

Tracing Hybrid Collectives of Illness, War, and Medicine in Twentieth- and Twenty-First  
Century Narratives of Illness

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**Abstract**

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English

“Varieties of warfare and war-related illnesses, mental and physical,” is the red thread that organizes this dissertation. My study compares and contrasts illness narratives (fiction and non-fiction) from modernism and the early twentieth century with texts of the late twentieth and early twenty-first centuries to better understand the psychologies of war trauma and techniques of narration from opposite sides of the twentieth century. In narratives about traditional and nontraditional warfare, I analyze how the social is deconstructed by the powerful mediators of illness and death and has to be reassembled in new forms of social organization. By tracing real connections across realms of existence normally separated by fields of study, I analyze the connections between medicine, literature, and the events related to war and its history. The compelling strength of this dissertation is the comparative breadth of its perspective. The

methodologies I deploy are not normally engaged in conversation with each other: the “narrative medicine” of medical practitioners, the “narratives of illness” of cultural and formalist literary critics and humanist scholars, and “medical intertextual” investigation that links literary, medical, and social texts. Moreover, my literary analysis is consistently based on historicized readings, such as of shell shock and PTSD and of the medical quarantine. As my umbrella methodology to justify such a procedure, I rely on Bruno Latour’s Actor-Network Theory in an effort to trace hybrid networks that bridge “narrative medicine” and fictional and non-fictional literary representations of mental breakdown and physical diseases linked to social disruptions caused by modern warfare. My aim is to exceed the boundaries of individual patient narratives (pathographies) by connecting them with other illness narratives in order to complicate and thus redefine the meaning of “illness narratives.” Furthermore, I study the artistic innovations in narrative renditions of the experiences of illness and profoundly altered mental states to enrich literary studies about formal techniques of representation.

In Chapter 1, I juxtapose Virginia Woolf’s modernist novel, *Mrs. Dalloway*, to Vera Brittain’s personal memoir, *Testament of Youth*, to compare fictional and non-fictional narratives about the rich lifeworlds of war-related illness and suffering of World War I. As a Latourian scholar, my focus is on the varieties of hybrid actor networks among soldiers, civilians, and health care providers amidst the reorganization of society for modern war, with its calamitous effects on mental health and physical well-being. Based on my findings, I argue that shell shock was a human rebellion against the unlivable situation of modern industrial warfare. While “rebellious”—as is important to note—shell shock was often an ineffective and self-destructive escape into illness. For some individuals, shell shock precipitated a profound personal transformation in their quest for a new state of health. Indeed, the rebellion of shell shock

opposed the official master narrative of modern industrialized warfare, according to which the medical diagnoses of “war neuroses” were not neutral scientific diagnoses, but medical instruments of the military system to discipline and treat soldiers in order to return them to the front. This chapter argues that the modernist literary, non-fictional, and philosophical works by Virginia Woolf, Vera Brittain, and Martin Heidegger selected here constitute counter-narratives of authenticity that challenge the veracity of the world of modern warfare as constructed by official nationalist and imperialist narratives. Moreover, *Testament of Youth* offers an alternative model for the fruits of melancholia and the workings of grief. Brittain’s autobiography derives its value not as an “individual pathography” but as the story of one life lived in acknowledgement and affirmation of our frailties, our mortality, and our shared responsibility for one another.

In Chapter 2, I study early twenty-first century nonfictional anthropological representations of the experiences of war and PTSD, *Fields of Combat: Understanding PTSD among Veterans of Iraq and Afghanistan* by Erin P. Finley and *Breaking Ranks: Iraq Veterans Speak Out Against the War* by Matthew Gutmann and Catherine Lutz, and one novel, *Sparta*, by Roxana Robinson. As a Latourian scholar, I distinguish the hybrid actor-networks that connect the two purist realms of medicine (objective; facts) and the self (subjective; the power of memory in the form of flashbacks). As I show, the contemporary diagnosis of PTSD (like the early twentieth century diagnoses of war neuroses) is founded on a rhetorical maneuver of purification that isolates mental trauma from the warfare that generates it; in short, PTSD is a disembodied, abstracted concept of the mind—an instance of a scientific artifact that Latour calls a “factish”—under the make-believe control of psychiatry. But real trauma produces hybrids connected to multiple sites that cannot be discounted as externalities. To counter the medical segregation of (mental) illness from politics, I trace the empirical connections in the actual

“assemblages” between the psychological suffering of U.S. soldiers *and* their combat experiences to reconsider “PTSD” as a complex hybrid that proliferates in response to war and its structural violence. Through the sharp contrasts I draw between the techniques of narration in each text, I show that opposing views about PTSD are based on conflicting answers to a much larger question: Is the human mind accurately understood as a machine *or* as part of an immensely complex, adaptive, and embodied living organism? Having debunked “PTSD” as a reductive biomedical diagnosis that erases moral concerns from the conversation, I propose my solution: A new version of PTSD that restores the “matters of concern” of veterans themselves via an ecological concept of the mind that replaces biological determinisms.

In Chapter 3, health and illness and the dying process are connected to nontraditional modes of warfare: In *Blindness*, when the population becomes white-blind, the government’s internment of the white-blind in medical quarantines makes war on the contagious people, not the microbe. In *Death with Interruptions*, the suspension of death is an allegory about the (mis)application of the critical care technology developed in war medicine to the civilian world in the end-of-life care of the terminally ill. Both novels are *anti-realist* fables that defamiliarize disease and death as fantastic conditions that are inaccessible to the medical/clinical gaze. In *Blindness*, I argue that rather than serving the purpose of protecting the public health, the location of the quarantine for the white-blind in an abandoned mental asylum unmasks the real carceral nature of medical quarantine as a distant successor to Foucault’s eighteenth century asylum for the insane. Indeed, the ostensible gesture of restoring health to the body politic is exposed as the internment of the white-blind in a twentieth century concentration camp, as aptly characterized in Agamben’s *Homo Sacer*. *Blindness* undercuts the master narrative for the containment of infectious disease, Patricia Wald’s “outbreak narrative.” After the universal

spread of white-blindness, the small society led by the doctor's wife "reassembles the social" in new patterns of organization amidst accelerating chaos and disequilibrium. In *Death with Interruptions*, the deconstruction of traditional social life with the proliferation of the dying is narrated alongside the reinvention of the social among the dying and their families. In my allegorical reading, I argue there is a parallel between the novel's fantastic suspension of death and the ontological condition of prolonged dying on the life-support machines of modern medicine that reveals the hubris of epistemological assumptions about the human capacity to control time and space through technological knowledge.

## Acknowledgements

I would like to thank my dissertation committee for their support of my research throughout all stages of the research and writing process. In those crucial early years of my studies at the University of Washington, Carolyn Allen provided important insight and guidance that enabled me to make the transition from the work world of the hospital to the academic world of the university. Robert Mugerauer has patiently guided me in my studies of phenomenology; his ongoing belief in my capacities to build bridges between literature, philosophy, and the hard sciences has been a wellspring of inspiration, especially during those most discouraging and daunting moments of the dissertation process. I am forever grateful for the critical guidance and support of Monika Kaup, Chair of my dissertation committee, who always asks the pivotal questions that push my work in new directions. I give Professor Kaup special thanks for her readings of and suggestions on the earlier versions of chapters of the manuscript and for her intensive teaching throughout my doctoral studies; consistently, she went above and beyond the call of duty in her interest in and support for my interdisciplinary research. I would like to thank everyone in the University of Washington English Department who has supported my doctoral studies and given me invaluable advice and encouragement. I would like to thank the English Department for the Barbara Bronson Himmelman Award on two occasions, which provided me with two academic quarters of research funding. A special thanks goes to my fellow students and office mates who helped me to balance teaching and my dissertation work and served as role models in their own studies. I want to thank Cuauhtemoc Mexica and Kirin Wachter-Grene for their guidance during many difficult moments in my research and my teaching. I am also grateful for the invaluable assistance of Norma Kaminsky in formatting my dissertation in its entirety.

## Dedication

I dedicate this dissertation to my children, Alexandra and Carl, for keeping our family together while I left home to achieve my life-long dreams, and to the future of my grandchildren.

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## Introduction

“Varieties of warfare and war-related illnesses, mental and physical,” is the red thread that organizes this dissertation. My study compares and contrasts illness narratives (fiction and non-fiction) from modernism and the early twentieth century with texts of the late twentieth and early twenty-first centuries to better understand the psychologies of war trauma and techniques of narration from opposite sides of the twentieth century. Broadly speaking, I address the question, how does illness reassemble the social? This question is particularly relevant with the chaotic destruction of war, when social bonds of solidarity collapse and have to be reinvented. Across three chapters, I counter medical perspectives which pretend that illness can be adequately understood according to medico-scientific paradigms. Instead, I show that illnesses are always connected through what Bruno Latour calls hybrid actor-networks to the larger world of human and natural experience. By tracing real connections across realms of existence normally separated by fields of study, I delineate cross-disciplinary networks that bridge medicine, literature, and the events related to war and its history.

More specifically, I study how the life-altering losses of warfare challenge survivors to surmount the crippling and even suicidal psychological effects and “reassemble the social” amidst worldly devastation. Since World War I, the psychological effects of warfare have been medically categorized as “shell shock”, “neurasthenia”, “battle fatigue”, and “Post Traumatic Stress Disorder”. In Chapters 1 and 2, I examine how such medical labeling contributes to the management of the consequences of war within the paradigms of dominant power. As counterpoints to such labeling, these narratives show that those who have suffered from the life-altering psychological effects of war often learn from their experiences to challenge medical assumptions that these effects are “pathological” and best managed with medical treatment. In

Chapter 3, I analyze two novels about non-traditional forms of warfare and how the social is deconstructed by the powerful mediators of illness and prolonged dying and has to be reassembled in new forms of social organization. In short, the narratives I study offer new aesthetic representations of the horrors of modern war and its aftermath that are particularly relevant to the current challenges of global pandemics, displacement, and environmental catastrophe.

To investigate my research topic, varieties of war-related illness and traditional and non-traditional war, this dissertation assembles a diverse set of primary works and their war specific sites. It engages an assortment of very different methodologies to address four major questions:

1. Why do narratives matter to the investigation/study of illness?
2. Since illness is a reminder that we are situated in communities, and, oftentimes, social bonds are altered and even destroyed due to the disruptions of life-altering illness, how are communities reimagined in various narratives of illness?
3. What are the cross-disciplinary networks of action and meaning that narratives of illness make and are inserted into?
4. What does fiction do that's special in the representation of illness? How does fiction modify, color, and affect the possibilities for narrating illness?

Because my dissertation engages a variety of very different methodologies, in the following section, I provide an overview of the field imaginary of each, including a review of intellectual procedures and problems they pose. I have divided the material into four distinct groups organized both by my four key research questions and by the distinct perspectives afforded by leading scholars. In addition, I include main ideas of Latour and from phenomenology that are central to my study.

My first research question is: why do narratives matter to the investigation/study of illness? In recent decades, a host of health care practitioners, ranging from Rita Charon, an internal medicine doctor, to the three nurses, Patricia Benner, Christine A. Tanner, and Catherine A. Chesla, and the experienced medical ethicists, Richard Zaner and Arthur Kleinman, have studied how narratives of illness are important in direct patient care. Together, they reveal what's missed by the typical focus of evidence-based, technology-driven medicine to instead offer alternative, narrative models for medicine and nursing. Their work counters the abuses of unequal power relations and calculative, rational thought at the expense of respect for the individuality of patients and their families, through their reliance on patient narratives as the means to consistently engage in meditative thinking in the daily practice of health care providers.

In complementary fashion, a number of literary critics and humanities scholars, including Virginia Woolf, Anne Hunsaker Hawkins, Einit Avrahami, Ann Juresic, and Arthur Frank, contribute to the study of how illness autobiographies—a subgenre of autobiography labeled as “pathography”—reinforce the links between culture and the individual to challenge post-structural and post-modern literary theory about the fictive reality of the self. Of note, the narratologist, Shlomith Rimmon-Kenan, compares the disruptions in illness narratives to other stories characterized by turning points, like migration and conversion stories, to ask, what is unique to illness narratives. She points out that just as narrative theory can illuminate how illness narratives contribute to the interdisciplinary juncture between medicine and literature, illness narratives elucidate central notions and problems in narratology and narrative theory. Together, these health care practitioners and scholars elaborate the many ways that narratives of illness matter because physicians and nurses depend on these stories to provide therapeutic care. Phenomenologist of medicine Fredrik Svenaeus summarizes this well when he writes that

narratives are the medium in which patients create their own radical changes in understanding that advance the process of recovery; these changes are particularly important for effective psychiatric care. The narratives I study show that such “radical changes in understanding” are prompted by the devastation of war. As such, the boundaries of ‘pathography’ extend beyond the narrow concentration on individual personal and family dynamics in the rendering of entirely new social relations and organization. For example, in Chapter 1, Vera Brittain situates her memoir as that of a generation both affected by and responsible for the historic changes in British and other European societies precipitated by the Great War. Indeed, she constructs her memoir according to extensive epistolary narration to offer a blended genre of multiple autobiographies that connect events and individual experiences separated by place and time into meaningful associations, based on the insights of the letter-writers, the subsequent deaths of many letter-writers, and the shared struggles by the survivors to reconstitute meaning in the face of these deaths. Speaking strictly from a therapeutic angle with regard to her suffering from war neurosis, when Brittain is threatened by thoughts of suicide, she rejects control by the medical establishment with its demands to “get over” the war. Instead, she purposively affirms her attachment to the dead through her on-going work for the living. Thus, *Testament of Youth* demonstrates the power of narratives to repair the webs destroyed by war by connecting individuals separated from one another both by death and by the medical-military establishment. Rather than meaning imposed by others, through the composition of her memoir, Brittain invents the ontological and existential meaning of shell shock and war neuroses. She demonstrates that through the stories they tell, people can find the mutual support with others who have had similar experiences to learn what they need to heal. Thereby, storytelling becomes both a therapeutic means and a form of quotidian resistance to war and its long-term devastation.

My second research question is: Since illness is a reminder that we are situated in communities, and, oftentimes, social bonds are altered and even destroyed due to the disruptions of life-altering illness, how are communities reimagined in various narratives of illness? Because war is suffered *en masse*, survival and even recovery is a shared matter of coming together in new forms of social organization. The unique value of my collection of narratives is that each one, in different ways, shows that reimagining human communities is central to the dialectics of survivorship through repair of the webs broken by war: the social has to be reassembled. Accordingly, in Chapter 1, in contrast to Vera Brittain, in *Mrs. Dalloway* I argue that Septimus Warren Smith commits suicide in rebellion against his abject isolation and confinement by the military-medical doctors. Likewise, in Chapter 2, I point out the manifold ways in which nonfictional and fictional narratives provide health care providers, civilians, and soldiers with possibilities for overcoming post-war isolation by building narrative bridges between those whose war experiences have been collective. In Chapter 3, with *Blindness*, I analyze the medical quarantine as a form of nontraditional warfare that destroys the communities that could be sources of sustenance in the face of a pandemic. I extend Patricia Wald's argument that the "outbreak narrative" has been the guiding framework for public health policy during the twentieth century. Deploying metaphorical language about individual carriers, contagion, and cultural practices, the outbreak narrative redraws the social map as communities are re-imagined along the lines of nationalistic containment, isolation, and dependency for the ill and of international freedom of movement, exchange, and development for the healthy. In *Blindness*, after the quarantine of the white-blind deconstructs the social, the small society led by the doctor's wife reassembles the social, thus demonstrating the possibilities for the self-organizing

generation of “order out of chaos,” as established by scientist Ilya Prigogine and philosopher of scientist Isabelle Stengers and further elucidated by Fritjof Capra.

My third research question is: What is the cross-disciplinary network of action and meaning that narratives of illness make and are inserted into? To rephrase the question: In individual texts across a range of disciplines in the hard sciences, the human sciences, and fiction, how does the migration of recurrent myths, metaphors, symbols, and allegories reveal shared imprints and common sources and aesthetic effects? How do memoirs of illness, case studies, journals, and letters open up or close off worlds of meaning about how illness is defined, understood, and experienced in the work of other disciplines? In my approach to these questions, phenomenology is one toolkit for interdisciplinary study. According to the accepted views of Edmund Husserl, Martin Heidegger, and Maurice Merleau-Ponty, phenomenology aims to describe the structures of our shared lifeworld experiences in order to provide an account of the modes in which persons and world are inseparably intertwined. Its approach allows us to analyze the manner in which the phenomena given to us and our responsive embodied consciousness co-constitute (that is, together bring forth) meaningful concrete existence. Therefore, phenomenology is an analytic for appreciating that illness reminds us that human immersion in the world is a matter of embodied finitude in being-toward-death.

Moreover, the problem that the phenomenology of illness responds to is the normalization of patient care based on statistical, evidence-based knowledge and technology. In search of an alternative science, Georges Canguilhem argues that living organisms are completely different than machines, in large part because they have the generative capacity to generate new life; irregularity and anomaly arise among living species who are viable to the extent of their fecundity. I extend his argument to advocate for narrative approaches in medicine

and nursing that aim to individualize patient care according to “norms” of excellence rather than the “norms” of the statistical average. Such narrative-based contestations are grounded in a fundamental distinction between meditative and calculative thinking in Heidegger’s challenge to the instrumentality of technology as driven by calculative thought. In “The Question Concerning Technology” he counters with the perspective of meditative thinking that considers technology not as a means to an end but as a way of revealing the world. “The question concerning technology is the question concerning the constellation in which revealing and concealing, in which the essential unfolding of truth propitiates” (Heidegger 338). Throughout this dissertation, in my interrogation of medical diagnostics and treatment founded on laboratory science and technological intervention, the underpinnings of my critique originate in the overarching concerns of phenomenology about the existential reduction of human life in the modern world. In the place of reductive science, Fredrik Svenaeus relies on Hans-Georg Gadamer in his advocacy of authentic-being-together through language and dialogue via the stories we tell one another; these stories are vital to the hermeneutics of the phenomenology of illness. In Chapters 1 and 2, based on the insights of Svenaeus about illness as “unhomelike being-in-the-world,” I argue that shell shock and PTSD are psychological crises precipitated by falling into an existential state of homelessness wrought by participation in the mass destruction of the home and of homelike being-in-the-world. As a revolt against this destruction, these life-altering and disabling psychosomatic illnesses confront individuals in war zones with the essential meaninglessness of their former lives and the brokenness of the world. I show that recovery depends on generating a new homelikeness of being-in-the-world by renegotiating the existential meaning of being-toward-death; this recovery is a creative process in which storytelling is a vital aesthetics to the meaning-making of embodied attunement, understanding, and discourse.

To complement phenomenology, Bruno Latour provides the major toolkit for my interdisciplinary study. More on the action side of things, his Actor-Network Theory is a process-oriented approach to the social as making and being made in hybrid collectives that constantly assemble and reassemble the social. Refusing dichotomies and dualisms, Latour seeks to trace hybrid networks that extend across established realms that are normally separated, such as science versus culture and nature versus society. Latour's major point has been that the nature of modernity is self-contradictory. On the one hand, in theory, modernity tries to purify the world by dividing it into separate and opposed realms. On the other hand, in practice, modernity has done nothing but produce increasingly complex hybrids extending across the realms (society/nature; science/literature) it insists to segregate in theory. Latour's approach is especially relevant for my dissertation project, which analyzes narrative of illness and seeks to trace, via close-readings of such narratives, connections that link science and medicine (infections and disease) with culture (narrative and narrative constructions) and history (war).

As a preliminary, one central point of ANT is that 'facts' themselves are both real *and* they are artificial constructions. With ANT, the meaning of 'facticity' itself changes from 'matters of fact' that are reducible to the natural and permanent to "factishes" that are 'matters of concern' that are irreducible, associative concatenations of mediators as they act upon the world to make the world what it becomes, at each and every moment. Fragile rather than durable, such are the "factishes" of everyday contemporary life. This central point recurs throughout this dissertation in the interdisciplinary network I trace between literature and medicine and war-related illness. For example, in Chapter 1, I argue that, contrary to their would-be status as medical-scientific facts, shell shock and war neuroses are actually *contended* factishes because they are constellations variously composed by opposing (alliances of) actors. (I make a parallel

argument about PTSD in Chapter 2.) On the one side, these official medical diagnoses are fabricated factishes in the master narrative of modern militarism. On the other side, in the modernist counter-narratives of authenticity of Heidegger, Brittain, and Woolf, it is possible to map a starkly different region in the actor-network of war-related illness. Countering the disciplinary factishes of medicine and technology, these counter-narratives by survivors of the war construct a factish that, building on Heidegger's analysis of the central role of the anticipation of death for Dasein (human existence) in *Being and Time*, I call the "modern authentic being-toward-death." I show that literary variants of Heidegger's philosophical "factish" of "authentic-being-toward-death" appear in the writings of Woolf and Brittain. In all its instances in the cross-disciplinary network, authentic being-toward-death poses a direct challenge to the inauthentic life demanded by the factishes of medical diagnoses and discipline. To summarize, in cross-disciplinary fashion, as a literary critic, in my analysis of *Testament of Youth* and *Mrs. Dalloway*, I consider how the literary contributes its own mode of narration of shell shock. On the other hand, my close-reading of these literary texts is enriched by my concerns as a Latourian scholar and a phenomenologist to better appreciate the evocative, revealing, and healing power of storytelling.

The other preliminary point to stress about ANT is that for Latour, the "social" is not the larger 'context' or 'hidden structure' that accounts for events and human actions, but a network of associations and assemblages. As he explains in *Reassembling the Social*, rather than an autonomous realm, the social is nothing but "a type of connection between things that are not themselves social" (Latour 5); the social is composed in ongoing, heterogeneous networks created by multiple actors, human and non-human. According to his principle of "irreduction," Latour refuses to divide reality into a world of surface phenomena or appearances and an

underlying but hidden reality, with the latter figuring as the absent cause that produces the former. Instead, he places phenomena of all types (cultural, scientific, economic, religious, political, etc.) on one single, interconnected, ontological plane, without deciding in advance what the paths of cause and effect are. Consequently, to perform an actor-network analysis is not “to glide like an angel” gazing down at the social world from above, but “to trudge like an ant” on the ground, tracing even the “tiniest connections” between things (Latour 25). (The insect is the fortuitous homonym of ANT, the acronym of Actor-Network Theory). Actually, such analysis necessitates the adoption of a deliberately myopic perspective, making no pre-judgments about causality by abstracting to pre-established social formations. Tracing an actor-network means to follow an actor or actant, whether human or non-human, to map the resulting heterogeneous network of associations and assemblages it/he/she is making. An actant is defined as someone (or something) “who makes someone do something” (Latour 58) *and* “what is made to act by many others” (Latour 46). Rather than passive intermediaries, actants are active mediators, for example, germs and diseases are mediators that redraw the social map and rewrite narrative scripts. In my literary analysis across three chapters, two cross-disciplinary “Latourian” questions my dissertation asks include: Given that the history of medicine is interrelated with war, how long can we study the history of war without entering a (mental) hospital? Given that medicine and illness are inseparable from narrative constructions, how long can we study the history of illness without entering narrative representations of the lifeworld of illness?

