THE POETICS OF HEALING: VOICING ILLNESS AND TRAUMA IN LITERATURE, NARRATIVE MEDICINE, AND REFLECTIVE WRITING

By

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To Tom, my Hero
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This interdisciplinary study explores the use of emotional self-disclosure in the literary narratives of seriously ill or traumatized people, presenting a poetics of healing that authors have understood intuitively for centuries and that medical professionals are now using in clinical settings. Although each of these narratives, in differing degrees, represents actual events in the lives of historical figures, none of the primary texts chosen is purely autobiographical or biographical in form. Rather, the study is concerned to show that disparate literary genres contain a kind of self-disclosure or reflective writing, which manifests itself as an instinctual ordering impulse, a basic human need to find meaning and control in the midst of turmoil and pain through narration. This type of story-ing oneself surfaces in the writing of sufferers independent of genre as a means of psychologically confronting illness or trauma and mitigating its effects. In privileging these voices, the study thus aims to explore the types of knowledge that can be gleaned from these narratives, and demonstrate how reflective writing can be transformative in a therapeutic, healing sense. Using the Five Narrative Features of Medicine, identified by Rita Charon, as a framework to link the relevance of
these literary works to corresponding clinical challenges, each chapter aims to generate discussion between professionals in the humanities and Western medicine, with hopes for achieving true interdisciplinary appreciation and collaboration.
CHAPTER 1
INTRODUCTION

This is an invitation to professionals in humanities and medicine, and to any readers interested in the various disciplines within these fields, to consider how writing about one’s illness experience can help to heal the body and mind.

This dissertation examines a sampling of generically and historically disparate texts in order to articulate a “poetics of healing,” a way of reading and understanding the “medicine in narrative” for scholars but also laypersons, for medical professionals but also patients and non-professional caregivers. Using key concepts described by Rita Charon in *Narrative Medicine: Honoring the Stories of Illness*, I will examine qualitatively different texts with autobiographical elements to elucidate a poetics of healing that will help my readers understand how the authors used reflective writing therapeutically, albeit perhaps unintentionally, to achieve some measure of catharsis from trauma or illness. Elucidation, not theorization, is my goal. The intricacies and particularities of these texts, which span four centuries, mirror the experiences of sufferers and caregivers today. My study therefore views the narratives of writers (John Bunyan, Tobias Smollett, Jane Austen, W. H. R. Rivers, Robert Graves, and Pat Barker) to reveal some ways that they employ emotional self-disclosure in disparate genres and centuries, and how we can learn from and teach from different perspectives this literature that demonstrates the poetics of healing *in situ*.

The term “poetics” needs some qualified explanation. While it has been employed variously since Aristotle, for different purposes and disciplines, here I will use “poetics” to denote an awareness of how a text’s different narratological, psychological, and aesthetic elements combine and cohere to produce certain effects on the reader
and the writer. Such a poetics necessarily embraces the literary paradigms of narrative medicine and the therapeutic principles of reflective writing, all of which I offer cumulatively as another epistemological approach to the study of literature. This definition is apt for my purposes, then, because these “certain effects” are evoked in the producer of the text—the writing is healing, liberating, or restorative for the writer in ways that the reader can discern and appreciate in the narrative. “Poetics” therefore indicates what happens when writers are simultaneously sufferers and patients, narrators striving to make sense of pain, illness, and depression via the tools of narrative.

Although each text of the six writers examined could be read in the full theoretical light of Charon’s “poetics,” I have thought it best and clearest to emphasize one particular characteristic per chapter. Accordingly, in chronological succession from the seventeenth- to twentieth-century, each of my chapters will highlight and use one of the five “Narrative Features of Medicine” (39-62) that Rita Charon has distinguished to help illustrate the intuitive, healing impulses of the authors as they psychologically, narratively confront their trauma or illness. Using these features as correlates to health care’s divides, Charon has demonstrated the benefits of studying narrative to medicine. I hope to demonstrate the benefits of studying medicine in narrative, to physicians, literary scholars, and others, as we are “listening” for the poetics of healing. My exposition of four of these five features in major literary texts—temporality in Bunyan, singularity in Smollett, causality/contingency in Austen, and intersubjectivity in Rivers, Graves, and Barker—illustrates new ways of understanding these narratives as literary texts, but also as healing documents, as writings where sufferers and caregivers work
out via narrative their own healing and coping mechanisms. An additional chapter that highlights the fifth feature, “ethicality,” will be included when this manuscript is prepared for publication.

Because Charon’s ethos, and the ethos and guiding principles of narrative medicine generally, is interdisciplinary in intent, my study does not undertake a “top down” theoretical approach. Such an approach is relevant, without doubt, but the theorization of healing narrative is already underway via Charon, James W. Pennebaker, and others, and its augmentation is outside the scope of this project. In that generalizing and theorizing the healing process which occurs through narrative would necessarily employ specialized concepts of narratology and literary theory, the resulting discussion would be rendered inaccessible to readers outside the domain of my intended audience. A highly theoretical approach would miss the very nuances of the particular sufferers whose narratives I examine, the singularities that Charon urges doctors, readers, and scholars to note as they encounter patients and texts.

In an effort to avoid an approach that would prove elucidating only to a specialized literary readership and, instead, address a wider audience with varied interest in the broader fields of humanities and medicine, I have sought to allow these six writers’ healing narratives to speak for themselves, gradually building an overview of the poetics of healing by highlighting relevant concepts from Charon. My study therefore applies rather than revises Charon, demonstrating via narrative exposition some features of these texts and sufferers that might be missed by a reader, scholar, or caregiver too reliant on “comfortable” categories and generalizations.
Following this Introduction, in Chapter 2, I begin by contextualizing my interdisciplinary approach with readings of two texts: Franz Kafka’s story “The Metamorphosis” (1915) and Jean-Dominque Bauby’s memoir The Diving-Bell and the Butterfly (1997). Both texts exemplify the phenomenon of voicelessness in the illness experience—how articulating one’s suffering is so difficult and how listening (or not) to a sufferer’s story can affect his abilities to cope and heal. With these readings of different genres, I begin to demonstrate how illness and the chaos it creates compel the sufferer to tell his or her story, and how the resulting narration can prove to be healing somatically and psychically. The texts provide a foundation on which to base my discussion of the clinical work of James W. Pennebaker, whose studies of reflective writing demonstrate the biological and psychological benefits of “letting go” of emotions and telling one’s story. His work is central to the ideas expressed in this book, and are part of the narrative medicine paradigm Charon has created.

Chapter 2 continues with a discussion of the need for expanded interdisciplinary collaboration between English and medicine. Observing that the social sciences and some humanities disciplines, such as philosophy, history, linguistics, and anthropology, are already engaged in cross-disciplinary efforts with medicine and yielding fruitful research, I argue for English to become a greater presence in ongoing clinical studies of reflective writing and the educational objectives of narrative medicine. This argument is followed by sections that discuss these areas of opportunity and define them for unfamiliar readers.

Chapter 3 examines the first of Charon’s narrative features of medicine, “temporality,” as it relates to the 1666 conversion narrative of John Bunyan, Grace
Abounding to the Chief of Sinners. Part of a broader category of spiritual autobiographies, this narrative was written while Bunyan was incarcerated for religious dissent, and recounts the details of Bunyan’s angst-ridden quest for spiritual confirmation that he was indeed one of “the elect.” As such, the narrative registers Bunyan’s radical anxieties about salvation (or damnation) and gives us a window into the intense psychological pain that he experiences in his constant search in the scriptures for some sign of his predestination—pain manifested in a narrative replete with distortions of time.

Bunyan’s book is a vivid disclosure of narrative’s power to engage, articulate, and dissipate suffering, even when the causes may be temporally remote. Engaging Vera Camden’s questions about the traumas Bunyan suffered in his youth that are missing from his narrative, as well as some current neuroscience about time and memory distortion, I offer some potential reasons why he is unable to tell these parts of his story. Bunyan’s problems with temporality could stem from his unusual experience of compound trauma: social, religious and personal. His existential dread, as well as his sense of both earning and modeling his redemption through his time-obsessed narrative, serve to point out the value of reflective writing as a release valve and constructor of narrative identity.

In Chapter 4, I have chosen to highlight Charon’s notion of “singularity” by studying Travels through France and Italy by Tobias Smollett. It may indeed seem peculiar to readers to arrive at a discussion of an eighteenth-century travel book in a study of narrative medicine and reflective writing, especially when a more literary text, one of Smollett’s humorous novels for instance, with their bawdy allusions to bodies and
their malfunctions, could have served the purpose well. But along with my intention to demonstrate that sufferers employ written emotional self-disclosure intuitively, as an ordering impulse and coping mechanism for the turmoil of illness or trauma, I want to show how this abreactive discourse can surface just about anywhere—regardless of genre—and therefore that we may employ a widely varied range of texts in teaching the tenets of narrative medicine and reflective writing.

*Travels* reveals the ways that this surgeon copes with his own illness: tuberculosis. On his journey, he was also escaping a greater trauma: the recent death of his only daughter. As Smollett relates his travels in epistolary form, he is engaging in a therapeutic practice to allay the sufferings of body and mind. In one of the longer letters, Smollett demonstrates his need for singularity, as a patient who receives a consultation and written advice almost identical that given to his fellow travelers in Montpellier. Charon observes that when patients today feel as though they are being treated merely as a number—a faceless, nameless body among many—what they are protesting is dismissal of their singularity. This episode in *Travels* is but one instance of this narrative feature of medicine, and illustrates a kind of reflective writing that helps mitigate Smollett’s anger and indignation. His continental trek, during which his perceptions of each destination are filtered through and colored by his unique illness experience, is a useful example of the way suffering alters identity and requires new narrative strategies to accommodate it.

Chapter 5 features the nineteenth-century Jane Austen novel, *Persuasion*, and the narrative feature “causality and contingency.” While some critics have observed similarities between Austen’s life and the character Anne Elliot, my concern is rather to
situate the aims of the novel within the context of its writing than to forge any autobiographical links. Austen was ill and most likely dying when she penned this book, and its pages contain repeated considerations of accidents and illness. The number of these episodes is greater and the seriousness of their causes is graver than in any of her other novels, and her heroine attends in some way to them all. Thus, Anne Elliot takes on a nursing role that, dutifully executed despite her own depression, allows her to heal others and, in the process of caring for others, herself.

Anne understands only partially the cause of her depression when the novel begins: she recognizes that she was mistakenly persuaded to refuse Captain Wentworth’s proposal and, she believes, has thus lost the love of her life. But until she observes other marital contingencies—scenes in which illness and injury and her nursing recur—and moves from depression to better health, she cannot fully grasp the paradoxical nature of that refusal. Lady Russell’s advice was dutifully given and obeyed, but these prudent actions were nevertheless precipitous and unwise; Anne is wronged by doing right. Austen never veers far from the comic genre, always giving her heroines the happy ending. For Anne, however, and for Austen as she was writing this book, the future holds uncertainty and threatening contingencies.

In Chapter 6, the works of three twentieth-century writers—poet Robert Graves, psychiatrist W.H.R. Rivers, and novelist Pat Barker—are examined in an effort to demonstrate Charon’s concept of “intersubjectivity” and its effect on the kinds of reflective writing represented in their texts. In her 1991 historical novel Regeneration, Barker features Rivers as protagonist and Graves as a minor character. The two men actually did meet much as she portrays the scene, with Graves arriving late to the
hospital where Rivers is stationed during World War One, after missing the train on
which he had meant to accompany Siegfried Sassoon to Rivers’ care. Barker draws on
speeches and the actual medical notes Rivers made, as well as Graves’ personal
accounts of the war in his autobiography, to flesh out her fictional patients and imbue
the novel with the same gravitas and tenor as the historical documents. Thus, she
participates in literary intersubjectivity, with the result an artful interweaving of fact and
fiction that depicts illness and suffering from both the patient and the caregiver’s
perspectives. The novel provides a literary encapsulation of narrative medicine in situ.

The novel, I contend, is about the breakdown of language; it articulates the terror
of the inability to speak and to convey meaning when one can speak, as well as other
narrative distortions. The relationship between Rivers and Graves, who suffered from
“shell-shock” during and long after the war, began with their mutual fascination with the
mechanisms underlying the production of narrative, poetry, and dreams. Rivers, who
believed in the merits of the “talking cure,” sought to help his soldier-patients speak of
their afflictions, often engaging them in acts of reflective writing such as poetry-writing
and writing down their dreams. Graves, a published poet when they met, believed in the
merits of psychoanalysis. Their intersubjective experience was based, in many ways, on
their shared desire to understand the elusive nature of language as a vehicle for
emotional expression—how to put into words the unspeakable.

When Charon describes the aforementioned narrative features of medicine, she
is showing how narrative exists in medical practice on a daily basis, in an attempt to
bridge what she perceives as divides between doctors and patients in the American
health care system today. Narrative competence, she contends, a heightened
awareness of and facility with the narrative features that physicians repeatedly encounter in practice, can bridge these divides and create better doctors, more contented patients. I borrow and interweave these concepts into my chapters, along with Pennebaker’s clinical proof that writing helps heal, with the hope that this study can help bridge existing divides: between humanities departments and the public, who needs a better understanding of what these disciplines “do”; between literary scholars of different specializations, with concentrations in any era; between scholars and medical experts, who can benefit enormously from each other’s expertise; and between teachers and students of any field, all of whom may experience illness or trauma some time in their lives, and need to tell their stories.
CHAPTER 2
THE POWERS OF LANGUAGE AND HEALTHY COLLABORATION: WHY ENGLISH AND MEDICINE NEED EACH OTHER

Of Physiology from top to toe I sing;
Not physiognomy alone, nor brain alone, is worthy for the muse
—I say the Form complete is worthier far.

—Walt Whitman
Leaves of Grass

Gregor Samsa awakes one morning to find that he has become a bug. Franz Kafka’s hapless protagonist of “The Metamorphosis,” who must now negotiate the limitations of this strange new body and contend with the reactions and behaviors of the people around him, embodies a moving metaphorical expression of the experience of illness with all its physical and psychological discomforts, as well as the domestic turmoil it brings. This dissertation is in large part about the experience of the sufferer, whether ill or coping with some external trauma, and his vital need to voice that experience in narrative form. As the growing body of scholarly discourse from a wide array of disciplines attests, and as I shall attempt to unfold below, spoken or written disclosure of stressful or traumatic events—telling one’s story—and “psychologically confronting” the experience, as the clinical work of James W. Pennebaker has taught us, “produces long-term benefits in psychological and physical health” (69). This idea, drawn and expanded from the groundbreaking work of Breuer and Freud (1895), and backed by increasing numbers of clinical studies, suggests, among other things, that healing is not a passive state and that, even with no outside intervention at all, the sufferer has some agency in alleviating his own ordeal. In this study, I will highlight these intuitive impulses of psychological confrontation in written works of suffering that span 400 years. With an aim to demonstrate the importance of narrative to healing, my
work endeavors to join a much larger conversation about restoring the human to the center of cultural concern.

**Reading Gregor as the Patient**

In “The Metamorphosis,” Gregor’s first thought – “What’s happened to me?” – is a universal query of anxiety for anyone who has experienced the onset of serious illness (Kafka 11). His grotesque bodily transformation is complete when he awakens, and he “clos[es] his eyes to avoid seeing” what he can no longer recognize. If unable at first to adjust or right his position in bed, he can at least still call out to his family, who take turns trying to rouse him, knocking at his bedroom door. Yet even this last tenuous connection to his humanity is failing fast: Gregor is losing voice. Attempting to allay his family’s fears – for, as their sole financial support, his very presence at home at this late morning hour is abnormal – he communicates with “words [that] retained their clarity only at the very outset” and quickly “became distorted…so that you couldn’t tell if you had heard them correctly” (13). Only minutes later, Gregor’s “speech [is] no longer intelligible” (19) and is reduced to “animal language” that incites suspicion from his employer, who has arrived to demand an explanation for his salesman’s truancy. The sounds induce pure panic in his mother, who acknowledges the infirmity with shouts of alarm: “Gregor is sick. Fetch the doctor fast. Did you hear Gregor speaking just now?” It is the last time they will listen to him.

Kafka crafts this absurd, sudden bodily metamorphosis to underscore, from the sufferer’s viewpoint, the unbearable pain of real, gradual psychological schisms that often occur in human relationships when illness is present. The loss of his voice is Gregor’s undoing; it is catastrophic. He has been instantly othered and isolated: a voiceless, somatic entity now horrible and unrecognizable to those closest to him, and
yet a psychic entity unchanged. He can barely maneuver this ungainly body with all its new spindly legs, and he has no way of communicating his altered wants, needs, or his comparative calm. In his typical dreamlike style, Kafka generates nightmarish tension between the chaotic events and environment of the story and the protagonist’s detached, observant stoicism. Even when his family’s misunderstandings cause him physical injury and excruciating pain, Gregor endures it without complaint. Gregor should be more upset than he is, the unsettled reader thinks. Kafka has stripped him of all agency. Illness can seem so surreal – particularly when it is real.

Reading only at the surface level, one might consider Gregor’s predicament just bemusing fictional entertainment. (It is an enjoyable read.) One need not plumb the metaphor and consider its implications because illness does not happen this way, does it? Yes, quite nearly. Jean-Dominique Bauby awoke from a long, deep coma to find he’d become a quadriplegic with no ability to speak. It took more time for him to come to understand that he had suffered a massive stroke a month earlier and was now permanently a victim of “locked-in syndrome.” With great patience, compassion, and fortitude, Bauby’s therapists and Claude Mendibil, his amanuensis for the poignant memoir, The Diving Bell and the Butterfly (1997), worked hard to allow his voice to be heard. They “listened” to him and recorded his story through his only means of communication: blinking his left eyelid. Bauby’s caregivers had to adapt to his language if he were to be able to communicate.

This comparison helps me make several points in brief about illness narratives that I will develop more fully with featured texts in the body of the dissertation. Putting aside for the moment more conventional concepts of narratology that affect my choice
of texts – for instance, that these two are wholly different genres, contain different types of narrators, different contingencies – I want to use this Kafka short story and Bauby’s memoir to illustrate some of the facets of the relationship between the sick person and the potential obstacles he faces as he attempts to tell his story and find meaning in his experience.

First, serious illness (or trauma) is an unforeseen disruption of the living of life that can transform the active, vital subject-self into a constrained, diminished object-self. The sufferer is abruptly made less than because he is constrained by forces beyond his control, lacks the agency and freedom taken for granted in health, and can no longer live his life as before. To make matters worse, as we can see in both Kafka and Bauby’s texts, the “ill person...having been interrupted by disease, is now considered infinitely interruptible in speech, schedule, sleep, solvency, and anything else” (Frank 57). Because humans “have a basic need for completing and resolving tasks” (Pennebaker 90) – whether simple or profound – the inescapable interruption of illness and all its accompanying intrusions rupture the order and meaning in one’s life, and thus force the sufferer into a cyclical, ceaseless psychic rehearsal of unfinished moments of living. The object-self must contend with searing psychological pain and an internal, personal narrative in chaos.

Second, this interrupted object-self, its mind in turmoil, is trapped within the body that betrayed it in the first place. In firm opposition to the centuries-old notion of Cartesian dualism, many scholars, such as Rita Charon, Arthur Frank, Howard Brody and Iain McGilchrist, among others, point to an important problem of corporeality: “The self has—and is—a body” (Charon 76). Human beings are not just in their bodies; they
are their bodies. In health, most of us never ponder this intertwined nature of our personal identity, but illness thrusts the matter into consciousness with frightening rapidity. “Man” swiftly devolves into merely the “sick-man” or, worse, becomes known as just the sick body or the sickness (“Oh, she’s the lung cancer in Room 224.”). The sick-man’s voice can become totally negated, his suffering experience relegated to the background of his treatment. Both Bauby and the fictional Samsa, whose embodied selves are now broken, must discover a way to comprehend and, if possible, stabilize their altered identities, “transcend their definitions by their bodies” (76), and regain some control and subjectivity in their illness experiences.

How can they achieve these aims if their bodies no longer serve their selves? If the sufferer’s voice is no longer audible or clear, how can her story be heard or comprehended? I make my third point about the above textual comparison by drawing on philosopher Paul Ricoeur and his notion of narrative identity, which states in part that our individual identities are also indivisibly linked with those of the people around us – our families, colleagues, countrymen. We make sense of who we are by situating ourselves amongst and against the other people in our life’s story, in the same way we do with the protagonist and the other characters in a novel. So if we can no longer communicate successfully with others, if we have been in some way silenced or if no one will listen, we find ourselves in deep crisis indeed. Bauby and Samsa are each abruptly silenced in their hellish illness experiences and strikingly (for an actual person and a fictional bug) share many of the same feelings of fear, shame, guilt, and isolation in their mute states. But they can be sharply contrasted in terms of the people who serve as constituents of their identities.
Bauby’s caregivers were fixedly determined to interrelate; Gregor’s family refuses to even try. Horrified by his bodily transformation, they never attempt any means of communication with him once his natural, human voice is gone. So complete is Gregor’s psychological quarantine, “the others, even his sister, not understanding him, had no idea that he could understand them” (Kafka 27; original emphasis). Gregor is fully aware of his receding identity in this family unit. The Samsa family’s immediate disgust with this bug-body make them forget and eventually erase the subjectivity of the son and brother who has hitherto unselfishly worked to repay his father’s debt and support the entire family for years. Although the disrupted social arrangements trouble them at first, they soon adjust by eliminating Gregor from their routines; they find work themselves, they stop knocking at his door. By degrees, the erasure is made disturbingly complete. “In front of this monstrous creature, I refuse to pronounce my brother’s name” . . . “It’s got to go…that’s the only remedy, Father. All you have to do is try to shake off the idea that that’s Gregor” (47) says Gregor’s beloved and once loving sister, whose own identity has rapidly metamorphosed into one of powerful influence over the parents who used to scorn her. To his family, who refuses to listen – every sound, every move this repugnant animal makes is suspect – Gregor, reduced to impersonal pronouns, no longer exists; his suffering no longer matters.

If, as Ricoeur posits, one’s personal identity is constructed by and within the unique characteristics of one’s life narrative, then the sufferer must necessarily undergo a radical identity shift in his vulnerable state, because he cannot function as the untroubled “character” did in the old stories. He must shape his essential self anew to fit the troubling circumstances that form his emerging narrative. And crucially, he must be
able to resituate and re-present himself amongst the people with whom his altered identity intersects. But with no voice, no agency, he is incapable of initiating a metamorphosis of his own identity and, troublingly, he assumes a passive role that seems to puncture one of Ricoeur’s primary conclusions: that we can change and effect change in others. However, Ricoeur was not, it must be noted, considering illness experiences. In illness, we become a different animal.

In contrast to Gregor’s experience, though, some of the people in Jean-Dominique Bauby’s ken are very much aware that he’s “there” – seemingly the same man in mind, even if his body and facial features are paralyzed and contorted beyond recognition. If treated purely diagnostically, Bauby’s condition might well have been dismissed as idiocy in Kafka’s time. His selfhood would have been acknowledged only by the exceptional caregiver. Bauby ascribes near-divine status to the woman who listens and gives him voice: “The identity badge pinned to Sandrine’s white tunic says ‘Speech Therapist,’ but it should read ‘Guardian Angel.’ She is the one who set up the communication code without which I would be cut off from the world” (39). Sandrine has listed the letters of the alphabet in order from the most to least frequently used letters in the French language. Those who use the system to “hear” Bauby “speak” begin by naming each letter until he blinks at the sound of his letter of choice. In this way, he slowly spells out word after word for Sandrine, family members, many friends and colleagues, his psychologist, and to Claudine, to dictate his book chapters. Most of the physicians and staff do not use this code, however, and Bauby laments that he has only the “skimpiest arsenal” (39) of winks and grimaces to express his needs. Still, Sandrine’s appearance in his room twice daily “sends all gloomy thoughts packing” and
makes the “the invisible and eternally imprisoning diving bell [seem] less oppressive” (40). Her efforts help Bauby tell his story and thus “transcend” his embodiedness enough to reclaim his narrative identity and, importantly, complete a crucial life-task that his stroke interrupted.

We should note that, unlike Bauby, Gregor’s family never attempts to bridge this gap of language and never reaps the benefits of connectedness, either. Both he and they are worse for the neglect. As if he had died, Gregor’s narrative identity terminates with the onset of his bodily change and the loss of his voice. Bauby’s voice, on the other hand, despite all of the inadequacies of language in the expression of illness and angst, permanently resonates in a narrative of poetic vitality.

The above three points, these obstacles to narrative, presuppose the validity of many scholars’ claim that language is a clumsy instrument for conveying the indescribable features of illness and pain. Scholars Susan Sontag, Elaine Scarry, David B. Morris, and others discuss the limitations of language as a tool for the sufferer to use to accurately define her perceptions of and construct meaning from her illness or traumatic experience. I will rely on their expertise and explore some of the nuances of their observations in the chapters that follow, but here suggest that this deficiency of language is embedded within each of the obstacles I have named. To recap the three points and illustrate this suggestion: the chaotic internal monologue of the object-self defies orderliness and full expression in words; the self that both has and is a body mistrusts and resists language created by its own cerebral functions; and the self that must fashion a new narrative identity by relying on those around her finds that these people can as often hinder as help her, because her language sounds different from
before. Language really does present us with difficulties. But it’s all we’ve got. And, as I hope to show below and throughout the dissertation, it can be completely transformative and healing for the sufferer who puts her experience into narrative form.

When the slipperiness of language, particularly as it relates to the problematic nature of social interaction between the sufferer and healthy others, ensures that stories of illness and trauma remain unspoken, un-narrated and suppressed, something vital is lost. The person who does not or cannot tell her story must actively stifle her language and inhibit her thoughts -- a process Breuer and Freud (and many others since) deemed pathogenic. By virtue of her experience alone, the sufferer understands something that others around her do not, an inexpressible “something” that lies at the core of the new narrative identity she so desperately needs to build. For this suffering narrator, I see a disjunction in the very meaning of the word “narrative” that, if language does not elude me here, I will try to pin down.

H. Porter Abbott reminds us that the word “narrative,” originating in ancient Sanskrit, “comes down to us through Latin words for both ‘knowing’ (‘gnarus’) and ‘telling’ (‘narro’). This etymology catches the two sides of narrative. It is a universal tool for knowing as well as telling, for absorbing knowledge as well as expressing it” (11). The sufferer knows, but so often cannot tell. She has absorbed knowledge unique to the situation of which she is a victim, and she builds upon that knowledge continually as she contends with the fallout. But the telling of it is confounded by the inadequacies of language and obstructed by one or more of the forces we’ve been discussing: her mindedness, her embodiedness, her interrelatedness. What she knows can torment
her, as it remains trapped in her mind – in that old, chaotic, interruptible, internal thought-storm that suffocates and breeds dis-ease. She needs to abreact, to tell.

The narrative that results in the telling provides new knowledge for all who listen. If the narrative can be told and heard (Ricoeur was right), the sufferer can change herself and effect change in others. The illness narrative can be its own kind of “education” (from the Latin for ‘a leading out’) for everyone involved. From sufferer, to healer, to those who study narrative professionally, the reciprocal acts of telling/listening and writing/reading can lead us to different kinds of practice and guide us to new ways of knowing. I will discuss these in the three sections that follow.

The Bug as Humanities

Above, we’ve considered the implications of suffering and not being easily understood by others in relation to “The Metamorphosis.” For my purposes in this introductory chapter, one of the most helpful ideas in Kafka’s story is that Gregor understands more, taps into more knowledge qualitatively, than his family. He has gained insights from his experience that his family could learn from if they were amenable to listening and attempting to communicate; but, because he cannot tell them what he knows, the information is useless, unavailable everywhere except in his mind. This epistemological fissure in the family’s communication dynamic corresponds with a growing problem in American universities that, because it relates directly to the interdisciplinary foundations of this study, needs explication here. Once again, I rely on etymology and “metaphor”: Kafka’s bug will “carry across” my meaning. If Gregor Samsa is the sufferer, possessed of new knowledge but inexplicable to his caregivers, he is also the humanities scholar whose efforts are thwarted, at least in part, by the
inexplicability of his language and the fragmented nature of his approach. Or to tweak this trope a little more plainly, the humanities are the bug.

Kafka’s bug, we should remember, has not always been an awkward thing out of place with his surroundings. Once widely admired for his hard work and valuable contributions to the social and personal well-being of his university-family, the bug awakes to find that his standing has now drastically fallen in their estimation. When he tries to speak in his behalf and describe his agenda, the family acts immediately baffled and suspicious. “Did you even understand a single word?” “[H]e isn’t trying to make a fool of us, is he?” (Kafka 18). The family does not speak the bug’s language anymore, but the bug lingers awhile in denial. Despite the shocking change he has undergone, the bug refuses to entertain “the slightest doubt” (14) that “the alteration in his voice” is anything “more than the harbinger of a nasty cold” (13-14). He believes unrealistically that all will be well soon. But the family continues to revile and isolate him, finds alternate sources of income, and even privileges the public – a few opinionated lodgers who, “since they were after all paying rent there” (43), feel authorized to be rude to everyone. Denial reigns here, at the nature of the problem and the extent of the consequences, until displacement takes over.

Gregor’s new experience and subjectivity are metaphorically flung back at him as he tries to retain his grasp on familiarity and equality. When the bug urgently attempts to communicate his desire to hold on to his desk and the familiar furnishings of his former life, his father angrily “bombard[s] him” with apples, one of which “actually penetrate[s] Gregor’s back” and remains there “in his flesh as a visible reminder” (38) until the day he dies and gets swept out with the trash. This universal symbol of knowledge, hurled
so hard by the head of the family, punctures the bug’s body, rots there, inflames and infects him until he dies. Their disaster of miscommunication is made even more tragic for the bug “because the others…not understanding him, had no idea that he could understand them” (27; original emphasis). Once again, there is insight here – qualitatively different knowledge, if only it can be communicated.

In the American university system, the humanities in general and English departments in particular find themselves marginalized in the university setting and increasingly under negative scrutiny by administrative authorities and the general public alike. Our distinct type of knowledge has been rejected and hurled back. Some administrators devalue the liberal arts based on the bottom-line; some disciplines generally do not draw consistent grant dollars from federal or private sources, nor obtain and sell profitable patents like their counterparts in science and medicine. Additionally, the public, whose opinions weigh particularly heavily in election years, often judges some areas of study in liberal arts to be outmoded or obsolete, and perceives the subjects to be useless when compared to (what they perceive to be) the great utility, prestige, and practicality of disciplines such as finance, marketing, and law. As education becomes increasingly equated with career training and earning potential, the awkwardness of the bug becomes more apparent. Further, many people, both inside and outside of the academy, believe us to be obscurants, producing opaque and pointless discourse for small privileged audiences. (“Do you even understand a single word?” they might ask.) Like the suffering human, the humanities need to construct a new narrative identity that allows them to interrelate with others in (and out of) academia.
more freely and “tell” what they “know” in a way that can be understood and appreciated by everyone.

For English departments, establishing this identity and achieving such comprehension and appreciation has been a complicated endeavor, as yet unsuccessful for many reasons that are frequently discussed in professional journals. For one thing, many English departments have found it difficult to voice a single defense of our mission because we have been “a fragmenting and increasingly atomizing discipline” for “at least the past thirty years” (Kolodny 157), ever inclusive of new kinds of texts – from Indian, Caribbean and Asian, to post colonialist, Marxist, and feminist, to film, comic books, and hypertext media. What we see as the richness of diversity, others may perceive as a scattering of focus to “lesser,” obscurantist topics of study. Because we are trained for and attuned to our work in our fields of specialty, we understand, of course, the value of having diverse specializations and the necessity for this array of focused studies. Explaining that significance to others presents some challenges.

Another reason we may be less respectable in others’ eyes is that our “service functions [composition courses, general education requirement literature courses, etc.], by their very nature, carry little prestige and are simply taken for granted by senior administrators” (159). Ironically or not for the discipline that teaches writing, we have failed at communicating to people outside the discipline the value of these service courses. Through them, we provide students with not only the basic composition skills many lack as entering freshmen, but with training in critical thinking and rhetorical writing necessary for success in any discipline and any career path they may undertake.
– and for the non-career path, the business of life. In other words, we help them formulate and articulate their ideas, challenge their assumptions, reason and argue for their beliefs, and prepare to become better, more engaged citizens. As writing teachers, we teach students new ways to learn and then how to tell what they know. In Gen-Ed literature courses, we immerse students in the study of genres, texts and authors of different eras, thereby opening pathways to knowledge and understanding of human experience that they might not receive anywhere else. These courses prompt sometimes intense discussions of textual challenges, whether stylistic, cultural, historical or personal, and in so doing force students to acknowledge differences, sometimes agree to disagree, and, in general, engage in discourse in more respectful ways than, say, the media or political candidates model for them over the airwaves. The service courses (not to mention all our others) contribute deeply to the “leading out.”

Many people do not understand what we do, and thus yet another cause for our foundering status is that, like Gregor’s family, they do not care to listen. Using language to convince a disinterested public of the value of “English” seems pointless sometimes when many people believe that, once one has learned to speak, read, and write in elementary and secondary schools, further study in one’s native language is superfluous. Never mind that college English courses do not further one’s knowledge of parsing sentences nor encourage further practice of penmanship. Some people (even educated ones) still believe that they do. Widespread misunderstandings abound. All of these reasons – and several others besides – help explain why it is difficult to communicate the value of English studies to skeptical “outsiders,” even if they are members of our own university family.
In a perfect world, we would all understand each other better. Then Humanities and English departments would not need to explain the merits and practicality of what we do. We would all be able to grasp the implications of and agree with an observation like this now-famous one by Stanley Fish:

To the question 'of what use are the humanities?', the only honest answer is none whatsoever. And it is an answer that brings honor to its subject. Justification, after all, confers value on an activity from a perspective outside its performance. An activity that cannot be justified is an activity that refuses to regard itself as instrumental to some larger good. The humanities are their own good. There is nothing more to say, and anything that is said . . . diminishes the object of its supposed praise. (“Will the Humanities Save Us?”)

But such a conceptual answer to this oft-repeated, straightforward question is no longer sufficient. To many who oppose us, that answer only proves their point: humanities departments do nothing, make nothing, and speak too loftily – and then dare to posture when asked to explain, justify, communicate.

On one hand, I agree wholeheartedly with Fish. He is resisting the loud objections and growing numbers of people in the education-as-career-training camp by indirectly criticizing their single-minded insistence on functionality in every area of academia. Not every college discipline, Fish seems to say, should be quantified in numerical terms and held to an accounting of its utilitarian success. Although addressing a different topic, Iain McGilchrist, a neuroscientist, psychiatrist, and former professor of English at Oxford, makes the same point: that humanistic achievements in arts and literature, and even human behaviors, such as smiling and laughing, are “gloriously – useless” (124). “Instead of looking…for utility, we should consider…that finally, through intersubjective imitation and experience, humankind has escaped from something worse even than Kant’s ‘cheerless gloom of chance’: the cheerless gloom of
necessity” (124). Fish is refusing to submit the humanities to judgment by the same business-like, bottom-line criteria that bring other fields so much laud.

But, on the other hand, Fish’s comments make me cringe, because the people in that other camp – people we must interrelate with and possibly depend upon – cannot or will not understand his meaning. To many outside the humanities, except for the bit they both believe and expect to hear (the answer “none whatsoever”), Fish’s response sounds inscrutable, like bug-speak, condescending and practically wrongheaded. (“He isn’t trying to make a fool of us, is he?” they will demand.) To them, Fish seems to be completely circumventing the question.

In actuality, Fish is giving a complete, considered response – but one that only a like-minded audience will be willing to interpret and accept. His reply ignores the needs of the inquirer. In terms of McGilchrist’s mammoth study, a root cause of this kind of communication failure, this ideological divide, can be found in the nature of language within the divided structure of the brain. To put it in grossly simplistic terms, the right and left hemispheres hold and control different values; a thinker’s particular values reflect those of whichever side is dominant in him. For example, like the people who ask this reasonable question of Fish, the “left hemisphere is always engaged in a purpose: it always has an end in view, and downgrades whatever has no instrumental purpose in sight” (McGilchrist 174; original emphasis). But by contrast, like the field of humanities generally, “the right hemisphere…has no designs on anything. It is vigilant for whatever is, without preconceptions, without a predefined purpose. The right hemisphere has a relationship of concern or care (what Heidegger calls Sorge) with whatever happens to be” (174). In short, we simply do not think the same way as the people who want to
define the “purpose” of humanities; we do not assess problems similarly, nor hold similar regard for the outcomes. Fish has given a right-brain answer to a left-brain audience. Like the bug, he can understand their question, but his reply makes no sense whatsoever to the listeners.

As universities more often become structured and run like corporations, and more people demand “justification” for every discipline, the need for the humanities to express its worth in practical terms and plain language will increase. “To put it more sharply, programs and projects that do not conform to this [corporate] logic are potentially outside the safe harbor of legitimization” (Uwe Hohendahl 10). We may find that we must justify ourselves in order to survive. Nationally at this moment, higher education faces a depressed economy, dwindling endowments, downsizing in departments, hiring freezes, retiring baby boomer faculty, dismantling of programs, decreasing state funds, gubernatorial attacks, reduced numbers of courses despite increased enrollment, and abysmally low faculty and graduate student morale. Yet, as bleak as the big picture seems when spelled out this way, for humanities, especially English, the interrelatedness that troubles us, that is so necessary to crafting our new narrative identity, will also, happily, give our work a new “purpose” that can actually be quantified. Collaboration, many experts agree, will generate new knowledge and create advances in education in the 21st century.

