is particularly problematic is that experiences of mental illness, grief, or chronic illness rarely move toward a destination understanding of healing, at least in the sense of the outcome-based model of health that returns one to "normal." An insistence on overcoming circumvents the difficult realities of ongoing illness and disability and often aims to overwrite differences in narratives by refusing to hear more difficult experiences of chaos and uncertainty. This tendency to impose a narrative line even when one may not feel accurate to a person's experience. Triumph, then, can negate the right of others to self-determine the meanings of lived experiences. Chronological stories provide little room for uncertainty and because of familiarity with triumph stories, often rescript experiences to fit within a standardized narrative arc.

The triumph narrative, then, is composed of a spatially directional plot and metaphor that work in conjunction to move one *towards* either a previous state of health or a future ideal state of health. Importantly, an insistence on directional movement—like the chronological plot

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[7] See Jennell Johnson, Maurice Charland, and Drew Holladay.

and metaphor of broken/fixing that pervade the triumph narratives—foreclose a narrative structure for sitting with and in suffering. After all, as Rita Charon explains, sitting in a place of uncertainty with the realities of incurable suffering is extremely difficult, and it is tempting "to move too quickly to deny the chaos" (18). To reclaim a sense of agency, both listeners and tellers of suffering tend to push for a directional movement. Narrative Identity scholar McAdams explains that tellers and listeners of stories of illness "expect a story to have a beginning, middle, and end, and this expectation is typically couched in terms of time or chronology" (112). Generally, this chronological movement takes one of two directions. Either, in moving backwards in a *return* to a "natural" state of health, what Arthur Frank calls the "restitution myth," and what Colleen Derkatch calls the "logic of restoration." Or else, tellers and listeners try and move *toward* what Arthur Frank calls the "Quest myth" and Colleen Derkatch calls the "logic of enhancement." In *The Wounded Storyteller*, Frank offers a third myth for illness narratives: the "Chaos myth" as the one most people refuse to listen to or accept, for it is marked by the absence of directional movement- or perhaps moving in many directions at once. In either case, the chaos narrative resists a chronological plot toward cure. Derkatch argues that the logic of health continuously cycles through these two backward/forward directions and are supported by an imaginary ideal of health that is easily "achievable." I join Derkatch in critiquing this imagined ideal state of health, along with these directional movements in the Triumph narrative chapter, using disability theory to argue that these directions are built from ableist ideas of normalcy (Davis). I describe how the directional push is encoded in the metaphor of broken/cure that pushes toward closure; and plots, that offer a cause-and-effect chronology with the happy ending of health. While these demands toward health have already been critiqued by many rhetorical scholars, like in Eli Clare's book

Grappling with Cure, I particularly look at the way that these directional pushes get coded in plots and metaphors within narratives—in ways that are not always obvious.

I particularly look at how this push in the direction of triumph can have dire consequences in patient narratives and search for ways that listeners and tellers of suffering resist moving toward and learn to "inhabit" within one's own or with others' ongoing realities. In each chapter, I include patient narratives that describe how being constituted as mentally ill made them rhetorically suspect as narrators of their experience, but particularly, that the directional expectations made it difficult for others to join them *in* their suffering. For example, in the Triumph chapter, I include quaker and pedagogical scholar Palmer Parker's discussion about his severe depression episode, in which he explains how religious and cultural narratives that glorify suffering and claim that healing is a matter of will-power brought fissures in his relationships with others and himself. He explains how people's attempts to "help fix him" insisted on a directional movement toward cure; this spatial orientation—this plot and metaphor of broken/fixed—foreclosed the possibility of rhetorically listening to his suffering. He explains how one man was able to come sit with him in silence and "join" him *in* his difficult place rather than insist he moves in a trajectory *toward* health. To return to narrative identity scholar Dan McAdams, he explains how unfamiliarity with alternative plotlines and metaphors can end up foreclosing the listening and telling of stories that that would "dwell" in a place of ongoing suffering and mystery:

> Stories that defy structural expectations about time, intention, goal, causality, or closure may fail to elicit curiosity and interest and may strike audiences as incoherent, or at least incomplete. The listener expects a story to have a beginning, middle, and end, and this expectation is typically couched in terms of time or chronology… if the narrator does not do this, listeners may do it for themselves, imposing a coherent temporal structure onto an account that seems to lack one. Or listeners may just give up, concluding that the story simply does not make sense (McAdams 112).

Importantly then, the structural expectations configured by the triumph narrative that include the most common narrative in all stories, those of causality and closure, can keep people from hearing, believing, or understanding stories that resist these trajectories. In fact, stories that do not fall into these categories can be given up on; like I explained in the section on a vulnerable rhetoricity, divergent stories can be ignored, belittled, or rejected when they are unrecognizable to listeners or tellers. Triumph plot and metaphors are responsible for failures to acknowledge the legitimacy of suffering by demanding certainty, cure, closure, and chronology.

I explain in the Triumph chapter how expectations around health quickly turn into moral imperatives to create a "coherent" account. In these narratives, one's pain serves a larger purpose and working toward ending can cause not only isolation but also great personal harm. In order to be heard and believed, then, writers like Lisa Olstein, Kate Bowler, and Lydia Yuknavitch initially ended up "imposing a coherent temporal structure" on their accounts, even though this felt inaccurate. Eventually, not only did forcing their experience into this framework feel inauthentic, it also became extremely painful. For example, in chapter 1, I examine Lisa Olstein's *Pain Studies*, wherein she describes the cause-and-effect plots she tried to use to control her chronic pain; for, she believed if she could locate the cause of her suffering then she could find a solution and change the outcome. This type of plot quickly failed her. By the end of her memoir, she explains the damage caused by the cultural insistence on a chronological plot and the demand to give a purpose to suffering. Her testament to these negative effects closely parallel my critiques in chapter 2 on the *Healing Handbooks*. They caused her to feel a sense of shame and culpability when she couldn't get "cured," a sense of feeling less-than and broken or sub-human, a sense of victimhood and loss of agency, an inability to communicate or be listened to by others, and a sense of a lack of cohesion in her life. In addition to Parker Palmer and Lisa Olstein, other patient narratives include personal stories by Brian Teare, Sue and Dan Hanson, Joan Didion, Lidia Yuknavitch, Sarah Manguso, Kate Bowler, and case studies in the medical field that include patient narratives. Each of these stories demonstrate the isolation, sense of culpability, and resistance to accepting the realities of their condition they experienced.

I've chosen these patient narratives because they all describe how listeners' denial of the severity of their pain and their refusal to believe in the neutrality of their illness (as something natural, and not awful and deviant in need of fixing) is an effect of cause-and-effect linkages. Consequently many of these authors intentionally resist plots. For example, Lidia Yuknavitch's *The Chronology of Water* describes how her process of grief over losing her child could not align with traditional plot trajectories. In order to allow for the complexity of her own experience, she creates a new trajectory through the metaphor of water, which rescripts an understanding of chronology and brings her "illness" into a metaphor from the natural world—water—instead of the negatively connotated broken metaphor. Lisa Olstein, who, as I mentioned before, grew critical of cause-and-effect plots, also turned to alternative narrative structures in order to more accurately portray her experiences. She employs fragmented and cyclical forms that allows her to mimic in form and rhythm the "purposeless" and unexpected ruptures that flare-ups of her illness causes (Olstein). By analyzing these patient narratives, all of which describe limitations in the narrative elements made available for understanding and communicating their conditions with others, I make clear the stakes and exigency for divergent narratives. I attend to these patient narratives as a call for alternative narratives to resist the foreclosure of these structures. In order to resist the directional imperatives, I look to authors who search for alternatives to plotlines and metaphors that ask for a denial of the reality of one's pain.

The spatial directions of narratives of illness includes learning to reside *in* suffering or to join in another's current situation. For example, in the Gothic and Transient narrative chapters, I offer divergent plots and metaphors that allow one to "inhabit" a space without moving in any particular trajectory. Through the Gothic narrative, I offer the haunted house as a divergent metaphor. The Gothic house is a metaphor for the protagonists' bodies, and while the house holds terror and suffering, and is full of uncertainty around every corner, the protagonists learn to navigate the dangers and mysteries through an acceptance of the house's condition. They lean into their embodied responses to the house as a source of knowledge, even though the medical professionals in their lives say the house's hauntings aren't real. The house offers a spatial metaphor of a dwelling place that allows one to accept mysteries and uncertainties. The Transient novels offer divergent metaphors and plots through descriptions of the natural world and its transient and impermanent states as a metaphor for the body. While the triumph narrative scripts bodies of difference as broken and in need of curing, the Transient novels use nature to describe the body's fallibility and mortality as "natural" and part of the cyclical cycles of nature, making room for a dwelling in the present through an acceptance of life's precarity.

A Fuller Engagement with Suffering: The Call for Rhetorical Listening

If engaging fully with illness and disability is the goal of this project, then I have attempted in this chapter to show how certain stories (like triumph and its narrative components) foreclose this engagement by over-scripting individual realities that do not conform to the demands of triumph plots. In order to address the issues of having one's suffering ignored or dismissed, I critically challenge stories that attempt to circumscribe the difficult realities of ongoing illness or unrealistically imagine that a person has control over a disability. In the following section, I will discuss the need for divergent narrative forms that create the possibilities that Gothic scholar Sarah Wasson says there is a need to allow one to be "equal while also being different" and to see the "obvious fullness of disabled life," aspects that are rarely represented in triumph narratives but are defining features of the divergent novels I analyze (Wasson 134). Instead of drawing away from suffering and pain, I turn to narratives that embrace and draw toward that pain; not for its ability to make someone stronger, or to be overcome, but to be represented in the accuracy and fullness of living in a body. Thus, I explore the possibilities of divergent narratives that allow for a radical acceptance of the uncertainties of mental health conditions.

Admittedly, stories of suffering are difficult to accept, narrate, and listen to. As Narrative Medicine Founder Rita Charon explains:

> It can be extremely difficult to read or listen to representations of shattering experiences. Researchers working with healthcare practitioners have found hearers [this may be friends, family members, doctors, or anyone listening to those experiencing suffering] are likely to deny the horror of such narration and recuperate them into more positive stories, seeing the misery as linked to depression, or trying to frame the suffering as potentially alleviated in the future by scientific breakthroughs. Yet moving too quickly to deny the chaos runs the risk of failing to recognize the validity of the speaker's suffering. Clinicians and cultural theorists alike have called for the urgency of witnessing the reality of another's experience of suffering, without the auditor/reader taking flight by diminishing or reframing it (18).

Rita Charon calls for the need to listen to difficult stories of ongoing suffering and describes the common practice of "diminishing and reframing" stories told by those who are suffering. The rescripting is a result of expectations created by narrative elements that demand closure or purpose from suffering. For example, if a person is suffering from symptoms of depression, a common triumph narrative response would be to tell a person to "think more positively" so as to "move beyond" one's experience or to insist that pain has "made you a better person." Other responses might include phrases like “buck up” or “perk up,” implying that one’s mood state is within one’s control. In this way, the limitation of the narrative works to reduce a person’s agency by denying the reality of their experiences. Such responses fail to acknowledge present suffering, and in Charon’s terms represent a kind of “flight” away from the experiences the speaker or sufferer has shared. This begs the question: what might divergent care look like? What does care without cure or fixing—without the forward progression of plot—entail?

I see in Gothic and Transient literature many affordances for narrating medical experiences. I see it in the Gothic narrative’s acceptance of mystery and ambiguity despite a medical system that privileges classification and absolute knowledge. I see it in the Gothic’s use of signs and symbols, in the plots of decoding a great mystery – much like the matrix of invisible symptoms that must be deciphered to find a diagnosis. Listeners of the Gothic narrative are asked to trust narrators they find to be unreliable, believe in the realities of the unaccountable, and question medical authorities that deny the embodied realities just witnessed on the page; likewise, readers can apply these reading practices of the Gothic to patient narratives, taking up the same invitation to engage contemporary illness stories with, if at least initially, a trust of unreliable narrators, belief in unaccountable suffering, and questioning of absolute authority (Wasson 11). One of the affordances of Gothic novels, then, is how they bring the reader’s attention to the risks of ignoring the claims of those suffering with lived experiences just because there isn’t a logical explanation for them. In apt and nuanced ways, these novels voice the difficulties seen in patient narratives of having one’s pain and illness dismissed because of an uncertain and difficult to prove medical cause. In this way, a key affordance of the Gothic is that it provides readerly invitations to rhetorically listen to a model of alternative engagement with suffering that makes room for difficult realities.

The Transient and Gothic novels I explore not only provide a path for a reader to *recognize* their own suffering in the protagonist, but to *feel less alone* in one's pain. As these novels have made explicit, it is through authoring one's story, and keeping as accurate to one's embodied experience as one can—by resisting interpretations and explanations that do not resonate—that one enacts agency: even if that story has no clear plot or purpose, even if there is no heroic overcoming or happy ending. In the patient narratives and case studies I examined in the previous section, the medical system encourages—if not often enforces—triumph narratives; but, through the Gothic and Transient narratives, one encounters an alternative story that honors one's body even in its terrors, uncertainties, and mysteries. Affordances of the Gothic and Transient narratives invite readers to identify with protagonists not because they "overcome" their illness but because they hold steadfast to their lived experiences in the *ways* they insist upon and narrate their stories. In the ways they insist on their felt knowledge.

My goal in attending to both listeners and tellers of stories is to allow for relationality and the "recognition" of a particular experience. For nearly all the patient narratives and characters in the novels I examine center the utter isolation the authors feel in having *no* one to listen to, believe, or understand their suffering. In later chapters, I will discuss the sense of alienation for those thrust into a medicalized preformulated cast. I'll define "being-towards-death" as the sudden forced awareness of the body's vulnerability, mortality, and the ever-present uncertainties that those in the land of the "healthy" cannot understand (Stolorow). In such a world, the "absolutisms" that able-bodied people insist upon, often rooted in the triumph narrative, like "everything happens for a reason" collapse. One's world is thrown into terror. Therefore, the sense of isolation that so many characters and patients describe is caused by an unwillingness for others' to *join* in this altered temporal reality where directional *toward* plots and metaphors that point toward cure and cohesion collapse. The failure to rhetorically listen is rooted in an unwillingness to, what Rita Charon calls, "be in suffering" (92). To make the isolation and issues of being listened to and believed even more difficult, having a mental health diagnosis can lead to the questioning of one's rhetoricity, compounding the foreclosure that narrative expectations of the triumph narrative create. Catherine Prendergast talks about this effect, in which a medical diagnosis causes one to talk into a "rhetorical black hole" (157). Thus, while I primarily address issues of self-understanding and self-authorship, I also address the problem of the "rhetorical black hole" and imagine how becoming listeners of divergences in literature can allow for closer listening in the stories of others (Prendergast). I look at examples like a patient story who has schizophrenia, who attempts to communicate his reality but rarely feels listened to, believed, or understood- for his reality is deemed unreliable.

Expanding Rhetorical Possibilities and Rethinking Agency in Authorship

While I am concerned with the ways illness is constituted through narrative discourses, I am primarily concerned with how illness is *reconstituted* through fictional representations. This brings me to my last MHRR question that guides this project: "What individuals, organizations, or communities resist the dominant models and/or suggest alternative ways of addressing mental health conditions?" I believe that fictional representations offer fresh "connections between discourses of mental health and its representations" and have the power to transform and remake through fresh metaphors and literary imaginaries "mental health realities" (Reynolds 2). Many writers, like Adrienne Rich, have discussed "the arts of the possible" and have claimed that literature invites readers to reimagine and reconstitute experiences of difference outside of one's own.

My method of embracing divergent rhetorical possibilities for self-authorship relies on decolonial theories that embrace the pluriversal and value multiple embodiments, realities, and ways of knowing. As I mentioned previously, Renee Linklater explains the risks of universal lenses that foreclose many forms of knowledge. Similarly, in the introduction to *Decolonizing Projects: Creating Pluriversal Possibilities in Rhetoric*, Ellen Cushman describes how "pluriversality opens up the possibility of helping to make visible multiple ways of creating knowledge, with a goal, ultimately, to create value for all such knowledges" (Cushman 3). This moving toward the multiple closely aligns with Audre Lorde's theories of difference: "Difference must be not merely tolerated, but seen as a fund of necessary polarities between which our creativity can spark like a dialectic… But community must not mean a shedding of our differences, nor the pathetic pretense that these differences do not exist" (112). If the body is rhetorical and can produce its own knowledge, then bodies of difference provide especially important information to challenge pre-formulated narratives. This means that rhetoricity cannot be estranged from the body but that rather attention should be paid to the "body as a material condition in which and through which such ways of thinking and living are encouraged and enabled" (Hawhee 100).

To give an example of the rethinking-of-literature approaches I employ, Gothic studies often frames the "mad" heroines of the novels as misunderstood victims of an oppressive society[8]; to paraphrase Emily Dickinson, they describe characters who are sane in an insane world. Such interpretations of mental illness attribute the ailments to constraints of domestic

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[8] See scholarship on women's madness as the result of social oppression, including, Melissa Edmundson's *Women's Ghost Literature in Nineteenth-Century Britain*, and Sandra Gilbert's *The Madwoman in the Attic: The Woman Writer and the Nineteenth-Century Literary Imagination.*

spheres where women have historically been confined (Showalter). When readers take up this interpretation of Gothic texts, this can lead (to give one broad example) to assumptions around motherhood or the domestic sphere as a site of oppression. These common feminist interpretations of Gothic spaces[9] are often centered in values of autonomy/the public sphere/and capitalism that imagines agency as looking like working a job or speaking in a public platform rather than acknowledging agency in relationality/ caregiving and in the private authorship of a secret journal. Such limited framings of agency can compel readers to search for oppression instead of agency in other's narratives; this is especially true of illness narratives, which have historically been habituated to evoke pity/empathy. For example, many interpret structures of fragmented, chaotic, and cyclical narratives of those who are ill as a loss of control in one's life instead of as an expression of agency[10] as is authentic to their embodied experiences. Thus, patient agency can be expanded not by moving narrators toward "empowerment" and idealized versions of health, but by shifting values around what well-being and resilience is imagined entailing (Becker 4). But, to recognize agency in stories that have typically represented the *loss* of agency, the reader must first shift their values away from the narrow script of rhetoricity that Yergeau, Molloy, and Prendergast critique.

In addition to these disability scholars, feminist rhetorical scholars, like the authors of the recent collection *Feminist Rhetorical Resilience* aim to reshape the values around health

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[9] See Andrew Hock-soon Ng's *Women and Domestic Space in Contemporary Gothic Narratives: The House as Subject* and Ellis Kate Ferguson's *The Contested Castle: Gothic Novels and the Subversion of Domestic Ideology*.

[10] This is even the case in scholarship and methods in counseling, where practitioners are encouraged to watch for signs of incohesiveness in the client's structure, pacing, style, etc. of narration and to move clients toward an "agentic" narrative that employs structures like cause-and-effect (McLean and McAdams 1927).

focused only on cure and closure toward a more contextual and relational understanding of the many ways that agency is manifested. The calls in Flynn's text are mirrored by scholars in the field of RHM who urge the need for an "Ethics in Praxis" that would shift patient care toward a "situational, embodied, and relational" approach instead of interpreting patients' needs based on universalized ideas of health (Melancon 2). For example, because cultural narratives (see the multi-billion-dollar wellness industry) teach that self-care should look like alone time, lavender baths, and expensive facials, other forms of self-care—like taking care of a grandparent on one's time off or mowing the neighbor's lawn while they are out of town—get interpreted as work that is draining (Derkatch 18). This narrow story of self-care forecloses the possibilities of what daily wellness practices might include in specific, embodied, and relational contexts.

In my approaches to literature, I complicate understandings of agency by attending to narrative strategies that authors use to render their characters rhetorical in ways that are not typically understood as agentic. This approach is shaped by Letizia Guglielmo's methodology in the book *Remembering Women Differently: Re-Collection as Feminist Rhetorical Practice* that invites historiographers and rhetoricians to consider the "often limiting ways in which women have been remembered or recovered" (13). Particularly, Guglielmo describes how scholars have sought sites of difficulties for women and focused on social oppression instead of looking for places where women enact their agency amid constraints. Since, as Plato explains, the process of remembering is also a process of selection and erasure of what is left out, searching for agency in patient narratives might include noticing places where patients have *embraced* their illnesses instead of overcoming them (Guglielmo 10). Guglielmo calls for rhetoricians to rethink "which rhetorical acts are valued, investigated, and remembered and which are not" (13); and while her methodology focuses primarily on historiographies, I argue that this same rethinking of illness narratives in fields like Gothic studies and poetics can offer affordances for how to approach illness narratives.

While Gouge, Flynn, and Guglielmo offer methods for approaching personal narratives and histories, I extend this methodology to fiction. I argue that the erasure of agentic actions that Gouge discusses might be recovered through attending closely to authorial choices like chaos, uncertainty, and fragmentation as not a reflection of the loss of agency, but rather as an intentional act of narration. To give an example from the texts I analyze, when the protagonists of *Wide Saragossa Sea* and *Mexican Gothic* burn down their houses, I interpret this action as a rhetorical act of communication that insists on the severity of their mental suffering despite everyone's denial of their story. In the chapter on transience, I examine representations that fully embrace the physical and mental suffering and estrangement the characters face due to their illnesses yet allow for the rich affordances and fullness of humanity in the poeticism of their perceptions. Using Gouge's approach of divergence, I describe the affordances of Transience and the Gothic for the characters (and potentially for any reader grappling with the constituting powers of a medical label) to claim their rights to self-determination. Thus, the novels that I have selected in this dissertation are not only rich portrayals, but they are also, first and foremost, assertions of the validity and unique knowledges of one's embodied differences. The novels' divergences are enacted as much through their narrative forms as their content, be that in: their non-linearity (Chapter 2), uncertainty and acceptance of mystery and horror (Chapter 3), or descriptions of transience through natural settings (Chapter 4).

While the kinetic and flexible agency that a person of embodied difference must enact in order to reclaim their rhetoricity is primarily informed by Gouge's concepts of divergence, my method is also informed by the disability studies concept of Métis[11]. Métis views bodies of difference as actors whose differences allows them to navigate the world in ways that others cannot. The term Métis is a reference to the Goddess who understood how to navigate her bodily constraints through trickery and deviance, employing whatever her available means were and often shape-shifting (she is typically represented as an octopus) so as to meet the developing needs of her situation (Dolmage). Often, Métis is also linked to another God, Hephaestus, whose feet were oriented differently and allowed him to move sideways instead of back and forth, giving him an advantage through his difference. I take up this conceptualization of Métis especially in chapter 4 wherein the metaphor of the natural world allows illness to be depicted as a natural occurrence instead of a deviation; just as there are seasons, so bodies, also, go through phases of illness and death. Whereas the triumph narrative offers a return to an imagined "natural" state of health, the metaphor of transiency in the natural world conveys that there is no permanent or static state of health, only a perpetual adapting that requires new negotiations by the hour. Métis is a powerful concept because it embraces a bodily intelligence. A recognition of Métis means an acknowledgment that agency is contingent and can look like many things for many people and can even look differently for the same person at different times. Flynn explains that an embracing of Métis as an understanding of health and resilience that is:

> neither static nor goal oriented; it is pragmatic, situational, and kinetic… A feminist rhetoric of resilience mobilizes the power of imagination and reflexive meaning making in order to continually reinvent selves and possibilities and to precipitate change. Yet feminist rhetorical resilience entails ongoing refashioning of identity and possibility, not just maintaining but recreating meaningfulness (Flynn 8).

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[11] See Debra Hawhee, Jay Dolmage, Drew Holladay, and Storm Christine Pilloff.

This situational and responsive understanding of agency is central to my understanding of how characters in divergent novels recuperate their ethos. The "power of imagination and reflexive meaning making" can be observed, modeled, and emulated through works of fiction wherein the characters continually reshape themselves (Flynn 8). Characters such as Jane in "The Yellow Wallpaper" or Noemi in *Mexican Gothic* who continually try to convince their doctors they are very ill can provide readers—including individuals who are similarly trying to convince others they are suffering with an invisible condition but have been dismissed as a "hypochondriac"—with models of self-narrating that eschew imperatives that health is an achievable state.

The means by which the characters enact their agency is directly tied to their seeing their illness not as a problem to be fixed, nor as a static identity, but as requiring identifications and reidentifications through a continual "refashioning of identity" (Flynn 8). Ultimately, I locate narrative strategies used by protagonists in Gothic and Transient novels that allow them to insist upon the validity of their lived experiences, even in the midst of everyone's attempts to belittle and reframe their invisible suffering as "imaginary." They resist the temptation to fall back upon readily available glorified narratives of triumph and cure that would cause them to deny their felt truths. Such a responsive, fluid orientation allows them to navigate moment-by-moment through a Métistic orientation. Most importantly, they understand that acceptance of their difficult realities is an act of agency.

An understanding of Métis, in an applied context, means that what may look like "health" for some can look like harm for another. For example, getting up off the couch and exercising might look like health for some bodies on some days, but for bodies with chronic health conditions, on some days this could cause extreme harm. As another example, enacting

Métis might look like Simone Biles deciding not to perform at the Olympics because she relied on the intelligence of her body which let her know she was in danger of the “twisties” (Biles). While many critics described her decision to not compete as giving into weakness, Simone Biles made a “situated, embodied, and reflexive” choice in a high-stakes emerging context that ultimately rescripted many current conversations, like the reframing that happened in articles such as “Tokyo 2020: Simone Biles’ withdrawal is a sign of resilience and strength” (Rhodes).

The term “spoonie,” adopted by some living with chronic illness, came from an online post by Christine Miserandino, a blogger living with lupus. Her 2003 blog post explained how she looked into her body’s metaphorical silverware drawer and took daily stock of her available “spoons”: how much mental, physical and emotional energy did she have available *that day* to meet basic tasks? Spoonies acknowledge that for one person, taking a shower may only take 1 of 20 available spoons for the day but for another, dealing with a flare-up of a condition, a shower might take 1 of their only 3 available spoons of the day. Miserandino put words to this practice of starting the day with self-assessment of energy and capacity in order to gauge an appropriate and non-harming level of activity. This consideration of the body’s particular needs allows the rhetor to frame *not* showering or *not* going to an exercise class as an act of agency instead of fallibility/victimhood. Miserandino’s post resonated strongly with the disability community, and fostered conversation with able-bodied friends and community members. Lymphoma Action UK reproduced Miserandino’s original post as a way of introducing to both people newly diagnosed with lymphoma and people around them to changing daily abilities in the face of new illness. The “Spoonie Society,” an Australian online community of people living with chronic pain and illness, characterizes “spoonie” community as a space of “resilience, solidarity, and mutual support.” Counting spoons accepts the limitations and realities of a person’s embodied conditions not in comparison with others’ abilities, but through a dialogue with and frank acceptance of the disability.

Novels like *Mexican Gothic, Housekeeping, Mrs. Dalloway, Tinkers, Jane Eyre, Wide Sargossa Sea, Tinkers, The Haunting of Hill House,* and *We Have Always Lived in the Castle* provide narrative elements that allow for the *acceptance* of uncertainty as a way of regaining agency. The protagonists of these novels insist upon listening to the strange and unprovable experience, diverging from a shared preference for triumph. In this they take great risks, including estrangement or forced institutionalization. In taking those risks to honor the inner experience, with its changeability and uncertainty, exercise agency. The protagonists in Gothic and Transient narratives face the severity of their terrors head-on, despite the voices of friends, family members and doctors, who continually try to enforce an oversimplified narrative of triumph. The nature of chronic illness calls for the *acceptance* and management of illness rather than eradication or triumph over it. However, this truth cannot be known from the outside, it can only be known by living that reality haunted by what others may not see, hear or feel, paying attention, and reinforcing it through stubborn narrative.