My fourth research question is: What does fiction do that’s special in the representation of illness? In this dissertation, fiction is another toolkit for ways to modify, color, and affect the possibilities for narrating illness. It provides an ideal laboratory for a new quest for meaning through the reinvention of the self and mythologies of the self. Fiction is an invaluable frame for

making the meaning of meaning because the world of the imagination allows for thinking things otherwise, often because it offers more latitude in experimenting with narrative techniques of representation. Moreover, in world-making, mythologies are an essential part of the world; originating as fictional narratives, myths evolve as the world is transformed. As the privileged mode that conducts these things, fiction provides literary confirmation and proof of what nonfictional illness narratives are about. On this note, Shlomith Rimmon-Kenan points out that in conditions of illness, storytelling acquires an existential urgency and that all narratives of illness are ‘fictionalized’ because of what is left out and what is included by the storyteller. Precisely because fiction offers more freedom in loosening the boundaries of verisimilitude than allowed by non-fiction, it is an ideal mode for narrating the fragmentation and vulnerability of illness to expose the limitations and hubris of narratives with more coherent and cohesive structures.

For my purposes, fiction is a distinct realm of freedom to imagine meaningful relations in the chaotic disruptions of war-related illness. In the four novels I study, the authors have greater freedom to recast “reality” in imaginative ways to reveal the subjective experiences of living through strange, extraordinary circumstances than do the authors of my three nonfictional texts. For example, during Septimus Smith’s hallucinations, Clarissa Dalloway’s epiphanic moments, and the extradiegetic narrator’s commentary, readers penetrate the world of being shell-shocked, and they do so with imaginative guidance about its ontological and existential origins and significance. Similarly, in *Sparta*, readers enter the mind of Conrad, a veteran with PTSD, during his nightly descent into the nightmares of war and his impending suicide. Having engaged in these fictional worlds, readers can better judge nonfictional—specifically, medical and scientific—claims about war neurotics. Of broader import, readers who are themselves soldiers,

civilians, and health care providers for the wounded, as well as readers who have no direct experience with warfare, can experiment with innovative techniques to better narrate stories about moments of crisis and of peace and quietude.

By tracing real connections across realms of existence normally separated by fields of study, I analyze the connections between medicine, literature, and the events related to war and its history. In addition to blending insights from phenomenology to strengthen major ideas from Latour's work, I establish a germinal dialogue between medical theories and narratives of illness based on pivotal Latourian concepts. My on-going contribution is to move between the theoretical and the concrete: How does theory emerge *from and in* specific narratives of illness and in the real world outside the text? My intention is to show that if we can replicate the chaos of war through (embodied) language, we can create new forms of order.

For example, in Chapters 1 and 2, one major insight is that shell shock and PTSD are medical factishes that are profoundly limited as modes of meaning-making, as seen in the two novels, *Mrs. Dalloway* and *Sparta*. As another example, in Chapter 3, based on Latour's argument about the semiotic nature of laboratory studies, I demonstrate the application of the semiotics of technological language to the provision of health care for the terminally ill to render my allegorical interpretation of *Death with Interruptions*. The compelling strength of this dissertation is the comparative breadth of its perspective, according to which I develop ANT as a methodology to connect individual illness stories to war and society to both recognize the value of the first-personal and to go beyond individual pathographies to the world. In sum, to supersede the purifications of the modern world, I offer close-readings of multiple texts from across the disciplines to reveal the proliferation of hybrids in our nonmodern world.

The methodologies I deploy are not normally engaged in conversation with each other: the “narrative medicine” of medical practitioners, the “narratives of illness” of cultural and formalist literary critics and humanist scholars, and “medical intertextual” investigation that links literary, medical, and social texts. Moreover, my literary analysis is consistently based on historicized readings, such as of shell shock and PTSD and of the medical quarantine. As my umbrella methodology to justify such a procedure, I rely on Bruno Latour’s Actor-Network Theory in an effort to trace hybrid networks that bridge “narrative medicine” and fictional and non-fictional literary representations of mental breakdown and physical diseases linked to social disruptions caused by modern warfare. My aim is to exceed the boundaries of individual patient narratives (pathographies) by connecting them with other illness narratives in order to complicate and thus redefine the meaning of “illness narratives”. Furthermore, I study the artistic innovations in narrative renditions of the experiences of illness and profoundly altered mental states to enrich literary studies about formal techniques of representation.

In Chapter 1, I juxtapose Virginia Woolf’s modernist novel, *Mrs. Dalloway*, to Vera Brittain’s personal memoir, *Testament of Youth*, to compare fictional and non-fictional narratives about the rich lifeworlds of war-related illness and suffering of World War I. As a Latourian scholar, my focus is on the varieties of hybrid actor networks among soldiers, civilians, and health care providers amidst the reorganization of society for modern war, with its calamitous effects on mental health and physical well-being. Based on my findings, I argue that shell shock was a human rebellion against the unlivable situation of modern industrial warfare. While “rebellious”—as is important to note—shell shock was often an ineffective and self-destructive escape into illness. For some individuals, shell shock precipitated a profound personal transformation in their quest for a new state of health. Indeed, the rebellion of shell shock

opposed the official master narrative of modern industrialized warfare, according to which the medical diagnoses of “war neuroses” were not neutral scientific diagnoses, but medical instruments of the military system to discipline and treat soldiers in order to return them to the front. This chapter argues that the modernist literary, non-fictional, and philosophical works by Virginia Woolf, Vera Brittain, and Martin Heidegger selected here constitute counter-narratives of authenticity that challenge the veracity of the world of modern warfare as constructed by official nationalist and imperialist narratives. Moreover, *Testament of Youth* offers an alternative model for the fruits of melancholia and the workings of grief. Brittain’s autobiography derives its value not as an “individual pathography” but as the story of one life lived in acknowledgement and affirmation of our frailties, our mortality, and our shared responsibility for one another.

In Chapter 2, I study early twenty-first century nonfictional anthropological representations of the experiences of war and PTSD, *Fields of Combat: Understanding PTSD among Veterans of Iraq and Afghanistan* by Erin P. Finley and *Breaking Ranks: Iraq Veterans Speak Out Against the War* by Matthew Gutmann and Catherine Lutz, and one novel, *Sparta*, by Roxana Robinson. As a Latourian scholar, I distinguish the hybrid actor-networks that connect the two purist realms of medicine (objective; facts) and the self (subjective; the power of memory in the form of flashbacks). As I show, the contemporary diagnosis of PTSD (like the early twentieth century diagnosis of war neuroses) is founded on a rhetorical maneuver of purification that isolates mental trauma from the warfare that generates it; in short, PTSD is a disembodied, abstracted concept of the mind under the make-believe control of psychiatry. But real trauma produces hybrids connected to multiple sites that cannot be discounted as externalities. To counter the medical segregation of (mental) illness from politics, I trace the empirical connections in the actual “assemblages” between the psychological suffering of U.S.

soldiers *and* their combat experiences to reconsider “PTSD” as a complex hybrid that proliferates in response to war and its structural violence. Accordingly, I critique Finley’s composition of *Fields of Combat* based on a contradiction between her theoretical appreciation for first-personal testimony as a primary source for social studies and her practical work that repackages first-personal testimonials into third-person stories. These third-person narratives erase the first-personal moral concerns of the veterans to corroborate Finley’s scientific iconoclasm of altering the medical factish PTSD into her own medical fetish of PTSD as a curable condition. By purifying the experiences of combat veterans during and after the war to exclude real world complexities, Finley reinforces illusory attempts to protect “normal” civilian life at home from the actual proliferation of disruptive and dangerous hybrids of the occluded underworld of war. In sharp contrast, in *Breaking Ranks*, Gutmann and Lutz are consistent in their practical application of their theoretical valuation of first-person testimonials to honor veterans who break loose from their ensnarement in the networks of the medical-military establishment to become mediators actively working to change the trajectory of personal and collective life. Gutmann and Lutz adopt an ecological point of view that is relational rather than isolating and aids in my project of tracing the actual assemblages in the experiences of combat veterans to construct a new version of PTSD. In *Sparta*, Robinson crafts a more direct view of the psychosomatic reactions to war through the internal focalization of the protagonist, Conrad Farrell, a veteran of the Iraq war. Readers enter the “wild state” of Conrad’s embodied mind as he experiences nightmares, rage, and insomnia and tries to make sense of his bewildering inner world as well as his frightening responses to civilian life. Conrad is represented neither as the subject of his own making—a myth he himself dispels—nor an object for others to help; instead, he struggles against suicide as the only exit from entrapment by his internal psychological

hybridization. *Sparta* is an anti-war novel that offers no reprieve from the war: PTSD is not curable nor can family and civilian life at home be purified of the war. Like the combat veterans in *Breaking Ranks*, Conrad is unable to tame his wild anguish from the war and, instead, learns that this anguish is well-founded and harbors vital lessons about the spiritual and existential meaning of life, both at home and in the war zones. Indeed, I show that opposing views about PTSD are based on conflicting answers to a much larger question: Is the human mind accurately understood as a machine *or* as part of an immensely complex, adaptive, and embodied living organism? Having debunked “PTSD” as a reductive biomedical diagnosis that erases moral concerns from the conversation, I propose my solution: A new version of PTSD that restores the “matters of concern” of veterans themselves via an ecological concept of the mind that replaces biological determinisms.

In Chapter 3, health and illness and the dying process are connected to nontraditional modes of warfare: In *Blindness*, when the population becomes white-blind, the government’s internment of the white-blind in medical quarantines makes war on the contagious people, not the microbe. In *Death with Interruptions*, the suspension of death is an allegory about the (mis)application of the critical care technology developed in war medicine to the civilian world in the end-of-life care of the terminally ill. Both novels are *anti-realist* fables that defamiliarize disease and death as fantastic conditions that are inaccessible to the medical/clinical gaze: *Blindness* narrates a white-blindness that is a luminous, hybrid condition that disrupts the modernist dichotomy between health and disease, and in *Death with Interruptions*, the suspension of death is a hybrid condition that disrupts the modernist purification of death from life. In *Blindness*, I argue that rather than serving the purpose of protecting the public health, the location of the quarantine for the white-blind in an abandoned mental asylum unmask the real

carceral nature of medical quarantine as a distant successor to Foucault's eighteenth century asylum for the insane. Indeed, the ostensible gesture of restoring health to the body politic is exposed as the internment of the white-blind in a twentieth century concentration camp, as aptly characterized in Agamben's *Homo Sacer*. *Blindness* undercuts the master narrative for the containment of infectious disease, Wald's "outbreak narrative." After the universal spread of white-blindness, the small society led by the doctor's wife "reassembles the social" in new patterns of organization amidst accelerating chaos and disequilibrium. In *Death with Interruptions*, the deconstruction of traditional social life with the proliferation of the dying is narrated alongside the reinvention of the social among the dying and their families. In my allegorical reading, I argue there is a parallel between the novel's fantastic suspension of death and the ontological condition of prolonged dying on the life-support machines of modern medicine that reveals the hubris of epistemological assumptions about the human capacity to control time and space through technological knowledge. Thus, in the imaginary worlds of these two novels, Saramago demonstrates the narrative power of fiction to invent scenarios and maladies that turn out to be forms of "seeing" during social crises, when established social reorganization is revealed as the problem (the dis-ease), not the ontological conditions themselves.

Chapter 1: The Early Twentieth Century: The Great War & Narrating Shell Shock in  
Modernist Literature and in Autobiography

Demonstrations in the streets have been called for this afternoon. Prices have been soaring everywhere for months past, and the poverty is greater even than it was during the war. Wages are insufficient to buy the bare necessities of life . . . . The men with one arm are carrying the placards . . . it is strange how a face without eyes alters—how in the upper half it becomes extinct, smooth and dead; and how odd the mouth is in comparison, when it speaks! Only the lower half of the face lives. All these have been shot blind . . . then come the shakers, the shell-shocked. Their hands, their heads, their clothes, their bodies quake as though they still shuddered with horror. They no longer have control of themselves; the will has been extinguished, the muscles and nerves have revolted against the brain, the eyes become void and impotent. (Remarque, *The Road Back* 266-269).

1. The Great War and Shell Shock: Contending Theories

During the first year of the Great War, military men realized that this war was different from previous wars because of the massive explosive power of the weaponry of industrial production to destroy life and the land. In the first months of the War, on the Western Front, the German Army invaded Belgium and France and then was stopped in this offensive campaign by the French and British armies. For the next four years, the opposing armies deployed massive firepower against each other in offensive attempts to gain territory while they erected defensive

barriers of barbed wire and underground trenches against the onslaught. As a ground war, an air war, and a war at sea, the military concentrated massive human and material resources into the development of new weapons of mass destruction, such as tanks and aerial bombers; with each innovation, the soldiers had to readjust their tactics. In the trenches, to meet the constant demands to both attack and defend, the troops on both sides bombarded each other from a distance with snipers, mortars, and howitzers, and attacked at close range with machine guns, rifles, and bayonets. Within the first year of the war, millions had been killed and millions more had been wounded; nonetheless, those in power rejected negotiated settlement in favor of battle.<sup>1</sup>

In the early months of the war, military officials were confronted by something relatively new in warfare: many soldiers suffered from nervous breakdown, often manifested in physical debilitation; even though they were not physically wounded, these soldiers lost mental coherence and were paralyzed, became deaf, blind, and mute, had uncontrollable spasms, and a range of other mental and physical ailments. Quite often, they were stunned and simply wandered off, unaware of their circumstances; when caught by the military police, they were prosecuted for cowardliness and desertion and, at times, executed. Mentally incapacitated, men were removed to the medical Clearing Houses and then to military hospitals hastily constructed to support the soldiers in the trenches. As the war became a prolonged fight instead of a quick victory—as the opposing sides had initially projected—increasing numbers of men suffered from mental and related physical breakdown. In January, 1916, the British government changed from a volunteer army to a system of conscription, and concern arose that conscripts were feigning psychological

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<sup>1</sup>While much of the literature on the War focuses on the Great War as a modern industrial war, the major source of power was horse power and man power (the infantry). With the impetus for technological development, the transition to the human dependency on fossil fuels was a chief consequence of World War I. Key sources are *A History of the First World War* by Liddell Hart and *World War I in Color*, which shows six hours of film from the archives of the Imperial War Museum in London.

and physical disabilities to avoid service when they collapsed in battle. Intense debates ensued about whether psychologically debilitated soldiers were cowardly malingerers or truly suffered from “shell shock”—the popular term widely adopted for conditions medical doctors and psychoanalysts referred to as “war neuroses.” These included two broad categories: “Anxiety states” among officers were distinguished from “conversion hysterias” among rank-and-file soldiers.<sup>2</sup>

Even though old disciplinary methods of punishment were often effective in getting psychologically stricken soldiers back into battle, once in the trenches, they frequently succumbed again to nervous breakdown. Without reconsidering their reliance on discipline, the top ranks of the military and civilian authorities reorganized medical care at the front to respond quickly to the early signs of neurosis to lessen its exacerbation into permanent mental disability and to isolate the individuals to prevent its “infectious spread” *en-masse* to the other soldiers. When hospitalized near the front, they were kept in separate sections or buildings from soldiers suffering from physical wounds. For the relatively few who were sent home to Britain, old institutions, such as asylums for lunatics, were converted into separate hospitals for the care of the psychological casualties of the war.

After the war, many veterans continued to suffer from psychological and psychosomatic symptoms acquired during the war, while other veterans only developed these symptoms in the years after the fighting stopped. Naturally, families of the afflicted soldiers were alarmed by the paradoxical nature of the change in the soldiers from the men they were before the War to the tormented and incapacitated men they were after combat. Often, families became convinced that soldiers who were executed for “desertion” actually suffered from shell shock. Of significance

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<sup>2</sup> For a thorough yet concise summary of the contemporary medical views of war neuroses among U.S., British, and French military psychiatrists, see *War Neuroses* by John MacCurdy.

for mutiny against the war and for its aftereffects, the soldiers themselves, both those afflicted by mental breakdown and those who maintained physical and psychological functionality, debated the meaning and appropriate responses to mental breakdown at the front.<sup>3</sup>

To gain a more complex understanding of the widespread mental suffering of modern warfare from inside as well as outside the medical and military gaze, I examine literary strategies developed by modernist-era texts to represent shell shock and war neuroses. In doing so, I compare these texts to the official documents of the government and medical establishment. Based on my findings, I argue that shell shock was a human rebellion against the unlivable situation of modern industrial warfare. While “rebellious”—as is important to note—shell shock was often an ineffective and self-destructive escape into illness. For some individuals, shell shock precipitated a profound personal transformation in their quest for a new state of health. Indeed, the rebellion of shell shock opposed the official master narrative of modern industrialized warfare, according to which the medical diagnoses of “war neuroses” were not neutral scientific diagnoses, but medical instruments of the military system to discipline and treat soldiers in order to return them to the front. This chapter argues that the modernist literary, non-fictional, and philosophical works by Virginia Woolf, Vera Brittain, and Martin Heidegger selected here constituted counter-narratives of authenticity that challenged the veracity of the world of modern warfare as constructed by official nationalist and imperialist narratives. In their post-war works, written under the traumatic impact of WWI, Heidegger, Brittain, and Woolf offered alternative and critical descriptions of the reality of modern warfare and human existence

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<sup>3</sup>According to the historian, Jean Norton Cru, little can be learned about what trench life was actually like except through the narration provided by soldiers ranked below the level of officer. Here, I highly recommend Louis Barthes’ *Poilu: The World War I Notebooks of Corporal Louis Barthes, Barrelnmaker 1914-1918*.

in the modern technological world more broadly that take into account the existential perspective of WWI veterans and veteran medical practitioners.

In the last resort, the psychological experiences and effects of modern industrial war are connected to broader changes wrought by modernity and the Great War. As Miles Orvell explains, the perceived results of an increasingly mechanized world are visible in images that recur in modernist writing of broken connections between men and nature and men and the world. As the abstract lessons of the new sciences of relativity infiltrated popular consciousness, people were aware of a growing distance between the inner sensory world and the “real world” whose physical structure was a product of the fabricated material, technological, and information environment. To repair this division between the inner and outer world, “a new culture was developing in the early decades of the [twentieth] century—one that aimed at the creation of a kind of authenticity deemed otherwise lacking in the culture of imitation that maintained its old grip during this period” (Orvell 141). After the war, modernist artists aimed to unseat an outdated aesthetic “realism” that had lost touch with contemporary reality by inventing new forms of “authentic” knowledge about living in a technological and scientific world where fundamental questions about the relationships between persons, things, and language were often obscured. Orvell uses the example of American modernism to point to the unique role modernist artists played in accepting “the challenge of defining authenticity in a culture that was coming more and more to thrive on caricatures of itself” (Orvell 286). I consider the works of Heidegger, Brittain, and Woolf to be three variants of what Orvell calls the “modernist culture” (or, counter-narrative) of “authenticity” in their respective disciplines of philosophy, literature, and non-fiction.

Taking another step back to my overall methodology, in this and subsequent chapters, I rely on Bruno Latour for an integrated and networked (“irreductionist”) methodological approach that brings scientific facts and human values and beliefs onto one single and level playing field. Irreductionism means immanence: nothing is reducible to anything else. There is no ultimate reality, no final box of truth to translate surface phenomena into. As established in the Introduction, Latour’s Actor-Network approach (“follow the actor, trace the network”) traces hybrid collectives across realms normally separated from each other: science (including medicine) and politics, nature, and culture/society; matter and mind; facts and values. Overall, the shift Latour effects from analytical mechanisms to describing patterns of relationships in complex networks crossing established domains (such as medicine and literature) undoes the Cartesian split between facts and values that gave rise to scientific mechanism and scientific positivism, which had fuelled the obsession with quantification and reduced the complex and nonlinear world of the living to the operations of a mechanical system. In this chapter, Latour’s methods of tracing a hybrid network of human as well as non-human actants from scientific and non-scientific disciplines aids me in establishing the complete network of interactions regarding shell shock and war neuroses in the context of WWI.

Of particular relevance in this context is Latour’s notion of the “factish”, a portmanteau word conflating the terms “fact” and “fetish.” A neologism, “factish” is intended to challenge modern scientific reductionism, which delegitimizes non-scientific beliefs as delusions (“fetishes”) to enthrone scientific “facts” as the only truth and reality. Refusing to grant science superiority, Latour points out that human agency creates both scientific facts and cultural, religious, social fetishes—all are human fabrications though their sites of production vary:

scientific facts are produced in the modern laboratory. In contrast, the “factish” is an inclusive concept designating both scientific facts and non-scientific beliefs as constructed entities.

The factish suggests an entirely different move: it is *because* it is constructed that it is so very real, so autonomous, so independent of our own hands. As we have seen over and over, attachments do not decrease autonomy, but foster it. Until we understand that the terms ‘construction’ and ‘autonomous reality’ really are *synonyms*, we will misconstrue the factish as yet another form of social constructivism rather than seeing it as a modification of the entire theory of *what it means to construct*. (Latour, *Pandora’s Hope* 275)

Latour’s irreductionist methodology allows me to bypass the fruitless debate over social constructionism by reinterpreting everything as a ‘factish’. Because of the comparative nature of my dissertation on literature and medicine, when Latour places everything on the same level and immanent playing field, he provides me with theoretical tools to affirm literature and culture vis-à-vis fact-oriented scientists and their authority.

Specifically, this chapter argues that, contrary to their would-be status as medical-scientific facts, shell shock and war neuroses were actually *contended* factishes because they were constellations variously composed by opposing (alliances of) actors. On the one side, official medical diagnoses fabricated both shell shock and war neuroses as factishes playing a part in the master narrative of modern militarism. On the other side, in the modernist counter-narratives of authenticity of Heidegger, Brittain, and Woolf, it is possible to map a starkly different region in the actor-network of war-related illness. Countering the disciplinary factishes of medicine and technology, these counter-narratives by survivors of the war construct a factish that, building on Heidegger’s analysis of the central role of the anticipation of death for Dasein

(human existence) in *Being and Time*, I call the “modern authentic being-toward-death.” As I will show, literary variants of Heidegger’s philosophical “factish” of “authentic-being-toward-death” appear in the writings of Woolf and Brittain. In all its instances in the cross-disciplinary network, authentic being-toward-death poses a direct challenge to the inauthentic life demanded by the factishes of medical diagnoses and discipline.