For several years now, scholars have proposed “inter- and cross-disciplinary collaborations as a means both to maximize resources and to foster curricular innovation and new research alliances” (Kolodny 155). While some scholars of English may still see no reason to regard their work “as instrumental to some larger good,”
several aspects of it already are and can be shown to be so – justified, if you will – in some relatively new and promising ways. Because the medical establishment has been exploring the uses of literature and art in their academic and professional settings for several years now, we now have opportunities for collaboration that were unheard of two decades ago. Two programs, or movements as some scholars call them, Narrative Medicine and Arts in Medicine, engage collaboratively the expertise of literary scholars, physicians, social workers, anthropologists, psychologists and others to facilitate in a wide array of audiences a deeper understanding of and appreciation for stories, poems, language, and the way they work.

As I noted on page one, a growing body of research demonstrates the importance of stories to healing. Through Kafka’s protagonist and Bauby’s own story, I have attempted to reveal the need for telling or writing one’s story and the obstacles intrinsic to doing so. Now I would like to show how stories – reading, writing, telling, sharing them – matter in the practice of medicine, and what collaborative opportunities exist for English because of medicine’s interest in stories’ “use.” Literary scholars’ particular expertise is uniquely suited for these two movements. Our facility with language, our training in close reading and interpretation, and our experience with writing and teaching texts all enable us to share existing and produce new knowledge with medical experts that can be quantified in meaningful ways.

Below I will examine these two movements so that humanities scholars who may be unfamiliar with them may know more and may possibly be able to identify new research possibilities. These overviews are also necessary background to the chapters that will follow, as I continue to explore the sufferer’s voice in my chosen primary
sources. Through collaborative efforts with departments in medical and social sciences, the humanities can begin to revitalize its image, reconstruct its narrative identity in a way that both “brings honor” to the disciplines and shows what purposes they serve. If to survive we must make our work “practical in the ways that parents and the general public understand the meaning of that term” (Kolodny 159), then these intersections between literature and medicine can do it. By telling what we know in a medical arena, we can find listeners who understand and want to hear, and later explain to other members of the family how profound the study of literature and different forms of writing are in terms of the health of human and whole academic bodies.

**Narrative Medicine**

Throughout this study, I will engage the precepts of narrative medicine, which, with no pretensions to comprehensiveness, I will here give some definition, background, and explication. A practicing internist, a professor of medicine at Columbia, and a PhD in English, Rita Charon coined the term “narrative medicine” to encompass a “new frame for health care” in the United States that “offers the hope that our health care system, now broken in many ways, can become more effective than it has been in treating disease by recognizing and respecting those afflicted with it and in nourishing those who care for the sick” (4). Charon’s book *Narrative Medicine: Honoring the Stories of Illness* (2006) describes with authority, empathy, and conviction: the narrative features that exist in medical practice already; what narrative competence means both to diagnostic accuracy and to the mutual wellbeing of doctor and patient; how this kind of competence can be and is now being accomplished in the overburdened public system; how narrative awareness can be taught in many arenas—not just within the professions, but, for example, to “ward clerks, transport workers, and dietary aides” who
are also “united in the efforts to treat patients” (227); and what the implications will be for narrative medicine’s widespread implementation. As such, Charon’s work establishes the possibility for a fundamental shift in the way medicine is done in this country, and also invites literary scholars to join in the interdisciplinary challenge of facilitating the shift.

In the body of this dissertation, I plan particularly to draw on Charon’s discussion of the “narrative features of medicine” (39-62), along with other sources, to illustrate what I will argue are the intuitive, healing impulses of “psychological confrontation” in mostly autobiographical writings by sufferers in four centuries. Besides the remarkable methodologies that bring the practicalities of the study of literature into the fore of medical education, Rita Charon has distilled for medical students the salient concepts of reflective (autobiographical) writing that, if no longer intuitive, are certainly healing in profound ways. Here, for readers unfamiliar with her work, I provide an overview.

What exactly is narrative medicine? Calling it the “clinical cousin of literature-and-medicine,” Charon defines narrative medicine as “medicine practiced with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness” (vii). This primary, action- and goal-oriented definition works well in medical education settings, serving as a kind of outline for medical students to follow as they undertake the somewhat alien tasks of reading literature and writing reflectively in medical school. Discussing her coinage, Charon expands the definition and explains that the term “narrative medicine” occurred to her as “unifying designation” that could “signify a clinical practice informed by the theory and practice of reading, writing, telling, and receiving of stories” (viii). The former, primary sense of the term focuses on the goal of
narrative competence and its ends; this secondary sense makes clear what instructional
tools or resources might be employed to stimulate the actions that help to produce that
narrative competence. The secondary sense also elucidates the potential role of English
scholars in this movement in medical education. But because narrative medicine is here
again defined from the practitioner’s perspective – as a clinical enterprise, something
practiced by physicians, nurses and social workers – I would like to propose for the
purposes of this dissertation a broader taxonomy that recognizes the teaching of
narrative medicine from the point of view of English professors (and aspiring ones). My
definition may be helpful to those in my field who have not yet heard of narrative
medicine, or who have no connection or prior experience with medical humanities
departments and the instruction of medical students.

From the literary scholar’s perspective, narrative medicine is a discipline, a field
in medical education amenable to close reading of literature, reflective writing, and
narratology, taught with the aim of heightening interpretive skills, and increasing both
self-awareness and empathy in medical students and the professional. Teachers of
narrative medicine must develop pedagogical approaches that are sensitive to the
needs of medical students in their particular institution, as curricula vary widely.
According to Charon, medical students at Columbia read literature – canonical and non-
canonical works – to learn to discern, trace, and appreciate the structures of many
varied forms of narrative. Grounding students in close reading “drills,” Charon and her
colleagues teach students sophisticated textual observation skills which they separate
into five elements: Frame, Form, Time, Plot and Desire – work that builds on and
incorporates the narrative theory of Genette, Rimmon-Kenan, Lubbock, Barthes,
Brooks, Booth and many others (114-127). Students learn to comment on genre and structure and to distinguish the components of narrative, just as in some literature courses: plot, character, temporality, diction, figurative language, and so on. To what end? Young, soon-to-be doctors

realize that our ‘reading’ of disease takes place at the level of the body’s surface and its pathophysiological structure underneath the skin, while our reading of what a patient says takes place at the level of the evident meaning of the words and their implications buried in the clinical and/or personal state of affairs represented. (109)

As health professionals, these students will need to “be prepared to comprehend all that is contained in the patient’s words, silences, metaphors, genres, and allusions” (107; original emphasis). In other words, narrative medicine figures the patient as interactive, intersubjective text. The more “transparent to themselves as readers” medical students and experienced physicians become, the better diagnosticians they will become and, what is often just as significant from the patient’s perspective, the better they will demonstrate compassionate listening skills, too. Charon writes, “We want to equip them with the skills to open up the stories of their patients to nuanced understanding and appreciation” (110). Three decades earlier, writing to propose his biopsychosocial model of medicine, George Engel had characterized these same proficiencies – “to elicit accurately and then analyze correctly the patient’s verbal account of his illness experience” – as “the most essential skills of the physician” (Engel 132). Learning to read literature closely, Charon insists, facilitates stronger clinical communication. Teaching medical students and professionals these abilities will facilitate stronger and more substantial interdisciplinary communication, too.

As students learn to interact with and read their patients, they must evaluate how their own subjectivity contributes to the medical story that is unfolding and how they co-
create this story. Students immediately learn that the patient’s narrative does not come solely from the patient herself. Much of the patient’s story is contained in the voluminous medical records that have accumulated over the years or during the course of the illness. Since, in a hospital setting, many people write in a patient’s chart (the ER admit clerk, nurses at shift changes, residents, various specialists), many “narrators” contribute to this singular tale of suffering, of care given (or not). Additionally, as George Engel pointed out as part of the biopsychosocial model, the patient’s family may also have important details to contribute, pieces of the medical puzzle to fit in; they do not, of course, actually write in the chart, but their oral vignettes often provide relevant information that helps the treating physician fill in missing details. The savvy doctor must read, as when studying a novel, both what is and is not written on the page in its many convolutions and authorial voices, with all the problems of interpretation and credibility. Interpreting complex narratives, always reading between the lines, becomes a doctor’s daily, crucial task.

As an essential part of practicing medicine and contributing to the patient narrative, medical students must learn a new way of writing. Charon takes pains to “acknowledge the enduring place of writing in clinical care” (140), even as she challenges some of the conventions. To give readers an idea of how and why clinical writing must be detached and objective, she provides a discussion of the necessary standards of physicians’ charting. As they enter the rigorous clinical rotation phase of their training, third-year medical students must learn how to write in hospital charts. Grappling with the awesome new challenge of putting theory into practice with sick patients in the hospital wards, these students must also “struggle to master the
complexities of what gets included in the hospital note—how to structure the sentences, how to array the words on the page” (141). Charon explains that, in the U.S., charts share common forms and some conventions. Writers must “impeccably” (141) respect the temporal order of entries; they must strike through empty spaces; they write iteratively, repeating sometimes “almost exactly the same words, perhaps as proof that each author has read prior entries” (141). Moreover, students must learn (or unlearn, if, following most writing instruction, they tend to construct mostly active sentences) always to use the passive voice, so that in the hospital chart, the writer is never the subject. The active “‘I pushed 80 mg of Lasix’” gets necessarily muted to the passive “‘80 mg of Lasix was pushed’” (142).

While English professors would never be called upon to teach the language of charting, they could easily provide a fresh, contextualized understanding of how this language works and why it is necessary in this form in charts. I think many third-year students, under the stress of performing well this kind of writing, might find that a few review lessons in syntax and passive voice come as a relief. The language of charting is restrictive and prescriptive; the language allowed in the Parallel Chart is anything but.

Charon juxtaposes the strictures of professional charting methods with the pedagogic tool she calls the “Parallel Chart,” a narrative written in “ordinary language” (155) by a medical student (or doctor) about the patient he or she is caring for. This chart does not exactly parallel the passive, iterative, dispassionate, scientific-detail-laden medical chart. Instead, it is a form of reflective writing “indexed to a particular patient” (157), through which students explore their own experiences as caregivers and “develop their interior lives as doctors” (155). Thus, this kind of writing allows students
to probe the sometimes incongruous urges and anxieties they experience as empathic humans and authoritative professionals in training, “to recognize more fully what their patients endure” as well as “to examine explicitly their own journeys” (156). Charon considers this textual work both practical and essential. As a form of reflective writing, it becomes a therapeutic channel that allows the students to put order to the entangled thoughts of over-tired minds and make sense of their new roles and responsibilities.

We can see the pedagogical implications of Charon’s ideas when we consider what happens with Parallel Charts during meetings with students. Parallel Chart discussions are interactive and reciprocal meetings in which the writing is shared and studied. Charon’s third-year students (a group of five or so) meet several times a week; one meeting is devoted to reading Parallel Charts aloud and applying the close reading (or listening) observational techniques to the student-author’s writing. Students write about and then read aloud a narrative about their work with one of their patients that week. In doing so, they have the opportunity to share their clinical trials and triumphs with their peers, gaining practical, medical knowledge and, importantly, knowledge of self in this telling and receiving of stories. Hastening to distinguish the Parallel Chart and its function from “‘touchy feely’ or ‘soft’” labeling, which she acknowledges as “the death knell of any innovation in medicine or medical education” (as it seems to be also with English studies, which eschews sentimentality and subjectivity in academic writing), Charon is quick to set ground rules for writing and meeting (156). The practice of meeting does not constitute group therapy (or any psychological intervention); the writing is not a diary or “a general exploration of one’s life and times” (157). Rather, it is a serious component of clinical training through which students forcefully realize “how
central and *exposed* is the doctor’s self in the care of patients” (157; original emphasis) and how one may use writing as a coping tool. As such, Parallel Charts are instruments of professional maturation and indispensable methods for personal growth. Like all reflective writing, Parallel Charts offer writers a critical outlet for pent-up thoughts and emotions and, in this way, help caregivers care for themselves. Further, because they make use of both reflective writing and *discussion* of reflective writing, these meetings create dialectics that press the students into new awareness and new kinds of knowledge about their medical work.

For literary scholars, narrative medicine offers collaborative and career possibilities with medical schools that seem very promising indeed. Although Charon assures readers that she does not think “one needs doctoral training in literary studies” to conduct the narrative scrutiny necessary to lead a Parallel Chart discussion, neither “must one be a physician…to do this, although one does need a modicum of familiarity with and sympathy toward the clinical enterprise” (156). She has created a unique blueprint for wider opportunities for English in medical education—a blueprint which some schools are already employing. Columbia, for example, now offers an M.S. program in Narrative Medicine whose faculty consists mostly of English literature scholars. Penn State Hershey College of Medicine features a medical humanities department with a deep pool of faculty talent and builds humanities requirements into their curriculum. By studying Charon’s model and other models currently in place, literary scholars can discover other ways of establishing collaborative links that could allow us to forge allies in medicine, locate funding and grants for interdisciplinary
projects, and borrow on medicine’s prestige as we demonstrate that the humanities are “instrumental to some larger good.”

**Arts in Medicine**

The growing practice (and creation) of art in health care presents another potential and even more public collaborative opportunity for English and medicine. Whereas the practice of narrative medicine centers on the medical student and physician, Arts in Medicine programs in praxis concentrate *on the patient*. The primary objective of these programs is to offer patients who are enduring a hospital stay the instant pleasures of a variety of expressive arts, including painting, sculpture, music, dancing, acting, and, specifically English-related, poetry reading and writing, journal writing, storytelling and oral histories. As deliberate distractions from the sterile, scientific hospital environment in which so many patients find themselves the passive, objectified recipients of health care, these forms of art grant the ill and injured a joyful means of expression and employ a mode of healing inaccessible to modern medicine. Because relatively few people outside of hospital medicine have ever heard of Arts in Medicine, and because programs vary widely, I want to take time here to explain some of the generic modes of “language arts” applied in these settings.

Increasing numbers of major university hospitals and medical centers – Johns Hopkins, the University of Florida, Cleveland Clinic, Texas Children’s Hospital, to name just a few – have instituted Arts in Medicine (or similarly named) programs in their clinical settings as a means of providing patient care, but also to study the effects of these artistic diversions on illness and pain. For some, art has become a fundamental part of the hospital’s culture and mission. “What began as an investigation of how art might help reduce the stress of hospitalization has grown into a philosophy of care for
an entire institution – a philosophy that centers on the belief that art is an integral component to healing” (Arts in Medicine homepage). Today, this belief in the healing power of art is consistently strengthened and confirmed by ongoing study and peer-reviewed literature that propounds its scientific validity. But experientially, for the patient, and unlike narrative medicine, the science is kept separate from the art and the focus is trained purely on creativity and emotion.

To run such programs with the best interests of patients in mind, hospitals often rely on a corps of volunteers that includes physicians, nurses, medical students, artists (some of whom hold special licensure), and laypersons who simply want to help. Some programs, such as the Arts in Medicine Programs at the University of Florida, employ Artists in Residence who specialize in one or more forms of expressive art and facilitate workshops for groups of patients who share a common illness. These artists also oversee students and lay volunteers, accompanying them to individual patients’ bedsides to put art, literally, into medical practice. Their work affects the patient and her family in immediate and lasting ways:

The dynamic of patient and artist working together fosters open communication, provides avenues for expression, offers opportunities to deal with fear, and strengthens the patient’s sense of control during times of crisis brought about by serious illness. This collaboration serves two purposes: it allows patients and families to participate in activities that enhance the hospital experience and then to display their work in order to personalize the physical setting and make it more inspiring. (Arts in Medicine)

By extending attention and care beyond the patient to her family and immediate environment, as well as their emotional needs, these artists foster improved relationships with the numerous health care workers and providers whose jobs require
interactions that must often remain brief, impersonal, and clinical. The artists are liaisons. The health care becomes "holistic" (Graham-Pole xviii).

Scholars of poetry, literature, and creative writing have and can create many teaching, research, and practice opportunities in Arts in Medicine (AiM), because our expertise is in demand and valued, both by the scientists who are now studying what language can do to and for us physiologically and the sufferers who are creating it for their health. Before we take a closer look at the genres that are central to these opportunities, I think I must stress two points to literary professionals who, by this point, may be feeling uneasy at the prospect of collaborating in alien clinical settings with physicians, social scientists and sick patients.

First, and most obviously, AiM is not for everyone. As humanities scholars, even when we collaborate on a project, we still carry out most of our work in solitary fashion, in a quiet, familiar desk-and-chair environment. Not everyone can or wants to endure close contact with people who are in pain, on gurneys, with I.V. poles and machines all about. The genres I will describe are typically meant to be practiced with patients in clinical settings, but, as I will propose briefly below, there are other, more conventional classroom praxes that interested English professors might develop to support their university's AiM programs. The second, most important point about these cross-disciplinary opportunities is that, whether we work alongside artists, physicians, patients or students, our primary responsibility in this creative-medical process is simply to do

\[1\] I cite the single word here to emphasize the ethos behind it and thus dispel the "New Age" connotation that causes many to disregard it. John Graham-Pole, M.D. is a pediatric oncologist, poet, and the founder of the Arts in Medicine Programs at the University of Florida, who has written extensively on the topic of AiM in academic and lay publications.
what we do best: focus on the text and its author. As experts in reading and writing, our skills are useful in scenes of sickness. Practicing AiM requires only that we illuminate our particular strengths to show how English is very much instrumental to some larger good. In Kafkaesque terms, AiM is a way for the bug to talk so that he’s understood.

The claim that language heals does seem incredible in every sense, yet many physicians unhesitatingly endorse its effects. “I have no doubts that poetry heals,” says Robert Lawrence, MD. “Healing,” in this sense is not curative, of course, but therapeutic, restorative, and often health-giving. Lawrence says, “I think it can help the person who’s sick [to] get a different understanding of what health is about and maybe even what hope is about, and it may even help them find a different path to healing.”

Lawrence is one of the physicians interviewed in an hour-long PBS documentary called Healing Words: Poetry & Medicine that features the AiM Programs at UF. Like some of his colleagues in the film, Lawrence, a pediatrician, writes poetry as a means of giving voice to the sick or injured children in his care; his poetry also provides an expressive outlet for the emotional stress his profession places on him daily. Similar to Charon’s students, who write reflectively about their experiences with patients in Parallel Charts, these doctors write poetry to attend to and mitigate the stressors of their medical practice and thus, as they take care of others, learn self-care in creating their own verse narratives. In the documentary, we learn that the AiM Programs at UF encourage reflective writing for students and staff, and sometimes engage them in self expression through a process called poetry therapy. I characterize this process below for anyone unfamiliar with poetry therapy and to illustrate the interactive, reciprocal nature of this act of creation.
Poetry therapy, one form of the older, established bibliotherapy, “has evolved over the past fifty years as a profession that uses poems and poem-making to help people deal with any manner of physical, emotional, and spiritual trauma” (Graham-Pole 101). This art form is one of the PBS documentary’s main foci. We see certified poetry therapist (CPT) John Fox accompany Graham-Pole, an accomplished poet himself, on his rounds to see his patients in the pediatric oncology wing. On a visit with a young female patient perhaps three or four years old, what ensues is a remarkable exchange between the CPT, the MD, and the child. A friendly conversation diverts her attention away from hospital goings-on to answering questions about her favorite pet cat. Only minutes later, Fox has deftly extracted the most striking images and verbs from her speech and inserted a few connecting phrases. He then reads “her poem” back to her. It’s difficult to tell if the child, barely old enough to speak, cares much for poetry; she seems much fonder of the finger-painting in subsequent scenes. But her parents and the other adults present are all laughing at the verbatim observations captured in the new the poem. Poetry here provides a welcome respite from the agony that must accompany in-patient cancer treatment of one’s child – a bright spot, perhaps, in an otherwise bleak and tense experience. The poem, an artistic rendering of the child’s point of view, becomes a precious record.

It is important to note that such therapy is not a mere exercise in sentimentality. Here, the artist is treating the family while the physician treats his patient. Everyone in the room benefits from the exchange: in emotional ways that are evident by the light mood; in professional ways that result from the parents’ and patient’s decreased stress; and, significantly, in physiological ways that doctors are still researching. The artist,
rather directly, is helping the patient “narrate” her story to the people with whom she is connected (the step that Gregor Samsa can never take). In the next section, I will briefly discuss some of the clinical research that supports the physical benefits of AiM and writing.

For a group session of adult neurology patients shown in the film, the therapeutic process of poem-making is almost immediately life-changing: a Vietnam war veteran is released from the burden of four decades’ worth of unrelenting guilt; an elderly woman imaginatively revisits her beloved childhood home; a young woman recovering from a brain tumor recovers the “words” she thought she’d lost after her speech and memory were affected in surgery. Why is this verbal art project life-changing—why may it be legitimately called a “therapy”? As Fox focuses on the language the patients themselves use to describe a meaningful time, event or place of their choice, he helps them create poetry, voice their story, in their own words. He permits them to sift through what Arthur Frank would call their “narrative wreckage” (53) and helps them find new meaning, even beauty, in it. Thus, this gentle analysis acts as a verbal twist of the human release valve, letting loose pent up poisons, freeing the mind to wander home again, liberating language from scarred recesses of the brain. It is practical proof that the creation and reading of poetry is “a cognitive enterprise with real-world consequences” (Brooks 35). Although many might say that poetry needs no such “practical” legitimation, Fox’s therapy nevertheless demonstrates it.

Although each is more multifaceted and nuanced than I have space to describe, the other English-related genres of AiM, which require no certification or licensure to conduct, are more familiar and need less explication here. Poetry writing and journal
writing (for patients and their families) are both encouraged and guided in AiM programs. Either form can be spontaneously created by the writer, or prompted and directed by the artist in one-on-one or group sessions. Journal writing in the latter category is now often structured in line with the prompts given in many of James Pennebaker's clinical studies: to get the writer to discuss a traumatic event not just factually, but also to explore her emotions at that time and, importantly, in the present.

Storytelling is the most ancient and informal of the genres and most often takes place among groups. Graham-Pole illustrates the dynamics of storytelling as he recounts one particular Thanksgiving day with patients cooped up in the cancer ward, and extols the particular benefits of this informal type of AiM for patients and staff alike (3, 83-4). Throughout A Fish in the Moonlight, a book both of and about storytelling in a bone marrow unit, Sidney Homan corroborates these claims of the reciprocal nature of healing as he ponders the salutary effects of storytelling on himself, the teller.

Another form of storytelling in AiM, one often carried out by geriatric and terminally ill patients, is the oral history. As in poetry therapy, receiving (not taking) a patient’s oral history requires careful listening skills and quick writing by the attending artist, some of whom prefer to use tape recorders to avoid missing a word. Artists will prompt patients with open-ended questions if needed, but find that many are eager to recollect and re-collect salient moments of their lives. The most attentive artists strive for authenticity; they capture the patients’ idiosyncratic speech and later transfer it to the page: their grammatical anomalies, uniquely personal diction, even their specific regional dialect. The artist’s aim is to preserve, as nearly as possible, the “voice” of the patient as she narrates her own “story,” and to produce a written narrative that endures.
I have described these genres of Arts in Medicine to demonstrate to literary scholars some of the ways that narrative is used therapeutically in medical settings, both as a way to support claims I will make throughout this dissertation and in the hopes of stimulating further conversation about collaborative possibilities. Although it is far beyond the scope of this project to propose and particularize the specific means of such cross-disciplinary partnerships, I would like briefly to recommend (in the spirit of Annette Kolodny’s article) some ways to achieve it.

First, English departments could work with AiM faculty and artists to create general education courses centered on these genres, and visibly recruit for them, that would draw a base of students from undergraduate, pre-nursing and pre-med programs. Second, because AiM’s growing prominence and relevance generates clinical research, English faculty whose research interests overlap with medicine’s studies of the effects of poetry and writing could partner with these clinicians and perhaps help engender new research paths altogether. Faculty might find that grant monies, even in this faltering economy, exist to support research efforts in this area of study. Third, faculty and graduate students could facilitate these “language arts” in various support groups, bringing this brand of AiM to an out-patient setting. Finally, presenting public, non-credit workshops could provide newsworthy community service and bring in a bit of departmental revenue. Any of these collaborative steps could highlight both our work and medicine’s claims that outstanding patient care depends and *thrives* upon a reinforcing compromise between the empirical data of science and the more mysterious, aesthetic powers of art.
The Intersection of Narrative Medicine and Arts in Medicine: Reflective Writing

In the previous two sections, we looked briefly at ways that medicine is making “use” of literature and writing to improve the clinical competence and self-care of doctors, in addition to their patients’ experiences and well-being. In this section I will discuss “reflective writing”: the junction of narrative medicine and the language arts employed in most AiM programs, as well as one of my subjects of focus on the featured texts in the following chapters.

Reflective writing is referred to by many names by the many scholars who have characterized it in books resulting from their research: “life writing” (Couser); “personal writing” (J. Berman); “self-storying” (Frank); “directed writing” (Pennebaker); structured writing; illness narratives; pathography; trauma writing and others. All of these designations have in common emotional disclosure about serious illness and/or trauma and elements of autobiography. I have chosen to use the term “reflective writing” most consistently in this study for a few reasons. First, because “reflective” encapsulates many of the other adjectives (i.e. “life,” “personal,” and “self”) and contains the verb “reflect,” it is a fuller descriptor, suggestive of both genre and a specific type of authorial action. Second, the term shortens Gillie Bolton’s “reflective practice writing,” but adheres to her notion that this writing is a crucial element of the wider methodology of “reflective practice,” which is, in part, “learning and developing through examining what we think happened on any occasion, and how we think others perceived the event and us” (7). Bolton, a professor of English at Kings College London, has developed, refined, and expanded reflective practice for a variety of professional and academic contexts since 1989. Third, I prefer “reflective writing” because of the metaphorical significance of “the Venetian mirror” Georges Gusdorf describes in his landmark 1956 essay, observing
that the genre of autobiography is “the mirror in which the individual reflects his own
image,” (33) of which more below.

Whatever appellation we choose, what reflective writing does remains the same.
And “[w]hat is clear is that narrative does things for us” (Charon 39; original emphasis).
Thus, putting our stories into writing allows us to accomplish a multitude of
psychological goals: to re-shape the “disruption of self” that occurs with illness and
suffering (Brody 47); “to construct a framework of meaning to understand and thereby to
control a frightening experience” (Hawkins qtd. in Brody 90). This act of writing functions
to order the disorder of the sufferer’s chaotic internal monologue; it is a way to “simplify
our experiences” (Pennebaker 97), by organizing and summarizing. By writing
reflectively, we acquire new types of knowledge and new ways of knowing, like
Charon’s medical students do in their Parallel Charts. It is a “method of externalizing”
that preserves “the memory and value” of traumatic events (98). It is a technology for
problem-solving – or problem resolving. Reflective writing, like any good narrative,
“moves us to a resolution” so that our thoughts can be “psychologically complete” (103).
And, of course, it provides a means of venting, releasing emotions that take great effort
to inhibit and can be harmful to our health.

Reflective writing, as we’ve seen above, has gained academic currency over the
last two decades, especially since numerous research studies conducted in the social
and medical sciences have shown lasting beneficial effects on the writer. As public and
administrative attitudes of late demonstrate a clear preference in academics for science
over the humanities, and “reflect a growing tendency within the academy to identify
intellectual activity and achievement with the production of visible, measurable, and
more or less immediately applicable knowledge” (Herrnstein Smith 24), literary scholars have a perfect opportunity to participate in a different brand of intellectual activity that teaches immediately applicable knowledge and achieves meaningful, lasting results that can be quantified. Scientists are studying how, and their research indicates that, reflective writing plays a physiologically and psychologically significant role in healing the human body and mind.

James W. Pennebaker’s work is central to most of these emerging lines of scientific study. As a young psychologist, some of Pennebaker’s early work focused on the effects of confession and inhibition. He noted a relationship between psychological events and biological activities when, conducting polygraph examinations, he measured marked improvements in the subject’s blood pressure, heart rate, respiration, and skin conductivity when the subject finally confessed and “psychologically confronted” the event. Conversely, he learned that inhibiting the truth (or lying, in some cases) “requires physiological work” that “affects short-term biological changes and long-term health” (9). This early work led to further study in which Pennebaker began to question whether Breuer and Freud’s ideas about catharsis and the “talking cure” could work without a listener or psychoanalyst. He wondered if the abreaction needed for catharsis could be achieved by the sufferer alone, through writing. Since then, he has teamed up with his graduate students, as well as experts in other fields, to study “directed writing” and its effects on health.

The results of the first study showed that the student-subjects “who wrote about their deepest thoughts and feelings surrounding a trauma evidenced” a “50% drop” in illness rates, as measured by their monthly visitation rates to the student health care
center, a finding corroborated by the students themselves in questionnaires mailed four months after the study (34). In a later, similarly designed study conducted with immunologist Ron Glaser, the clinicians drew blood samples from subjects – both before and six weeks after the study – to measure immune functions, the action of T-lymphocytes. The group whose writing combined both the facts and their emotions about a traumatic event “evidenced heightened immune functions compared with those who wrote about superficial topics” (35-7) and, once again, they made fewer trips to the college infirmary. Numerous clinical trials in the last two decades have been conducted to explore the effects of reflective writing on immune functions.

While Pennebaker’s studies recruited and tested only healthy subjects, soon physicians began testing reflective writing’s effect on the symptoms of chronically ill people. The first of these clinical trials was conducted by two psychologists, a pulmonologist and a rheumatologist through the SUNY-Stony Brook School of Medicine. Their study, published in the Journal of the American Medical Association in 1999, concluded that “[p]atients with mild to moderately severe asthma or rheumatoid arthritis who wrote about stressful life experiences had clinically relevant changes in health status at 4 months compared with those in the control group” (Smyth, et al 1304). Though they found these gains to be “beyond those attributable to the standard medical care that all participants were receiving,” the physicians acknowledged the need for further study to be able to determine the mechanism facilitating these changes. Other clinical studies with chronically ill patients have since followed.

“How does it work?” John Graham-Pole shrugs and repeats the question to the camera in the PBS documentary (Healing Words). How does writing heal? The
mechanism is still unknown, but Graham-Pole proffers the physiological hypothesis that he and his colleagues currently favor: endorphins. Endorphins are “feel-good proteins,” he says, “our bodies’ valium.” Experts think that these natural opioids are released in the brain when a person engages in any number of pleasurable activities, including art-making and reflective writing. In his book, Graham-Pole discusses the importance of this “mind-body connection” (33) as he acknowledges the published works of Dr. Robert Ader (1981) and Dr. Candace Pert (1997) in the field of psychoneuroimmunology. Pert’s so-called “‘molecules of emotion’ have been shown to have potent effects on the immune and hormonal systems” (Graham-Pole 34). Because plenty of “evidence now shows that [the] conscious and unconscious mind are linked to [the] unconscious physical processes, for good or ill” (33), the search continues for the structures and reasons underlying the links. How poetic that medical science is slowly revealing the mysteries of brain and body that can help us understand humans’ intuitive responses to poetry. Walt Whitman could never have imagined in 1855 how thoroughly attuned he was to his muse.

Coda

Gregor Samsa’s first words – “What’s happened to me?” – signify a natural ordering impulse. As we have seen, that his experience is never narrated is a tragic failure of caregiving on the part of the family. To his family, his ordeal is never voiced, never explained. Narrative does not have a chance to solve, or resolve, this problem. No one asks any questions and, critically, no one learns a thing. Relieved to be free of the burden of caring for him, Gregor’s parents are quietly watching and idly making marriage plans for their now-doted-upon daughter. In Kafka’s final sentence, they take it as a “confirmation of their new dreams and good intentions when” the girl stands up and
stretches “her young body” (Kafka 52). Forget that young Gregor was full of dreams and good intentions; forget that his bodily metamorphosis struck him completely, without warning. The Samsas do.

But the author was keenly aware of their folly. It is important to realize that, although he has stripped the bug of all agency, Kafka has given himself a voice here: he was three years into a diagnosis of tuberculosis when he penned this story. No surprise that he creates a character who is similarly situated and of a comparable age. In fact, “Gregor’s apartment and living arrangements are very similar to Kafka’s own at the time of writing” and even the surname is linguistically analogous to his own (Appelbaum iii). The sad demise of this author so like his protagonist lends a different kind of urgency and a disquieting realism to this surrealist piece of fiction.

I have been at pains to explain the ways narrative is used in medical settings, because I need this grounding as I turn to a discussion of, primarily, literary texts. That is, in what follows, I will conduct an examination of medicine in narrative settings. Sifting language, creating and analyzing narratives to glean knowledge from them – this is what we do in English. The grounding above in narrative medicine and reflective writing will allow me to approach these texts in a way that privileges the insights of the sufferer. By contextualizing his or her narrative within the milieu of its social, political, and medical history, and analyzing it against one or more of Charon’s five features of narrative in medicine—temporality, singularity, causality/contingency, intersubjectivity, and ethicality—I aim to grant these literary sufferers a different kind of profundity, relevance and vitality.
Attempting to make sense of the world when confined in chaos – in mind, body, and relationships – is the natural ordering impulse of the sufferers in these texts. Indeed, as storied entities, humans know no other way than narration to put the events in order. Although I can offer no scientific evidence that healing occurred in the writing of these literary narratives, clinical evidence and the conviction of medical specialists tell me that something restorative happens in the body when we engage the mind in this storying process. What I can do is read below “surface-level,” listen to the language and learn, and help others to, too. As Robert Scholes observes, “Humanists must insist on their uniqueness, the differences between what they do and scientific study, while at the same time learning more about the sciences and how to use them intelligently” (9). In this interdisciplinary study, I will attempt to do just that.
CHAPTER 3
JOHN BUNYAN: TEMPORALITY AND *GRACE ABOUNDING*

And be not conformed to this world: but be ye transformed by the renewing of your mind, that ye may prove what is that good, and acceptable, and perfect, will of God.

—Romans 12:2

“There are two silences. One when no word is spoken. The other when perhaps a torrent of language is being employed . . . The speech we hear is an indication of that which we don’t hear.”

—Harold Pinter
“Writing for the Theatre”

Resolving that he would “be not conformed” to the religious dictates of the Restoration, John Bunyan was imprisoned and served a lengthy sentence during which he was “transformed by the renewing of [his] mind.” Bunyan writes to make sense of life and salvation and discovers that language is both his captor and his release. “O, if it were not for these three or four words, now how I might be comforted!” (60), he laments as he struggles, years into the torturous conversion experience recorded in his *Grace Abounding*, ¹ to decode and interpret a Bible verse that might soothe his nerves and bring relief “now.” By this point in his undulant narrative, with his hopes having perpetually risen and fallen, Bunyan has tried and failed numerous times to find certainty of his salvation in any one moment or any one verse. His temporal preoccupations and exegetical crises, as I shall argue below, are symptoms of his depression and anxiety, as well as a means of self-fashioning and survival. Examining these crises will also help me illustrate, as counter-examples to my poetics of healing,

¹ All citations from *Grace Abounding* come from the 1998 Oxford edition, John Stachniewski and Anna Pacheco, editors.
how Bunyan’s version of “close reading” defeats his attempts at wider understandings of the scripture and keeps him “sick in [his] inward man” (73).

In their respective professions, literary scholars, physicians, and, as we see in his spiritual conversion narrative, preacher John Bunyan, all engage texts in similar ways; they all closely read, analyze, and then authoritatively communicate the textual findings. For literary scholars, close reading allows for careful, sustained scrutiny of particular features and passages of a text that unveils its meaning. As a conduit for New Criticism, a school of literary theory most popular in the mid-20th century, close reading imports the text’s meaning solely from the words on the page and their structure. New Critics disregard other channels of analysis and knowledge-gathering from the text, such as the author’s narrative intention, any biographical information about the author, historical and cultural contexts and others; these are invalid methods of interpretation in New Criticism. Today, though, most literary scholars draw freely from a mixture of other theoretical wellsprings—feminism, psychoanalysis, New Historicism, for example—to come to their analytical conclusions. While they still use and value close reading and its emphasis on the particular, scholars recognize the need for tools that allow them to interpret the text’s “big picture.”

In all studies within the realm of narrative medicine, we must understand readers and their texts more broadly. For physicians, the patient is the text. Too often, however, only the disease—what is quantifiable or objective—gets a close reading. In other words, as S. Kay Toombs writes, “the patient’s illness is understood to represent a pathoanatomical and pathophysiological fact” (“Temporality” 227), while the personal, “familial, community, and societal consequences of disease” (Engel qtd. in Charon 26)
go largely undetected and undiscussed in the medical setting. Like New Criticism, which evolved as a reaction to earlier, subjective, philological schools of literary-theoretical thought, this objective, histology- and pathology-based approach to medical treatment evolved from earlier modes in which, as N. Jewson observes, “disease was defined in terms of its external and subjective manifestations rather than its internal and hidden causes”\(^2\) (228). To recognize this deficit implies no disrespect: the astounding advances of medical science and technology are obvious and valued by most people, physicians and laypersons alike. However, physicians’ attention has been for some time “directed away from” the whole person, “the living totality” (231), who presents not merely with the biological disorder, but most likely with some psychological miseries, too. According to the ethos of narrative medicine, the physician needs a wider, more inclusive reading—of soma and psyche alike, and other sources, too—if he is to be able to fully comprehend and interpret the patient’s needs. In this mission, close reading, though essential, is not enough by itself for the physician or the literary scholar to make a comprehensive assessment of the text.