CHAPTER II: THE TRIUMPH NARRATIVE IMPERATIVES

The Narrative Turn in Medicine: The Risks of Storying Illness

In order to engage with narratives that allow for the complexities of uncertainty, ambiguity, and a lack of closure so common to experiences of chronic illnesses and disabilities, a greater understanding of the imperatives embedded in dominant narratives is crucial. This chapter examines the consequences of a dominant narrative of triumph that configures illness/disability as an “unnatural” problem in need of fixing that leads to demanding certainty and cure through chronological plots that give purpose to suffering. This chapter will be broken into five sections:

1) The Narrative Turn in Medicine: The Risks of Storying Illness
2) The Logic of the Triumph Narrative: A Disability Studies Critique
3) The Imperatives of the Triumph Narrative: A Case Study of Healing Handbooks
4) The Impact of the Triumph Narrative: Patient Lives
5) Resisting the Triumph Narrative: Divergent Plot Techniques

In the past three decades, there has been a “narrative turn” across disciplines and fields. Sociologist and medical practitioner Parul Sehgal lists many academic and career fields that have rapidly shifted toward storytelling as an approach to understanding and communication. Sehgal claims there has been a “narrative takeover of reality—an evocation and understanding of the world which was purely narrative…the narrative turn has spread to economics, law, and medicine… and has been a business strategy” (23). The “narrative turn” has particularly impacted the field of medicine, with new fields like Columbia’s Narrative Medicine program forming in 2001, as well as narrative branches in psychiatry, counseling, and psychology. In the article “Taking a Narrative Turn in Psychiatry” psychiatrist Bradley Lewis explains how rapidly even the most clinical of the medical fields (not only fields like counseling that have long been open to narrative approaches) are now adopting narrative methods as essential to their practices (23). As these methodologies incorporate narrative tools for understanding and communicating illness and disabilities, what is meant by the inherent “values of storytelling” often remains vague (Sehgal).

One of the reasons that practitioners argue for the value of writing is that, when a person is given a sudden diagnosis, often one’s sense of self can be challenged, creating an exigency for a new narrative identity. Narrative Medicine founder Rita Charon explains that since we are inherently “sense-making, meaning-seeking creatures,” when illness strikes, we turn toward stories to restore meaning in our lives (1669). Arthur Frank explains that “Stories have to repair the damage that illness has done to the ill person’s sense of where she is in life, and where she may be going. Stories are a redrawing of maps and a finding of new destinations” (Frank 53). The call to story, then, derives from the interruption of an illness to one’s previously coherent narrative. In this way, illness functions as a “call to story,” demanding meaning in chaos and seeking to restore order and chronology to what feels suddenly out of one’s control (Frank). This deeply rooted human desire to make meaning in the midst of sudden illness is leading to a fraught rapid shift in methodologies for understanding, practicing, and treating disabilities and illnesses.

Narrative Medicine aims to bring practitioners’ attention to how a sudden illness or new diagnosis can shock a person’s self-understanding and emplotment of their life, encouraging empathy toward this narrative crisis (Charon 1668). When the narrative exigency is taken up by doctors in the form of their providing a new story (or map, as Frank calls it) for the patient in the wake of their ruptured one, there are severe risks. In the wake of losing one story, the doctor may offer a new story of the self–and may do so even without intending to. The risk is that these stories may not center the values and meanings the patient has built their life upon. Or the stories may simply not serve the patient well–causing more harm (leading to feelings of shame or guilt in the patient) than good. This is especially the case with stories like the triumph narrative, which focuses on a positive reframing and cure. While critical attention to the narrative components of storytelling is provided by rhetorical and literary scholars, this is not yet fully the case with medical practitioners' research. As narrative studies continue to gain traction, especially in medical fields like Narrative Medicine, the benefits of encouraging patients to actively narrate their illnesses is often widely accepted as beneficial, while the narrative *structures and techniques* and tacit logics that sustain these medicalized narratives are not critiqued.

For example, in the Western medical world, storytelling has only recently garnered qualitative research used to establish narrative methods now implemented in the fields. While, admittedly, storytelling is an ancient component of healing used across cultures, there is no one-size-fits-all method. Moving storytelling into the hard sciences, which universalizes and categorizes, poses dangers. Postcolonial Disability scholarship is working to acknowledge pluriversal methodologies and aims to decenter and expand Western medicine methods. Indigenous storytelling healing practices, for example, are the foundation of newly established medical methodologies like Narrative Therapy (Epstein).

While these medical fields cite long histories of storytelling as healing ceremonies, the co-opting of these Indigenous healing methods rarely acknowledges how radically different the *stories* around healing are- and how each story is rooted in and offers different value systems and cultural norms[12]. For example, the cultural values of storytelling and healing in Dion Million's book *Therapeutic Nations* reveal how Indigenous storytelling healing practices are rooted in community, relationality, and resilience. Western medicine tends to think of healing as an individual and not a communal problem, whereas many other cultures honor the role of the collective community in an individual's well-being. To offer another cultural difference that shapes the stories told of illness, Western medicine tends to prioritize a rapid recovery and a goal-oriented construction of healing, rather than configuring resiliency as an ongoing process that moves through cycles of grief and pain in non-linear trajectories. Thus, the increase of these "new narrative methods" should be implemented with caution. If storytelling is deemed to be universally beneficial, one risks unquestioningly adopting or assuming another's value system. I encourage an awareness of how culture, embodiment, place, religion, and history shape narrative tropes within Western medical discourses, and how these are embedded in the storytelling encouraged in narrative medicine. I believe the way literary and rhetorical scholars can contribute to the narrative turn in the medical field is by closely attending to narrative structures rooted in hegemonic stories of illness and disability—the tropes, themes, metaphors, and plots—that make up dominant stories.

To look closer at one example of a new medical methodology that builds upon Indigenous healing practices, I turn to Narrative Therapy. Narrative Therapy, largely founded by Michael White and David Epstein in the 1980s, invites patients to story their lives through descriptions that give richer meanings to simplified narratives of suffering (Morgan). Narrative

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[12] According to Indigenous scholarship such as Dion Million's *Therapeutic Nations*, Irene Visser's "Trauma in Non-Western Contexts," and Renee Linklater's *Decolonizing Trauma Work.*

therapists describe the centrality of plot and theme and the role that cohesive meaning-making has for those experiencing illness or a sudden shock (Morgan 7). More than most medical practices that employ a storying methodology, Narrative Therapy has closely attended to story elements. The field posits that a person's ability to conceptualize themselves in a story—with a theme, across time, and according to a plot—is interrupted when a person experiences a sudden life altering incident (Morgan 12). Narrative Identity Psychology is another field that has recently been developing theories of the impact that a dissolution of narrative order—especially the sense of living chronologically across time and causal plot points—can have on a person's life (McLean). Narrative Identity psychologists define an inability to exist as a "being in time" (harboring a sense of a beginning, middle, or end in one's life) as a devastating force that--as they've empirically shown--lowers an individual's "overall well-being" (Stolorow 182). Narrative psychologists and therapists attend to the plots people use to make sense of difficult experiences because they argue there are "problematic" plots that cause people to live in a permanent state of rupture, and beneficial plots, like the "redemption" sequence.

For example, the stories individuals are encouraged to tell often provide a sense of coherence to the "ruptured" plot of one's life. Valuing coherence and giving purpose to suffering through plot is so deeply enmeshed in Western medical practices, that there are even medical methodologies that directly address the dissolution of plot in people's lives. For example, the methodology of Coherent Narrative Therapy (CNT) takes "the whole story that a person holds about themselves, studies it, fills it out, notices pattern and ruptures, inconsistencies, distortions and contradictions, and alchemizes this unsorted data into healing sense-making" (Noppe-Brandon). In methodologies like these that thoroughly emphasize coherence, "distortions" and "inconsistencies" become problems, and the healing comes through the “sense-making” that resolves these inconsistencies into a coherent narrative. My aim in this section is not to criticize particular narrative methodological approaches, but rather to establish how central an idea of “cohesion” and plots are to storying experiences of illness and to argue that, given the narrative components in these methods, practitioners could benefit from scholars (like literature narratologists) who attend closely to alternative possibilities and structures of narrative plots.

One of the risks of cohesive narratives is that, in attempting to move toward cohesion, these trajectories encourage moving away from a sense of uncertainty, chaos, and loss of control in one’s life—and these experiences of chaos can themselves be beneficial. One of the plots that tends toward coherence is the chronological plot. Chronological plots are most popular for narrating illness because they allow one a sense of certainty in a world that has, often in a few devastating moments, become uncertain. A chronological plot as a way of making-sense is so central to stories that, as Dan McAdams explains, stories that do not include these aspects are often dismissed by their listeners as “stories that depict characters whose actions seem to have no motive or goal, or lay out plot lines that seem to go nowhere, or fail to provide a causal account for a sequence of events, or never reach a culmination, resolution, or satisfying sense of an ending may also seem incoherent” (112). This push toward resolution and causality by doctors, family members, and friends moves beyond just discomfort with uncertainty. Stories that resist cohesiveness and closure, that wind around in circles, might not even be listened to as stories, might be treated as incoherent ramblings. Stories that resist emplotment often don’t count, aren’t heard or understood in the same ways as cohesive stories. As Arthur Frank explains:

> Narratives possess the shortcoming that they drive toward ends, preferably tidy ones. Interruptions divert the narrative from such ends; they give stories the confusing

> or inconsistent quality that Watkin observes physicians and patients find uncomfortable in patients' stories. The stories are uncomfortable, and their uncomfortable quality is all the more reason they have to be told. Otherwise, the interrupted voice remains silenced (58).

My goal in this project is to move listeners and tellers of stories toward the uncomfortable places of ongoing illness and uncertainty.

My purpose is to locate narrative elements that will allow others—friends, neighbors, family members, health care providres—to sit with those who are in a place of suffering. So often, people are pushed toward a denial of their embodied realities and told that their suffering exists "only in their heads" or isn't as bad as it seems. In many cases, if the suffering does not have a name in the form of diagnosis, it is dismissed because of its uncertainty and the impossibility of a cure. Or a dismissal of one's reality is communicated through stories of chronic pain where no cure–no "end" or triumphant overcoming–is viable. To be listeners of these stories, one must become practiced in attending to narrative elements—like plots—that resist coherence, closure, and cure. One must practice becoming literate in narrative techniques. Admittedly, it is painful to listen to suffering; an empathetic response in the listener often leads to their trying to offer solutions and to fix what is wrong. Cure, in the form of a plot that pushes for a speedy overcoming, can function as a denial of one's embodied realities or suffering. Dr. Remen, a practicing professor of medicine, explains the difficulties as a practitioner of coming to terms with the limitations of medicine:

> We thought we could cure everything. But it turns out that we can only cure a small amount of human suffering… no one is comfortable with loss; being that we're a technological culture, our wish, or our first response — let's put it this way. Our first response to loss is to try and fix it. When we are in the presence of a loss that cannot be fixed, which is a great many losses, we feel helpless and uncomfortable, and we tend to run away; either emotionally or actually, distance ourselves (8).

Instead of running away from suffering, this project argues for a deeper engagement with embodied realities and limitations and a willingness to sit in uncomfortable places of loss. Often, what is most needed isn’t someone to fix the person, but someone who will listen carefully to their story–someone who will acknowledge, as Million explains of the First Nations women's stories, their right to author “what it felt like to me” (82). The question of self-determination and agency, I argue, must include considerations of how narrative components (like plots) impose constraints on one’s self-narration. Many barriers to care in a capitalist healthcare system result from the imposition of a linear, goal-oriented, or outcome-based model of health, which may not allow for the chaos, uncertainty, and ongoingness of experiences of chronic and mental illness.

The Logic of the Triumph Narrative: A Disability Studies Critique

Narratives that move toward healing—either in returning to a previous “natural” state of health or in overcoming the illness and becoming stronger than before—can be dismissive to the realities of ongoing health crises and disabilities[13]. In this section, I argue that there are inherent dangers in shaping one’s experience through triumph narrative elements—such as plot, theme, and metaphor—that push individuals toward certainty, cure, and fixing the broken self. In order to show the impacts of these typified triumph narratives, I draw upon research in the field of Rhetoric of Health and Medicine (RHM) and Disability Studies to describe how dominant stories are built upon conceptualizations of health that are closely tied to normalcy and an “ideal” body that one can “return” to.

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[13] See Disability scholarship that critiques the push toward health and healing in scholars such as Jonathan Metzl, Jay Dolmage, Kate McLean, and Kathlyn Conway.

In order to prove how pervasive triumph narratives are, I include examples of narrative guides written by medical professionals who encourage the narration of experiences of trauma, illness, and disability. I turn to these books—written by psychologists, therapists, medical professionals, and those with lived experiences—to further demonstrate the momentous narrative turn. There are dangers in the scientific and absolute tone textbooks backed by the authority of "science" and medical professionals that claim there is a wrong or "right way" to heal and narrate one's life.

These healing handbook texts offer metaphors, plots, and themes that reveal patterns of narrative expectations, ableist hierarchies, and social norms coded in medical discourses. These handbooks 1) encourage narration as a healing practice 2) offer plots, metaphors, and themes that closely align with the triumph narrative 3) are sustained by medical imperatives toward health by creating the "problem" of the ill/disabled body that moves the person toward an imaginary ideal state of health. While the dehumanizing effects of assumptions around health have been well-established by writers with lived experiences of disabilities as well as disability scholars, the ways metaphors, plots, and themes encode these assumptions is not always as obvious.

The "triumph" narrative is one of the most common stories that patients and doctors take up. The triumph narrative is about the disabled body that "overcomes" adversity or illness through great feats of willpower and strength. In disability studies, the triumph story is often called the "supercrip myth" (Dolmage). In mythology studies, the quest is called the "hero's journey," in which (as famously described by Joseph Campbell) the "ordinary man" leaves the comforts of one's mundane world in order to embark on grand adventures and face impossible adversities. On this transformative journey, the individual discovers and fosters internal resources that allow them to conquer the enemy of illness/disability. This forging-through-fire redeems the broken/disabled self into a rarefied triumphant other: a hero rather than a victim, a person whole instead of fractured. Arthur Frank describes this heroic overcoming as the "Phoenix narrative," where, despite the shortcomings of disability, the hero rises from the ashes against all odds. I am particularly drawn to disability scholar Kathryn Conway's definition of triumph from her book *Illness and the Limits of Expression,* and will use her theory to frame this chapter and my dissertation. In her book, Conway asserts that:

> As a culture we hide suffering. By keeping the ill, elderly, and dying out of view, we manage to keep the story of the damaged body, of physical weakness or limitation, out of earshot. When we do encounter the ill and disabled, we meet them with coercive insistence that they rise above their suffering, battle their disease, and believe that everything will be fine in the end. We insist on optimism, put a spin on illness, and silence those who hurt, complain, or give up, labeling them "bad patients." We endlessly celebrate "survivors," while ignoring their equally valiant counterparts who did not survive. By subscribing so insistingly to the narrative of triumph, we participate in a hysterical denial, as if by chanting "triumph" we can ward off mortality (Conway 18).

In Conway's definition of triumph, those who encounter natural conditions of life (like physical weakness or dying) are often denied if their stories do not align with the "everything will be fine in the end" mentality. Because these people's lived experiences bring attention to the mortality and fallibility of the body, often these stories are relegated out of "view" or "earshot" because listeners/witnesses would prefer optimism. Even when these stories do get told, Conway explains that they often get reframed by putting a spin on the story that allows the body's fallibility to become a "testimony" to some larger purpose or meaning. But, this optimism, this "hysterical denial" as Conway calls it, can become toxic when ignoring the body's fallibility. The triumph narrative aligns with, enables, and even furthers a medical emphasis on cure and healing that insists on the construction of plots that are linear, goal-oriented, and outcome-based models of health.

Together, the triumph narrative's metaphor of brokenness and cohesive plot encode a number of assumptions and imperatives rooted in cultural values. Besides the cohesive plot, the triumph narrative also depends on the metaphor of brokenness that conveys two key underlying assumptions: that to be ill is to be broken and that health is an ideal, natural, and achievable state of being. The assumption that health is achievable provides the basis for the chronological plot that moves one toward a cohesive narrative of health. The triumph narrative first encodes a construction of normalcy based on a rare, glorified (and often made up) "ideal" healthy body. Then, it assumes that it turns the ideal into what is normal, insisting health is a natural and rightful state that everyone can achieve. Since ideal health is rendered achievable by all, the locus of control moves to the individual. In this way, the triumph narrative insists that it is the individual's responsibility to achieve a state of health. And not just any health: a rapid return to health. A needed "return" to wholeness and productivity. Furthermore, moving the locus of control to the individual allows for imperatives and punishments of the "deviant" body who stays unwell. The ill body becomes unnatural, a problem in need of fixing; one must *move* beyond one's ill state through a forward plot progression that allows for the transformation of brokenness into wholeness. This leads to the tyranny of plot, in which the present and the pain is not a state one can dwell within; instead, one is required to move toward the ideal of health. And, the second tyranny of metaphor, that dehumanizes those with embodied differences by storying them as broken, less than, and evoking only pity. In the following section, I will explore all of these ensuing logics, encoded in the triumph narrative, by turning to the healing handbooks.

The Imperatives of Health: A Case Study of Healing Handbooks

While searching for popular handbooks that encourage narrating illness, I noticed a pattern of metaphors and plots among many of the book covers. Many book covers depict a common metaphor for illness, disability, and trauma: the metaphor of brokenness. Through each cover jagged lines crack through the neutral background colors, which appear to be marble or stone that have been torn apart by a substance-altering force. The title and cover of *Restoring the Shattered Self* imagines that there was once a whole self that has been "shattered" but can again be restored; this logic of restoration assumes that health is the natural state of being and therefore that return is possible. In *The Unexpected Gift of Trauma,* the lines that have cracked through the cover appear to be patched up; the natural state has been shattered but instead of imagining a return to a previous whole state, the book frames the breaking as a gift that can lead to growth–another typical configuration of the triumph narrative, with the hero returning stronger. *The Strength in Our Scars*, likewise, has a crack running across the cover but this brokenness is reframed as triumph. In the final example, *The Guide to Healing From Past Trauma*, the cracks are deep and substantial, and the reader is invited to move away from trauma and toward healing; a state of being that is not "broken" or shattered but can be made whole again. These covers demonstrate how pervasive the metaphor of broken/wholeness is, as well as the cohesive plot line that can make a greater meaning out of suffering, thereby giving purpose and a happy ending to the "enemy" of illness.

In order to understand what leads to these metaphors, one must first understand the social construction of health. Health, as it tends to be configured in the Western medical world, is a conceptualization of an "ideal" and "natural" state of being while illness is conceptualized as a falling away from normalcy (Davis). Influenced by medical discourses, the stories that patients are often invited to take up as a part of their efforts at self-understanding begin with the configurations of an imagined idea/whole body. After all, the DSM constructs illness and disability as the "other," the unnatural against the natural, the abnormal against the normal, the irrational against the rational. Disability scholar Lennard Davis elucidates in his article "Constructing Normalcy: The Bell Curve, The Novel, and the Invention of the Disabled Body in the 19th Century" that understandings of the normal body emerged with the field of statistics and that concepts of means, averages, and deviance allowed for the invention of the "average" body that subsequently created the disabled body.

Many of these healing handbooks depend on the embedded logic of the "wrongness" of illness and the "brokenness" of the disabled/ill body. Two examples are psychologist's Dr. R. Dilley's *Writing Your Way to Healing and Wholeness* and trauma scholar Jen Cross's *Writing Ourselves Whole: Using the Power of Your Own Creativity to Recover and Heal from Sexual Trauma* and *Writing Your Way to Healing and Wholeness.* Each of these titles is constructed through the metaphor of brokenness. In Jen Cross's book, she invites the reader to "begin now to write yourself whole" (1). This metaphor of wholeness implies a broken, shattered self–that carries with it health imperatives to fix, or in the least make better–the self. Healing handbook authors can employ the metaphor of brokenness only because they can draw upon the idealogue of health- which assumes *every*one wants health and that health is always in individual's best interests. Disability scholar Leah Piepzna-Samarasinha emphasizes the assumptions about health in a "pop-quiz." She asks, "Do you think it means becoming as close to able-bodied as possible? Do you think it is always sad or terrible to be sick or disabled? Do you think everybody wants to be able-bodied and neurotypical, and would choose it if they could?" (97). Healing handbooks, for the most part, would answer these questions in the affirmative: the readers they invoke aim to heal from the unnatural state of illness and to overcome or return to a state of health. Critically however, if health is an idealized version of what able-bodied and able-mindedness are supposed to look like, then, for many, to become "healthy" might mean to disregard or come to despise the realities of one's ongoing illness and disability. In the theories of radical acceptance I offer in chapter 4, despising one's embodied reality does not lead to health, but rather ill-health.

In triumph narratives, ill-health or disability is the "evil" that must be overcome and, since it is not a natural occurrence, demands a justification. Imagining illness/disability as an aberration from how things are "supposed to be" demands an explanation for *why* one is not in one's natural, healthy state. The circulation of the triumph narrative is therefore supported by long histories of orientations to illness as a deviant condition. These histories can be tracked back to, for example, Nietzsche's famous extrapolations about how society tends to configure health as the normal state of being and ill-health as the abnormal. Neitzsche explains:

> There is no health as such. And yet, our language, metaphors, and conceptualization of illness rarely take illness and the decaying body for *granted* as the state of the human condition; rather we tend to take health as the for-granted human condition. For example, those whose meaning-making systems are rooted in religion rarely ask why God has made them healthy but rather more commonly question *why* God has allowed their young child to become severely ill or die, etc. When health is the assumed state, then illness becomes the aberration, the punishment, design flaw.

Nietzsche's observations are just as relevant today and are carried out not only by religion and pharmaceutical companies, but also in the extensions of demands for stories. For, if illness was considered a natural state of life—and not the rupture/disruption it is so often described as—there would not be the same demand for an explanation in the form of a narrative. In illness narratives, the story is rooted in the desire to answer the "why"; to provide a plot, theme, and message for the suffering that "should not" be occurring.

The risks of accepting an ideal form of health as the norm is that bodies that do not align with this ideal can be labeled as deviant and in need of fixing. The moral lineage of health has been well documented by disability scholars. This "body gone wrong" becomes the "deviant" body. And deviance, as medical scholar Kenneth Boyd explains, carries connotations of evil and immorality and necessitates redemption (another configuration of triumph) (14). As Boyd explains, "Illness has three definitions. Two of them are of the way the word was used up to the 18th century—to mean either 'wickedness, depravity, immorality,' or 'unpleasantness, disagreeableness, hurtfulness.' These older meanings reflect the fact that the word 'ill' is a contracted form of 'evil'" (Boyd 9). These histories can elucidate the feelings of culpability that many patients describe after being diagnosed. When health is conflated with goodness and ill-health with deviance/evil. This logic is evident in Janet Groom's book. She claims that there is a way to "Do the work and your own healing journey will be rewarded with well-being while transforming your life, bringing you back to a state of love and joy" (2). Here we are asked to do the work of *return* by going "back to a state of love and joy," imagining that these are the true states of being and that being "broken" is an unnatural state that makes experiencing joy and love difficult, if possible. Narratives that render the individual who is ill as the responsible party who must have "done" something for the illness to happen to them; or else they must "not be doing" the right thing if they remain ill and are not cured. Understanding such histories can also elucidate how medical practitioners often encourage patients to take up a story embedded with metaphors that can lead to shame, blame, and a sense of overall culpability for one's illness or disability.

One way that the difficult realities of illness and disability are discredited is through moving the locus of control into the realm of the individual. Plots that engage the triumph narrative further shift responsibility to the individual through assumptions that health is the natural state of being and ill-health must therefore be the natural consequence of something in the plotline: a lack of willpower, a moral failure, the necessity of difficulty in order for a person to grow stronger, etc. Meghan O'Rourke, who struggled with chronic illness, explains in her memoir *The Invisible Kingdom: Reimagining Chronic Illness* that:

> The hardest lessons come from the solutions people, who are already a little disappointed that I am not saving myself. There is always a nutritional supplement, Bible verse or mental process I have not adequately tried. "Keep smiling! Your attitude determines your destiny!" said a stranger named Jane in an email, having heard my news somewhere, and I was immediately worn out by the tyranny of prescriptive joy (9).

As O'Rourke explains, the risks of these narrative configurations for those who are ill and do not quickly recover will "fall short" of the triumph story. These long histories of equating illness as a sign that one has done something evil to cause it (i.e. if one would have been a better person, had not turned down x street, had taken more vitamins, etc.) leads many to try and determine a meaning in which they can locate a cause for the uncertainties of their suffering. Therefore, the individual who gets a new diagnosis, especially a highly stigmatized mental health or chronic pain diagnosis, must struggle to integrate their culpability in the "unnatural" condition that has befallen them.

In this way, moral imperatives that insist that one heal and become healthy become bound up with narratives of illness that if something is wrong "it must be my fault" that so many patients have described sensing, without being sure why. Jonathan Metzl writes in his introduction to *Against Health: How Health Became the New Morality* how "'health' is a term replete with value judgements, hierarchies, and assumptions that speak as much about power and privilege as they do about well-being. Health is a desired state, but it is also a prescribed state and an ideological position" (2). Thus, imperatives of health that push through what healthy “ought” to look like are riddled through narrative medicine literature and are exemplified in the healing handbooks. These plot lines focus on the final destination and outcome, either through forward moving (toward cure) or backward movement (toward restoration of natural health). In either case, permanently remaining disabled/in a state of ill health is foreclosed through demands for plot. This dual logic of restoration to a natural state and of overcoming to achieve an even better state are what health scholar Colleen Derkatch identifies as “two opposing philosophies of health that cycle into and amplify each other: restoration, where people use natural health products to restore themselves to prior states of wellness; and enhancement, where people strive for maximum wellness by optimizing their body’s systems and functions” (2). Both directions: the idea of the “triumphant return” or “triumphant conquering” propels stories of suffering forward, drawing upon the hero’s journey mythology: the story guaranteed to sell.

Importantly, the imperatives of this plot line—to heroically overcome—are buoyed by the idea of health as a natural condition; for, if health is indeed the natural condition, everyone should be able to achieve health. The achievability of health is seen *in The Healing Power of Storytelling: Using Personal Story to Navigate Illness, Trauma, and Loss* wherein Annie Brewster claims that one can harness the power of storytelling “in order to move toward optimal health” (2). In this description, her underlying assertions that “optimal health” is an ideal state that is spatially formed as a destination one can move “toward” (2). Such goal-driven configurations assert not only that there is an “optimal self,” but that it exists and is possible to anyone. And, more importantly, that everyone should *try* and achieve it. This trying is rendered in the “easy” step-by-step guides toward health, such as in Janet Groom’s book *Write to Heal: 10 Ways to Use Writing and Words to Boost Your Well-Being and Transform Your Life.* Groom assumes the universality of health and ignores the differences of bodies when she suggests "simple steps" and claims that well-being can be achieved through a singular straightforward method. She begins her introduction with, "We all want to be happy and enjoy a life free of pain and suffering" (4). Herein are several assumptions that claim the "normal" body is a healthy body and that achieving a painless life free of suffering is a possibility for all bodies.

If health is a guaranteed natural state, then it becomes the responsibility of the individual to either triumph or "succumb." The guarantee of the "possibility" of health demands a triumphing over illness- or else one will be deemed lazy, weak-willed, indulging a victim mentality etc. As Eva Illouz explains in *Saving the Modern Soul*, many issues of health, especially mental health, left the "realm of experts and moved to the realm of popular culture, where it interlocked and combined with various other key categories of American culture such as the pursuit of happiness, self-reliance, and the belief in the perfectibility of the self" (155). Such narrative structures interlock with American values of autonomy, rendering systemic problems as disabilities instead of impairments or placing the onus of healing on the individual. What's more, because a quick, accessible cure is assumed possible, the individual is expected to quickly get better. Many who have chronic illness are encouraged to *rapidly* bounce back (to an ideal state) or triumph over the condition quickly, at all costs. The consequences of making health into a matter of self-fixing can be dire, as Emily Johnston describes in her article on PTSD and mass shootings. She says that the rampant "biomedicalization and pathologizing of suffering" of countless experiences has transformed the natural conditions of human life into an issue of health (28). Using newspapers, interviews, activists, and interventions she examines the rhetoric of PTSD, which was freely used as a descriptor for the experiences of both those who had been at the mass shooting or for those who were in close relationship with those who were. This pathologizing language, she notes, is a shift from how the media had generally discussed such events in the past. She explains how moving a tragic experience like shootings into medical discourse allowed for health imperatives to be assigned to those suffering. Most critically, "the classification of PTSD in the DSM-5 normalizes survivors who "bounce back" from mass shootings, returning quickly to normal functioning; simultaneously, it pathologized survivors who suffer intensely for prolonged periods of time" (3). In any configurations, then, health is an ideal outcome, a call for patients to quickly move *beyond* their illness and/or disabilities so they can get *back* to being "productive" members of society (Johnson 29). What's more, given that health is often configured as the body's natural state, many assume that such a return should be a quick and easy process for anyone who has moral fortitude.