In point of fact, when Heidegger changes the history of phenomenology by departing from Husserl, it was in reaction to the factishes produced in the wake of World War I. Having started out as Husserl’s star student, Heidegger begins his departure from Husserl’s transcendental abstractions as he responds to his own students, many of whom were veterans of the war. Facing the post-war and economic crisis, Heidegger understands that phenomenology cannot “bracket” the external world as Husserl proposed: to be human is to be *in the world*. By inventing existential phenomenology, Heidegger joins the ANT network of WWI trauma to sponsor a core actant of the modernist counter-narrative to modern war: existential authenticity via being-toward-death. In the following discussion, I will show how, parallel to Heidegger, Brittain responds to the post-war crisis from her personal struggles with war neurosis to become a woman who authentically faces the imminence of death by living in memory of those killed in the war. Along the same lines, Woolf participates in the modernist culture of authenticity through her stylistic innovations of epiphanic modernism and free indirect discourse with multiple focalizers. More to the point, she counters the medical factish of shell shock through Septimus Warren Smith’s choice to commit suicide rather than be entrapped by the medical authorities in an inauthentic life of conformity to the dictates of the military-medical machine.

In summary, shell shock was *not* a mental condition that could be neatly categorized to end the debates. Instead, the conflicts about the nature of “the real” intensified because the

human actors were in conflict both about how to respond to those who suffered from psychological breakdown from the War and about the future of modern warfare itself. To control the “aftereffects” of the War, the institutional changes made by medical and military authorities in response to the enduring mental breakdown of combat soldiers were vital lynchpins in their preparation for the next war and the institutionalization of warfare as a permanent feature of modernity. In contrast, narratives of illness present the perspectives of soldiers, civilians, and health care providers who counter the military with far more accurate representations of war neuroses that trace the intricate connections between the mental anguish and lived experiences of those afflicted. As a literary critic, in my analysis of *Testament of Youth* and *Mrs. Dalloway*, I consider how the literary contributes its own mode of narration of shell shock. Here, my concerns as a Latourian scholar and as a phenomenologist are enriched by literary texts through the evocative, revealing, and healing power of storytelling.

## 2. Narratives Matter

I begin by discussing the contribution of narratives of illness to narrative medicine, which confirms the insight of literary scholars that “narratives matter.” In *Narrative Medicine: Honoring the Stories of Illness*, Rita Charon shifts the conversation about the meaning of suffering and illness to the narrative knowledge that improves biomedicine through empathetic care. She emphasizes that

narrative knowledge enables one individual to understand particular events befalling another individual not as an instance of something that is universally true but as a singular and meaningful situation . . . . Medicine can benefit from

learning that which literary scholars and psychologists and anthropologists and storytellers have known for some time—that is, what narratives are, how they are built, how they convey their knowledge about the world, what happens when stories are told and listened to, how narratives organize life, and how they let those who live life recognize what it means. (Charon 9-10)

From my own Latourian perspective, Charon is suggesting that health care providers act like ANTS who rely on patient narratives to gather all the “facts” into far more accurate differential diagnoses and treatment plans than those available within the strict purview of evidence-based, biochemical medicine.

The literary critic, Ann Hunsaker Hawkins points out that autobiographies of illness—the subgenre of “pathography”—offer sensitive accounts of new ways for making sense of ourselves and our lives in a troubled world. Moreover, illness formulations are based on shared myths that represent the ways a given culture(s) has come to understand experience over time. In *Mrs. Dalloway*, Woolf presents the conundrum of Septimus Smith on his journey before the war, when he was on a path of bourgeois success, to his transformation by the war into a veteran who is offered the same opportunities for success and yet who is overwhelmed by his memories of the war. In his hallucinations, Septimus sees himself as the new Christ, and his journey, now mythic, becomes wed to the destiny of humanity. Facing Holmes and Bradshaw, he sacrifices himself for the greater good of humankind: peace, not war. Ann Juresic, another advocate of illness narratives, adds that myths such as Septimus’s often help to express the meaning of suffering in human life. The literary critic, Einit Avrahami, confirms the power of mirror images in Brittain’s hallucinations of her own facial wound: Gazing in the mirror, she is horrified to see herself as a grossly deformed war veteran, and the image threatens her with the psychic split between her

present, wounded self and her past, pre-war self. In summary, these literary critics clarify key points about the power of narratives of illness to assist us in our quest for authenticity in the face of imminent death.

*Testament of Youth* and *Mrs. Dalloway* demonstrate the power of nonfictional and fictional narratives to exceed medical knowledge in the comprehension of the ontological and existential meaning of shell shock and war neuroses. Through the stories they tell, people can find the mutual support with others who have had similar experiences to learn what they need to heal. Thereby, storytelling becomes a form of quotidian resistance to war and its long-term devastation. As seen in Rita Charon et al., narratives of illness matter because physicians depend on these stories to practice therapeutic medicine—in stark contrast to the military professionals who practice “medicine” to instill conformity to the existential conditions of modernity.

*Mrs. Dalloway* shows that authors of fictional narratives have greater freedom to recast “reality” in imaginative ways to reveal the subjective experiences of living through strange, extraordinary circumstances than do authors of nonfictional narratives. During Septimus Smith’s hallucinations, Clarissa Dalloway’s epiphanic moments, and the extradiegetic narrator’s commentary, readers enter the world of being shell-shocked, and they do so with imaginative guidance about its ontological and existential origins and significance. Having entered this fictional world, readers can better judge nonfictional—specifically, medical and scientific—claims about war neurotics. Of broader import, readers who are themselves soldiers, civilians, and health care providers for the wounded, as well as readers who have no direct experience with warfare, can experiment with innovative techniques to better narrate stories about moments of crisis and of peace and quietude.

*Testament of Youth* directly challenges basic tenets of the therapeutic approach of the British military medical doctors to war neuroses in their opposition, first, to the psychoanalytic methods aimed toward restoring to soldiers their memories of the traumatic experiences that precipitated shell shock, and, second, to civilian sympathy for war neurotics. By recounting her own memories of the War, Brittain struggles to shape the effects these memories have on her psychological life and personal choices, and she convincingly advocates for sympathetic support as a means of recovery, confirming W.H.R. Rivers's testimony to the British War Office Committee. According to Rivers, the human mind does not have the capacity to repress memories of the horrors of war, so these memories will return, whether in the unconscious forms of the symptoms of war neuroses or with the resolution of these symptoms through conscious acknowledgement of the experiences of war.

‘If,’ said the Doctor, ‘you think about the experience which men went through in France, seeing their friends at their side with their heads blown off and things of that sort, the process of repression is altogether unsuited for an experience of that kind, and yet that process was going on an enormous scale and in the early stages of the war was habitually recommended by everybody. “Put it out of your mind, old fellow and do not think about it; imagine that you are in your garden at home.”’ (*Report 58*)

In Brittain's case, she attributes the failure of her attempts to stop hallucinating to the fact that she has been completely silenced by her shame for having such hallucinations. When Brittain writes *Testament of Youth*, she recovers from this “mutism” to divulge her visions of horrible facial disfigurement to others. Now, with the reassurance of others, hopefully, these delusions will lose their power to plague her with sublimated memories from the War. Furthermore, her

narrative discloses the vital connections between grief and war neuroses such that by acknowledging the presence of the dead in her life, she finds ways to heal from her grief, so her nightmares end.

Brittain narrates her own story and the stories of others through the letters they write to one another—and their poetry—to offer a blended genre of multiple autobiographies presented contiguously and as Brittain interrelates them as the narrator of the entire book. This blended genre of autobiography extends the boundaries of “pathography” beyond the myopic concentration on individual personal and family dynamics in the studies of pathography by Hawkins and others. Thus, when Brittain is threatened by thoughts of suicide, rather than a Freudian process of de-cathexis from her loved ones, Brittain affirms her attachment to the dead through her on-going work for the living. This work, in honor of her memories of those killed in the War, renews her self-confidence and sensitivity such that she can form new attachments and commitments. I argue that *Testament of Youth* offers an alternative model for the fruits of melancholia and the workings of grief. In other words, Brittain’s autobiography derives its value not as a “pathography” but as the story of one life lived in acknowledgement and affirmation of our frailties, our mortality, and our shared responsibility for one another. My overarching point is that by writing her memoir, Brittain provides other health care providers, civilians, and soldiers with a model for the power of autobiography to overcome post-war isolation by building narrative bridges between those whose war experiences have been collective. Serving as what I call Vera Brittain’s “distant double,” Septimus Smith commits suicide in honor of his attachment to Evans, in condemnation of the crime of war.

### 3. Narrating Trauma in Modernism: Trauma and the Shattering of Time and Space

Narrative is intimately connected to spatiality and temporality. In the early twentieth century, the immense shifts in the spatial and temporal experiences of daily life are central to the traumatic dislocations and destruction of World War I. To better understand these shifts, it is valuable to turn to the insights of Henri Lefebvre about fundamental changes in perceptions of space.

The fact is that around 1910 a certain space was shattered. It was the space of common sense, of knowledge (*savoir*), of social practice, of political power, a space thitherto enshrined in everyday discourse, just as in abstract thought, as the environment of and channel for communications; the space, too, of classical perspective and geometry, developed from the Renaissance onwards on the basis of the Greek tradition (Euclid, logic) and bodied forth in Western art and philosophy, as in the form of the city and town. Such were the shocks and onslaughts suffered by this space that today it retains but a feeble pedagogical reality. (Lefebvre 25)

Similarly, in *The Culture of Time and Space*, Steven Kerns analyzes the sweeping changes in technology and culture between the 1880s to the outbreak of World War I that created new modes of thinking about and experiencing space and time. In general, he considers these new modes as a shift from common sense and Euclidian space and from local, solar-based time with its natural rhythms to modes prompted by the ever-changing material foundations of technological innovation. For example, with telephones, people's sense of space shifted and with

the construction of railroads, people had to readjust a plethora of local times to the clock ticking to the incessant and impersonal beat of Standard World Time.

In 1914, when war was declared, overnight, people had to divert every personal interest and fortune into the highly accelerated demands of the official war effort. There was an abrupt break between life in the past and in the present as individuals filled new roles that demanded vastly different skills and effort than before the War. To highlight the difficulties of accurately rendering life-altering, traumatic events when individuals themselves change, Brittain quotes Charles Morgan in *The Fountain*,

‘In each instant of their lives men die to that instant. It is not time that passes away from them, but they who recede from the constancy, the immutability of time, so that when afterwards they look back upon themselves it is not themselves they see, not even—as it is customary to say—themselves as they formerly were, but strange ghosts made in their image, with whom they have no communication.’  
(Brittain 13)

On a different but related note, Ernst Bloch points out that through the persistence of the past—perhaps through its recidivist recollection—time is nonsynchronic.

In general, different years resound in the one that has just been recorded and prevails. Moreover, they do not emerge in a hidden way as previously but rather, they contradict the Now in a very peculiar way, awry, from the rear. (Bloch 22)

Adding to the insights of both Morgan and Bloch, I suggest that for many survivors of World War I, the years of the war endlessly recur, when individuals are ghosts of their former selves. Facing the devastation wrought in themselves and the world, they struggle in a state of homelessness, living in a strange and bewildering world, now strangers to themselves. This

pervasive homelessness is one reason that, instead of the old “realism,” the experimental techniques of modernist literature are intended to represent the early 20<sup>th</sup> century “culture of authenticity that Orvell calls “reality itself.”

Helpful to the elucidation of the psychological traumas of modern warfare, S. Kay Toombs explains the effects of disabling neurological conditions that entail severe loss of “normal” physical function. Relying on Sartre in *Being and Nothingness*, Toombs argues that,

[i]n neurological disorder shame manifests itself as an increase in the severity of symptoms. In the experience of the ‘gaze’ of the Other an already existing tremor invariably intensifies, spastic limbs become more rigid, difficulty controlling movement is more pronounced. (Toombs 18-19)

Shame exacerbates acute physical symptoms, delayed psychological effects, and permanent reduction in psychological capacities for coherence and well-being. Toombs’s argument supports my argument that Vera Brittain and Septimus Warren Smith are “distant doubles” of one another because they are haunted by their shame for having participated in the mass slaughter of war.

In addition, the following insights of literary critics about modernist narrative techniques for the representation of trauma are helpful. Michael Levenson connects the desolation of mass slaughter to the ravaging of space. The War burst the strong enclosing lines of formal containers, leaving indelible memories of the open, exposed horizon.

From this point forward, many modernists—including Eliot and Woolf—could not suppress pictures of traumatically broken space but were compelled to visualize the outspread, uncontrolled, and perilous terrain: the waste-land. Among other effects, these new images marked a return of the Real. (Levenson 225)

Levenson points out that Virginia Woolf's celebrated "realism" of "the ordinary mind on an ordinary day," was an experimental form that appeared in extraordinary days of violence. And, with the supersession of the individual narrator, impressionism is no longer the working of a rarefied mind isolated by its bewilderment but the public world of the war in which scenes of physical chaos, delayed recognition, and uncanny dislocations of space and time are realized on the battlefield. As Randall Stevenson points out, both time and space are shattered when "[t]he war sliced across time and history as sharply, as absolutely, as its trenches cut across space" (Stevenson 142), and Woolf's reliance on moments of epiphany is her method to repair the broken continuities of linear chronology in the aftermath of the War. Similarly, Peter Nicholls highlights the scene in *Mrs. Dalloway* in which Clarissa is sewing her torn party dress to appreciate her mixed style of poetic rhythm, extended simile, and contrived allegory to achieve the heightened "condition in which life and death are inextricably entwined" (Nicholls 288).

In my subsequent close readings, in *Mrs. Dalloway*, I concentrate on Woolf's experimental techniques of epiphanic modernism<sup>4</sup> and free indirect discourse with multiple focalizers in her composition of an unspoken conversation between a veteran with shell shock and a suicidal civilian to highlight the existential crises precipitated by modern warfare. Woolf's deployment of an invisible narrator who at times becomes the extradiegetic focalizer makes the novel a critique of the system of medical and legal control of the soldiers who fought in the War. In *Testament of Youth*, I concentrate on Vera Brittain's techniques of epistolary narration that produce a testimony to the Mitsein in opposition to modern warfare.

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<sup>4</sup> Morris Beja's *Epiphany in the Modern Novel* is a wonderful source on the central importance of "moments of epiphany" in the modern novel. Many modern novelists feel "that the work of art attains its greatest power when the artist does not merely record, but produces in his audience a sense of new and sudden vision" (Beja 19). In regard to Woolf, specifically, Beja considers *Jacob's Room* to be "her first full-fledged 'epiphanic' novel" (Beja 116). He points out that "as her art improved and her work became more characteristically her own, her use of epiphany also became increasingly significant, until with *Mrs. Dalloway* and her later works it dominates her novels" (Beja 132).

#### 4. The Work of an ANT: Shell Shock and War Neuroses as Factishes

This section establishes the historical background on shell shock and WWI by doing the work of an ANT-theorist and assembling the networks between three distinct standpoints: first, the archival record of lived experiences of warfare and shell shock; second, “shell shock” and “war neuroses” according to the official military and medical gaze with its prescribed disciplinary and “medical” treatments in contrast to the psychoanalytic gaze with its alternative medical treatment; and third, subsequent scholarship on the war that lends further insight into the factishes of shell shock and war neuroses.

To begin with the testimony offered in the primary archives about the lived experiences of shell shock during the war, one witness to the British War Office Committee, Squadron Leader Tyrell, offers the following description of shell shock:

‘In rest billets it was usually associated with the history of insomnia, nightmares, hysteria, mutism, amnesia, melancholia, petty crime, and, in some cases, by self-inflicted wounds. In the field by melancholia, depression, hysterical fits, uncontrollable shivering and wringing of the hands, staring eyes, blindness, amnesia, irresponsible chattering, acute mania, sudden insensibility, self-inflicted wounds, generally to the left hand or the feet; fear, and the very characteristic look of furtive fear—the hunted animal’. (*Report 32*)

He likens shell shock to “feminine outbursts of hysteria” and adds that to prevent its spread to the entire battalion, it was necessary to quickly isolate those suffering from shell shock. Based on his experiences treating soldiers at the front, Dr. Henry Head explains that when a man was being shelled in the trenches and had no intention of running away, he fell victim to a substituted

condition in which he was paralyzed from the waist downwards or had some other disability that made it impossible for him to remain in the trenches. Dr. Head also saw such “conversion” as a form of “hysteria.”

Soldiers shifted between prolonged periods of immobilization under heavy shelling in the trenches, to going “over the top” into man-to-man combat. Dr. W. Johnson recounts his personal testimony about the effects of going over the top.

‘I was with the field ambulance, in the first Somme battle, 1916. The division was kept in until practically everybody was done up and there one saw the men streaming down. There was nothing wrong with them, except that they were absolutely fagged out, and could not go over the top again. They had been over about 11 times in a fortnight and simply could not do it again. The only thing was for them to come down sick [with shell shock]’. (*Report 82*)

The only witness in the *Report of the British War Office Committee* who had himself suffered from shell shock was an anonymous officer who explained the traumatizing effects of the tactic of the enfilade, when one Army would relinquish one trench in order to subsequently attack the invading Army from the surrounding trenches, which had not been relinquished. Soldiers caught in the cross fire were utterly helpless. Caught for days in an enfilade, he describes his mental state in which a whole day passed in his mind, but when he looked again at his watch, one second had passed. Similarly, based on the experiences of Austrian and German doctors, Dr. Ernst Simmel attributes the onset of shell shock to the experiences of battle.

For instance, a man after being wounded several times has to return to the front, or is separated from important events in his family for an indefinite time, or finds himself exposed irretrievably to that murderous monster, the tank, or to an enemy

gas attack which is rolling towards him; again, shot or wounded by shrapnel he has often to lie for hours or days among the gory and mutilated bodies of his comrades, and, not least of all, his self-respect is sorely tried by unjust and cruel superiors who are themselves dominated by complexes, yet he has to remain calm and mutely allow himself to be overwhelmed by the fact that he has no individual value, but is merely one unimportant unit of the whole. (Simmel 32)

This very brief exposition of the lived experiences of trench warfare is the setting for the following analysis of how medical doctors came to understand and treat the psychological breakdown of soldiers.

In the early months of the war, the military and medical authorities were quick to attribute the psychological breakdown of trench soldiers to the advent of modern industrial warfare. As Malcolm Brown describes the reactions of the authorities,

it was as though the harrowing conditions of modern industrial warfare, with its emphasis on massive firepower and the use of guns of a caliber and range unimaginable in previous conflicts, had so destabilized [soldiers] as to sever their contact with reality. (Brown 162)

As the war continued, debates arose among psychiatrists and medical doctors about the causes and treatment of war neuroses. To understand these debates, I contrast the *Report of the War Office Committee of Enquiry into 'Shell Shock'*, published by the British Army in 1922, with *Psycho-Analysis and the War Neuroses*, published by The International Psycho-Analytical Press in 1921, and Sigmund Freud's testimony to the Austrian government's enquiry into the abuses of the War in 1919.

*The Report of the War Office Committee* presents a confused, even jumbled, “scientific” presentation of “shell shock” ranging from measurable, organic indicators of dysfunction—in particular, the signs and symptoms of hyperthyroidism—to distinctions between “commotional shock” and “emotional shock” to defense of the military execution of the “cowardly”—although cowardliness was often indistinguishable from uncontrollable “bona fide” psychic derangement. Since the aim of the Report is to be better prepared for the next war by guarding against shell shock and its damaging effects, the health and fitness of soldiers is of interest solely in order to make men into effective killing machines in campaigns of national aggrandizement.

Consequently, training officers need to

[c]reate the atmosphere of war by instilling into men a knowledge of the purpose and the goal of war. The purpose of war is to kill, the object of killing—the goal of war—is victory. War is a killing match. Every Bosche killed is a point scored. The army which scores the most points wins the match. Peace implies for one side, victory; for the other, defeat. The task in hand is to kill another million Bosches. That is a tangible goal; that is victory; that is peace. Every Bosche brings peace a minute nearer. (*Report* 206)

Such motivations confined the “scientific” presentation of the psychological suffering of soldiers to the need for the rulers to have apt and ready fighters. From the statistical analysis in the *Report*, the Committee concluded that 80% of the cases of shell shock were “emotional” in nature and origin because there were no signs of any physical injury. Nonetheless, the medical view accepted the mind as a “muscle”—something organic—that could be trained through exercises of repeated stress in military training. Furthermore, the Committee accepted modern warfare as the new norm to which humans have to adjust. Consequently, “psychosis” and

“psychopathic tendencies” were terms developed to “explain” the inability of certain individuals to adjust psychologically to modern warfare. Thus, while the Committee planned the minute details of adequate training and preparation for the next war—carefully constructing the mental asylum of modern life—they relegated shell-shock to a form of psychological “madness.”

These post-war preparations set into relief the cruelty of the treatments implemented for soldiers with shell shock during the war. In the *Report*, Dr. Gordon Holmes, a leading witness, argues there is no such thing as shell shock. His stance is identical to that of Dr. Holmes in *Mrs. Dalloway*.

‘In many cases it was found sufficient to insist that there was nothing wrong and that there was no reason why the patient should not recover. It was found in most Centres [near the front] that the quickest method was to tell the patient that we should give him electricity to help him along and almost invariably he got his speech back within half an hour’ (*Report* 39).

While Holmes was one of the few witnesses who denied shell shock, many medical witnesses to the Committee recommended the use of electric shock as an early treatment with the claim that its use often resulted in no reoccurrences of shell shock, and faradic therapy was prescribed in the medical manuals on treatment. Even though Freudian psychoanalysis was strongly rejected, other methods of “psycho-therapy” were advocated. Again reminding us of the doctors in *Mrs. Dalloway*, foremost, “persuasion” was a method whereby the medical officer convinced the patient to make the necessary effort to overcome his disability and return to battle. To achieve the patient’s cooperation, the physician had to completely dominate the situation to impose social priorities at the expense of selfish tendencies; key to successful treatment, the patient must not

find any way to escape from such domination, and very little harm could be done by electric shock therapy as a form of persuasion.