It is not enough for John Bunyan either, the self-professed “chief of sinners,”—not enough as he labors to interpret Bible verses, nor even when his own life is offered up as the text. In his Preface to Grace Abounding, Bunyan exhorts his congregants to examine what God has done for their souls “by reading his work upon me” (4), thus figuring himself, along with the written autobiographical narrative that ensues, as a text

\(^2\) See N.D. Jewson’s article “The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870” for a discussion of this evolution of medical knowledge-gathering. Jewson traces the social structures of the eras in question and the growth points of medicine, from (the earliest to most recent) Bedside Medicine to Hospital Medicine to Laboratory Medicine.
to be studied for their spiritual edification. But for his Puritan audience then and for scholars today, reading John Bunyan—the autobiography and the man—is a complicated task, in part because the distinction between applied, specific close reading and more comprehensive, inclusive understanding of the text remains unclear for Bunyan throughout most of his narrative. As he sifts through his Bible and extrapolates from decontextualized passages to determine whether he is one of God’s elect, he vacillates between moments of perfect clarity and joy, and long periods of being “confounded, not knowing what to do nor how to be satisfied in this question, whether the Scriptures could agree in the salvation of my Soul?” (60). Reading the man John Bunyan requires that we pore over his written narrative, study the other known facts of his life, and speculate judiciously about the gaps in the record. To comprehend Elstow’s poor tinker properly and to understand how he achieved lasting prominence in literary, religious, and political history—despite receiving little education and pastoral training, despite suffering repeated trauma and sustained persecution—Bunyan scholars must interpret the text’s lacunas as often as its content.

I will argue in what follows that what Bunyan ultimately learns from considering the meaning of the whole Biblical text, as well as what we can learn from reading Bunyan as a “living totality,” can be viewed as a lesson in miniature of the usefulness of narrative competence as championed by Rita Charon and many other medical humanists today. What does Bunyan’s 1666 spiritual autobiography have in common with modern-day medical practice? Both rely on narrative forms, and both require acts of reading and interpretation if they are to be understood. Both also employ a fundamental set of narrative parts or features that make the reading and interpretation
cogent. Crucially, both challenge readers to see the “big picture,” to appreciate the whole before making final determinations.

Thinking about a seventeenth-century conversion narrative in terms of reflective writing or narrative medicine may seem counterintuitive to many twenty-first-century readers. It is for precisely this reason, however, that I choose this genre and text: specifically to demonstrate that, even in a genre whose works generally conform to prescribed structural patterns, we can trace the concurrently universal and individualistic ordering, “storying” impulses of the sufferer, as well as the healing effects of writing it all down. Moreover, in this text we can especially “hear,” coinciding with his effort to narrate a painful past, the author’s struggle to find and embrace his authorial voice. This act of writing is for Bunyan a method of coping with the competing realities of his traumatic young adulthood, his deeply troubling conversion experiences, his interrupted ministerial works and, crucially, his lengthy incarceration. *Grace Abounding to the Chief of Sinners*, in other words, is among other things a work of reflective writing, a work that ponders closely “the Experience of former days” (Bunyan 38) and accounts for the writer’s feelings about those experiences then and “now.”

While several noted scholars have written about the intriguing autobiographical elements Bunyan incorporated into his more successful and better known fictional works, I direct my focus to the thoughts and events that the author chooses to relate as his own—and to those he chooses to ignore. In this chapter, I will show how Bunyan’s text reveals his attempts to work through and narrate the most publicly relevant facts of his life, namely his conversion experience, while simultaneously suppressing the most traumatic events of his young adulthood. In so doing, I hope to demonstrate that, as
Bunyan struggles to establish a poetics that works for both his congregation and himself, he stifles and still suffers from his past, carrying with him the “inward pollution…that was [his] plague and [his] affliction” (25). His inability to tell the whole story, completely “lay down the thing as it was” (5), contributes to his myopic reading of scripture and, more troubling, provokes a terrible anxiety that twists time out of joint for John Bunyan.

**Temporality: Charon’s First “Narrative Feature”**

By first remembering that illness and trauma are disruptions to normal life that can transform us from active subjects into diminished object-selves, from acting to being acted upon, we can more easily see that one’s perspective on temporality depends on one’s physical or mental health. In all of the above dyads—doctor/patient, reader/text, reader/writer—each half of the pair experiences and presents the temporal facets of the shared relationship differently. Bunyan’s narrative covers the thirty-eight years of his life at the time of writing, but the text takes only a matter of hours to read, and took about year to write and publish. In the temporal obscurities of *Grace Abounding* we can hear the author still grappling with the difficulties of unresolved past traumas, present dangers, and future fears and uncertainties. To illustrate temporal concerns in medicine, Charon points out that “doctors equipped with temporal sense might not make patients wait through a weekend for the results of a biopsy, realizing that the fear of an illness is almost as painful as the reality of it” (44). Again, while the subject matter—conversion narrative, narrative medicine—differs in obvious ways, we learn from both to consider and negotiate dissimilar perspectives of temporality and how this “narrative feature” instructs us in matters of illness and trauma.
As a work of reflective writing, Bunyan’s 1666 spiritual autobiography presents clear evidence of psychological distress and temporal confusion that has received much attention, even clinical attention, from Bunyan’s biographers. For example, in Richard L. Greaves’ biography *Glimpses of Glory*, he carefully and extensively assesses Bunyan’s psychological state through his affective language and reported behaviors. Reading *Grace Abounding* alongside the *DSM-IV*, Greaves determines that the Bedford preacher likely suffered from dysthymia and dysphoria: mild, but persistent forms of depression and anxiety that were periodically overladen by major depressive episodes (30-74). Other noted scholars have written about the evidence of Bunyan’s psychological troubles, too, rebutting the commonly held critical view that the agonies he expresses in the text are merely conventions of the genre meant to emphasize the intensity of the writer’s conversion experience. Roger Sharrock notes in *Grace Abounding* “significant departures” from the conventions of seventeenth-century autobiography (xxxi). He remarks that the conversion years take up “almost two-thirds of the book”—with other sections atypically shorter in length—and are “devoted largely to [Bunyan’s] moods of despair” (xxxi) and emotional agonies about whether he was one of the elect, chosen by God to savor the “Milk and Honey” that lies “beyond this Wilderness” (Bunyan 5).

Bunyan’s narrative is qualitatively different from his peers’ in the force and realism of its affective expression, as well as its lasting literary value. “It is the unflinching excavation of the abject” that separates *Grace Abounding* from so many other spiritual autobiographies published in the seventeenth century; Bunyan “takes the reader down

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3 Scholars “such as Josiah Royce, William James, Esther Harding, . . . Vera Camden and Vincent Newey” (Greaves viii) have commented extensively on Bunyan and mental illness.

4 This view is held by scholars such as William York Tindall and Paul Delany, among others.
into that experience of knotted feeling” (Stachniewski xiv-xv) that he cannot himself escape.

Scholars have also remarked upon the temporal oddities of Bunyan’s narrative. The pages relating his conversion years are a torrent of language, steeped in temporal phrases and references that challenge readers in search of a progressive timeline. The relation of a mere moment may stretch over paragraphs while, at other times, whole years seem to pass in a single sentence. Greaves’s meticulous, moment-by-moment account of time in *Grace Abounding* (33-35) reveals that, “if we take [Bunyan’s] timing literally,” one period of his conversion story “occupied approximately seven years,” though Greaves’ “provisional chronology allows only four” (34). In this temporal accounting, Greaves observes that, “[a]lthough Bunyan thought it necessary to locate his experience in time, he periodically seems to have lost his sense of it, as reflected in vague statements about its passage” (35). Bunyan frequently uses indefinite phrases to describe his memory of thoughts, feelings, and events: “in little time,” “for some considerable time” (9), “about a moneth” (11), “upon a day” (14), “About this time” (16, 18), “a pretty while” (22), and so on. Bunyan’s protracted conversion experience unfolds in fits and starts—a narrative comprising what Christopher Hill calls a “chronology [that] is at best imprecise, at worst chaotic” (63). Readers must sift through Bunyan’s spare accounts of concrete, external life events even as they attempt to sort out the rapid swings of hope and despair that attend his internal, spiritual travails. We feel the ups and downs; we partake of the disorder of temporality and mood while we puzzle over them. In this way, despite its many compelling literary attributes, the text can be tedious for those who try to plot events in linear time.
As a framework for thinking about the temporal complexities of Bunyan’s text, I turn to a passage from its penultimate section, “A brief Account of the Authors Imprisonment” (87-93), that finds Bunyan worrying about his prospects in language engaging both temporality and trauma. Writing from the Bedford Gaol, Bunyan recollects how he had foreseen that he would face incarceration after the Restoration and what troubled him most about this impending hardship:

Before I came to prison, I saw what was a-coming, and had especially two Considerations warm upon my heart; the first was, How to be able to endure, should my imprisonment be long and tedious; the second was, How to be able to encounter death, should that here be my portion” (88).

In context Bunyan’s “considerations” seem straightforward enough, yet they belie the complex nature of the anxieties he was contending with as he wrote from prison, which will be discussed in greater detail below. We should note in this passage, first, that even before his imprisonment in 1660, Bunyan feared that weakly defined policies enacted after the Restoration could gravely affect or possibly end his life. Second, these comments help readers see that, while he understood his nonconformist preaching in the 1650s to be unquestionably problematic for his freedom, Bunyan was ultimately and persistently worried about his expenditures of time: the time in his life “before” his conversion and ministerial works—the time back “[in those] days” (8) when, as a young man, he found merely witnessing others reading “books that concerned Christian Piety…would be as it were a prison to me” (8). Third and most important, this passage touches on the mystery superseding Bunyan’s earthly, time-bound concerns—the crux of his lingering fears and existential dread—the moment when he must pass into Eternal Time. Bunyan’s preoccupation with time-after-death is expressed by turns frenetically and expansively throughout his conversion narrative and “confession.” The passage
encapsulates the themes of imprisonment, fear of death, and troubled fixation with time—all sources of great anxiety that Bunyan addresses repeatedly in his autobiography.

So it is paradoxical, for a work so preoccupied with time and seeming to attempt a linear narrative structure, that Bunyan’s narrative time frame is discordant, revealing ambiguities and discrepancies that point to the symptomatology of the aforementioned mood disorders identified by Greaves. Clinical psychologists report that intense worry, a symptom of both depression and anxiety, prompts “uncontrollable, abstract thought which [develops] as a result of unresolved emotional experiences from the past,” and can hinder our ability to articulate those experiences clearly to others (Borkovec, et al. “Disclosure” 52). Worrying about how and what to disclose from a particularly traumatic period of his young adulthood makes Bunyan unable to tell his whole story. Worry is Bunyan’s defining characteristic in this narrative, as he seeks certitude of his salvation before “that day and that hour” (4) of grace have passed him by. Preoccupied with time, and vague about its passage, Bunyan’s narrative deals heavily in abstractions; he toils to situate and communicate his mental and affective states within snippets of experiential time, as he searches for certainty of Election.

We can see how the dysthymic and dysphoric symptoms noted by Greaves manifest themselves in the narrative’s strained timeline in one of Bunyan’s numerous bouts with uncertainty and exegetical skepticism. Debating with himself the central question of how to tell if he is Elected or not, Bunyan plunges into a period of doubt in which he appeals to God for comfort and apparently receives instead counsel from Satan:
O Lord, thought I, what if I should not [be Elected] indeed? it may be you are not, said the Tempter: it may be so indeed, thought I. Why then, said Satan, you had as good leave off, and strive no further; for if indeed you should not be Elected and chosen of God, there is no talke of your being saved. (20)

Though this “conversation” seems to take place in real time for the reader—that is, it feels like a natural and actual conversation—it in fact takes place outside of time, narratively and realistically speaking. This conversation that has only a psychic reality precipitates the more objective passage below, which is preoccupied with time and very shortly follows one of the book’s most compelling scenes: a “Dream or Vision” (18) that takes place at an indeterminate time in which Bunyan “was comforted” and felt “exceeding glad” (19). A flash of doubt and the Tempter’s discouraging words send Bunyan into a tailspin of emotion during which the temporal structure of the narrative becomes even more harried, if specifically named:

By these things I was driven to my wits end . . . Thus therefore for several dayes I was greatly assaulted and perplexed, and was often, when I have been walking, ready to sink where I went with faintness in my mind: but one day, after I had been so many weeks oppressed and cast down therewith…that sentence fell with weight upon my spirit, “Look at the generations of old, and see, did ever any trust in God and were confounded?” (20; emphases mine)

When Bunyan recalls this verse, he is again “greatly lightened, and encouraged in [his] Soul” and “thus at that very instant” he begins to seek the verse in the Bible, but cannot find it (20). Poring over the whole text and even consulting other believers to no avail, Bunyan continues to search “above a year” for the verse that seems to hold his eternal fate. At last he locates the scripture, somewhat to his discouragement, “at the first,” in one of the books of the Apocrypha (Ecclesiasticus)—“not in those Texts that we call holy and Canonical” (21). “After this,” however, the qualified “comfort” Bunyan feels at finally tracing the elusive passage is shattered “by that other doubt [that] did come with
strength upon me”: “how if you have over-stood the *time* of Mercy?” (21). He is once again seized with uncertainty, and rephrases and repeats three times in a single paragraph his unyielding fear of being “too late” for the “*day* of grace” (21).

While the Ecclesiasticus incident—if a series of events so fractured can be called an incident—features emotional undulations typical of the genre of the conversion narrative, Bunyan’s temporal relation of them is distinctive, disturbed and a bit disorienting. Within the space of three pages, we have seemingly traversed the space and events of about two years, including an actual, comforting-then-unsettling Dream or Vision whose duration is unknown and which takes place at an unspecified time; a frightening, imaginary, moment-by-moment conversation with the Tempter; an almost overlapping sequence of oppressing days and weeks; an instantaneous compulsion to search for the text of a heartening verse that might vouchsafe his election to Eternal Time; a search that lasts more than a year—and is successful!—but then is immediately followed (narratively, in any case) by gripping, almost convulsive fear that the day of grace is already past. Bunyan’s “great distress” erupts from “comfort” (21) again, and all the ups and downs are uneasily folded into that nebulous span of time beginning (when, exactly?) perhaps with the beautiful Vision of the sun-drenched mountain as the symbol of “the Church of the living God” (19). Discussing these swings of mood and spiritual certainty, Roger Sharrock notes that almost “immediately after [Bunyan] has received some relief and token of his election, he is buffeted by another wave of temptations” (xvii). And so the whole narrative goes, a litany of “castings down and raisings up” (Bunyan 3), causing the reader to find it “extremely difficult to say when Bunyan is converted” (Stachniewski xix).
Anyone closely reading the text might assume that the above dream-vision,⁵ for example, illustrates the moment of God’s grace, the day of Election for John Bunyan, particularly given the symbolic rebirth and entry into the Church of the living God it depicts, and the way it echoes his first truly meaningful spiritual encounter with the poor women of Bedford. In the dream-vision, Bunyan describes seeing some of the Bedford congregants sitting on a warm “Sunny side of some high Mountain” that was encompassed by “a wall,” while he was alone, “shivering and shrinking in the cold” and “dark clouds” (18) outside of it. Because his “Soul did greatly desire to pass” through this wall, he begins “prying,” trying to discover “some way or passage” to get through—“but the passage [is] very straight and narrow” (18-19). At last, after “great striving” and “difficulty,” or laboring, we might say, through a “passage. . . wonderful narrow,” he “at first did get in [his] head, & after that by a side-ling striving, [his] shoulders, and [his] whole body” (19). It seems quite clear that Bunyan is symbolically born again in that moment; he is “exceeding glad” as he sits “down in the midst” of his Bedford friends, and is “so comforted with the light and heat of their Sun” (19) or, we may surmise, their Son. But Bunyan does not read this dream-vision to confirm his actual salvation, for he is once again “in a forlorn and sad condition” after he interprets the symbols and determines that the wall figures as “the Word that did make separation between the Christians and the world,” and the narrow “gap which was in this wall [is] Jesus Christ, who is the way to God, the Father,” who is represented by the Mountain and Protestant Church (19).

⁵ In the first edition, Bunyan announces this episode as “a Dream or Vision represented to me.” In a subsequent edition, he alters this to “a kind of Vision, presented to me.” I use the term “dream-vision” here purely as shorthand.
That he has just been safely delivered through the narrow gap seems to have been only a dream, but an illuminating one for readers even if the dreamer remains in the dark. Contrary to Bunyan’s Pauline model, and to several scholars’ insistence on the conventionality of the text’s narrative structure, in *Grace Abounding* temporal and evangelical registers are destabilized, resulting in a conversion narrative that wanders from a linear order and a single, definitive *kairos* of conversion. We see throughout the remainder of his narrative how literally he interprets the Word to be an inscrutable obstruction between the sunlit Christians and the darkened sinful world, between absolute certainty of his salvation or damnation, and we feel how viscerally he suffers as he tries to determine “How many Scriptures are there against me?” (60).

Bunyan’s pained narration gives us myriad examples of his compulsion for closely reading the Bible as a determinant of eternal life or death. Depression and anxiety complicate his struggle to read with keen-edged precision and arrive at the “correct” interpretation. Some readings of verses that heave him into long periods of despair are quite like his temporality—fractured, vague, and decontextualized—yet display his literary ingenuity in vivid imagery and metaphors. I quote at length here to illustrate this interplay of too-close reading, temporal fixation, and despondent mood:

And truly I did now feel my self to sink into a gulf, as an house whose foundation is destroyed. I did liken my self in this condition unto the case of some Child that was fallen into a Mill-pit, who though it could make some shift to scrable and spraul in the water, yet because it could find neither hold for hand nor foot, therefore at last it must die in that condition. So soon as this fresh assault had fastened on my Soul, that Scripture came into my heart, *This is for many days*, Dan. 10.14. and indeed I found it was so: for I could not be delivered nor brought to peace again until well-nigh two years and an half were compleatly finished. Wherefore these words, though in themselves they tended to discouragement, yet to me, who feared this condition would be eternal, they were at some times as an help and refreshment to me.
For, thought I, _many days_ are not for ever; _many days_ will have an end; therefore seeing I was to be afflicted not a few, but _many days_, yet I was glad it was but _for many days_. Thus, I say, I could recal my self sometimes, and give my self a help: for as soon as ever the words came in, at first I knew my trouble would be long, yet this would be but sometimes, for I could not always think on this, nor ever be helped though I did. (57; original emphases)

Bunyan here reads and interprets only a fragment of the passage from the book of Daniel. That the verse is sometimes a “refreshment” to him is hard to comprehend, despite his time-centered explanation, because of the meaning that this clipped paraphrase omits. In its entirety, the King James Version of Daniel 10.14 reads “Now I am come to make thee understand what shall befall thy people in the latter days: for yet the vision is for many days.” This entire Biblical chapter concerns Daniel’s prophetic vision of the Hellenistic wars, circa 2 BCE, and here the speaker is thought to be the angel Gabriel. So Bunyan, whose in-depth knowledge of the Bible is unquestioned, nevertheless attaches the ambiguous pronoun “This” to the final few words of the passage, and because of this fragmented and decontextualized verse, suffers spiritual—and probably mental—chaos for more than two years (if we can trust his narrative’s temporal details). We must allow for interpretive difficulties in this early age of widespread public access to the Bible, with literacy increasing exponentially, and the mediation of priests confined to the Church of England (and indeed despised by most Dissenters). But by parsing the original verse and reading the newly formed sentence as wholly disconnected from its complete biblical text and context, as well as from any concrete, external event in his own autobiography, Bunyan obscures the lesson he is trying to share—particularly since, at the end of the quoted passage above, he punctures the reader’s hope by severely qualifying the ability of the Bible verse to comfort him.
Through his metaphorical language, however, we can begin to understand what Bunyan wanted, and what he might have intuited the writing process could help him achieve. In the image of the child in the Mill-pit, we hear faint echoes of Bunyan in his actual childhood, when chronic nightmares left him “much cast down and afflicted in [his] mind” by the “dreadful visions” of death among devils and the “eternal darkness” of Hell (7). As a metaphorical child cast into a Mill-pit, we see the resemblance to the author, whose deep exegetical crisis allows him to “find neither hold for hand nor foot” in the scripture, and who thus fears that, despite all his entrenched efforts, he “must die in that condition.” The verse from Daniel, though, whittled down to meet his spiritual and psychological needs and fashioned to deliver him from the depths, saves him at least temporarily from certainty of damnation: “Thus, I say, I could recal my self sometimes, and give my self a help.”

Hope remains for Bunyan. His re-vision of the passage in Daniel, with its promise of a finite if ambiguous period of suffering, allows him to cast himself a lifeline in the watery Mill-pit, find a foothold, and give his tortured self a lift. More concretely than in the dream-vision that begins with him shivering in “dark clouds” and ends with him sitting on the Mountainside basking in the heat of the Sun, Bunyan is able to draw strength from the Mill-pit vision, separating the imagined child from the corporeal prisoner, and assuages the pain of each “fresh assault” by envisioning metaphorical versions of self-help that put him on solid ground. Thus we see that, as the narrative goes on, Bunyan uses figurative language to write his way out the misery he feels. Although he had very little schooling as a child, Bunyan increasingly employs simile and metaphor to describe otherwise indescribable feelings, to sort out and ascribe meaning
to some of the chaos he is enduring. This is the way that reflective writing helps one heal: as a problem-solving technology that enables us to carry across meaning that heals and gives our selves “a help.”

“A Thousand Calamities”: Historical Context

To understand how Bunyan’s illness likely upset the temporal clarity of his text, and thus generated his need for a more stable second constructed by self-narrating, we must first consider his authorial intentions and the historical context in which he wrote. May of 1660 marked King Charles II’s return from exile to resume the monarchy, just over a decade after his father’s execution. In the uneasy political atmosphere following the king’s restoration, religious nonconformists were suspect; any minor skirmish or protest could trigger disproportionate alarm, with the government fearing it might represent deeper collective resistance to the new order. Although Bunyan professes nothing but peaceful ministerial intentions in his actions, he was nevertheless arrested in November 1660, charged under an obscure Elizabethan statute with refusing to attend the established church and preaching at unlawful conventicles or meetings. I suggest that one important reason Bunyan wrote his autobiography was that it was so “difficult for religious dissenters to distinguish themselves from political resisters” (Lynch 277) in these turbulent times. Bunyan was a religious dissenter; no evidence ever surfaced to suggest that he was a political resister after his return home from serving the parliamentary forces in the English Civil War in 1647. His text therefore becomes a
means of publicly distinguishing his moral character from the character of dissenting insurgents such as the Fifth Monarchists.\textsuperscript{6}

But Bunyan’s stated purposes are above all spiritual and ministerial. With \textit{Grace Abounding}, Bunyan joins a rapidly growing number of published, Protestant dissenters in the genre in the mid-seventeenth-century. He attempts in print, as we have seen, to make sense of his worldly existence and secure his election into the afterlife. Through writing he attempts also—perhaps most importantly to him—to reach beyond the confines of prison to minister to his congregation, offering them assurances through his example that they, too, will know God’s grace if they remain steadfast to their faith and take care to “commune with” their hearts, “look diligently, and leave no corner therein unsearched” (5). Tending and encouraging his flock, particularly since he has been imprisoned for public preaching, is his stated intention (3-5), and most scholars agree that this is his true purpose. Some reasonably surmise that a “second intention” was the “desire to convert” others (Tindall 25) or perhaps to “win sympathy” that might “unify . . . supporters on the outside” (Freeman 134). Other readers, however, interpret the text to be spiritual propaganda, a mere advertisement for faith and withstanding persecution. Such reductivist readings ignore and invalidate the story of human suffering that its author discloses even as he seeks to retain his pastoral presence in the community. Is he crafting a persona for congregants? Undoubtedly he does, as most preachers must if they are to set an example as leaders. But Bunyan is freighted with the “pressure towards truth-telling” (Stachniewski xiii) in his narrative, believing that God is the true

\textsuperscript{6} This group of dissenters tried to take over London for “King Jesus” in a rebellion in 1661 that resulted in about fifty of them being hanged, drawn, and quartered for high treason against the Crown.
Author of his life events and that, although the earthly authorities have proscribed his preaching, he is duty-bound nevertheless to counsel his flock and tell them of “the work of God upon my own soul” (Bunyan 3). As Rivkah Zim notes, “Bunyan knew that his personal authority to edify the faithful depended not only on his being a particular kind of Christian but also on being recognized as such by others—a recognition that his experience in the Bedford prison could instantiate” (309). *Grace Abounding to the Chief of Sinners* thus reflects the author’s sharp awareness of his readership: the intended audience of Calvinists, as well as the larger, potentially dangerous audience into whose hands it might fall. And while he doubtless had manifold spiritual reasons for writing, I suggest that Bunyan has significant personal reasons for putting down the words and grappling with the Word: he needs to tell his story because he is in pain.

If his spiritual and ministerial goals are best reflected by his stated intentions, Bunyan’s pain can be seen in his working out of these goals. The text makes clear that Bunyan suffers the pain of isolation and imprisonment, the pain of separation from his family and congregants, the fears and hardships associated with his incarceration, and most crucially, the pain of potential or present alienation from God—all of which becomes grist for his spiritual mill. In one of the most poignant passages in his narrative, Bunyan’s anguish for his family is captured in a simile of merciless, bodily violence: “the parting with my Wife and poor Children hath oft been to me in this place, as the pulling the flesh from my bones” (89). He does not speak of his own “hardships, miseries and wants,” but his “poor family[′s]” (89). Upon hearing of Bunyan’s arrest, his wife Elizabeth went into premature labor that lasted for eight days and delivered an infant that died at birth, a fact, like some others, that was apparently too painful to
discuss in *Grace Abounding*,

though he records the tragedy in private documents. But

he does relate his distress for his “poor blind Child,” Mary, fearing that she “must be

beaten, must beg, suffer hunger, cold, nakedness, and a thousand calamities” (89)

while he languishes in prison making shoe-laces for a scanty income. It is evident, as

Bunyan contends, that he is ministering to others through this document; yet he is doing

something more: he is trying to heal himself. He is working through his mental turmoil,

releasing his pain and anger through his pen, and stabilizing the topsy-turvy timeline of

his life’s events to the best of his ability. From Bedford Gaol, he engages in self-

authorship to craft a public self that the private self can become: a stable narrative

identity that can “give my self a help,” allow him to cope with his abundant grief and past

and present fears, and cultivate a future that subsumes and transcends the anxieties of

times past.

Yet, as we will see, Bunyan’s autobiography is as compelling for what it omits as

it is for what it contains. With the above examples of some of the text’s temporal

distortions now in place, and with some historical context and discussion of the author’s

intent as further groundwork, I now turn to the critical lacuna of Bunyan’s story—his

trauma-filled “moratorium”—to consider the psychological underpinnings of these

experiences. Although Bunyan speaks only the truth in conveying his story, he does not

tell us the whole truth because parts of his life, in the five-year span between his

sixteenth and twenty-first years, are unspeakable. Understanding the traumas Bunyan

We learn of Elizabeth’s misfortune in *A Relation of the Imprisonment of Mr. John Bunyan*, a series of
documents, some transcript-like, that Bunyan wrote about the circumstances surrounding his arrest,
prosecution, (mis)trial, and imprisonment. Elizabeth Bunyan, who “rounds magnificently” in her “spirited
attempts to have his case reconsidered at the midsummer assizes,” reports this sad episode to a judge in
response to his queries about the family (Stachniewski xxvii). The *Relation* was published by John
Bunyan’s descendants, but not until 1765, more than a century after it was written.
suffers in this time span, which most likely affected both his memory and present-day perception of time as he writes his life story from prison, can help us understand why this textual gap exists.

“Leave No Corner Therein Unsearched”: Trauma, Temporality, and the “Moratorium”

In her essay “Young Man Bunyan,” Vera Camden questions the omission from *Grace Abounding* and Bunyan’s other written works of any discussion about his years of service in the New Model Army and that army’s subsequent execution of Charles I in 1649. She also ponders critics’ persistent neglect of this fact of omission in the scholarship and their seeming unwillingness to try to imagine, given the sparse but verifiable facts that we do have about Bunyan’s life, what those years must have been like for him. Nowhere in his writings does Bunyan ponder “what it meant that the King had been captured and killed” (Camden 44)—an unprecedented, unholy act—by the same parliamentary forces he had recently served. In fact, Camden observes, Bunyan “mentions his military service, with political neutrality, only once” (43) in the narrative, but otherwise skips any description of events or his experience. It is an astonishing exclusion, given the manifold relevance of the Civil Wars and the regicide in Britain during his lifetime both to the individual and to society at large. Although, as Camden

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8 This solitary mention of his experience as “Souldier” is startlingly violent and, as it occurs within the pages of the narrative containing the “moratorium,” which I argue Bunyan essentially avoids, it requires comment here. Early in his narrative, Bunyan describes being part of a company that was to “besiege” an unnamed place; at the moment of departure, he consents to a fellow soldier’s request to take his place. “[C]oming to the siege, as he stood Sentinel, he was shot in the head with a Musket bullet and died” (8). The passage is a vivid account of war trauma, and is likely an expression of survivor guilt—a devastating event that I count among the repeated traumas Bunyan actually experience during this moratorium period defined by Camden. However, I do not consider this episode to be part of the confessional, reflective writing Bunyan was attempting from gaol, because he added this incident after the first published edition. Stachniewski estimates the dates of these revisions to be between 1672 and 1674—*after* Bunyan was released from prison in March of 1672. This incident, then, may be survivor guilt and/or a traumatic memory recalled from the safety of freedom.
readily acknowledges, we may suppose Bunyan remains silent on these martial
subjects due to political “caution” (Hill 64) or religious, pacifist convictions, what is
equally puzzling is that he also omits mention of important personal details: the deaths
of his mother and sister within weeks of each other, and his father’s hasty and possibly
scandalous⁹ remarriage—all taking place the summer before Bunyan began his military
service. What a time of emotional upheaval for a sixteen-year-old to endure! And yet he
passes silently over these traumatic events in his narrative.

Instead, Bunyan sketches a quick portrait of himself in this period as a wayward
young rogue, committing dissolute acts (by Puritan standards)—dancing, playing sports,
bell-ringing, and indulging in a torrent of swearing—that sorely tweaked his conscience,
yet whose biographical and even spiritual importance must pale in comparison with the
domestic and military events of his late teens. These dissolute but relatively harmless
acts apparently test his moral fortitude and preface his first real, spiritual awakening
among the poor women of Bedford. Camden analyzes the ways that these “mental
strivings of Bunyan’s youth fathered the mental capacities of his manhood” (49). What
should be noted, however, is that the suffering, hardship and challenges faced by
Bunyan during the missing years could have furnished more significant lessons for his
congregation, yet he does not include them.

Allowing that we must be, in Camden’s phrase, “frankly speculative” (43) about
what Bunyan doesn’t say, we should consider “Bunyan’s possible reactions to
participating in a revolution” (43) as he may have been compelled to remember them

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⁹ Some biographers calculate that Thomas Bunyan’s new wife was pregnant at the time of their sudden
marriage. That he christens the new baby “Charles” in 1645, biographers generally agree, is good
evidence that Thomas Bunyan was a Royalist.
from his prison cell while writing *Grace Abounding*. Camden borrows the psychosocial term *moratorium* from Erik Erikson, using it to characterize this period of Bunyan’s “military service and the roughly two years in Elstow following his demobilization” (42). For Erikson, a moratorium is “a span of time after [young people] have ceased being children, but before their deeds and works count toward a future identity” (42), a time when “[y]outh stands between the past and the future, both in individual life and in society” and “also stands between alternate ways of life” (48). I propose that, when an adult and prisoner, *remembering* and trying to write about his revolutionary youth may have distorted the narrative that Bunyan intended, from gaol, to maintain and cultivate an “alternate,” emancipated, ministerial way of life. That Bunyan suppresses traumas that should have been of significant effect, personally and nationally, must elicit interest from any reader or scholar trying to understand his life. But in particular here, in a discussion of Bunyan’s text as it pertains to narrative medicine, the distortions in the narrative’s temporal features are consistent with the “alteration[s] in time sense” – the “rupture in continuity between present and past” now known to be experienced by long-term prisoners (Herman 89). In short, a dysthymic prisoner actively resisting memories from a traumatic period of life might be expected to produce just these kinds of gaps and temporal distortions in a narrative.

Traumas such as those Bunyan experienced in the youthful years of the moratorium can greatly affect one’s adult memory and time-sense. Though the subject is vast and complex, we should briefly survey and amalgamate here the present-day work of experts in neuroscience, mental health, and philosophy, to show how Bunyan may have been stopped by traumas from voicing that period of his life in *Grace*
Abounding. By considering the experience of traumatic stress and mental illness from three theoretical levels—the psychobiological, the clinical, and the phenomenological—I submit that we “leave no corner unsearched” as we read this seventeenth-century text and its lacunas with a wider, empathic perspective on the human condition and the relevance of sufferings past. We begin to see the author as a “living totality”; John Bunyan’s inexpressibility of pain is still our own, even though we understand the mind and body more than medicine did then.\(^\text{10}\)

In psychobiological study, neuroscientists have isolated three areas in the limbic system that are radically affected by the experience of traumatic stress: the prefrontal cortex, the amygdala, and the hippocampus. These structures perform interrelated functions associated with, for instance, differentiating between conflicting thoughts, assigning emotional meaning to stimuli, and storing memories, among many others. Crucially, both the hippocampus and prefrontal cortex play important roles in the temporal dimension of experience and memory, with the prefrontal cortex linking one’s understanding of the past (memory) and the future (planning, goals) (Fuster, et al. 349). What the structures have helped us understand now is that the nature of traumatic memories is profoundly, qualitatively different from the nature of ordinary memories: we encode and imprint them differently in the brain; and we store and access them with different degrees of intensity and success.

\(^{10}\) I should note that what is today considered to be “trauma” or experienced as “traumatic” may not have been so in Bunyan’s time. However, the textual evidence in his narrative, as well as twenty-first-century criticism by some of the most prominent literary scholars in the field, indicate that studies of trauma and memory disruption can lead us to deeper understandings of this author and his work.
Each of the three components serve specific roles that, with the help of functional Magnetic Resonance Imaging (fMRI), show neuroscientists how emotion, memory, and temporality are intertwined in our thinking.¹¹ The amygdala’s primary functions are to evaluate and assign emotional meaning to incoming stimuli, whether the event is ordinary or traumatic. “Once the amygdala has assigned emotional significance to sensory input, it passes this evaluation on to other brain structures, including the hippocampus, whose task it is to begin organizing the information and integrating it with previously existing information about similar sensory input” (van der Kolk, et. al. 294-5). The actions of these two structures are closely related; the stronger the amygdala’s assignation of emotional significance, “the more strongly the memory will be retained” (295) by the hippocampus. Traumatic memories, in fact, are indelible, though they may completely resist integration. From the hippocampus, the information then passes to the prefrontal cortex, whose complex cognitive roles include integration into long-term memory, expression of personality, planning for the future, alignment of goals, inhibition of inappropriate thoughts, feelings and behaviors, and many other tasks, all of which are pertinent to reading Bunyan.

However, in this triadic process, if the amygdala is overstimulated—if the emotion is so extreme that it cannot be properly processed, as with a traumatic event—then the amygdala can interfere with hippocampal function. In other words, “high levels of emotional arousal may prevent the proper evaluation and categorization of experience”

¹¹ Although generally accepted today, there is no evidence to suggest that any of the clinical findings discussed here would be universally experienced by all victims of trauma.
(295) that the hippocampus performs under normal circumstances. And in cases such as this,

because the hippocampus is prevented from fulfilling its integrative function, these various inprints are not organized into a unified whole. The experience is laid down, and later retrieved, as isolated images, bodily sensations, smells, and sounds that feel alien and separate from other life experiences. Because the hippocampus has not played its usual role in helping to localize the incoming information in time and space, these fragments continue to lead an isolated existence. Traumatic memories are timeless and ego-alien. (295)

Thus, given this fragmentary and atemporal nature of traumatic memories, we can appreciate why so many trauma victims report “that they initially had no narrative memories for the events,” and that “they could not tell a story about what had happened, regardless of whether they always knew that the trauma had happened, or whether they retrieved memories of the trauma at a later date” (288). Trauma defies narrative and has no anchor in time. Like his disjointed hermeneutics and rephrasing of Bible verses, Bunyan’s narrative identity is not yet organized into a unified whole as he describes the youthful antics of the moratorium (7-14). He captivates readers with his game of Cat and his unrestrained blasphemy. But below these anecdotes lie the graver memories of the multiple familial traumas he experienced in the summer of 1644, and the subsequent violence, disease, and death he witnessed during the war—a bloody civil conflict, brother against brother, which ended with the national trauma of the sovereign’s beheading. These are the intensely formative episodes of a compelling life story that Bunyan wants to tell, but physically cannot. He does not tell readers his whole truth, because a portion of his truth lies in pieces that resist unity.