The glorification of the *rapid* overcoming of any illness manifests across cultural expectations in many ways, such as the Phoenix rising from the ashes metaphor. For example, the woman who returns to work two days after childbirth or the policeman who was injured but returns to his shift by mid-afternoon is described as strong or resilient. Such stories of a quick return are so prevalent, in fact, that often the individual who does not have a linear recovery is shamed and thought to be weak or self-indulgent. As Arthur Frank explains in *The Wounded Storyteller* there are dangers in narratives that insist on bouncing back or moving on from suffering. "The risk of the Phoenix metaphor: [is] they can present the burning process as too clean and the transformation as too complete, and they can implicitly deprecate those who fail to rise out of their own ashes" (135). Here, Frank explains that someone whose illness is uncertain or who fails to find a quick cure for their illness or disability are imagined to be at fault. This Phoenix-to-ashes understanding of illnesses can lead to family, friends, co-workers, educators, and professionals withdrawing support if the person doesn't "get over" hardship within certain timeframes or in the ways that they are "supposed" to.

In the triumph narrative therefore, illness and disability are configured as the enemy, the problem that must be solved; the evil that must be overcome and conquered. Histories that render illness as an evil or lack of will power allow value judgments about health and difference to invade narrative discourses. Not only are people naturally born with disabilities, but also bodies grow ill, bodies get injured, bodies grow weak, bodies often do not recover, and of course bodies eventually or all-too-soon die. The problem with the triumph narrative, however, is that there is little room for these obvious contingencies and normal bodily states. Rather, these handbooks and narratives deem illness unacceptable and demand that the ill patient return to health.

The Impact of the Triumph Narrative: Patient Lives

Now that I've established the prevalence of the triumph narrative across healing handbooks (and in popular culture more broadly) that encourage people to write their way toward health, I will identify further constraints of the triumph narrative by turning to patient stories that articulate the foreclosing and isolating power that the narratives have had in their lives. These patients' stories move my theoretical critique into an embodied, situational, and culturally contextual one that reveals how, for example, cultural and religious narratives intersect and infuse with the triumph narrative. The stories demonstrate how one's identity, relationships, and medical treatment can all be influenced by the expectations that arise from these narratives. The triumph myths constrain the rhetorical possibilities not only of the meanings patients are allowed to make of their experiences, but also in how others are able to receive and interpret their stories. Particularly, the patient stories describe the estrangement (from others and even from oneself) that the triumph narrative creates when individuals are asked to deny and ignore their suffering for a more “positive” reframing of their embodied experiences.

In Joan Didion’s famous essay, “The White Album,” she describes a nervous breakdown and psychiatric intake she had in the 1960s when she became unable to make sense of the chaos in society and in her personal life. She had a “collapse” when her life’s narrative cohesiveness dissolved and she could no longer see herself as existing in time, according to a plot, with a coherent theme. Didion describes the inexplicable events that disrupted her day-to-day existence and ability to move through the world that allowed her to believe it to be safe or orderly. She says:

> We tell ourselves stories in order to live… We look for the sermon in the suicide, for the social or moral lesson in the murder of five. We interpret what we see, select the most workable of the multiple choices. We live entirely, especially if we are writers, by the imposition of a narrative line upon disparate images, by the "ideas" with which we have learned to freeze the shifting phantasmagoria which is our actual experience (9).

Didion’s articulation of the human desire to create a “narrative line” over disparate sets of incidents takes on a new meaning, years later, when she again struggled to create a coherent narrative after a “sudden rupture” of her husband’s illness. After Joan Didion’s husband suddenly dies of a heart attack beside her in their living room, she describes in her autobiographical novel *The Year of Magical Thinking* how the lack of a cause-and-effect plot that might explain *why* he died made it impossible for her to accept his death.

I claim the triumph narrative affected Didion’s ability to make meaning of her grief and communicate it with others. One reason Didion was unable to come to terms with his death was that his story did not fit within the triumph story. Even though Joan Didion is a brilliant experimental writer who critically constructs and plays around with literary structures, the triumph narrative still held power over her life and foreclosed her grieving process. She was unable to reach closure because the construction of the triumph narrative required that his death serve a greater purpose; but she could find no purpose for his death and therefore no triumph narrative arc. I argue that the *lack* of narrative structures that would have made room for his senseless death and the ongoing cyclical nature of her grief contributed to her difficulties in storying and communicating her grief with others, contributing to the extreme isolation and estrangement she felt during this time.

Her grieving process was altered because she could not find a narrative-line to impose over the image of him lying slumped in the room they'd sat in together thousands of nights before. The sudden shock was too extreme; the lack of explanation too overwhelming. In order to accept his death, she felt she had first to give a plot and message to why the illness happened. Consequently, in the wake of finding no explanation in the form of a plot for his death, she became convinced that at any moment he would return to her; for, if there was no reason for his death to happen, then there could be no reason he would remain dead. Her brain, she explained, rejected his death because she could not find a "meaning in it" (Didion 17). There was no explanation or cause-and-effect plotline she could trace. Bending his death backwards, through her magical acts, somehow seemed more possible than accepting that his death could occur without serving a bigger purpose, a larger plotline—a narrative trajectory. Thus, in the wake of having no storied explanation, she began to engage in small rituals or "magical thinking" that she believed could return him to her. These rituals allowed her to enact what I call "plot points" that she thought might change the outcome of his death; these rituals gave her a sense of control in the wake of the dissolution of her life's plot. The need for a cohesive narrative was so strong, that it was easier to deny the reality of his death than it was to deny that there was, after all, no "moral lesson" or story behind what had happened.

Didion's magical thinking and bartering with God is a common response for those who believe that life is plotted across a time and theme according to a greater purpose. Lisa Olstein, a lauded poet, for example, writes about this instinct to barter with whoever might be "in control" or her life's plot. In her book *Pain Studies*, she beautifully articulates the human impulse to turn toward a causal understanding of illness. Lisa Olstein writes about and suffers from shattering chronic migraines. In her book, she grapples with the difficulty of articulating and making meaning of her chronic embodied pain; but also, with the difficulties she had in trying to understand why—what plot elements cause the ongoingness of her illness. Like Didion, Olstein grapples with questions of causation, engaging in magical thinking that presumes that if she could but change a plot point, she might change the overall plot trajectory of her illness. Often, the magical thinking would take the form of bartering games with whatever imaginary force was responsible for the story that unfolds the illness in her life. She wonders aloud what she would trade to rid herself of her unbearable pain. Her examples show just how embedded a causal understanding of illness is to her experience of it and how deeply she desires to find a sense of coherence and chronology for her pain. She admits, like Joan Didion, that this is, of course, logically nonsense. And yet, she can't stop herself from thinking in this way; from hoping that she could change something in her control/the plot elements of her life story to alter the pain she is powerless to stop. In one of her meditations on causality and illness she says:

> Sometimes chance is chance, but is it ever what we mean by causality? Chance is cause stripped of meaning, an origin story or fated end without moral or lesson. But any cause as yet unknown glows luminous. Answerless, we search for answers, because questions call and press. Somewhere out there, we feel sure, is the information that means, but,

> beyond our reach, it can't matter yet. And when causality's riddle turns out to be procedural or a purely chance operation, can it ever? Maybe it's a question of meaning versus meaningfulness. Chance may not teach us anything, but chance identified is a kind of answer and therefore a kind of balm, a version of no blame, I mean, in a way it's reassuring now clearly the migraines come and go of their own volition, according to their own logic (Olstein 175).

This passage comes at the end of Olstein's extended grappling with why her pain occurs and her inability to gain a sense of control over it. By the end of the book, she comes to terms with her longing for answers as a part of humanity's desire for stories. She acknowledges that these questions will always press upon her. The pull of cause-and-effect is so strong that it takes her the entire book to grapple with and resist the triumph narrative. She longs for an alternative to the triumph narrative, a story that would be a "balm, a version of no blame" in which she would not be culpable for her illness (175). She learns to resist the idea that she might heal by changing a plot point through her own efforts.

In addition to Didion and Olstein, Sarah Manguso struggles with this same impact of blame or culpability for her illness. In her memoir *The Two Kinds of Decay*, Manguso grapples with coming to terms with her chronic illness. In one of her poetic vignettes, "Causation," she documents her difficulty in coming to terms with her illness. She writes:

> Was the CIDP s physical manifestation of a spiritual illness? / Did the medication trigger the depression, or did the depression trigger the CIDP? / What about those yogis who can lie down on a bed of nails, then arise, streaming blood, then stop the flow of blood from each wound individually, with the power of their minds? Isn't frailty often a choice? / And if frailty is a choice, then isn't an autoimmune disease a semi-intentional suicide? / What came first, the suicidal depression or the suicidal autoimmune disease? / Did they happen independently of each other, or not? / Sometimes I think that in the real universe, I am born already in possession of my CIDP, my depression, my whole life and death, and the text of this book. That I'm incapable of making the events of my life happen – either because they've already happened, or because they're always happening, at every possible point in spacetime. / And then sometimes I think I've made everything happen starting with making myself be born (Manguso 21-22).

In Manguso's meditation, she tries to understand the limits of what is or isn't in her control surrounding her health. Because, as I mentioned in the healing handbook section, the triumph narrative moves health/illness into the individual's locus of control, she is forced to engage with her culpability for her suffering. In order to narrate her illness, she tries to come to terms with how much the plot of her illness is or is not in her control. She asks, "isn't frailty a choice?" wondering if the effect of her illness, written along some timeline she can't understand, is the result of her failure. The empowerment logic in the healing handbooks, that is meant to restore agency to the individual, leads to a sense of guilt. For Manguso, the pain caused by the illness is doubled by the narrative imperatives to make sense of and give a chronology to the illness. Not only must she endure pain, she also must wonder if she is the cause of it. This passage usefully critiques the damage that the triumph plot can afflict while also showing how strong the desire for plot can be in one's life.

Like in the theory of divergent narratives I discussed in the introduction, sometimes agency does not look like reclaiming control over one's body. Instead, sometimes it means leaning into the lack of control. In her struggle with causation, Manguso reaches for plots that aren't chronological that have "already happened, or because they're always happening, at every possible point in spacetime" because a plot—that isn't that of the chronological triumph narrative—would move her illness outside her realm of control. And while accepting that one is "incapable of making the events of my life happen" might appear to look like "helplessness," leaning into a lack of cause-and-effect actually provides relief and can look like another form of agency. Not the typical "ableist, mastery-and-control models of agency to which complicate expectations are bound" but a divergent agency (Gouge 127). That acknowledges the reality of one's body and lack-of-control one often has over it. As Guglielmo explained, "searching for agency in patient narratives might include noticing places where patients have embraced their illnesses instead of overcoming them" (10). This embrace, for Olstein, Didion, and Manguso requires a rejection of the triumph narrative and a new form of agency that would relinquish imagined control one has in one's life and instead radically accept what is beyond one's power.

In Duke theologian professor Kate Bowler's book *Everything Happens for a Reason: And Other Lies I've Loved,* she grapples with these same issues of plot, causation, and culpability- particularly as they are tied to her religious upbringing. For Bowler, the triumph narrative intersected with the Christian stories of suffering she and those she loved most used to make sense of their lives. Understanding how religious and cultural myths intersect with the triumph narratives reveals how imperatives are upheld in individual's lives through personal identification and relationships with others. In her 30s, Kate Bowler was suddenly diagnosed with stage IV colon cancer and was then forced to reconsider the prosperity gospel stories that shaped the meanings she had previously made in her life. Just like in the triumph narrative of brokenness/wholeness, the health-and-wealth prosperity narrative operates under the belief that God has a perfect will for each human being, and that if one is living in God's perfect will, they will have an ideal, healthy body. After all, in heaven "There shall the eyes of the blind be opened, and the ears of the deaf shall be unstopped" (Isaiah 35:4) and the evils of illness and disabilities will be done away with. A belief in the triumph metaphor of "wholeness" (in the form of God's will of ideal health) led Bowler to the same causation narrative crisis that Olstein and Manguso became entangled within that moved illness into the locus of her control. Like the triumph narrative, Olstein explains that "this type of Christianity celebrated the American can-do spirit, implies that if you "can't do" and succumb to illness or misfortune, you are a failure" (30). On top of her physical suffering, Bowler had the pain of feeling like she had somehow caused or drawn the illness toward her. Like Manguso, who wonders about the yogis who could control their own flow of bloods, her life felt like a puzzle: a plot she must disentangle. She says, “In a spiritual world in which healing is a divine right, illness is a symptom of unconfessed sin—a symptom of a lack of forgiveness, unfaithfulness, unexamined attitudes, or careless words. A suffering believer is a puzzle to be solved” (29). This construction of health and illness as the consequence of faith or sin led to her living with the conviction that she could “control the shape of her life with a surge of determination” (28).

As her illness continued to progress and seemed less likely to be cured, she drew away from others, tired of them blaming her for not getting better or being more positive. She felt everyone was sure she must have caused the effect of her illness. This led to a deep sense of shame and guilt and loneliness. Instead of being able to communicate her suffering with others, the demands of a cause-and-effect plot shut down her ability to voice her experiences. The meanings of her story were already predetermined for her through a chronological plot. The loneliness she experienced stemmed from others’ inability to sit with her in a space of uncertainty and stasis: in a plotless pain that had no purpose:

> The only thing worse than saying this is pretending that you know the reason. I’ve had hundreds of people tell me the reason for my cancer. Because of my sin. Because of my unfaithfulness. Because God is fair. Because God is unfair. Because of my aversion to Brussels sprouts. I mean, no one is short of reasons. So, if people tell you this, make sure you are there when they go through the cruelest moments of their lives, and start offering your own. When someone is drowning, the only thing worse than failing to throw them a life preserver is handing them a reason (41).

In this account, even those who were closest to her and wanted to help were unable to communicate outside of the triumph narrative. The narrative quite literally came between her and others. Those who loved her were quick to dictate the shape of her narrative by clinging to the only story structures they knew: a story in which everything bad stems from a cause-and-affect plotline that would allow them to regain control.

This passage makes evident how the insistence on a chronological plot can estrange and foreclose a person's ability to share their story with others or to have it received without being reframed. And yet, narrative structures of cohesiveness, as I demonstrated in the healing handbooks, are lauded in the field of Narrative Medicine where one's well-being is closely tied up with one's ability to create a coherent narrative (McAdams). Later, Bowler usefully redefines what psychologists call "narrative agency" and cohesion as actually being a form of imaginary control for what is out of one's control. She says that: "Spiritual laws offer an elegant solution to the problem of unfairness. They create a Newtonian universe in which the chaos of the world seems reducible to simple cause and effect. The stories of people's lives can be plotted by whether or not they follow the rules. In this world there is no such thing as undeserved pain. There is no word for tragedy" (18). In this passage, Kate Bowler attributes the human impulse to give an absolute meaning to illness as an unwillingness to surrender to uncertainty. Bowler has to fight not only her own guilt, but also has to fight the doctors, her friends, her pastors, her coworkers, and her family's desire to shape her life into a triumph narrative arc. Those closest to her, like her family, cling the hardest to the triumph narrative, imagining they are offering hope when they are in actuality denying the place of suffering she was in. The impulse to say "*if* one eats brussels sprouts one will get healthy" allows the listener of the story, who daily eats brussels sprouts, to feel safe and out of harm's way. Importantly, insisting on a cohesive plot allows the listener to *other* themselves from the person who is ill. A cohesive plot provides a way out of a deep engagement with another's suffering, since one can listen from the safe distance of assurance through logic like: *I will not end up like this suffering* *person for I will not do/think/be/have/become the things they have and are* that depends on a causal plotline.

Bowler explains that what was most needed and also most unavailable during this difficult period of her life was for someone to listen to her suffering and *not* give a reason why it was happening. Someone who could listen and sit with her in her pain, without laying a plot or metaphor or theme over what she told. Bowler says, “To become chronically ill is not only to have a disease that you have to manage, but to have a new story about yourself, a story that many people refuse to hear—because it is deeply unsatisfying, full of fits and starts, anger, resentment, chasms of unruly need. My own illness story has no destination” (19). She wanted only to communicate the concrete details of what the pain felt like to her in her body and not always to be forced into a storied explanation. Relief came when she could voice her embodied reality to another and have it be heard, accepted, and acknowledged instead of rescripted into something else.

Like Kate Bowler, in the Podcast *On the Soul of Depression* Parker Palmer says that what he needed most in his illness was not a solution or an explanation for his suffering, but rather for someone who could be present with him, joining *in* his suffering instead of trying to do away with it. As a Christian theologian, Palmer describes how he had always been able to make meaning of his life through a spiritual narrative, but as he grew ill, he began to feel that “many of the qualities by which I had defined myself were abandoning me, and that I was no longer the person whom I had previously been.” This spiritual crisis for Parker Palmer also became a narrative identity crisis that shook his storied reality. He explains how so many people who cared deeply for him tried to help “fix” him. One of the most common ways people tried to help was to remind him of all the great things he’d done in his past and why he had no “reason” to feel depressed. He explained how people would often turn toward the past—to show there was no cause-and-effect reason that he should be sad—imagining that all depression must have a root cause, and because his didn’t, then it shouldn’t be there or he shouldn’t wallow in it. Or else, in an attempt to push him beyond his suffering, they would try and have him do things (change the plot points of his life), telling him to “go outside and smell the flowers!” or enjoy the “beautiful day,” actions they believed could move him toward the destination of getting better. These responses, just like Bowler and Manguso, only made him feel more isolated and guilty, like he had no reason to be sick and was weak for not getting over it.

But primarily, he speaks of his complete estrangement created from others’ unwillingness to be with him in uncertainty, outside of a plot that would move him toward becoming all “better.” According to Palmer, no one in his life could accept that “suffering is just suffering” and that there was no greater “purpose to [his] suffering.” The nature of his illness brought him into a new reality that no one else wanted to join him in, which is why, Palmer says, that “one of the particular forms of anguish of depression, is, I think depression is above all an illness of loneliness.” The loneliness could only be breached by those who were willing to put aside the triumph narrative and try a different approach.

Palmer describes a turning point in his depression when his friend tried an alternative approach that moved him out of his utter isolation. Palmer explains that he had one friend who found a way to connect with him through his body, rather than through an existential meaning of why his body and mind were suffering. This friend would come by every day at around 4 o’clock, sit with him in his living room, take off Parker Palmer’s shoes, and then massage his feet:

> But beyond that [rubbing his feet], he would say hardly anything. He would give no advice. He would simply report, from time to time, what he was intuiting about my condition. Somehow, he found the one place in my body, namely the soles of my feet, where I could experience some sort of connection to another human being. And the act of massaging just — in a way that I really don't have words for — kept me connected with the human race. What he mainly did for me, of course, was to be willing to be present to me in my suffering. He just hung in with me in this very quiet, very simple, very tactile way. And I've never really been able to find the words to fully express my gratitude for that, but I know it made a huge difference. And it became, for me, a metaphor of the kind of community we need to extend to people who are suffering in this way, which is a community that is neither invasive of the mystery nor evasive of the suffering, but is willing to hold people in a space, a sacred space of relationship, where somehow this person who is on the dark side of the moon can get a little confidence that they can come around to the other side.

Palmer's story is powerful for several reasons. First, because it shows that illness cannot always be reasoned with or narrated- sometimes, suffering is simply an embodied experience that resists plots or metaphors (just as the body resists words). Therefore, touch became the only way of accessible communication. The communion Palmer was able to find was dependent upon his friend's willingness not to "invade" with solutions and cures nor to "evade" Palmer's deep suffering. A human connection was made possible because of his willingness to sit in the discomfort of pain and to treat Palmer's illness as if it were something natural and not something he ought to overcome. The act of kindness came through treating Palmer's story and subjectivity as inherently valuable and not in need of being framed as a problem that needed fixing. Granted, it is incredibly difficult to join a person in a space of "mystery," uncertainty, and ongoing pain without moving them toward cure (Palmer). After all, it is painful to watch suffering just as it is painful to suffer.

And yet, paradoxically, the healing Palmer experienced did not come through moving *beyond* but through a sitting *in* stasis. In the triumph narrative, the "fixing" of the "broken" person is spatially arranged as needing to move "towards" "overcoming" (forward and upward movements). Nowhere in these directional metaphors is healing a matter of stasis; of not moving toward another place, but in being ok to be present in discomfort and pain. Sitting with suffering does not mean one has "given up," rather, sitting with pain is often the most effective means of mitigating it. His friend's ability to be present depended upon his willingness to resist a pushing him *toward* any goal-driven direction. His friend's only spatial directional response was joining the "sacred space" of sitting alongside, within, and among suffering and never toward a different place (Palmer).

Unfortunately, the "hysterical denial of suffering" that Kathlyn Conway discusses in her definition of the triumph narrative does not allow for the stationary; it demands a moving *toward* cure. This begs the question: what might divergent care look like? What does care without cure or fixing, without the forward progression of plot, entail? What is needed, according to Narrative Medicine scholar Rita Charon, *is practice with listening to stories that are not triumphant:*

> Here is a painful and bifurcated truth: Facing head-on the realities of serious illness in our settings of contemporary Western health care takes the savage imagination to recognize and then countenance the facts of suffering: unfair, unwarranted, vengeful, impersonal, neutral, demolishing of those whom it visits, without consolation, without the silver linings so often fabricated by those it fingers. There are only two paths open to those who must witness suffering: (1) pretend it is something else—predictable, respectable, eventually curable, spiritually enhancing, the thing that happens to others—or (2) see it fully and endure the sequelae of having seen" (Charon 1669).

In other words, in mitigating suffering, one can either choose option 1) the triumph narrative that imagines suffering to be transformative, curable, and at a safe distance or 2) engage—fully engage—and endure. Endure, yes, because to truly see suffering, without the comfort of having it be "the thing that happens to *others*" means to come close to suffering: to come up against one's own limitations. It is a movement toward a radical acceptance and deep engagement. What this radical acceptance actually looks like requires several chapters to explain. Therefore, in the Gothic chapter, I'll discuss how care that allows one to fully engage with illness requires an acceptance of uncertainties and a lack of closure; while in the Transience chapter, I'll discuss how a full engagement with illness requires seeing the impermanence and beauty of all things, including the decaying body. If engaging fully with illness and disability is the goal of this project, then I have attempted in this chapter to show how certain stories (like triumph and its narrative components) foreclose this engagement by over-scripting one's reality. In offering a critical lens to the components of the triumph narrative, and by offering divergent narrative components in the following chapters, I hope to increase the possibility of engagements with suffering that would allow for radical acceptance, connections, and intimacy.

I've described how, if medical practitioners (like those writing the healing handbooks) are oblivious to the histories and cultural values embedded in the stories society tells, then the shapes the narratives take and the values that drive them will likely unwittingly reinscribe values of ableist ideals, overcoming difference, and outcome-driven understandings of health. These values can damage a person's capacity to find their own resilience practices and ways of connecting with others. However, tempting it is to offer a cure—especially when triumph narratives wait at every corner—to do so can cut short an honest engagement with pain. In critiquing the narrative turn, I do not critique the *desire* to find a coherent narrative for the rupturing effects of illness; I acknowledge the values of reclaiming a sense of agency and connection with others through storytelling. The value of narrative cohesion, after all, has been well documented in psychology and counseling fields. But, a deep engagement with suffering often includes paying close attention to the details of one's embodied condition- not a bypassing of them through a directional movement like overcoming. Engaging with the concrete details of one's reality, finding associative organizational strategies, and storying the beauty of one’s suffering through poetic stylistic choices, are just a few examples of divergent narrative techniques that literature can offer. In this last section of the chapter, I offer two brief examples of narrative approaches that resist chronology.

Resisting the Triumph Narrative: Divergent Plot Techniques

Now there shall be a man cohered out of tumult and chaos – Walt Whitman

I have now critiqued the limitations of the triumph narratives and in this closing section, I consider alternative structures to the chronological plot. For example, many authors have experimented with divergent methods of fragmentation, non-linearity, and associative organization to rescript their experiences of illness away from chronology. These forms allow authors to insist on the ongoingness and neutrality of their embodied experiences instead of adopting a narrative frame that their illness is a problem that needs fixing. I believe that by reading these alternative narratives, those experiencing chronic health conditions or disabilities can find new possibilities for reclaiming agency by storying their experiences in ways other than through medicalized triumph narrative tropes. I also believe that practicing listening to non-chronological narrative structures can expand medical practitioners’/those who are caretakers’ abilities to attend to the stories of those who are suffering. To exemplify the rhetorical possibilities, I will now briefly mention two writers who grappled with the problem of a coherent, orderly narrative and developed innovative writing strategies in their art that both satisfies the need for a story while still remaining authentic to the chaos of the experiences they felt.

Virginia Woolf famously experimented with plot forms and temporal structures in order to reflect her fragmented sense of the world shaped by her ongoing depression, trauma, illnesses, and loss of so many people she loved. Woolf acknowledged the human impulse toward narrative order that drove her need to create art. She says, “It is only by putting it into words [what is most painful] that I make it whole; this wholeness means that it has lost its power to hurt me; it gives me, perhaps because by doing so I take away the pain, a great delight to put the severed parts together” (72). While Woolf uses the language of wholeness and severed parts, all one need do is turn to her fiction to discover her resistance to chronological plots and the triumph metaphor of “wholeness” that she understood would undermine her experiences. Her plot arrangements radicalized possibilities of novel structures, changing what “order” in a plot can mean through her use of fragmented and cyclical structures. Even though her books grapple with a teleology, she finds resolution in the process of creating art that *reflects* instead of controls the chaos: not by forcing her life story into a narrow mold of a cause-and-effect linkage.

Importantly, Woolf allows for the harmonies between disparate details to resonate through their associative arrangements- not through causation. For example, in the following two chapters (on the Gothic and Transience) I will analyze Virginia Woolf’s *Mrs. Dalloway,* a novel that implements a radical temporal structure and, like Joyce’s contemporaneous book *Ulysses*, takes place in the course of a single day. *Mrs. Dalloway* is set as much in the past as in the present, jumping around in time and scenes connected by associations. These connections are tenuous and circle around a “centre which, mystically, evaded them” rather than through a linear plot (Woolf 14). Despite the disjointed temporality and shifting points of view, Woolf still allows for a narrative unity that provides a sense of “wholeness” without rendering the person who is ill/disabled as broken. In her writing, Woolf seeks to suggest that “behind the cotton wool is hidden a pattern; that we—I mean all human beings—are connected with this; that the whole world is a work of art; that we are parts of the work of art” (72).Woolf’s innovative structures allows for a lack of causation while *also* allowing for unity in her art—the result of attending to the minute details of experiences in precise language. In allowing for patterns of unity through resonances, she is able to create narrative meanings that provide a sense of agency without reducing the difficult truths of her reality. Woolf says that by making her pain into a work of art it loses "its power to hurt me" (72). For Woolf, the wholeness was in allowing for the severed parts to come together- in the chaotic form that she experienced them in real life. The wholeness and "power" she reclaims in writing stories derives from capturing details to create a narrative that mimicked chaos in the form itself. Reading Virginia Woolf's works like *Orlando*, *To the Lighthouse*, *Mrs. Dalloway*, and *The Waves* offer models of divergent plot structures that can provide the sense of cohesion so needed in times of rupture without enforcing a causal plot that would put the onus of healing on the individual or render their embodied differences as brokenness. As I will describe in the Transience chapter, Woolf alters the relationship with illness and disability, so it isn't merely a problem to be overcome, but rather an embodied difference that offers its own rich affordances.

Like Woolf, poet Lidia Yuknavitch struggled with the tension of needing to make art from a difficult experience in order to regain a sense of agency while feeling that the form of the story—the chronological plot and metaphors for grief—did not do justice to her difficult experiences. In her grappling with narrative order, Yuknavitch ultimately creates and offers the reader a fresh metaphor and structure for understanding and narrating grief. In her gorgeous book, *The Chronology of Water*, Lidia Yuknavitch writes about grappling with the loss of her first child, a newborn she was in labor with for days who was born dead. The novel tries to make sense of the fragments of her life that led to this death, how much control she had over them, and the resonances she saw between her past, present, and future (in non-chronological order.) She describes her longing to give her suffering a meaning and the near impossibility of authentically doing so. While she struggles to find a cohesive purpose for what has happened, she knows that to give a greater purpose to her child's death would be demeaning, a denial of her own thoughts and feelings and the child's life. And yet, the desire to story her suffering is overwhelmingly strong. She feels, like Virginia Woolf, that she must make art out of what has happened in order to give it a sense of wholeness.