In contrast to the British medical establishment, the international psychoanalytic community found proof in war neuroses for the basic tenets of psychoanalysis: Neuroses are psychic in origin, not organic, due to the repression in the unconscious of traumatic experiences. In *Psycho-Analysis and the War Neuroses*, Dr. S. Ferenczi summarizes the psychoanalytic perspective that the mental casualties of the War are not due to “mechanical” influences, such as nerve blockages or microscopic destruction of tissue. To the contrary, psychic terror and the memories of it produce an unconscious flight from psychic conflicts into somatic illness, manifested in the signs and symptoms of war neuroses. Moreover, such neuroses offer further substantiation for a long held view among psychoanalysts that the sciences of anatomy and physiology gloss over the fact that *the paths between the physical and the mental are entirely unknown to scientists*. In another essay in this book, Dr. Ernst Simmel states that the war neuroses have definitively confirmed the psychoanalytic conclusion that in “hysteria,” all physical symptoms are conversions of the psychical. “The body is the instrument of the mind upon which it (the mind) allows its unconscious to manifest itself in plastic and mimic expressions” (Simmel 31).

In 1920, Sigmund Freud addressed the Austrian War Ministry during their enquiry into war neuroses and its brutal treatment by army doctors. In agreement with his colleagues, Ferenczi and Simmel, about the psychic sources of war neuroses, Freud clarifies that *war neuroses of the soldiers are not identical with pre-war neuroses* but are, instead, new in their precise formation and in their widespread prevalence. Nonetheless, war neuroses *are similar* to pre-war neuroses in having unconscious origins in the psyche; indeed, they afford new

opportunities for analysis of the unconscious mind in its power to affect human consciousness, the somatic symptoms of illness, and human behavior in general. He condemns electrical treatment of shell shock for several reasons, and emphasizes that the procedure was flawed in its inception as “therapy” due to its intended purpose of sending men back into war.

Here Medicine was serving purposes foreign to its essence. The physician himself was under military command and had his own personal dangers to fear—loss of seniority or a charge of neglecting his duty—if he allowed himself to be led by considerations other than those prescribed for him. The insoluble conflict between the claims of humanity, which normally carry decisive weight for a physician, and the demands of a national war was bound to confuse his activity. (Freud 17)

I suggest that the lack of pro-war sentiments accounts for the willingness of these psychoanalysts to rely on therapeutic methods aimed toward regaining memories of the traumatic experiences of war and to offer sympathetic confirmation to the soldiers of the validity of their affective, cognitive, and physical reactions to these experiences.

In stark contrast to the medical advice of the *Report of the War Office Committee*, Dr.Simmel argues that the act of falling ill is the moment when the healing process begins.

Consciousness refuses to take up ideas or to assimilate at the moment those things which are too horrible in their reality to be consciously tolerated. Therefore those psychic shocks, those fainting attacks and profound loss of consciousness denote . . . a power of the unconscious that attracts to itself the entire psychosis in a salutary manner. (Simmel 34)

Even the dreams of anxiety, terror, and rage of war neurotics are attempts at self-healing. In this regard, Vera Brittain’s experiences exemplify one individual’s reliance on her dreams,

hallucinations, and insomnia to narrate her journey and to recover from war neurosis. And the brave veteran, Septimus Smith, longed to share his hallucinatory insights with a receptive audience.

Finally, this section concludes with a shift in focus from primary archives about shell shock to summarizing key points from the secondary literature that inform my own analysis. Like many scholars, Eric J. Leed attributes shell shock to the prolonged dangers of steel and chemicals to soldiers as they held their deadlocked positions in the trenches; in repressing their fears, these emotions became manifested in the neurotic signs and symptoms of shell shock on an enormous scale unprecedented in combat. Leed argues that diagnosis with “war neurosis” was functional for the authorities responsible for keeping the combatants in the war. His argument corroborates my view that war neuroses were factishes, constructed but very real; moreover, the invented fiction of war neuroses in the official medical narrative had *real* effects in the *real* world.

As Leed explains, fearful that mental collapse could be seen as a legitimate exit from the war, the official view insisted that only a medical evaluation could determine the legitimacy of the symptoms *and* “medical discipline” was a necessary complement to military discipline with the advent of industrial warfare. Even the definition of “neurosis” was extended to include overt attitudes of rebellion among soldiers who were intensely hostile to officers, the staff at the rear, and politicians. The breadth and ambiguity of the category “war neurosis” made it an effective means for identifying disciplinary and morale problems among the soldiers in order to isolate aberrant individuals and treat them on an individual basis in a medical setting in which doctors assumed judicial and political functions.

These military-medical attempts were meager and belated responses to the threat posed to the rulers by widespread mutiny among the troops. As Anthony Babington recounts, mutinies in the French army started at the end of April, 1917 and increased during May. Due to the war-weariness of the troops and their huge losses and lack of confidence in their leaders, entire regiments marched on Paris to demand a negotiated peace settlement with Germany. Many units refused to fight on the line, officers were threatened by assault, and mass desertions were reported. Corroborating Babington's account, in *A History of the First World War*, Liddell Hart explains that the mutiny of no less than sixteen corps was the soldiers' response to the utter failure of the April offensive by the French and British armies, an offensive futilely prolonged by the generals with troops

thrown against barbed wire and machine guns to no apparent effect . . . The flame of revolt broke out in a regiment of the 2<sup>nd</sup> Colonial Division on May 3<sup>rd</sup>, and although momentarily extinguished soon spread to the tune of such cries as 'We will defend the trenches, but we won't attack!' 'We are not so stupid as to march against undamaged machine guns!' . . . . A significant sidelight is that cases of desertion in the French Army rose from 509 in 1914 to 21,174 in 1917. So general was the rot that, according to the Minister of War, only two divisions in the Champagne sector could be relied on fully, and in places the trenches were scarcely even guarded. (Hart 361)

With the French mutinies, the British Expeditionary Force had to take on a greater role in the fighting. In the Flanders offensive in late July 1917, known as the 'Third Battle of Ypres' or by the name of the town, 'Passchendaele', the BEF lost 31,000 men and gained about 3,000 yards.

By the early autumn the battlefield had deteriorated into a vast wilderness of liquid mud, with scarcely a tree, a hedge or a building left standing. Ammunition and supplies had to be carried forward to the trenches along narrow duckboard tracks, which formed the only access through the swamps on either side. The evacuation of the wounded was difficult, slow, and agonizing under such circumstances. (Babington 100)

When they entered the deserted and destroyed town of Passchendaele, the BEF had suffered 238,000 casualties. The official figures showed that “267 officers and 3,771 other ranks were listed as ‘battle casualties’ due to shell shock” (Babington 100).

In this setting, Babington evaluates the “medical” treatment intended to counter the mutiny of the troops. In contrast to Freud, Simmel, and Ferenczi, according to Babington, there was a consensus among official military, medical, and government opinions in the British *Report of the War Office Committee of Enquiry into ‘Shell Shock’* that the soldiers with shell shock were suffering from traumatic neuroses common to civilian life, *In other words, the problem was not modern warfare itself but the psychological breakdown in response to war.* Indeed, industrial warfare was now accepted as a permanent condition of modern civilization to which soldiers would have to adapt. Consequently, the ethical demands on psychiatry would be to serve the military needs of the nation.

Retrospectively, Elaine Showalter categorizes “shell shock” as “male hysteria” in her challenge to English psychiatry and its assumptions about absolute and natural differences between women and men. Faced with the wholesale mental breakdown among men, rather than a form of hysteria, the psychiatric theories which developed around shell shock involved diagnostic distinctions that maintained the differences between men and women. While my

research provides evidence that shell shock *was* seen as “hysteria”—most likely to corroborate it as a form of cowardliness—nonetheless, there is much value in Showalter’s argument that traces the origins of shell shock to the crisis of identity produced by the demands of the Victorian masculine ideal to suppress fear and other strong emotions. The long-term repression of fear that led to shell shock in war was only an exaggeration of the male sex-role expectations of self-control and emotional disguise in civilian life. Unable to respond to fear by escape from combat, men were silenced and immobilized and forced, like women, to express their conflicts through the body. The “body language of masculine complaint”, shell shock was a disguised male protest not only against the War but against the concept of “manliness” itself.

Both Leed and Showalter elaborate the damaging psychological effects of immobilization in the trenches, and I supplement this emphasis to argue that shell shock was a response to the experiences of battle, when, *en masse*, men went “over the top” to attack and murder one another with machine guns, rifles, and bayonets. Often, men were sent into battle by those in command with the knowledge that most, if not all, of the men would kill each other—the slaughter was immense. During battle, the men went over the top to fight, not for victory but, if they survived, to be immobilized alongside the wounded, the dying, and the dead in collapsing, mud-filled trenches. Then, they were forced to go over the top to fight, again and again. When one reads, for instance, of the Battle of the Somme, this was not a days-long “event” but a “battle” that lasted for months with millions of men killed and wounded. Therefore, I argue that, in the vast network of trench warfare, the experiences of prolonged immobilization *alternating with periods of direct attacks, even hand-to-hand fighting-to-the-death*, resulted in the psychological breakdown of shell shock. The abrupt yet continual shifts between the arresting chronotope of time when

immobilized in the trenches and the cataclysmic chronotope of time when “going over the top” constituted the phenomenology of causation of shell shock.

As I have pointed out, the constellation of shell shock was, indeed, unique to modern industrial warfare. While medical doctors and other military officers constructed “shell shock” and “war neuroses” as factishes by utilizing their pre-existing understanding of female hysteria and industrial shock in conformity with the demands of the official master narrative that legitimized modern warfare, in modernist counter-narratives, soldiers, civilians, and writers grappled with the lived experiences of being in a war-torn world and traced the actual psychological effects of those experiences to construct alternative factishes of their own about the reality of shell shock and war neuroses. Clarifying the contrasts between the factishes of these counter-narratives and those constructed by the medical and military gaze, Allyson Booth studies how the disconcerting experiments of modernist aesthetics can be traced to the experiences of war and of a world shaken by war. Booth emphasizes that for the combatants, the presence of corpses made life a macabre experience. In the trenches, dead men blended with the mud and duckboard landscape, emerging through the surface of the ground when disinterred from shallow graves by exploding shells and the rain-soaked mud. A common nightmare was of being buried alive in a bombed bunker.

This fear expresses how profoundly disturbing combatants found the lack of a clear boundary between life and death to be, for to be buried alive means literally to occupy the positions of life and death simultaneously—to become a conscious corpse. (Booth 61)

The presence of disinterred corpses with the constant threat of becoming one, subverted the structure of war, first, due to the inability to distinguish between allies and enemies, winners and

losers; and second, body counts no longer designated the victor when so many died on both sides of the conflict. Soldiers soon learned that the injuries and deaths of war erased the country of origin from consciousness, making the enlistment into national causes, nonsense. Along with the erasure of national borders, the boundaries delimiting the self were blurred with this invasion of the abject (corpses) into the self, overwhelmed by constant fears of being buried alive, severely maimed, or burnt with inhaled gases and of dying in agony after mutilating other men.

According to Booth, these experiences are pivotal for modernist writing by combatants and civilians, who no longer perceive life and death as sequential experiences ending with the usurpation of the former by the latter. Instead, the two states exist in an unpredictable relation to each other as the distance between life and death collapses. Quoting Eliot's *The Waste Land* (Eliot 47) Booth continues,

As the strange array of apparently contradictory verb tenses here displays, language itself relies on certain conceptions of death and its relation to the orderly progression of time in one direction; for death to constitute both a definite conclusion ('He who was living is now dead') and a continuing process ('We who were living are now dying') disrupts the ability of language to chart sequential time. (Booth 62)

Relying on Michael Levenson, she argues that the point of view of the opening of *The Waste Land* is that of a corpse who is viewing the arrival of spring, and we have the irony that those buried are not yet dead.

Booth connects the modernist sensibility that acknowledges the instability and dissolution of the boundaries around the self to the ways in which the war undermined confidence in the

stability of death; the modernist imagination investigates how the instability of death alters our concepts of the self.

Both at the front and in modernist works, corpses sprout, fluctuate in and out of consciousness, appear to sleep or to speak. They camouflage themselves as pieces of the material world but then emerge from that camouflage and pronounce themselves emphatically separate from the landscape. Corpses prompt multiple and elaborate responses, demand further interpretation, prove themselves infinitely susceptible to metaphor. In other words, in neither trench experience nor modernist language does death represent the possibility of closure. The past refuses to remain in the past. (Booth 63)

In literary texts, the past remains stubbornly present so characters cannot create new selves and the plot moves back to the past instead of forward to a new future. Language is trapped in the circularity of the self-reflective demands of psychological realism fixated on those who died and almost died. Likewise, in trench warfare, the shadow of death lay on the dial of time because the trench lines at the front are deadlocked in position; for every move forward, there is movement backward. The days and months pass in exact replication of one another; living by the clock is a mechanical process in which nothing happens. The past is gone, there is no future; there is only the present of killing, dismemberment, and entrapment when the clocks of modernism tick without anything changing due to the paralysis of modern warfare.

5. Early Twentieth Century Protests against the Mechanization and De-humanization of War and Psychiatric Medicine: Heidegger's Being-toward-Death and the Recovery of the

Authenticity of Dying in Brittain's *Testament of Youth* and Woolf's *Mrs. Dalloway* /  
 Intersections between Literary Modernism and Modern Phenomenology

This brings us to the central part of my argument and my close reading of Heidegger, Brittain, and Woolf as cross-disciplinary varieties of a modern existential counter-narrative of “authentic being toward-death” that these authors create in opposition to modern industrial warfare and official factishes. Martin Heidegger develops the philosophical branch of this modernist counter-narrative—existential phenomenology and the analysis of human existence (Dasein) and its ultimate responsibility, facing up to anxiety in the face of death. As noted, he does so in response to his students, who were veterans of the war—veterans such as Erich Remarque. *Being and Time* is vital for my analysis because Heidegger develops core insights about the existential choice between authentic being-toward-death and inauthentic obeisance to the they-self, insights that are central to the intersections between literature and medicine in my own analysis.<sup>5</sup> In this section, I summarize key aspects of Heidegger's philosophy and apply these in my analysis of my primary literary texts in the following sections. Since Heidegger does not write about illness, concepts by Eric Svenaeus, whose central focus is the phenomenology of illness, will fill the gap.

Complementing the autobiographical and literary voices of Brittain and Woolf, the early Heidegger of *Being and Time* is preoccupied by the meaning of life in light of the imminence of death—an acute awareness that the veterans brought home to civilian life. The challenge of the post-war world is to reject complacent denial of our mortality, although many people try to

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<sup>5</sup> Here, I find it interesting that Sianne Ngai is another 21<sup>st</sup> century scholar who looks at modernist aesthetics by juxtaposing Heidegger's presentation of anxiety in *Being and Time* with the Alfred Hitchcock film, *Vertigo*. Ngai focuses on Heidegger's theoretical framing of Dasein's possibilities for authenticity, and she close reads his particular perspective on anxiety in the human quest for truth and knowledge.

escape the war and concerned engagement in world-making. Heidegger cautions his readers that the uncertainty of the exact timing of death requires living in full awareness of death's imminence rather than in the habitual denial that displaces death to the distance of the future—*then*, not *now*. Such acute awareness changes the significance of all previous time into its meaning at the moment of death, when the impossibility of possibility erases being and time for the individual: In the face of death, what has been the meaning of each moment of one's life? Instead of wasting life on meaningless material pursuits—obviously of no value once the individual is dead—the hope is to live in view of the essential spirituality of being human, in concerned being with others.

Heidegger considers that we are “thrown into the givenness” of the world. Nonetheless, as essentially spiritual rather than corporeal beings, humans have

a potentiality-for-Being—a temporality which understands, and for which its own Being is an issue. But this *potentiality-for-Being*, as one which is in each case *mine*, is free either for authenticity or for inauthenticity. (Heidegger 275[232])

Since the end of Dasein's Being-in-the-world is death, Dasein can only exist as an authentic potentiality-for-Being-a-whole in awareness of being-toward-death. Furthermore, Heidegger argues that I “am guilty” is a core predicate in the ontology of being human. He asks, what is the existential meaning of “guilty,” and why and how does being guilty become perverted in its signification by the everyday way of interpreting it as having debts, owing, and being responsible for one thing or another? In opposition to such perversion, Heidegger offers an entirely new meaning to “being guilty.” Rather than a lack or a failure to comply to laws or “oughts,” Dasein, in its potentiality-for-being, is “guilty” of “being-the-basis-of-a-nullity.” In the ontological

condition of human existence, Dasein has to choose, and in choosing one possibility, it nullifies all other options for being.

The nullity . . . belongs to Dasein's Being-free for its existentiell<sup>6</sup> possibilities.

Freedom, however, is only in the choice of one possibility—that is, in tolerating one's not having chosen the others and one's not being able to choose them.

(Heidegger 331[285])

With this “freedom,” rather than choice as an act of “autonomy,” Dasein is limited by its thrownness into the “there” of its worldliness. As such, Dasein, in its falling into the world, is constantly faced with the possibility of inauthentic being in forgetfulness of being-toward-death. Or, in its ontological condition of having to nullify all other possibilities, Dasein can foreclose the inauthentic in favor of choosing authentic being-toward-death.

The ontological basis for Dasein to make the choice between inauthentic and authentic Being-in-the-world, is that Dasein has a conscience—not the “bad” conscience that merely warns and reproves, but the “good” conscience that offers something positive in that it calls Dasein to come face to face with its ownmost potentiality-for-being. To do so, Dasein must be closed off from the “they-self” to be free to understand the appeal of the “call of care.” Understanding the appeal, Dasein can project itself upon its ownmost authentic potentiality for becoming “guilty” by rejecting the nullity of inauthenticity and choosing, instead, to confront *and accept* the impossibility of all possibility: Death itself. In a mood of resoluteness, in the silent discourse of

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<sup>6</sup> Heidegger distinguishes Dasein as the kind of Being who understands itself in its Being; therefore, he designates this existential ontic as Dasein's essentially ontological “existentiell”: “Dasein always understands itself in terms of its existence—in terms of a possibility of itself: to be itself or not itself” (Heidegger 32[12]). The convention in quoting from *Being and Time* is to give both the page numbers of the translation (first) and the German original (second).

conscience, one is ready for the mood of anxiety necessary for authentic understanding of oneself and of others.

When resolute Dasein frees itself *for* its world, a relationship of being *with* others opens up that is an alternative to the conflicts and opposition between Dasein and the they-self.

Dasein's resoluteness towards itself is what first makes it possible to let the Others who are with it 'be' in their ownmost potentiality-for-Being, and to co-disclose this potentiality in the solicitude which leaps forth and liberates . . . . [I]t can become the 'conscience' of Others. Only by authentically Being-their-Selves in resoluteness can people authentically be with one another. (Heidegger 344[298])

Ultimately, the authentic potentiality-for-Being-a-whole of the individual is situated in the collective experience of shared anxiety and authentic understanding of the common human condition in being-towards-death. As we shall see, in Brittain's memoir, the extensive inclusion of letters from soldiers on the front provides extensive testimony about the shift from loyalty to the they-self to identity with the Mitsein in opposition to the War.

This shift involves understanding the unique temporality of the appeal of the call of care. Caught between the past and the future, in authentic understanding, the present is held in "a moment of vision" which temporalizes itself in terms of an authentic future. In contrast, inauthenticity is forgetting Dasein's ownmost thrown potentiality-for-Being when, in the fear of its thrownness in the world, bewildered and forgetful, *Dasein* clings to possibilities for self-preservation. Only a moment of vision will bring *Dasein* back to the present as a disclosure in the current situation of the potentiality of authentic being-toward-death.

When resolute, Dasein has brought itself back from falling, and has done so precisely in order to be more authentically there in the ‘moment of *vision*’ as regards the Situation which has been disclosed.

Temporality makes possible the unity of existence, facticity, and falling, and in this way constitutes primordially the totality of the structure of care . . . . [I]t temporalizes possible ways of itself. These make possible the multiplicity of Dasein’s modes of Being, and especially the basic possibility of authentic or inauthentic existence. (Heidegger 376-7[328]).

As we shall see, in *Mrs. Dalloway*, Woolf’s epiphanic modernism is founded on reliance upon core moments of vision that reveal a hidden and lost authentic existence. Clarissa Dalloway—the eponymous heroine in the novel—relies on such moments to face her conformism to the inauthentic they-self through her upper-class pursuits and aspirations.

Here, Heidegger emphasizes that he has neglected Being-towards-the-beginning with the birthing of new possibilities—envisioned during moments of epiphany. He asks if Dasein can be understood in a way more primordial than revealed in care, rooted to death, guilt, and conscience.

But death is only the ‘end’ of Dasein . . . . The other ‘end’, however, is the ‘beginning’, the ‘birth’. Only that entity which is ‘between’ birth and death presents the whole which we have been seeking . . . . Dasein has been our theme only in the way in which it exists ‘facing forward’ . . . leaving ‘behind it’ all that has been. Not only has Being-towards-the-beginning remained unnoticed’; but so too, and above all, has the way in which Dasein *stretches along between* birth and death. The ‘connectedness of life’, in which Dasein somehow maintains itself

constantly, is precisely what we have overlooked in our analysis of Being-a-whole (Heidegger 425[373]).

To correct this fault, he suggests further investigation into the temporal basis for this connectedness through which Dasein, existing between birth and death, simultaneously faces forward into the future and backward into the past.

In *The Hermeneutics of Medicine and the Phenomenology of Health*, Fredrik Svenaeus applies key points in Heidegger's philosophy to the ontological and existential meaning of illness and health. First, the essential moment of anxiety necessary to reach authentic understanding makes evident the same phenomenon that is brought to attention in illness—the *not* being at home in the world: “unhomelikeness” (*Unheimlichkeit*: meaning both the “uncanny” and “not at home”). In contrast to illness, health is the being at home that keeps the not being at home in the world from becoming apparent. When we are healthy, we can quickly recover our bearings to once again feel at home in the world. But in illness, not being at home is transformed into a pervasive homelessness that takes control of our being-in-the-world.

The basic experience of being ill is connected to the body—usually taken for granted when healthy—such that the patient is aware that the body as lived (*Leib*—the German term for body as subjectively experienced, a concept in phenomenology since Husserl) forms a vital part of our transcendence into the world.

What breaks down in illness are the meaning-patterns of being-in-the-world, the way we inhabit the tool-structures [of our bodies that] we transcend through in our homelike being-in-the-world. The unhomelikeness of illness is consequently a certain form of senselessness, an attunement of, for instance, disorientedness, helplessness, resistance, and despair. (Svenaeus 115)

Based on the intrinsic role of embodiment in all human experience, Svenaeus recommends adding the lived body (*Leib*) as a fourth existential to Heidegger's three existentials of attunement (mood), understanding, and discourse (language). Svenaeus suggests that our homelike or unhomelike being-in-the-world is a promising basis for the analysis of diverse illnesses with varied forms of breakdown in meaning-structures and transcendence into the world.