As with psychobiology, clinical psychology also has much to teach us about Bunyan’s reticence in his narrative. The mood disorders from which Bunyan suffers at
the time of writing, identified by Greaves as depression and anxiety, are most likely causally related to the traumas of his youth, as well exacerbated by his state of imprisonment at the time of his autobiographical writing. While some literary scholars have scrutinized the relation of the temporal oddities and affective markers in the text, clinical psychology shows us that these discrepancies might be explained or at least qualified by considering Bunyan's prison time. People with depression, Greaves tells us, “typically have an altered sense of the passage of time, which appears to move more slowly” (35). And time in prison moves slowly indeed. While reading *Grace Abounding*, we must strive to remember that imprisonment itself is a trauma. Indeed, as psychiatrist Judith Herman observes, it can be a kind of “chronic trauma” (86) that causes “[a]lterations in time-sense” (89) and, in prolonged captivity, “alterations in identity” (99) in which the prisoner becomes “preoccupied with shame, self-loathing, and a sense of failure” (100). To cope with an “unbearable reality,” prisoners practice forms of “avoidance,” one of the “most exaggerated” features of traumatic stress observed in “chronically traumatized people” (87).

In its simplest clinical sense, avoidance is a form of psychological resistance—a coping mechanism that a person employs to remove a perceived threat or as a response to fear or shame. By avoiding shameful thoughts or subjects, for example, or by keeping away from threatening situations or people, one can ostensibly avoid the negative consequences of interaction, as well as the painful thoughts or feelings associated with these phenomena or people. Worry is a cognitive process that can be a healthy form of avoidance. Since “threat represents the most significant problem that organisms face, given that it relates to survival” (Borkovec, *et al.* “Avoidance” 77), and
since Bunyan perceives that his captors and perhaps even the unsanitary gaol environment he lives in threaten his survival, we can understand that he is worried how to endure death, should that here be his portion in prison. After all, worry can be a problem-solving mechanism that helps one avoid future trouble.

However, excessive worry can of course be psychologically and physically unhealthy. As one of the defining characteristics of both anxiety and depression, worry, “by its process or content, [may] actually increase anxious meanings,” (95) such as in the Ecclesiasticus incident and the Mill-pit metaphor described above. The extent and intensity of the affective markers in Grace Abounding reveal a “cognitive style of depressive and worried thinking [that] entails abstract generalizations and attributions beyond the immediate situation” (Leahy 277). For some worriers, this thinking carries the consequence of difficulty “being fully present in and aware of the current moment” (277). Bunyan’s thinking, at least as he narrates it, often seems to leap in logic from the initial reading of an innocuous Bible verse to panicked generalizations about death and damnation. The comfort afforded to him by his first interpretation of the text is invariably brief and mild compared to the lengthy, anguished fears that doubt provokes. With no reference to religion, clinicians comment on this attentional phenomenon.

The most poignant feature of a life spent lost in one’s thoughts, especially thoughts that constantly create negative experiences based upon the illusion of nonexistent futures, is that such a way of being disconnects the person from present-moment experiences—which are, in the final analysis, the only reality that is available to us. (Borkovec, et al., Anxiety 97)

Bunyan certainly did not spend his whole life lost in thought; his later ministerial and literary achievements confirm his ability to live fully and mindfully in the present moment. But I suspect that his writing life, in prison, was anxiously spent this way—
“lost” in his fragmented memories and worries for the future—and the experience of this chronic trauma surely colored the story he is able to tell.

*Grace Abounding*’s chaotic chronology, then, is symptomatic, signaling the attempt to cohere and organize unnarratable, traumatic memories and negotiate the strictures of unconscious coping mechanisms as Bunyan was writing it. Deploying defense mechanisms such as avoidance (and possibly others) would have helped him steer clear of writing about the momentous events of his moratorium. Worrying and writing instead about “superficial” events—playing Cat, ringing the church bell, dancing, and swearing—helped Bunyan avoid “more distressing thoughts and emotions deriving from past traumas” (Borkovec *et al.*, 102). While in the acts of reflection and composition, his psychological resistance to facing the moratorium’s cataclysmic events, as well as the shame these memories called to mind, exacerbated his dysphoric and dysthymic symptoms, affecting the narrative’s temporal coherence and evangelical clarity.

From theory based on clinical studies of psychobiology and abnormal psychology, I turn to the third theoretical foundation for my argument that Bunyan cannot tell his whole story: phenomenological philosophy. Phenomenologists have explained the problematic nature of temporality in ways that help us understand why it is difficult to pinpoint time in our attempts to articulate our life’s events and simultaneously to create a new narrative identity. As humans, our experience of time presents us with a chronotopic challenge: we are all *in* time and we embody time. And this distinction, a complication for the genre of autobiography generally, is not easy to make while telling one’s story of self. “It is not that [we] exist in the present and then happen to have the
capacity to envisage the future and remember the past,” says philosopher David Carr, referring to what Martin Heidegger calls *Erstreckung* (95). “[R]ather, human reality is a kind of ‘reach’ or ‘stretch’” that “makes us both participants in and surveyors of the temporal flow, both characters in and tellers of” our own stories (95). The narrator’s reach can be obstructed by memories of the past, the writing space inhabited at present, and worry about the future. As an imprisoned “surveyor,” Bunyan’s here-and-now—his place and time—shapes the version of his story (and history) he tells, as he casts himself as a “participant” in events that will help him inspire and appease his disparate audiences, even as he intuitively strives to heal his psychic wounds through “words” that provide him with “great refreshment to [his] Spirit” (Bunyan 75).

Phenomenologist S. Kay Toombs uses Edmund Husserl’s ideas specifically to help physicians understand the perceptual differences of time as experienced both by their patients and themselves. When patients are asked to give a history of their pain, for example, physicians hope to obtain a chronology of symptoms and to learn the duration of the pain. While “referring to the objective time scale to provide a common language for time is important” (234) (and indeed the importance in general of finding a common language cannot be overemphasized), patients are “often hard pressed” (232) to report their experience this way. “The ‘now’ of pain appears to be endless,” and does “not follow the regular and ordered sequence of seconds and minutes” of objective or “outer” time (232).

Husserl’s analysis of inner time-consciousness indicates that, in living through the ongoing flow of consciousness, the individual lives in a dimension of time which is incomparable with that which can be measured according to the objective time scale. Consequently, such a dimension of time is *incommunicable.* (234-235; emphasis mine)
Bunyan’s text repeatedly demonstrates this incommunicability, this “unsharability [that is] characteristic of pain” (235), in its distortions, conflations, and unevenness of time. He, like any autobiographer, must describe his life experiences in objective time (which presumably readers can understand); yet even in recollection, he experiences his pain in the frightening immediacy of subjective, “inner time,” which cannot be conveyed in language that others can effortlessly understand. Being unable to convey time coherently and to tell the whole story may have made Bunyan feel more anxious and depressed, because “the whole of life is always there, and concern with its wholeness is an underlying and recurring concern” (Carr 96). A man striving not only to survive, but to build a future life in Bedford and an eternal life after death, Bunyan knows that “[w]hat is at stake” in the lucidity and power of his narrative is his “own coherence as a self, the unity and integrity of [his] personal identity” (Carr 96).

**The Moratorium Imagined: Bunyan’s “Secret Shame” and “Unexpressable Groanings”**

In *Grace Abounding*, John Bunyan confesses the “secret shame” he feel when he is “silenced” by the reproofs of a neighbor who overhears him “cursing and swearing” and playing the Mad-man” (11-12). Although his “prodigious profaneness” (13)—legally, a criminal offense at this time—demarcates this time of youthful waywardness from his conversion to being a pious adult by depicting his dysfunctional relationship with language, from this event in the moratorium years we can nevertheless infer what kind of man he would become. Here we read Bunyan’s rationale for both his habitual swearing and his adult, ministerial goal: “to make my words have authority”

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12 See Vera Camden’s article “Blasphemy and the Problem of Self in *Grace Abounding*” for an in-depth psychoanalytic examination of this compulsion in Bunyan.
In the autobiography, only after his spiritual awakening at his encounter with the Bedford women do his words begin to demonstrate this godly authority. Bunyan’s text of self seems to have two distinct personalities.

Scholars such as Vera Camden and Paul Delany comment on the textual peculiarities that seem to separate and differentiate Bunyan’s narrative of his youth from that of his adulthood, a difference that could reasonably be attributed to his inability to speak the unspeakable—while in prison. Camden writes, “When he is called to join the Bedford congregation, he marks a shift in his identity which cannot be ‘read’ as continuous or unified with the Bunyan of the early pages of *Grace Abounding*” (45). I propose that this discontinuity derives from his need to sift through fragments of traumatic memory during the early pages. If these memories were never integrated, it is possible that his anxious deliberation about how or whether to narrate them prompted him to avoid altogether the burdensome topics of repeated trauma and write instead about youthful antics—the only sins psychologically “safe” to explore. Sometimes for worriers, as we have seen above, the “content of daily worrying may…serve as a distraction in an effort to avoid accessing more distressing emotional material from the past” (Borkovec, et al. “Disclosure” 52). In this way, the concentration on the daily sins of bell-ringing, swearing, or dancing become a type of cognitive avoidance, allowing Bunyan to push aside the fragmented memories of trauma he cannot face or narrate.

As the moratorium recedes from Bunyan’s narrative timeline, his autobiography stabilizes into a more confident stride, an improvement noted by critics though not explained. Delany asserts that the “gloomy” passages relating the events of Bunyan’s youth, “darkened by…chronic preoccupation with his many sins,” are “entirely
conventional” in the genre. Yet Delany curiously notes—almost off-handedly—that as the narrative “progresses [Bunyan’s] writing improved” (89-90). I agree with this latter assessment, but not in the same spirit as Delany. I attribute the improved writing to a corresponding calmer mood, a lessening of anxiety and increase of creativity once Bunyan had wrestled with his memory of the distressing moratorium years and moved into more currently germane, spiritually stable rhetoric: his conversion years. After all, we know from the evidence of Pennebaker’s repeated clinical studies that writing about one’s personal experience of trauma can initially be extremely upsetting and produce symptoms of anxiety and depression in otherwise healthy subjects. Thus, to get through this portion of the narrative (whether he narrated them or not), Bunyan would have been compelled at least to recall the traumas of 1644-1649, which would likely have triggered negative affective responses that impacted his writing. Avoidance would have helped him quash some of those feelings. Although the temporal distortions remain, the later pages of the narrative do read differently from the early ones. Once the moratorium years have been written down, however sporadically (approximately pages 7-14), the language opens up, becoming fluid and lyrical, featuring imagery and metaphor, as well as longer, smoother, more rhythmic sentences.\textsuperscript{13} This shift, in narratological terms alone, signifies a shift in the narrator’s mood. In psychological terms, it reads as a lift in the symptoms of depression and anxiety.

\textsuperscript{13} Compare these two sentences, for example, disregarding Bunyan’s orthography and grammar: 1. “In these days the thoughts of Religion was very grievous to me” (8); and 2. “Further, in these dayes I should find my heart to shut itself up against the Lord, and against his holy Word, I have found my unbelief to set as it were the shoulder to the door to keep him out, and that too, even then when I have with many a bitter sigh cried, Good Lord break it open” (25).
The physical and spiritual constraints imposed by Bunyan’s prison setting would impact the story he is able to tell. Recalling Herman’s claim that imprisonment ruptures “the continuity between past and present” (89), we recognize some of the psychological constraints, too. In the freedom of his youth, Camden observes, Bunyan was able to isolate the “grief, rage, and helplessness” he felt as a victim of these traumas, and throw himself “into the pleasures which ‘cut off’ both memory and guilt” (58). But as an adult, bound by spiritual law more than English law, he can find no pleasure in prison, and this “cutting off” (or countercathexis) cannot be sustained. In his current state of carceral isolation, Bunyan cannot isolate himself from those painful feelings or memories as he attempts to write about the past, because it is so affectively volatile that it destabilizes the present and threatens and obscures the future. He cannot piece together his whole story. As Arthur Frank observes in *The Wounded Storyteller*, illness or trauma “dislocates the relation of this whole: the present is not what the past was supposed to lead to, and whatever future will follow this present is contingent” (60). To write this “imaginative reappraisal” of his life and conversion, even in the relative quiet and solitude of a gaol cell, Bunyan’s emotions may have been “recollected in tranquility” as Sharrock observes (xxiv). But the environment must have impinged on his acts of recollection. Early modern prisons were generally filthy, unsanitary, for-profit institutions, in which prisoners had to pay for their own food, clothing, bedding, and furniture. Disease was widespread and too frequently fatal, a constant death-threat to those within their walls—yet another anxiety-producing reminder that death could visit him at any time.
Given such a stressful setting, we can easily understand Bunyan’s “two considerations,” “warm upon [his] heart” before he was arrested in 1660 for holding a conventicle, (the passage cited on page 68). He wondered whether he could endure a long imprisonment, and he worried about his ability to encounter death in prison, whether from execution or disease. Bunyan’s present trauma of incarceration fitfully coalesces with his past traumas of the moratorium, intensifying his anxiety and depression. Both considerations concern the passage of time. The first, more obviously, worries how he will withstand the duration of a long prison term. To allay the fears of his first consideration, Bunyan writes. He publishes extensively in these years—poetry, treatises, and a conduct manual in addition to his autobiography—as a means of preaching and teaching, and cultivating his reputation as a spiritual leader.

But Bunyan’s second consideration is in fact more pressing: “death” for Bunyan is a question of eternity; one way or the other, salvation or damnation, death means the beginning of experience for all time. In other words, the temporal dimensions of Bunyan’s life and the temporal “limits” of God’s grace do not end with his life; they continue beyond death into an eternal time that, for Bunyan, as we have seen, is the most vexing of all subjects. To allay his anxieties about this threat, Bunyan writes. From the experience of his earlier poetry writing, he surely recognized that transforming abstractions and mental images into words served to calm him.

This passage begins “Before prison, I saw what was a-coming. . . .,” which scholars immediately identify as a reference to his indictment at the assizes for preaching in 1658. We can also see that, with long years of prison behind him, innumerable hours of quiet reflection undertaken, and the vast majority of his narrative
now written, Bunyan was thinking back to the moratorium years, too, to the events that he cannot write or speak of “now.” He agonized about those years before and during prison. Throughout so much of Grace Abounding, his present writing looks at past worries about the future. This preoccupation with time and worry, this “turning in of the mind upon itself,” as Sharrock has it (xxvi), obliges Bunyan to experience not only the tumultuous “emotions of his conversion experience,” but also the actions and anguish of his youth, the pain of his present circumstances, and fear of the future. In other words, everything begins and ends with the moratorium. Telling readers about those years of his young manhood would require reconciling all the “times” of his life, a task too great for Bunyan at this point.

As Camden suggests, we should “listen’ to Bunyan’s silence” (42). These silences in texts of personal narratives are crucial to understanding the mechanisms of emotional disclosure, the nuances of reflective writing, and empathy in narrative medicine. In Bunyan’s silence, I hear shame too painful to describe and worry too indefinite and too grave to articulate—evidence, as we have seen, of the affective pathologies that Greaves has identified. What is he not saying? Why would Bunyan feel so debilitated by shame and worry that he cannot write about this time, when he devotes considerable detail to other, arguably less significant, periods of his life?

To answer such questions, we might look at the factual events of Bunyan’s moratorium as gathered by historians and literary scholars, try to contextualize them with his narrative, and frankly speculate about what he must be omitting. As a young man leaving home, venturing out on his own for military service in the greatest social, political, religious conflict of the century, and holding political beliefs in apparent
opposition to his own father’s, Bunyan would have been ashamed at the grim, penurious conditions of life in Newport. Soldiers’ pay was delayed for weeks, food was scarce, clothing was insufficient. Some men shared clothing—one clothed while the other stayed in bed; others pawned their clothes for bread. Weapons, ammunition, horses, tack, and defensive supplies of every sort were sorely lacking (Greaves 11-21). Even the governor of Newport found these deprivations difficult to describe: “‘The lamentations of the soldiers here,’ wrote Sir Samuel [Luke], ‘are so great through misery and want, that my pen is not able to express it.’” (Years later, neither was Bunyan’s.) Returning home at age 19, probably undernourished, in rags, and still owed money for his service, Bunyan would have avoided discussion of the New Model Army’s shameful conditions with his Royalist father. His deprivations were hardly identifiable with either glorious battle or honorable service. Writing about this military experience from prison after Charles II’s restoration, Bunyan could not characterize the period as a noble adventure in a cause, nor could he confidently “confess” his involvement as sin either. These years inflicted a kind of battle wound that festers, rarely heals.

Additionally, a man of Bunyan’s sensitivities about death and sin would surely have been ashamed of the regicide of Charles I—a staggering act that was never a part of the original parliamentarian plan. The King’s execution was “experienced [by English society] as a collective trauma,” Peter L. Rudnytsky suggests, “the moment at which patriarchal culture literally acted out the killing of the primal father in the person of the king” (14-15). If the anxieties conveyed in his young-adult and conversion experiences are any indication, Bunyan would have carried a concern with the king’s death with him.
all of his life. He would have felt with good reason that this trauma, more than any other in the moratorium, could never be discussed, especially in print. When Bunyan “saw what was a-coming” before prison when the Restoration seemed certain, and particularly after his trial when he feared he might be executed himself, this was the time period he was recalling but not writing about—his participation in the calamitous events of 1649.

Furthermore, as he wrote *Grace Abounding*, Bunyan’s regrets and confusion about his military service must have been compounded as he reflected on his relationship with his spiritual mentor in Bedford, John Gifford. The two men met in 1650, only a year after the regicide. Gifford had served in the royalist forces, was captured by parliamentarians, imprisoned, and sentenced to execution. He avoided that fate only by escaping, after which he converted. Gifford, Bunyan writes, “invited me to his house,” “took occasion to talke with me, and was willing to be perswaded of me, though I think but from little grounds” (24). What could it have meant to him that Gifford, this kind, biblically conversant father-figure, very unlike his biological father, had led Bunyan to

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14 Indeed, during the episode of his conversion years in which Bunyan has “sold Christ” and now wonders whether he can be redeemed, he ponders Psalms 68:18 and writes this curious passage:

*The rebellious? thought I: Why surely they are such as once were under subjection to their Prince, even those who after they have sworn subjection to his Government, have taken up arms against him. […] This sometimes I thought on…but…I was driven with force beyond it, like a man that is going to the place of execution, even by that place where he would fain creep in, and hide himself, but may not.” (46)

15 We surmise that Bunyan’s father knew little about the Bible in part because when Bunyan asks him “Whether we were of the Israelites or no,” Thomas Bunyan replies no; this dashes John’s spirits. Also, Bunyan seems to contrast his father with his first father-in-law, a “godly” man who bequeathed two religious books to Bunyan’s wife (9). Bunyan’s only direct mentions of his father in *Grace Abounding* are quite negative, fueling scholars’ speculation that their relationship was contentious, and that Bunyan may have enlisted as a parliamentarian simply to be one of “the rebellious.” The first mention, about “my fathers house being of that rank that is meanest and most despised of all the families in the Land” (3), tells us Bunyan’s attitude about his family’s social “descent” from being land-owners. After the swearing incident described above, Bunyan wishes he were a child again so that “my Father might learn me to
But these memories and emotions are unspeakable. They are “unexpressable groanings” (32) that defy language. There is no way safely to narrate them, not because Bunyan is merely being discreet or concealing culpability. (After all, his gaolers knew his past.) For Bunyan, and many other trauma victims, to follow that thread back means reaching into an irregularly categorized memory bank and provoking, reawakening the same affective responses originally felt in the time of the trauma. And that inexpressible pain must someway erupt from the very silence it produces, in the emotional process, speak without this wicked way of swearing” (12)—which could help explain his tortured relationship to language.
fracturing time for John Bunyan and other sufferers who “must needs write and speak the Experience of former days” (38).

“Had I a Whole World”: Bunyan’s Poetics of Healing

Throughout *Grace Abounding*, John Bunyan yearns for certainty of salvation: “had I whole world, it had all gone ten thousand times over, for this, that my Soul might have been in a converted state” (23). Thwarted in his recollections by a past in pieces, he tells us as much of the whole story as he can. Closely reading the Bible for confirmation of an eternal future, he decontextualizes and abridges verses, pitting one perceived meaning against another in a maddening exegetical approach that severely limits his understanding of whole verses, let alone whole passages and books. His anxiety heightens as he weighs the significance of each individual word until he can “hardly forbear at some times, but to wish them out of the Book” (60). Words have always carried great authority in Bunyan’s life. But not until he imaginatively consults the authority of authors—specifically New Testament writers Paul, John, and Peter—does he come to the realization that he must read the text in its entirety to understand the whole message. “Then methought…all the Writers did look with scorn upon me, and hold me in derision; and as if they said unto me, All our words are truth one of as much force as another; it is not we that have cut you off, but you have cast away your self” (60; emphasis mine). He discovers at last that, to “give my self a help” to find grace and comfort, to ravel chaotic time and steady his self, he must “learn to apply the whole sentence” (59) and, if possible, read the whole text of his life.

After a two-year period of anguished introspection and despair, John Bunyan aptly describes his epiphanic moment—*the* moment of his recognition of God’s abounding grace—*with* a prison metaphor:
But one day, as I was passing in the field, and...suddenly this sentence fell upon my Soul, *Thy righteousness is in Heaven*; and methought withal, I saw with the eyes of my Soul, Jesus Christ at God’s right hand...Now did my chains fall off my legs indeed, I was loosed from my affliction and irons, my temptations also fled away. (65-66)

However disjointed the telling, and despite whatever silences we hear, the fragments of the past, in the end, do come together to form a whole narrative that achieves Bunyan's stated intentions and others. The metaphorical language that brightens his writing after the moratorium section is an indication of healing, uplifting both reader and writer from the despair so prevalent in his story’s emotional swings.

With his gift of grace more assured than ever (albeit never certain), his pain greatly assuaged, and narrative near completion, Bunyan attains authority over his self-text and unfettered access to the Biblical text that has stymied him for so long. Even though the Bedford prison walls still confine his body, the Wall of the dream-vision, separating him from the sunlit mountainside of God’s love, has tumbled down like Jericho’s from the rushing currents of compassion and comprehension that seem to flow between reader and text: “I never had in all my life a greater inlet into the Word of God as now” (99). Although

Bunyan was haunted by the desire to survey his whole life in one glance, to hold his soul in his hands, the better to possess himself...he strove to recapture all the threads of his past at one go, and knot them to a present that was always slipping through his fingers; he wanted to press his past to him, wrap it around him to ensure that it really was his. (Talon qtd. in Sharrock xxxii)

Though he would always experience occasional doubts, Bunyan manages to help himself live comfortably in the present. Empathy, understanding, and deep learning

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16 See, for example, Chapter 8, "Metaphor and Poetry" in Gillie Bolton’s *Reflective Practice*, for a discussion about the use of metaphor as an aid to understanding in reflective writing.
require reading the narrative (and the patient or sufferer) *in toto*—interpreting the language that we easily share, the words that seem incoherent on the surface, and the words that never get voiced at all.
CHAPTER 4
TOBIAS SMOLLETT: SINGULARITY IN TRAVELS THROUGH FRANCE AND ITALY

I have never been anywhere but sick. In a sense sickness is a place, more instructive than a long trip to Europe, and it’s always a place where there’s no company, where nobody can follow.

—Flannery O’Connor
Letter to A., 28 June 1956

In his Travels through France and Italy (1766), Scots author Tobias Smollett records his perceptions of the usual tourist attractions with intellectual flair and sharp perception—art museums, architecture, historical landmarks, and landscape—yet curiously and famously “vents his spleen,” pouring forth in his travel notes a stream of negative feelings, from grief and fear to frustration and rage. A former surgeon himself, Smollett’s promising and prosperous career as novelist was seriously threatened during the 1760s by his worsening tuberculosis, a condition that led him to undertake a Continental journey and, via the Travels, to improve his condition both therapeutically and financially. In the definitive scholarly edition of the text, Frank Felsenstein posits that Smollett finds “both an emotional outlet and a purgative against self-pity” (xxv) in his effusions, responding to personal sufferings with leavening “touches of self-mockery and self-criticism” (xxv). The Travels therefore resonate with the author’s singular voice—a voice that becomes as much a part of his story as the journey itself.

Smollett’s text is ideal to examine in light of narrative medicine and reflective writing. People who are ill need to tell their stories, in part because their lives have been disrupted and, along with their bodies, do not function as before. Narrative serves as a healing agent when it gives the sufferer a channel for expressing what physiological change has wrought on his personal and social self, because not to tell the story is to suppress emotions actively, wreak further havoc on the body, and remain stuck
unhealthily in the tumult caused by the disruption. Arthur Frank opens *The Wounded Storyteller* (1995) with an apt travel metaphor that helps us understand both the urge for communicating one’s illness story and Smollett’s text. “Serious illness is a loss of the ‘destination and map’ that had previously guided the ill person’s life” (1), and thus the patient’s story is his attempt to gain a new orientation and perspective on his relationship to the world. Telling the story helps the ill person to rechart his course when he finds himself suddenly in dangerous, unfamiliar territory. This new “map” may not save his life, but it at least gives him direction; it helps heal him emotionally and allows him to continue meaningfully on his life’s journey by making sense of the changes and disentangling his expectations about the new “destination” from the former one.

Smollett was desperately trying to construct a metaphorical new map to contend with his tuberculosis when he departed England for the Continent in June, 1763. In the *Travels*, he immediately makes explicit the connection between his illness and his narrative, stating in his opening paragraph that, without “such employment,” his travels “would be rendered insupportable by distemper and disquiet” (2), both terms that, in the eighteenth-century, denoted disturbances of bodily and mental health. In addition to his physical illness, Smollett suffered mentally and emotionally. His money woes and failed efforts to obtain another ship’s surgeon position with the British army in Portugal caused him to lament in 1762 to his friend Dr. John Moore, “If my Health had held out, I would have buffeted the storms of Life without having Recourse to the Protection of any man” (*Letters* 108). When he and his wife set out for France, he was also troubled by the failure of a periodical he edited, *Briton*, that compounded his chronic financial
difficulties. He departed for the Continent, “unprotected” and in need of ways to sustain his family and his well-being.

More significantly, he was coping that June with the most painful loss of his life—the death of his only daughter, Elizabeth, who had died at age fifteen in April. He mentions this “domestic calamity” (2) in Travels rarely, although we can now read in his private letters how her “Death has overwhelmed” him and his wife “with unutterable Sorrow” (Letters 114). Smollett’s illness was severe, but his grief was even more consuming, and he movingly expresses his feelings to his friends: she was “dearer to me than Health itself, my darling Child, whom I cannot yet remember with any degree of Composure” (Letters 117). Lost in “painful reflections” as his journey begins, Smollett’s metaphorical map is obscured by his “many inducements to leave England”; yet he “was in hopes” that “a succession of new scenes” and “the change of air” would “have a happy effect upon” his wife and his “own constitution” (Travels 2). Even before he departs, he knows that telling the story of his illness will be his best means of coming home to London again—a manuscript to sell to maintain his livelihood, certainly, but more important, a way of working through his pain and waning physical condition.

His tour of the Continent lasted for two years, and the meticulous tracing of his steps and description of each route and destination provided eighteenth-century readers with almost a literal map to follow, particularly if they contemplated seeking refuge from the cold, wet climate of Britain to improve their health. Smollett, who had trained early in life as a surgeon in Glasgow and Aberdeen, was steeped in Enlightenment thought that valued close observation and testing theories empirically. Thus, in Travels, he set about assessing each of his destinations in terms of how it affected his own, and might affect
others’, physical condition, even compiling a Register of the Weather that measured daily temperatures and commented on humidity and wind directions (349-372). Throughout the narrative itself, he describes the terrain carefully, making note, for example, of areas that might be vulnerably exposed to northerly winds: “The wind that blew, is called Maestral, in the Provincial district, and indeed is the severest that ever I felt” (109). He evaluates water quality, noting in Boulogne that it “never fails to occasion pains in the stomach and bowels; nay, sometimes produces dysenteries” (22). In efforts to keep readers apprised of each region’s salutary or harmful attributes, he describes healthy indigenous foods: “The soup or bouillon of this animal is always prescribed here as a great restorative to consumptive patients” (165) While intended for a wide British audience that was enjoying in this century the new vogue of middle-class tourism, Travels nonetheless seems to cater at times principally to the needs of tuberculosis patients. Smollett is unquestionably looking after his own health and seeking the way to wellness, but he is also scouting the territory for the benefit of other consumptives who might make their way south. He is thus both a tourist and diagnostician of each place he visits.

In this volume, then, Smollett fulfills what Frank argues is the social and ethical obligation of every “wounded storyteller”—to share the knowledge of one’s illness experience so that others may learn from it. Even though sickness is ultimately a place “where nobody can follow,” and each of us must construct his or her own map and journey alone on that path, we can nevertheless share valuable insights with others who may be forced to find their way through “the kingdom of the sick.” Smollett plots a literal course to wellness that other readers can follow, and thus helps other sufferers
construct their metaphorical maps, too. Yet his map and course are not executed
without contradiction and tension. While the enlightened doctor confidently categorizes
and describes, as a patient he also struggles with what Rita Charon terms singularity,
the unique needs of his situation.

**Tone and Form: “Particularities” of Smollett’s *Travels***

If Smollett’s *Travels* is discussed at all today, it is usually in terms of its irritable
tone and narrator’s complaining, elements that, while unquestionably present, are not
what make the text important or even interesting. This reception is the lasting legacy of
one man’s mockery. The notorious “splenetic tone” of *Travels* was famously parodied by
Laurence Sterne in *A Sentimental Journey through France and Italy* (1768), a tale in
which he lampoons Smollett in the character of the “learned Smelfungus,” whose “sad
tale of sorrowful adventures,” Sterne insists, “‘twas nothing but the account of his
miserable feelings” (39-40). Though undeniably successful, Sterne’s acerbic brand of
humor invalidates the personal sufferings detailed in *Travels*, and furthermore, ignores
Smollett’s employment of the persona of a civilized, educated Briton with disdain for
vulgar, ignorant foreign ways. Sterne’s text also slights Smollett’s earnestly self-
 depreciating humor, as well as innumerable passages of beautiful description and
appreciative observation that balance *Travels*’ negativity. Through his mean-spirited
caricature of Smollett, Sterne’s novel squelched the popularity of *Travels*, effectively
halting sales and marking a shift in public attitudes about and acceptance of the
“splenetic” travel book. By parodying the work, Sterne both discounts Smollett’s pain
and injures his livelihood—a fact made all the more puzzling, since Sterne, too, was
gravely ill with tuberculosis during these years, and died only three weeks after
*Sentimental Journey* was in print.
Upon its publication in 1766, *Travels* was received enthusiastically by British readers and lauded in numerous London newspapers and other periodicals for its elegant language and precise descriptions, as well as Smollett’s scathing social commentary. Ironically, however, the Francophobic rhetoric would, within two years’ time, damage the author’s reputation in France and, compounded by Sterne’s novel, blight Travels’ reputation at home. “More than any other factor,” Felsenstein remarks, “Sterne’s clever, though hardly fair, portrait served to undo the reputation of the Travels” (lxii). The Seven Years War had just ended in 1763 when the Smollett couple set sail from Dover, and anti-French sentiment was strong in the English public consciousness (if not in the Scottish). In fact, Felsenstein shows that the “insular prejudice of the British tourist in the mid-eighteenth century is reflected in the names of several travel works (xviii),” all of which “assume an implicit distrust of things foreign” and employ querulous tones that are inseparable from these authors’ patriotic biases. Smollett’s book, then, is not unique because of its splenetic tone, even though that has been its most enduring and renowned attribute.

After Sterne’s vilification, Smollett’s text fell out of print in the 1770s and was largely ignored by the Victorians, although a handful of celebrated early nineteenth-century writers still discussed Travels in terms of its literary merits and its author’s struggles. In his Lives of the Novelists, Walter Scott remarks on the hypercritical tone Smollett maintains in the Travels, while deprecating the deleterious effects of both his personal crises and his illness on his journalistic acumen: “Nature had either denied

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1 See Felsenstein’s “Critical Reputation” section in his excellent Introduction, for an in-depth discussion of *Travels*’ reception and subsequent decline (xlviii-lxii).

2 See Felsenstein’s survey, pp. xvii-xix.
Smollett the taste necessary to understand and feel the beauties of art, or else his embittered state of mind had, for the time, entirely deprived him of the power of enjoying them” (57). Already in 1821, Scott felt he must situate the work against Sterne’s response, noting that both Smollett’s “harsh censures” and “the sarcasm with which his criticisms are answered by Sterne are well known” (57). Yet Scott is also sensible of Smollett’s persona in Travels, recognizing in it the same unexpected warmth he exhibits behind the masks of assorted ill-tempered fictional characters:

> Yet, be it said without offence to the memory of that witty and elegant writer, it is more easy to assume, in composition, an air of alternate gaiety and sensibility, than to practise the virtues of generosity and benevolence, which Smollett exercised during his whole life, though often, like his own Matthew Bramble, under the disguise of peevishness and irritability. (57)

Yet Scott, though aware of Smollett’s ill health and recent personal losses, does not interpret the book with these matters in mind. He finds in Smollett’s near-perpetual peevishness only the comic persona, a matter of technique, and thus discounts the sufferer by giving him too much credit, rather than too little as Sterne had done. Again, the verdict would prove ironic. Scott would later dismiss some of his own late works, written after he had suffered three strokes, by remarking on their “smell of the apoplexy” (Lockhart 10:38). Terminally ill, he would take his own tour of the continent, in 1832, noting in a letter to James Ballantyne that “My present idea is to go abroad for a few months, if I hold together as long. So ended the Fathers of the Novel—Fielding and Smollett—and it would be no unprofessional finish” (Lockhart 10:9). Illness is a road we truly understand only by traveling it ourselves, even if others have mapped the journey ahead of us.

Although *Travels* fell into obscurity for more than 150 years, late-twentieth-century scholars have been reassessing its literary merits. Scott’s observation that
Smollett’s persona resembles Matthew Bramble is echoed by Jerry C. Beasley, who recognizes that “Smollett’s traveler is more than just a dry run” (184) for Bramble, the “[i]rritated, constipated, gouty” (188) hero of *The Expedition of Humphry Clinker* (1771). This picaresque, epistolary novel resembles the travel book in several important ways, above all its tone and form. Beasley writes that Smollett “admirably prepared himself for the more ambitious fictional narrative” by writing the non-fiction *Travels* with a distinctive voice, and to no identifiable correspondent, with the effect that, as the sole registering consciousness, he is able to keep the focus about equally divided between the objects of his observation and his always precise and extremely idiosyncratic responses to them. (184)

Thus, despite the precipitous decline in interest in *Travels* beginning in 1768, Smollett’s greatest literary achievement—the reimagining of a journey, observed by quirky characters with singular voices—was still to come. Sadly, Smollett did not live to enjoy his renewed success, surviving only three months after *Humphry Clinker* was published.

Smollett’s accounts of his own physical symptoms and unpleasant sensory experiences, along with his consistent concern “to read the bodies of others,” as Aileen Douglas notes (36), give *Travels* its distinctive place in the then-burgeoning travel genre. “The strange mixture of realism and bare-faced dogma is an important characteristic of the Travels,” Felsenstein writes (xxiii), while also asserting that Smollett’s unwavering “intellectual honesty . . . is behind the desire for exactness of detail”—like any man of science in the Age of Reason. Smollett’s diction reminds us not only of those curmudgeonly personae fashionable in travel narratives of the time, but also that he is a surgeon, used to the brutal realities of human bodies and their (mal)functions, as well as a sufferer himself. Whether discussing locations, manners,
food and wine, or his own bodily indications, the word “particular” is everywhere in his letters. His journey is a quest for particulars, specifics, singular causes and effects.

Throughout the narrative, travel is depicted with reference to the healthfulness of the environment. In an era when travel was “prescribed” for the sick, when the terminally ill might die on the road, searching for the right climate and accommodation to add a few months to their lives, we should perhaps not wonder at Smollett’s constant description of his surroundings in terms of their beneficial or detrimental effects on the body. Writing from Nice, for instance, he describes the very air of the place as though he were prescribing physic:

This air being dry, pure, heavy, and elastic, must be agreeable to the constitution of those who labour under disorders arising from weak nerves, obstructed perspiration, relaxed fibres, a viscidity of lymph, and a languid circulation. In other respects, it encourages the scurvy, the atmosphere being undoubtedly impregnated with sea-salt. (194)

Boulogne’s atmosphere is immediately suspect: “The air of Boulogne is cold and moist, and, I believe, of consequence unhealthy” (21). The gales of wind are both “loaded with great evaporation from the sea” and “subject to putrid vapours,” a combination that may be responsible for “the scrofula and rickets, which are two prevailing disorders among the children in Boulogne” (21-22). Of the Boulogne water, Smollett is particularly suspicious; he speculates on its chemical make-up, supposing it to contain not only nitre but also “a proportion of arsenic, mixed with sulphur, vitriol, and mercury” (22). Though clearly more invested in such matters than the “typical” travel narrative, much of Smollett’s obsession with his surroundings would be better described as health worries—his own and others’—rather than merely the chronic complaining with which he is often unfairly charged.
For all the disparate categories of touristic and doctorly description he covers, Smollett chose to organize his *Travels* in the epistolary form made popular by Samuel Richardson in *Pamela* (1740) and *Clarissa* (1748), possibly as a means of experimenting with the form prior to his final novel. A few months after his return to England in 1765, Smollett wrote to his friend John Moore that he has “thrown into a Series of Letters” the “observations I made in the course of my Travels through France and Italy” (*Letters* 125). The result is a series of forty-one familiar letters, which extend from June 1763 to June 1765, and both begin and end at Boulogne. The letters address a variety of anonymous correspondents, mostly Dear Sir and Dear Doctor, with one curious direction—“To Dr. S— at Nice” (Letter XXXVIII, 318)—that some scholars take as a bit of authorial humor, a letter Smollett addresses to himself. Some scholars have tried to trace the links between the letters published in *Travels* and Smollett’s personal correspondence, and although it is “probable . . . that Smollett did send earlier drafts of some of the letters to his correspondents in Scotland and England” (xxxvii, original emphasis), Felsenstein concedes that “the extent to which” one parallels the other “will probably never be known” (xxxvi). What is clear from comparisons of a few published and private letters, though, is that *Travels* is largely autobiographical, depicting authentic experiences and observations in a conventional form that allows the author to give “intimacy and spontaneity to the factual description of places, while permitting . . . Smollett to indulge” (xli) in creating literary nuances in his real-life story.