Through the book's structure and her resistance to chronology, she offers a wider meditation on the impact that typified narrative structures have on the sense-making aspects of grief that Joan Didion and Lisa Olstein wrote about. In the book and her interviews, she describes the difficulties of storying one's life outside of chronological plots, explaining that in first drafts of her book, chronology was inescapable. Ultimately, this is why she decided on a direct engagement with chronology- even in her title. After many drafts, she arrived at a metaphor outside of the triumph narrative's brokenness/wholeness/closure/cure framing. Instead of a chronology toward overcoming suffering, she arrives at the metaphor of "the chronology of water" that allows her to move toward a deeper engagement with pain and to authentically capture her fragmented and profound experiences of loss and illness. Her divergent metaphor of the chronology of water allows for the circularity, ongoingness, impermanence, uncertainty, and lack of closure she experienced: valuable affordances I will discuss in the following chapters.

Her alternative narrative form gives room for the associative and winding path of grief and illness that she endures. The narrative structure of her book is a fragmented, disjointed account that draws the reader into scenes from her past, present, and future in a dizzying mixture. Her relief and healing come only when she allows for an associative rather than chronological structure for understanding her pain. In explaining the cohesive meaning she was eventually able to make she says, “Your life doesn’t happen in any kind of order. Events don’t have cause and effect relationships the way you wish they did. It’s all a series of fragments and repetitions and pattern formations. Language and water have this in common” (Yuknavitch 14). In order to heal, Yuknavitch had to articulate some sort of pattern, much like Virginia Woolf describes of the pattern behind the “cotton-wool” of everyday life. And yet, even within Yuknavitch’s need to find a pattern, her healing finally comes only when she recognizes the impossibility of imposing a cause-and-effect relationship on what has happened to her. Yuknavitch’s book is a powerful testament to the suffering inflicted because of the triumph narrative and the relief she found once she loosened herself from the bonds of grief’s assumed typified healing structures. By attending closely to the pattern of arrangements in the texts, particularly to water as a matter that allows for transience, movement, divergences, and anything *but* a neat and tidy closure and chronology, readers are made aware of new narrative possibilities. I’ve offered these two writers, Woolf and Yuknavitch, as examples of disabled writers who understand the discursive, ongoing engagement with making illness “whole” through alternative metaphors like water or plot structures that do not urge the destination of overcoming difference. Authors like Woolf and Yuknavitch grant readers practice with new narrative techniques that can make it easier to attend to patients’ stories of ongoing suffering; and also for patients to borrow new plots, metaphors, and other constructions for self-understanding.

While it is difficult in the face of illness (whose myths of overcoming and overcompensating are readily available) to resist pre-formulated narrative structures and meanings, literature can provide means for these engagements. I believe part of the way that one regains agency is in the very *form* of the story itself. In the novels I've chosen that I will examine in the following chapters, the authors resist typical illness myth structures by experimenting with ways of ordering that hold the story together without ascribing cause-and-effect explanations, who aim to accurately depict their experiences in the form as well as content. The connections across the way a story is revealed (sequentially, associatively, etc.) can shape (for the teller) or reveal (for the listener) the meanings that a person makes from their illness.

In fact, my argument about what literature can do and the affordances of fiction can only be understood as a direct resistance to the problems of the triumph narrative. In the novels and patient narratives I explore, I see inroads through deep narrative cracks. I see, in the triumph narrative shortcomings, rhetorical possibilities. In the following chapters, I further examine the affordances of fiction through several questions. These are: If the problem is a demand for certainty and closure, then what might a story look like that has no fixed meaning but allows for uncertainty and impermanence? If the problem is a story that renders the ill as broken in need of fixing, then what would a depiction of illness look like that allows that allows wholeness and beauty? Through my literary approach, I move toward the possibilities of tolerance of chaos, uncertainty, neutrality, paradox, and ambiguity in listening to and crafting stories of ongoing illnesses or disabilities. In the following chapters, I will talk at length about two divergent narrative themes—uncertainty and transience—that provide alternative plots and metaphors to the foreclosing stories encouraged in the handbooks, narrative medicine tropes, and dominant narratives of triumph I explored here.

CHAPTER III: THE AFFORDANCES OF UNCERTAINTY IN GOTHIC NARRATIVES

Doubt is not a pleasant condition, but certainty is an absurd one. - Voltaire

In this chapter, I attend to the affordances of Gothic narratives and imagine how they can expand rhetorical possibilities and the "menu[14]" of narrative options that can be taken up as a way to mitigate problems of ethos and medical exigencies connected to the triumph narrative. I argue that Gothic novels are particularly useful for representing mysterious, psychosomatic, difficult-to-diagnose illnesses that might be described as "existing only in the head" because they allow for both the realness *and* uncertainty of mental health and other illnesses. In the previous chapter on triumph, I described the narrative push toward closure, cure, and a rapid return to an imagined "ideal" of health. I also explained how the demand for the triumph narrative can foreclose the telling and listening to stories that do not follow this trajectory. In this chapter I explore the medical exigency of the demand for certainty that stems from the triumph narrative, impacting expectations around everything from the decision of whether or not to seek treatment, to the process of receiving a diagnosis for an invisible condition, to choices in medication and ongoing treatment plans.

In the Gothic novel, protagonists move out of the "ordinary world" of light and logic and into a new and menacing setting of the haunted house (a symbol of illness) where around every corner looms a possible attack by a ghost or an invisible force (Wasson 5). The Gothic

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[14] In the introduction, I use Narrative Identity scholars' definition of the limited narrative strategies available for self-authorship, which are determined by the elements one has been previously exposed to (McLean 237). Dan McAdams explains, "It would seem that different cultures offer different *menus* of images, themes, and plots for the construction of narrative identity, and individuals within these cultures appropriate, sustain, and modify these narrative forms as they tell their own stories" (McAdams 237).

allows readers to join the protagonist's path of decoding symbols and believing in the mysterious as we are plunged into an atmosphere of suspense and superstitions. Navigating a body that is chronically ill, that may be immobile and wracked in pain one day and functional and tolerable the next, is not unlike tiptoeing through a dark hallway. In the Gothic novel, instead of moving through a world of reason and order, one is trapped inside a claustrophobic world where one's ability to reason and "conquer victimhood thoughts" is less important for one's survival than a heightened awareness of one's bodily sensations and predilections (Anolik). The strong atmospherics of Gothic novels—the many scenes that take place at night, the candles needed to navigate long, dank passageways and heavily curtained rooms—create an affective state that many with chronic illness claim to closely recognize (Mikalsen). As one patient describes it, the setting captures the terror of a looming illness that one cannot control (Wasson 7). In these ways and others, Gothic novels invite readers to reject explanations by medical authority figures that dismiss the embodied realities of the character's experiences (even when the protagonist's experiences seem made-up or irrational.)

I argue that Gothic narratives, with their metaphors of the mysterious house and their plotlines of uncertainty, are particularly suited to describe the dynamic relationship of experiencing the uncertain, impermanent, contingent, embodied, and situational components of mental illness. Importantly, Gothic novels parallel calls for responses that encourage an acceptance—not resistance or reframing—of difficult realities and disabilities. As in the other chapters of this dissertation, I encourage a close attending to the fullness of human suffering, not a diminishing of it in order to move toward a "positive" outlook. The agency and authorship that the protagonists in Gothic novels enact is a model of embracing ongoing and acute suffering as natural and worthy of close attention and narration.

Usefully in the Gothic narrative, the house offers an alternative metaphor to overcoming, a spatial relationship of *inhabiting* a mysterious space rather than a moving away from suffering and toward cure. Through the metaphor of the house, a learning to sit *with* and attend to what is difficult, and often filled with horror, is made possible (Ng-Hock-Soon). In the triumph narrative, metaphors like "battling cancer" enable plot sequences wherein the enemy is clear and externalized and the weapon of medication can be used to fight and defeat illness or disabilities (Sontag). But, in Gothic narratives, the elusive "enemy" of mental illness cannot always be named, fought, and conquered—it is a mysterious and indistinguishable force (like a ghost, or supernatural haunting) that is always changing; there is no fighting this elusive force; but rather, according to psychologists, mental illness often needs to be accepted, integrated, cajoled, or even befriended (Brach). The Gothic house, which I read as a metaphor of the body, is full of uncertainties and dangers that are out of a person's control and difficult to prove. The protagonists learn to negotiate their relationships with the house, listening carefully to its needs to discover its nature, even as they fear it. Repeatedly, the protagonists must decide whether to trust their own observations experienced through their concrete senses, even when there is no rational explanation to back them up, *or* trust the claims of the "professionals" that insist the house is "normal" (Jackson). Additionally, protagonists must choose either to deny the realities of their bodies, or to retreat into isolation, no longer able to be believed or understood by others. I've selected these novels because their protagonists choose their subjective, singular, embodied realities and thereby offer models of divergent agency that moves toward an acceptance of suffering instead of triumphing.

In conjunction with exploring metaphors of the haunted house, like every chapter in this project, I explore how a vulnerable ethos[15] can lead to the foreclosure or rescripting of patients' authorship of their embodied experiences. Crucially, if the protagonists believe what the doctors tell them about their bodies, they would have to reject the realities of their embodied experiences. I focus on the diagnosing of invisible illnesses like mental health conditions, the accuracy of which are entirely dependent on communications and interpretations between doctors and their patients. Treating invisible mental illnesses is complicated by the fact that the doctor must first decide whether they believe that their patients' claims to suffering are real or not. And, as I described in the introduction chapter, doubt regarding the material reality of bodily suffering can stem from comorbid diagnoses of mental health conditions like anxiety, schizophrenia, or bipolar disorder.

Throughout this chapter, I describe an exigency through medical articles, patient stories, and case studies that offer an explicit invitation for medical uncertainty. While I particularly center medical scholarship more so than in any other chapter, I do so to make clear what the stakes are for all listeners/tellers of illness stories across rhetorical contexts. An ability to sit with stories of ongoing suffering is a skill needed not just for doctors, but for family members, friends, caretakers, and any listeners to suffering. Often, the trajectory of seeking care for mental health conditions does not lead "toward" a destination of health and cure. But rather, requires an ongoing, contingent, "situational agency," a Métistic orientation, for navigating shifting symptoms and conditions (Flynn 15). I challenge linear cause-and-effect plots (like in

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[15] To return to my explanation in the introduction, a "vulnerable ethos" is shaped by one's embodiment and other social determinants of credibility. One's age, gender, class, race, education level, or mental health diagnosis are example factors that can determine whether or not a person will be seen as "rhetorically suspect" (Yergeau 3).

the Healing Handbooks critiqued in the Triumph narrative chapter) that insist upon absolute certainties and closures. I offer in their stead plotlines and metaphors of mystery and uncertainty: where, around every dark corner, dangerous and mysterious possibilities await and cures are never guaranteed.

Becoming familiar with uncertainty is largely a *narrative* skill that can, according to Rita Charon, be practiced through reading and discussing narrative strategies used in fiction (18). In one recent call by medical professionals, the article "Embracing Uncertainty to Advance Diagnosis in General Practice" describes the need for this narrative skill as a "core clinical skill."

> Diagnostic uncertainty deserves attention; not as evidence of sloppy practice, or professional failure, but as an inherent feature of, and condition for, advanced medical diagnosis. The nature of clinical knowledge rests on interpretation and judgment of bits and pieces of information which will always be partial and situated. In this commentary, we argue that the quality of diagnosis in general practice is compromised by believing that uncertainty can, and should, be eliminated. On the contrary, we suggest, appropriate management of intrinsic uncertainty is a core clinical skill, which cannot be obtained from an essentialist attitude to knowledge where certainty is taken for granted as the standard. Only by embracing uncertainty as a predictable and inevitable companion of general practice, will the GP be able to meet the clinical challenges and develop the proficiency needed for diagnostic work (Malterud et. al. 244).

According to this article, developing proficiencies in "interpretation and judgments" in patient stories can be practiced through attending to narrative choices that appear in everyday language. For example, the body/mind dichotomy that still pervades Western medical discourses appears in Gothic narratives through language like "it's all in your head." By noticing the harm such language has on the characters' sense of self, the potential harm of saying "you're just anxious" or "depressed" is brought to the forefront of listeners' attention. In apt and nuanced ways, these novels voice the difficulties seen in patient narratives of having one's pain and illness dismissed because of an uncertain and difficult to prove medical cause. I propose that the Gothic novels' readerly invitations offer models of divergent engagements that can be applied to patient stories.

In order to offer these rhetorical recognitions and divergent techniques, I have selected Gothic narratives[3] that sponsor rhetorical recognition of characters who navigate their agency by insisting on the validity of their embodied experiences. I primarily focus my analysis on *We Have Always Lived in the Castle* by Shirley Jackson, "The Yellow Wallpaper" by Charlotte Perkins Gilman, *Wide Saragossa Sea* by Jean Rhys, *Mexican Gothic* by Sylvia Moreno-Garcia and *Mrs. Dalloway* by Virginia Woolf (although other Gothic texts make brief appearances). I've chosen novels that are thoroughly discussed in scholarship and across online discourse communities[16] (Mikalsen). Of the many affordances, I primarily see possibilities in how the Gothic brings attention to, and insists upon, bodily differences in the midst of every other character's denial of the severity, and sometimes even the reality, of illness. Ultimately, I am invested in locating the narrative means by which the protagonists insist on the integrity of their lived experiences, accept the uncertainty of their illnesses, and navigate the contingencies of their shifting conditions through an acceptance of reality – instead of falling back upon readily available narratives of triumph and cure.

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[16] See Sara Wasson's introduction to a special edition of Gothic studies that focuses on the intersections of the Gothic with medical humanities. She speaks at length about online discourses wherein patients speak about the impact Gothic novels have had in their lives and identifications.

A Medical Exigency of Ethos and Misdiagnosis and Uncertainty

For both patients and physicians, entering the realm of the medical world often means entering a space of mystery and uncertainty. Communicating invisible suffering, being believed, receiving an accurate diagnosis, and experimenting with treatment plans are often fraught processes. And yet, “Empirical evidence suggests that clinicians rarely communicate clinical uncertainty to patients, and indeed the culture within healthcare environments is often to equate uncertainty with ignorance or failure” (Simpkin, Armstrong 2586). Even though the medical field openly acknowledges that the process of seeking mental health treatment is often a long, uncertain, and winding path of trial-and-error, dominant health narratives make little room for such uncertainty (Arrango). In part, this is because the triumph narratives that doctors, patients, and the medical system so often use to communicate illness are highly resistant to aspects of uncertainty. One of the reasons both doctors and patients turn to the triumph narrative is that often patients prefer to have a diagnosis—any diagnosis—than to be told that doctors have no idea what is wrong with them; after all, such uncertainty can be terrifying. For how is one to cure an illness that one can’t even name? How is one to communicate to family members, friends, and coworkers a story of illness without a diagnosis? And if there is *only uncertainty* to communicate, what is to stop others from questioning the severity—and even the reality—of one’s illness?

While research continues to show that psychosomatic and many other illnesses like neurological pain or depression *do* start in the head, it is also true that because an illness begins in the head, it does not make it separate from the body; for, the head is a part of the body (O’Sullivan). And yet, treating the mind and body as entirely separate is a common rhetorical and medical move which shifts control and responsibility of the illness to the individual

(Anolik). The belief that one can be cured through willpower if an illness exists in the mind leads to a frequent dismissal of neurological and cognitively based symptoms that are especially difficult to communicate for they are perceived to be "imaginary" (Brown 9). Phrases like "it's all in your head" are so commonly perpetuated and so often adopted because this approach conveniently aligns with the triumph narrative; since, if the illness begins in the head and is not real, then it can be overcome simply by changing or fighting one's thoughts. In contrast to these cultural assumptions, medical research has shown that mental illnesses and psychosomatic symptoms are often outside of a patient's control (Tilahan et. Al. 253). For example, just because the origins of seizures and psychosomatic seizures, or Parkinson's disease and psychosomatic Parkinson's disease, have different root causes and treatments, they still cause (often equally excruciating) bodily symptoms and are experienced in very real physical ways (Tilahan et. al. 253). Most importantly to my focus on rhetorical listening and narrative possibilities, when the root cause or logical explanation of an illness cannot be discovered, telling a patient that their illness is, in fact, unreal does not alter the reality of the patient's suffering (O'Sullivan). Therefore, as a way to expand rhetorical listening possibilities, I ask: what is to be done in cases of invisible illness, where the cause and cure of the illness may remain mysterious, and yet the suffering remains real?

There are many barriers to care that reside at the intersection of a suspect rhetoricity and a vulnerable ethos. In the first place, if a patient is not believed—is dismissed as an uncredible source because of their gender, race, class or other social determinants of health—they run the risk of not getting the help needed (Molloy). In the second, if the diagnosis is determined too quickly with the goal of a speedy recovery and is later found to be inaccurate, then the patient may have difficulties accepting and maintaining treatments with doctors who are believed to have repeatedly "gotten it wrong" (Malterud et. al. 244). Thirdly, an accurate diagnosis is complicated by the wide cultural variations in the descriptions, metaphors, and existential meanings ascribed to mental illnesses, which often leads to miscommunications of symptoms (Fogel et. al.) Furthermore, as Elaine Scarry explains in *The Body in Pain*, experiences like depression and pain resist articulation in language and are difficult to describe. For these reasons, miscommunications across mental health conditions lead to frequent misdiagnosis and always contain elements of uncertainty, since accuracy is tied up with interpretations of language and cultural meanings. As explained in *Diagnosing Madness: The Discursive Construction of the Psychiatric Patient*, doctors should proceed with caution when diagnosing invisible illnesses, allowing for communication differences and the ever-present possibility that an initial diagnosis can be incorrect (Berkenkotter). I emphasize these contingencies not to critique the process of diagnosis, but rather to lay the context for a complex rhetorical situation that calls for a narrative of uncertainty.

In addition to the problem of ethos, barriers to care arise because of the prevalence of the cultural narrative of triumph, which creates expectations for practitioners to provide a speedy diagnosis and to communicate the treatment plan with absolute certainty (Brown). This rhetorical dilemma is determined by health narratives that insist on only one plot trajectory – 1) identifying and naming the root problem 2) locating the treatment and cure and 3) ultimately overcoming and triumphing over the illness. Any deviance from this plot can impact the trust between patient and doctor. Thus, the demand for certainty, as explained in the article "Clinical Uncertainty," creates a double-bind for both practitioners and patients. In clinical contexts, certainty is determined by imperatives toward a resolution of illness and can have devastating consequences:

> Resolution of an encounter comes by achieving a level of certainty that the provider and patient can hold with confidence. In the worst situation, most force a resolution by imposing or agreeing to an unnecessary test or prescription, blaming patients for our inability to explain what is going on, or taking shortcuts in clinical reasoning to arrive at an inadequate diagnosis. These responses, sometimes referred to as premature closure, are costly. They are the main cause of medical errors. They can leave patients feeling alienated or unheard. Our own anxieties, though briefly relieved, might return to haunt us that evening or when we see those patients' names on our lists another day. Premature closure is a flailing attempt to impose a higher level of certainty on a situation than that situation is ready for (Guenter 121).

In this passage, "premature closure" is described as leading to dangerous medical errors; and yet, even though this issue has been established across medical literature, there are still pressures from many directions for practitioners to arrive at an absolute diagnosis in their communication. Doctors frequently report that if they are not able to quickly identify what is "wrong" with the patient in a way that complies with the structures of the triumph narrative, then patients, who expect this trajectory, will begin to question the doctor's competency (Guenter 122).

Furthermore, even when doctors are willing to resist patient and practice pressure to *expedite* certainty in their diagnostic process, the logistical dimensions of the current medical-industrial healthcare model render a diagnosis as a prerequisite to receiving treatment (Barbash). To give an example from the counseling profession, insurance companies will rarely cover the cost of counseling sessions unless they are "medically necessary" and in order for sessions to be medically necessary, one must first receive a diagnosis (Killian). Consequently, while many therapists think it unethical to diagnose someone after only one 50-minute session (given that presenting symptoms like "depression" may be the result of external circumstances, medical issues, past traumas, and not necessarily a diagnosis like bipolar) if a therapist does not quickly decide upon a diagnosis, the patient may be financially unable to continue to receive treatment (Stevens). In this current medical model, the patient must immediately in the first appointment be moved out of a category of uncertainty and be given a DSM categorical explanation that can be entered into the patient chart (Edersheim 116). Many practitioners from across specialties critique the insistence from insurance companies that one be diagnosed immediately, and yet, often the question of access to care poses risks that can rival the risks of a premature diagnosis (Lamkin 897).

In addition to the problems of a speedy diagnosis, many patients expect they will quickly find an effective medication and are unaware of how much uncertainty there is in determining effective pharmaceuticals (Lichstein 339). After all, popular and pharmaceutical narratives around mental health treatments do not include uncertainties (not having a guarantee would make selling their product difficult) but portray a tidy before-and-after medication story (Laranjeira). But, this narrative is false. As Dr. Friedman, professor of clinical psychiatry, explains that "Many people need to try two or three drugs or drug combinations before experiencing relief. Some go through six or more. It's a hit-or-miss, trial-and-error kind of process" (Schuyler).

The medication and treatment script, then, is tied to rhetorical aspects of persuasion, what doctors call "medication adherence" and "patient non-compliance," a rhetorical situation that RHM scholar Judy Segal discusses in her book *Health and the Rhetoric of Medicine*. Importantly then, there are rhetorical consequences if the first diagnosis turns out to be incorrect, since patients may begin to doubt the doctor, rather than understand that such trial-and-error procedures are routine practices and that the doctor's willingness to shift diagnoses is often a sign of thorough and responsive treatment- not of poor care (Fricchione). After communicating certainty at the outset, it may be difficult, if not impossible, to retroactively persuade the patient of the tentative nature of diagnosis and treatment.

A Medical Exigency of Ethos and Misdiagnosis: According to Patient Stories

Now that I've described the constraints on doctor-patient communication in medical conditions that can lead to problems of diagnosis/misdiagnoses, I turn to several patient stories that articulate their difficulties in getting an accurate diagnosis but also, and especially, of being believed to be a credible author of their own embodied reality. I begin with a recent patient narrative that closely aligns to many of the Gothic texts I will examine. Brian Teare is an established poet and Guggenheim fellow who wrote in an article "Neither Chaos Nor Quest: Toward a Nonnarrative Medicine" about his experiences of illness and his resistance to typified narrative approaches espoused by the newer field of Narrative Medicine. Brian Teare's narrative illustrates the devastating consequences of seeking treatment that does not allow for narrative uncertainty. In Teare's article, he describes how he visited specialist after specialist, seeking an explanation and treatment for his dozens of confusing and debilitating bodily symptoms that had come to disrupt nearly every aspect of his life. After several tests and doctors failed to find what was the matter with him, instead of continuing to allow for uncertainty, one doctor eventually diagnosed his symptoms as the result of severe anxiety and depression. Brian Teare explicates that his anxiety diagnosis was just another way of saying he was "making" his bodily symptoms up. He explains that one of the most difficult aspects of this period of his life was that, in the wake of his anxiety diagnosis, those around him stopped believing in the severity and reality of his bodily suffering. The worst of it, he says, was that after the visit where he received a mental health diagnosis, on the way out of the office, his life partner called him "crazy" for having imagined symptoms for months on end and indulging in such fantasies. The diagnosis that rendered his mind an uncredible source had the power to change even how the person closest to him listened to and understood Teare's story of his body. In this way, the medical foreclosure changed Teare's rights to author the story of his body, causing him to be "rhetorically suspect" (Yergeau 3). For, either his story was accurate or the doctor's was; both could not be true.

Over time, his symptoms grew worse and even more debilitating so he continued to seek a doctor who would take him seriously. Finally, after many more specialists, Teare received an accurate diagnosis for a rare chronic health condition that is difficult to diagnosis and can have devastating consequences if left untreated (Saur). Teare describes the permanent damage that the doctors' disbelief in his illness caused in his psyche and personal life, and, in addition, how not having his suffering legitimized by a doctor made it difficult for him to receive support or sympathy from those around him. He especially grieves that the diagnosis ended his relationship with his partner who left shortly after he found out he was "crazy" and making his symptoms up "in his head."

Teare ascribes culpability to the doctors' unwillingness to rest in uncertainty and mystery, and rails against the medical-industrial complex's tendency to determine *any* diagnosis, rather than engage with the uncertainties of his condition. Toward the end of the article, Brian Teare wonders what would have happened if the doctor who diagnosed him as "just anxious" had not diagnosed him at all. He says, "I keep imagining what it would have meant to have encountered a doctor who said, "Though I couldn't diagnose your illness, I believe you are ill and you need more comprehensive testing than public health can provide" (Teare). In this narrative, Teare calls for what I interpret as ways of communicating invisible illnesses that would allow for the in-between spaces; the inevitable uncertainties in the process of seeking help.

The desire to be seen as rhetorical and to be the expert on the story of one's own body, and, especially, to be listened to and believed, is core to the patient narratives of uncertain and invisible conditions. In one study based on patient narratives, "It's Incredible How Much I've had to Fight: Negotiating Medical Uncertainty in Clinical Encounters" medical professionals who surveyed more than 250 participants found that "The main source of their [patients] discontent is not the lack of biomedical knowledge, but doctors who fail to communicate acknowledgement of patients' experiences, knowledge and autonomy" (7065). In other words, the patients' main complaint is a refusal to acknowledge their rhetoricity and embodied knowledge. Further, as one patient expresses, those suffering with illness become:

> frustrated by the attitudes people have to the illness, particularly that healthcare personnel are allowed to treat people so badly because they don't 'believe in the illness' and worse, that they put pressure on patients to 'pull themselves together' or to undergo treatment that only makes the patient worse. […] To be treated so badly, and also be disbelieved and told that one is lazy, has an eating disorder, that it is a matter of willpower etc. when one is seriously ill, is a terrible additional strain (7066).

In this passage, the triumph narrative works to discredit the patients' stories in several ways. Through the cause-and-effect plotline that holds those who do not get better as culpable of their illness, of laziness, and not trying hard enough.

In particular, the triumph script led to a denial of the body's limitations—inviting the patients to ignore what their bodies were trying to communicate—engendering dangerous results. In these patient stories, doctors' advice to push through the pain and ignore "imaginary symptoms" frequently led to further harm or a relapse of illness. To center the patients' own words, I include several examples of medical uncertainties that led to culpability and imperatives to deny one's limitations. One patient explains that, "In the end, I collapsed from going for walks and was told that 'since I didn't want to go for walks and take tablets, I could just go home. It was my own fault that I was ill!'" (7210). Another patient states that "The GP I had up until that point did not take my illness seriously and treated me like an unmotivated psychiatric patient […] And therefore gave advice that made me more ill (to increase my activity level and not to rest so much)" (7714). In a final example, one patient describes how physical symptoms were attributed to mental symptoms. "I experience from all sides of the public health system that this is a mental illness. For me, this illness is physical but of course it affects me mentally, I am after all a whole human being (7308)." In these stories, being medically constituted as mentally ill led to a precarious position. The patients were rendered non-rhetorical; their "felt" reality denied. Denying their rhetoricity not only led to physical harm, but also to extreme isolation and estrangement from others. This need for self-authorship is best articulated by disability rhetorical scholar, Margaret Price's, claims in *Mad at School* regarding those who have been constituted as mentally ill, who desire but often lose the "basic human need to be received, listened to, and understood" (Price 26). Ultimately then, the triumph narrative and its demand for certainty meant that the patients' stories could not be taken seriously: the patients had to speak into a "rhetorical black hole" (Prendergast 46). These stories demonstrate the demands of the triumph narrative and the power these scripts have to void the patients' attempts to communicate and self-author the experiences of their own bodies.