While Svenaeus (like Heidegger) does not speak directly about shell shock, his comprehension of illness in general is applicable to it. Based on his insights into illness, I argue that shell shock is a psychological crisis precipitated by falling into the existential state of homelessness wrought by participation in the mass destruction of homelikeness. As such, shell shock is a revolt against this mass destruction of the home. In killing and witnessing mass murder, the ideals of the heroic self and the homeland are destroyed, and the individual is stranded with neither the homelikeness of the embodied self in the world nor of the old, familiar world in which Dasein was thrown before the War. Thus, the extinction of old illusions about the "homeland" is accompanied by the acute awareness that the material and personal possibilities of the past have been erased. These losses involve defaced illusions about the self, for whom the human potentiality-of-being has become filled with terrifying dangers. Of pivotal importance, the individual with shell-shock is incapacitated by *the loss of the nullity of choice*. This loss of the ability to choose has two major prongs: 1) the psychic barriers have been destroyed and the inner monsters unleashed, so the "self" is no longer homelike and dependable; and 2) the loss of physical control due to psychosomatic symptoms disrupts homelikeness in the world.

To recover from life-altering, disabling illnesses, Svenaeus emphasizes that the process involves regaining homelikeness. Such restoration cannot involve a backward movement to the

state of health before the illness but makes the demand to move forward to a new and different form of being-in-the-world. Since the self-understanding performed by the everyday Dasein is often dismantled by illness, illness can precipitate an existential crisis that confronts individuals with the essential meaninglessness of their former lives and the brokenness of the world. In these situations, sometimes, individuals develop authentic interpretations of being-toward-death. Accordingly, I argue, recovery from shell shock depends on regenerating a new homelikeness of being-in-the-world; this recovery is a creative, often an aesthetic process, as in the narratives about Septimus Smith and Vera Brittain. Finally, Svenaeus relies on Hans-Georg Gadamer in his advocacy of authentic-being-together through language and dialogue via the stories we tell one another; these stories are vital to the hermeneutics of the phenomenology of illness.

[L]ife is structured as a narrative in many ways, and the story of illness is a story that is in the process of breaking down and falling to pieces. The homeless life of illness is characterized by a lack of meaning . . . highlighted by the breakdown of the tool-structure of the world and the failure of coherent transcendence. The coherence of narrative is another aspect of the homelike being-in-the world. The way the patient is able and allowed to tell the story of his illness is essential, not only to the doctor's understanding of the illness, but also to the patient's self-understanding and identity. (Svenaeus 144)

Narratives are the medium in which patients create their own radical changes in understanding that advances the process of recovery.

## 6. *Testament of Youth*

I now turn to my two primary literary texts as narratives of illness, providing anti-institutional and experiential counter-narratives of shell shock. I begin with Vera Brittain's non-fictional memoir because she gives testimony to Heidegger's authentic being-toward-death as a veteran of the War: She prides herself on providing nursing care to the soldiers on the front while in the direct line of fire. In her counter-narrative to the military-industrial complex, she responds to the "call of care" with her own modernist call for authenticity through opposition to death in war. Furthermore, she composes a counter-narrative of authentic being-toward-death precisely through the associations she makes between the war and its aftermath by virtue of what she learns from the "factishes" presented by her own war neurosis. Thus, in addition to Heidegger, Latour continues as key to my analysis. Through her extensive epistolary narration from the Western Front, Brittain affords a backdrop of first-hand accounts of soldiers that will subsequently augment our understanding of the mental crisis faced by the brave soldier, Septimus Warren Smith, in *Mrs. Dalloway*. Brittain cares for the horrifically wounded and those who died excruciating deaths, and she remains haunted by war memories for decades after the War. This allows for a multi-faceted study of the interplay between wounds and corpses *and* neuroses and grief in wartime suffering and its post-war aftereffects. Overall, Brittain strives to live in authentic being-toward-death because she has been transformed by her encounters with death to become acutely aware of human mortality: her memories of the dead remain present in her life to remind her of what the war has taught her about the ontological condition of being human and the value of life. In order to resist suicide, she has to negotiate with her memories of her loved ones, killed in the war but who remain active players in her inner world. At the same

time, she insists on being-toward-birth through the power of human creativity—perhaps Brittain’s deepest conviction and the ultimate source of her hope. I argue that, according to Vera Brittain, war neuroses and shell shock are the factishes of warfare *vital to the remembrance of war and the potential to heal from its aftermath*. In other words, in Brittain’s memoir, shell shock is transformed from a disciplinary factish in the service of industrialized warfare into a liberating “factish of recovery” from that war.

I need to clarify two points as preliminaries. First, in her symptoms of war neurosis and her resolve to live in authentic being-toward-death, Brittain’s experiences are tied to the suffering and deaths of her beloved fiancé, brother, and friends. Consequently, she faces death not as an isolating personal event but as a shared condition of human mortality. In her opposition to war, she articulates the inauthenticity of being-toward-death not only for lone individuals but for those killed in mass slaughter. After the war, in Brittain’s advocacy of authentic being-with-others in peaceful relations of solicitude, she substantiates her new ideals and hopes for humanity—ideals that she believes uphold the worthiness of those killed in the war because, if they had lived, these new ideals are what they would have worked to achieve. In her lived realities with the hallucinations, insomnia, and nightmares of war neurosis, Brittain remains in contact with the dead, and living becomes a quotidian response to the ghosts in her life. Thus, the nature of her recovery is, of necessity, tied to the fate of others, and, in acute awareness of the imminence of death, she lives in authentic-being-toward-death in a life dedicated to being-together—the living and the dead—on a journey in search of a new destiny for everyone in opposition to death in war. Here, Brittain modifies the individualism attributed to Heidegger’s philosophy to recover the collective quest for authentic death. Indeed, corroborating Heidegger’s concept of “Mitsein,” she finds widespread support among other antiwar, feminist, and socialist

speakers, writers, and activists, so she is able to establish a new life that is tremendously exciting and fulfilling to her. From her narrative, I conclude that since war is a collective crisis, recovery from war depends on the innovations individuals make in their relations with each other to establish new networks of social support. Together, people can heal; isolated and marginalized, recovery is impossible.

Second, I refer to Brittain's psychological signs and symptoms as "war neurosis" rather than "shell shock." This is because Brittain was not a soldier in the trenches but a bedside nurse for wounded soldiers. The differences between her experiences and mental suffering and those of soldiers, such as Septimus Warren Smith, highlight the particular causes of war neuroses and shell shock and the ways in which these conditions shaped the lives of individuals after the War. Like many soldiers and other health care providers, Brittain's symptoms developed acutely, but only after prolonged exposure to danger, exhaustion, illness, stress, and mass injuries and death. Unlike the soldiers, she did not go "over the top" into battle nor was she immobilized in the trenches while under attack from artillery, tanks, gas, and aerial bombs. Consequently, she did not develop the paralysis, tremors, blindness, or mutism that plagued many soldiers. Significantly, she did not have to repress her memories of barbaric acts nor did she suffer from remorse and self-abnegation for killing others or failing her comrades in battle. Nor did she have to repress her rage at being dominated by military officers and the imposition of military discipline. While helpless to stop a war that she opposed, during her years as a nurse, she worked as fast and as hard as she could for prolonged periods of time to perform the crucial tasks of providing hands-on nursing care to injured and dying soldiers. Therefore, she escaped the embodiment of the physical signs and symptoms of "shell shock," but she did suffer from hallucinations, nightmares, and insomnia that mirrored her experiences of embodiment in caring

for the wounds of soldiers, often as they died. And even though she became a public speaker for international peace, she could not tell others of her own personal suffering and disfigurement by the war for many years—not until she wrote her narrative about the war, *Testament of Youth*—so she did experience her own form of “mutism.”

Keeping in mind these preliminary points, to trace the exact constellation of Brittain’s war neurosis, it is important to note that Brittain’s nightmares started during the War and continued long after the war in recurrent dreams about her fiancé, Roland, and her brother, Edward. In these nightmares, the one is missing and hiding due to hideous facial wounds and the other is silent and turned against everyone; the wounds she tends during the day in her embodied experiences of providing nursing care, reappear. For example, based on her diary entry on March 22, 1918, Brittain recalls a moment when she stood

gazing, half hypnotized, at the disheveled beds, the stretchers on the floor, the scattered boots and piles of muddy khaki, the brown blankets turned back from smashed limbs bound to splints by filthy blood-stained bandages. Beneath each stinking wad of sodden wool and gauze an obscene horror waited for me—and all the equipment that I had for attacking it in this ex-medical ward was one pair of forceps standing in a potted-meat glass half full of methylated spirit. (Brittain 410)

She wonders if they might lose the war as the camp resembles a Gustave Doré illustration to Dante’s *Inferno*.

This scene from the fourth year of the war follows Brittain’s sequential account of the experiences of the volunteers who enlisted in 1914. In early August, 1915, when Edward comes home on a long military leave, he and Vera read in *The Times* “that the total estimate of

European war casualties was already five million dead and seven million wounded” (Brittain 175). In September 1915 before the Battle of Loos, Roland writes,

‘The dug-outs have been nearly all blown in, the wire entanglements are a wreck, and in among the chaos of twisted iron and splintered timber and shapeless earth are the fleshless, blackened bones of simple men who poured out their red, sweet wine of youth unknowing, for nothing more tangible than Honour or their Country’s Glory or another’s Lust of Power . . . . [B]ut look at a little pile of sodden grey rags that cover half a skull and a shin-bone and what might have been Its ribs, or at this skeleton lying on its side, resting half crouching as it fell, perfect but that it is headless . . . . Who is there who has known and seen who can say that Victory is worth the death of even one of these?’

Had there really been a time, I wondered, when I believed that it was?’

(Brittain 197-198)

Exhausted from her hospital work in London, and desperately worried about Roland, Vera describes her mental condition as “not far from insanity.”

After Roland’s death in December 1915, Brittain has her first nightmare, when, in addition to the wounds she cares for, grief becomes a persistent factish in her life. Fortunately, she has a year to work through her grief about Roland’s death during an easy nursing assignment in Malta. There, one May morning in 1917, Vera receives a cable from Edward to say that their dear friend, Geoffrey, has been killed in battle. Stunned, she sits on the rocks on the seashore all day in her pajamas and dressing gown with the cable in her hand, in a

state of suspended animation when neither heat nor cold, hunger nor thirst, fatigue nor pain, appear to have any power over the body, but the mind seems

exceptionally logical and clear. My emotions, however, in so far as they existed, were not logical at all, for they led me to a conviction that Geoffrey's presence was somewhere with me on the rocks. (Brittain 343)

Faced with the deaths of Roland and Geoffrey, she returns home to London to care for their beloved friend, Victor, blinded by a bullet that severed his optical nerves. When he dies, she seeks solace at her old school, St. Monica's. She recalls,

I became aware of a periodic thumping, like a tremendous heart-beat, which made one parched corner of the gamesfield quiver; the sound might have been a reaping-machine two hundred yards away down the valley, but I knew it for the echo of the guns across the Channel, summoning me back to the War. (Brittain 366)

In her grief, she feels summoned to serve in the war effort to do what she can to support those fighting in the trenches. She rejoins the Red Cross as a Volunteer Army Detachment nurse (V.A.D.) and leaves for France on August 3rd to be assigned to No. 24 hospital at Étaples, a few days after the beginning of offensives around Ypres on July 31, where Edward is fighting with his old 11<sup>th</sup> Battalion. As she cares for "the gasping pneumonias, the puffy, inarticulate nephritics and the groaning, blanket-swathed rheumatic fevers" she can no longer visualize the world or her own existence without the war (Brittain 393). Thus, her grief has affected her life decisions in ways that put her in a grievous situation in which subjective time stands still, and there is only death, loss, and suffering: the world of war.

Following the deaths of her fiancé, Roland, in December, 1915, then of their best friends, Geoffrey and Victor, in the spring of 1917, when her brother, Edward, is killed in June, 1918,

Brittain experiences the life-altering grief that transforms her as a person. She describes herself as having turned against duty to God, King, and Country. Now, her only hope is to become an “automaton.”

Thought was too dangerous; if once I began to think out exactly why my friends had died and I was working, quite dreadful things might suddenly happen.

Without the discipline of father and courage, disillusion and ferocious resentment would ravage unchecked; I might even murder my Ward-Sister, or assault the distinguished ecclesiastic. (Brittain 450)

Life seems “unreal” as she struggles to survive in a world emptied of her brother’s lifelong and unflinching companionship and consolation. For the next two years, Brittain feels completely alone in her thoughts and feelings, and later attributes this to her decision that nothing would ever console her for the loss of Edward—and nothing ever has, she writes in 1933. At the time of Edward’s death, amidst the dull routines of living, internally she is paralyzed by the shattered ideals of the war, “trampled into the mud which covered the bodies of those with whom I had shared them . . . . I walked in a darkness, a dumbness, a silence, which no beloved voice would penetrate, no fond hope illuminate” (Brittain 446).

A year after Edward’s death and eight months after the Armistice, when she has resumed her studies at Oxford, Brittain suffers from the first of the hallucinations that continue to plague her even as she writes her memoir. Feeling acutely estranged from the post-war world, grief is once again a precipitating factor. In the summer of 1919, she plans to meet her dear friend, Nina, at a summer school, but Nina dies of a weak heart and pneumonia (influenza). Trying to escape her death, Brittain writes,

I looked one evening into my bedroom glass and thought, with a sense of incommunicable horror, that I detected in my face the signs of some sinister and peculiar change. A dark shadow seemed to lie across my chin; was I beginning to grow a beard, like a witch? Thereafter my hand began, at regular intervals, to steal towards my face; and it had quite definitely acquired this habit when I went down to Cornwall [two weeks later]. (Brittain 484)

The imprint of her memories of infected wounds and deforming facial injuries is discernible in this hallucination. The delusion becomes a permanent, fixed obsession, and during the next year, she drifts along the “borderland of insanity.” Although she struggles to forget the war, she admits that by Easter of 1920, “its extraordinary aftermath had taken full possession of my warped and floundering mind” (Brittain 496).

In the autumn of 1920, her living quarters at Oxford are moved from Keble Road to a room in a Bevington Road house where her fellow Oxford student and friend, Winifred Holtby, lives. The room has five mirrors and is on the ground floor where “armies” of large mice converge at night. The mirrors and the mice precipitate hallucinations of five identical witches’ faces staring coldly at her, and her fear of the growth of an “impending” beard prevents sleep. Unable to ask for another room because of the secret dread of putting her fears into words, she is terribly ashamed by her “sinister transformation” in the mirror. Looking back, she thinks that because she could not talk with anyone about these hallucinations, no one could dispel them through reassurance. Finally, her insomnia becomes so severe that she has to escape the room to sleep on Winifred’s couch.

As I have explained, Brittain’s nightmares are the subconscious form in which Brittain’s grief plays itself out, both her grief over the deaths of those she loves and the sublimated grief

about those whose wounds she witnessed in the war. Somewhat differently, in her hallucinations—the second symptom of her war neurosis—she is herself deformed by a horrifying wound of war: the growth of a disfiguring fungal infection across her face. Here, her memories of the wounds of war become manifest in this persistent delusion that expresses Brittain's repressed fears as she confronts herself as a stranger—so transformed has she been by war—and now, after the war, she scrambles to adjust during “peacetime.” Much like soldiers who repressed their fears only to have them unconsciously revealed through physical symptoms such as paralysis and mutism, for Brittain, her fears of permanent and debilitating personal deformation by her wartime experiences are expressed in these hallucinations of facial wounds. While these fears are subconscious, the hallucinations provoke new, conscious fears. First, she is ashamed of the hallucinations so she fears telling others about these effects of the war. Her silence is the form in which Brittain experiences ‘mutism’—different than the mutism of “shell-shocked” soldiers, but part of her own war neurosis. Her greatest fear is a descent into insanity, when she will actually believe in her physical deformation by this infection. Her insomnia—her third symptom of war neurosis—is due to her fear of the secret spread of the fungal growth during sleep, when her hallucinations will enter her nightmares to become her lived reality when she awakens.

Two years earlier, at the time of the Armistice, she knew she had touched the bottom of a spiritual gulf, and felt that she had to either climb out of it or die. During her two years at Oxford, Vera often thinks of suicide, and later attributes this to her desire to join the dead, since the world itself seemed emptied of meaning with their absence and the obliviousness of the other Oxford students to the tragic experiences of the war—it startled Brittain how this next generation after hers had entirely different concerns and ideals to those of her own generation; as a survivor,

Brittain's personal struggles are those of a "lost generation." She laments her insomnia due to the exhaustion it causes her and her dulled mental acuity during her difficult studies to keep pace with the competitive standards set for the Oxford students. While Brittain is alienated from the other students, Winifred, who was also a nurse on the front, finds tremendous support from these same students. But Winifred does not suffer from war neurosis, and, unlike Winifred, Brittain finds herself at Oxford in an existential state of homelessness.

Only gradually did I realise that the War had condemned me to live to the end of my days in a world without confidence or security, a world in which every dear personal relationship would be cherished under the shadow of apprehension; in which love would seem threatened perpetually by death, and happiness appear a house without duration, built upon the shifting sands of chance. I might, perhaps, have it again, but never again should I hold it. (Brittain 470)

Three years after the war, she and Winifred travel to Italy to Edward's grave high in the Alps and then to Roland's grave in France. For awhile after this trip, Brittain's hallucinations, night terrors, and insomnia cease, and at the end of 1921, when she joins Winifred in their own Bloomsbury studio, she feels herself to be almost a "normal" person.

Finally, in 1925, during her indecision about marrying G., Brittain had

the last of those dreams with which, for ten years, the griefs and losses of the past had haunted my nights . . . . I dreamed that . . . Roland had never really died, but had only been missing with a lost memory, and now, after indescribable suffering, had returned to England . . . changed beyond recognition by cruel experience, but unchanged towards myself, anxious to marry me and knowing nothing of G. in America. So sharp was the anguish of the decision to be made that I woke up

quite suddenly . . . . And then I remembered, that there was no resurrection to complicate the changing relationships forced upon men and women by the sheer passage of earthly time. There was only a brief interval between darkness and darkness in which to fulfil obligations, both to individuals and society, which could not be postponed to the comfortable futurity of a compensating heaven.

(Brittain 650-1)

To marry, she feels that she has to somehow dissociate from the past; only then can she embark on a new future. She asks herself if she, a “wartime veteran,” could transform herself into a young wife and a mother, giving to fate once more the power to hurt and destroy her as it had done in the years following 1914. She concludes that only by grasping the nettle of danger could she pluck the flower of safety. Nonetheless, she hesitates until she can reassure herself that she is not saying good-bye to Roland, Edward, Geoffrey, and Victor. Instead, she directly asks them for their permission to live her life fully, after promising to always live with them in mind, knowing she will always carry the dead with her, not only in mourning but in the heartfelt conviction that, from the grave, they wish her well. Subsequently, while she finds a certain resolution in her grief to accept distance from the tragedy of war, grief continues to haunt her in her chronic hallucinations.

These “irrational” beliefs of Brittain can be connected to Latour’s critique of the fact/fetish duality via the concept of the “factish.” According to rigid rationalism, clearly, Brittain believes in a “fetish”—the continued presence of the souls of the dead in modern war—an empty screen onto which she falsely projects agency. Rational iconoclasts would want to destroy this belief and replace it with the medical-scientific “facts” of war neurosis. Latour would counter that the “facts” are never declared at the outset. Instead, facts are always political and need to be

negotiated. In this instance, the overriding question is: What is the reality of modern warfare? Contesting the official version of dominant psychiatry, Brittain's talks with the dead (as does Septimus Smith during his hallucinations) pose the factishes of a lived counternarrative to the official narrative of wars of conquest.

From the viewpoint of a phenomenologist, it is important to retrace the threads in the emergence of Brittain's war neurosis. In the opening chapters to *Testament of Youth*, Brittain details her young life before August, 1914, when she is a first-year student at Oxford. She highlights the idealism, sense of entitlement, and blindness to everything happening outside the class purview of her peers. They were teenagers when the war started and matured as soldiers and nurses on the front during the war. Initially, they think the war will be quickly won and eagerly join the war effort to prove their dedication to lofty ideals of heroic protection of the national homeland. At the same time, their previous sense of health and well-being has been disrupted by the threats to their homeland posed by warfare. As the war continues, frequently, they confront their confusion and lament their losses in their letters, diaries, and poetry. Profoundly bewildered and troubled, when the young men "go over the top" into battle, they write that the old life world itself has been replaced by another world, unrecognizable, baffling, and terrible. For both men and women, the past becomes an illusory house of cards and their dreamt-of futures are eradicated. They have entered the realm of "unhomelikeness." Latour's deconstruction of the opposition of hard facts versus fetishes explains the illusion as one fleeting moment replaced by the next: Not an illusion, but something merely replaced by a new alliance, another association, a broken connection, in the formation of a new network by human and non-human actors.

Although they are not ill, these young people become strangers to themselves, and with each battle and the on-going, wholesale destruction of the “home” of “old” English and European society, the world becomes a threatening and dangerous territory. In their letters they express deepening anti-war sentiment as they realize that their patriotic enlistment in the war has served ends other than noble causes, and they lose faith in the leadership of the war and its overall purpose. For the men, at any moment, they expect to die, but there is no exit from war, other than cowardliness or death. Ironically, even though they have been thrown into a world of domination by the they-self of the modern industrial military machine, they choose being-toward-death by sacrificing themselves to the slaughter rather than fleeing from death as cowards. The option of mutiny is never mentioned, perhaps because they are officers. None of the men survive, and Vera Brittain, as a nurse at the front, could easily have been killed, like so many others killed on the front. Only the timing of her absences saved her.