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4 See Felsenstein’s Introduction for a discussion of The Origin of the Letters Comprising the *Travels* (xxxv-xli).
Letter-writing has long been employed in clinical settings, and continues to be studied as a psychotherapeutic means of exploring emotions and unconscious conflict. For some patients, unsent letters permit the voicing of extreme feelings—blame, anger, dissent, desire—that they cannot speak aloud in a therapy session. For Smollett, using the letter form for his published travel narrative is a way of creatively conveying closely observed detail, acerbic personal opinion, and at times, personal distress. Beasley comments on the risks and benefits of the form:

The epistolary mode is reflective, since a letter is a private communication written in a condition of isolation, and yet it is outwardly directed too. By writing, the author of a letter seeks to take possession of his or her audience—the public beyond the self—by contriving to manipulate it into understanding. But the form engages necessarily in a paradox, for the letter-writer is also at risk of being owned by the public world, which is the provocation for private expression and, to a great extent, its determinant as well. (186)

Smollett’s letters thus serve both practical as well as therapeutic ends, though the approach certainly did expose his narrative, and its narrator, to personally directed criticism that must have made the author feel “owned by the public world.”

Though reflective, Smollett’s letters are not wholly personal and subjective rants; his assessment depends on his own medical training and experience. Yet even in his effort to describe his travels diagnostically, as in the passages cited above, Smollett creates and reflects. In his narrative rendering of his changing environment, Smollett relies on the “prior categories” that Charon cites as habitual for the physician (or in

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5 See, for example, the findings of a 2009 clinical trial conducted by Jan Prasko, et. al., which concludes with the assertion that “The use of the letter-writing is an excellent intervention in cognitive behavioral therapy for patients with anxiety, affective and personality disorder (167). The investigators also commented on the “inherently collaborative” process required by letter-writing, claiming it facilitates “patient empowerment.”
Smollett’s case, the surgeon’s)\(^6\): safely distant diagnostic judgments that note the generalities of conditions. Charon develops this notion with a medical example, challenging the idea that a dermatologist’s description of a psoriasis rash is described minutely and exactly without reference to prior knowledge and experience, and that there is no creation involved in the act of describing it. “Not so: despite the commitment to describe only what one sees, one’s seeing is influenced by prior categories, diagnostic impulses, comparative memory, conventionalized diction, and concurrent clinical facts…” (46). Charon here makes the point that the medical observer observes and assesses based on a complex of extant discourse patterns, and that the new phenomenon (the psoriasis, in this case) is therefore described in the midst of other descriptions, categorized by “donating” to other categorizations (46). The most objective diagnosis must then be wrought with creativity, Charon argues, an idea that may prove threatening to “those who regard themselves as dutiful observers of reality and careful scribes of what is found” (46).

We see such an effort in Smollett’s account of France and Italy, rendered through the eyes of a caregiver, knowledgeable about sickness and its causes. He is everywhere assessing the places, weather, food and cultural practices with reference to his medical knowledge. Yet he also experiences France and Italy both as a unique observer and as a sufferer himself, giving his description and “characterization” of place

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\(^6\) In eighteenth-century medicine, surgeons were not considered physicians. Jeremy Lewis explains that physicians were “the aristocrats of the medical world,” who “did not demean themselves by touching or handling their patients” (16-17). By contrast, surgeons ranked beneath physicians and did not merit the title “Doctor.” Surgeons and barbers were actually lumped together professionally until 1745, with surgery seen as “a manual job, akin to hairdressing” that included “lancing boils, dressing abrasions, pulling teeth” and “blood-letting,” along with excising tumors, gangrenous limbs, and syphilitic chancre, etc. (18). Surgery rarely included internal treatment, which was reserved for the even humbler apothecaries, who were responsible for concocting medicines to be taken internally.
“singularity and creativity” (46). While detecting and reporting the dangers of wind, water, or cleanliness is, by Charon’s reasoning, already creative, his experience of France and Italy as a sufferer and patient renders his description singular, particular. This detached yet personal viewpoint is precisely what made his next and final novel, *Humphry Clinker* (1771) so compelling—a novel that Michael McKeon observes to be an “innovation in epistolary form” for its suggestion that “the truth of things may lie in a composite and mixed view of reality” (691). By telling that novel’s story via an assemblage of letters from different writers, Smollett achieves innovative results “not through overarching detachment but through a protosociological sampling method that appears to derive a general truth from the multifarious data of particularity and disagreement” (McKeon 692). In *Humphry Clinker*, the many particular voices of Smollett’s characters are channeled through the equalizing view of the title character who “has no particular interests at all…and this authorizes him to represent all interests at large” (692). What occurs by painstaking authorial design in the novel—a narrative multiplicity—we can see Smollett rehearsing in *Travels*, a narrative rendered uneasy because Smollett himself is the sole conduit of the different interests, concerns, and discourse methods.

*Contra Sterne’s Smelfungus, Smollett’s cantankerous surgeon is not smelling fungus on his journey, but does frequently employ olfactory descriptions to help readers get a sense of place. He smells garlic, which he believes himself “poisoned with” in Montpellier (75), boiled silk cocoons in Nice, decaying animal flesh from a stockyard in the Levant, animal discharge and dirty water in Rome, and “a girl quite covered with the confluent smallpox” in Porto Maurizio, “who smelled so strong as to perfume the whole*
house” (307). While some of Smollett’s protests may be written off as provincial petulance and British disdain, then—the complaints about the garlic are all too typical of an eighteenth-century British traveler—others are entirely reasonable objections coming from a medical man, especially one terrified about his own health. His era still accepted the miasma or “bad air” theory of disease, Smollett is understandably unnerved by the smells of rotting animals, urine, and stagnant water, to say nothing of the pox victim. Some smells recall locations of disease and trauma whose unsanitary conditions he knew all too well, such as the Sardinian galley that “smells like an hospital, or crouded gaol” (130). There is no need to dismiss Smollett’s complaints as mere whining (à la Smelfungus) when they are both knowledgeable and—if read empathically—mostly justifiable.

As “threatening” as Smollett’s take on such places may be, in Charon’s sense, his subjective contribution as a knowledgeable sufferer makes his journey unique and valuable. Smollett’s domicile in Porto Maurizio is not the boarding place for a continental wanderer’s Grand Tour of the Italian coast. It is a house containing a smallpox victim, horrifying in its particulars, a warning to travelers taking in Italy for health reasons. However much his attitude may have been parodied later, his travel writings served as an authentic instance of Roland Barthes’ le scriptible, the writerly text of which the reader is “coauthor” (Charon 46). Readers who are sensible of and sympathetic to Smollett’s health concerns find in Travels valuable information about Porto Maurizio and about Italian travel generally.

One must never forget that the travelling surgeon, for all his methodical assessment of the surroundings, is also a travelling sufferer, subject to the moodiness
and self-recrimination of any patient searching after causes, punished by pain. Soon after his arrival in France, he finds himself “seized with a violent cough, attended with a fever, and stitches in my breast, which tormented me all night long without ceasing. At the same time I had a great discharge by expectoration, and such a dejection of spirits as I never felt before” (13). These symptoms provoke a penitential response in the sufferer, as though Smollett could surprise or punish his body into health: “I was sensible that all my complaints were originally derived from relaxation. I therefore hired a chaise, and going to the beach, about a league from the town, plunged into the sea without hesitation” (13). Smollett was a vocal proponent of exercise for improving ill health, and this shocking or “bracing” into health becomes a favored idea in the Travels, a kind of manly and character-building exercise that Smollett eventually hugs to himself with pride:

As my disorder at first arose from a sedentary life, producing a relaxation of the fibres, which naturally brought on a listlessness, indolence, and dejection of the spirits, I am convinced that this hard exercise of mind and body, co-operated with the change of air and objects, to brace up the relaxed constitution, and promote a more vigorous circulation of the juices, which had long languished even almost to stagnation. For some years, I had been as subject to colds as a delicate woman new delivered. If I ventured to go abroad when there was the least moisture either in the air, or upon the ground, I was sure to be laid up a fortnight with a cough and asthma. But, in this journey, I suffered cold and rain, and stood, and walked in the wet, heated myself with exercise, and sweated violently, without feeling the least disorder; but, on the contrary, felt myself growing stronger every day in the midst of these excesses. (308-9)

Smollett almost brags in this passage, an atypically optimistic one in Travels, citing his victory over the ordeal of illness that had in the past reduced him to a “delicate woman new delivered.” Near the end of his journey to wellness, he believes, mistakenly, that he has seen the worst.
After returning from his continental trip, Smollett traveled to his native Scotland in 1766, only to be met with more physical and mental suffering. On this trip he visited his mother for the last time—she died later that year—and was tortured by rheumatism, the recurrence of his tubercular symptoms, and a potentially cancerous, persistent ulcer on his forearm that hindered his ability to write. Reflecting on this domestic journey, Smollett seems regretful and apologetic about the toll that illness and personal troubles had taken on his behavior. He wrote to his friend Dr. John Moore, “Had I been as well in summer, I should have exquisitely enjoyed my expedition to Scotland, which was productive of nothing to me but misery and disgust” (Letters 131). His remarks reveal his awareness of strain on his mental functions: “I am now convinced that my brain was in some measure affected; for I had a kind of coma vigil upon me from April to November, without intermission” (131). In resorting to Latin (in a letter written to a physician), Smollett seems to seek the comfort of a diagnostic category to excuse his irritability; his bad temper has been part of a coma vigil, a waking coma that made his actions and behavior unconscious. He enjoins his friend to “tell good Mrs. Moore . . . that, with regard to me, she has as yet seen nothing but the wrong side of the tapestry” (131)—a Cervantean allusion in which he figures himself as a text, of which the reader, Mrs. Moore, has only read the “wrong,” the unintended and inexplicable side.

The Singular Medical Case: Smollett’s Indignation for Professor Fizes

Nowhere in Travels is the notion of singularity brought into sharper focus than in the detailed exchange that takes place between Smollett and Professor Fizes, the

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7 Vol. ii, p. 403 of Smollett’s translation of Don Quixote (1755) reads: “a translation from one language to another, excepting always those sovereign tongues, the Greek and Latin, is, in my opinion, like the wrong side of Flemish tapestry.” See Knapp for further “tapestry” references made by Smollett (131, n.3).
physician he consults about his symptoms in France, whom he calls "the celebrated professor F— . . . the Boerhaave of Montpellier" (89). As argued above, Tobias Smollett—surgeon and sufferer, writer and text—makes of his illness journey the only journey he can make, within his physical and financial limits. While hoping to provide delight after the manner of a witty and perceptive travel narrative, as a medical man, he cannot resist diagnosing and prescribing the scenery, telling his readers which areas to avoid by providing litanies of their ill effects. Seeking precision in his descriptions of people and places, he simultaneously creates an amalgam in his descriptions by relying on his own medical knowledge and recounts his own health struggles and resulting "dejection of spirits." He wants to write dispassionately of rickets in the water and scurvy in the air, but he is everywhere running up against his own singularity as a sufferer. This very singularity is denied and dismissed by the French expert, who shocks and outrages Smollett by reducing his case to an impersonal narrative, poorly read and gravely misunderstood. In a text preoccupied with suffering and informed by the author’s need for healing, the Fizes episode strikingly demonstrates all that can go wrong between patient and caregiver.

The Fizes account makes apparent Charon’s ideas about the patient as a text to be read by the doctor. Charon brings the narratological ideas of the story (l’histoire) and narrative discourse (le recit) into the patient-and-caregiver experience by emphasizing the particular instance of storytelling that makes a sufferer’s experience unique. Citing

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8 This exchange takes place in Letter XI, pp. 89-104. Herman Boerhaave was a famous seventeenth-century Dutch physician, who came to be known as “the father of physiology.” Along with chemistry achievements in the laboratory, and new symptom discoveries and diagnostic successes, his work helped establish the modern academic (teaching) hospital.
Gerard Genette, she challenges the diagnostician’s assumption (and so disrupts his comfort level) that the illness is solely an object to be identified and codified: “no story...replicates any other story. No representation of that story in words...repeats any other representation” (45). By bringing up the irreducible quality of narrative, Charon upholds the notion of the patient as a text but asserts (contra structuralism) that “the text remains a zone of indeterminacy, of the pleasure of the new, the never seen” (45). A casual reader of Smollett’s Travels might question the pleasurableness of the narrative but, of course, the pleasure it affords does not depend on the delight of the narrator. In Barthes’ formulation, the “pleasure of the text” becomes jouissance or bliss when the reader partakes of the writerly text, that which permits interaction and, for the narrator, an escape from the position of subject. As a caregiver, Smollett’s writing partakes of the beauty of the singular, the particular, constituting that “magical time outside the generalized statistic” (Charon 48, original emphasis).

Smollett’s encounter with Fizes furnishes an exceptional example of a self-aware patient (with medical training) who seeks advice for his particular illness experience and range of symptoms, and receives instead a disrespectful, replicated response that proves to Smollett that he has, in Charon’s words, “been reduced to that level” at which he “repeat[s] other human bodies” (47) and becomes an object. After his subjectivity, along with his narrative, is dismissed or ignored by the famous Dr. Fizes, Smollett is evidently shocked by the experience.

In his consultation with Fizes, Smollett neglects no particular—he has in fact spent most of Travels proving to the reader that he never neglects particulars. He clearly invests time and effort to describe methodically the minutiae of his case to this
well-known expert, a peer of Smollett’s, whatever his renown; he also pays him well. Smollett is expecting individual attention and professional courtesy. He gets neither and subsequently does not flinch from publicly divulging the unfortunate outcome of the consultation.

The circumstances leading to Smollett’s written exchange with Fizes are worth recounting because Smollett wrote down his formal case history instead of seeking a physical examination, after being influenced by other travelers’ harsh reports of Fizes’ “private character” (89). Although Smollett had arrived at Montpellier in reasonably good health and spirits, “with the hope of much amusement” during his stay, several days of rain and wind left “the air so loaded with vapours” that his “asthmatical disorder . . . became now very troublesome,” with debilitating physical symptoms and an accompanying “lowness of spirits” (89). He had already obtained the “advice of Dr. Fitz-maurice, a very worthy sensible physician settled in this place,” but wanted to know the opinion of Dr. Fizes, in spite of having heard “from some English people to whom he was known” that this “great lanthorn\(^9\) of medicine” was “very insolent,” “very slovenly, very blunt, and very unmannerly” (89). Although Fizes’ stellar medical reputation had preceded him, Smollett apparently learned only upon arrival in town that his “personal deportment” (89) was something altogether different. Tactfully, he decided to write to him rather than see him in person, and to keep his consultation formal and professional. Interestingly, it is highly likely that he heard these reports of Fizes from Laurence Sterne and his wife, particularly since Smollett recounts a brief tale about Fizes’ ill treatment of another consumptive that he heard from “Mrs. S—e who was on the spot” (104).

\(^9\) i.e. lantern
According to biographer Jeremy Lewis, Smollett met Sterne “several times in Montpellier” (237)—apparently the only place they met, unlike Sterne’s fictional accounts in Sentimental Journey, in which the narrator encounters Smelfungus at the Pantheon in Rome and again in Turin.¹⁰

Though Smollett never mentions Fizes by name in Letter XI of Travels, maintaining discretion with the conventional use of only the initial of his surname, we discover Fizes’ name from Smollett’s account of this consultation as he relates it in a private letter to his long-time friend, Dr. William Hunter (Letters 120-24).¹¹ To Dr. Hunter, Smollett reports that he found Montpellier a “very agreeable” place where he “met with some Families of English People with whom I could have passed my Time in a very sociable way” (120), had his stay not been so short. It is almost certain that Smollett counts the Sternes among these pleasing acquaintances. Because, as Lewis states, Sterne, too, was “[a]nother of Dr. Fizes’s unsatisfied patients” (237), we may safely assume that Sterne shared his dissatisfaction with Smollett at one of these Montepellier meetings—a natural discussion and exchange of opinions between two literary British tourists, both ailing and seeking medical help in France. If so, then the damage wrought by Smelfungus, however unintentional, seems all the more regrettable.

¹⁰See Sterne (40, n.13), for New and Day’s comments about the lack of veracity in these scenes’ settings in the novel. These imagined meetings are merely distortions of Smollett’s persona’s curmudgeonly commentary which Sterne used to creative effect in his novel, and then expanded upon so convincingly that readers believed the parody and shunned not merely the persona that narrates, but the person who composed Travels.

¹¹William Hunter was a celebrated London physician and one of Smollett’s most loyal friends. His brother John Hunter was a surgeon, and both men were anatomists interested in human dissection. Smollett adds a fascinating postscript to this letter, written from Nice, February 6, 1764: “I forgot to mention that scurvy is not known in this Country; and all the People have the whitest and the soundest Teeth that ever I saw. I wish I could send you a Head, but I am afraid I shall find no opportunity” (Letters 123).
Smollett’s presentation of his own case history to Fizes begins simply—in the Latin and third-person perspective appropriate to medical notation—with the most necessary facts: “The patient’s age is forty-three; his constitution moist, gross, abounding with phlegm, and very subject to rheums, accompanied with fever, dejection and difficulty breathing” (92). Fizes incomprehensibly and haughtily responds: “It appears by this case that the consultor, who has not thought proper to mention his age . . . has been heretofore subject to frequent rheums; tho’ there is no detail of circumstances” (97). In fact, Smollett goes into the “detail of the circumstances” for pages. “No mention is made,” Fizes complains, “whether the fever has any exacerbations; whether the patient has a good appetite; whether he coughs or spits; in a word, he says nothing of these particulars” (97-98). Again, Smollett devotes whole paragraphs each to fever and appetite, and vividly describes the nature of his cough and the appearance of his “copious expectoration” (92). All of the “particulars,” which Smollett painstakingly reports, provide Fizes with a history spanning years that charts all major changes in the illness, including Smollett’s awareness of the impact of mental distress on the body, as he admits having suffered a “domestic calamity which grievously affected him both in mind and body” (94)—the death of his darling Elizabeth. Writing in the third-person appropriate to case histories, but with an undeniably literary touch, Smollett admits:

He fled from the scene of this misfortune, to foreign climes, but found himself pursued by unutterable grief, anxiety, indignation, and the cruel remembrance of his irretrievable loss. The hectic fever, asthma, and dejection returned, attended with an almost incessant cough, and an acute pain in the side. (94)

His unutterable anguish has pursued him across the Channel. What must it have cost this traveling, tubercular surgeon and childless father to pour out his miseries in the
dispassionate form of a case history to an eminent physician who might have had answers that would help restore his health, but whose response lacks even a modicum of awareness or doctorly concern? To be sure, it exacted much more than the “loui’dore” (90) Smollett enclosed with the request for consultation.

When a seriously ill patient seeks a physician’s expertise, he is vulnerable and exposed, and arrives at the appointment with his entire life in tow. We both have a body and live our body, and illness often makes it nearly impossible to distinguish between being and experience. Both the patient and caregiver, Charon reminds us, “enter whole—with their bodies, lives, families, beliefs, values, histories, hopes for the future—into sickness and healing” (12). As the patient has lost his map and destination and does not know how to proceed, he seeks first, with fear and trembling, for direction from the caregiver. “What, the doctor should learn to ask, is different about this disease as it manifests itself in this particular patient? What . . . is unique about this patient as host of the disease?” (27). If the caregiver ignores the singular instance of the particular illness in this particular patient, and treats only the illness—not the individual—he sends the patient, along with all the other ill people of his “type,” down the trodden trail of hit-or-miss treatment, where every body is treated exactly the same.

While we cannot, of course, expect that Dr. Fizes would have taken anything resembling Charon’s twenty-first-century narrative medicine approach, we can nevertheless appreciate Smollett’s angry disappointment at the slapdash response he received—a complete rejection of his singularity, his needs. After all, the anxiety and disorienting nature of severe illness that Smollett describes in his case are universally experienced, however personally, uniquely we each must contend with them when we
are ill. Smollett, like any patient, sought understanding and advice for the symptoms that would result from assessment of his precise combination of exact details; but Fizes’ “prescription” is for everyman (and no man), a letter “replete . . . with a disgusting repetition of low expressions” that does not make sense for this specific case (*Travels* 100). (Smollett may perhaps refer here to the repeated mention of “a course of asses milk” that Fizes prescribes [98].)

Refusing to be lumped into Fizes’ broad category of respiratory patients, he makes another pitch for his singularity: “I could not but, in justice to myself, point out the passages in my case which he had overlooked” (100). Smollett begins another letter, this time in Fizes’ “mother tongue” (99) rather than the formal Latin of the case history, that addresses point-by-point the physician’s errors and omissions, though in a very civil manner. “I cannot think there are any tubercules on my lungs, as I never spit up purulent matter, nor anything but phlegm or *pituita* in colour and consistence like the whites of eggs” (102). He emphasizes his inclusion of this “detail” from the original letter by restating the Latin: “*Sputum albumin ovi simillimum*.” Smollett re-presents his own diagnostic guess for Fizes’ consideration:

I imagine, therefore, that my disorder was originally owing to a sudden intermission of bodily exercise, intense application of the mind, and a sedentary life which hath relaxed the whole fibrile system, and that now it may be called a *pituitary*, not a *purulent* consumption. (102)

He cordially asks Fizes to take a second look at his case, and receives an arrogant, even insulting note, asserting that “he was sure” Smollett’s medical history could not have been “written by a physician” (102), and reaffirming his initial opinion and prescription. No “justice” was done in this second attempt for medical advice. Smollett pays an additional “twelve livres” (103) which he and his servant understood to be for
the servant’s “advantage” for dispatching the letters. But Fizes “put the money in his pocket; and the fellow returned in a rage” (103).

The whole episode becomes a cautionary tale for the traveling consumptive; Montpellier becomes another point on the literal map Smollett is constructing for those who must yet find their own way through the foreign terrain of life-threatening illness. He has a responsibility to other sufferers. But it is more than that. Smollett devotes sixteen pages of *Travels* to Letter XI—sixteen pages that could be devoted to describing scenes and people, were this a conventional travel book. He *needs* to tell his story to a broader audience than the unsympathetic Fizes. It is a crucial part of this journey. To paraphrase Robert Frost, narrative is a temporary stay against the confusion of illness. The story is not told merely for the sake of highlighting Fizes’ “unjustifiable negligence” (102), or solely for the benefit of the reading public, however useful the information may prove for other valetudinarians. Pursued by grief and unable to quell his deteriorating symptoms—his life’s “story” in ruins—Smollett tells of his illness experience (“in justice to myself”) as a means of reclaiming his selfhood and identity. As Frank observes, “He is declaring himself a witness to his illness, and he is calling on his audience. . .to become witness to his witness” (62). Relating the incident in such personal, singular terms, then, makes of Letter XI a *scriptible* text, one whose context and utility the reader supplies.

But, again, the service is done not only for his readers. This portion of his journey must be represented in all its ugly particulars, because, Smollett knows, to remain silent about it will only make him sicker. To Fizes, he describes his intensifying symptoms that erupt into fever as a process not unlike his intuitive understanding of his need to
abreact: “then Nature finding herself in danger of being oppressed, endeavours to expell the excess, by means of a new fever” (*Travels* 93). Smollett’s writing is like a “new fever.” Nature has built in us all the impulse to “expell the excess” worries, fears, grief, and pain that we often work hard to silence, keep in check, or run away from by fleeing “to foreign climes.” As Louise DeSalvo insists, through reflective-writing teachings that draw on Pennebaker’s clinical work, expressing “a shock or a blow” or an illness or trauma “in language . . . assuages our pain” (43) and gives us insight. The physiological processes that ensue from reflective writing, Pennebaker demonstrates, “are telling us that our thought processes heal” (*Opening Up* 38). Smollett understands that he needs to sort out the internal chaos through his pen; thus, the pages of his *Travels* are fevered with his endeavours to purge his oppressive emotions. Letter XI sits oddly, but tellingly, in the middle of his travel narrative. In the act of telling the illness experience, Frank says, “[t]he self is being formed” (55). By “venting his spleen,” asserting his medical knowledge, and declaring his singularity, Smollett is shaping a self that will sustain him as he endures the vulnerabilities and indeterminacy of his suffering.

In his letter to Dr. Hunter after the unfortunate consultation, Smollett does not go on at length about the symptoms he presented to Fizes or spell out in detail the numerous blunders contained in Fizes’ response. Instead, he assures his friend that “[t]he Correspondence between us was diverting enough. If ever I return to England, you shall see the original Papers” (121).12 He tells Hunter his unequivocal opinion of the Boerhaave of Montpellier—that he “is an old sordid Scoundrel, and an old woman into

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12 These original papers were included in their entirety in the first edition of *Travels*. In a subsequent edition, Smollett added his own English translations.
the Bargain”—and succinctly expresses his indignation at Fizes’ lack of professionalism: “I sent him my Case in Latin, which he answered in French” (121). Hunter, no doubt, would have been as appalled as Smollett by such a breach of medical propriety, particularly by a prominent physician. More shocking than this misstep, however, is Fizes’ indifferent and inaccurate reply. It is bad enough, according to eighteenth-century norms, for a physician to write his assessment of a case history in the vernacular, when it has been presented to him (by a surgeon) in Latin, the language of medicine. It is something much more ethically egregious, in any century, to take the patient’s fee and not to assess the case at all. Fizes either “did not understand Latin, or . . . had not taken the trouble to read” Smollett’s history (100), issuing a form letter rather than a considered evaluation.

Smollett’s dismay over the Fizes incident may have broken his confidence in the objective tone and language, the comfortable “categories” in which, with difficulty, he had tried to relate the diagnostic particulars of France and Italy. He was thrust into the role of helpless sufferer, anxiously awaiting the diagnosis himself for a malady that has caused serious pain, discomfort, and “dejection.” Fizes’ response is not merely impersonal; it has made of Smollett’s case—of his body—a repeatable, passive text. Smollett cites the experience of one Mr. Maynes with Fizes to convey his own horror at being “reduced” to uniformity by the doctor: “Mr. M—e . . . consulted F— at Montpellier. I was impatient to see the prescription, and found it almost verbatim the same he had sent to me; although I am persuaded there is a very essential difference between our disorders” (Travels 116). “Essential difference” indicates Smollett’s awareness the importance of singularity. In his letter to Hunter, Smollett writes that “I found he had a
set of Phrases and Prescriptions which he applied to all Cases indiscriminately, for when I arrived at Nice, Mr. Mayne, an English Gentleman (now dead), shewed me a Paper of Directions written by Fizes in exactly the same words which he had used to me” (Letters 121). Smollett’s situating of that crucial phrase, “now dead,” within parentheses is not to be missed. It reminds one of similar casual mentions for comic effect in Smollett’s novels, as in Roderick Random: “I concealed my agitation as well as I could till the head of the officer of marines who stood near me, being shot off, bounced from the deck athwart my face” (Chapter 29, my emphasis). Fizes’ utterly generic caregiving results in dead patients. His literally duplicated diagnoses offend Smollett both personally and professionally.

“T’was Nothing”: The Legacy of Travels

It is the regrettable fate of Smollett’s Travels that so personal, intimate, and singular a narrative would be, in Felsenstein’s words, “relegated to an unmerited obscurity” so soon after its enthusiastic reception, dismissed as casually by the public as the journey of “the learned Smelfungus” is mocked by the narrator of Sterne’s Sentimental Journey:

The learned Smelfungus travelled from Boulogne to Paris—from Paris to Rome—and so on—but he set out with the spleen and jaundice, and every object he pass’d by was discoloured or distorted.—He wrote an account of them, but ‘twas nothing but the account of his miserable feelings. (39-40, my emphasis)

Further, Felsenstein observes that “[o]f all Smollett’s creative writings, none has had a more chequered critical history than his Travels” (xlviii), although limited scholarly interest revived in the last century. Although he forever seeks the comfort of prior diagnostic categories, Smollett’s narrative justifiably filters in his “miserable feelings”; he is right to relate them and, in fact, in light of Charon’s discussion of singularity, and
Frank’s reflections on the responsibilities of illness-storytellers, they constitute the most significant portion of the book.

As Smollett planned his departure for the Continent, he was expecting death. “To tell you the Truth,” he wrote to John Moore, “I have a Presentiment that I shall never see Scotland again” ([Letters 106]). Smollett had determined to face death honestly, even if, as he told Hunter, he could not bring himself to say good-bye: “I am now ambitious of nothing so much as of dying with the Character of an honest man. Such is the Tenderness of my nature enervated by ill Health and misfortune that I cannot well stand the shock of parting from my best Friends” ([Letters 114]). As he wended his way south, he journeyed deeper into the “kingdom of the sick” (Sontag 3), reflecting on his condition as he mapped a path for others.

Both he and Sterne exchanged their “good passports” for the bad and “emigrate[d] to the kingdom of the ill” (Sontag 3). While both recognized that they must “live there” and face the discomforts and uncertainty of this “onerous citizenship” (3). While Smollett worried after the fact that he had been too exposed, too honest and irritable in Scotland, revealing for Mrs. Moore the “wrong side of the tapestry,” Sterne reveals only the “right” side of technical smoothness and narrative consistency. His narrator thus dismisses Smollett’s narrative (“t’was nothing”) for its honesty, the very forthrightness and “character of an Honest Man” that enable Smollett’s singularity.

The final missive, Letter XLI, ends with Smollett’s narrator eagerly waiting to “tempt that invidious straight” [sic] (345), the English Channel, and to be restored to his unnamed, seemingly well-known correspondent. Here the narrator prepares to return home, if not to his native Scotland, to London where he has spent thirty years living and
writing, whose residents are his friends, colleagues, and former patients. The story ends in the literal place where it began, Boulogne, with the narrator now enjoying some improvements in his general health. Yet it also “ends in wonder,” as, Frank says, “the good story” should do (68)—with a rejection of Smollett’s offer of singular caregiving to a fellow traveler and a rumination on the peculiarities of English reserve. Smollett had learned of “an English gentleman laid up at Auxerre with a broken arm,” and had sent his “compliments, with offers of service,” but was told the man “did not choose to see any company, and had no occasion for my service” (Travels 344). Although Travels is well known for Smollett’s dim view of French manners, Smollett reflects with disappointment on what he considers to be a shortcoming of the typical English disposition:

When two natives of any other country chance to meet abroad, they run into each other’s embrace like old friends, even though they have never heard of one another till that moment; whereas two Englishmen in the same situation maintain a mutual reserve and diffidence, and keep without the sphere of each other’s attraction, like two bodies endowed with a repulsive power. (344)

Knowing the history of the text’s decline, it is hard not to think about what would happen after the publication of Travels when one reads this passage in the last letter. Smollett’s book seemed to receive that “native embrace” initially, although the public body rejected the singular suffering body with such “repulsive power” that the printing presses did literally stop. He could not have known (and neither could Sterne, for that matter) how Sterne’s sardonic portrayal would infect readers’ consciousness (perhaps their self-consciousness) and distend into successive centuries. But he knew what he was doing when he wrote down his insights and sensitivities in these letters, for all of their affective variety and opinionated discernment. He was telling his story as he saw it, weaving in
intermittently the snappish persona of British subject abroad, with absolutely no reservation about venting his spleen over the ugly foreignness he was experiencing in his own bodily frame.

Stories of illness and suffering are unpleasant and disquieting; many who are well would rather not hear them. Again, Frank’s perspective is valuable here: “Telling an interrupted life requires a new kind of narrative . . . 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). One could hardly accuse either Sterne or Smollett of being diffident. But Smollett understood his multifarious responsibilities to “expel the excess” pain with the aid of his pen—not to produce poison with it—and with a voice that so many pens have commented upon in the ensuing years, taught us in his Travels that, if we must journey along that onerous kingdom’s path, we will feel better for narrating the journey.
CHAPTER 5
JANE AUSTEN: CAUSALITY/CONTINGENCY IN PERSUASION

Was it new for any thing in this world to be unequal, inconsistent, incongruous—or for chance and circumstance (as second causes) to direct the human fate?

—Jane Austen
Emma

Jane Austen was the casualty of such “unequal” first and “second causes” when illness befell her at the height of her professional literary career, ending her life in July 1817 at age forty-one. Just as she was realizing the strength of her authorial powers—through positive, published reviews and growing sales and self-confidence—the weakness of her body interrupted and soon stopped her writing. Certainly it has seemed to legions of readers, as it did even to some members of the Austen family, that the author’s health suddenly waned in 1816, triggering alarming inconsistencies in her energy levels, mobility, and capacity to work. In the spring of that year, Cassandra Austen accompanied her beloved sister to the spa town of Cheltenham, where they hoped that the regimen of a pint or two of the salty spa water, taken daily before breakfast, would prove beneficial and perhaps curative. Other than inspiring the sparkling, comic ideas that she used for her unfinished final novel, Sanditon, Austen gained nothing by the visit. Despite her inexplicable back pain and fatigue, she returned home to Chawton and finished Persuasion, writing “Finis, July 16, 1816” on the manuscript she’d begun the previous summer while negotiating terms, with her brother Henry’s help, for the publication of Emma. Thus begins the end of a lamentably brief body of work brimming with wit and vivacity, whose author now is discussed frequently in the context of illness and death.
Although this perception of the sudden onset of a terminal illness held sway with Austen’s interested public for almost two centuries, more recent scholarship posits the theory that Austen struggled throughout her lifetime with serious infections, indications that she may have suffered from chronic immune deficiency, and that her decline began much sooner and was more gradual. According to A. Upfal (2005), even as English readers were delighting in the newly published *Pride and Prejudice* in 1813, Austen was beginning to experience the symptoms of a fatal lymphoma—the final illness of a life riddled with mysterious infections. Austen’s weakened immune system, Upfal surmises from evidence culled from Austen-family correspondence, originated with complications resulting from Austen’s four-week post-mature birth. In post-mature pregnancies, the placenta begins to deteriorate, causing tissue-wasting in the fetus coupled with poor intrauterine nutrition.

Upfal’s pieced-together medical history indicates that Austen acquired oddly timed illnesses—like severe whooping cough at age 30 (when it is rarely seen in children above 10), or the painful herpes zoster and facial neuralgia at age 37 (which typically affects people well into their fifties and sixties). These conditions, along with prolonged bouts of other serious ailments in her life mentioned in the family record—typhus at age 7; chronic conjunctivitis that began in 1799; a severe, perhaps chronic infection of the outer ear; and possibly pruritis, an intensely burning, itchy skin rash that is a common early symptom of Hodgkin’s disease—seem to suggest that Austen’s immune functions were compromised early on. Reading these symptoms alongside Austen’s own spare descriptions of her condition in her final year, we may indeed see the ominous pattern that Upfal traces to fatal lymphoma and gain new causal and
temporal perspectives of the author’s final illness. Austen’s entire body of work, then, if
Upfal is correct, can be read with the specter of illness looming; her narrativity and
subjectivity would thus depend on and be defined by the challenges of pain and
suffering—a supposition that seems incongruous with the nature of her plot lines and
characters, and requires some interpretive leaps over evidentiary gaps.¹

Whatever the cause of Austen’s untimely death, scholars and lay persons alike
continue to probe the mystery, as though its revelation will somehow provide some
indefinable comfort for readers or help us come to some new understanding of her body
of work. While Upfal’s widely read article and plausible (if highly speculative) claims
eclipsed scholars’ long-held notion, posited by physician Sir Zachary Cope in 1964, that
Addison’s disease claimed Austen’s life, Upfal and Cope are only two of many
researchers still seeking the cause of Austen’s demise. A quick perusal of only the most
prominent theories espoused since Upfal’s article reveals the efforts expended in the
search for an answer. For example, K.G. White (2009) partially supports “Cope’s
hypothesis of infective tuberculosis as the source of her illness” (100), but argues
against Addison’s disease in favor of disseminated bovine tuberculosis, which might
have been transmitted via contaminated milk. In a 2010 article, Linda Robinson Walker
makes a compelling case for Brill-Zinsser disease, a recrudescent typhus. The
infectious agent of typhus, which Austen caught as a child while at boarding school,
lingers dormant in the body and can fatally recur as Brill-Zinsser disease (as chickenpox
can recur as shingles) if the immune system is weakened in some way. Several

¹ Indeed, many of Austen’s letters have literal gaps: lines and sometimes whole paragraphs cut away,
most likely by Cassandra in attempts to protect her sister’s privacy. Cassandra and the other Austen
siblings burned many letters completely.
scholars, advancing their claims of varying illnesses, have speculated that the family’s financial crises of 1815-16 placed undue stress on Austen that could have weakened her body’s immune responses and set (whichever) fatal chain of events in motion. And, in 2011, yet others in the scientific community, prompted by crime novelist Lindsay Ashford, were hoping curators at the Jane Austen House Museum would agree to allow neutron activation analysis of one of Austen’s locks of hair, speculating that her apothecary may have unintentionally poisoned her with arsenic-laden medications (Jabr 2). Though the outcome of Austen’s illness remained unchanged, the pursuit of its source—by fans and forensic experts—has not abated because knowing the medical cause seems to promise the relief of conclusiveness. Perhaps if it is found that hers was unquestionably a “terminal” illness, as we understand that term today, that knowledge might assuage our regret for the “futility of a death from an illness that now offers recovery” (Upfal 3) or mitigate the yearning for novels never written. The search goes on because many people feel they just need to know.