The denial of one's rhetoricity and right to authorship because of an "imaginary" illness is perhaps most acute in the medical marvel (to use Jennell Johnson's words) of Morgellons disease (14). In the article "The Devil's Bait," reporter Leslie Jamison discusses Morgellons disease, a highly debated illness believed by most doctors to be an imaginary disorder. The extensive article, set at an annual Morgellons disease conference, explores the enormous stakes and difficulties of having one's suffering dismissed by nearly everyone. Jamison explains that whether or not the disease is imaginary or real does not preclude the patient from suffering. She says of the patients who believe that parasites live beneath their skin, "They didn't know what this stuff was, or where it came from, or why it was there, but they knew—and this was what mattered, the important word—that it was *real*" (Jamison). Jamison quotes a woman who believes she carries the disease: "It is bad enough that people are suffering so terribly. But to be the topic of seemingly the biggest joke in the world is way too much for sick people to bear. It is amazing to me that more people with this dreadful illness do not commit suicide." According to these patient stories, the need to be listened to and have one's story be believed is a need so deep as to be life-threatening. Indeed, in the case of the Gothic novels, the continual rejection of the protagonists' reality and the refusal for anyone to believe in their suffering or circumstances led to the burning down of their houses and several suicides.

In these patient stories, the desire to be rhetorical instead of "rhetorically suspect," to have one's story be taken seriously, was almost more important than getting treatment (Yergeau 3). The right to self-authorship and to insist on the reality of one's embodied experience was so strong, in fact, that one Morgellons' patient went to school to become a nurse so she could gather the ethos to author her bodily experience in a scientific study. She explains that "I was so angry at the misdiagnosis for so many years… Being told that it was anxiety, in my head, female stuff. So, I tried to spin that anger into something positive. I got my graduate degree. I published an article in a nursing journal" (Jamison). Just as this woman with Morgellons felt she needed to create a written record as proof of her experiences, in nearly all of the Gothic novels the protagonists keep secret written diaries as a way to insist on the realities of their bodily and mental suffering and their right to self-authorship- even if no one else will read or believe them. What she sought was the right to author her story, but she also wanted the social currency of being believed and being taken seriously. The compounded risk for many, as Dr. Stone explains, is that "Without a diagnosis, patients lack social legitimacy as 'sick' people with 'real' illnesses. They often describe feeling blamed for their own distress" (Stone 193). This sense of culpability intensifies the isolation one experiences from not being listened to or believed.

Importantly then, the relief for patients came not in the treating or curing of the illness, but in the acknowledgement that the illness and suffering were, in fact, real. According to many patients, the doctors that offered the most relief were the ones who simply said "I believe you" (O'Sullivan). Jamison explains that, after seeing several doctors who had said the worm in her leg was imaginary, she actually felt "relief" to find that the parasite living in her body was actually there. She explains the existential angst and doubt regarding whether or not she could trust her own mind was far worse than having the parasite itself:

> They asked if I'd recently taken any mind-altering drugs. The disconnect felt even worse than the worm itself—to live in a world where this thing *was*, while other people lived in a world where it *wasn't*. It was almost a relief to finally see the worm bobbing out of my ankle like a tiny white snorkel. I finally knew it was real. It's the Desdemona Problem facing Othello: fearing the worst is worse than knowing the worst. You eventually start wanting the worst to happen (Jamison).

Consequently, stories like this about the parasite do not easily fit into triumph narratives; for, they are stories where the "happy ending" comes not from triumphing *over* illness but from finding that one does, after all, *have* an illness. In this patient story, the relief comes from having one's suffering confirmed and legitimized by others- from the currency that the illness provides. Primarily, the relief resides in the fact that the patient no longer has to be "rhetorically suspect" (Yergeau 3). One of the reasons Gothic narratives are valuable for understanding invisible illnesses is that they emphasize, like these patients' stories, that questions of rhetoricity and authorship about one's body are central concerns of inexplicable, mysterious illnesses. The crux of the crisis, then, was the failure to listen and acknowledge the patient's suffering- not a failure of accurate treatment.

I want to clarify that I am not stating that the Gothic novel should be used as a tool to argue for the importance of *always* believing the patients' interpretations or insistence that they are ill. I am, however, arguing that a person's right to be listened to is the central concern of these patient stories and novels—more so even than the treatments they receive. In the next Transience chapter, I discuss at greater length the problem of believing in stories of madness or experiences of illness that are, in fact, delusional. It is a tricky rhetorical situation; how to treat delusions as rhetorical acts and listen for what they are trying to communicate.

Ultimately, in this project I emphasize the importance of rhetorical listening to difficult stories of illness. I argue both in this chapter and the next that believing that another's reality is "true" is less important than understanding that another's reality is *true to them*. When someone communicates "this is what it felt like to me," I argue for the recognition of their right to author their subjective reality; or, in the least, to recognize that the "madman's" reality is as real to that person as the "sane person's" reality is to them. I believe that to be effective rhetorical listeners, this recognition is crucial.

In conclusion, the primary affordance of the Gothic model is that it illuminates how central, and not just tangential, questions of uncertainty are for the protagonists; and how difficult it is for characters when their uncertain conditions are not believed. In the following section on the Gothic, I will talk at length about how the protagonists listened to their bodies and insisted on the validity of their embodied experiences even at the risk of being labeled insane. If the process of seeking help is truly a process of trial-and-error, and if it can take months or years to find a diagnosis or treatment that works, new temporal narrative structures are necessary, along with metaphors that can move toward a radical acceptance of ongoing suffering and uncertainties.

Reclaiming Agency and Authorship in Gothic Narratives

I will now argue that Gothic narratives sponsor rhetorical recognition and an increase of narrative possibilities by offering divergent narrative elements like plots of uncertainty and the metaphor of the haunted house. I ask: How might Gothic narrative techniques be employed to more fully engage with the listening and narrating of illnesses that exist primarily "in one's head"? How might the Gothic offer alternative ways of making meaning that allows for an acceptance of horrors and suffering, without trying to diminish, or over script these realities through the triumph narrative?

The Gothic texts I have chosen were written by authors who intentionally engaged with experiences of illness – both the social exigencies and the embodied realities. I've intentionally selected these novels because their authors were profoundly aware or personally impacted by discussions of health and illness and the rapidly developing discourses of institutionalization and treatments. My selection includes: Charlotte Brontë's *Jane Eyre* (1846) and *Villette* (1853); Charlotte Perkin's Gilman's "The Yellow Wallpaper" (1892); Virginia Woolf's *Mrs. Dalloway* (1925); Shirley Jackson's *The Haunting of Hill House* (1959); Jean Rhys's *The Wide Saragossa Sea* (1966)*,* Marilynne Robinson's *Housekeeping* (1980) and Silvia Moreno-Garcia's *Mexican Gothic* (2020).

The Gothic narrative was forged out of a necessity to communicate what was real, but also "unreal," in that there was no explanation for their hauntings (Rondinone). Throughout the novels, the protagonists question whether or not what they are seeing and hearing is "rational" and must decide whether they will believe their own subjective and embodied experiences of reality or the “experts” who say the ghosts and supernatural creatures they witness don’t exist. In many ways, the texts were written as social commentaries and as acts of resistance to the disbelief with which the medical world met their mental and physical suffering. For example, Charlotte Perkins-Gilman in her essay “Why I Wrote the Yellow Wallpaper” explains that she created her famous short story in order to critique treatments like “rest cures” to which she herself was subjected in an asylum. Women, like Charlotte Perkins Gilman and Virginia Woolf, who both spent time in asylums, innovated literary forms that reflected experiences that were foreclosed by other narrative structures available to them.

Because necessity demanded a new script, one that could encapsulate the uncertain nature of the female authors’ illnesses in a patriarchal world that insisted on “scientific” explanations that often stood at odds with their lived experiences, Gothic tropes emerged (Anolik). Because so little was still known about the female body, nearly all medical conditions were described as hysteria, what Elaine Showalter calls the “female malady” (3). After all, how were these women to describe the nuances of their illnesses through the literary structures available to them, when the medical world nearly universally dismissed their ailments as “female problems” (Johnson 9)?

In “Gothic Infections: Storytelling as Therapy in Dark Narratives” Paula Ryggvik Mikalsen explains:

> Much like the modern pathography, one goal of the Gothic is to provide a voice for those who have been silenced, by either societal, familial, physical or mental causes. Female-centric narratives share a unique position in this regard. Many of the tropes that characterize the Gothic novel are metaphorically comparable to life in incarceration, be it in a whalebonecorset or behind the iron bars of a prison or a mental institution. The haunted castles, mysterious apparitions, isolation, a threatening masculine presence might seem obvious allegories to the social constrictions that governed the gendered relations of Regency society. One factor remains steadfast throughout was health or rather “ill health”. It is interesting to note, that some of the most respected and well-read female authors of the nineteenth-, and twentieth centuries produced such narratives as to shed

> light on the lack of understanding for female ailments, and the horror of the medicalization of women, body and mind (Ryggvik Mikalsen).

Crucially, to believe the doctors would require a denial of their own lived experiences. If the supernatural elements represent the loss of belief in one's reality, the Gothic setting: its confined, haunted, dark and claustrophobic spaces represent the loss of control over one's agency (Noad). The more the narrator loses hold of her grip on reality, the greater her fears that those around her can control her rights to choice. One of the terrors of a mental health diagnosis is the fear of impending insanity - the possibility that one's sense of self and one's understanding of reality can become unhinged (Moscicki).

Like many contemporary illness narratives, early Gothic novels addressed the difficult-to-prove nature of illnesses which often undermined the protagonist's authorship (Wasson). In *Villette, The Haunting of Hill House*, "The Yellow Wallpaper," and *Mexican Gothic,* for example, the protagonists seek out medical professionals in the wake of strange symptoms. In fact, each of the novels includes doctors as primary characters. In *The Haunting of Hill House*, the "doctor," as he is named, stays with the protagonist the entire length of her stay at the haunted house. In "The Yellow Wallpaper" the protagonist's husband is a practicing doctor. In *Mexican Gothic*, the protagonist consults a doctor many times throughout the novel. In *Villette*, the protagonist's closest friend is a practicing doctor who treats her when she falls into a nervous depression. In *Mrs. Dalloway*, Dr. Holmes appears at moments of crises. The prevalence of doctors throughout the novels allows readers access to the protagonist's struggles to articulate and convince medical professionals of new and worsening symptoms.

To exemplify this tension, in a scene from Jackson's *The Haunting of Hill House,* the doctor discusses with the protagonist (Eleanor) the terrifying experiences she keeps encountering. "Nervous?" the doctor asked, and Eleanor nodded. "Only because I wonder what's going to happen," she said. "So do I." The doctor moved a chair and sat down beside her. "You have the feeling that something—whatever it is—is going to happen soon?" (Jackson 91). While we see in the doctor's body language (his sitting down close to her to listen attentively) that he takes what she says seriously, we also see a dismissal in his choice of words like "feelings" to describe her physical encounters and his emphasis on the vagueness and uncertain nature of her descriptions through the words 'something' and then 'whatever it is' " (91). As the protagonist continues in the following chapters to insist that something is terribly wrong with her, and that something awful is about to happen, the doctor dismisses her symptoms as simply succumbing to a petty and nervous temperament. "Fear," the doctor said, "is the relinquishment of logic, the willing relinquishing of reasonable patterns" (42). In the doctor's address, he appeals to logic to insist that the protagonist's suffering is only the result of her fearful musings and could be overcome if she were to master her thoughts; thus, he denies the possibility of her physical experiences since there is no logical explanation for them.

As another example, there is a scene similar to *The Haunting of Hill House*, wherein the medical professionals' arguments in "The Yellow Wallpaper " portray yet another instance of a doctor who insists that there must be a reasonable explanation for the protagonist's symptoms or else the symptoms cannot be real. "John does not know how much I really suffer. He knows there is no reason to suffer, and that satisfies him… Nobody would believe what an effort it is to do what little I am able, to dress and entertain, and order things" (6). In both of these texts, the doctors' references to logic and reason reframes the experiences that the women try to articulate as merely unreasonable "fancies," - even as hysterical responses (Perkins-Gilman 6). In the opening page of "The Yellow Wallpaper" the protagonist says:

> You see he does not believe me sick! And what can one do? If a physician of high standing, and one's own husband, assures friends and relatives that there is really nothing

> the matter with one but temporary nervous depression—a slight hysterical tendency—what is one to do? My brother is also a physician, and also of high standing, and he says the same thing… Personally, I disagree with their ideas. But what is one to do? (4).

In this passage, the protagonist is helpless to insist that something is wrong with her when the doctor has an ethos of "high standing" and has the absolute power to interpret and dismiss her symptoms (4).

Because of this repeated dismissal of their subjective realities, throughout the novels, the protagonists become progressively more isolated and desperate, unable to communicate their severe suffering since no one even believes it is taking place. In the case of the ending of "The Yellow Wallpaper," the protagonist is found locked in her room slithering on the floor alone in such a frightful condition that her husband breaks down the door, sees her, and faints. In *The Haunting of Hill House*, the protagonist loses herself to the house in the end; her sanity seemingly irrevocably destroyed as she drives into a tree. In *Villette*, after an extended period of depression and isolation that causes severe disorientation, the protagonist collapses on the street and consequently gets a concussion. In *Mexican Gothic*, the protagonist and her sister lose control of their minds and bodies and nearly commit murder as a result. The extreme endings of the novels are marked by our horror that something is taking place that can't be quantified and nevertheless is becoming progressively worse.

Gothic novels emphasize the terrors and isolation of having one's suffering denied and belittled, paralleling many patient stories of uncertain diagnosis (Wasson 8). The women can scream and beg those they trust for help, but their terrors are routinely dismissed as folly. The plot relies on the mysterious and unquantifiable nature of their suffering; and we move through the novel in terror not just of the "ghosts" that haunt them, but even more so in the suspense that they will be unable to get the help they desperately need- so long as the nature of their suffering cannot be decoded. By the end, readers dread not only the hauntings and loneliness of having no one to communicate with, but they read in terror lest the protagonist should *even try* and communicate with anyone. For, by this point, not only will their suffering be denied but their claims to illness will be used against them. Ultimately, the novels' endings are marked by the *isolation* the characters feel at having no one to communicate their torment with who will not call them crazy, emphasizing the same need articulated across the patient narratives I've examined to resist the "estrangement" and "isolation" of not being taken "seriously" (Mikalsen)

Because the stories of Gothic protagonists were so often questioned by others, the narrators generally turned to discreet writing forms that allowed them the agency to author their realities in a form that would not be challenged by others' dismissals. In one aspect, these diary-driven first-person novels are manifestos of the author's sanity. The confessional approach of *Rebecca*, "The Yellow Wallpaper," *Jane Eyre,* and *Villette* allow the protagonists to insist on the authenticity of their experiences. I argue that writing an accurate account of their experiences of illness allowed the protagonists to assert their reality and agency amidst others' denial. For, in the wake of totalizing illness narratives that claim that illness exists "only in one's head," the confessional mode keeps the characters from having their experiences gaslit. As the narrative in the novels progress, the protagonists garner increasing confidence as they are forced to question the "truth" others insist upon that contradicts their own reality. As Gothic scholar Olivia Moscicki explains, "Female gothic heroines engage in a deep questioning of and resistance to forces which seem to control them, and they are able to gain power over these forces as a result" (Moscicki 12). As the narrators' certainty in their own perceptions increases, necessarily, our certainty of the medical figures' perceptions decreases. At times, readers wonder if the protagonist is seeing through the holes of hypocrisy in the social constructions of the world around her. Often, readers are invited to wonder if the protagonist's insanity is perhaps the only "sane" reaction to the trauma and oppressive systems she lives within. Readers usefully begin to question, not just the medical practitioners' and the character's reliability, but also their own certainties and *ways of knowing*.

As previously described, in the era that Gothic novels emerged, professional understanding about women's bodies was especially limited, and while women held key sources of knowledge about their own bodies, their interpretations of their experiences were often dismissed. In the strange, foreign atmosphere of the haunted house in which Gothic novels are set, the body and its instincts and insights become important sources of evidence; often more important to the plot than the "logic" the doctors would insist upon. This is one of the Gothic novel's affordances that usefully overlaps with patient stories. Because the Gothic narrative gives *experiential* and embodied representations of uncertain health conditions, readers are given access to an alternative logic of the body (whether through the narrator's dreams, cold sweats, tingling hands, or hallucinations). The knowledge produced from the body is a type of proof the protagonists cannot deny. In this way, the body is depicted as a valuable source of knowledge that the readers must grapple with. As the novel progresses, it becomes difficult for readers to dismiss illogical symptoms that might easily be chocked-up to "spooked women" and, having imagined these bodily experiences alongside the protagonists through concrete sensory details, readers are invited to believe in the validity of this bodily knowledge- even if their doctors do not.

Therefore, the brilliance of the Gothic setting is that one moves into a world where everything cannot be named (through a diagnosis) or understood (through a clear medical explanation). While as readers our values may align with the rational *certainty* that there are explanations for the characters' “superstitions,” through Gothic novels we are immersed into a series of bodily sensations and images that can’t easily be explained away (Wasson 5). One of the supreme powers of Gothic novels, therefore, is that readers find themselves suspending absolute belief in medical logic and becoming increasingly receptive to a world of mystery and unaccountable encounters (Wasson 3).

Thus, readers of the Gothic are asked to trust narrators that they find to be unreliable, believe in the realities of the unaccountable, and question medical authorities that deny the embodied realities just witnessed on the page; likewise, readers can apply these reading practices of the Gothic to patient narratives, taking up the same invitation to engage contemporary illness stories with, if at least initially, a trust of unreliable narrators, belief in unaccountable suffering, and questioning of absolute authority.

The Metaphor of the House: Renegotiating Relationships with Illness

I turn now to perhaps the best-known Gothic metaphor, that of the house of mystery and horrors, which I will argue functions as a metaphor for the realness of illness and the complicated relationship that navigating it requires. The metaphor of the haunted, mysterious, terrifying house that slowly merges with the protagonists’ identity is central to nearly every Gothic novel. For the purpose of this chapter, I use the haunted house as a metaphor for understanding the body and invisible illness. The Gothic offers an alternative spatial configuration of dwelling *within* difficulties, rejecting the triumph’s directional movement toward getting *away* from illness. The characters inhabit the haunted houses, much like people inhabit their bodies. A person cannot fight and overcome one’s habitation and one cannot fight and overcome one’s body- even if the house/body is the site of horror and suffering. The house has agency, just like the body has agency, and cannot be controlled by the protagonist any more than one can control illnesses (even if they do only exist "in one's head"). The best one can do is to learn to live within the liminal spaces and to listen when the house speaks its desire and demands. Over time, the protagonists shift their relationship with the house much like a patient must shift their relationship with illness through accepting a diagnosis and making changes that can accommodate ongoing illness or disabilities.

Interestingly enough, in Gothic novels, the house often merges with the protagonist, slowly taking over and becoming *a part* of her while yet remaining outside of her control. As I described earlier, an illness like psychogenic Parkinson's exists "all in the head," and is *caused* by the mind and is therefore part of the person, and yet, it is nevertheless an illness that is independent from the person's willpower. This "merger" is reflected in the affective power the house has over the protagonists. For example, in *Mexican Gothic*, the protagonist begs her sister to leave the house, certain that if they can just get away from the house then their physical symptoms will diminish and they will regain control of their mental state; at one instance she tries to flee, panicked, in the middle of the night, sure she will never return to health if she spends even one more day in the house. As another example, in "The Yellow Wallpaper," the protagonist begs her husband/doctor to move her out of the room with the yellow wallpaper, sure that she is growing rapidly ill because of the house's power over her- a power that is out of her control. Additionally, in *The Haunting of Hill House*, the narrator explains the house's impact on its inhabitants: "Essentially,' he went on slowly, 'the evil is the house itself, I think. It has enchained and destroyed its people and their lives," and later the narrator continues to explain that "Hill House itself, not sane, stood against its hills, holding darkness within" (Jackson 12). In each case, the medical professionals tell the protagonists that their experiences are delusional and refuse to agree that their illness is caused by something "outside" of them, insisting that to acknowledge the house's effects would only encourage their indulgent "fancies" (Perkins Gilman 6). And yet, the protagonists remain sure that the house is the source of their ailments and even though the "how" can't be explained, they still have an embodied knowledge that their suffering is real. Reading the Gothic novel in this light contributes to a fuller understanding of mysterious and difficult-to-diagnose illnesses or mental disabilities as both being a part of, *and* simultaneously being outside, not a part, of a person. The house, like the body, has agency: an agency that is outside of the individual's control. Therefore, the house, like the body, cannot be merely ignored or denied. In this way, the metaphor of the house allows a shift of culpability away from the person to an external force that works upon them, while still insisting that the powers of the house are real and are overtaking the individual.

Each of the novels follows a shifting relationship to the metaphor of the house that closely mirrors the patient narratives examined in the previous section. In patient accounts in the medical literature that I've examined, they each described almost identically: the terror of illness, failed attempts to communicate illness with others, moving toward acceptance of the uncertainty surrounding illness, and final attempts to communicate with others through desperate means. In the Gothic novels, the narrative follows this progression through the metaphor of the house. First, the protagonist rejects the house in great terror and uncertainty. Then, the protagonist tries to communicate the terror of the house with others but are repeatedly told they are silly and there is no mystery whatsoever; they then turn toward their private journals where they continue to assert via written record that the mysteries of the house are *real*, thereby resisting the assertions of those who would tell them otherwise.

Finally, over time, they come to terms with the house's mysteries and begin to accept the difficult realities of living in a house riddled with uncertainties that require constant life adjustments from them (including daily activities like when they sleep or eat). Ultimately, toward the very end, when those in power decide to take action (the action may be, for example, threatening to send the protagonist to an asylum) against the protagonist's insistence on the haunted aspects of the house, the protagonist makes one final attempt to communicate that the house has a vital impact on them and is not just an imaginary problem existing only within their heads. This final attempt is achieved by either burning down the house or jumping from the window of a house in an extreme form of communication that can no longer be ignored.

Therefore, I see the burning down of the house as a rhetorical act of communication; a way, when all other ways have failed, to insist on the acuteness of their suffering and the accuracy of their narrative. They enact a resistance to being further misinterpreted. When the protagonist burns down the house it is as if to say, *here is tangible proof. See? I've been saying all along something is wrong, very wrong with this house and now you can see it for yourself, ablaze*. For the protagonists, burning down the house is a way to make the horrors that everyone said existed "only in their heads" *tangible*. For example, the protagonist tries to convince her husband that the wallpaper is tied to and causes her suffering. She cries, "I wish John would take me away from here!" (17). But throughout the story, her relationship toward the wallpaper shifts and she begins to grow fond of the wallpaper, to accept it. By the end she says, "It is so pleasant to be out in this great room and creep around as I please!" (19). Her final act of tearing the wallpaper down and crawling behind it is not one of escape, but rather it is a way to communicate with her husband "to astonish him," to offer physical proof that the wallpaper, which she kept claiming was causing her suffering, really did have an effect upon her (19).

Finally then, I do not believe that the protagonists burn down the houses primarily to free themselves from an oppressive domestic space or illness, as many feminist Gothic interpretations claim[6]. Rather, I agree with literary scholar, Madi Hester, who explains, "the haunted house narrative and the violent, retributive act of purging the haunted house (the afflicted body) with fire (faith, conviction, ownership, agency, etc.) suggests that the ultimate (and perhaps only) healing is to be witnessed." Like Hester, I believe that the protagonists burn down the houses as an act of *insisting* on and making visible the effects of their illnesses. For example, in *We Have Always Lived in the Castle,* Merricat burns down her house at the novel's ending: not as an act of *escaping* an oppressive house (for she describes the house like a sanctuary), but rather she sets the house on fire as an act of preservation before the "outsiders" can come into the house and determine a meaning that would contaminate and further misinterpret her own. For, the house is an inextricable part of her life that the outside world could not possibly understand; thus, she burns the house down as an act of resistance.

Similarly, in *Housekeeping*, before Ruthie and her aunt flee from those who would take them to an institution, they burn down the house so that the authorities, who were coming to find evidence in the house of their mental unfitness, cannot use the house as proof against them. In the ending of *Wide Sargasso Sea*, the protagonist burns the house down not because she wants to escape, but because she wants to maintain her interpretation of her past and right to author her sense of self. In each of these stories, then, the burning down of the house is an external resistance against those in authority who refuse to fully hear the suffering of the narrators, or, alternatively, who would misinterpret what the house is or means. This reading of the house as a rhetorical object used by the narrators closely aligns to Bridgete Read's interpretation of the ending scene in *Wide Sargasso Sea*, wherein:

> The burning the house is not to escape, nor is it an act of madness, but rather an act of resistance that returns her to her former self, "When she [Antoinette, otherwise known as Bertha, the "madwomen in the attic," from *Jane Eyre*] sets her fatal blaze at Thornfield Hall, it's because she imagines a red dress spilling across the floor like a flame, recalling an episode in which Christophine tells her to wear a red dress instead of a white one bought for her by Rochester. When asked "You frightened?" for the last time in a hallucination, it is by Tia, a Jamaican girl who was her friend before a mob descended on Antoinette's childhood plantation home, burning it to the ground. In response to Tia's call, Antoinette jumps toward her out on the mansion's ramparts, and *Sargasso* ends. It is an act of resistance, not madness (Read).

Here, readers can see that the protagonist burns the house as an act of resistance to the narratives others would project upon her: narratives that undermine the complexity and meanings she gives to her past experiences of suffering.

To offer another example of a radical act of resistance after a character's experiences of illness have been utterly denied, I turn to Virginia Woolf's *Mrs. Dalloway*. Like Bertha Mason's final act of jumping out of the window in *Wide Saragossa Sea* and *Jane Eyre,* in *Mrs. Dalloway*, Septimus likewise jumps out of the window after being pursued by Dr. Holmes, the doctor treating his psychiatric condition. Like Rhys's representation of Antoinette, Septimus jumps from the window not primarily to escape oppression, but rather as an act of "resistance" to a misinformed medical narrative that leaves him feeling misunderstood. Clarissa, the protagonist in *Mrs. Dalloway,* whose life parallels Septimus', understands the act of jumping from the house for what it is—not escapism—but an act of "defiance," an attempt to communicate (Woolf 184). His jumping from the window is a last resort way to communicate his experiences of mental suffering (he cries "give it to them!" as he jumps) to those who failed to understand his previous attempts to insist on the severity of his condition (149). This is further demonstrated when Clarissa hears of Septimus' death and thinks, "Death was defiance.

Death was an attempt to communicate; people feeling the impossibility of reaching the centre, which, mystically, evaded them; closeness drew apart; rapture faded, one was alone. There was an embrace in death" (Woolf 184). Clarissa instinctively understands Septimus' act as an attempt to communicate because she, also, has been unable to make her suffering understood by others. She well knows the isolation of being unable to narrate one's affliction when it is an uncertain condition that has no root cause; and, for this reason, can more aptly interpret Septimus' intentions for taking his life. Clarissa understands his act of jumping as a rhetorical statement meant to assert his reality among medical professionals, family, and friends who deny the extent of his suffering (150).

I see in the advice from the doctor to Septimus the enforcement and logic of the triumph narrative, which renders illness the result of personal weakness that might easily be overcome. Dr. Holmes, when visiting Septimus, claims that health is merely a choice: "Health is largely a matter in our own control. Throw yourself into outside interests; take up some hobby" (91). Dr. Holmes continues to insist, "Wouldn't it be better to do something instead of lying in bed? For he had forty years' experience behind him; and Septimus could take Dr. Holmes's word for it-there was nothing whatever the matter with him" (92). This passage demonstrates how thoroughly Septimus' illness was disregarded. The doctor, clearly, never fully listened during his treatment of Septimus: for even after the suicide the doctor says, "Who could have foretold it? A sudden impulse, no one was in the least to blame (he told Mrs. Filmer). And why the devil did it, Dr. Holmes could not conceive" (150). Clarissa, because of her own difficulties in attempting to communicate her suffering to anyone else, is better able to understand Septimus' struggle and to interpret his death as an act of rhetorical agency. In Septimus' case, then, just as in the other protagonists' narratives, I see characters who were willing to insist on the validity of the mysteries of the house and insist on the sincerity of their suffering no matter the cost to communicate it: even if it took burning down the house or jumping from the window.

Although it may seem strange to describe the house as a site of terror and suffering while simultaneously claiming it as a space one learns to dwell within, the paradox of the house metaphor provides an innovative divergent narrative as a model for modern day illness stories. It would be easiest to read the metaphor of the house as an illness that strips the protagonist of their personhood or turns them into a victim. But, one of the reasons so many with chronic illness *choose to identify* with the protagonists in Gothic novels is that the protagonists allow for uncertainty regarding the house and seem to garner a greater sense of agency as they accept and lean into the house's mystery and even horrors (Wasson 5). I interpret this acceptance of the house/illness and the mystery of their circumstances as a step toward a situated and responsive agency. This responsive agency is found in the grappling with illness and accepting of it *in* its mystery. There is an ever urgent, and as I described in the exigency section, growing need in the medical world for what psychologist Stephanie Duchek calls:

> flexibility, adaption, and even improvisation in situations predominantly characterized by change and uncertainty. It goes beyond the successes and failures of the current situation. The resilience capacity uniquely searches for and finds meaning despite circumstances that do not lend themselves to planning, preparation, rationalization, or logical interpretation" (Duchek 220).