The constellation of Brittain’s war neurosis accounts for her persistent refusal to commit suicide and her successful struggles to recover from the existential condition of the unhomelikeness of warfare. I argue that the single most vital factor in her recovery was the busy little ant that she was, both during the war and afterwards. During the war, she could have stayed in England and lived as a “sheltered” civilian. Instead, Brittain joins the war effort as a nurse, and works incredibly long hours doing hard physical labor under conditions of extreme shortages of supplies, poor sanitation, and minimal auxiliary help while caring for the mass casualties of industrial warfare. As a V.A.D. nurse, Brittain changes from a youth with idyllic illusions about Western civilization into a mature woman who herself has mastered the nuts and bolts of the practical world—this is very difficult for her, as she recounts, after her sheltered and pampered bourgeois upbringing. Doing so gives her tremendous self-esteem and confidence in her work

abilities, and she forms lifelong friendships with other nurses who share none of her intellectual interests but all of her natural human sympathies and good humor. After the war, as a young intellectual, she is determined to get her Oxford degree, now in History instead of English, and has to work very hard to master this change in her studies. When she graduates from Oxford, Brittain rejects an academic career to write a new script for her life. She follows no prescribed roles or paths. She forges a new trail. This is her way of saying, “No more. No more war. No more accepting the lies and the deceit by blindly following the advice of others.” For Brittain, her survival and her recovery depend on facing the guilt of survivorship of warfare—not the guilt of indebtedness or responsibility, but Heidegger’s guilt for living one’s life as a conscious, nullifying choice—by living in authentic being-toward-death in honor of those killed in rebellion against obedience to the they-self of the master narrative of military conquest. In doing so, she seeks others who share her sympathies, and she finds lots of company. Through the power of discourse with others and her narratives—both fictional and nonfictional—Brittain generates new belief in herself, new social relations, and new convictions about the possibilities for a future that would house a new home for everyone together, at peace with the world. This is the intersection where literature and psychology and medicine collaborate and recompose in rejection of the old divisions between health and illness.

If Brittain had remained isolated, as she was from most of the Oxford students, she would have been alone with her signs and symptoms of war neurosis and her grief, and it is difficult to imagine how she would have been able to regenerate a new life and new hope for herself. Instead, the widespread and ongoing support of the antiwar and aesthetic movements during the 1920s and early 1930s was germinal to her actual recovery. Her political involvement and creative work were not directed to her war neurosis in the ways that psychotherapy would have

been directed to the alleviation of her hallucinations, nightmares, insomnia, and mutism. Instead, her life activities were antidotes and substitutes that provided a living alternative to her wartime experiences, even though it was never her intention to replace, repress, or forget these experiences. This leads to another crucial point in my analysis: Unlike many soldiers with shell shock, Brittain did not have repressed memories because she had not been buried alive or nearly suffocated nor had she murdered anyone or been herself violently wounded. Everything she had experienced was there for her to remember in writing *Testament of Youth*. Remembering through rereading her diaries and the letters and poetry of family and friends, Brittain's memoir is a testament to the power of autobiography to reveal the truths and the lies of war and peace.

### 7. *Mrs. Dalloway*

My analysis of *Mrs. Dalloway* parallels my approach to *Testament of Youth* in reading for Woolf's construction of factishes related to war neuroses. Moreover, with the novel, I rely on Latour's argument that accurate comprehension of science and society comes through a precise focus on "local" networks complemented by panoramic "big picture" views of the "global." In Woolf's use of free indirect discourse, the movement shifts from the interior thoughts and impressions of one character to another, and, adding to these local perspectives, the extradiegetic narrator affords a panoramic view of the far distant past and the future of human civilization. In regard to shell shock, one protagonist, the veteran Septimus Warren Smith, commits suicide due to his subjection to the medical recommendations of his doctors. The other protagonist, the civilian Clarissa Dalloway, discovers the secret meaning of his death in a moment of epiphany through her inner reflections. Here, Clarissa, as the resident phenomenologist in the novel, is

alert to Heidegger's call of care, so she provides the vital connection between Septimus Smith and Vera Brittain in their respective decisions to live in authentic being-to-death in the aftermath of war. From the local to the panoramic, the extradiegetic invisible narrator steps back from these local events to offer a bird's eye view about the "global" reach and effects of the British Empire. Thus, *Mrs. Dalloway* offers a critical perspective on the official views about shell shock and its medical treatment and the entire enterprise of modern British society. It is no coincidence that the novel's time period is one day in mid-June, 1923, exactly one year after *The Report of the War Office Committee of Enquiry into 'Shell Shock'* was completed on June 22, 1922. Actually, *Mrs. Dalloway* offers a thorough-going critique of that Report in narrative form.

Whereas the stated goal of the Report is preparation for the next War, *Mrs. Dalloway* is an anti-war novel in which the protagonists untangle their confusion to prefer death rather than inauthentic being-in-the-world in compliance to the they-self of permanent military and medical domination. As critics have noted, Clarissa and Septimus are sane and insane doubles; my analysis of the centrality of war neuroses enriches existing analyses of their kinship of strangers.<sup>7</sup> Woolf's use of free indirect discourse with multiple focalizers serves to narrate Septimus's inner world of hallucinations and his decision to commit suicide alongside Clarissa's moments of epiphany. Clarissa reveals the secret meaning of Septimus's death in his rebellion against the administered life of modernity. My claim is that the core of their kinship is their shared quest for authenticity, destroyed by the War and its aftermath.

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<sup>7</sup> In *Madness and Sexual Politics in the Feminist Novel*, Barbara Hill Rigney states, "Woolf juxtaposes her 'sane' character to an insane doppelganger: Clarissa Dalloway represents the 'normally' alienated person who functions in her society, but whose other and perhaps better self is the madman Septimus Warren Smith" (Rigney 41). In *Woman of Letters: The Life of Virginia Woolf*, Phyllis Rose also writes about the relationship between insanity and sanity in the kinship of strangers between Septimus Smith and Clarissa Dalloway. "Septimus, without Mrs. Dalloway, is as incomplete a portrait of the artist as she is without him. He may be in touch with the depths, he may dive down into the ocean of the unconscious and come up with a pearl, but she can see that the pearl is displayed and handed around" (Rose 139).

*Mrs. Dalloway* exemplifies the power of fictional narratives of illness to offer richer and more accurate representations of the lived experiences of warfare than the official presentations of war and its effects. Since Vera Brittain recovers from her war neurosis outside the purview of medical care—I assert she recovers *because* she remains on the outside to initiate her own healing process—she offers scant comment on the medical care of war neurosis. In contrast, *Mrs. Dalloway* affords the opportunity to examine the medical system in its diagnosis and treatment of “shell shock.” Therefore, unlike in my analysis of war neurosis in *Testament of Youth*, I here concentrate on the literary representations of this medical system.

Similar to Brittain’s experience with war neurosis, the evolution of Septimus Smith’s shell shock is a factish of his grievous memories about the death of war. To trace this evolution, I follow the path of Woolf’s introduction to Septimus’s crisis in the opening scenes of the novel with the question, is the war over? As Clarissa walks along the streets filled with variegated sights and sounds, she appreciates

what she loved; life; London; this moment of June.

For it was the middle of June. The War was over, except for some one like Mrs. Foxcroft at the Embassy last night eating her heart out because that nice boy was killed and now the old Manor House must go to a cousin; or Lady Bexborough who opened a bazaar, they said, with the telegram in her hand, John, her favourite killed; but it was over; thank Heaven over. (Woolf 4-5)

In Clarissa’s self-reflective longing to be different than she is, if she could live life again, she would choose to be like Mrs. Bexborough, different even in appearance from Clarissa’s own “ridiculous little face, beaked like a bird’s” (Woolf 10). Assuming the role of the resident phenomenologist in the novel, her preoccupations shift to her class hatred of her daughter’s tutor,

Miss Kilman, and how this brute of hatred residing in her own soul mars the beauty and authenticity of each fleeting moment. Later, when Septimus attacks the medical doctors as the “brutes of human nature,” we are reminded of the brute of class hatred in Clarissa’s soul. Unlike her peers in their unsparing duplicity, Clarissa is the upper-class double of Septimus who shares his insights about the brutishness of human nature in European civilization.

In the flower shop on that June morning in 1923, when Clarissa startles at the “violent explosion” of a motor car, readers are introduced to

Septimus Warren Smith, aged thirty, pale-faced, beak-nosed . . . with hazel eyes which had that look of apprehension in them which makes complete strangers apprehensive too. The world has raised its whip; where would it descend? (Woolf 14)

Like Clarissa, Septimus is birdlike in appearance, and for him, the brutes and monsters in human life appear to him in his hallucinatory and metaphoric perceptions of the two doctors, Holmes and Bradshaw. Consistently, Septimus’s hallucinations are both his nemesis and, like Clarissa’s epiphanies, a pathway to deeper truths about the ontological and existential condition of human being.

Soon, it becomes clear that Septimus depends on Rezia—much like Clarissa’s dependency on Richard Dalloway—to protect him from a descent into insanity or suicide. As Septimus overhears the crowd reading the skywriting of the aeroplane, only the weight of Rezia’s hand on his knee prevents him from flying among the elm leaves as he closes his eyes to escape from the visual and auditory hallucinations that tempt him with the beauty of madness.

But they beckoned; leaves were alive; trees were alive. And the leaves being connected by millions of fibres with his own body, there on the seat, fanned it up

and down; when the branch stretched he, too, made that statement. The sparrows fluttering, rising, and falling in jagged fountains were part of the pattern . . . Sounds made harmonies with premeditation; the spaces between them were as significant as the sounds . . . All taken together meant the birth of a new religion—

‘Septimus!’ said Rezia. He started violently. People must notice. (Woolf 22)

While Septimus is enchanted by his hallucinations and longs to enter this world to the exclusion of the ordinary world of the human brutes, to Rezia, his hallucinations are shameful signs of cowardliness and must be hidden from public view. Her shame prevents Rezia from calling upon others for help. Subsequently, in her isolation and vulnerability to Septimus’s threats of suicide, in desperation, she seeks medical advice—unaware of the judicial power of medical authorities to isolate and confine those designated as dangerous to themselves due to mental illness. With the intervention of the doctors, Rezia and Septimus are ensnared in the vast network of military and medical authority established during the war to keep soldiers in the trenches; together, Richard Dalloway and Sir William Bradshaw conspire to strengthen this network through post-war parliamentary legislation.

Initially, when Rezia fears that Septimus is going mad, she promises to never tell anyone. For his part, Septimus wants to tell the entire world that there is a beneficent God, so he writes the news on every scrap of paper he finds. In his hallucinations, the boundaries between the living and the dead have dissolved with the return of his dead comrade, Evans, killed in the trenches alongside Septimus, who seemed to himself to be unscathed. Yet now, five years later, while sitting on a bench with Rezia, he hears in the voices of sparrows a song sang in Greek

from the trees in the meadow of life beyond a river where the dead walk, how there is no death.

There was his hand; there the dead. White things were assembling behind the railings opposite. But he dared not look. Evans was behind the railings!

(Woolf 24)

When Septimus looks at Rezia's hand without their wedding ring, he is terrified and filled with both agony and relief. Their marriage is over, and he is freed to call forth the truths of human civilization to the Prime Minister and the Cabinet: All of life must be protected by universal love in a world changed forever by the absence of "crime."

Fortunately, even during his hallucinations—a honking motor car becomes an anthem and the piping of an old man's penny whistle becomes a shepherd boy's elegiac piping among the snow and red roses—Septimus can differentiate between his inner world and the external world. This ability to return from the world of hallucination back to the honking car and the penny whistle constitutes the line between shell shock and insanity. Nevertheless, rather than protecting him, the medical authorities threaten Septimus with isolation and silence, and Septimus knows that with this seclusion, the world of his hallucinations would take full possession of his mind. Insane, he would be forever subject to the they-self—the brutes of human nature, loosed upon the world.

Earlier in the day in Regent's Park, with the tolling of the bells at 11:45, Rezia announces it is time to visit Sir William Bradshaw. Startled in his reverie, at this very moment, in Septimus's mind, being and time have been reconfigured by the appearance of the dead in the world of the living.

The word 'time' split its husk; poured its riches over him; and from his lips fell like shells, like shavings from a plane, without his making them, hard, white, imperishable words, and flew to attach themselves to their places in an ode to Time; an immortal ode to Time. He sang. Evans answered from behind the tree. The dead were in Thessaly, Evans sang, among the orchids. There they waited until the War was over, and now the dead, now Evans himself—

'For God's sake don't come!' Septimus cried out. For he could not look upon the dead.

But the branches parted. A man in grey was actually walking towards them. It was Evans! But no mud was on him; no wounds; he was not changed. I must tell the whole world, Septimus cried, raising his hand (as the dead man in the grey suit came nearer), raising his hand like some colossal figure who has lamented the fate of man for ages in the desert alone with his hands pressed to his forehead, furrows of despair on his cheeks, and now sees light on the desert's edge which broadens and strikes the iron-black figure (and Septimus half rose from his chair) and with legions of men prostrate behind him he, the giant mourner, receives for one moment on his face the whole— (Woolf 68-69)

Septimus faces the monumental tragedy of war. With the death of Evans, the war became an intolerable situation for Septimus, and now, years later, his hallucinations offer an escape from his grief: Evans returns from the War, neither wounded nor dead—unlike the legions of dead whose corpses lay behind Septimus, the “giant mourner.” For him, shell shock evolves according to the dictates of caring as much about the fate of others as for his own fate. Like Brittain, the

boundaries between the living and the dead have dissolved as the individual and the collective have melded together in a shared destiny.

As Septimus and Rezia are on their way to Sir William Bradshaw's office, the narrator tells the story of Septimus's life, highlighting the transformation of Septimus into a manly-man and his seeming indifference to the death of Evans, an officer with whom Septimus was inseparable during the four years of warfare. As the narrator recounts, immediately after the Armistice, Septimus experiences sudden "thunderclaps of fear" that he could not feel. In this paradox between how Septimus sees himself (unfeeling) and what he is actually experiencing (acute and terrifying emotion), in his concerns that he can no longer feel, Septimus rejects the manly ideals of the heroic soldier who feels nothing about the deaths inflicted on others—the killing machine of modern industrial warfare.

According to early twentieth century psychoanalysts and twenty-first century advocates of narrative medicine, soldiers with war neuroses need the benefits of a listening and sympathetic ear. Through talking about their experiences in battle and, in particular, those experiences when their signs and symptoms of neuroses first become perceptible, repressed trauma can be revealed and acknowledged in disclosure of the psychic effects of such trauma. In contrast, Septimus, like millions of other soldiers, is discharged to civilian life and expected to act as though the war had never happened: Peace, on command of the Armistice! Nonetheless, Septimus considers the aftereffects of the war on his own terms. Since his mind seems to work perfectly, he considers his inability to feel to be the fault of the world. Hence, he directs much attention to the state of the world, and wonders if, indeed, the world itself is without meaning. Unlike before the war, now when he read Shakespeare, Dante, and Aeschylus, he discovers a secret signal passed from

one generation to the next of intense hatred and despair for humanity. After five years, he concludes

that human beings have neither kindness, nor faith, nor charity beyond what serves to increase the pleasure of the moment. They hunt in packs. Their packs scour the desert and vanish screaming into the wilderness. They desert the fallen. They are plastered over with grimaces. (Woolf 87)

Living in the “madhouse of England,” he wonders if he will go mad like the lunatics paraded through the London streets for the crowd’s enjoyment.

In the medical diagnosis of Septimus Warren Smith, not only are the diagnostic indicators of “nervous breakdown” listed in the War Office Report—the signs of hyperthyroidism—completely irrelevant, but, as William James argues, “[t]he worst a psychology can do is so to interpret the nature of these [personal] selves as to rob them of their *worth*” (James 141). Exactly so, Bradshaw and Holmes intend to silence Septimus through seclusion and “rest”—certainly his extensive writing in which he pours forth the personal meaning and valuation of his experiences, would not be part of such therapy. James continues,

Does not a loud explosion rend the consciousness upon which it abruptly breaks, in twain? No, for even in our awareness of the thunder the awareness of the previous silence creeps and continues; for what we hear when the thunder crashes is not thunder *pure*, but thunder-breaking-upon-the-silence-and-contrasting-with-it . . . . The thunder itself we believe to abolish and exclude the silence; but the *feeling* of the thunder is also a feeling of the silence as just gone. (James 146)

In Septimus’s acute anxiety that he can no longer feel, Septimus is troubled by the widening gulf between his current state and his past self—acutely, he feels the presence of thunderous psychic

transformations, and he longs for the silence of the past so he could feel as he did before he became a manly soldier seemingly indifferent to the violent death of Evans.

Even as he condemns himself for having no feelings, when Rezia cries for the first time, he descends another step into the pit of insanity. “Now he surrendered; now other people must help him. People must be sent for. He gave in” (Woolf 88). With no escape from the unlivable post-war situation of medical control and the duties of marriage, Septimus experiences paralysis, another symptom of shell shock, and becomes bedridden. When Holmes visits, he tells Septimus that there is nothing wrong that a couple days of rest aided by bromide won’t cure. Rejecting the doctor’s advice, Septimus faces his many crimes to judge himself, but the verdict is that of the brute, human nature: death to the war veteran. During Holmes’s second visit, he brushes aside Septimus’s headaches, sleeplessness, fears, and dreams as nothing more than nerve symptoms, and besieges Septimus with the counsel to exercise self-control by forgetting his inner reality through activities in the outside world. When Septimus refuses to see Holmes on his third visit, Holmes has the power to barge into the room and impose his diatribe of husbandly responsibilities on Septimus, who faces his entrapment.

Human nature, in short, was on him—the repulsive brute, with the blood-red nostrils. Holmes was on him. Dr. Holmes came quite regularly every day. Once you stumble, Septimus wrote on the back of a postcard, human nature is on you. Holmes is on you. Their only chance was to escape, without letting Holmes know; to Italy—anywhere, anywhere, away from Dr. Holmes. (Woolf 90)

Without Rezia’s presence beside him at every moment, Septimus feels deserted by a world clamoring to him to kill himself for the sake of the victorious brute with the red nostrils. Even though he feels that life is good and resists killing himself, he begins to search for the means of

suicide, comforted by his world of hallucinations where the brutes cannot reach him. He hears Evans speaking from among the dead, who populate his world, much like the dead who populate Britain's world as memory-factishes in the aftermath of war.

On this June day when Big Ben strikes twelve o'clock, as Rezia guides Septimus down Harley Street to Dr. Bradshaw's residential office at the advice of Dr. Holmes, Clarissa Dalloway lays her green dress on her bed. To conjoin these strangers, the narrator gives her third major soliloquy. Like the grey motor car of the royal family,

Sir William Bradshaw's car [was] low, powerful, grey with plain initials interlocked on the panel, as if the pomps of heraldry were incongruous, this man being the ghostly helper, the priest of silence . . . its sober suavity, grey furs, silver grey rugs were heaped in it, to keep her ladyship warm while she waited. (Woolf 92)

After the narrator elaborates upon the complicity between the patriarchal medical establishment and royalty in the rule of the British Empire, in his conversation with Rezia, Bradshaw declares the law: With threats of suicide, Septimus has lost his freedom and is now subject to the dictates of the medical authorities. The narrator recounts,

So they returned to the most exalted of mankind; the criminal who faced his judges; the victim exposed on the heights; the fugitive; the drowned sailor; the poet of the immortal ode; the Lord who had gone from life to death; to Septimus Warren Smith, who sat in the arm-chair under the skylight staring at a photograph of Lady Bradshaw in Court dress, muttering messages about beauty. (Woolf 94-5)

When told of his enforced confinement, Septimus has no need for any outside commentary, as he accurately assesses his situation: these brutes of human nature, Holmes and Bradshaw, are on

him, and they will apply the rack and thumbscrew in their remorselessness. As he searches for words to confess his crimes to his torturer, he can only think of love in the place of crime, and Rezia knows they have been deserted.

In response to this attack upon the defenseless young couple, through external focalization disguised as free indirect discourse and Rezia's focalization, Woolf's extradiegetic narrator launches a panoramic diatribe against Sir William Bradshaw's advocacy of "proportion" and "conversion." In his denial of "madness" as a legitimate diagnosis, Sir William prospers from the "proportion" of secluding England's lunatics, outlawing childbirth, penalizing despair, and silencing the unfit. The narrator counters that madness is Sir William's sense of proportion, and with this deft turn of "madness" from the insanity of the population into the madness of modern medicine, the narrator shifts her critique to Proportion's sister, "Conversion," an even more formidable Goddess. As Rezia also divines, under the guise of love, duty, and self-sacrifice, conversion loves death more than building as she feasts on the human will. To aid his patients in their conversion to a system of proportion, within the grey walls of his office, Sir William Bradshaw models his medical practice along the lines of military training of the human will through his strange demonstration of military drills for their emulation. Indeed, the narrator's diatribe against Bradshaw echoes the language of the 1922 War Office *Report*.

And then stole out from her hiding-place and mounted her throne that Goddess whose lust is to override opposition, to stamp indelibly in the sanctuaries of others the image of herself. Naked, defenceless, the exhausted, the friendless received the impress of Sir William's will. He swooped; he devoured. He shut people up.  
(Woolf 99)

With the doctor's years of experience treating patients who believe they are Christ and threaten to kill themselves, Sir William, the prototype of the medical establishment in the novel, responds to Septimus as one among multitudes. Challenging his authority, as they await the arrival of Holmes to take Septimus to Bradshaw's asylum, Septimus asks, how can Bradshaw control him—by what right and by what power? In a frantic attempt to salvage his copious writing from the coming assault by the “brute with red nostrils,” Septimus has Rezia bundle his papers together and hide them. In choosing death, he renounces a life of silence emptied of the authenticity he achieves through writing.

*Mrs. Dalloway* is a novel that confronts readers with a soldier who survives the War only to be driven to suicide by the medical authorities. Entrapped by Holmes and Bradshaw, Septimus confronts a lose-lose situation: On the one hand, if Septimus acquiesces to their power, he will be separated from Rezia and isolated from all reality except the world of his hallucinations—precipitating a sure descent into insanity. On the other hand, the only way he can escape their power is to commit suicide. Rather than live an inauthentic life of submission to the they-self, Septimus chooses suicide through the lessons he has learned from the factishes of his own shell shock about the existential meaning of being human in a world of modern warfare.

As Septimus's sane double and the resident phenomenologist in the novel, Clarissa is hard at work tracing the existential networks that ensnare each character in a web both of their own making and yet imposed on them by the facticity of falling into a world already given. Unlike Lady Bradshaw, who converts to the belief system of her husband, willing to tell lies for him and confine her life within his stipulations, Clarissa's quotidian task is to string together precious moments of epiphany about the essential meaning of life because she believes that no person or idea can solve the mystery of human life. Instead, the mysteries of life are its miracles,

to be treasured and reflected upon, not solved. Nevertheless, like Septimus Smith, Clarissa has a dreadful fear of the passage of time,

a dial cut in impassive stone, the dwindling of life; how year by year her share was sliced; how little the margin that remained was capable any longer of stretching, of absorbing, as in the youthful years, the colours, salts, tones of existence, so that she filled the room she entered, and felt often as she stood hesitating one moment on the threshold of her drawing-room, an exquisite suspense . . . . [Now, she felt] as if she had left a party . . . and stood alone, a single figure against the appalling night . . . feeling herself suddenly shriveled, aged, breastless, the grinding, blowing, flowering of the day, out of doors, out of the window, out of her body and brain which now failed, since Lady Bruton, whose lunch parties were said to be extraordinarily amusing, had not asked her.