So it is poignant and revealing (and, given this unending speculation about causality, somewhat ironic) that, in the midst of uncertainty about her health and life expectancy, she gave us Persuasion, a novel that problematizes the notion of certainty and questions the implications of having, for good or ill, a “character of decision and firmness” (Austen 74). Although Austen probably never heard of the Romantic poet John Keats, and knew nothing of his concept of “negative capability,”² she, like Shakespeare, seems nevertheless to have “possessed so enormously” this quality

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² Keats’ most important poems were published two years after Austen’s death; further, his letter describing negative capability was published long after his own death from tuberculosis in 1821.
Keats describes as the capacity for “being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason” (Keats 109). We see Austen’s negative capability enacted in her heroine, Anne Elliot—a woman who wrestles with doubt for eight unhealthy years before choosing a life of happy uncertainty at the novel’s end. While working out her personal and fictional doubts, Austen uses the sick room in *Persuasion* as in no other novel: to illustrate how chance and circumstance—accident and illness—can direct human fate, and how doing one’s duty to others (or neglecting to) exposes one’s morality in ways that can significantly alter lives and future events.

In narrative medicine, Rita Charon uses the terms “cause” and “contingency” to indicate both the healer and patient’s different needs for understanding the root causes of suffering and their mutual hope for the best possible outcomes. They are terms particularly suited to explicating Austen’s autumnal novel, not only because of the circumstances of its writing but also because of the illness/recovery experiences that serve to mold the novel’s protagonist. By shaping pivotal moments of the plot to hinge on depictions of accidents and illness to which Anne Elliot dutifully and intelligently responds, Austen literally builds healing and caregiving into the novel while at the same time, always the educating, comic novelist, she allows her heroine to gain an important measure of certainty of self by observing in the contingent examples of other characters what her own life might have been.

Specifically, for Anne, whose early refusal of her true love’s hand in marriage has seemingly fixed her in spinsterhood and dependence on a loveless family, Austen introduces three marriages, each of which portrays the intersection of duty and sickness. She thus gives Anne three potential versions of what her own marriage might
have been, had she not been persuaded by Lady Russell to refuse Captain Wentworth eight years before—a circumstance which may be likened to a misdiagnosis, Lady Russell’s expert but hasty, incomplete attempt to manage Anne’s behavior through the demands of prudence and caution. As Anne struggles to understand the causes of her own unhappiness, she encounters in her sister Mary, Mrs. Smith, and Mrs. Croft, (whose handling of their own illnesses and duties directly inform their characterizations) three marital contingencies: one, Lady Russell had wished for—for Anne to accept Charles Musgrove, as her sister Mary ultimately did; another, Lady Russell’s advice was meant to preempt—the financially disastrous union of the Smiths; and third, the happiest possibility that Lady Russell could not guarantee for her dear Anne and young Wentworth, “who had nothing but himself to recommend him” (27)—the happy marriage of the loving and wealthy, but duty-bound, seafaring Crofts. As Anne interacts with Mary, her new acquaintance Mrs. Croft, and old friend Mrs. Smith, she learns that how one contends with the uncertainties of illness and accident can determine one’s personal happiness, and reaffirms her essential characteristic and long-held belief that “a strong sense of duty is no bad part of a woman’s portion” (198). We may surmise that this highly developed sense of duty stems from Anne’s own suffering, and therefore that she serves as an example, unique in Austen, of an empathic healing figure that heals herself, too.

Anne Elliot as Austen’s Reflective Writing

The concept of “duty,” which my discussion will emphasize as a key component to Anne’s developing understanding of “cause” in the novel, was apparently central to Austen during the novel’s composition—a period in which she served as Henry Austen’s nurse during his prolonged, near-fatal illness before falling ill herself and journeying to
Cheltenham with Cassandra. The only portion of Austen’s completed novels to survive in manuscript form is the revised concluding chapters of *Persuasion*, now preserved by The British Library. Claire Tomalin observes in her biography that some words were “underlined” as though the author “paused to think of their significance and stress it: ‘Persuasion,’ ‘Duty’” (258). In a variety of scenes in the novel, the two terms seem to herald the progression of Anne Elliot—from the faded and submissive, “persuaded” spinster, insulated by poetic indulgence as she quotes lines to herself in the autumnal walk to Winthrop, to the “persuader” of others, an exponent of duty, empathy, and obligation, blooming, revitalized and firm once she takes the sea air at Lyme.

While critics have often understood Anne Elliot’s recovery in terms of sexual reawakening, the connections with health have been less noted. In fact, Austen describes Anne’s physical characteristics during this progression as though the heroine were moving from sickness to health, with Anne “faded and thin” (11), even “haggard” (12) at Kellynch Hall, a home environment emphasizing insularity, oppression, and confinement, and later lively, fresh-faced, and self-confident in the freedom of Bath, “blessed with a second spring of youth and beauty” (101) by which even her narcissistic father is impressed. The catalyst for Anne’s change may be the exposure she gains to new scenes and people, but it is her steadfastness to duty that brings her these occasions, positions her where she may be of service, and allows her to discover her newfound strength and vitality. Anne’s dutifulness emerges along with her own search for cause; as she tries to understand the prudent but apparently erroneous advice of Lady Russell, the cause of her own heartsickness and physical decline, she finds the fortitude to relieve others’ suffering.
What we see in the character of Anne Elliot is Austen working out some her own most pressing concerns in her fiction, shaping a reflective narrative that does something more than any of its predecessors: it repeatedly explores frightening contingencies in the way that one might do through writing when faced with mortality. It is thus no coincidence that Anne, more than any of Austen’s other heroines, encounters problems of the sickroom and, as David Nokes observes, comes “so close to [Austen’s] own sensibility” in so many ways (490). Anne is an older, more sober, morally conscious, self-composed woman capable of, and indeed sometimes requiring, periods of quiet reflection. Austen’s illness as she composed the novel in 1816, as well as her acute observation skills, would have enabled her to sense the gravity, or at least the abnormality, of her condition enough to feel the pressure of time in ways that we can trace in some of the plot’s hasty resolutions (the relationship between Mrs. Clay and the scheming Mr. Elliot, for example), the novel’s comparatively abbreviated length, and the narrative’s alignment with the seasons, moving from degenerative fall to promising spring. Several scholars surmise that the autumnal mood and melancholy storyline in *Persuasion*'s first half, so unlike the tone and plot in her other books, signal Austen’s awareness that she was, in fact, in “her November of life” (*Persuasion* 75). The novel’s reflective and ailing heroine thus imitates the novelist’s own ailing reflectiveness.

Although the romantic (and Romantic) elements of the text that scholars often highlight are indisputably present, and may well exemplify the author’s yearning for

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3 See Nokes’ biography, pp. 487-494, for an interesting assessment of some of the parallels between Austen’s life and the character of Anne Elliot.
blooming youth and lost love, the problems of illness and accident that run quietly through the narrative, entangled strands of realism entwined with the romantic relationships she creates, reveal that Austen was grappling with larger questions and more sobering possibilities. Like Romantic lyrics, the novel’s poetic scenes of nature, such as those found in the “last smiles of the year upon tawny leaves and withered hedges” (71) along the paths to Winthrop and the sensual description of Lyme’s landscape, reflect and augment Anne’s character development while interweaving dichotomous concepts—firmness and tenderness, past and future, old and new—into her growing self-awareness.

A close examination of recurring binaries and their syntheses helps readers to recognize in Anne a more fully developed protagonist. Nina Auerbach discusses, for example, the “paradoxical mixture of pleasure and pain” that is pervasive in the tone of the novel (128). “Emotional extremes meet and marry in an intensity of feeling” that is “almost savored” by author and reader alike. I posit that such intensity of feeling arises from the author’s own attempts to cope with questions of health and illness, life and death—a preoccupation that surfaces even in language she relates to Anne’s love interests. For instance, Anne had experienced no “second attachment, the only . . . sufficient cure” (28) for the wound left by her refusal, and later felt that Wentworth’s letter “was not to be soon recovered from” (191). However exquisite its descriptions of nature or Romantic its emotional overtones, *Persuasion* certainly considers the

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4 Austen’s 1796 letters to Cassandra about the handsome Tom LeFroy come to mind, as do the flirtatious letters she wrote to her sister in 1816 about the surgeon Mr. Charles-Thomas Haden, who attended Henry Austen during his severe, prolonged illness. Austen was her brother’s constant nurse through this ordeal, only sharing the duty with her siblings when Henry was believed to be dying.
sickroom more frequently and more seriously than any of the novels since Marianne Dashwood’s life-threatening fever in *Sense and Sensibility*. And in each of these scenes, Anne is there: either an active, quick-thinking nurse or a comforting, calm presence, always dutiful, empathic, and kind. Anne is thus an apt reader of patients and suffering, exemplifying one of narrative medicine’s aims.

As Austen develops this heroine, while trying to come to terms with her own uncertainties about her health and still supply readers with triumph over adversity and the comic ending expected in a novel “By a Lady”\(^5\) at this time, she creates a fictional work blended with personally revelatory, reflective writing. Anne Elliot becomes a vehicle for Austen’s psychological confrontation of illness and the site of both authorial wish-fulfillment and Keatsian negative capability. Austen restores Anne to her one true love *and* to blooming vitality, neither of which was a likely eventuality in her own life. As Austen would write to her niece in 1817, “I must not depend upon being ever very blooming again” (*Letters* 335-6). And yet she emphasizes the danger and uncertainty inherent in the match in the novel’s last few lines, acknowledging “the dread of a future War, all that could dim her Sunshine” (213). Throughout the protagonist’s growth, Austen demonstrates the importance of remaining true to one’s moral obligations—doing one’s duty—and remaining even-tempered or even sanguine when chance events or painful circumstances threaten to overwhelm one. As a sufferer, Anne attempts to grapple with this best possible prognosis; she draws on her own unhappiness to relieve others’ unhappiness.

\(^5\) Austen published all of her novels anonymously during her lifetime, using this byline for her first, *Sense and Sensibility*. Subsequent bylines proclaimed “By the Author of [the title of her most recent novel].”
Anne and Wentworth: Grappling for Cause

As noted above, the conflict of *Persuasion* lies largely in Anne Elliot's need to understand her own apparently undeserved suffering, a heartsickness and depression that affects not only her own emotional and physical health but also her perception by family and acquaintances. By opting for the prudent path that Lady Russell prescribed—a prudence that is usually rewarded in Austen's other novels—Anne has reluctantly invited suffering and loneliness into her life, to say nothing of powerlessness and isolation. Even when her personal health and dutiful effectiveness increase in the course of the novel, Austen makes it clear that her credibility does not, that she is rendered voiceless by the lack of empathy in her “patients,” those family members who depend on her selflessness and, ironically, lack of usefulness.

Significantly, then, Austen crafts a heroine whose “word had no weight” (11) in family concerns, one rendered useful by her status as a hopeless spinster. When the novel opens, Anne lives at Kellynch with her father and eldest sister, Elizabeth, both of whom consider her to be “nobody” (11) and speak to her, if at all, with baseless disrespect. Compounding this familial misery, we learn, is depression: “Her spirits were not high” (18). Almost eight years have passed since she “was persuaded to believe” her engagement with Wentworth “a wrong thing,” and her “suffering” and “regrets” have “clouded every enjoyment of youth” (28). She has aged and seems to wither like the tawny leaves, under the burden of the latest disappointments—her father’s heavy debt and shameful need to leave the family estate.

If her words have no weight with her family even now, in her late twenties, they do with Lady Russell, an authority figure to whom Austen remains sympathetic, even though her persuasion of Anne before the novel’s timeframe has been the cause of
Anne’s decline. Lady Russell privately consults Anne about how best to proceed in the delicate matter of convincing Sir Walter Elliot to economize, a family ill that Anne responds to with moral precision. Appalled by her father’s extravagances, Anne considers it “an act of indispensable duty to clear away the claims of the creditors” and urges that Lady Russell push for “the most comprehensive retrenchments,” however severe the Elliots’ sacrifice. Moreover, she wants these actions “to be prescribed, and felt as a duty” (16). Anne’s words may carry no weight with Sir Walter and Elizabeth, but we immediately grasp the fortitude of her character in her quiet management of this debacle; she grasps moral propriety and painful necessity more resolutely than those who scorn her. This opening scandal—an egregious breach of duty by titled gentry—sets in motion all of the action that will lead Anne to other acts of duties, scenes of illness, and uncertain marital contingencies. Further, it confirms Anne as a decision maker on Lady Russell’s own level, though her prescriptions are given behind the scenes, and must in fact be administered through Lady Russell to have any weight.

Anne is established, through the retrenchment calamity and consultation with Lady Russell, as a heroine more sensible, knowing, and prudent than her family members, yet one who finds herself voiceless and in a position of powerlessness. The novel ponders how this situation could have come about, hinting early on that its cause has been the same cause as all of Anne’s other “symptoms”: her surrender to Lady Russell’s well-meant advice to break off her engagement to Wentworth has rendered her a useless, even ugly nonentity with her family members. Her path to a happy ending in marriage is therefore a path to credibility and, as is made obvious by the novel’s
diction and tropes, to recovery as well. Anne will heal when she understands her health and “narrative” in a way that her caregiver and advisor did not.

Before discussing Anne’s learning and healing via the “contingencies” of other characters more chronologically below, it is worth considering the novel’s denouement here, as the culmination of the heroine’s search for “cause.” This was not the original ending of the novel, which featured a surprise meeting and hasty reconciliation and engagement between Anne and Wentworth at the Croft home. Austen revised for a more powerfully contemplative outcome, choosing uncertainty for Anne over the pat simplicity of marriage with no thought of future conflict. In arguing about the constancy of women with Captain Harville at the White Hart Inn, Anne finally sees herself as following the path of duty—here, duty to her sex—by continuing to love Wentworth, despite the ill-usage of her family members and her abundant suffering. In short, Anne fully acquires voice.

In an oft-quoted passage, one which Nina Auerbach calls “the most consistently misread scene in all of Jane Austen’s novels” (124), since many readers want to style Austen as a feminist in twentieth-century terms after reading it, Anne and Captain Harville discuss the relative views of constancy as experienced by their respective genders. Some readers proclaim (and some scholars have written extensively) that Austen is a feminist writer based, in part, on Anne’s telling dismissal of histories in prose and verse written by men. I do not seek to argue with or invalidate such readings; rather, I am more interested in the passage in which Anne attempts to explain “the

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6 Cassandra noted on her sister’s manuscript that the revised ending was finished 6 August 1816. Why Austen did not pursue immediate publication has long been a source of speculation. The novel was published posthumously, along with Northanger Abbey, in 1818.
nature of any woman who truly loved" (155). Here, I think, Austen crystallizes her own feelings about the limitations of her domestic station:

We certainly do not forget you, so soon as you forget us. . . We live at home, quiet, confined, and our feelings prey upon us. You are forced on exertion. You have always a profession, pursuits, business of some sort or other, to take you back into the world immediately, and continual occupation and change soon weaken impressions. (155)

In other words, Anne insists, men have the certain advantage of duty to engage them, body and mind. Women (those who don't have the fortitude and stamina of someone like Mrs. Croft, the admiral’s wife who becomes Anne’s most influential example of contingency) are stationary, at home, and comparatively inactive beside the wide-ranging pursuits of their husbands, sons, brothers. Austen chooses the word “confined,” which conveys both a sense of imprisonment (Anne has suffered in her solitary confinement for the past eight years) and of childbirth, the “natural” duty of wives. This is not to say that Anne, ever dutiful, has ever been idle or neglected her familial and societal obligations. Yet the necessary interiority, the stifling and stamping out of any expression of emotion has been for Anne a detrimental sentence. I agree strongly with Auerbach’s point that middle-class nineteenth-century “Women feel, quite simply, because they are given nothing else to do. . . They suffer because their social role creates for them a life without exertion, in which state one’s feelings become a torment” (125). With strengthened emotional awareness, by this point revitalized and blooming again from her exposure to so many other domestic examples, Anne makes the salient point that duty creates a kind of freedom for men that women, relegated to their domestic spheres, do not, cannot enjoy.

Moreover, by countering of Harville’s argument, she reveals that her struggle has been with voice and narrative. While Harville insists that “I do not think I ever opened a
book in my life which had not something to say upon woman's inconstancy," Anne
counters with "Men have had every advantage of us in telling their own story. Education
has been theirs in so much higher a degree; the pen has always been in their hands"
(126). Her own narrative has been misread—by Wentworth, who imagined her unfeeling
and easily misguided, and others—because the dominant narratives regarding female
behavior in love affairs have been authored by men. Despite this injustice, Anne regards
her unceasing affection for and faithfulness to Wentworth to be her duty. While such
apparent unrequited devotion certainly earns the novel its romantic reputation, Anne is
clearly suffering out of a sense of duty, like anyone bearing up under terminal illness,
trying to remain strong and hopeful about her prognosis. She possesses an authority in
this interaction that she has not been able to express (at least, not to any man)
anywhere else in the novel.

Anne as Nurse: Domestic, Medical, and Narrative Contingencies

Anne Elliot’s physical and emotional regeneration, her recovery from voiceless
nonentity to authoritative narrator of her own story, is achieved through her exposure to
a carefully rendered selection of domestic examples. These interactions between Anne
and three other married or widowed wives significantly depend on Anne’s skill as nurse,
listener, and caregiver. Through her empathic sense of duty, she becomes the physical
and emotional physician of others and, through discussion and consideration of their
narratives, she recovers her own.

The first marital contingency Anne encounters is that of her sister, Mary
Musgrove, who, though ineffectual and critical, is “not so repulsive and unsisterly as
Elizabeth” (29). Alistair Duckworth sums up Mary as “selfish, incapable of disciplining
her own children, absurdly vain of her ancestry, and forever seeking ‘precedence’ in
personal as well as social areas” (Estate 188). Mary is, moreover, overly dependent on Anne to cure her phantom ills and fulfill her parental functions when, in fact, nursing duties are actually needed for her injured child. In Mary, Anne thus grapples with an example both of what she herself might have become—she, not Mary, had been proposed to first by Charles Musgrove—and of an undutiful and insensitive caregiver. Their scenes together highlight simultaneously Mary’s laziness and Anne’s willingness to serve, but also point out the experience and deliberation necessary to become an effective nurse. Mary should naturally possess the empathy to serve as nurse to her injured son, yet she is too self-centered to do so, preferring instead the excitement of dinner with guests at her the home of her in-laws. This early domestic example therefore points out Anne’s depth compared to her married sister, while propelling the plot to new scenes in which the heroine can examine other examples of marriages and begin to realize her own worth.

Yet the scenes with the Musgrove family also hint at future recovery for Anne via the path of empathic duty. Anne stays at Uppercross because she can be useful. “To be claimed as a good, though in an improper style, is at least better than being rejected as no good at all; and Anne [is] glad to be thought of some use, glad to have any thing marked out as a duty, and certainly not sorry to have the scene of it in the country” (23). After the necessary business of preparing Kellynch Hall for its new tenants has established both her good sense and familial voicelessness, Anne’s being claimed as a nurse by Mary does not indicate actual caregiving for physical ailments. Austen uses the term here to mean simply “task” or “service,” which is noteworthy because this meaning contrasts with the weightier (and perhaps more Romantic) sense of duty—as
“moral obligation”—that she employs in other key scenes. Nevertheless, no matter the seeming insignificance of Mary’s request, this simple service will become Anne’s pathway to freedom: for the short term, in avoiding the domestic “imprisonment” (90) she is used to at Kellynch Hall and anticipates at Bath, and for the long term, more importantly, in reuniting her with Captain Wentworth.

Alistair Duckworth describes Anne’s behavior at Uppercross as indicative of both duty and self-reflection: “she must withdraw into herself, while still maintaining subjectively an adherence to received standards of behavior” (188). She appeases her sister and acts courteously to her cousins when she agrees to take the walk to Winthrop. Her determination to repeat to herself “some few of the thousand poetical descriptions extant of autumn” (37) on this walk stems from her wish to examine and understand her own solitary life and indulge in concentrated feelings very like the ones she will soon caution Captain Benwick to dilute with prose. Depressed and with no prospects for a brighter future, Anne self-medicates with poetry. Her musings upon nature—the season’s “last smiles of the year” and the withered state of vegetation—poignantly reflects her mood and even parallels her “haggard” physical appearance; they also anticipate Benwick’s somewhat morbid attachment to poetic sentiments. This transitional period in the country at the Musgrove residence is a place devoid of the typical abuse Anne has been subjected to at Kellynch. While her father and Elizabeth begin their less lavish new life in Bath, Uppercross allows Anne serendipitous opportunities for self-reflection, empathic listening, and serving. Here, she can begin to heal.
Anne’s understanding of marital contingencies is especially augmented by her meeting Admiral and Mrs. Croft while staying at Uppercross. In Mrs. Croft particularly, Austen gives us a female character unlike any other in her fiction and possibly her most positive example of a successful marriage, as well (the Crofts were “particularly attached and happy”) (42). She is a prescient character, both in her voicing disdain for brother Captain Frederick Wentworth’s notion of the feeble and comfort-seeking female on-board navy ships, and in her insistence on sharing the Admiral’s rugged life by accompanying him on his journeys. She is no beauty, as admirable women in novels often are; but she is an ideal. By representing the life Anne might have led if Lady Russell hadn’t persuaded her to decline Wentworth’s proposal, Mrs. Croft first and most persuasively suggests a viable healing narrative for Anne, albeit one that seems hopelessly out of reach at that time. Moreover, in her portrait Austen paints a woman who reasons, entertains no fear for the dangers of the sea, and has “no doubts of what to do” in any situation (33). Hers is a life of duty and love, of sacrifice and self-fulfillment.

The Croft marriage both strengthens Anne’s developing claims to a fully recovered selfhood and reinforces Austen’s traditional understanding of marital roles. However stolid she may be, only separation from her husband causes Mrs. Croft alarm. In his absence, she cannot function, and her dysfunction is expressed in terms of health and illness: “I lived in perpetual fright [when he was away in the North Seas], and had all manner of imaginary complaints from not knowing what to do with myself” (48). This inability to function does not arise from frail helplessness—a frail, helpless woman could not accompany the Admiral on his journeys. Nor do the imaginary complaints make of Mrs. Croft a Mary Musgrove, languishing in her own imagined ills. Rather, Mrs. Croft in
isolation does not know “what to do with herself,” or by herself, since her wifely duty is to complement the Admiral’s life and activities. Austen figures the ideal wife as a woman whose love for and duty to her husband will take her on the roughest voyages into the most brutal climes. And she would not have it otherwise. In other words, domestic duties are not drudgery to be escaped; rather, their fulfillment both provides a wife with useful, healthful employment and satisfies an emotional need. In Admiral and Mrs. Croft’s unusual, but ideal, union, Anne finds sense and sensibility intertwined. As a marital narrative exemplifying both utility and happiness even in the midst of calamity, the Crofts’ solution belies Lady Russell’s prudent advice about not marrying a sailor.

Between the examples of Mary, Mrs. Croft, and, later, Anne’s old school friend, Mrs. Smith, Anne gradually discovers that happiness does not reside in one’s station, as her family believes—that seemingly prudent decisions and the pecuniary benefits they may yield are no guarantors of peace. She will ultimately learn that the duties her family members neglect, such as failing to pay creditors or care for the poor, will keep them confined in misery. Conversely, the duties in which her friends engage, such marital dedication and Naval service, are means of freedom from loneliness and imagined ill health. Importantly, the steps to this realization are played out in the three women’s varying experiences and strategies of coping with illness. For instance, despite a respectable match with Charles Musgrove and all the comforts of Uppercross, “[for] Mary…being unwell and out of spirits, was almost a matter of course” (25). Alternatively, Mrs. Croft “never knew what sickness was” after setting to sea with the Admiral. The model, loyal wife, she cannot fathom separation from her husband, no matter the course or climate—a domestic situation that recognizes mutual dependence yet which is also
somewhat radical in Austen’s time for its refusal to allocate each partner to a different and distinct sphere. “The only time that I ever really suffered in body or mind, the only time that I ever fancied myself unwell...was the winter that I passed by myself at Deal when the Admiral...was in the North Seas” she says (48). Mrs. Croft's imaginary sickness stems from worry, isolation, and the inability to be useful to her husband; Mary’s psychosomatic illness stems from boredom with her domestic situation and envy of her husband's sporting routines.

Mary’s unnatural, hypochondriacal behavior makes it so “any indisposition sunk her completely; she had no resources for solitude” and “was very prone to add to every other distress that of fancying herself neglected and ill-used” (25). By sharp contrast, Anne’s third alternative or “contingency,” Mrs. Smith—who actually is ill from the effects of rheumatic fever, as well as ill-used by her husband and his friend, Mr. Elliot, who have left her penniless—remains extremely resourceful in her sequestered state. A friend from their school days, Mrs. Smith has since sunk in society and is an invalid living in the shabby Westgate Buildings in Bath. Nevertheless, “Anne found in Mrs. Smith...good sense and agreeable manners...a disposition to converse and be cheerful beyond her expectation” (101). Just as Mrs. Croft’s happiest days were “spent on board a ship” sailing to continents unknown (47), Mrs. Smith too had “lived very much in the world,” yet “neither sickness nor sorrow seemed to have closed her heart or ruined her spirits” (101). Unlike Mary, or Sir Walter for that matter, both Mrs. Croft and Mrs. Smith understand that when they make themselves useful, especially when utility is an empathic aid to another person, a position of caregiving, they are liberated from boredom, frustration, self-pity, low spirits and even physical pain. While Mrs. Croft
shows Anne that union with Wentworth could, and should, have been possible, Mrs. Smith shows Anne that bearing up under physical decline and marital disaster also is possible.

Austen creates in these two undeniably strong, remarkable women what we might call “narrative buttresses”: characters that reinforce through their actions what is acceptable outwardly, to others, and inwardly, to themselves. It is fitting, I think, that Austen should lead her heroine out of her lonely, “persuaded” state by the examples of two very different, positive female characters who emphasize, in different ways, that freedom from the ills of isolation is often a matter of how one thinks about a situation and certainly how one uses one’s time. Ever dutiful to her unappreciative family members both at Kellynch Hall and Uppercross, Anne has remained heretofore nevertheless unhappy, finding in her self-sacrifice only insulation from harsh scrutiny and criticism. From Mrs. Croft and Mrs. Smith, she will learn that duty can be more than mere responsibility; it can in fact be a healthful, fulfilling, confidence-building affirmation.

Through the transformation and recovery brought on by her reflective encounters with these contingent narratives, Anne turns from being persuaded to persuader. Keith G. Thomas comments that “Anne may seem dangerously open to persuasion in the first half of the novel because of her wise passiveness, but once she openly asserts her firmness of character from the Lyme chapters on she succeeds in persuading others by sheer dint of self-affirmation, by simply being who she is” (911). Typical of this novel, the conversion and healing are expressed in self-consciously literary terms, in a shift from the indulgently poetic to the more usefully prosaic. On the walk to Winthrop Anne was wont to indulge in all of the “impassioned descriptions” of the autumnal landscape
that poetry could provide; a couple of months later, she has grown firmer and more resolute. She is the persuader, and rhetoric requires reasoning, logic. At Lyme, “she had the hope of being of real use to [Benwick] in some suggestions as to the duty and benefit of struggling against affliction, which had naturally grown out of their conversation” (67). Affliction is something Anne understands, a feeling she battled with on that walk and assuaged with poetic recitations. But now, she “prescribes” prose—language more “calculated to rouse and fortify the mind” (68), words arranged in logical, realistic order that provide a concrete image for readers—like a travel narrative. Samuel Johnson said that poets give clues and the readers fill in the blanks. Therein lies the danger for Benwick (and formerly Anne), whose excessive attention to Scott and Byron has led him to “abstraction” (67). Anne is “emboldened” to influence Captain Benwick, “feeling in herself the right of seniority of mind” (68). Lyme is Anne’s paradise regained.

Soon after hearing Benwick’s sad history about the death of his fiancee (a fourth contingency, that of the morbidly grief-stricken lover who has lost), Anne has an opportunity to compare emotional notes with this new object of her duty. Though Benwick is grieved, she reasons, “he has not, perhaps, a more sorrowing heart than I have. I cannot believe his prospects so blighted forever. He is younger than I am: younger in feeling, if not in fact” (65). Anne is able to advise Benwick and to comfort him because, as Ann W. Astell observes, she “regulates her own emotional response to poetry, first of all, by limiting her reading of it, and secondly, by submitting the strong emotions aroused by poetry to the order of reason reflected in expository writing on moral and religious themes” (281). As she comes to realize with Mrs. Smith, sufferings can be lessened, even conquered, by rational means, by sufficient “doses” of the
prosaic. Poetic feelings, the novel argues, are like rich foods; if they are injudiciously indulged, they only amplify suffering. Benwick is a case in point: not merely melancholic and poetic, he is also morbid and unhealthy, considering “his disposition as of the sort which must suffer heavily” and having a propensity for “sedentary pursuits” (65). Moreover, he has lost his self-sustaining usefulness to society and has instead become the Harvilles’ dependent, “living with them entirely.” In his youthful sorrow and miserable reliance upon others, Benwick resembles no one else in the novel so much as the younger Charles Musgrove, the wounded, helpless child and special object of Anne’s caregiving in the novel’s first half.

Significantly, this earlier caregiving episode had been the most restorative for Anne. Her “usefulness to little Charles” had provided what might be the only “sweetness to the memory of her two months visit” to Uppercross (63); likewise, her usefulness to Benwick, signals her increasing confidence in her abilities to prescribe and “persuade.” It is a role to which she may be uniquely suited as a woman, emphasizing the natural empathic gifts of the feminine—as she tells Mary, “Nursing does not belong to a man, it is not his province” (38)—and yet her comfort to Benwick is rendered in terms which celebrate the (more “masculine”) rational and the prosaic, not the emotional and the poetic. Like a parent scolding a child for playing with fire, Anne cautions against “the misfortune of poetry,” that it is “seldom safely enjoyed by those who enjoy it completely, and that the strong feelings which alone could estimate it truly, were the very feelings which ought to taste it but sparingly” (68). After giving her advice to the doubtful but obedient Benwick, she marvels at her newfound ability to “preach patience and resignation to a young man whom she had never seen before.” The submissive drudge
of the novel’s early chapters has become the confident teacher and physician, the persuader of others.

If Benwick represents for Anne a person with whom she can sympathize because she has been in his place—grieving a lost love, and unhealthily insulating herself with poetry—Mrs. Smith, the friend she meets again in Bath, represents another person Anne might easily have become: a woman who has sunk socially and perhaps physically as the result of an injudicious marriage. It is significant, then, that her woes and her strategies of coping with them are rendered in prosaic rather than lyric terms. While I do not wish to place undue emphasis on the goodness of the character of Mrs. Smith, she remains one of the most misread and least appreciated characters with whom Anne interacts—unfortunate, since she is also one of the most important to Anne’s increasing awareness of her sense of self-worth. Jon Spence writes that “Mrs. Smith’s impecuniousness is…equally the effect of living carelessly and selfishly, with regard for nothing beyond one’s own immediate pleasure” (630). On the contrary: Mrs. Smith’s economic woes are due to her deceased husband’s financial mismanagement and Mr. William Elliot’s negative influence on him. Her mistake was in marrying badly—a mistake which Anne was persuaded, wrongly or not, to avoid at age nineteen. Moreover, I see little in her revealed character that could make a reader believe in her lack of regard for anything beyond her “own immediate pleasure.” To what pleasure does Spence refer? Nurse Rooke sometimes has “something to relate that is entertaining and profitable”; “call it gossip if you will,” but this is Mrs. Smith’s greatest “treat” and hardly indicative of selfishness (103). “She had difficulties of every sort to contend with” including poverty, the unfinished affairs of her late husband, physical pain
and disability, a “very humble” apartment, no comfort that a servant might provide, and is “almost excluded from society” (101). If there is any pleasure in gossip, I would readily grant it to a character who must endure so much. Her reduced mode of living makes it hard to censure her for “living carelessly,” especially since she has been driven to it by her husband’s unwise speculations.

Some scholars take issue with the way Mrs. Smith earns her living. Alistair Duckworth writes that “Mrs. Smith’s apparently exemplary attitudes mask a cynical view of society” and “that her charity is largely false. In association with her nurse, who sells Mrs. Smith’s products among her rich patients, Mrs. Smith is able to obtain (almost extort) enough money to survive” (192). Far from being cynical, however, I see Mrs. Smith’s actions as simply realistic, proceeding from her own self-respecting industry and from the lack of charity in others. If Benwick is cast in the part of grieving romantic hero, Mrs. Smith, with her commonplace name and unromantic domestic troubles, reminds us of the confident, energetic female protagonists of Defoe, grappling for the basic necessities of existence. As such, reality rather than cynicism determines her actions. A woman stricken in health and rendered powerless by marital misfortune, she nevertheless achieves subsistence, comfort, and self-respect.

Even though she can recognize and acknowledge the less admirable qualities of human nature that a sick chamber may furnish to observers, even though her pragmatism leads her to support herself by selling trinkets to the convalescent wealthy, Mrs. Smith is yet idealistic enough to lament to Anne, in a low and tremulous voice, that “There is so little real friendship in the world!” (103). Such a statement indicates that Mrs. Smith would rather find goodness in people than otherwise, that she would prefer
to be a part of society instead of being crippled and confined as she is. Additionally, in
spite of her severe rheumatism and poverty, she is an exemplar of utility, and some of
her “products” are meant for people even less fortunate than she:

As soon as I could use my hands, [nurse Rooke] taught me to knit…and
she put me in the way of making these little thread-cases, pin-cushions
and card-racks, which you always find me so busy about, and which
supply me with the means of doing a little good to one or two very poor
families in this neighborhood. (102)

As poor as she is, Mrs. Smith gives money to those who are poorer still. How is this
“false charity”? Since it is only “among those who can afford to buy” that nurse Rooke
“disposes of [her] merchandize” (102), and since the lack of real friendship in others
does not prevent Mrs. Smith from remaining an industrious, self-supporting member of
society, it is hard to accept Duckworth’s characterization of her as “misanthropic” and
“disaffected with society”(192).

One reason that we should see Mrs. Smith as a critical teacher for Anne lies in
the way Austen incorporates free indirect style, allowing Anne to study and ponder her
character. It is evident that Mrs. Smith is unlike anyone whom Anne has met. A second
and equally important reason is that Anne discovers through Mrs. Smith’s friendship that
by performing one’s duty one can find freedom and fulfillment, even when duty lies in
self-healing, in fighting off the despair caused by illness and misfortune.

Anne had reason to believe that she had moments only of languor and
depression, to hours of occupation and enjoyment. How could it be?—She
watched—observed—reflected—and finally determined that this was not a
case of fortitude or of resignation only.—A submissive spirit might be
patient, a strong understanding would supply resolution, but here was
something more; here was that elasticity of mind, that disposition to be
comforted, that power of turning readily from evil to good, and of finding
employment which carried her out of herself, which was from Nature
alone. It was the choicest gift of Heaven; and Anne viewed her friend as
one of those instances in which, by a merciful appointment, it seems
designed to counterbalance almost every other want. (102; emphases mine)

Anne’s epiphany is that she, too, has been all along blessed with “the choicest gift of Heaven”—the ability to engage in whatever largely empathic responsibilities might “[carry] her out of herself.” As she examines her friend in this moment, Anne intuitively realizes that the buoyancy of spirit and “elasticity of mind” that enable Mrs. Smith to “counterbalance” emotionally what she might lack in fortune and society is the same capacity that enables her calmly to cope with Louisa Musgrove’s crisis at Lyme, to resist depression when her family abuses her, to overcome the pain of losing the only man she ever loved and to accommodate that pain upon meeting him again after eight long years, only to find him seemingly cold and indifferent.

In this moment Anne recognizes her self, the value of her own nature. And she is strengthened by it. Anne Elliot’s regained healthfulness, her bloom, stems from her acceptance and recognition of the possibilities inherent in her internal makeup; her “bloom” is not solely emblematic of her relationship with the processes of external nature in its seasonal revolutions. “Nature” is here celebrated in its human form. If someone as infirm and underprivileged as Mrs. Smith can be cheerful, productive and outspoken, what might not someone as able-bodied and fortunate as Anne accomplish? The comprehension of such boundless possibility could make anyone blossom and grow. For a heroine long suffering from depression, the creation of an author writing in a race with terminal illness, Anne’s recovery exemplifies a state consistent with the goals of narrative medicine: a healed selfhood, strengthened by empathic caregiving and service to the sufferer. The “cause” of Anne’s suffering almost becomes irrelevant here;
like Austen herself, she finds bulwarks against her ailments in the duties of being a listener, nurse, and advisor.