The Gothic, I argue, particularly lends itself toward such situational, responsive, and embodied strategies for navigating situations where "logical" explanations and straightforward diagnoses and narratives of overcoming will fail.

Since the Gothic form allows one to voice lived experiences in their complexity, without having to insist upon a simple triumph narrative, its rich narrative possibilities provide a way for patients to reclaim their authorship. It provides the type of narrative most needed in ongoing illness, a structure that psychologist Dan McAdams says is vital in situations of disability and uncertainty: “In narratives of acceptance, the protagonist aims to come to terms with life and the inevitability of loss and suffering, to reconcile conflict, manage (rather than overcome) adversity, and sustain interpersonal bonds of intimacy and warmth. Narratives of acceptance may nourish valued human characteristics like grace, humility, and wisdom” (McAdams 104). Through such acceptance narratives, even as readers watch a protagonist lose control and descend irrevocably further into their illness or madness, the story still emphasizes the characters’ agency in their refusal to deny or belittle their embodied realities. These novels offer models for modern patients with chronic and uncertain conditions, who seek to take control of their narrative but do not want to construct their life in a way that is disingenuous to the complexity of their pain.

The Gothic emphasizes the value of embodied knowledge, reworking the broken/cure metaphor in the triumph narrative and making the body a source of knowledge. Because authorship is central to agency, the affordances of the metaphor of the Gothic is that the protagonists can see in the house what others cannot; they are able to insist on a “felt” bodily knowledge as a way to combat their “rhetorically suspect” minds. I believe the Gothic is an especially effective mode for narrating illness/disability since it requires a listening to one’s body and observations filtered through concrete senses. Since articulating what it “felt like to me” is central to self-authorship, the Gothic offers valuable narrative techniques that make possible the articulating of a singular, subjective reality in its complexity and ambiguity and a casting off of universalized assumptions (Million). The protagonists value their right to their subjective reality, and claim the validity of what their bodies know is true, even when this is irrational.

Thus, the Gothic is a way to tell a story *about* the difficulties of finding a story; a way to speak about chaos and uncertainty without having to resolve them in a tidy package. It is through these narrative features of uncertainty, that the characters can insist on the reality of their experience: on the reality of difference in a normalized world. These paradoxical solutions: a focus on mystery as a way of knowing; an emphasis on the loss of control as a way to regain agency—are compelling narrative solutions to a difficult problem of making narrative meaning of the seemingly meaningless, of insisting on one's lived experience in the face of other's denial of it.

CHAPTER IV: AFFORDANCES OF THE TRANSIENT NARRATIVE

Medical Exigency: Listening for a Desire for Rhetoricity

In this chapter, I suggest that a different kind of rhetorical listening is necessary; one that allows for the realities and severities of ongoing suffering, but *also* one that allows for the affordances of embodied differences. The novels I will examine elucidate how treating someone's experiential and embodied reality as untrue and untrustworthy, and the over scripting through a medicalized narrative of one's complex self-understanding, can be a dehumanizing rhetorical act. The triumph narrative, that frames the ill body as broken in need of fixing, forecloses the affordances and epistemologies of embodied differences. As the last chapter in this dissertation, I shift my focus away from the need to tell/listen to the severity of suffering and move toward the need to tell/listen to characters' use of Métis and divergent agency in stories of embodied differences. I turn to three divergent novels, *Tinkers* by Paul Harding, *Housekeeping* by Marilynne Robinson, and *Mrs. Dalloway* by Virginia Woolf because they offer an alternative engagement with illness and disability that refuses to pathologize the characters' realities. Instead, the authors allow their protagonists to insist on the rich insights made available through their embodied perceptions and facilitated through the novels' emphasis on what I will later define as "transience." In these novels' highly aesthetic forms, and through the transient metaphors and plots they offer, the authors provide valuable alternatives to reductive medical frames. Through literary techniques these divergences invite identification with characters whose self-understanding are rich, agentic, filtered through their singular and embodied subjectivity, and fully wrought.

Particularly, in this project I explore questions of vulnerable ethos and the desire for authorship and acknowledgment of one's subjective reality. The central right of personhood—

the self-authoring of one's subjective, embodied, experienced reality—is a right that comes into question for those who've been constituted as mentally "insane." To insist on the value of one's subjective reality requires ongoing recuperations of ethos to demand the richness and agency of personhood (Molloy). As I described previously, a medical diagnosis also works to invite a person to take up a new identity and dominant narratives such as when the triumph narrative can over script one's previous sense of self. The medically constituted mind is often deemed "irrational" or "involuntary," the moods, perceptions, and thoughts (the core of what makes a person who they are) can no longer be trusted. Thus, to be medically constituted as "insane" or "mad" is to have one's version of reality; one's authoring and communicating of one's reality, discredited as "rhetorically suspect" (Yergeau). In the last chapter, I demonstrated how dangerous it is when invisible suffering and pain is discredited. I explained how the push toward triumph and cure combined with the vulnerable ethos of an "unreliable mind" to invalidate stories of ongoing suffering. But, in this chapter I will discuss another type of "rhetorical black hole" (198). This time, it isn't a refusal to see suffering, but a refusal to see the affordances and agency of authorships of reality that come from a "rhetorically suspect" mind (Yergeau 3).

Primarily, the novels that I examine bring to the reader's attention how important the authoring of one's embodied subjective reality is to a sense of personhood and agency. In this chapter, I'll argue that, through divergent literature that centers around those whose realities are dismissed as only the symptom of an "ill mind," one can arrive at a more nuanced understanding of the stakes for patients who are asked to take up a medical identity. The characters emphasize that rhetoricity "is who we are, and beyond that, it is *who we are allowed to be,*" an important distinction made by Margaret Price (27). For these characters, the powerful foreclosure of a medical diagnosis obliterates the possibility of being listened to and received. Because of cultural norms, most respond to mental differences as “pitiable,” and, therefore, shifting toward seeing embodied differences as natural and offering something valuable presents many challenges. There can be a kind of discomfort in acknowledging the rich affordances of “deviant” minds[17]. These novels bring attention to these issues and depict characters who are willing to leave society and live a transient life in order to cling to their dignity and remain authentic to their versions of realities. The novels emphasize the shock of having one’s subjectivity disregarded; of calling someone’s joy, pain; of rendering perverse what someone finds to be beautiful. To be given a “mad” diagnosis is to tell the characters that instead of an agentic life with an insightful inner world, that their “happiness” is actually only a tragic delusion. These novels reject affective responses such as pity and the understanding of illness through a medicalized or triumph framework.

In my discussion of rhetorical listening, I explore a set of foreclosures beyond those of ongoing suffering, asking what listening to and acknowledging the right to rhetoricity in another’s “mad” subjective reality entails (Smilges). I believe there is almost as much discomfort with seeing another’s mad subjectivity as *desirable*, inviting the reader to self-recognition, as there is resistance to sitting with pain and horror (Leweicki-Wilson). I grapple with the same crises that I did in the Gothic chapter of unreliable narrators, only instead of issues of credibility leading to a refusal to accept suffering, I explore issues of credibility that impact the rejection of seeing one’s reality as merely a symptom of one’s illness. Margaret

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[17] See work like Arseli Dokumaci’s, “People as Affordances: Building Disability Worlds through Care Intimacy” and Faye Ginsburg and Rayna Rapp’s book *Disability Worlds* or Eli Clare’s *Brilliant Imperfection: Grappling with Cure.*

Price claims that “To lack rhetoricity is to lack all basic freedom and rights, including the freedom to express ourselves and the right to be listened to” and this lack of freedom of expression often extends to denying or foreclosing articulations of joy, beauty, dignity, poeticism, and other aspects of one’s reality that would invite the listener to desire or emulate the character, instead of only pity them (26-27). The freedom I want to extend is the freedom of self-authorship that moves beyond affective responses of “isn’t this sad; I’m so glad that’s not me.” To this end, I examine the protagonists’ reasons for resistance to medicalized self-understandings, beginning with how one’s agency is reduced, or how characters are patronized through medicalization.

I argue that Transient novels offer the reader alternative engagements with illness that invite identification with characters which stigmatized and triumph narratives cannot. I focus on Transient narrative techniques that reject the triumph plots of cure and metaphors of brokenness, and instead offer plots and metaphors of transience, that accept embodied differences as natural, aesthetically appealing, contingent, shifting, and impermanent. I explore what divergent agency that does not move toward getting “better,” but rather toward a radical acceptance of the ongoingness of suffering can entail. We are all temporarily able-bodied, always moving toward death and decay. Health is a temporary state; not the natural, static state of man that the logic of “return” would have one believe. Accepting the body as transient is, for these novelists, the key to allowing for the rich and agential subjectivities they create. Through an acceptance of life’s transiency, the deep listening and identification that this project encourages can be a possibility.

The divergent techniques in Transient narratives are made possible through two metaphors: time (in the form of clocks) and nature (in its ever-changing elements). These metaphors hold rhetorical possibilities for chronological plots and metaphors of brokenness which I've critiqued. In the first section, I explore transient time through the alternative plotlines represented in the motif of clocks. As a theoretical framework, I use philosopher and psychoanalyst, Robert Stolorow's, theory of "being-towards-death" as a framework to understand how the characters' illness shapes their "being-in-time" as impermanent, short-lived, non-coherent, and out of one's control. Importantly, this sense of being-towards-death is not a reduction of agency or a representation of the loss of control, but rather an articulation of divergent agency that allows the characters to be hyper-attuned to the present and their embodied responses to the world. In the second section, I look at transiency as represented in nature and how nature becomes a metaphor for the body. The descriptions of the characters' bodies are often described through heightened poetic descriptions of nature and changing seasons, allowing each shift to bring its own particular beauty and affordances. Thus, transiency surfaces across the texts in many ways: especially in the nature of being-in-time and the transient nature of the body through metaphors of the natural world and its ever-shifting elements.

The authors render the characters' subjectivities as desirable, inviting identification, showing the isolating effects of universal narratives, while also allowing for the full range of suffering. Additionally, illness and death are portrayed neutrally and naturally—instead of as something problematic and unnatural, offering models of radical acceptance for ongoing disabilities. I argue the need to become better rhetorical listeners of suffering, to listen to suffering without offering a "cure" for the "broken" person or a rescripting of that person's subjective experiences, forcing a denial and gaslighting of embodied realities. These novels attend to the characters' singular perceptions through attention to concrete details filtered through their embodied knowledge. This allows a "felt knowledge," a way of insisting on what an experience felt like to them, according to their embodied realities, and of resisting universalizing frameworks that would foreclose their rhetoricity.

A Case of Schizophrenia: Rhetorical Listening to Unreliable Realities

I now turn to a patient narrative to address a set of tensions in rhetorical listening to subjective realities that are deemed "delusional." In Margaret Price's book *Mad at School* she asks, "What does it mean when a person with a mental disability—schizophrenia, for instance—bumps up against this basic human need to be received, listened to, understood" (Price 26)? I take up Price's question through an analysis of a narrative of a patient who has schizophrenia that focuses on his parents' attempt to receive, listen, and respond to his untethered reality. The patient narrative, like the novels I will look at in the next section, asks readers to grapple with what it would mean to be told that one's reality, and everything one knows, is not true and should be switched out for another person's narrative. I examine the Podcast *On Being: Room for J: One Family's Struggle with Schizophrenia* that extends the questions I brought forth in the last chapter on the Gothic, about how to respond to "imaginary" or uncertain experiences of illness that are presumed to be "made up" in one's head, and ask what rhetorical listening would be in these complicated rhetorical situations (Kerschbaum). While this is a relatively extreme case, it pushes the limits of what care, rhetorical listening, rhetoricity, vulnerable ethos, and acceptance of others' embodied reality might look like. Therefore, it can be useful in thinking about the applications of this argument across many kinds of disabilities (such as cases of mild anxiety that shape one's way of perceiving the world). Unlike the first-hand accounts of the patient narratives, I have examined in the rest of the dissertation, this account is from J's parents' point of view, wherein they explore the limits and possibilities of identification with his perceptions. Other than a few intertextual excerpts from J's notebooks, his voice is not included. Nevertheless, I found the parents' various rhetorical approaches to be a rich site of analysis for probing the complexities of listening to a rhetorically suspect mind. While J's case is relatively extreme, the dialogue his case creates between the parents could be applicable to a wide variety of mental health conditions that render speakers as unreliable authors of their realities.

In the Podcast *OnBeing*, Krista Tippett interviews the parents (Sue and Dan Hanson) of Joel Hanson, who goes by the name of J. According to the Hanson parents, Joel at the age of 20, came home and announced to his family that he was God. In Joel's words from the opening of his book, he says, "I am, myself, Jesus Christ reincarnated, Ishua, Jehovah, J, Joel Steven Hanson, infinitely 99.999 percent of the universe, the greatest individual independent being." His parents explain that after this "shocking" announcement, Joel was diagnosed with schizophrenia and, despite being on and off medications throughout his life, according to his psychiatrists, he will never be "cured." The incurable nature of his illness presents a challenge to the triumph narrative, since there will be no plot trajectory to overcome his illness nor way to "fix" what is broken. Accepting that one's disability is incurable and that it requires accommodations is complicated in examples of delusional realities; for, a radical acceptance can lead to the person's endangering themselves or others. For example, in the case of someone who is in a wheelchair for life, a denial of the body's limitations and the reality of the disability—to tell a person to "get up; what you say isn't true, you can walk; get rid of the wheelchair"—sounds absurd. Yet, the approach to accepting a mental disability often takes different forms. The parents exemplified these differences when they explained that accepting his schizophrenia symptoms (which shapes his reality and what he tells them) has been entirely different from accepting the reality of their daughter's case of diabetes, in which they never attempt to persuade her that the illness isn't real. The parents explain that, when he first told them he was God, they would say things like "Oh, gee, you don't really think that" and were always trying to "cure" him of his delusions. And while they eventually rejected what I call the triumph narrative, that he will never be "cured," they still grapple with trying to change his delusional thoughts. Thus, in cases like J's, whose psychiatrists say that, because he does not see himself as ill, there is almost no chance that he will give up these "delusions," the question of accepting his symptoms becomes complex.

This situation raises questions of rhetorical listening, and what identification with others' subjective realities is possible or advisable. Eventually, J's parents come to take a rhetorical approach that they say allows them a close connection with him. This approach is not to argue with his reality, but instead they explain that "we've come to accept Joel, including his belief system, and we don't try to change his belief system, we accept him for someone who believes he's God." At first, this seemed to them like feeding into his fantasies and "indulging" his delusions. However, the parents discuss how accepting his reality as real to him—and treating him as if his subjectivity is as vivid and real to him as theirs is to them—marks, they say, the beginning of a vital shift in their relationship with J. If I were to propose that reading fiction allows readers to understand that others' realities are as true/real as their own, I would seem to be arguing for absolute relativity, and that no objective reality exists. I concede, it would likely be dangerous if a person walks into a doctor's office and is told that the voices they hear are real and should be listened to; dangerous to accept another's reality unconditionally. But neither I, nor J's parents, are arguing for a belief in his reality *as* objectively real—but for an understanding that *his* belief in his reality is real. They explain "he's been on most of the major antipsychotics, almost all of them, at different times, and nothing has taken away his delusion. And we call it a delusion, he calls it reality. People tell him he's not God, he's not Jesus. In his mind, that's as real as my being a wife and mother." Usefully, the parents recognize that his reality is real to him and that he desires to have his subjective reality, just as everyone does.

I argue that, fundamentally, this desire to be heard and understood is a desire to be seen as fully rhetorical (and to have the right to self-authorship). According to his parents, "The other dimension of it [communicating amidst his delusions] for Joel is that Joel, like all of us, wants to be treated with respect. He wants to be confirmed as a special person. He wants people to believe in him." This aligns with what I discussed, in the Gothic chapter, about how the dismissal of the protagonists' realities felt like a stripping of their agency that they wanted to reclaim through their furtive diary entries. Like for the women in the Gothic novels, the fear of losing his rhetoricity, of "not being believed," of being told that his reality is only "in his head" is part of his resistance to seeking treatment. The parents explain that "when he's treated as if he needs medication to make him real or to make him a person, he has a very, very difficult time dealing with that, and he feels treated as if he were a child. And here he is being forced to do something that he does not believe he needs and doesn't want to do." In this passage, the parents share that J's resistance to being labeled ill is a resistance to losing his agency (by being treated like a child) and having his personhood denied (as if he isn't real when he is ill). I argue that this narrative emphasizes that the resistance to a medical diagnosis, and taking up an illness subjectivity, is also a resistance to being seen as rhetorically suspect, or even non-rhetorical; a fear that everything one says or thinks, will be denied. After all, I argue that his subjective reality is what makes him who he is—it is his identity—and accepting a medical understanding of his identity would be to reduce his perceptions to a symptom of illness only.

I describe the alternative approach the Hanson parents (after many years of trying to convince him he wasn't ill) to be a form of rhetorical listening that allows for a Métistic understanding of their son. They explain that an "acceptance" of his reality as real shifted their ability to be in relationship with him. And, interestingly, the rhetorical effect of *accepting* his reality, instead of trying to persuade him otherwise, did not send him further into delusions, but instead tethered him to their own reality. "What's kind of paradoxical about that is that in accepting his fantasies, if you want to call it that, or his unreality, you in fact tether him more to reality in a way that doesn't happen when you try to convince him that he's wrong." I believe that when the parents were able to drop the triumph narrative, and the narrative expectations that wrote their son as "broken" or in need of cure, they were able to recognize the rich affordances of his mind; they were able to take a Métistic orientation. They explain that "Once we open the door to the conversation and don't try to fix him or don't try to change him, he will reveal that kind of wisdom to us and talk to us for hours, literally, if we let him." I argue that a shift away from the metaphor of brokenness, the triumph narrative imposed on their relationship, allowed them to see his full humanity again. They describe the valuable insights he offers them and the long conversations where they learn from him. In what I call a rhetorical listening through radical acceptance, now, when the Hanson parents:

> take walks with him, we let him tell his fantasies and his — and some of them are quite profound, his perception of things…he does have powerful insights, if you read between the lines or if you look at words like he does, created at the moment. And I think in doing that, we have become, in some ways, his touchstone to this reality, and he appreciates our acceptance. And it took us a while to really get that.

In taking a Métistic approach in their relationship, dropping the problematic triumph plotlines and metaphors that foreclosed their intimacy, they were able to make him feel, according to what he once told his parents, like "someone's listening to me, someone's hearing me." I argue that the orginal triumph narrative approach foreclosed identification with the rich affordances of his embodied differences. I am not glorifying his illness, nor arguing that his illness is a good thing. Many times, the parents still had to call the cops and ambulance and have him forced to be institutionalized when he became a danger to himself. But, I am arguing for a narrative approach that doesn't begin with a deficit model that negates all identifications with J's perceptions and wisdom.

I argue for a rhetorical listening approach that *first* respects the right to rhetoricity, to claim and articulate one's subjective reality and perceptions as valid and worthy of listening to, so that to receive a diagnosis does not mean to forever have to speak "into a rhetorical black hole" (Prendergast). While this case is rather extreme, and many people with mental illnesses do not have delusions that they are God, this case pushes my argument about listening to what is uncertain and imaginary (as I addressed in the Gothic chapter). It also centers the fundamental need to be listened to and believed as a central concern of what care must incorporate. I argue that the only way people can enter into the type of listening that Rita Charon, and others in the field of Narrative Medicine,[2] claim is desperately needed for those suffering from alienating aspects of illness, is by rejecting the universal medical label of illness and accepting his embodied and subjective reality with its affordances.

In the Transient novels explored in the next part of the chapter, I describe the characters' desire to be seen as fully agential to feel that their embodied realities are taken seriously and valued. I search for what Catherine Gouge calls in her RHM essay "Desire Lines and Divergent Pathography in Health and Medicine" the "paying attention to the rhetoricity of divergent behaviors… a tracing of "desire lines" or "desire paths"" (23). The desire lines of these novels take a similar shape as in J's narrative. The characters' desire to be allowed to focus on what is beautiful and not just what is tragic in the world; to be allowed to author their own realities and communicate their beliefs with others; to have their choices be respected and valued; to feel they have something to offer and can evoke admiration and not only pity in others; lastly, to have others' identify with their subjectivity, to say*, yes, exactly, I know what you mean*; this is a desire to feel *known*. In the following sections, by analyzing these novels, and the rhetorical acts of resistance that the protagonists take, I hope to extend an understanding of what agency can look like.

Resisting the Universal: Insisting on Agency and Rhetoricity

I've chosen three novels that diverge from medicalized portrayals and instead offer rich, singular representations of embodied differences. I categorize these novels as "Transience" novels. The three novels I will use are: Paul Harding's Pulitzer prize winning novel *Tinkers* (2008), Pulitzer prize winning Marilynne Robinson's novel *Housekeeping* (1980), and Virginia Woolf's novel *Mrs. Dalloway* (1925). I've narrowed my selection down to these three for several reasons. The first reason is that the primary characters in all three novels are deemed mentally ill and rendered "rhetorically suspect" (Yergeau 3). In *Tinkers*, I discuss the protagonist and narrator Howard Crosby, who has epilepsy and is deemed "insane" after a seizure that causes him to almost bite his son's finger off. In *Housekeeping*, I examine the protagonist Ruthie, and her aunt who has custody over her, who suffer from an identified mental illness (likely, what many would call depression, post-traumatic stress disorder, and dissociative tendencies, although, Marilynne Robinson would resist such pathologizing of her characters). Finally, in *Mrs. Dalloway*, I analyze Septimus Smith, a war veteran who suffers from what the characters in the novel call shell-shock and has delusions, hallucinations, and suicidal thoughts.

Early on in each of these novels, Septimus, Howard, and Ruthie encounter society—in the form of friends, loved ones, or those around them—that frame them through medical language and offer a deficiency-based interpretation of their personhood. In each case, as the illness progresses, an incident stemming from the illness presents itself, the protagonists' family members call upon medical or social services. These medical professionals diagnose the characters and tell their family members that they are "officially" insane. In *Housekeeping*, this diagnosis leads to the authorities trying to take Ruthie from her "unstable" aunt's home and put her in foster care; they think of taking the aunt to a home for those who are mentally unwell. In *Tinkers,* the doctor convinces the man's wife that he should be put in an asylum. In *Mrs. Dalloway*, the doctor tells Septimus' wife that he should go to an asylum.

As a result of being medically constituted as insane, and under threat of being institutionalized, the characters flee society and choose to live a transient life. In *Housekeeping*, the aunt and Ruthie pack up and leave the night before the aunt and Ruthie are supposed to be taken by the authorities; they burn their house on the way out, a rhetorical act that I described in the Gothic chapter. In *Tinkers*, Howard finds the brochure for the asylum on his wife's desk and packs up and leaves that same day; he is so devastated and demoralized that he is unable even to tell his wife or kids goodbye. In *Mrs. Dalloway*, when the doctor comes up the stairs to potentially take Septimus to an asylum, he jumps out the window to escape and defy being medically constituted. Thereafter, Ruthie and Howard live transient lives in the sense that they've left their families and society behind. Ruthie and Howard have no home but wander in the countryside from place to place. Septimus, is also a transient character, typically portrayed wandering through the outside world. In conclusion, I chose these novels because of their many parallels: 1) they are constituted as insane by medical professionals 2) their family/friends' responses to their officially being named "insane" results in radical shifts in their relationships and 3) their subsequent abandoning of society lead to transient lives 4) their engagement with temporality and time through the symbol of clocks 5) their engagement with death-in-life through the transient seasons in nature.

The authors of these divergent novels refuse to reduce the protagonists to medical labels and instead emphasize the estrangement and isolation that follows having one's singular subjectivity over scripted by a universal label. The authors adhere to a close-third heightened poetic and embodied perspective that illuminates the characters' nuanced self-understanding and rejects *all* pathologizing descriptions of the characters. In fact, the only clinical language that enters the novels comes from other characters' interpretations of the protagonists' personhood. Importantly, when this clinical language does appear, instead of revealing something important in our understanding of the characters, readers witness how medicalization forecloses all possibilities of human connection. The medical labels only estrange the characters from others, inviting pity that dehumanizes the characters, rendering them, in the eyes of others, as victims instead of acting agents. Therefore, the labels work to strip the protagonists' right of authorship of their own experiences and realities. Additionally, the novels refuse to construct illness as a problem that must be cured (as seen in the triumph narrative), but rather, the harm done to the protagonists stems from society's construction of mental illness.

Importantly, characters do not have an antagonistic relationship with what others call their illness/disability (they accept it, even welcome it); nor is the illness an enemy to be fought and triumphed over. Instead, the novels' tension resides in how *others* constitute the protagonist through a stigma story that insists on the plots (cure) and metaphors (brokenness) of triumph. Thus, not only do the authors reject framing their characters as medical subjects, but they also reveal to the reader the damage the dismissive universalizing diagnosis causes to the characters' relationships. I argue that through this authorial resistance to medicalized understandings of personhood, the novels invite contemplations regarding the consequences such constituting has on human relations.

In *Tinkers*, for example, Howard finds a brochure for an asylum on his wife's dresser after a doctor has told her that Howard is mentally ill. In this passage, when Howard runs away from the house, he thinks:

> Is it not true: a move of the head, a step to the left or right, and we change from wise, decent, loyal people to conceited fools? Light changes, our eyes blink and see the world from the slightest difference of perspective and our place in it has changed infinitely: Sun catches cheap plate flaking—I am a tinker; the moon is an egg glowing in its nest of leafless trees—I am a poet; a brochure for an asylum is on the dresser—I am an epileptic, insane; the house is behind me—I am a fugitive.

In the first part, Howard describes the sudden shift (in one wrong move of the head) that caused him to "change" from a wise, decent person in their eyes into a fool. His wife of years, his children—in the moment that a medical label is thrust upon him—instantly changes toward him and, therefore, his "place in it [the world] has changed infinitely." To them, he is nothing but a fool. In the series of *I am that I am* statements that follow, he says: 1) I am a tinker, which is an assertion of his role as a working person, who exercises agency 2) I am a poet, which is an assertion of his creative capacity to experience the world in rich and beautiful ways. But then, after identifying as a poet, a semi-colon establishes the close-yet-distant relationship of his poet identity with the brochure sitting on his dresser. The brochure (and impending confinement in an asylum) threatens to reconstitute him; to strip him of his identity and turn him into what his family has re-constituted him as: “an epileptic, insane” (124). When Howard claims the identity “I am an epileptic, insane” he follows it up with, semi-colon, “the house behind me,” demonstrating his leaving them behind as an act of resistance to being reduced.

Howard decides to leave behind the identities that would render him non-rhetorical. He runs from these labels and those who would label him so, as a fugitive, fearful of being constituted in ways other than as a poet and tinker- the agential capacities through which he wishes to identify himself. He must leave his family because he fears they will strip him of his dignity. In the next line, after telling us he is a fugitive, he says, “The despair came from the fact that his wife saw him as a fool, as a useless tinker, a copier of bad verses from two-penny religious magazines, an epileptic, and could find no reason to turn her head and see him as something better” (124). Importantly, while his recent epileptic episode that led to his diagnosis was violent and painful, he does not despair of the illness itself but of the way the illness renders him a “fool” in others’ eyes. He understands that being labeled with a diagnosis and sent to an asylum will not just impact one area of his life but will alter his rhetoricity and agency in all other areas of his life; particularly, in his capacity to make art and to describe what is beautiful to him and not just what is sad. In his mind, after being medically constituted, his job as a tinker (work we learn earlier in the novel she once admired him for) is reduced to “useless” work only a fool could complete. And his poetic tendencies, that once made her fall in love with him, are reduced to his being only a copier of “bad verses” (125). When he says that “she could find no reason to turn her head and see him as something better,” he acknowledges that his diagnosis, for her, casts him in a different light and over-scripts his other identities (125). He wishes to get out of this light, that changed infinitely when he was labeled ill, and to recuperate a light that allows him to be perceived "as something better." The only way to accomplish this, he believes, is to leave everyone who would dismiss him as simply ill.