(Woolf 29-30)

To recover from her petty despair over this snub by Lady Bruton, as she sews the tear in her party dress, Clarissa remembers the retired seamstress, Sally Parker, who made the dress. She considers visiting the old lady, but knows her own time is running out, so she won't be able to see her again. In light of her acute awareness of human mortality, Clarissa weaves together her epiphanies about human life.

Resting on her couch, she pinpoints in her mind what life has meant to her. She defends her parties as her gift to others, not a gift of anything big like the fate of nations, but an offering for the sake of an offering, to bring solitary people together before they each die, when no one in the whole world would know how she had loved it all. Meanwhile, as Richard Dalloway buys

Clarissa flowers, he marvels at the miracle of life when thousands of poor chaps lay all shoveled together in mass graves, already half-forgotten only five years after the Armistice.

That evening at her party, when she hears of the young man's suicide, Clarissa retreats to a side room to consider what he had preserved by throwing away his life.

She had once thrown a shilling into the Serpentine, never anything more. But he had flung it away. They went on living (she would have to go back; the rooms were still crowded; people kept on coming). They (all day she had been thinking of Bourton, of Peter, of Sally), they would grow old. A thing there was that mattered; a thing, wreathed about with chatter, defaced, obscured in her own life, let drop every day in corruption, lies, chatter. This he had preserved. Death was defiance. Death was an attempt to communicate; people feeling the impossibility of reaching the centre which, mystically, evaded them; closeness drew apart; rapture faded, one was one. That was the embrace in death. (Woolf 180)

In this epiphanic moment, Clarissa envisions the lost center of authentic being-toward-death that Septimus regains to escape domination by “das Man”—the they-self of her own generation.

In sum, much like Vera Brittain, who faces herself honestly due to the deaths of her loved ones during the War, Clarissa Dalloway faces herself honestly due *to the courage of Septimus to commit suicide*, which she only learns about second-hand. From her window, she watches her neighbor lady get ready for bed, then pulls the blind as she thinks,

The young man had killed himself; but she did not pity him; with the clock striking the hour, one, two, three, she did not pity him, with all this going on . . . and the words came to her, Fear no more the heat of the sun. She must go back to them. But what an extraordinary night! She felt somehow very like him—the

young man who had killed himself. She felt glad that he had done it; thrown it away. The clock was striking. The leaden circles dissolved in the air. He made her feel the beauty; made her feel the fun. But she must go back. She must assemble. She must find Sally and Peter. (Woolf 181-182)

Whereas *Mrs. Dalloway* begins by posing the question, is the war over, the novel ends with Clarissa's embrace of the challenge to choose authenticity rather than imitation in the aftermath of the war. While casting Proportion and Conversion as female Goddesses, Woolf's sleight-of-hand is to cast a female member of the British upper class, Clarissa Dalloway, as the heroine of the novel. At the end of the novel, readers are left to wonder about the future of the women characters rather than of the men, whose fate is epitomized when, in Septimus's hallucination, Peter Walsh appears as Evans, a dead man in gray, walking toward Septimus in Regent's Park. While Peter is a mere imitation, oblivious to the suffering of the married couple, through the power of Septimus's hallucination, Peter is replaced by Evans—Septimus's authentic memory-factish of the war, who calls to Septimus from the graveyard of the war to tell him about what is real in human life.

## 8. Conclusion

To conclude, I would like to offer some final insights about the ways in which *Mrs. Dalloway* and *Testament of Youth* speak to one another as “dialogic narratives.” *Mrs. Dalloway* is a narrative about a soldier—an isolated individual—with shell shock, who is the voice of the young men who fought in the War. Their collective plight is subject to the post-war negotiations of the older generation in their exercise of ruling power—Clarissa Dalloway and Sir William

Bradshaw's generation, now in their mid-fifties. The lone soldier's address is intergenerational and twofold: Septimus Warren Smith speaks to the older generation and to members of the current adolescent generation, such as Elizabeth Dalloway, who are the same age as the war generation when sent to the Western Front. So, too, *Testament of Youth* is a statement by a member of the "lost generation" who fought in the Great War. As a young nurse in that War, Vera Brittain addresses her personal testimony to both the older generation, entrenched in the power of victory, and the younger generation, ready to forget the War.

My comparison of Septimus Smith's suicide with Vera Brittain's regeneration of hope supports my thesis that shell shock was a revolt against modern industrial warfare. Further, it shows that these two protagonists are "distant doubles" of one another: Both suffer from war neuroses, and both choose authentic-being-toward-death. Whereas Septimus is forced to commit suicide while Brittain can live on in authentic dedication to those killed in the War, Septimus's story is the negative proof that corresponds to Brittain's positive proof of the same problem. On the one hand, Septimus Smith is an individual soldier with shell shock who is thrown into the world of institutional entrapment by the medical and military authorities as they struggle to maintain their control over a population impoverished and traumatized by modern warfare. Due to his shell shock, Septimus chooses authentic being-toward-death through suicide to escape a dishonorable life of insanity. On the other hand, Vera Brittain is an individual nurse and scholar suffering from war neurosis who is thrown into a world of support for her advocacy of peaceful means for the settlement of human conflicts. Therefore, in response to her war neurosis, Brittain is able to "birth" a new life of authentic being-toward-death in honor of those killed in the War. Their common experiences with war neuroses have afforded both Septimus and Brittain an intimate knowledge about the unhomelikeness of illness caused by warfare, and they each choose

to nullify the inauthentic being of denial and conformity in favor of authentic being-toward-death through rebellion against modern warfare.

While both Brittain and Septimus try to break the vicious cycle of warfare, there is another point of contrast between them. On the one hand, Brittain is shamed by the hallucinatory spread of the fungal infection across her face *and* by the fact of having hallucinations—which mean that she is herself a “casualty” of the war, as distinct from being a “war veteran”—the latter is an identity of which she is quite proud. On the other hand, Smith believes in the veracity of his hallucinations as moments of vision, which is why he wants to share with others what he learns from these hallucinations about the crimes of war—as a self-styled prophet. The connection between the two is that both depend on their narratives of illness to heal from their wounds from the war. Brittain’s journey is not that of the heroic individual but that of a fragile individual who bravely takes advantage of every opportunity that is offered to her to challenge the voracious monsters who force Septimus Smith to commit suicide. Told alongside one another, the journeys of Smith and Brittain compose a dialogic narrative of enduring significance in the early twenty-first century. As a eulogy to Septimus, I offer this reflection by Brittain.

[T]he fact that, within ten years, I lost one world, and after a time rose again, as it were, from spiritual death to find another, seems to me one of the strongest arguments against suicide that life can provide . . . [N]othing could prove more conclusively than my own brief but eventful history the fact that resurrection is possible within our limited span of earthly time. (Brittain 495-6)

Chapter 2: The Early Twenty-First Century: Counterinsurgency Warfare and Narrating  
PTSD in Anthropology and Literature

‘[A]ll of a sudden I saw American soldiers. There was chaos in the house. We didn’t know where to go . . . .

And I want you to focus on this moment: I’ll remember it for the rest of my life. They were taking things, and my daughter Zamzam had been studying for her mid-year exams, and her books were on the floor when she went to bed. They started taking her books and putting them into a bag.

I asked my son, Ali, to ask them to leave the books, they were French lesson books. Ali asked them not to take the books, that they belonged to a student. They hit Ali on the head. They hit him so hard his neck almost broke . . . . When I think of the raid, it was misery. It had deep psychological effect. We always remember that night. I still remember my daughter Sarah screaming. She kept screaming and crying. It still affects her . . . . When she hears a noise, she screams: “The Americans! The Americans are coming!” (Iraq Veterans Against the War and Glantz 109)

1. Introduction

In Chapters 1 and 2, I study how narratives matter in aesthetic and medical representations of the war neuroses of World War I and the psychological suffering among combat soldiers in the U.S. war of aggression against Iraq and Afghanistan following the

bombing of the World Trade Center towers on September 11, 2001. My primary texts, fictional and nonfictional, provide a bridge from the early twentieth to the early twenty-first centuries. There is an intriguing parallel between *Mrs. Dalloway* and *Testament of Youth*, on the one hand, and *Fields of Combat*, *Sparta*, and *Breaking Ranks*, on the other, in posing the question of the co-constitution of war trauma and the atrocities of warfare, as well as institutionalized medicine's definition of health in its unwillingness to confront this connection. While *Mrs. Dalloway* is about a young veteran with shell shock who commits suicide rather than be subjected to the domination of the military-medical establishment, the veterans in *Fields of Combat* accept their confinement within these dominant institutions based on their diagnosis of Posttraumatic Stress Disorder. Complementing my reading of *Mrs. Dalloway* as an anti-war novel, *Sparta* is also an anti-war novel about a young veteran who, like Septimus Warren Smith, is torn between two worlds—the world of war and death and the civilian world of hypocritical denial of the underworld of war. *Testament of Youth* is the story of a young woman suffering from the long-term psychological and spiritual effects of war who recovers through her anti-war activism. Likewise, the veterans in *Breaking Ranks* reject the diagnosis of PTSD to become anti-war activists. Though separated by a century of modern warfare, these texts highlight the marked similarities between the debates about the psychological effects of war in the early twentieth and twenty-first centuries. Today, “Posttraumatic Stress Disorder” is the successor to “war neurosis”—commonly referred to as “shell shock”—as the medical diagnosis for the psychological problems experienced by combat soldiers.<sup>8</sup> Unfortunately, like shell shock, PTSD

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<sup>8</sup>The American Psychiatric Association defines Posttraumatic Stress Disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, 5<sup>th</sup> ed. (DSM-V) as follows: A. The person was exposed to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing or witnessing or learning about the traumatic event(s) or repeated exposure to aversive details from the traumatic event(s). B. The traumatic event(s) is persistently re-experienced in one (or more) of the following ways: 1) recurrent, distressing, and intrusive memories of the event; 2) recurrent nightmares about the event; 3) reliving the event through dissociative reactions, e.g. “flashbacks;” 4) intense or prolonged psychological distress *and/or* 5) physiological

is a medical diagnosis that is based on scientific reductionism: It is a factish in Latour's sense because PTSD is a purification that discounts as externalities key aspects that impact psychic suffering. In peacetime, it is considered "normal" to be horrified, or at least concerned, by atrocities one witnesses. However, warfare depends on the suspension of such "normal" reactions. In other words, the dichotomy of health/illness is unstable, because it is linked to an unacknowledged conflict with another opposition, that between peace/war. Institutionalized medicine tends to be in denial about this fact. As a diagnosis, PTSD offers no improvement in post-war therapy over that offered by the medical establishment after World War I. Like the veterans of that war, today, hundreds of thousands of veterans are suffering from the long-term psychological effects of combat with no relief in sight, possibly crippled for life. Why is this? The purpose of this Chapter is to explain why and to offer new directions for narratives of recovery from war.

In general, I argue that narratives about wartime psychosis are deeply implicated in the reconceptualization of modernity urged by Bruno Latour in his work. According to Henning Schmidgen, even in Latour's early work on Pasteur, what really matters is

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reactions to exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. C. Persistent avoidance of stimuli associated with the traumatic event(s) as evidenced by avoidance of 1) distressing memories, thoughts, or feelings about the traumatic event and/or 2) external reminders (e.g. people, place, activities, and situations) that arouse such distressing memories, thoughts, or feelings. D. Persistent negative alternations in cognitions and mood associated with the traumatic event(s) as evidenced by the persistence of two (or more) of the following: 1) amnesia about the event; 2) negative beliefs about oneself; 3) distorted cognitions about the cause or consequences of the event that lead to self-blame or blaming others; 4) negative emotional states (e.g. fear, horror, anger, guilt, or shame); 5) disinterest in significant activities; 6) detachment or estrangement from others; 7) inability to experience positive emotions. E. Persistent symptoms of increased arousal that were not present before the trauma, as indicated by two or more of the following: 1) irritability or outbursts of anger; 2) reckless or self-destructive behavior; 3) hypervigilance; 4) exaggerated startle response; 5) difficulty concentrating; and 6) difficulty sleeping. F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month. G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. H. The disturbance is not attributable to the physiological effects of a substance (e.g. drugs or alcohol) or another medical condition.

the fact that Pasteur played an essential part in constituting what we understand today as ‘modern society’: an enormously complex structure, which is shaped by industry, technology, and science, as well as ‘biopolitics,’ that consists in the main in partially private and partially public hygiene. That this society is not modern in the sense usually assumed is one of the points Latour will put forward in *Les microbes*. (Schmidgen 59)

Modernity, according to Latour, is characterized by a fundamental contradiction. Defined by the official logic of “rupture” and segregation of pure realms (nature/society, mind/matter, etc.), in practice modernity has been sponsoring the very expansion of hybrids across the supposed pure realms of nature vs. society that it overtly denies. Along these lines, I argue that war trauma narratives can be divided into two types: those that enrich our understanding of the cross-disciplinary networks of what Latour calls the occluded “nonmodern” hybrid and those that reinforce what Latour calls the official “modern constitution” in efforts to “purify” and segregate hybrids by reasserting the false dichotomies of dominant modernity. As I will show, the contemporary diagnosis of PTSD (like the early twentieth century diagnosis of war neurosis) is founded on a rhetorical maneuver of purification that isolates mental trauma from the warfare that generates it; in short, PTSD is a disembodied, abstracted concept of the mind under the make-believe control of psychiatry. But real trauma produces hybrids connected to multiple sites that cannot be discounted as externalities. To counter the medical segregation of (mental) illness from politics, I trace the empirical connections in the actual “assemblages” between the psychological suffering of U.S. soldiers *and* their combat experiences to offer a new version of “PTSD” as a complex hybrid that proliferates in response to war and its structural violence. I argue that the suffering of the soldiers is *directly* connected to their two primary moral and

existential concerns about the war: 1) the harm they have inflicted on Iraqi and Afghani civilians during the counterinsurgency campaigns of the U.S. military and 2) the death and dismemberment of fellow U.S. soldiers.<sup>9</sup>

Based on Latour's critique of modernity, in my critique of the purified version of PTSD as an official diagnostic category, I consider the diagnosis to be a "factish" rather than a medical "fact." The term factish (a portmanteau word blending fact/fetish) represents a major revision of the modern dichotomy of scientific facts vs. non-scientific beliefs. Indeed, Latour's concept of the "factish" is one of his key contributions to sociology and integral to ANT and his critique of the dichotomous rhetoric of modernity. A highly valuable innovation, the concept of factish takes us out of the sterile debate over realism vs. constructivism. According to Latour, both scientific facts and non-scientific beliefs or "fetishes" are artifacts, constructions that are nevertheless felt to be real. As Latour explains,

If we add to the facts their fabrication in the laboratory, and if we add to the fetishes their explicit and reflexive fabrication by their makers . . . [what appears] in their stead is . . . what I call the factish . . . . But if human agency is restored in *both* cases, the belief that was to be shattered disappears, along with the shattering

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<sup>9</sup>For combat soldiers, across the span of the early twentieth to the early twenty-first century, modern warfare has changed from the mass killing of brother against brother in trench warfare to the mass killing of families of men, women, and children, and their displacement as refugees in wars of occupation and counterinsurgency against former colonies of the European and U.S. empires.. These wars include those fought by the U.S. military in Vietnam and in Iraq and Afghanistan—wars that have been germinal for the medical diagnosis, Posttraumatic Stress Disorder. In *Knife Fights: A Memoir of Modern War in Theory and Practice*, Lieutenant Colonel John A. Nagl recounts writing *The U.S. Army/Marine Corps Counterinsurgency Field Manual* (2006). This field manual presents the U.S. military counterinsurgency strategy to "clear, hold, and build:" First, "clear" an area of all insurgents through massive military force; second, "hold" the area against insurgents who defend the area; and, third, "build" what was destroyed to gain support among the "population." Nagl ignores the inherent contradiction in counterinsurgency strategy: The insurgents *are* the population. Therefore, to destroy the insurgents is to destroy the population. Consequently, not only does counterinsurgency lead to more war rather than to peace, but "counterinsurgency" itself becomes a rhetorical ploy to disguise the horrific facts and hidden motives of such military campaigns.

fact. We enter a world that we had never left, except in dreams—the dreams of reason—a world where arguments and actions are everywhere facilitated, permitted, and afforded by *factishes*. (Latour, *Pandora's Hope* 273-74)

As I will explain, PTSD is a factish created and tested in the medical laboratory—in short, an artificial being that has subsequently become an autonomous force in the external world through its therapeutic application by the medical establishment.

To elaborate Latour's argument about how scientific "facts" are constructed and yet real, in *The Pasteurization of France*, Latour examines the central role of the modern laboratory in the production of Pasteur's attenuated anthrax bacillus. Latour distinguishes the "wild" anthrax microbes on the farms from the attenuated anthrax bacillus that Pasteur "discovered" in his laboratory. To confirm his suspicions that a "microbe" was the cause of anthrax, Pasteur had

[t]o get the new agent to do everything that the old disease did . . . . [To do so] Pasteur invented the impossible experiment: he diluted the original bacillus thousands of times, by taking several times a drop of the culture liquid an [sic] order to start a new culture, and still caused the complete disease with the last drop of the last culture. He lost his hero [the "wild" bacillus] on purpose, as Tom Thumb is lost in the fairy story. The bacillus, too, emerged triumphant . . . . It became, therefore, the sole agent of the disease. (Latour 76)

This new object, the "anthrax bacillus," translated the disease into the language of the laboratory. The next step was to move from the laboratory to the field by inoculating farm animals with the bacillus in its purified state and observing that, subsequently, the animals remained disease-free. With Pasteur's discovery, the attenuated bacillus—the domesticated microbe—displaced the wild anthrax on the farm. Latour emphasizes that the work of the hygienists and other key

players was vital to the naturalization of Pasteur's laboratory bacillus as a newly-discovered "fact" of nature. One reason for Latour's invention of the word, "factish," is to avoid the confusion of regarding the products of laboratory science as "discovered" facts of nature. Instead, they are factishes: Both constructed and real, factishes are invented by scientists in the laboratory, and, once invented, they acquire the autonomy to do things in the world outside the laboratory.

Along these same lines, I argue that in the 1970s and 1980s, psychiatrists had the opportunity to construct a convenient laboratory among the large population of post-Vietnam War veterans who suffered from the psychological effects of that war.<sup>10</sup> Much like Pasteur's wild anthrax bacillus, initially, the mental anguish and bizarre behavior of the Vietnam veterans confronted psychiatrists with a unique and puzzling mystery—something "wild" and outside the bounds of existing psychiatric theories and therapeutic techniques. For years, the psychiatrists debated whether or not this "wild" mental anguish of the veterans was something unique that deserved its own diagnostic category. Similar to Pasteur's purification of the wild anthrax by first removing it from the farms, to construct "PTSD" psychiatrists purified the "wild" mental anguish of veterans by divorcing their suffering from their combat experiences. By placing trauma-in-a-vat, PTSD is a diagnosis aimed at taming the wild genie-out-of-the bottle of post-

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<sup>10</sup>Throughout the literature on the psychological suffering of warfare, the "laboratory" plays a vital role. But the concept of "laboratory" is variable. Latour is particularly interested in the modern scientific laboratory as the new site of scientific "discovery" where nature can be translated into measurable hybrid objects that re-appear in the outside world in epidemiological statistics, nosographical tables, and mapped epidemics. In addition, Latour notes that military barracks were an ideal "laboratory" where legions of healthy young men were subjected to a uniform regime such that military medicine was quickly "pasteurized." In contrast, in *The Aftereffects of Brain Injuries in War*, the psychiatrist Kurt Goldstein describes the careful design of ideal "laboratories" for the full recovery of brain-injured veterans in the years following World War I. "[W]e realized very soon that observation in the laboratory did not furnish sufficient material. To gain a better insight in a patient's capacities we had to observe the man actually at work. This led to the establishment of workshops in connection with the hospital, where we could observe these men under practical conditions . . . Thus the *hospital*, the *psychologic laboratory*, the *school*, and the *workshop* represented a unit" (Goldstein 68).

war suffering by fabricating the construct of a genie-in-the-bottle of medical isolation from the tragedies of war. Such isolation reduces veterans to the status of marionettes managed by the medical-military establishment. In other words, veterans are reduced to being passive intermediaries rather than active mediators in their recovery from war. As Latour explains,

An intermediary . . . is what transports meaning or force without transformation: defining its inputs is enough to define its outputs . . . . *Mediators*, on the other hand . . . transform, translate, distort and modify the meaning or the elements they are supposed to carry. No matter how *complicated* an intermediary is, it may, for all practical purposes, count for just one . . . . No matter how apparently simple a mediator may look, it may become *complex*; it may lead in multiple directions which will modify all the contradictory accounts attributed to its role. (Latour, *Reassembling the Social* 39)

Latour offers the examples of a well-functioning computer as a complicated intermediary and a banal conversation that turns into a complex chain of mediators when passionate attitudes and opinions bifurcate at every turn. But if the computer breaks down, it becomes an extremely complex mediator, and an impassioned conversation deteriorates into an intermediary when a sophisticated panel rubber stamps a decision made by others. In my project, Latour's distinction between mediators and intermediaries is central to tracing the networks that constitute PTSD and evaluating the effects of the diagnosis on the lives of the veterans.

To explain how war trauma was purified from its wild occurrence post-Vietnam, in *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*, Alan Young argues that PTSD is a constructed fact of modern science, and one that he directly challenges.

[The] generally accepted picture of PTSD, and the traumatic memory that underlies it, is mistaken. The disorder is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by various interests, institutions, and moral arguments that mobilized these efforts and resources. If, as I am claiming, PTSD is a historical product, does this mean that it is not real? Is this the significance of my book's title? On the contrary, the reality of PTSD is confirmed empirically by its place in people's lives, by their experiences and convictions, and by the personal and collective investments that have been made in it. My job as an ethnographer of PTSD is not to deny its reality but to explain how it and its traumatic memory have been made real, to describe the mechanisms through which these phenomena penetrate people's life worlds, acquire facticity, and shape the self-knowledge of patients, clinicians, and researchers. (Young 5-6)

In his study, Young points to the conflicting ways in which the psychological suffering of combat soldiers has been understood at different historical moments in debates between psychoanalysts, neurobiologists, veterans, and many other influential figures, including victims of other kinds of trauma. "PTSD" was one of several possible diagnostic rubrics that psychiatrists considered before they finally settled their disputes and agreed on the designation, "Posttraumatic Stress Disorder," as specified in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (*DSM-III*), published in 1980.