**Miraculous Recovery: Anne’s Happy Ending**

The overheard exchange between Captain Harville and Anne, as we know, precipitates Wentworth’s writing of the letter that contains the renewal of his proposal to Anne—a healing, successful communication, the restoration of the happiest narrative contingency, the final element of Anne’s recovery which comes unexpectedly to her, even if readers expect it. And so we come full circle: Anne’s dutiful nature as a young woman precipitates her uneasy declination of marriage, a narrative consistent with prudence and with the heroines of earlier Austen novels who evaded similarly imprudent unions. As an older, disappointed and depressed woman, trying to understand her apparently unravelling narrative through self-reflection, she stations herself at Uppercross out of a sense of duty to her sister. There she serves Mary’s emotional needs and the physical and emotional needs of the Musgrove child; there also she encounters her lost love. In the climactic declaration of a recuperating Anne Elliot to Captain Harville that “I will not allow books to prove anything” (126), she champions a narrative, informed by both her own suffering and her various encounters with other domestic and romantic contingencies, that allows the unmarried woman to be chastely, dutifully truer than the man. At last, her duty to her own feelings of love and commitment and to the better constancy of her sex in love enable a narrative, one that runs contrary to Lady Russell’s advice and to those narratives “all written by men,” that will free her from the family circle that has so long suppressed her. She will be liberated; like Mrs. Croft, she will join her husband in duty and Nature, sailing ships in the service of England.
Yet, if she is liberated, she is also “taxed,” one more sense of duty and obligation in the closing sentence of the revised ending of Austen’s final novel: “She gloried in being a sailor’s wife, but she must pay the tax of quick alarm, for belonging to that Profession which is—if possible—more distinguished in it’s [sic] Domestic Virtues, than in it’s National Importance” (177, emphasis mine). Here the duty or “tax” is nationalized; it is made part of what any British man and wife owe to each other and to their country. Anne’s new narrative—the climax of her recovery, composed (like any suffering) of “half agony, half hope”—is dramatically reinforced by this final identification with British duty and patriotism.

In any comic ending, the union of the couple signals final order and stability; conflict is satisfied, resolution achieved. Yet Anne and Wentworth do not relax into ease and comfort as, say, Elizabeth and Darcy had done. Their union is composed of vigilance and duty, of “the tax of quick alarm.” Eileen Gillooly notes this phrase in her assessment of Persuasion’s climax, one that sees in Anne Elliot’s painful recovery yet another of Austen’s confident “jokes” about the compromised and miserable lot of “nineteenth-century middle-class feminine life” (122). While Gillooly’s reading can certainly be supported by the novel’s characterization of Anne’s love as “agitation”—Gillooly notes that this word recurs “at least half-a-dozen times” in the novel (122)—to see in the novel’s illness and suffering tropes merely the quips of a self-confident author about the marital state is to misread the sufferings of both Anne and Austen. Anne’s symptoms, duly noted by Gillooly, are virtually dismissed as “hysterical” and “psychosomatic” (122), the imagined symptoms, self-created and seemingly deserved, of a character designed to parody the comic ending, the happy union.
The reading is at odds with the autumnal mood of *Persuasion*, the self-reflective mood of an ailing author that I have noted above. It is also at odds with Anne Elliot, by discrediting her suffering; like Duckworth’s reading of Mrs. Smith, Gillooly seems not to trust the person in pain. Where Duckworth suspected Mrs. Smith’s motives and “misanthropy,” Gillooly doubts whether Anne can even know herself, so crippled is she by the “psychological dangers of romantic idealization” (122), even though Anne has successfully aided in “curing” Benwick of just such dangers. Both critics undervalue the restorative power of Anne’s nursing and reflection, of her empathic “duty” to those around her. If “agitation” occurs a half-dozen times, “duty” is invoked more than a dozen-and-a-half. As a clever pun on a national “tax,” it serves to close the novel.

The tax or duty of quick alarm is a phrase redolent with the themes of injuries, nursing, and recovery that pervade the novel. Their engagement announced, the couple has a chance to reflect on bygone years and the causes of their separation. Anne reasons:

> If I was wrong in yielding to persuasion once, remember that it was to persuasion exerted on the side of safety, not of risk. When I yielded, I thought it was to duty; but no duty could be called in aid here [if I were to accept Mr. Elliot’s proposal]. In marrying a man indifferent to me, all risk would have been incurred, and all duty violated. (163)

Austen’s diction is remarkable in this passage, signaling that Anne nears the end of her progression and full, unlooked-for recovery, of her meditation on duty and healing in its many manifestations. Anne submitted to Lady Russell, allowed herself to be persuaded in her initial refusal because she felt obligated—a sense of moral and social duty—to the woman whose “tenderness of manner” and “steadiness of opinion” meant as much to her at nineteen as her own dear mother’s (19). Early in the novel, just after she learns that the Crofts were to become the tenants of Kellynch Hall, twenty-seven-year-old
Anne recollects Lady Russell’s influence as “over-anxious caution which seems to insult exertion and distrust Providence!” (21; emphasis mine). Anne recognizes in that moment exactly what a sacrifice she has made; duty to Lady Russell, to family opinion and aristocratic tradition, has cost her eight years of happiness. The naissance of her understanding of a sense of duty to her self, with the help of Mrs. Croft and Mrs. Smith, ultimately leads her to that “cheerful confidence in futurity” that she missed out on in her youth (21). She recovers health, bloom, selfhood and her lost lover by moving from duty to duty.

*Persuasion* leads Austen to look beyond the wedding to the marriage, and decide that choosing the “right” man does not secure happiness, any more than choosing the “wrong” one guarantees misery. Far from being the passive recipient of either happiness or misery, different from Gillooly’s sympathetic but clueless “agitated lover,” *Persuasion*’s heroine finds that attitude and action, reflection and duty, make the difference, and that within moral obligation there is room for growth and even happiness. “I have now, as far as such a sentiment is allowable in human nature,” she realizes at last, “nothing to reproach myself with; and if I mistake not, a strong sense of duty is no bad part of a woman’s portion” (164).

**Causality and Contingency in Narrative Medicine: The Need for a New Narrative**

In the field of narrative medicine, the ‘need to know’ the cause of illness stems from and is driven by the differing needs of doctor and patient as they confront the disease, and can obstruct a course of treatment and its outcome if both persons stand firm in and communicate poorly about their different beliefs about the source of the problem. Patients may arrive with preconceived notions about the cause of their condition based on their own cultural, social, familial, or idiosyncratic constructions of
disease. Because the Western-medical explanations these patients will receive may diverge so sharply from their own perceptions of the illness, often the physician must find a way to help the patient merge causal stories into one coherent narrative that allows both parties to pursue the best course of action. Both doctor and patient seek the same contingency: improved health, maybe a cure. But if either gets stuck in a cycle of questioning or obstinately asserting causes, the relationship will most likely be damaged and swift action possibly compromised.

In the last year of her life as her health sharply declined, Austen struggled, as any of us would, with the impulse to understand the underlying cause of her symptoms or, at the very least, the triggers of its episodic nature. Her letters, which she understood to be a healing mode of communication and a site for venting her frustrations (as Jane Fairfax did in *Emma*: “now that she has written her letters, she says she shall soon be well” [384]), reveal her shifting opinions,⁷ even from her first mention of illness in a letter to Cassandra in September 1816: “Thank you, my Back has given me scarcely any pain for many days.—I have an idea that agitation does it as much harm as fatigue, & that I was ill at the time of your going, from the very circumstance of your going” (*Letters* 320). Several months later, in January 1817, during a brief intermission of her symptoms, she wrote to her childhood friend Althea Bigg: “I think I understand my own case now so much better than I did, as to be able to keep off any serious return of illness. I am more & more convinced that *Bile* is at the bottom of all I have suffered, which makes it easy to know how to treat myself” (326-7). In February, to her niece Fanny Knight, Austen

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⁷ That Cassandra destroyed so many portions of Jane’s letters, not to mention countless *entire* letters, indicates that she probably wanted to keep her sister’s frustrations and very private medical details from the public eye.
praised “Aunt Cassandra” for nursing her “so beautifully!” through what she now called “rheumatism,” and believed herself “almost entirely cured” (329). Early that spring, after “suffering from a Bilious attack, attended with a good deal of fever” she thought her “complaint appeared removed”; but the “shock of my Uncle’s Will brought on a relapse, & I was so ill on friday [sic] & thought myself so likely to be worse that I could not but press for Cassandra’s returning” (338).

By April 27, 1817, however, Austen was resigned to her fate and aware that her situation was desperate. On this day she secretly composed her Will and Testament and tucked it away in her papers, unwitnessed. In the last letter she ever wrote, near the end of May, there is no irritable reaching after fact and reason. There is only Austen—gently witty, explicitly grateful, and quietly acquiescent. She wrote of her illness, “I am getting too near complaint. It has been the appointment of God, however secondary causes may have operated…” (343).

This is the Jane Austen that creates and sustains the vision of Anne Elliot, her most injured protagonist, a unique combination of sense and sensibility, trying to endure bravely her very real sufferings without always understanding their cause. Just as Anne’s recovery is precipitated by her evolving understanding of narrative—of her own, of others’—so Rita Charon identifies the gulf between doctors’ and patients’ understanding of causality as one that can be spanned effectively by strengthening doctors’ narrative competence. She writes:

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8 Her mother’s wealthy and childless brother, James Leigh-Perrot, left everything to his wife for her lifetime, with a small gift to his sister upon Mrs. Leigh-Perrot’s death. After Austen’s brothers suffered some major financial upheavals (Henry’s bank failed, Edward was involved in a major lawsuit, and Charles’ ship wrecked), the family was generally in dire straits and unable to continue to contribute to Mrs. Austen’s care as before. The money would have made a tremendous difference to their mother’s standard of living.
Our clashes . . . over the causes of disease signify the desperate need for answers, for knowing, for certainty about why disease comes and how to remedy it. The bridge over this chasm may come not from more knowledge, but from the bravery to face the contingencies of health and illness and death. (30)

Sometimes the answers simply cannot be found: an aggressive lung cancer appears in a healthy, non-smoking man with no family history of cancer; an athlete develops heart disease; a lifelong teetotaler goes into liver failure. Facing the contingencies can mean that the causes have to be let go, then, so that both doctor and patient can ask the more immediate and meaningful question, “Can we treat this problem?” And if the prognosis is grim, both must grapple with uncertainty and ultimately come to ask, as Richard Zaner’s work helps us to, “How can we live and make sense of our lives in the face of awful happenings of chance events?” (101). When life as one knows it is violently interrupted by trauma or disease, and the story of one’s life suddenly spins beyond control and demands an unexpected chapter or two and perhaps a premature ending, how does one craft a narrative to fit the circumstances and imbue it with meaning for oneself and those whom one loves? Somehow, to find peace and strength enough to contend with illness and death, I submit that one must become comfortable with shaping a narrative devoid of its “engine,” as Charon would say—“its urge to make sense of why things happen” (48)—a new story that contains a plot less concerned with making causal connections than it is with embracing uncertainty as a state of power and beauty in the midst of so much helplessness and fear. Anne Elliot achieves such an embrace through a developing practice of empathic duty; she forgets her tragic state of having been misguidedly persuaded and becomes the healthful persuader of others, prescribing physical, financial, emotional and even literary measures as the various “patient” requires.
It seems, then, that understanding John Keats’ notion of “negative capability” might help doctor and patient to co-construct a new narrative that helps both face the worst contingencies. Seeking causes, Charon notes, is always one’s effort to “try to bring order” to the illness experience and to “unearth Genette’s ‘knowable at the heart of the mysterious’” (49). Perhaps, when causes are lost, true narrative competence for the physician entails helping herself and the patient to strive to become “capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason” (Keats 109). If both come to recognize and accept that inevitable elements of doubt and mystery can actually become more important than the quest for cold facts, in cases that are beyond medicine’s control, both will suffer less from the anxiety of ‘not knowing’ and may appreciate after all that there is somehow, in some ways, authentic beauty even in the saddest inexplicable truths.
Nothing will come of nothing. Speak again.

—Shakespeare
King Lear

I should e’en die with pity to see another thus.

—Shakespeare
King Lear

In the climactic chapter of her historical novel Regeneration, Pat Barker features a psychological breakthrough; it is the doctor’s, more than the patient’s. The protagonist Dr. William Rivers, based on the British physician W.H.R. Rivers, is trying to save the life of David Burns, a character compositely drawn from historical accounts of soldiers, including Robert Graves. In this scene, Barker crafts a Lear-like tempest raging across a bleak, black landscape, and depicts the combative forces of madness and reason struggling for dominance in the deafening crash and rumble of the storm. In these pages, she crystallizes several of the World War One-era novel’s major themes, imagining for Rivers a crucial moment of intersubjectivity. The scene takes place while Rivers is visiting for a few days with his former patient, the now honorably discharged officer Burns. Burns—severely shell-shocked, dangerously emaciated, reticent about his illness, and still suffering from physically sickening nightmares—has disappeared from his bed and house into the harsh weather. His absence might have gone unnoticed but for the startling “report of a maroon” being set off near Burns’ coastal home. This alert-rocket, which sounds “like the explosion of a bomb” (177), summons to duty the village lifeboat crew to find and aid a ship in distress; it also awakens and alarms Rivers, who discovers Burns missing, and must act swiftly to find and aid his distressed young host.
As Rivers is “walking quickly towards the marshes,” with the old Martello tower coming into view, he suddenly recognizes the scene “with greater force” (179). The latent “resemblance” in the Suffolk landscape “that had merely nagged at him before” in the light of day now appears ominously recognizable: “This waste of mud, these sump holes reflecting a dim light at the sky, even that tower. It was like France. Like the battlefields.” Rivers breaks into a run and, “slithering and floundering through mud,” slides down into the rapidly-filling moat where, groping in the darkness, he finds Burns motionless, catatonic, “huddled against the moat wall,” and “staring up at the tower, which gleamed white, like the bones of a skull” (180). Fearing for their lives in the rising floodwaters of this malodorous, trench-like structure, Rivers tries in vain to get some response from Burns as he cradles his skeletal frame, “coaxing, rocking” (180) him, a tender gesture by this “male mother” (107) that underscores the novel’s questions about gender roles and exemplifies one of the Great War’s ironies: that, in the trenches, the truest form of masculinity necessitated “feminine” acts of nurturing and domestic comfort. With the rain slanting down in the cold darkness, Rivers “looked up at the tower that loomed squat and menacing above them, and thought, Nothing justifies this. Nothing nothing nothing” (180; original emphasis).

In this appalling epiphany, an echo of Lear’s soul-rending howl, Rivers grasps the absurdity of the Great War with both body and mind. He recognizes with visceral clarity this haphazard simulacrum of the Western Front, because his patients so often have relived its horrors in their dreams and recounted them for him in their waking hours. Here, terrified and immobilized in a foul, muddy “trench,” exposed to the elements and vulnerable to external forces, Rivers suddenly knows why Burns and countless other
suffering soldiers now perceive the war to be meaningless, or, worse, “a joke” (18) whose horrors cannot be described to people back home. Even in this maternal role, Rivers himself grapples with the same childlike helplessness that so many of his patients exhibit in consequence of prolonged periods of living like rats, with rats, in holes in the ground, largely defenseless against deadly mortars fired randomly by an unseen enemy. Rivers is now transplanted into Burns’ nightmare; one’s terror is (finally) the other’s. And despite the chaos, the physical commonality of their situation—their shared subjectivity—enables a new emotional understanding of self and other, and deepens the empathy between them. Intersubjectivity fosters a psychological breakthrough for doctor and patient alike: a shift that sharpens attunement and allows for healing to begin.

My chapter is about intersubjectivity and how it was manifested in the relationship between W. H. R. Rivers and the officer and poet Robert Graves, both of whose personal experiences are reflected in Barker’s fictional depiction of Rivers and the character David Burns. To elucidate the reflective writing in these men’s writings, I will discuss how “empathy and the body,” as Maurice Merleau-Ponty contends, play roles in one’s “construction of reality” (McGilchrist 147), and how reality can torment and silence the subject if either one’s empathic impulses or one’s body is ignored. Further, I will demonstrate the concepts of literary intersubjectivity by examining interpretive and authorial acts in Pat Barker’s *Regeneration*. The historical men’s writings help Barker imagine the horrors of the war and the mental illness so rampant in its wake; they also help Barker create empathic, complex characters whose interactions demonstrate the difficulties of treating traumatic stress, particularly in these early days of psychoanalysis.
What we can grasp occurring between these two men in their separate writings and sketchy correspondence, Barker’s award-winning novel recreates: a doctor-patient, reader-text paradigm for narrative medicine.

The term intersubjectivity encompasses many varied approaches and definitions across several different disciplines.¹ For our purposes, Rita Charon’s explanation of the concept for narrative medicine is helpful in its simplicity: intersubjectivity is “the situation that occurs when two subjects, or two authentic selves, meet,” and notes that it is “in meeting with other selves that the self comes alive” (51). Christian Beyer paraphrases Husserl’s phenomenological definition: “[i]ntersubjective experience is empathic experience; it occurs in the course of our conscious attribution of intentional acts to other subjects, in the course of which we put ourselves into the other one's shoes” (n. pag.). Describing intersubjectivity theory, Donna M. Orange comments extensively on the role of empathy in doctor-patient relationships and reasons that empathy “is emotional knowledge gained by participation in a shared reality. It is knowledge arising from attunement” (Understanding 21). So, to acknowledge as Charon does that the “self comes alive” in an intersubjective meeting is to observe that each self (or subject) benefits from the knowledge acquired from the other through that empathic exchange.

In the context of the World War One soldier and sufferer, this notion of intersubjectivity is important not merely mentally and emotionally, but somatically. Deeply influenced by Husserl’s philosophy of intersubjectivity, Merleau-Ponty

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¹ See Gillespie and Cornish, “Intersubjectivity: Towards a Dialogic Approach” (2009), for a helpful discussion of the ways different disciplines use the term. The authors “suggest that [the various definitions] are not mutually exclusive and that each captures a different and important aspect of the phenomenon” (19).
broadened phenomenology with his theory of embodied existence. Discussing these philosophers’ work in the context of neuroscience, Iain McGilchrist contends that the “self-experience of the human being is embedded in the world, with the body as the mediator” and the body is thus “the means whereby consciousness and the world are profoundly interrelated and engaged with one another” (148). If we accept this assertion, we can appreciate how, in at least two respects, Merleau-Ponty’s theory of the lived body informs the reading of the texts in this chapter and, more widely, the fields of narrative medicine and literary study. First, the trench warfare of WWI imposed prolonged conditions of fear, stress, and helplessness that caused a shell shock epidemic in which, as Elaine Showalter observed in a now-famous essay about Rivers, “soldiers lost their voices and spoke through their bodies” (64). Barker’s *Regeneration*, a “story of the loss of the story,” as critic Ankhi Mukherjee aptly describes it (51), depicts the creation of intersubjective spaces by Rivers and some of his silenced patients—empathic, therapeutic exchanges that enabled both parties to find themselves and their stories and to “speak again.” It is the existence of this intersubjective space—particularly between the real Rivers and soldier Robert Graves—that make their writings and Barkers’ compelling texts for narrative medicine.

Second, and more generally, understanding how the lived body theory applies to the practice of medicine can help us see why disjunctions in doctor-patient relationships occur and, importantly, how these disjunctions might be amended. Patients seek medical attention because of some malfunction in or damage to the body, with full consciousness of the body’s pain and the fear and urgency of their visceral experience. Doctors encounter patients as part of routine practice; they do not experience the
patient’s pain, obviously, and their sense of urgency is moderated both by the
knowledge gathered as they assess the patient and years of acquired proficiency. Calm
professionalism can seem like apathy and arrogance to the patient living the pain. To
the doctor, the panic and emotion expressed by the patient may seem like
distractions—a kind of audio interference that he or she must tune out to focus on the
problem at hand. Simply put, each party engages the pain or illness or wound
differently: the patient subjectively, the doctor objectively. Each of us carries our own
perceptions, sets of organizing principles, and belief systems; when we meet with
another and both pay attention, we share and can create qualitatively different sets of
knowledge. But if either lacks the skills to “read” or listen effectively to the other, the
potential for shared understanding is lost, sometimes with catastrophic consequences.

Rivers and Graves’ Emotional Understanding in Historical Context

The soldiers of the First World War understood intensely what it meant to suffer
in and from combat, and to be ineffectively “read” or listened to by most doctors of the
era, who were overwhelmed by and seeking therapies for the wide-ranging and poorly
understood wounds of modern warfare. Hundreds of thousands of “shell shock” victims\(^2\)
were among the casualties suffered by the British Army, presenting with a bewildering
array of somatic symptoms—mutism, paralysis, stammering, amnesia, blindness, tics,
tremors, sweaty hallucinations and sick nightmares, to name a few—and constituting a

\(^2\) The actual number is unknown. Even on the British side, Peter Leese comments that the “official
statistics are notoriously unreliable, chiefly because of the limitations placed on doctors by Army medical
policy and the lack of standardized diagnostic techniques” (9). However, the “most credible” estimate
comes from “the Ministry of Pensions . . . who would certainly have preferred to give the lowest figure”
(10). The Ministry claims that “around 200,000 soldiers were discharged from active service due to
various mental disorders” (10). This figure does not account for those who went untreated, misdiagnosed,
or those who suffered but were killed in action.
medical crisis that Rivers himself acknowledged had “never previously been known in the history of mankind” (“Repression” 2). What became clear, though only to a relatively small number of physicians early on, observes Peter Leese, was that these were psychic wounds being expressed by the body, “a physical style for expressing inner pain” (2). With its etiology unknown, and the fields of psychiatry and psychology still fairly undefined disciplines academically and institutionally, shell shock—what is now termed post-traumatic stress disorder (PTSD)\(^3\)—impelled the establishment of special treatment centers in France and psycho-neurological hospitals on the home front. One such treatment center was Craiglockhart War Hospital in Edinburgh, the setting for much *Regeneration*, “one of six special hospitals for nerve-shattered officers set up by the War Office” (Shephard 85) in Britain, and the site where physician William H. R. Rivers famously treated the war poet Siegfried Sassoon.

While much has been written about both the fictional and historical Rivers and Sassoon, whose lasting friendship began as an empathically attuned doctor-patient relationship, much less work has been done in this context on the man who, in effect, brought them together: Robert Graves. The relationship that developed between Rivers and Graves deserves closer examination, for both its literary merits and historical interest, and for what it can teach us about narrative medicine and the therapeutic nature of writing.

By the time he first met Rivers at Craiglockhart in July 1917, Graves was a twenty-two-year-old Captain engaged in his fourth summer of the war and preparing his

\(^3\) Although the nomenclature did not exist until its mention in the 1952 *DSM-I*, I will use “PTSD” as a designation for Graves’ affliction, which was variously named in the war years and for decades following (i.e. “shell shock,” “war neurosis,” “neurasthenia,” and so on).
third volume of war poetry for publication. Only twelve months earlier, he had been badly wounded—and officially declared dead—in one of the bloodiest offensives in history, when a shell fragment pierced his back and right lung before exiting his chest. Graves describes the episode rather dispassionately in *Good-bye to All That* (195-202), but as D. N. G. Carter attests, it affected him profoundly:

> On the only occasion I met Graves I asked him, naively enough, whether the war had not been the most important experience in his life. He was quick to reply ‘No,’ and immediately said what *had* been – his ‘death,’ which occurred on his 21st birthday when he was officially reported ‘died of wounds’ during the Battle of the Somme. (20)

On the heat-oppressed and overcrowded hospital train, a trip he would recall “only as a nightmare” (*Good-bye* 198), Graves writes that doctors anxiously “marked the gradual progress of my heart with an indelible pencil on my skin” (200) as the lung filled with blood and pressed the heart farther to the left side of his body. They were forced to aspirate him on the journey. Graves would recover enough physically to return to the front by January 1917, but only for about one month. His respiratory health was compromised and his nerves were shattered; he was given to frequent weeping and, for another decade at least, experienced anxiety and distressing startle-responses to trains, loud noises, sweet smells, and many other stimuli. Except through his poetry, it is almost impossible to imagine how Graves felt about this event he deemed the most significant of his lengthy, successful life, particularly since in his autobiography he dismissively calls this “death” a “joke” (201). The consequence of the enemy shrapnel was that he suffered critical somatic damage that, in turn, inflicted lasting psychic damage. The consequences of the army’s gaffe and the public announcement, by contrast, were that the whole trauma could be safely ignored, laughed at even, by those
at home who knew him best, because the outcome was not literal death; for them, the bad news had a happy ending.\textsuperscript{4}

In July of 1917, as an officer serving the Royal Welch Fusiliers regiment, Graves' role in securing a medical board for his friend and fellow officer Sassoon (thus saving him from a likely court martial or worse) became the stuff of war legend, as well as the opening plotline in \textit{Regeneration}.\textsuperscript{5} While recuperating at Osborne House in the Isle of Wight from the bronchial condition that prompted his swift return from France, Graves received the newspaper clipping of Sassoon's protest, “A Soldier’s Declaration,” and immediately persuaded his own medical board, as a favor, to deem him fit for home service. By then Sassoon’s “Declaration” had been printed in newspapers and read aloud in Parliament, and the scandal was brewing in the public consciousness. Graves hurried to Liverpool, where the Fusiliers were based, managed “to rig the medical board” (Graves, \textit{Good-bye} 233) for Sassoon, giving evidence in his behalf, and famously missed the train upon which he was supposed to accompany Sassoon to the hospital in Edinburgh. Graves met Rivers for the first time when Sassoon was admitted to Craiglockhart—a scene Barker depicts in Chapter Three.

\textsuperscript{4} Such a disjunction of understanding and disregard for a person’s physical or mental pain is best described in-depth by Elaine Scarry, whose work explores how and why “pain comes unsharably into our midst as at once that which cannot be denied and that which cannot be confirmed” (4).

\textsuperscript{5} For readers unfamiliar with the novel, I should note that it begins with Sassoon’s historical crisis, which was instigated by his voicing opposition to the continuance of the war. Barker's opening lines are actually Sassoon’s; she includes the full text of his “Declaration” before any of her own. Sassoon arrives at Craiglockhart in the opening chapter, where Rivers has been going over his file. The character of Robert Graves, who does not figure prominently after the beginning, and who was supposed to accompany Sassoon to hospital, shows up late to Craiglockhart, as he did in real life, and reports to Rivers the facts of Sassoon’s medical board. Barker character Rivers follows W.H.R. Rivers’ actions closely, including mention of his nerve experiments with Henry Head, his brief leave from Craiglockhart for his health, and his subsequent decision to take another RAMC post in London. All of the other patient-characters are composites drawn from details in Rivers’ actual charted notes, World War One soldiers’ biographies (such as Graves’), and the author’s imagination.
We may assume that Rivers took an immediate interest in Graves and his work, based on the content of letters exchanged between Graves and Sassoon only a couple of weeks after Sassoon’s admission to Craiglockhart. Rivers had tried to buy Graves’ recently published volume of poetry, *Fairies and Fusiliers*, but mistakenly ordered Charles Graves’ *War’s Surprises*. Ever injecting humor into his prose, Graves quips to Sassoon, “What a disappointment for Rivers to get *War’s Surprises*: it must have justified its title when it arrived” (O’Prey, *Images* 82). In the same letter, he promises to send Rivers a copy of his latest poem “as a token of esteem and regard” and bids Sassoon to “salute for me that excellent man” (82). Although Rivers and Graves seem to have got on well from the start, Rivers’ general interest in poetry and Graves’ poetry in particular likely had more to do with his hypothesis (as he would later write) that “the mechanism of the production of poetry is closely similar to that of the dream” (Rivers, *Conflict* 148). One suspects that, like the concerned psychologist on Sassoon’s medical board who told Graves that he should be before the board himself, Rivers spotted Graves’ PTSD symptoms immediately and, learning that he was a poet, ordered his book for research purposes. By his own account, Graves “was in nearly as bad a state of nerves as Siegfried” and “burst into tears three times in the course of my statement” to Sassoon’s board (*Good-bye* 233). In fact, Graves was surely suffering more than Sassoon, then and later, as Rivers never did diagnose the latter with war neurosis. Graves’ “fragile mental state,” on the other hand, had been “recorded at Rouen” (Seymour 61) along with the bronchial condition that ended his tour of duty in France; his “recovery” from various physical and emotional symptoms “took another ten years” (60). As an empathic physician, Rivers’ “read” Graves immediately in the somatic
symptoms expressed by his mental condition—Graves’ extreme startle responses were probably a giveaway. Rivers read his poetry just weeks into their acquaintanceship to analyze better the unchecked conflicts in his mind.

Rivers’ exploration of poetry-writing as therapy almost certainly began at Craiglockhart, where, ahead of its time, the “writing cure” was employed as a uniquely prominent “method of reordering a neurasthenic patient’s chaotic psyche” (Martin 37). Considered “the largest and most important” (Leese 104) center for treating shell-shocked officers, and perhaps a forerunner of mind-body medicine, Craiglockhart featured a medical staff that created a therapeutic atmosphere in which physical and cognitive activities for patients were encouraged to stimulate feelings of both comfort and order, as well as facilitate healing. The Hydra, the hospital’s patient-written-and-run literary magazine, was one of many (re)creational, salutary outlets for the officers, providing a channel through which they might “reconnect with both their social class and with their past communities of school and home” (Martin 44) as they also connected with each other. The approaches taken at Craiglockhart were not unlike some of the Arts in Medicine programs found in U.S. hospitals today, in which, as I indicated in the opening chapter, genres such as poetry therapy, story-telling, and journaling are modes of reflective writing employed to facilitate healing.

Thus, the doctors at Craiglockhart developed and practiced medical treatment of shell shock, as Leese describes, with a “variety of approaches” that fit with their

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6 The poet Wilfred Owen was prescribed the editorship of The Hydra by his doctor, Brock, for four months in 1917. He met both Sassoon and Graves at Craiglockhart during this time. Sassoon is credited with helping him find his voice as a war poet, and his friendship and poetic interests shared with Graves grew over the next year. He was planning to transfer to Graves’ base when the war ended, but was killed in action one week before Armistice.
“individual preferences,” but always with the collective view of “re-education’ as a social and occupational activity” (106) and as a therapeutic goal that could be achieved through the neurological and narrative ordering prompted by the act of writing. Although Rivers and his colleague, Captain Arthur J. Brock, formulated different methodologies, both achieved measures of success in mitigating their patients’ symptoms. Meredith Martin outlines the physicians’ approaches to “realigning linguistic ruptures, manifested by expressive stammers or even complete aphasia,” with “theories that grasped the centrality of practice to psychic healing” (37), including specifically the practice of writing. Whereas Brock’s techniques focused on ordered and prescribed writing activities—for example, “composing in meter” (37) to empower soldiers to regain control of time—Rivers’ approach was shaped more by expressive Freudian psychoanalytic concepts grounded in narrative (re)construction: talk therapy, autognosis,² repression, abreaction, and dream interpretation. Because of Freud’s importance to Rivers’ thinking and techniques, it is worth briefly exploring how Rivers departed from them to achieve more productive interventions with the soldiers in his care.

Despite his adaptation of Freud’s theory of the unconscious,⁸ Rivers “was never a Freudian,” as Ben Shephard asserts in A War of Nerves (87). Rather, like so many other doctors during this war’s medical crisis, he took what Tracey Loughran styles as

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⁷ Defined as self-understanding, or awareness of one’s own psychodynamics.

⁸ While Rivers diverged from and modified many of Freud’s views in his own work, he nevertheless did much to effect wider acceptance of Freudian thought in the British psychiatric community. He read a paper, later published in The Lancet, to the Edinburgh Pathological Club on March 7, 1917, entitled “Freud’s Psychology of the Unconscious.” The paper appeals to its audience to consider the merits of Freud’s work, arguing that Freud’s “views . . . have stirred up such a hotbed of prejudice and misunderstanding that their undoubted merits are in serious danger of being obscured, or even wholly lost to view, in the conflict produced by the extravagance of Freud’s adherents and the rancour of their opponents” (1).
“a magpie approach to psychoanalysis and other theories” (82), choosing what he found useful and modifying or replacing what was not. For example, unlike Freud, who employed the process of free association to interpret dreams, Rivers contended that, to avoid the dangers of suggestion and prevent elements of discussion accidentally being “incorporated into the tissue of the dream,” “the ideal condition for an irrepresachable analysis of a dream is one in which the dream is fully recorded before the analysis begins” (Conflict 8). He therefore requested that all his patients write down their dreams upon waking. From their written account of the manifest content, Rivers and his patients would begin to explore the dream-narratives and their images for latent meanings. In this paradigm, physician and patient become co-analysts of the patient’s textual narrative, and co-interpreters of its meanings, without the risk of altering its original components. It was Rivers’ extension of this technique to the original drafts of his patients’ poems, as well as his divergence from Freud’s notion of dreams as wish fulfillment, that sparked Graves’ imagination and later drew him into sustained discussions about psychology and psychoanalysis with Rivers. Rivers presciently sought in his soldier-patients’ poetic texts, as in their dream texts, narrative clues to assist his diagnostic or therapeutic choices.

While the war raged on and medical debates escalated about the etiology, treatment, and (for some) even the existence of war neuroses, Rivers was one of only a few doctors in Britain, as Loughran indicates, who were “spurred to a sophisticated analysis of the psychological causes of shell-shock and the mechanism of its development” (88). His therapeutic and empathic approach could be sharply contrasted with the so-called disciplinary method employed by doctors such as Lewis Yealland,
which included applying electrodes to vocal chords to induce speech in mute patients, as well as the occasional cigarette to the tongue. Mukherjee notes that “Disciplinary therapy treated the symptom as an expression of the will of the patient, whereas the analysts asserted that it was wholly determined by unconscious motives and conflicts, which were then coerced into representation” (50). For Rivers, who had observed that many of his patients experienced completely new symptoms in hospital or while convalescing at home, some of these unconscious conflicts were a consequence of soldiers being “almost universally” urged by “relatives and friends, as well as by their medical advisors” to “banish all thoughts of war” (2). In fact, soldiers were told that it was their “duty to forget” (3).

But striving to forget the death, destruction, and danger that lately had besieged them on the front, even from the safety and comfort of hospital and home-care, proved detrimental to soldiers’ mental and physical health, as Rivers well understood. Thus, in his famous 1917 paper, “The Repression of War Experience,” Rivers expanded upon the work of Breuer and Freud, who had proposed in Studies in Hysteria (1895) that repressing traumatic memories would create a strangulated affect; such stifled memories would become pathogenic and manifest themselves in somatic symptoms in the patient. Guiding the patient to abreact, to remember and objectivize in language the traumatic events—thus, to tell in order to heal—would help them achieve some measure of catharsis. In this paper, Rivers discusses several cases in brief and argues simply, and yet radically, that “many of the most trying and distressing symptoms” suffered by shell-shocked soldiers are not necessarily the “immediate and necessary consequence of the war experience,” but are instead “due to repression of painful
memories and thoughts, or of unpleasant affective states arising out of reflection concerning this experience” (2). In such cases, Rivers asserts, touting the therapeutic benefits of abreaction and catharsis, “the greatest relief is afforded by the mere communication of these troubles to another” (9). When we speak of our pain, he argued, we lessen it. This lesson would later prove invaluable to Robert Graves, and undoubtedly strengthened his affinity for Rivers, as the intense nervous symptoms he developed in France were subsequently exacerbated by his own loved ones’ refusals to hear him speak of the war.

Advising soldiers to disregard their “duty” to forget and, instead, to speak and write of their traumatic experiences seemed counterintuitive to some doctors at the time, and much of the psychiatric community disagreed with Rivers; but many of his patients responded to his treatment and indisputably improved. This success may be partly attributed to Rivers’ innate (or at least highly developed) gift for empathy that drove his questioning and enabled him to attend closely and compassionately to others. In his prewar professional life all of his energies had gone into probing matters of the human condition: conducting anthropological works with native peoples of Melanesia and India; serving as a London physician and lecturer, as well as a ship’s surgeon; assisting in neurological and physiological experiments on nerves and vision; establishing and directing the first psychology laboratories in Britain at Cambridge; and writing for journals and textbooks in his fields of specialty. Rivers possessed a special relational quality that was appreciated and described in writing by colleagues, students, and patients. This empathic tendency is not merely kindness; for Rivers, empathy generated knowledge. For the soldiers in his care, among whom Sassoon expressed admiration
for this empathic quality most profusely, Rivers’ capacity to listen deeply and speak with his patients as if on wholly equal terms was in itself health-giving. “He made me feel safe at once, and seemed to know all about me,” writes Sassoon (Sherston 517), and “though there were more than twenty years between us, he talked as if I were his mental equal, which was very far from being the case” (518). Rivers’ extraordinary attunement, the foundation of all intersubjective experience, was eloquently explained by psychologist Frederic C. Bartlett, Rivers’ student, and later colleague and friend:

There is really no word for this. *Sympathy* is not good enough. It was a sort of power of getting into another man’s life and treating it as if it were his own. And yet all the time he made you feel that your life was your own to guide, and above everything else that you could if you cared make something important of it. (14)

Although the word *empathy* was coined in 1909, it was apparently unknown to Bartlett in this 1923 memorial piece. But he defines it beautifully, nevertheless, and with this characterization of Rivers’ “power” helps us understand in part why Graves, who was never formally Rivers’ student or patient, would identify so strongly with this man, who valued his poems and gave him permission to remember and to express the horrors of his recent experiences.