He decides he would rather be estranged from those he loves than be constituted in the flat, dehumanizing way that would reduce his subjective reality to the ravings of a mad man. He leaves in the night, full of shame, but determined to flee his wife's outrage at his illness and the bitterness that would have him permanently committed. "God know my shame as I push my mule to exhaustion, even after the moon and Venus have risen to preside over the owls and mice, because I am not going back to my family—my wife, my children—because my wife's silence is not the forbearance of decent, stern people who fear You; it is the quiet of outrage, of bitterness. It is the quiet of biding time. God forgive me. I am leaving" (122). Thus, the stakes in the novel exist in how being labeled as mentally ill alters one's personhood; the crisis is not being ill (the illness is not constructed as the enemy as in the triumph narrative), but the crises is in the *naming* of their experiential reality as illness.

In *Mrs. Dalloway*, Septimus comes up against this same medicalized foreclosure; in being given a universal story through a diagnostic category, Septimus is asked to deny the rich internal life he lives. But, instead of accepting a new self-understanding, he decides to leave society and cling to his dignity. Septimus' final act of resistance—jumping from the window instead of being brought to an asylum—is an act of insisting on the value of his subjective reality: on the validity of his perceptions as experienced according to him. Much of the commentary we get about Septimus comes through Clarissa Dalloway, who understands his actions because she, too, struggles with depression and communicates it with no one, since she also fears a medical gaze (185). According to Virginia Woolf's "Introduction to *Mrs.*

Dalloway," Clarissa is Septimus' "double" and in the original version of the novel, they were the same person and Clarissa killed herself. Therefore, the interpretations that Clarissa offers about Septimus tells us important information for both characters and also about what Virginia Woolf wants us to understand about Septimus' actions. When Clarissa learns of his death, she understands why he would jump out the window:

> But this young man who had killed himself—had he plunged holding his treasure?... there were the poets and thinkers. Suppose he had had that passion, and had gone to Sir Willian Bradshaw, a great doctor yet to her obscurely evil, without sex or lust, extremely polite to women, but capable of some indescribably outrage—forcing your soul, that was it—if this young man had gone to him, and Sir William had impressed him, like that, with his power, might he not than have said (indeed she felt it now), Life is made intolerable; they make life, intolerable, men like that?" (185).

Clarissa imagines that the medical doctor (who she paints as a sterile, clinical, disembodied representation of objective medical framings of humankind) dismissed Septimus' subjective reality and articulations of beauty as "madness." Her imaginings are accurate, as demonstrated in the scene of Septimus' suicide.

On the day of the suicide, the doctor and Septimus' wife see only his suffering. For example, Septimus's wife looks over at him tearing up while they are in the park together and imagines that he is miserable and thinking about death. But, in fact, in that moment he is tearing up while meditating on nature and cries because he is reveling in "this beauty, this exquisite beauty, and tears filled his eyes as he looked at the smoke words languishing and melting in the sky and bestowing upon him in their inexhaustible charity and laughing goodness one shape after another of unimaginable beauty and signaling their intention to provide him, for nothing, for every, for looking merely, with beauty, more beauty!" (21-22). While they see tragedy, he is overwhelmed by a sense of beauty in the world. Thus, Septimus is estranged from others not only because they cannot fully engage with his sorrow, but also because they cannot engage with the beauty and richness he experiences in life; they have reduced him to only his illness and sadness and cannot imagine that his experiences in the world reaches beyond this.

Clarissa understands that his “plunge” toward death was tied to how a medicalized understanding might reduce Septimus by forcing his “soul” into a clinical self-understanding. Clarissa hopes that he “plunged” to his death, clinging to his “treasure,” rather than give up his “soul” and agency for the tragic victim label of madness they have of him (185). Like Howard, Clarissa imagines Septimus to be a poet and thinker, full of passion, who knows that being constituted as ill would strip him of his right to offer art or valuable insights created from his “unstable” mind. And the right to create something beautiful and of value is central to what Clarissa articulates as his “soul” (Woolf 185). Clarissa believes his ability to communicate ideas that others value, that evoke responses of admiration, not only empathize with, is essential to one’s personhood. She asserts the importance of, to return to Price’s words, a “basic human need to be received, listened to, understood” (26). According to Clarissa, “Life is made intolerable; they make life intolerable, men like that,” meaning doctors, those who would strip one’s agency and insist on a medical self-understanding (Woolf 185).

This desire to communicate and have his reality heard, according to Clarissa, manifests even in the rhetorical act of his death, meant to defy their medical labels and imperatives. He jumps and screams, “I’ll give it to!” and earlier in the day thinking, “Must,” “must,” why “must”? What power had Bradshaw over him? “What right has Bradshaw to say ‘must’ to me?” (Woolf 148). Septimus made the great escape—just like Ruthie’s escape in *Housekeeping* and Howard’s in *Tinkers*—not as a result of his illness, but primarily as an act of communication and resistance to losing his agency. Yes, Septimus dies of his “illness,” but it is not simply an effect of depression; it is instead a more nuanced desire to maintain his agency in the face of having his life reauthored by others. After all, moments before his death he says, “He did not want to die. Life was good. The sun was hot. Only human beings, what did *they* want?” (149). In this passage, the moment he flings himself from the window, it is only *they* that interfere with his life, with the lovely sun on his face. It is *their* interpretation of him that causes his suffering.

Most importantly, Clarissa understands Septimus’ act was spurned by his desire to be rhetorical. She says, “A thing there was that mattered; a thing, wreathed about with chatter, defaced, obscured in her own life, let drop every day in corruption, lies, chatter. This he had preserved. Death was defiance. Death was an attempt to communicate” (184). Clarissa claims that the thing that really matters in life can be obscured through the telling of one’s story—the re-shaping of one’s personal narrative—into a disingenuous framework; through communication with others (through the “lies, chatter, corruption”), one risks tainting one’s subjective perspectives and foreclosing the “beauty, the exquisite beauty” infused of one’s perceptions (184). Ultimately then, Clarissa respects Septimus because she believes that he clung to his reality rather than give up this thing that matters most: his rhetoricity.

In conclusion, the affordances of these novels are that they emphasize how central the feeling that one’s perceptions are valued is- and how a medical label can foreclose this. The novels depict how acceptance and understanding of one’s self-authorship is often threatened when one plummets into a “rhetorical black hole” (Prendergast 157). Besides revealing how important honoring someone’s singular subjectivity is, these novels also offer new conceptualizations of illness in their depictions. In the following section, I will describe how the novels cultivate a nuanced engagement with pain, the body’s fallibility, and mortality. In the Gothic novel, the metaphor of the house provided an alternative relationship with illness through the spatial "inhabiting" of one's body; this inhabiting allowed the protagonists to accept, instead of deny, the house's terrors and uncertainties and cultivating curiosity about the house. The Transient narratives similarly shift the relationship with perceptions of bodies. Instead of seeing illness and disability as tragic, the novels emphasize the beauty in the subjects' lives, not in "a hysterical denial of illness," or in a romanticizing of pain, but in a radical acceptance of illness and disability as a natural component of life (Kathlyn). In the following sections, I will discuss the alternatives to the triumph plot of cure and the metaphor of brokenness that allows for transiency and for "beauty" the term that Septimus/Clarissa, Howard, and Ruthie use to describe their subject reality.

Transient Plotline: Being-Towards-Death

In this section, I extrapolate on the narrative strategy of transient plotlines that plunge the characters (and readers) into a hyper-attuned engagement with the present. Through a continual awareness of life's precarity and impermanence, the strategy resists the Triumph narrative's causal forward-looking plotlines. Trauma scholar Robert Stolorow calls this sense of transient temporality "an authentic sense of being-towards-death" (58). Because the protagonists in *Mrs. Dalloway, Tinkers,* and *Housekeeping* have experienced sudden attacks of illness and loss, they move through the world in a way that is different from the other characters. They move according to, what some disability scholars have called, "crip-time" I established in the Triumph chapter that illness and disability can disrupt one's previously coherent narrative that allowed one to move through the world according to a plot, theme, and chronological plotline (Samuels). Stolorow describes how the rupturing experience of illness or disability "exposes the inescapable contingency of existence in a universe that is chaotic and unpredictable and in which no safety or continuity of being can be assured" (59. He explains that illness devastatingly disrupts the ordinary, "average-everyday linearity" and "ecstatically unity of temporality," the sense of "stretching-along" from the past to an open future (57). While narrative psychologists and therapists urged a return to a coherent plot that can return a sense of control to one's life, Stolorow argues that a return to such a plotline is impossible and there can be no going back to a "naïve" belief that everything is orderly. While once they could live out their days with a sense of causal predictability, now, they can no longer "function in the world, experienced as stable, predictable, and safe" (58). For, to move back into that stable world would require self-deception.

Stolorow calls the sense of being-in-time an ability to live within the "absolutisms of everyday life" that only those who are not living in a state of trauma or chronic illness can inhabit. Because those who have been plunged into an "authentic being-towards-death" cannot return to a world of "absolutisms" that most others exist within, this often leads to a sense of estrangement from others (60). His description parallels the story in the triumph chapter, in which the girl's mother keeps insisting that she would "get better soon!" The girl explained that she wanted to scream "Don't you know how sick I am?!" out of frustration for her mother's and doctor's insistence on a naïve sense of order in the world. She knows she has an exceedingly small chance of living with the cancer (Conway 34). Because the girl moved into a chaotic world of uncertainty, she cannot convince herself to believe such absolutisms and therefore cannot inhabit the ordinary world for they have been "Torn from the communal fabric of being-in-time" (Conway 59). The estrangement from others comes from a shifting experiential temporality—one that no longer contains a sense of order or a "structure of temporality" (Stolorow 58). Similarly, in *Tinker*s, Howard experiences life in an "order he could not control" (18).

Interestingly, the structures of both *Mrs. Dalloway* and *Tinkers* are non-chronological, jumping around in time and perspective, fragmented and with no chapters—and yet the book is marked by the striking of clocks; the clocks serve to delineate which characters exist as being-towards-death and which do not. Big Ben in the case of *Mrs. Dalloway* strikes on the hour, and the horologist guidebook, in the case of *Tinkers*, explains to Howard how to control time. The clocks do symbolize movement (but only movement toward death). They do not symbolize a causal ordering, but rather the impossibility of such. As the clocks throughout *Tinkers* and *Mrs. Dalloway* tick down the hours until the character's death, they are depicted through cyclical, not linear images. For example, Woolf describes the sound of the clock's ticking as "leaden circles dissolving in the air" (38). This mixed image of the passing "hour, irrevocable" is illustrated through a heavy, leaden weight that is also "dissolving," evoking transience, and moving in "circles," resisting linearity (38). Meanwhile, Harding rejects the clocks' "brass logic" and recognizes that one cannot "banish disorder" (17). He mocks those who assume that life moves orderly, predictably, and according to causal timelines: "The universe's time cannot be marked thusly. Such a crooked and flimsy device could only keep the fantastic hours of unruly ghosts" (17). Howard and Clarissa, who live in a being-towards-death understand that the chronologies others live by are "flimsy." When Big Ben strikes, it is represented as precarious and haphazardly, "indifferent, inconsiderate, [as if it were] swinging dumb-bells this way and that" (19). Instead of being-in-time as others, Clarissa, Ruthie, and Howard move through "unruly ghost" hours. Instead of a chronological order for life, Howard juxtaposes the clock image with what his life really is: a "shifting mass, the tiles of a mosaic spinning, swirling” (18). As Howard accepts the inevitably of his death, instead of developing an orderly, cohesive narrative that resembles anything like that of triumph, he rejects the symbol of the clock (doing away with the horologist guide intertextually woven throughout the book) and instead begins taking up a diary of the natural world, which is better able to reflect his temporal sense of being-towards-death.

In *Mrs. Dalloway*, for those who can live as a being-in-time—the “guests” breathed in the air with “rapture” and “relief”; alternatively, those whose embodied realities no longer allowed them to live in a predictable temporality and could have no rapture or relief “denied to the [Dr. Holmes] patients” (140). According to Stolorow, experiences of illness/trauma “individualizes us in a manner that invariably manifests in an excruciating sense of singularity and solitude” (60). This sense of estrangement with others is experienced by many characters in the novels who were forced to accept life’s transiency and could no longer live within the causal temporality of those around them. As Stolorow explains, the isolation the characters feel is a result of the fact that illness/disabilities/trauma “profoundly modifies the structured sense of temporality, the traumatized person quite literally lives in another kind of reality, an experiential world felt to be incommensurable with those of others” (62). Ruthie, Clarissa and Septimus accept the inevitability of ceasing to exist and do not resent death as a part of life, but instead lean into the new ordering of their worlds through their transient sense of time. This felt incommensurability, in turn, contributes to “the sense of alienation and estrangement from others that typically haunts the traumatized person” (62). In the transient novels, Ruthie, Septimus, and Clarissa describe this sense of alienation and estrangement. Virginia Woolf explains it in *Mrs. Dalloway* as always living “out, out, far out to sea and alone” (Woolf). In this altered state of being, they inhabit worlds that are “haunted” by uncertainties, much like in

Gothic literature. For example, in *Housekeeping*, Ruthie reflects on the transient and isolated life she has come to lead. Ruthie lost her mother to illness, a suicide, and this estranges her from others who are still able to live in the present. She says, “When did I become so unlike other people? … it was when my mother left me waiting for her, and established in me the habit of waiting and expectation which makes any present moment most significant for what it does not contain” (214). For Ruthie, her life’s plotline is structured around the present moment and uncertainties, not a causal trajectory. She lives in a constant state of transience, understanding that everything is impermanent, the possibility of death and illness exists at any corner.

The drawbacks for these characters, is that this “being-towards-death” leads to a sense of isolation and estrangement from those who can still live their lives according to a coherent, linear plotline. Living in this way, Ruthie says, makes her “so unlike other people [emphasis mine]” (214). Like for the protagonists in the Gothic novels, the conventional world loses its grip on Ruthie and she becomes isolated from others in society. She says, “I would be lost to ordinary society. I would be a ghost, and their food would not answer to my hunger, and my hands could pass through their down quilts and tatted pillow covers and never feel them or find comfort in them. Like a soul released, I would find here only the images and simulacra of the things needed to sustain me” (183). The “absolutisms” that Stolorow spoke about that many take for granted, things like food, shelter, and sleep, come to mean little to her because in them, she could find no comfort that could “sustain her” (183). After her aunt is labeled by society as mentally unstable, Ruthie comes to feel that the best she can do is move among them as ghosts; communion with them is no longer possible.

Ruthie, Howard, and Septimus leave everyone behind because they cannot authentically move through their world of absolutes and chronological plotlines but also, importantly, because others cannot accept their being-towards-death way of making meaning. Just as I spoke of in the Triumph chapter, Parker Palmer grew isolated because no one was willing to dwell with him in his place of uncertainty, but instead wanted him to move in a forward trajectory constructed around causal temporalities. Like Ruthie, who could find only "images and simulacra" in the world of others, the characters in *Mrs. Dalloway*, also live at a great distance from others, with a "perpetual sense" of "not knowing people; not being known. For how could they know each other?" (21). They move through the world in a transient, ghost-like state of impermanence, where nothing is certain or predictable and one can only hover at a distance from those who live in the solid world (Russ). In the following section, I continue to use Robert Stolorow's theories of the impact of a rupturing experience on the sense of estrangement, and the attunement to aesthetics, as a means of being towards death.

Transient Metaphors: The Natural World and Attunement to Embodiment

While the Triumph narrative, with its emphasis on positivity and overcoming, might see embracing death/illness/disability as giving in, or tending toward hopelessness, I argue that the divergent novels depict an awareness of transiency as an *affordance*, rather than a limitation. The characters' continual awareness of "being-towards-death" leads to an attunement to life's transiency and one's embodied reality, particularly through descriptions of the natural world. they have insisted on the realities of their pain when others denied them and guarded their perceptions (that were dismissed as crazy) as a "treasure" (Woolf). They've fought for the right to communicate: to interpret their worlds through their own perceptions. Because of their physical limitations, they are attuned to the contingent and embodied components of their lives.

As highly embodied forms, therefore, the novels emphasize the material, concrete, sensory, and physicality of the characters' worlds.

By focusing on death/decay, but doing so through the metaphors of nature, the authors are able to shape the meanings made of illness and to expand them beyond stigmatized metaphors of "brokenness" that would reduce one to only one's deficiencies. Woolf, Harding, and Robinson, like rhetorician Kenneth Burke, embrace the interconnectedness of life with death. In Kenneth Burke's theory of "deathiness," as described in Debra Hawhee's book, *Moving Bodies: Kenneth Burke at the Edges of Language*, Burke says "never a moment do I cease to think of these things [life/beauty] as the detritus of death, aspects of life's offal. I live with the thought that digestion and fertilization involve the life-giving properties of corruption, that life grows out of rot" (145). When Burke offers his theories of the body, he reminds the reader that to be in a body is to know that everything is moving toward death and rot: all bodies grow sick and die but this is natural, a part of life and not unnatural, as the triumph narrative would have it. In Burke's theories, the naturalness of death extends as a metaphor to describe the naturalness of the decaying/ill/dying body. This is not quite a paradox; knowing that beauty exists in its transience—the beauty of a plucked rose, for example—is not a new concept. And yet, when it comes to depictions of illness and disability in the triumph narrative, the primary response they evoke is of pity and degradation and not admiration. In the following sections, I locate descriptions of the body/ill body through metaphors in the natural world—which take the form of water, trees, earth, flowers, lightening/light, animals, to name a few—that invite the reader to understand the body through descriptions of the natural world. This diverges from the triumph narrative, in which health is the assumed norm and embodied differences are considered to be an *unnatural* deviation. In nature, death and transience are not only natural, they are neutral and necessary.

In addition to Virginia Woolf, both Harding and Robinson frequently reference life's fragility, but describe how the fact that all of life is "perishing" makes it the more valuable (Harding 78). For example, in *Housekeeping*, Ruthie, when out in the natural world, pondering illness and loss, picks up a berry and attributes its value to its transiency. "For when does a berry break upon the tongue so sweetly as when one longs to taste it, and when is the taste refracted into so many hues and savors of ripeness and earth, and when do our senses know anything so utterly as when we lack it?" (Robinson 152). Similarly, *Tinkers* is full of lines such as, "and all will perish, whether from the ocean siege or October breeze" and "trying to be equal to so many sudden orders of sorrow, any one of which alone would have wrenched us from our fragile orbits around each other," emphasize the inevitability of death of life (Harding 78). Because these images of death are of nature, the novels invite the reader to shift our relationship with death and illness to see perishing not as unnatural or as some evil, but rather as something as lovely as an "October breeze" (78).

This awareness of life's impermanence attunes Woolf's characters to the details and "beauty" of what is, without this awareness, just everyday "mundane," materials (Woolf). For example, something as simple as a flower can offer a "shock" of beauty when one considers its impermanence (72). This is evident in *Mrs. Dalloway*, wherein Clarissa and Septimus are often overcome with states of ecstasy, even in the midst (or perhaps because they are in the midst) of pondering death. The "inevitability" of death surfaces while Clarissa completes the most ordinary tasks—like "walking towards Bond Street" (24). Woolf writes, "Did it matter then, she asked herself, walking towards Bond Street, did it matter that she must inevitably cease completely? All this must go on without her; did she resent it; or did it not become consoling to believe that death ended absolutely?" (24). In this passage, the fact that, absolutely, death ends all, offers a form of consolation, and at another, awakens her to intense experiences. At one moment, for example, Clarissa thrusts her face out into the morning air and cries, "What a lark! What a plunge! ... like the flap of a wave; the kiss of a wave; chill and sharp and yet (for a girl of eighteen as she then was) solemn, feeling as she did, standing there at the open window, that something awful was about to happen" (19). This sense that "something awful is about to happen," that something "solemn" might happen at any moment allows her to feel, "the kiss of a wave," a feeling of plunging into life (19). Therefore, the fleeting nature of her body is what allows her to live in a state of attuned embodiment.

In *Mrs. Dalloway*, some of the most descriptive passages, rich in concrete details known through the senses (an embodied knowledge), are intertwined with scenes and conversations about death. Just a few hours before Septimus' death, he falls into one of his frequent states of rapture and "exquisite joy" (69). The world, in his awareness of the "now" and "now"—in its transience—is dripping with beauty (69). The most "ordinary things" filtered through his embodied epistemology, become imbued with "truth" and power. While he is, yes, ill—a result of his bodily condition—he is, yet, able to engage with the world in a heightened attentive way, because of this very body. He is open and receptive to the world, and, instead of pity, this description reveals the affordances of his sense of death's presence and nearness:

> Beauty, the world seemed to say. And as if to prove it (scientifically) wherever he looked at the houses, at the railings, at the antelopes stretching over the palings, beauty sprang instantly. To watch a leaf quivering in the rush of air was an exquisite joy. Up in the sky swallows swooping, swerving, flinging themselves in and out, round and round, yet always with perfect control as if elastics held them; and the flies rising and falling; and the sun spotting now this leaf, now that, in mockery, dazzling it with soft gold in pure good temper; and now again some chime (it might be a motor horn) tinkling divinely on the grass

> stalks—all of this, calm and reasonable as it was, made out of ordinary things as it was, was the truth now; beauty, that was the truth now. Beauty was everywhere (21).

In this passage, Septimus is not engaging in denial or "toxic positivity of triumph," but rather, his embodied suffering has given him what Woolf calls a sudden "shock-receiving" transforming everyday objects into stimulus for his heightened state of being (Conway 31).

Indeed, the characters in these novels move with a heightened awareness of the natural world around them; for they live *embodied* lives. Virginia Woolf describes this awareness of death-in-life as her "shock-receiving capacity" that allows her to be moved by the details and beauty in the world through an awareness of life's transiency (72). In her memoir, *Moments of Being*, Woolf describes how losing her mother early, and her own struggles with depression, caused her to think of death frequently, and this is what made her an artist. She extends this conversation on attention and artistry in *On Being Ill*, when she writes about the revelatory capacity of illness: "Considering how common illness is, how tremendous the spiritual change that it brings, how astonishing, when the lights of health go down, the undiscovered countries that are then disclosed" (4). Woolf explains the astonishing disclosures and vast "undiscovered countries" as "states of being" that the person who is on familiar terms with death and illness in particular have access to (72). She explains there are two states in life: states of "being" and states of "non-being" (72). In states of non-being, one moves through life without a hyper-attunement to the world, taking for granted life's predictability, but in states of "being," she is aware of the presence of "death in life" (71). Importantly, the metaphor of transience does not have the negative connotation of the triumph's metaphor of brokenness. Rather, transiency suggests transcendence (and, indeed, Harding and Robinson have been placed by many literary scholars in the transcendental tradition) (Lydon). The term transience evokes Woolf's "tremendous spiritual changes" and the "beauty" that illness and disabilities can offer, focusing on the potentialities and not just the shortcomings of illness (4).

Living in a state of transience, or being-towards-death, plunges one into an alternative plotline and temporality, a hyper-attuned embodied, *now, here, in this moment, only.* This perpetual change is evoked through metaphors of the natural world, in which life is seasonal, and ever evolving, vacillating between phases. In transient timelines, there can be no true "returning to" or "arriving at" a destination, but instead, in the natural world, states of being are fluid and circular, never static or predictable. The transient body is always shifting states and there can be no "reaching" a stasis or an idealized end version of health. As I mentioned in the last section, in the beginning of *Tinkers*, the intertextual elements come from a horologist guide, which represents the world of forward-moving time. But, when Howard leaves society, and rejects temporal and linear plotlines, he embraces life's transiency and the intertextual excerpts come from a nature journal he keeps. After rejecting a medicalized self-understanding by leaving society, Howard begins to think of his brain (and the seizures he has) through the language of the natural world. At one moment, nature is described through the body: the trees' "bare arterial branches turned to a netting of black vessels around brains made of light" and the trees also have "luminescent organs," thus, nature is known through the body (99). In another, the body is described through the metaphor of nature. A few lines later, Harding describes his own epilepsy through the metaphor of the trees, which are struck through with lightning. He writes, the trees are just "like Howard's brain—lit and used up and then dark. Lit too brightly. How much light does the mind need?" (99). In the word "too" brightly, Howard recognizes that his brain is, in fact, abnormal/different from others' brains who do not have too much/or not enough of what is needed. In this way, the body and nature often become interchangeable, both representing the impermanence of life and possibility of decay.

Although the descriptions of the body are of the natural world, and, through their aesthetic forms, mirror elements of the transcendental genre, in which nature has a spiritual component, there is nevertheless no romanticization of his suffering that would demand a meaning or larger purpose be given to his pain. There is not a belittling or denying of the suffering, as I critiqued in the Gothic chapter. As the novel progresses, his seizures begin to be described as “a bolt of lightning cold behind a rock or stump or within the hollow of a tree or some strange nest and which his passing would trigger to sprint, to explode, to impale him” (73). His illness is not something made magnificent; instead, the transient metaphor of the body is depicted in its beauty but also in its violence: he will “explode” or be “impaled” (73). And yet, this metaphor still allows his illness to be represented in the natural world, no more to be overcome than the lightning or seasonal changes. There is something “holy,” in the “mysteries,” and “sacred” in his embodied difference; but the value of the difference is not in the transforming of suffering into something else, but in the recognizing of the difference for what it is: natural (Harding 34). Natural and *neutral*, without the stigma of medicalization that would render his difference a “problem.”

Over time, Howard begins to think of bodies increasingly through metaphors of the natural world, which parallels his acceptance of his embodied reality and rejection of the world’s understanding of him. Howard begins to think about *all* bodies in their transient states, and instead of experiencing life’s precarity as disheartening, he takes great comfort in contemplations of death. For example, Howard imagines a man—a hermit who lives a transient lifestyle just like Howard, becoming one with nature and cozily moving toward death. Howard, “liked to think of some fold in the woods, some seam that only the hermit could sense and slip into, where the frozen forest itself would accept him and he would no longer need fire or wool blankets, but instead flourish wreathed in snow, spun in frost, with limbs like cold wood and blood like frigid sap” (34). This passage demonstrates the shift Howard has taken in his relationship with his body. Instead of the violent verbs used earlier in the novel, of the lightning's “impaling” and “exploding” his brain, in this passage, as the body merges with the natural world, the hermit “slips” into a “seam” where he is gently “accepted,” “wreathed,” and “spun” in frost (34). This delicate imagery, an almost lace-like intimate portrait, invites the reader to see death as something natural and welcome. Instead of the “natural” state of the body looking like health, the dying body is made natural as it turns into wood and sap; the body literally becomes elements of nature, taking on a transient form.

Increasingly, he understands his illness—which was his great enemy in the world of clocks and men—as part of the beauty of the natural world. In my favorite passage of the book, Howard gets closer to society than he has been in a long time. He approaches a stranger’s house, peddling his wares. Although he doesn’t speak with the woman we see, we still witness an imaginary scene and dialogue exchange. His imagining of her suffering is infused with imagery of the natural world, particularly of the snow and ice, the shifting states of water:

> He thought, Buy the pendant, sneak it into your hand from the folds of your dress and let the low light of the fire lap at it late at night as you wait for the roof to give out or your will to snap and the ice to be too thick to chop through with the ax as you stand in your husband's boots on the frozen lake at midnight, the dry hack of the blade on ice so tiny under the wheeling and frozen stars, the soundproof lid of heaven, that your husband would never stir from his sleep in the cabin across the ice, would never hear and come running, half-frozen, in only his union suit, to save you from chopping a hole in the ice and sliding into it as if it were a blue vein, sliding down into the black, silty bottom of the lake, where you would see nothing, would perhaps feel only the stir of some somnolent fish in the murk as the plunge of you in your wool dress and the big boots disturbed it from its sluggish winter dreams of ancient seas… So buy the gold, warm it with your skin, slip it onto your lap when you are sitting by the fire and all you will otherwise have

> to look at is your splintery husband gumming chew or the craquelure of your own chapped hands (34).

In this passage, Howard imagines the woman as incredibly vulnerable, as being-towards-death. There are many dangers just in this paragraph that could end her life: the roof will give out, her will to snap and she will kill herself, she will slip through the ice. But the verbs, just as when Howard imagines the hermit's death, are tender and not violent. She will *slide* into the silty bottom *stir* somnolent fish *plunge* in *sluggish* winter dreams of ancient seas and *slip* by the fire (34). The repetitive smooth shh- sounds has the effect of a lullaby, a slipping into the "soundproof lid of heaven" where everything is dark and calm, all stars and reflected frozen lakes and firesides. This vision of death he portrays is not to be recoiled from in horror.