In his biography of Rivers, Richard Slobodin relies on commentary gathered from published and private letters written by Rivers’ peers, to show how he was perceived personally and professionally. To judge from the “unanimous opinion of his memorialists” (66), Rivers was widely respected and loved. According to Sir Walter Langdon-Brown, Rivers “‘found himself’”—and his calling, perhaps—and came into his own as a clinician during the war as he “‘discovered his remarkable aptitude for treating the psychoneuroses’” (qtd in Slobodin 58). Certainly his training, intelligence, and global experiences had prepared him to negotiate the medical, military, and social demands of
this dire wartime emergency. His meticulous, scientific approach to problem-solving and knowledge-gathering, which had proved so groundbreaking in his anthropological pursuits, also undoubtedly helped him assimilate and examine the evidence at hand as he developed psychotherapeutic methodologies to treat the numberless strains of war trauma exhibited by his patients. Yet his faculty to be simply a “fathering friend,” as Sassoon would have it (“Revisitation” 9), was perhaps his greatest strength—a doctor who would provide ample measures of compassion and gentle authority, guiding his soldier-patients through “devastated regions / When the brain has lost its bearings in the dark / And broken in its body’s pride” (19-21). As these lines suggest, Rivers grasped the connection between psychological trauma and its somatic expression; he was thus ever striving to treat the whole patient, the human, not just the “soldier” or his symptoms.

Such a narratively skilled approach and openness to treating the whole patient—valuing the interconnectedness of body and mind—reveals Rivers’ grasp of the importance of “honoring the stories” of those in his care. In *Instinct and the Unconscious* (1920), a work that could be seen as precursor to George L. Engels’ biopsychosocial model, Rivers attempted to articulate these mind-body connections by drawing on his interdisciplinary training and experience. He writes in his introduction that his “purpose is to bring functional disorders of the mind and nervous system into relation with the concepts concerning their normal mode of working, which are held by the biologist and physiologist” (1). In the course of doing so, he examines the finer distinctions between intellect and emotion, what neurologists would understand today as left- and right-hemisphere functions in the brain. Rivers gave credence to emotion (especially as
expressed by masculine soldiers) and described the value of feelings that become “intellectualised” (167)—in other words, remembered, ordered, voiced, and narrated, written language. This dual nature of the psyche appealed tremendously to Graves, who would seize upon Rivers’ notion that writing could be therapeutic and by 1920 began seeking ways to use psychoanalytic thought to examine and improve his own writing process, not to mention his fragile mental health. With the war now over and his suffering unabated, Graves determined to learn everything he could from Rivers and reading about psychoanalysis in an effort to discover and articulate the underlying processes of poetry-writing.

**Dream and Poem: Intersubjective Writings**

In the post-war work generated by the doctor and the poet, we see evidence of their shared subjectivities, as their writings demonstrate their attempts to articulate the mechanisms of the production of dreams and poetry. With Graves hungry for knowledge of psychoanalysis (and the ability to apply its techniques to his own case) and Rivers still refining his interpretive approaches to dreams, these two authentic selves, corresponding and meeting as friends, developed a generative relationship to challenge and inform the other—an intellectual exchange that, in musical terms, amounted to riffing off of one another, picking up one’s phrases and ideas and elaborating on them. Characteristic of the equalizing tendencies of this “fathering friend,” Rivers acted in an unofficial therapeutic capacity to help Graves contend with the PTSD symptoms that plagued him. Neither physician nor poet considered Graves to be officially his “patient,” however much counsel Rivers gave. By all accounts, Rivers did not distinguish the boundary between “patient” and “friend” as mental health professionals do today. Still, the friendship that was cultivated between them comes close to a kind of psychoanalytic
treatment informed by intersubjective theory, in that it was established by nothing less than consultations, however unofficial, featuring what Orange expresses as “the dialogic attempt of two people to understand one person’s organization of emotional experience by ‘making sense together’ of their shared experience” (*Understanding* 8). As such, the intersubjective experience shared by Rivers and Graves is a kind of paradigm for the power of interdisciplinary conversation and the value of narrative medicine: a medical and a literary expert, each helping the other to deepen his self-understanding through a merger of disciplinary horizons. Such a cooperative effort—vitalized by the exchange of viewpoints; sustained by active listening and empathy; and devoid of the power dynamics sometimes present between physician and patient—emboldens each party to open up, “to reveal the self” (Charon 53) in ways that participate in the co-creation of new knowledge and meanings.

Rivers taught Graves, as he had done with patients at Craiglockhart, that his inner turmoil could be used as a potent source of healing and creativity, and as Miranda Seymour writes, River encouraged him to “get his secret fears and traumas on to paper” (107). Like the soldiers who had been counseled to forget the war, Graves repeatedly received the stifling edict never to speak of his experiences in France from his wife, Nancy Nichols. Nichols refused her husband the “opportunity to exorcise the past” by adamantly insisting that “[t]he war was never to be mentioned in their home”; her “counsel was always to suppress emotional feelings” (Seymour 81, 105). The object of Nichols’ well-meaning imperatives, and troubled by family and financial upheavals, Graves’ PTSD symptoms intensified. It was then that he began talking with Rivers more frequently and started to write “as though his life depended on it” (Seymour 103).
When he began to mine his mental state to unearth images and feelings, and to channel some of his anxieties into writing, Graves’ prolific writing career commenced in earnest. Between 1920 and 1925, Graves published a new volume of poems every year, alternating them with short prose books about poetry—in particular, as Paul O’Prey notes, books on poetry’s “psychological aspects and its therapeutic use as ‘the physician of mental disorders’” (Images 122), that explicitly acknowledge Rivers’ influence on his thinking. In The Pier-Glass (1921), a title suggestive of the self-examination therein contained, Graves made his “first conscious attempt . . . to draw on his mental state for inspiration,” thus “uniquely and courageously” exploring his psychological trauma (Seymour 104). Graves explained in a letter to Edmund Blunden that The Pier-Glass was “half a reaction against shell-shock by indulging in a sort of dementia praecox⁹ . . . of fantastic daydreams” and “half as an attempt to stand up to the damned disease and write an account of it” (O’Prey, Images 124). As Rivers intuited during the war and James W. Pennebaker’s clinical work makes evident, “attempts to inhibit thoughts actually exacerbate them,” and the healing potential of reflective writing—actually producing “long-term benefits in psychological and physical health”—lies in the act of “psychologically confronting upsetting experiences” (Pennebaker, Opening Up 59, 69).

The Pier-Glass contains several dark poems, rife with fantastic imagery and sinister imputations, which blur the lines between reality and unreality, waking and dreaming. For soldiers unwillingly silenced by others and the “damned disease,” Captain Rivers was a compassionate listener and reader. He gave suffering soldiers

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⁹ A “premature madness,” later replaced by the term “schizophrenia.”
leave to voice the unthinkable and authority to make it comprehensible, even beautiful—in all its horrors—to themselves and others through poetry, because he believed that it was possible “in many cases,” as he wrote in Conflict and Dream, “to show how these images are symbolic expressions of some conflict which is raging in the mind of the poet” and that the poem’s “real underlying meaning” is quite different from the meanings suggested by its “outward imagery” (Conflict 148). Rivers believed what neuroscience now knows: that some symptoms of PTSD are “related to the separation of traumatic emotional experience from language” (Pennebaker, Opening Up 96). He taught his patients that there is power in voicing pain.

And Graves’ pain is palpable in The Pier-Glass. Several poems, such as “Gnat,” “The Pier-Glass,” “Reproach,” and “Down,” confront the conflicts raging in his mind as he grappled with his peacetime roles of husband, father, undergraduate, and veteran. O’Prey rightly observes that most World War I anthologies “end at or just after the Armistice,” thus neglecting the voice and the critical “point of view of the survivor” as he attempts to “reconstruct his life and come to terms” with the war (“Strategies” 36). As a consequence, O’Prey asserts, the importance of some of Graves’ best work of the period, such as The Pier-Glass, has been underestimated.

In the following two readings of the volume’s eerie, finely layered poem “Incubus,” we can detect the poet’s internal battle with the realities of war and conscience. Graves depicts the struggle between mind and “Body” in the guise of the mythological demon of its title—a shadowy figure that steals upon a man “Asleep, amazed, with lolling head / Arms in supplication spread” (1-2) and commits its foul transgressions in the black night. The rape is unmistakable in the middle stanza, and is
a perversion of Tennyson’s heroic lines from “The Charge of the Light Brigade”: “Theirs
not to make reply, / Theirs not to reason why, / Theirs but to do and die” (13-15). As it
descends upon its victim, the incubus speaks:

Through darkness here come I,
Softly fold about the prey;
Body moaning must obey,
Must not question who or why,
Must accept me, come what may,
Dumbly must obey. (11-16)

With the subtly militaristic language of the poem, and the “Body” being figured as male,
we may identify the poem’s incubus as representative of the shell-shocked soldier’s
dream—a threatening vision that creeps in and forces itself upon him, long after the
battle is done. The dream-plagued soldier, whose “Body shudders, dumb with fear” (3)
as the demon casts its terrible nightly “spell,” “must accept” these advances “dumbly,”
passively. As the speaker in all but the last two lines, the dream-demon holds sway over
the trembling soldier until “Body wakens with a sigh / From the spell that was half
Death” (20-21) and, blinking in the reprieve of the “sun-commanded sky” (23), declares
he finds “nothing wrong” (25). The threat, the violent vision, is banished by light of day
and the duties of waking hours.

One could certainly imagine the poet to be the victimized soldier in the above
reading. But knowing that these poems attempt to probe his personal, psychological
turmoil, one could also interpret the incubus to be Graves himself, the cloaked specter
he imagined himself to be in the battlefield: a young Captain in charge of many young
enlisted Bodies, who were at times “Bound to lie at my command, / Horror bolted to lie
still” (8-9) in attempts to avoid discovery on nighttime patrols. In this reading, Graves
seems to demonize himself in the middle stanza where, after waking them and
“Stooping, muttering” (6) his directives in fatigued soldiers’ ears, he acknowledges that they are all merely “prey,” dumbly obeying and awaiting their fate at the hands of a ghastly predator—which could be either the German enemy or the British high command. Bodies mean nothing in war; they are expendable. In this war particularly, “Bound is Body, foot and hand” (7)—in muddy trenches and barbed wire—to submit to the orders of this disembodied demon-officer, who has accepted the exploitative commands of higher-ranking others miles behind the lines. The poem is at once an expression of anger and guilt in which the speaker is culpably resigned to “sap what sense I will” (10) from every Body in his command, knowing that all sense and sagacity have fled from those in control.

Further, the irony is bitter indeed in Body’s profession that there is “nothing wrong” (25). In the trenches, Body suffers silently because complaints are useless, either drowned out by mortar-fire or punished severely by superiors. As with survivors like Graves, “nothing wrong” becomes the routine of ordinary, post-traumatic life when the veterans cannot narrate the memories or will not be listened to if they do. Much has gone and is wrong for Body and, come what may, murder will out. Whether through madness or illness or violence or addiction or narration, Body will always express its pain.

The very month that The Pier-Glass was published, correspondence between Rivers and Graves had begun about the latter’s newest book—his first critical work—in which the former’s influence is wholly evident. Published in 1922 as On English
Poetry, \(^{10}\) Graves believed it to be his most important yet because it was a theory of poetics that combined his own methods of poetry-writing with what he learned of psychology (and anthropology) through reading and his congress with Rivers. Throughout 1921, Rivers was working on what became perhaps his most important work, Conflict and Dream. Though Graves’ influence on Rivers is never made explicit in its pages, we can surmise through their correspondence that meaningful exchanges of ideas were taking place.

Though the scattered extant records make the beginning of Rivers and Graves’ post-war relationship difficult to trace, we find discussions about these works-in-progress in a smattering of unpublished letters written by Rivers,\(^{11}\) most of which omit the year-date but are most likely all from 1921. In small, hurried penmanship that aligns with the stereotype about the illegibility of physicians’ hands, we are privy to details personal and professional. We can observe that Graves periodically visited Rivers in his rooms at Cambridge, and that Rivers also went to Graves and Nichols’ home in Oxford. Occasional mentions of correspondence with Sassoon indicate that this poet and sufferer, too, maintained a friendship with Rivers after the war, although by this time Sassoon’s friendship with Graves was strained.\(^{12}\) Rivers graciously responds to

\(^{10}\) The book initially held the interesting working titles of Pebbles to Crack Your Teeth On (Seymour 107) and then An Anatomy of Poetry (O’Prey, Images 123).

\(^{11}\) The corresponding letters written by Graves have not been published, to my knowledge. It is possible that they may still exist in Rivers’ papers, which are held by Cambridge, but I was unable to ascertain whether they do. I thank the Southern Illinois University Library for providing me with copies of these letters from Rivers to Graves. See also Graves’ published letters for his enthusiastic account of taking his manuscript to be “vetted with its author by Dr Rivers of St John’s—the greatest living psychologist” (O’Prey, Images 123).

\(^{12}\) See Sassoon’s letters and Sherston’s Progress for more details about his friendship with Rivers. Published letters by Sassoon and Graves give the clearest picture of their disagreements, although both poets discuss the pending break in their memoirs.
Graves’ apparent praise of his recent lecture “Affect and Dream” (Mar 9), later to become part of *Conflict and Dream*, and other lecturers and books are remarked on. Rivers discusses the demands of his schedule in these letters, and we get the sense from his frequent apologies for delays in writing, as well as his confession on March 31, 1921 that he had been “trying to recover from extreme fatigue,” had never been busier professionally, and perhaps suffered somewhat as a result. His responses unfailingly express genuine interest in Graves’ work and patience in answering his questions.

A series of letters in March reveals the intersection of their interests. Rivers wrote on March 2nd that he would be delighted to read Graves’ manuscript, and in the flurry of exchanges over the next several months, we see evidence of his editorial influence on Graves’ drafts, as each man endeavored to apprehend more fully the workings of the other’s profession. Initially, although he praised Graves for his grasp of the best recent “psychological knowledge,” Rivers expressed concerns about the interdisciplinary nature of the book—that, in its reception, there was a potential “danger that the work may fall between two stools, between the psychological dry-as-dusts and the literary critics” (Mar 31). Graves addresses this concern at once in the published book’s opening note, when he admits “It is a heartbreaking task to reconcile literary and scientific interests in the same book” (*On English Poetry* vii). The sentiment may have been shared by the two men, but each pursued such a venture in his writings, to some degree, nevertheless.

Rivers’ letters alternately show the depth of his engagement in the manuscript’s evolution, whether he was supportive of a given section’s arguments or gently pressing Graves on dubious points. He communicates his discomfort, for example, with Graves’
“view that poets arise out of special family conditions, and . . . that his work is the expression of an unusually strong central authority”¹³ (Mar 31). He cites from the book of William James’ letters he was then reading: “‘a poet is a person who can feel the immense complexity of influences . . . and make some partial tracks in them for verbal statement.’ This means much more than a strong central authority.” Rivers’ point of view attributes more reasoning and perceptual power to the poet, more sense and sensibility, rather than granting it to an external source, and underscores an idea important to him—namely that the confluence of affect and logic, emotion and reason, can result in extraordinary arts: poetic and medical.

Graves’ revisions reflect Rivers’ influence throughout.¹⁴ In On English Poetry, Graves uses the lexis of psychology to explicate his rhetorical approach to the analysis of poetry, and thus writes a critical work unlike any before it. His text omits a discussion of a “central authority”; instead, its argument rests on the author’s descriptions of the “two meanings of Poetry,” which essentially consists of one writing process and what we might view now as a kind of right- and left-brain dichotomy (13). As Graves describes it, in the first “meaning,” poetry is “the unforeseen fusion . . . of apparently contradictory emotional ideas”; the poet, Graves asserts, “creates in passion” (13). In the second meaning, or second half of the process, the poet must then, “by a reverse process of

¹³ Graves likely had in mind the strong central authority in his own life, his mother Amy von Ranke Graves. See Good-bye to All That, Chapters 2-4, in which he illustrates “how much more I owe, as a writer, to my mother than to my father” (36).

¹⁴ In fact, he dedicated the book: “To T. E. Lawrence of Arabia and All Soul’s College, Oxford, and to W. H. R. Rivers of the Solomon Islands and St. John’s College, Cambridge, my gratitude for valuable critical help, and the dedication of this book.” Lawrence, whom he had met at Oxford, became a friend and patron, helping Graves personally and professionally. Graves undoubtedly referenced a site of Rivers’ anthropological work in the dedication to acknowledge its influence on sections like “Poetry and Primitive Magic.”
analyzing,” test the emotional ideas and correct them “on common-sense principles” (13). In other words, poetry is born of spontaneous emotion, but reasoned into its final form. Rivers apparently read several manuscript drafts and nudged Graves to verbalize this distinction between feeling and thinking more articulately. Happily, the correction gives us insight into the doctor’s version of reflective writing which, like Pennebaker’s, calls for “letting go” on the page rather than organizing syntax, orthography, paragraphing, and so on (Opening Up 44). Rivers writes:

I do not like the word “rationalize” in the third line from the bottom of p. 13. I should prefer to say something like “take pen and paper and let the pen solve the apparently insoluble problem.” At any rate that is what the pen, or rather the typewriter, is always doing for me. (May 26, 1921)\(^{15}\)

Following Rivers’ thinking, Graves’ two definitions of poetry give equal importance to emotion and reason and seem to mirror the dream-analysis process Rivers had prescribed for patients at Craiglockhart. They both agreed that poems, like dreams, whatever their tenor, begin in a state of mental or emotional conflict. But whereas Graves believed that poems receive their fullest expression through secondary elaboration and that “poetry has the power of homeopathically healing other men’s minds” with the “allegorical solution[s]” presented in its finished state (On English Poetry 85), Rivers adhered to his conviction that only the “immediate unelaborated product of the poet’s mind” could “help us understand the part of artistic production which is comparable with the formation of the dream” (Conflict 149).

\(^{15}\) Graves includes the passage almost verbatim in On English Poetry, in Chapter VI: “Inspiration,” adding that the poet “learns in self-protection” to let the pen solve the problem (26, emphasis mine). This, I argue, Graves did for the rest of his life.
During the time of the above correspondence, Rivers was writing his last published work, *Conflict and Dream* (1923), in which he briefly discusses secondary elaboration as he believed it pertained to the interpretation of both dream and poem (21-22, 148-49). For Rivers, Freud’s principle of secondary elaboration—a rearranging of dream content to create a more comprehensible narrative—could be diagnostically important when a patient would bring his written account of his dream to a therapy session. While he apparently found the content of revised, polished poetry useful to discuss with his poet-patients, his true pursuit was discovering the mechanism by which dream and poem are produced.

Fascinated with the significance of dreams since his early work in anthropology, Rivers had been led to study Freud’s *Interpretation of Dreams* closely when dreams (or rather hellish nightmares) became “prominent symptoms of nervous disorder” in his wartime patients, and a useful means of discerning the “nature of the mental states underlying the psychoneuroses of war” (*Conflict* 5). Rivers fully credited Freud with the “great revolution in the attitude of psychologists” (2) as it related to this subject, but drew some distinctly different conclusions about dream interpretation based on his recent war experience, and delineated them in a series of lectures that subsequently formed a large portion of *Conflict and Dream*. He diverged most significantly from Freud by challenging “the view that every dream is a wish-fulfilment as an inadequate expression of the two kinds of content” (4), manifest and latent. Rather than fulfilling desires, he argued, dreams seemed to be attempts to resolve conflicts that had befallen the dreamer in waking life, with the nature of the conflict influencing the affect and memory
of the dreamer accordingly. Importantly to Graves,\textsuperscript{16} Rivers disputed Freud’s emphasis on sexual instinct as the sole impulse of dreams, because he discerned survival instinct to be most often at work in shell-shocked patients’ dreams.

\textit{Conflict and Dream} was left unfinished when Rivers died suddenly from a strangulated hernia in June 1922. His literary executor, G. Elliot Smith, acknowledges in its preface that Rivers had intended to “revise and alter the form” of the book, specifically naming the section on “the problem of myths” as one that “does not fairly represent Dr Rivers’s views,” though Smith felt it could not be eliminated (vii, ix). The myth section precedes the even briefer section “Dream and Poem.” Thus, we must wonder what Rivers’ final version would have contained, and how much his work on myth and poetry would have been shaped by his exchanges with Graves, whose own later works are steeped in considerations and translations of myth. In one of his letters, after deliberating over the use of “dissociation” in a draft of Graves’ manuscript, Rivers appreciatively jokes with the poet that “your work . . . is raising some new problems and I see no chance of settling them until my poor old ‘Unk’ [slang for “head”], as I believe it is now called, is given a reasonable chance of dealing with the matter” (May 29).

Whatever the resolution, and however much we may wish it explicated in \textit{Conflict and Dream}, we can appreciate nevertheless the existing products of the intersubjective rapport the two men shared.

Rivers’ influence on Graves did not end with his death. The prose books Graves wrote next—\textit{The Meaning of Dreams} (1924) and \textit{Poetic Unreason} (1925)—bear the

\textsuperscript{16} See a brief discussion about Graves’ 1949 remarks on this subject in O’Prey, Images 122. One can easily conclude from Graves’ writings that he experienced sexual uncertainty during the war and decade following, but this topic is beyond the scope of this project.
indelible stamp of their relationship, the latter especially including whole chapters devoted to secondary elaboration in poetry, extensive quotations from *Conflict and Dream*, and numerous references to Rivers. Years later, the anthropological theories of matriarchal societies Rivers had shared with him were manifesting themselves in some of Graves’ most famous works: the powerful, manipulative Livia, Augustus’ wife in *I, Claudius* (1934) and *The White Goddess* (1948), his mythological European deity.

In what may be the most famous of all Graves’ works, *Good-bye to All That*, Rivers’ counsel to narrate the pain is evident, although somewhat distorted by the author’s expressed intent to sever all ties with England. Graves’ anger echoes through the book’s bitter opening words. He asserts that one object of the book is to bring about his own “forgetfulness, because once all this has been settled in my mind and written down and published it need never be thought about again” (5). He did of course think about the war again, as his writings show, and, though he later claimed to renounce psychoanalysis, Graves carried for decades some of Rivers’ beliefs in the cathartic potentials of writing.

In the working relationship, medical relationship, and friendship of these two men, we can see the engagement of “two authentic selves” in a series of narratively significant dyads: doctor/patient, analyst/analysand, reader/writer; and listener/teller. As Charon maintains, the “tensions inherent” in these relationships as the two subjects share their narratives “produce the intersubjective connections that clarify” the role of one self to the other (53, original emphasis). Through these intersubjective connections, a new narrative is co-created and new meanings are generated. A true listener, like Rivers for instance, recognizes the “remarkable obligation toward another human being”
to acknowledge that other self and to be open to receiving whatever “deep and unknown truths” the speaker may need to reveal (53). The simple act of telling gives the speaker, as it did Graves, the “authority and the opportunity” (53) to release himself from the shackles of fear and suppression, even in so stifled a cultural context as Great Britain during the First World War, where a soldier’s public voicing of his anti-war feelings could result in execution. From the shared acts of genuine listening and telling, a connection based on trust developed between the two subjects, enabling each to achieve in the new co-created narrative some measure of self-understanding.

What Rivers and Graves learned about their selves can be discerned only partially, but purposefully, in writings that demonstrate their methods of self-analysis. Along with soldier-patients’ dreams, Rivers analyzes some of his own in Conflict and Dream; Graves takes pain to illustrate his use of the two-part approach to poetry-writing. Not all of their theories were correct—about neurobiology for Rivers, the mechanisms of poetry-writing for Graves—and most of their publications have fallen into relative obscurity. What seems most remarkable now is what Rivers got right, and that these teachings were evident and influential throughout so much of Graves’ long career.

Dream exploration and poetry-writing can deliver powerful messages from the unconscious and lead to therapeutic breakthroughs and healing. The physical body does turn on itself and negatively impact the mind when a person cannot or will not speak of traumas suffered. The image-laden dream and poem may or may not be generated by the same “mechanism,” but both do originate in the right hemisphere of the brain, where language, emotion, empathy, and metaphor also come from.17

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17 See McGilchrist, Chapters 2 and 3.
words, as Jean Decety and Thierry Chaminade affirm, “Self-awareness, empathy, identification with others, and more generally inter-subjective processes, are largely dependent upon…right hemisphere resources” (qtd in McGilchrist 57), just like dreams and poems. Both men were deeply interested in the interconnectedness of things; neither could have known that this drive for interdisciplinary knowledge was actually fueled by the same parts of their brains that created an empathic listener for an emotional teller, a compassionate reader of a poetic writer, an exemplary doctor to a troubled patient. In the narrative Rivers and Graves co-created, and the writings that resulted from this intersubjectivity, we can read two selves who have “come alive,” having learned to value holistically the potential for healing through writing, and who are now sharing their self-understanding so that other authentic selves may learn, too.

**Regeneration: Graves and Barker’s Intersubjectivity**

Literary intersubjectivity considers the relationships inherent in the textual acts of writing, reading, and interpretation. With the author’s words, the reader (a subject) is assumed to co-create the actual meaning of the text as he extrapolates from words on the page the intention or argument of the author (a subject). A novelist such as Pat Barker, who consulted numerous historical texts as research for *Regeneration*, has intersubjectively related to those authors and, thus, can create a text that is a convergence of her subjectivity (her values and perception, for example) and theirs. We commune with Barker through the act of reading and together build meanings from her text. In this concluding section, I will attempt to do just that as I briefly consider some ways in which the writings and intersubjective relationship of the historical Rivers and Graves described above inform the fictional relationship of the characters Rivers and David Burns.
As with the character Burns, the catatonic wanderer from this chapter’s opening scene, Barker merges her fictional representations of soldier-patients with the medical details of actual cases Rivers treated during his RAMC appointment at Craiglockhart; for example, she uses a disturbing case Rivers described in “The Repression of War Experience” to represent Burns’ trauma. Drawing thus from an ample array of sources, Barker creates a novel “so interwoven with fact and fiction” that she offers her readers a brief rundown of her source material to help them “know what is historical and what is not” (“Note” 251-2). The list is not meant to be exhaustive, however, and close readers discover that Barker culls details large and small from other texts, such as the autobiographies of soldiers, to craft some of the novel’s most gripping realism and character depth.

Barker draws on Edmund Blunden’s *Undertones of War* (1928), for example, a text not included on this list. Alistair M. Duckworth analyzes this remarkable “borrowing.” Pulling facts and feelings from a passage Blunden wrote from memory, Barker writes a very similar, important scene in the novel in which the patient Billy Prior describes to Rivers the explosive, gruesome event in the trenches that triggered his breakdown and caused his earlier mutism. Building on Blunden’s horrific experience, Barker crafts a shell-shocked character that also embodies several of the novel’s major themes, including the inability to narrate traumatic experience (“the loss of the story”), tenuous father-son relations, changing gender roles, and paradoxical duties. Although the novelist invents these attributes, we might still say that Blunden and Barker created Prior’s devastating war memory together.
Similarly, we might say that, with Rivers and Graves, Barker co-creates the fictional Rivers and Burns. By portraying in these two characters an empathic relationship like the real men shared, selecting details from their works to inform their characters, and devising a particularly profound moment of intersubjectivity between them—the Martello tower scene I describe above—she models the type of doctor-patient relationship that the real Rivers tried to nurture and that Charon advocates in her work: one based on mutual respect, empathy, and careful listening.

Duckworth also draws parallels between a passage in the novel and one in Graves’ *Good-bye to All That*, noting that Burns, like Graves in his autobiography, speaks of having gone on nightly patrols in France wishing for a “good wound”—one that would be serious enough to have him sent home, but still minor enough to recover from (64). The similarities between the passages are quite evident. Yet, Duckworth retreats from his initial supposition that Burns’ speech “may find its germ” in Graves’ text (64), saying later that “[h]owever suggestive the parallels between the episodes” in the two texts may be, “they fail to establish” *Good-bye to All That* “as a source” (67) for *Regeneration*. Following Paul Fussell, Duckworth observes that Graves’ autobiography “is less a point of origin than itself a creative elaboration . . . of many sources, some of them oral” (67). Even if this is true of the passage in question, and even if Burns’ words lack the “sequential specificity of the horrific details” in the words Prior echoes from Blunden, we may still indeed consider Graves “a likely influence” on Barker’s novel.

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18 In *The Great War and Modern Memory*, Fussell acknowledges Graves’ attempts as playwright when he characterizes *Good-bye to All That* as “a satire, built out of anecdotes heavily influenced by the techniques of stage comedy” rather than, as Graves himself calls it, “a direct and factual autobiography” (207). While his careful reading of Graves’ text yields much insight and accurately represents farcical elements that Graves undoubtedly included for laughs, Fussell seems not to hear the hurt and anger simmering beneath much of Graves’ sarcasm. Furthermore, to imply that any of Graves’ memories are not his own disrespects the sufferer’s story.
and her characterization of Burns (67). Duckworth’s initial reading is spot-on. While she may sequentially rearrange or in other ways alter the particulars, Barker clearly gleans images and ideas from *Good-bye to All That* to create dramatic, novelistic details in the Rivers-Burns scenes. In Burns’ character she thus creates a composite of traumatic war experiences, but one whose accounts of his “exceptionally early command” (Barker 184) and inability to tell his story closely resemble Graves’ experiences.

Moreover, in the intersubjectivity between Barker and Graves, we can see some of the novel’s most compelling themes. Graves emphasizes in Chapter XXI his belief that the war was being continued as “merely a sacrifice of the idealistic younger generation to the stupidity and self-protective alarm of the elder” (*Good-bye* 206). In the novel, just before visiting Burns, Rivers sits in church among “old men” singing hymns, pondering the “bloody bargain” that one generation makes with the next—that “you, who are young and strong, will obey me, who am old and weak, even to the extent of being prepared to sacrifice your life, so that you will peacefully inherit” the right to enforce the bargain in your own unborn sons (Barker 149). This theme of generational discord and mutual lack of empathy resonates throughout both texts and forms one of the meanings layered in Barker’s title. Soldiers are being “regenerated” in many ways in the novel: spiritually, socially, bodily, verbally, among others.

Similarly, Graves discusses his boyhood devotion to his faith repeatedly in his autobiography’s opening chapters (15-62), even quoting his mother’s inscription in a book of divinity he had won as a school prize (35). As Burns lies sleeping after his rescue from the Martello tower ordeal, Rivers notices books of theology piled on the shelves amid Burns’ boyhood annuals and games (Barker 181)—echoes of Graves’
own early interests in religion and mention of childhood games. This scene plays on the theme of father-son (and Father-Son) relations deeply interlaced in Barker’s text. In their quiet conversation later that morning (“Do you know what Christ died of?” Burns asks Rivers, who replies quietly that it was suffocation. [183]), the questions of imagination and its correlation to empathy—questions raised since the novel’s citing of Sassoon’s “Declaration” on its first page—find their most poignant expression. If, as Duckworth doubts, “borrowing” is the “wrong word” for these parallels (66), then they can be viewed as empathic responses—Barker’s demonstrations of her emotional attunement—to the realities shared by Graves and the other source-authors. The parallels denote literary intersubjectivity, even as they imaginatively recreate the intersubjectivity of doctor and patient, analyst and analysand.

Barker draws on one of Graves’ pivotal autobiographical moments to infuse the Martello tower scene with painterly details reflecting mood and historicity. The scene’s setting and Rivers’ actions gently echo Graves’ story of “Armistice-night” in Good-bye to All That. With the war at last at an end and the painful knowledge that life had irrevocably changed, Graves’ autobiography states that he “went out walking alone . . . above the marshes of Rhuddlan (an ancient battle-field, the Flodden of Wales)” where one of Edward I’s defensive castles, with its towers and moat, still stands (248). In the fictional scene in which David Burns has apparently wandered out alone in the storm, Rivers walks rapidly along with marshes in a landscape that resembles the battlefields of France. Both the fictional and autobiographical scenes feature nervous, conflicted officers—the actual Captain Graves and the fictional Captain Rivers—walking along marshland, in view of ruinous, moat-encircled martial structures that remind them of the
bloody battles waged there over the centuries, as well as battlefields of France. By ascribing Graves’ action to Rivers rather than Burns, Barker floods the reader with the import of his lucid, yet horrified reaction—a sentiment unequivocally shared by the grief-stricken Graves on that November night in 1918. Nothing justifies this, indeed.

The first indication that there is a relationship between Burns and Good-bye to All That is that Barker introduces the characters to readers and to each other in immediate succession, a sort of triangle of meetings. Burns meets with Rivers in a scene immediately followed by Rivers’ introduction to the fictional Graves—all of which takes place within three pages. We are introduced to poor Burns when he gets sick in the dining room at Craiglockhart; after nurses escort him upstairs, Rivers meets with him in his room (17-18). Rivers leaves him, and is mulling over the difficulties of Burns’ case when, looking down through a window, he sees a taxi pulling into the hospital’s drive and wonders if perhaps this is “the errant Captain Graves arriving at last? Yes” (19), it is Graves. That the first Rivers-Burns scene is directly adjacent to that of Graves’ arrival indicates that these historical men and fictional characters are most likely linked in Barker’s imagination and authorial plan.

In a final example of Barker’s emotional attunement to Graves’ autobiography and her characterization of Burns, I want to consider the “joke” as intersubjectivity. The telling of a joke is an intersubjective act; the success of the joke between two subjects lies in their shared grasp of its divergent meaning, from the literal denotation of the “punch line” to the humorous subtext of those words, which both parties “get.” Both Burns in the novel and Graves in his autobiography experience appalling, traumatic events at the front; both suffer shell-shock as a result of these trigger-events; and each
calls his respective life-altering event a "joke" (Barker 18, Graves 201) Graves, as we know, was declared dead after shrapnel passed through his chest and left him unconscious and dying. The “death” that he later solemnly identified as the most important event of his life—the impetus for such stirring poems as “The Second-Fated” (1957)—he first approached with some humor, as with this newspaper announcement: “Captain Robert Graves, Royal Welch Fusiliers, officially reported died of wounds, wishes to inform his friends that he is recovering from his wounds…” (202). An erroneous report of death and the absurdity of its publication in newspapers, after all, can be laughed at with no small relief. “The worst is not / So long as we can say ‘This is the worst’” (King Lear 4.1.27-8), one might jest in this case.

But the worst, for Graves, is that he cannot say “This is the worst.” The true gravity and persistent pain of his very-near-death experience was impossible to share with his wife and parents. Because all ended happily in their minds, or at least not with Graves’ death, where is the tragedy, then, the trauma? The “joke” obliterates his reality. Graves’ relationship with Rivers allowed him to voice what others could not bear to hear and sanctioned the poet’s attribution of different meaning to that death.

For Burns, however, the divergent meaning of the joke is utterly incapacitating—by far “the worst thing” (Barker 18). The fictional Rivers, as astute and empathic as the man himself, “knew exactly what Burns meant when he said it was a joke” (19). Burns suffers cruelly from his trauma: he cannot eat and awakens vomiting from his dreams. His psychological wound, borrowed by Barker from Rivers’ description of his actual patient, stems from being thrown by an explosion head-first into the swollen, rotting belly of a German corpse. Before he lost consciousness, Burns “had time to realize that
what filled his nose and mouth was decomposing human flesh. Now, whenever he tried to eat, that taste and smell recurred” (19). The intersubjective space created by this “joke” turns the tragic into the absurd—like physical comedy, like slapstick, a kind of atrocious pie-in-the-face scenario. Unlike the honorable wound Graves received and the retrospectively laughable conduct of those who reported him dead, this joke is unnarratable, unsharable; it is so unspeakable and unthinkable that readers sense Burns can think of nothing else. His own body wastes dangerously away under the gruesome burden of the joke. Burns has eaten shit from the gut of the enemy and now cannot swallow food, much less tell his story, to save his young life. We can read Rivers’ saving presence and the intersubjective realization in their shared near-death experience at the Martello tower, then, as a catalyst for expression in Burns. Now, we might say, Burns ranks among “the second-fated” as he slowly begins to talk the next morning for the first time to Rivers—not about the joke scenario, not about his pain, but—about “more bearable aspects” of his time in France (183). It is his first wobbly, yet hopeful, step toward recovery.

Throughout the novel, Barker shapes characters and forges new meanings through her intersubjective relationships with historical texts. She and Rivers and Graves, “strangers fused and nourished by words” (Charon 54), co-create an authentic vision of this cataclysmic war through mutual understanding of the damage inflicted to bodies and minds that make evident the nature of the historical relationship shared by the doctor and the poet. As Orange observes, “Empathic parents or therapists are those who are attuned to the emotional reality shared in the intersubjective situation. Empathic response comes from attunement to this shared reality” (21). Barker amply
demonstrates such emotional understanding; she figures Rivers as the “male mother” and “fathering friend” to character-patients suffused with the real and lasting pain of war, making evident in her fictional world how the relationship between the real Rivers and Graves transpired and how, through earnest communion with another, one can come to know better one's self.
LIST OF REFERENCES


BIOGRAPHICAL SKETCH

Sandra G. Weems was born and raised in New Orleans, where she spent her first twenty-eight years and began her college education, before moving to Florida in 1996. She studied literature at Cambridge University’s International Summer School in 1998 and earned an Associate in Arts degree with honors from St. Petersburg Junior College in 2000. In 2002, she was awarded a Bachelor of Arts degree in English with honors by the University of Florida, after which she entered graduate school to continue literary studies. Though a life-changing experience altered her educational pursuits, she graduated with a Master of Arts degree in 2009 and, with renewed purpose, changed the focus of her doctoral work to the interdisciplinary field of medical humanities. In December 2014 she successfully defended this dissertation, and was awarded her PhD by the University of Florida in May of 2015. She currently lives with her husband, an English professor, in South Carolina.