In the closeness of death, and the uncertainty of her future, Howard suggests the only thing to do is to lean into the mundane, concrete, materiality of life that allows for an embodied engagement. Despair is to be resisted with a trinket, a small gold necklace, a talisman of one's own against the perceptions of others that would not understand her. He tells her to "warm" that small gold trinket with her skin and to "slip" it into her lap and to "sneak" it into the folds of her dress. The way of survival, he says, is to find something secret all of one's own and to make it "sacred" (Harding 34). Howard, who has fled rather than have his subjectivity denied, imagines that this stranger of a woman, is also a captive of sorts in her own house, who must wait until her husband leaves to sneak out and chop through the ice toward her death. His answer to her estrangement, caused by what Stolorow calls being-towards-death, is to engage with what is one's own; (As I mentioned previously, Clarissa described Septimus' agency and personhood as a small "treasure" that he should "cling" to.) The secrecy Howard encourages, is to resist those who would reduce her rich inner world to a reductive story. Howard believes the secret to bliss is in having a possession of one's own that can allow her to quickly access her private world. Howard, Septimus and Ruthie, have found that protecting their inner world, and reclaiming an agential narrative, is more important than relationships that would foreclose this rich self-understanding.

At the end of the passages, Howard continues to imagine what he would tell the woman, who he imagines, like him, lives in a state of being-towards-death:

> rejoice that your uncertainty is God's will and His grace toward you and that is beautiful, and part of a greater certainty, as your own father always said in his sermons and to you at home. And as the ax bites into the wood, be comforted in the fact that the ache in your heart and the confusion in your soul means that you are still alive, still human, and still open to the beauty of the world, even though you have done nothing to deserve it. And when you resent the ache in your heart, remember: You will be dead and buried soon enough (35).

Howard, because of his illness and isolation, has come to embrace this uncertainty. For Harding, Robinson, and Woolf, this is not a form of nihilism. To reject triumph and embrace the mortal elements of their bodies is not to move toward hopelessness. Instead, as described here, to embrace the precarity of life is to become "open to the beauty of the world" (35). Howard is able to claim that "suffering" and an "ache" and "confusion" can provide "comfort" not because everything will be cured and fine, but because death is a certainty (35). His last line to her is to remind her to remember how soon she will be "dead and buried" (35). And, in this acceptance and awareness of mortality, he argues that the beauty and grace of the world will be opened up.

Finally then, unlike in the medical world, where everything is meant to be solved, understood, named, and cured, Harding creates a world where the characters "pay proper attention" to their fraught experiences without reducing ambiguity to a universalized classification system (34). In writing about *Tinkers*, Harding explains that "as a writer of literary fiction, I want to write about the irreducible mysteries of being human in this bizarre and gorgeous and ferocious world in which we find ourselves. Such mysteries are not ours to solve or explain away but to ponder. This is not to encourage mystification, of course, but to pay proper attention to our fraught and ambivalent experiences of being people" (4). Harding explicitly says he's aimed to write a novel that allows for the bizarre and ferocious to exist together. Unlike in the triumph narrative, the characters lean into the mystery of a transient life. This movement toward a contemplative life—where suffering is accepted—instead of a life where suffering is overcome or pretended not to be real, is informed by the omnipresence of life's vulnerability. In other words, Harding, like Woolf and Robinson, offer metaphors that allow both gorgeous/ferocious to exist together. The metaphors and plotlines of the cyclical, transient, natural world allow for a neutral portrayal, rich with ambiguity and paradoxes, instead of the oversimplified metaphor of brokenness; one where being present is possible, and desirable, and where destination-driven linear narratives collapse.

Finally, I value these authors because they provide divergent affective possibilities of responses. They ask readers to enter the protagonist's subjectivity and to see beyond medical identifications. As Harvard Divinity professor C. E. Morgan aptly describes of Marilynne Robinson's novel *Housekeeping*:

> Her extended examination of the omnipresence of death in life, and its natural attendant, human sorrow, is vital for a culture profoundly resistant to and fearful of melancholy, which we've medicalized in the great American project of positivity and progress, tolerating it only through the sugared grief of sentimentality. In this deracinated understanding of the human condition, suffering is not something to be tasted and understood in its complexity—a bitter but instructive sap from the tree of life—only an abnormality to be diagnosed and diminished. When we medicalize melancholy, we curtail awareness, and as Housekeeping reveals, it is precisely an awareness trained on sorrow that leads to theological insight and clarity (Morgan 9).

The novels accept the presence of illness as natural and neutral, allowing for beauty without enforcing triumph. These books offer a form of divergent agency that encourages an embracing of pain, what RHM scholar Catherine Gouge calls for:

> The emphasis on agency as agile, situated, and emergent can help form the basis of a more nuanced—and, perhaps, honest—understanding of divergent behaviors as rhetorical acts of becoming; of the limitations of narrow, oversimplified ideas of agentic action; and of the ableist, mastery-and-control models of agency to which complicate expectations are bound…. In so doing, divergent pathographies explore the many ways that agency is embodied, oriented, produced, and distributed (Gouge 127).

Because of the other characters' limited ideas of agency—the "rhetorical black hole" that Prendergast speaks of—the rhetorical acts of becoming the protagonists embark upon (leaving for a transient lifestyle) are acts to reclaim their subjective realities and rights to authorship. To have one's reality, what is most precious, stripped down to a name like "illness" is a denial of engaging with the complicated nature of illness and disability. These novels expand narrow, oversimplified ideas about the impact of illness by focusing on the affordances of embodied differences, and not just by focusing on illness as limiting and tragic. Harding, Robinson, and Woolf expand limited medicalized scripts by inviting readers into an understanding of agency that is "embodied and produced" through resistance to "mastery-and-control" models of agency (Gouge 127). The characters' estrangement from others is rooted in a narrow understanding of agency that would render what is most valuable—one's personhood—as broken and in need of curing, as tragic in need of triumph, and as unreliable, in need of another to author one's own reality. To return to disability scholar Martha Stoddard Holmes, "A more complete imagining of disability requires a reconciliation of the sometimes-painful material reality of disability with the value, humanity, and obvious fullness of disabled life" (134). I offer these creative writers' imaginings of fresh metaphors and new ways to treat time through their conceptualizations of the natural world and its connection to the body. These books invite us to “fully engage with suffering,” including in its affordances.

CHAPTER V: CONCLUSION: AUTHORSHIP THROUGH EMBODIMENT

In this dissertation, I have invited the reader to imagine an alternative engagement with illness, one that allows for the knowledge made possible through embodied differences. In each chapter, I have demonstrated how narrators reclaimed their right to author their own realities through resistance to universalized representations that would have rendered them as non-rhetorical. Furthermore, for the listeners of difficult realities, I described the need for rhetorical listening that allows for identification and not just affective responses of pity. By attending closely to these divergent scripts, I have located strategies for writing singular, agential, and embodied representations self-understandings. I sourced narrative techniques that insisted on an intuited and "felt" knowledge, through which one can assert the validity of one's lived experiences.

By turning to literary elements (like transient plots and metaphors of dwelling) that facilitate an ongoing relationship with illness that allows for shifting identifications instead of a static, totalizing, and dehumanizing diagnostic identity, my project focuses on singularities of personhood. Metaphors, plots, and literature, like the ones I analyzed in this dissertation, offer new possibilities for communicating and experiencing embodied differences. As disability scholar Jay Dolmage, argues, "metaphors of disability can table a new algebra of possibility. The result might be an exponentially expansive view of humanity. At the foot of this infinite multiplication, the author's words are just an opening stanza" (112). In pointing out alternative narratives (like the Gothic and the Transient), my aim has been to move the reader to more "expansive" views; not by offering another prescriptive script, but by disrupting triumph narratives in order to make room for new meanings. For, if narratives can negatively constitute a subject as non-rhetorical, then they also have the power to positively constitute a person.

Divergent narratives create a “gap” against the dominant narrative, an “inroad” that makes divergences possible. Further, knowing that one alternative is possible creates room for countless other alternatives. Reading literature for identification offers what RHM calls “dwelling spaces” and “borderlands”: in-between marginal landscapes where people may “pause and reflect on people, places, and things that are similar, different, and unknown” and move toward alternative identifications (Ratcliffe 83).

Identification and the Foreclosure of Universal and Objective Knowledge

This project does not invite empathy for those with embodied differences, but rather, works toward rhetorical listening that invites *identification*. As explained in the introduction chapter, medical labels invite classification via a cluster of symptoms. In novels told through a medicalized frame, the diagnosis of the main character is given up front so that the characters can be “understood through their diagnosis.” Often, medical novels serve a representative purpose. Not only is the reader supposed to understand the character *through* a diagnosis, but the character serves the purpose of helping the reader understand a medical diagnosis *through* the character. Representative novels function on the premise that certain people, with certain diagnoses, share a set of experiences, and, therefore, in reading representations one can better understand “what it means” to have or to “be” a person with schizophrenia, bipolar, epileptic, ADHD, etc.

In representative texts, medical labels work as a form of “othering,” inviting the reader to empathize with a condition that one does *not* have and therefore cannot fully understand. Through this construction, the readers are not invited to see themselves in a character, but to see what they are not (i.e., this character is schizophrenic, I am *not* schizophrenic, therefore I cannot understand what this is like, but by reading about this character, I can better empathize). The logic of representation claims to offer a better understanding of a person, but it is a false understanding; for, knowing a medical diagnosis does not truly tell the reader anything about a person's singular subjectivity. Such classification systems are the foundation of the field of psychiatry that depends upon knowledge of groups to understand the individual. This type of knowledge allows the reader to avoid a full engagement with difference, because it does not require the reader to face their own vulnerability. As established in the other chapters, coming face-to-face with one's own mortality, that deep listening and identification requires, can be terrifying. It is easier to empathize and to feel bad for a person; to leave a conversation thinking 'thank God I am not *that'* than to see oneself in another. A universalizing form of empathy—that presumes knowledge of a group based on a single representation—is a form of empathy that allows for pity, but not intimacy. I invite the relationality of identification.

The stakes of these pity/identification dynamics play out in the divergent narratives that I have analyzed, wherein readers are asked to witness the harm that diagnostic labels have on other characters' abilities to listen to, accept, or reject the protagonists' accounts of themselves. The literature I've examined in this dissertation moves the reader toward a deep listening to the complexities and nuances of embodied differences before *dis*identification can take place. As Rita Charon claims, "literature enriches and deepens stories, doctors, patients, nurses, family members—all who work together in caring for the sick—can thicken the telling and listening, can learn to sit comfortably with ambiguity and multiple perspectives" (34). To clarify the distinction I make between empathy and identification, I include Rita Felski's definition of reading for recognition in literature. Rita Felski, in *The Uses of Literature*, describes the ways that literature can invite readers into new identities by blurring the limits of what one knows. In the borderlands of the self and non-self, literature can “bring into play” what is unfamiliar. Felski explains:

> The phenomenology of recognition brings into play the familiar and the strange, the old and the new, the self and the non-self. It may help to confirm and intensify a sense of particularity, but it may also cut across and confuse familiar rubrics of identity. Recognition is about knowing, but also about the limits of knowing and knowability, and about how self-perception is mediated by the other, and the perception of otherness by the self. Precisely because of its fundamental doubleness, its oscillation between knowledge and acknowledgment, the epistemological and the ethical, the subjective and the social, the phenomenology of recognition calls for more attention in literary and cultural studies (28).

Like Rita Felski, I have approached these divergent novels for the ways they have complicated “familiar rubrics of identity” in the form of classification systems found in the medical world. Felski explains that the opening up to new possibilities of self-knowledge is made possible through “a sense of particularity,” which literature, in employing concrete details, encourages. “Particularities,” which are singular and contingent, offer a way to resist universalizing and dehumanizing scripts. Additionally, these novels' permeable language allows readers the possibility of identification, to experience “self-perception…mediated by the other”; to see what one may *be* instead of only what is.

By drawing away from medical meanings, which fall short of communicating the singular complexities of experiences of illness, readers can instead draw toward what Burke calls the “poet’s material,” opening up new metaphors and possibilities of identification. As rhetorical scholar Maurice Charland wrote, “The constitutive narrative itself, providing stories that through the identificatory principle shift and rework the subject and motives; (2) it can also proceed at the aesthetic level of what Williams terms the ‘structure of feeling’” (Charland 148). Divergent literature offers lyric “structure(s) of feeling” that can rework the typical triumph narratives and the affective responses of pity and relief that they typically elicit (148). The lyric, embodied, and contextual aspects of literature work on the reader at an aesthetic level, providing ways for the reader to identify with illness in its singularity and beauty instead of just its stigmatized form.

One of the best examples of how aesthetics can invite new “structures of feeling” through identification/non-identification with a diagnostic identity is articulated in rhetorical scholar Kimberly Emmons’ book *Black Dogs and Blue Words*. I’ve previously established that in today’s culture, a mental health diagnosis largely carries with it a negative stigma (Kessler). But this has not always been the case. Emmons explains that in the 18th century to be given a diagnosis also “signaled their incorporation into a social discourse that associated melancholy with ‘great depth, soulfulness, complexity, and even genius.’ Their performances were motivated by the desire to embody a poetic sensibility... it also represents their submission to a fashionable identity” (56). In this example, individuals were willing to identify with medicalized narratives of melancholia because such identification did not restrict their agency but rather offered an identity that *increased* their agency and others’ desire to identify with them. I have argued that one of the primary reasons that readers do *not* want to recognize themselves in medicalized stories is that they fear their rhetoricity will be forced into question. If, like in the 18th stories, we can turn to literary representations that don’t only offer the static and universal and stigmatized, but also turn to stories which offer “great depth, soulfulness, complexity, and even genius,” new identifications become possible (Emmons 56).

Case Study: Felt Theory and Moving Toward Valuing Embodied Epistemologies

Dion Million’s book *Therapeutic Nations* situates the narratives of several Metis women within the framework of what she calls a “felt theory.” Million explains that when these women insisted on their lived experiences, even when others did not believe them to be true, they brought new knowledge about the damaging effects of medical interventions that could not be known through “logic.” The lived experiences of these women, fastened into experiential narratives, detail *particulars* in time and place that resist reductive or universalized interpretations. Million argues that these writings “exploded” the “measured objective” accounts” of “hugely sterile” interpretations (Million 31). By insisting on the reality of what they knew *through* their bodies, they enacted a rhetorical approach. Because the necessary nuanced, intersectional theoretical framing did not exist in the when these women wrote their highly particularized stories in the 1980’s, their stories were initially discredited because they contradicted what was “medically known,” and therefore, their experiences could not be real (65). In doing so, their nuanced experiences confused the medical frameworks. They wrote counter narratives, “alternate truths,” even “alternate historical views,” that shifted narrow medical understandings that did not account for contingencies (Million 67). According to Million, the women storytellers “intuited, perceived, felt, and, finally, expressed” the lived experience of medical structures, contradicting the medical scripts they’d been given (Million 32).

Million interprets these women’s narratives as allowing for “a complexity that they feel/know, [but that is not] easily framed” (Million 64). To offer an example narrative, Million interviews Ruby Slipperjack, who she calls an “experiential narrator.” When others asked Slipperjack to “explain” her experience of trauma and illness, and to frame what it “means,” Slipperjack resists interpretative and analytical understandings of her experience. Instead, she insists on the lived experience as it felt in her body to *her*. She replied, “I cannot tell you why this and this and that happens, you figure that out yourself. Who am I to tell you something? It is there for you to see” (Million 65). Slipperjack insists on a singular story and also refuses to use her own story to make a generalized claim.

Felt theory offers particular counternarratives that trouble oversimplified framings and pose possibilities of resistance as the storyteller gains agency in their role as “teller.” The desire and right to self-authorship is at the core of the patients’ and characters’ resistance throughout every story I examined in this dissertation. As I have established, the rampant fear of being given a universal medical story is tied to the fear that one’s storied reality will become non-rhetorical. The right to self-authorship, and the right to be believed and heard, is at the center of this project. And, as these Metis women’s stories demonstrate, in order to tell one’s embodied story in its fullness, one must first begin from a place of “what it felt like to me.” The divergent literature I have offered up refuses to universalize any one experience or “true” knowledge and instead emphasizes the singularities and differences of embodied experiences.

In the characters’ and patients’ narratives I examined in this dissertation, those with disabilities/illness had to live at the intersection of their subjective sense of self, *and* their sense of self according to others. Importantly, according to Million, one of the central experiences of the residential school survivors who were labeled as mentally ill or traumatized was the felt experience of shame, of the “wrongness” of their personhood because of their deviant bodies. Million explains, “Shame is quintessentially ‘embodied’ socially, a primary self-reflective axis, a social/body relationship, in part a felt analysis, an assessment of your perceived status. Shame is part of ‘self-attention,’ the recognition of what others think of us. Shame is visceral interest” (Million 48). In the patient stories of those that came against the triumph narrative, many talked about the “wrongness” of their bodies and the sense that they were culpable for their illness/unnatural body when they could not get better. These patients described their shame and estrangement in knowing that others saw them through their “deficits” (Manguso). Additionally, I described how being constituted as mentally ill caused one to be seen as “less-than” and to be seen as “not fully human” (Yergeau). Through self-authorship, these women were able to change their relationships with their bodies. The articulation of their lived experiences allowed the survivors to reframe their subjugation and sense of embodied shame.

Million, through her “felt theory” explains how, through telling/writing their embodied and specific experiences, they were able to reclaim their agency. The writer, even when writing about suffering, is still in the position of power—the narrator, the seer, the author of their own suffering. By leaning into the specifics and what was sensory and concrete, these women created rich realities that diverged from the diagnosed, non-rhetorical position.

The business of fiction is the possibility of writing *through* the body and not just *about* the body. In Flannery O’Connor’s essay, “The Teaching of Literature,” she describes turns in culture that desires to make everything known, quantifiable, and understood and that “mystery is a great embarrassment to the modern mind” (124). She critiques “a generation that has been made to feel that the aim of learning is to eliminate mystery,” and encourages us to seek “mystery as we find it embodied in the *concrete world of sense experience*” (125). Like for Dion Million, for O’Connor, fiction is the movement toward a “concrete world of sense experiences” (125). The goal of fiction, unlike medicalized stories, is to communicate a single, situated reality full of mystery, ambiguity, and particularities.

If, indeed, the body can create its own knowledges through concrete senses, then literature, distinct from categorical genres like medical discourses, can open up new meanings through *particularities* and “sense” knowledge. Reading for affordances on literature invites the reader *into* an embodied experience rather than reading “about” an “other.” Fiction can uniquely do this work because it has somatic capacities that are “closely allied with “bodily” processes” (Burke 140). In the divergent narratives I analyzed, the characters refused to understand themselves through identifications like “illness,” not because they refused to believe they were ill, but because they understood their embodied realities as a *part* of their subjective reality: just as every other person’s realities are filtered through their senses. In RHM and rhetoric broadly, there have been many recent moves toward acknowledging the role the body plays in providing and framing knowledges and *ways* of knowing. In the 2022 anthology *Bodies of Knowledge: Embodied Rhetorics in Theory and Practice*, embodiment scholar Abby Knoblauch argues that:

> The presumed “normative” body and the knowledge made of and through it has ‘become ‘universal’ in modernist discourses because the bodies producing the discourse have been effectively erased, allowing them to become metonymies of experience and knowledge.’ This erasure further marginalizes embodied knowledge: that knowledge, this academic paradigm says, is specific, particular, and limited because it comes from the body, while “true” knowledge is general, expansive, universal, and “pure” because it comes from a disembodied (9).

Literature makes this centrality of the body to perception immediate to the reader. Because literature is closer to an embodied form than universalized theories, it resists the abstractions of absolute knowledge and the “ableist desire for mastery and closure” that disability scholars critique (Gouge). The literature I have identified refuses to essentialize “true” knowledge and instead emphasizes the singularities and differences of the conditions of being in a body. These authors adopt an orientation, like renowned poet Dylan Thomas, predicated on the belief that “All thoughts and actions emanate from the body.”

Like Million’s description of the Metis women, the characters in these novels insist on the validity of their embodied knowledge—at all costs. In the Gothic novels, the protagonists refused to ignore their illnesses, for this would require living a *disembodied life*; to believe that their illness was “all in their head” would require them to lie to themselves about their experiential realities. Importantly, they refused to deny the realities of their bodies and the knowledge their bodies would communicate. The protagonists clung to their embodied realities—including the suffering—as central to their subjectivity. Their worlds are depicted through their concrete senses.

Literary forms can help facilitate expression of one's embodied life, instead of a disembodied life, which the insistence on triumph can foreclose. For those who move toward embodied knowledge, there are no absolutes or "health states" of being that have definitive ends, but rather, such engagements require ongoing practices of attending to specificities through continuous revisioning of one's identity.

Resisting Static Identities: Flux, Chaos, and Contingencies

Literature, with its flexible and poetic forms, makes room for writers to reclaim agency through an insistence on the transiency and contingent needs of the body. In Gregory Orr's book *Poetry as a Means of Survival,* he describes the need for literary forms that allow for the flux of one's embodied subjectivity and sense of identity. He claims, in similar language to Arthur Frank's chaos narrative, that a sudden crises, like illness or a diagnosis can shake one's sense of self. He says that "Until a powerful crises destabilizes us, we may not even realize how precarious an entity that self really is" and when this crises ensues, "it's then that the personal lyric steps forward with its offer to restabilize us. What was buzz and din becomes an "I" whose actions articulations express and regulate the confusions of our situation" (41). While it is difficult in the face of illness (whose myths of overcoming and overcompensating are readily available) to resist pre-formulated narrative structures and meanings, literature can provide means for such ongoing engagements.

The literature I've proposed in this dissertation allows for fluidity and the ongoing possibilities of *being* rather than a static identity. The authors resisted typical illness myth structures by experimenting with ways of ordering that hold the story together without ascribing cause-and-effect explanations. The writers referenced throughout depict their experiences in their formal structures as well as content. Literary form can bring "the centrality of the self to… ordering" but this ordering, unlike a chronological plot, can "handle the flux and chaos of feeling" (O'Connor 40). I believe part of the way that one can regain agency is in the very *form* of the story itself. For, meaning is form; and form is meaning. As Aristotle says, it is in the *way* of telling, not just what is said that meaning is made. For, "if man's responses are to be effective, they must take into account the temporal and formal structure of the situations he addresses" (Poulakos 45). Literature can provide self-understandings and the restabilizing of the self through forms: which is why I have so closely looked at forms like plots and metaphors.

Finally then, I encourage a Métistic understanding that allows for the shifting states of the body. These divergent novels make room for a Métistic understanding of health that answers the field of Rhetoric of Health and Medicine's call for an "Ethics of Praxis" that engages not universal ideas of health, but an approach toward health that is "situational, emergent, and embodied" (Molloy.) A Métistic approach is "neither static nor goal oriented; it is pragmatic, situational, and kinetic… it mobilizes the power of imagination and reflexive meaning making in order to continually reinvent selves and possibilities and to precipitate change…and entails ongoing refashioning of identity and possibility, not just maintaining but recreating meaningfulness" (Flynn 8). This call by RHM scholars and medical professionals to allow for a self that is continually being reinvented through the power of imagination, is made possible through literature whose "distinguishing feature is the centrality of subjectivity coming to consciousness of itself through experience and reflection" (Culler 92). The formal possibilities of the novel makes space for circular, ambiguous, and paradoxical feelings- for the flux that is the experience of living with ongoing illness, rather than sticking to the false script that imagines fixed and goal-oriented states of health. Literary forms can offer containers for the “I” to understand itself. It also makes room for Métis: an embodied intelligence that is always “morphing” according to one’s needs (Flynn 8). The novels I’ve explored invite a continual reflective and reflexive rescripting of the self. If there is any progression, it is through “the logic of progressive realization of the spirit, in which the goal is for the subject to realize itself as itself” (Culler 38). It is rarely by achieving a final state of “triumph” or reaching the hero’s journey ending.

In this dissertation my aim has been to clarify that you can’t rush healing; there is no timeline to grief, and there is no “getting over” a depressive episode or the loss of a child by “deciding” to. Instead, insisting on closure can lead to a sense shame or isolation when one does not get better. I’ve argued that self-authorship often means a reconciling with the felt and embodied truths that contradict dominant triumph narratives, including the limitations of one’s body. I’ve encouraged shifting relationships with one’s body that, instead of ignoring pain, attends closely to it. To return to disability scholar Sarah Wasson’s Gothic medical humanities article, she says:

> It can be extremely difficult to read or listen to representations of shattering experiences. Researchers working with healthcare practitioners have found hearers are likely to deny the horror of such narration and recuperate them into more positive stories, seeing the misery as linked to depression, or trying to frame the suffering as potentially alleviated in the future by scientific breakthroughs. Yet moving *too quickly to deny the chaos runs the risk of failing to recognise the validity of the speaker’s suffering*: not bearing witness to the reality of what they feel right now. Clinicians and cultural theorists alike have called for the urgency of witnessing the reality of another’s experience of suffering, without the auditor/reader *taking flight by diminishing or reframing it* [emphasis mine]” (18).

I argue that we can, through training in literary forms, learn how to better listen and make room for others to structure chaotic meanings in their lives that feel authentic and to acknowledge the body’s limitations and affordances.

In this project, I've particularly brought attention to divergent narrative structures—that allow for uncertainty and the ongoingness of suffering. If one ignores such structures, one's ability to tell/hear a story can be forced into narrow meanings: by the structure alone. Unfortunately, most are largely untrained in reading, writing, or even listening to fragmented, "incoherent," winding stories lacking cause-and-effect shapes. I have offered alternative literary models that reject a cultural tendency to "steer away from honest engagement with the body and its pain," and instead allow the author/reader *to draw toward*—the more difficult realities of the body (Adams 9). What is needed, as disability scholar T.K. Dalton writes, is to:

> retire these flimsy fictions: the myth that illness is a fight, the myth that illness is finite, and the myth that illness is stably described in language. Illness is not a fight, it is not finite. It is discursive and, whatever the clock says, it long. That's where us such and disabled writers, and our readers, have an essential role: in writing and reading stories of the ongoingness of whatever ails one of us, any of us.

My aim has been to retire the flimsy fiction of the triumph narrative and to lean into the discursive components of authoring the body and to encourage narrative structures that allow for this ongoingness. I've also urged a more complete imagining of disability that "requires a reconciliation of the sometimes painful material reality of disability with the value, humanity, and obvious fullness of disabled life" (134). The "obvious fullness of disabled life" is not so obvious in the triumph narrative plotline. I offer these books' imaginings of disability as an alternative to triumph. After all, the denial of one's pain by labeling it as "made up" is a stripping of agency; but so is a refusal to see one's full humanity and the complexity of one's embodied subjectivity, what others may reduce simply to a term like "illness." The authors of these divergent novels expand imaginings of agency, not through a triumphing over illness, but through an embracing of how illness shapes perceptions.

Writers such as Adrienne Rich have discussed the arts of the possible; ways that literature allows us to imagine and experiment with experiences outside our own. In the case of illness narratives, this has meant seeing an experience of mental health not as a site of suffering, but a site of affordances. I've encouraged a move toward the pluriversal, for "Pluriversality opens up the possibility of helping to make visible multiple ways of creating knowledge, with a goal, ultimately, to create value for all such knowledges and to acknowledge that all are inescapably caught in the trappings of modernity" (25 Cushman). Through highlighting this literature, I have offered alternatives to medicalized forms which value ideals of health and cure that are often at odds with experiences of disability and illness and the knowledge they produce. I've explored literary techniques that allow for "a *métistic* orientation," an ability to "shape-shift," act with cunning, situational intelligence, resourcefulness, and an ability to understand the constraints and possibilities of rhetorical tools in any given context (19). The authors, while never diluting the seriousness of their character's illness, and while making us understand their unreliability and the precariousness of their social situation, also show us the spiritual possibilities and insights that their unique embodiment allows. I see these novels as granting their protagonist's full rhetoricity in ways we might not generally recognize as agency, thus expanding the possibilities of embodiment identifications. Literature moves into the realm of ambiguity, searching for forms that convey and mimic meaning while still resisting closure and mastery-an insistence on any universal right or wrong way.

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