Young places the debates about PTSD in the context of a paradigmatic shift in psychiatry during the final decades of the twentieth century from psychodynamic views of the mind to a

biological view of the mind as an information-processing system dependent for its functioning on hormonal-chemical neurotransmitters. From this biological viewpoint, the Cartesian split between the mind and the body is erased in favor of a hierarchical system of linear causation linking the biological function of neurotransmitters to the electrical synapses in the brain that account for “normal” and “abnormal” behavior and cognition. Many of the hormones, chemicals, and electric synapses have been identified and quantified in the laboratory and linked to pictures of the brain produced by powerful new imaging devices, such as positive electron tomography (PET scans). As a consequence, psychiatry has been remodeled according to the medical model for the diagnosis and treatment of organic diseases, and the psychiatrist’s gaze has shifted from the psyche and psychotherapy to the medical management of psychoactive drugs. Similar to the centrality of Pasteur’s laboratory in taming the wild anthrax, the modern scientific laboratory has been central in taming the “wild” anguish of post-war suffering: the laboratory is the site where the brain’s potent neurotransmitters produced by the autonomic nervous system and the endocrine system have been “discovered” and their physiologic effects studied. Based on this research, both the symptoms of the disease are explained and psychotropic drugs are developed to treat the symptoms.

As Young notes, the publication of the *DSM-III* demarcates a revolutionary turn in American psychiatry because now neo-Kraepelinian epistemology grants primacy to the facticity of scientific truths about mental disorders as determined by “reliable” scientific data.<sup>11</sup> However,

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<sup>11</sup>The key players in the workgroup responsible for the formulation of PTSD for the *DSM-III* were the two psychiatrists, Robert Lifton and Chaim Shatan and the Vietnam veteran, Jack Smith, who took an environmental and psychodynamic approach to explain the psychological troubles the veterans were having. In their recommendations for treatment, they emphasized individual and group psychotherapy to aid in the recovery and reprocessing of traumatic memories of the war. Aside from this workgroup, most of the psychiatrists responsible for the *DSM-III* in its entirety—over 800 pages intended to be comprehensive in its inclusion of every known psychiatric disorder—ascended to the ideas of the German psychiatrist, **Emil Kraepelin (1856-1926)**. Diametrically opposed to psychodynamic discourse, Kraepelin’s method in psychiatric classification is three-pronged: 1) Mental disorders are like physical disorders, such as infectious diseases, in having specific, generic causes; 2) mental disorders must be

the measuring tools for producing data about PTSD, among other disorders designated in the *DSM-III* and its subsequent revisions in *DSM-III-R* (1987) and *DSM-IV* (1994), were invented precisely to corroborate the symptomatic criteria that the psychiatrists used to classify the disorder. After detailing this *tautological production of facticity*, Young concludes that, rather than the facticity of PTSD, its inclusion as a diagnostic category in the *DSM-III* originated in the activities of the major players in contemporary debates about the Vietnam War and its aftermath. A side note is that with the publication of the *DSM-III*, “Posttraumatic Stress Disorder” became the first standardized nosology in U.S. psychiatry that creates a specific place for an environmentally-induced psychiatric disorder and for the traumatic memory.

Many psychiatrists have been highly critical of this “(re-)biologizing of psychiatry.” For his part, Young points to major contradictions and gaps in research studies conducted to discover “facts” about the biology of the mind. He highlights the inherent mistakes in drawing analogies between stress responses in rat brains in the laboratory and in the human brains of soldiers post-combat. He asks,

[d]oes the word ‘memory’ as applied to laboratory rats have the same meaning that it has in connection with the traumatic memories narrated by people diagnosed with PTSD? . . . . Analogical reasoning in science proceeds through technologies and social relations—the negotiation of meanings within networks of

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grouped solely on the basis of observable clusters of symptoms; and 3) the goal of empirical research is to identify the organic and biochemical origins of mental disorders. Kraepelin’s ideas also had a dominant influence on European psychiatry and were incorporated into the psychiatric nosology of the World Health Organization in its official publication, the *International Classification of Diseases* in 1986 (*ICD-9*). From the early 1950s onward, scientific research about the organic and biochemical etiologies of many diseases, such as vitamin deficiencies, syphilis, and epilepsy that had formerly fallen under the purview of psychiatry, also produced powerful psychoactive drugs, e.g. chlorpromazine (Thorazine) and diazepam (Valium). Many psychiatrists rejected psychodynamic approaches in preference for prescribing medications according to an operational research-based medical model.

knowledge producers . . . . Within these networks, the inescapable shock is connected to its target through an essential element, “stress.” *Inescapable shock purifies this element: strips it of words, purges it of subjectivity, and engraves its physical existence on neural pathways. It is less edifying to ask whether PTSD writers and researchers ought to be using this analogy than to ask how the analogy is made persuasive* [my emphasis]. (Young 284)

The underlying problem that Young’s critique identifies is the complete inability of neuroscience to connect the thoughts and emotions of the cortex—such as memories and perceptions of time and space—with the autonomic structures and processes in the brain (the locus of neurotransmitters).

From my perspective, these biological theories about neurological function have been (mis)applied to account for the psychological suffering of combat veterans as a “dysfunction” of the neurophysiology of the brain and to guide doctors in treatment designs. I counter these developments with my own argument that in the “wild” state of the brain’s physiological function—that is, prior to medical intervention—neurotransmitters are just physiological intermediaries that somehow function—in ways that are completely unknown to us—in the bridges between the lived experiences of combat *and* the cognitive, affective, and bodily consequences of those lived experiences—between the external and internal world of the veterans. While I agree that the levels of the so-called stress hormones released during “shock,” such as the potent neurotransmitters epinephrine and norepinephrine, precipitously rise during combat, the demands of combat account for the experiences of soldiers and their psychological realities, *not* these biochemical intermediaries. Furthermore, the long-term psychic effects of

combat cannot be accounted for by a persistent elevation and dysfunction in the veterans' stress hormones.<sup>12</sup>

These opposing views about neurotransmitters as mediators vs intermediaries stem from a much larger question: Is the human mind accurately understood as a machine *or* as part of an immensely complex, adaptive, and embodied living organism? Highlighting this fundamental difference, Fritjof Capra, Richard Lewontin, and Richard Levins offer ecological approaches to the scientific study of the human mind as alternatives to medical-scientific reductivism. In *The Web of Life*, Capra provides a broader context for a critical understanding of psychiatry and neurobiology. He points out that since WWII, the computer model of the mind as an information-processing system has dominated cognitive science and neurological research. The computer model reconfigures the mind according to “the Cartesian image of human beings as machines” such that the mind has the same sort of “intelligence,” “memory,” and “language” that computer scientists falsely attribute to their machines. To the contrary, Capra argues,

[r]ecent developments in cognitive science have made it clear that human intelligence is utterly different from machine, or ‘artificial’ intelligence. The human nervous system does not process any information (in the sense of discrete elements existing ready-made in the outside world, to be picked up by the cognitive system), but interacts with the environment by continually modulating

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<sup>12</sup>Abram Kardiner's *The Traumatic Neuroses of War* (1941) was extremely influential among psychoanalysts during the 1970s. Like Goldstein, Kardiner was a phenomenologist and a physician who studied the psychoneurosis of WWI veterans from the perspective of the embodied mind in a living organism and its milieu. Kardiner argues that when a traumatic experience pierces the protective mechanisms of the organism to prevent the maintenance of an adequate relation with the outer world for internal harmony, the “total ego” contracts itself, shrinks, and withdraws. Inhibitions in the voluntary activity of the skeletal system create disturbances in the activities governed by the involuntary autonomic system—*these disturbances in the autonomic nervous system are the effects—not the causes—of disruptions in the organism's interactions in a milieu altered beyond the organism's capacity to respond effectively.*

its structure. Moreover, neuroscientists have discovered strong evidence that human intelligence, human memory, and human decisions are never completely rational but are always colored by emotions . . . [and] our thinking is always accompanied by bodily sensations and processes . . . . [S]ince computers do not have such a body, truly human problems will always be foreign to their intelligence. (Capra 68)

Furthermore, ideas are different from and generative of information, and human decisions are based on experience, not information. In contrast to the computer model of cognition as context- and value-free, all meaningful human knowledge is contextual. Moreover, variations in human language are metaphoric, based on differences in shared cultural understandings of the world. Along the same lines, in *Biology Under the Influence*, Richard Lewontin and Richard Levins reject mechanistic and computer models for the human mind. As they point out,

[t]he analogy of the brain to a circuit network is also helpful: functions are concentrated in specific regions and damage to those regions impairs function. But [unlike computers] an activity is carried out in many part of the brain at once, and when there is damage to one part, the activities may be relocated in other sections . . . . Brains generate spontaneous activity . . . . *Therefore, the brain is never in the same state twice, so that the same stimulus need not evoke the same response . . . . The brain is doing many things at once and these things influence each other . . .* [and the brain] is not a separate physical entity from the body . . . . As against the hierarchical notion of a programmer aristocracy commanding the peasant body, we have the structures and activities of the body developing and controlling each other. (Lewontin and Levins 55-56)

Based on underlying assumptions about the mind as an information-processing machine, much of the medical research in the 35 years since the publication of the *DSM-III* and the institutional acceptance of “PTSD” has been aimed at containing and minimizing the fiscal and domestic costs of waging war. The refinements in the diagnosis of PTSD and its treatment are legitimized by the current standardized protocols for “scientific” medical treatment: Evidence-Based Medicine (EBM)—also a product of the modern scientific laboratory.<sup>13</sup> To appreciate the impact of EBM, it’s important to remember that as a label, PTSD is merely a descriptive term until the experts tie prescribed treatment regimens to the label. Today, the treatment protocols of Evidence-Based Medicine for PTSD include a combination of cognitive-based therapy (CBT), individual and group counseling, and pharmacological treatment with sedatives, psychotropic drugs that work by unknown mechanisms in the brain, and packaged neurotransmitters, such as serotonin reuptake inhibitors (SSRIs). Through the national and international acceptance and implementation of the diagnostic criteria requisite for the diagnostic label and these treatment protocols by mental health providers, “PTSD” has been used in the design of a vast institutionalized network for the provision of health care; these networks are the framework for how PTSD becomes a powerful mediator in the lives of trauma survivors, specifically, in my study, of veterans of combat trauma.

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<sup>13</sup>Evidence-Based Medicine (EBM) is the current “gold standard” in medicine. The central tenet is that treatment modalities or “protocols” should be judged on scientific evidence that establishes their ability to consistently produce positive health outcomes in clinical research trails—rather than on the accumulated experience of individual providers or the theoretical orientation of professional schools of thought. The underlying premise is that statistical averages can offer more accurate diagnoses than individual peculiarities and nuances. While EBM “sounds good,” in practice, difficulties abound. Simply put, many patients do not fall within the average case as determined by research studies—especially when the studies are biased toward proving the efficacy of highly profitable or “cost-effective” treatments. Some alternative models for optimal medical practice are based on the premise that the “norm” should be a standard of excellence for each individual patient rather than a statistical average beneficial for many patients.

A major concern among veterans and their families is that “PTSD” as a diagnostic category allows medical practitioners to position the veterans into pre-slotted drug regimens that severely limit their cognitive and affective capacities to be autonomous actors in their own recovery. I support this concern because when neurotransmitters are artificially extracted and packaged in potent doses and administered with other psychotropic drugs, they become powerful actants that make veterans do things—sometimes, the things intended by those who prescribe the drugs, but often with unintended consequences, such as the “untoward” side effect of committing suicide. In short, the drugs acquire autonomy with unpredictable and uncontrollable harmful consequences—they are the *pharmaka* of medicine, altering from remedy to poison. *Under the influence of these drugs, the veterans are doubly incapacitated by PTSD and its potent mediation by these drugs.*

To highlight the huge changes in psychiatry since the Vietnam War, Alan Young in *The Harmony of Illusions* and Ben Shephard in *A War of Nerves: Soldiers and Psychiatrists in the Twentieth Century* each narrate the emblematic experience of Sarah Haley, a psychiatric social worker who worked with Vietnam veterans in the early 1970s at the Boston VA Medical Center. One veteran told her about being in the village of My Lai during the massacre of hundreds of women and children by U.S. soldiers, and that, subsequently, his fellow soldiers threatened to murder him if he disclosed the massacre. He kept quiet for years until he had a mental breakdown and sought treatment at the VA. Based on her own childhood experiences listening to the war stories of her father, a WWII veteran, Haley believed that the Vietnam veteran’s experiences in My Lai were real (even though the massacre had not yet been covered by the U.S. media). However, when she shared his story at a staff meeting, her co-workers told her the veteran was delusional and suffering from full-blown psychosis. When she insisted on the

veracity of his story, she was “laughed out of the room.” Young and Shephard share Haley’s anecdote to show the drastic changes in professional attitudes that had to occur during the 1970s for “PTSD” to gain widespread acceptance among practicing psychiatrists. By the 1980s, most psychiatrists had come to acknowledge the atrocities of the War and, therefore, were capable of responding to the suffering of the veterans as “authentic” malaise rather than the faked “imitations” of malingerers.<sup>14</sup> Nonetheless, even though these psychiatrists now accepted “PTSD” as something “real,” they did not incorporate the veterans’ vital moral concerns about the war into either the diagnostic criteria or the treatment regimens for PTSD.

In their dissent from PTSD’s widespread professional acceptance, Young and Shephard challenge the diagnosis of PTSD and its recommended treatments. For his part, Shephard proposes that “[m]ore than any other war in the twentieth century, Vietnam redefined the social role of psychiatry and society’s perception of mental health” (Shephard 355). He attributes this to the vital questions about moral issues raised by the atrocities of the Vietnam War, of which the massacre in My Lai was only one. He points out that many people, such as Sarah Haley, argued that the environment of war was to be blamed for the long-term mental deterioration of veterans and advocated for a non-judgmental therapeutic approach (years of psychotherapy). Others, such as the journalist, Peter Marin, criticized psychotherapists who skirted the problem of atrocities and obscured the real nature of what had happened. Shephard claims that in its emphasis on human needs rather than social obligation, psychoanalysis has been honed into a vacuous view of human nature. Instead, he states that

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<sup>14</sup>This recalls the fault line between the imitation and the authentic drawn by Miles Orvell in *The Real Thing* that I pointed out in Chapter 1.

[t]he important point is the one raised by Peter Marin. Historically, issues of responsibility for one's actions and attitudes to authority have been at the heart of the war neuroses. Vietnam made it much more difficult to confront them. Instead of forcing the men to take responsibility for their actions, the psychiatrists and American society sympathized with them and excused them. What was done in Vietnam, instead of being seen as a moral outrage, an aberration, something never to be repeated, somehow became the norm, the standard. (Shephard 376)

Providing contemporary corroboration for Shephard and Marin's concerns, in *Beyond the Green Zone: Dispatches from an Unembedded Journalist in Occupied Iraq*, Dahr Jamail informs us that

[i]n 1968, in the Vietnamese village of My Lai, American troops massacred more than four hundred innocent civilians, the majority of whom were women, children, and the elderly. In Fallujah, during the November [2004] siege of the city, according to an Iraqi NGO, an estimated five thousand innocent civilians, the majority of whom were women, children, and elderly, were slaughtered. Five thousand innocent civilians, who, under the Geneva Conventions, an occupying power is required by law to protect, died in what was essentially a 'free-fire zone.' (Jamail 280)

Fortunately, during the mass demonstrations on February 15, 2003 against the planned U.S. invasion of Iraq, many millions of people worldwide expressed their opposition to the slaughter of modern war as a "new normal." Jamail and others have noted that these demonstrations were *the largest demonstrations in human history*. Ignoring people's concerns, the U.S. government extended its war against Afghanistan to invade Iraq on March 19, 2003.

To summarize my argument thus far, the purification in the official version of PTSD is twofold: 1) The traumatic psychic suffering of combat veterans is reduced to biological concepts about the pathological dysfunction of the brain and 2) the goals of medical treatment are to eliminate the “signs and symptoms” of war’s mental “illness” so life can resume as though the war never happened. There are three prongs to my critique of this reductive purification. First, I extend Latour’s argument about the actual constituents of the nonmodern world.

Matters of fact are not all that is given in experience. Matters of fact are only very partial and . . . very polemical, very political renderings of matters of concern and only a subset of what could also be called *states of affairs*. (Latour, “Why Has Critique Run out of Steam?” 232)

The suppression of traumatized veterans’ concerns about the war massacre of My Lai in the psychiatric fabrication of PTSD in the 1970s and 80s in the wake of Vietnam is eloquent support for Latour’s claim that the “matters of fact” legitimized by laboratory experimentation are actually constructed according to the “matters of concern” of (medical) scientists and their supporters. As I will show, when the matters of concern to the veterans with PTSD are considered, a proliferation of new “facts” offsets the poverty of the official diagnosis and its treatment protocols.

In the second prong of my critique, the moral concerns of the veterans do not have to be delimited by passive acceptance of modern warfare—as currently assumed by modern medical science in its protection of the false dichotomy between facts—autonomous of human control—and values—outside scientific facts. As Latour explains, since facts are both *fabricated and real*—and *therefore*, autonomous—ethics is not restricted to questions of values in face of the cold, hard facts of a given world.

It is impossible to begin to ask the moral question after the states of the world have been defined. The question of what ought to be . . . is not a moment in the process; rather, it is coextensive with the entire process . . . . Symmetrically, the famous question of the definition of facts is not reduced to just one or two stages but is distributed through all the stages. Perplexity counts as much for this question as the relevance of those who are brought in to judge it. (Latour, *Politics of Nature* 125)

Indeed, in the narratives of many combat veterans, they recount the dialectical process between the events of the war—the facts on the ground—and their reactions to the war; their ethical concerns evolved into staunch opposition to the war and motivated them to invent new facts: relations of peaceful reconciliation that, in turn, have changed their reactions to the war.

The third prong of my medical critique is a cautionary note about human action and mastery. Latour clarifies that what's at stake in granting scientists the eminent domain of the world's facticity is the modernist illusion of the human capacity to master the world by recreating it in its own image. He counters,

the [human] mind is not a world-creating despot that makes up facts to suit its fancy. Thought is seized, modified, altered, possessed by nonhumans, who in their turn, given this opportunity by the scientists' work, alter their trajectories, destinies, histories. Only modernists believe that the only choice to be made is between a Sartrean agent and an inert thing out there . . . . No model of political action can be offered as an alternative to the model of the critique until we modify our anthropology of creation. (Latour, *Pandora's Hope* 282-3)

The widespread, self-destructive psychological reactions to military combat are solid proof of the utter failure of political leaders to impose mastery on world events and of scientists and physicians to control the aftereffects of military “mastery.” Indeed, one of the hardest struggles for combat veterans with PTSD is to regain the ability to simply have a peaceful day instead of one filled with alarming rage, terrifying nightmares, crippling insomnia, and uncontrollable anxiety in a shrunken world emptied of productive work and family relations. Although humiliated and crippled, many veterans and their families have sought, not mastery, but peaceful reconciliation and mutual support to survive and make a difference in the world.

Having debunked “PTSD” as a reductive biomedical diagnosis that erases moral concerns from the conversation, I propose my solution: A new version of PTSD that restores the “matters of concern” of veterans themselves via an ecological concept of the mind that replaces biological determinisms. According to Fritjof Capra, an ecological view of the human mind depends on systems rather than analytic thinking.

Systems science shows that living systems cannot be understood by analysis. The properties of the parts are not intrinsic properties but can be understood only within the context of the larger whole. Thus systems thinking is ‘contextual’ thinking; and since explaining things in terms of their context means explaining them in terms of their environment, we can also say that all systems thinking is environmental thinking.

Ultimately—as quantum physics showed so dramatically—there are no parts at all. What we call a part is merely a pattern in an inseparable web of relationships. Therefore the shift from the parts to the whole can also be seen as a shift from objects to relationships . . . . In the systems view we realize that the

objects themselves are networks of relationships, embedded in larger networks.

(Capra 37)

The pattern of organization of all living systems is a network pattern capable of self-organization based on non-linear circular feedback paths of interconnectivity. Faced with baffling and often dangerous predicaments, post-war psychological recovery for combat veterans can seem utterly daunting and even impossible. But it happens, and this mysterious process is possible because, as Capra says, “self-organization is the spontaneous emergence of new structures and new forms of behavior in open systems far from equilibrium” (Capra 85).

Indeed, Capra appreciates the germinal work of Ilya Prigogine and his colleagues in their study of how living forms change, develop, and evolve as “dissipative structures” far from equilibrium. In ecological systems of life, dissipation is associated with the emergence of order, a higher order, instead of waste—the loss of order. According to Prigogine’s theory,

[w]hen a dissipative structure reaches such a point of instability, called a bifurcation point, an element of indeterminacy enters into the theory. At the bifurcation point the system’s behavior is inherently unpredictable. In particular, new structures of higher order and complexity may emerge spontaneously. Thus self-organization, the spontaneous emergence of order, results from the combined effects of non-equilibrium, irreversibility, feedback loops and instability. . . .

Many of the key characteristics of dissipative structures—the sensitivity to small changes in the environment, the relevance of previous history at critical points of choice, the uncertainty and unpredictability of the future—are revolutionary new concepts from the point of view of classical science but are an integral part of human experience . . . . In the deterministic world of Newton there is no history

and no creativity. In the living world of dissipative structures history plays an important role, the future is uncertain, and this uncertainty is at the heart of creativity. (Capra 192-3)

Similarly, I argue that this applies to the problematic of living with PTSD. The temporality of PTSD can be understood as: 1) the chaotic state of disequilibrium (war trauma) the psyche lapses into and 2) the recovery of health with the spontaneous emergence of higher order. In other words, to regain equilibrium after trauma, PTSD becomes part of a new mental organization instead of a chaotic disruption. As Capra notes,

far from equilibrium, dissipative structures may develop into forms of ever-increasing complexity . . . . As we move away from equilibrium, we move from the universal to the unique, toward richness and variety. This, of course, is a well-known characteristic of life. (Capra 181-2)

As active mediators, veterans with PTSD are in disruptive civilian states of dis-equilibrium and yet they afford their own unique and enriching challenges to the existential and moral dimensions of contemporary life.

These introductory concepts about an ecological view of the human mind indicate the benefits of theories of complexity about living organisms and their milieu. The growing interest in complexity, such as in my advocacy for a new version of PTSD, is part of a larger movement against the great errors and failings of applications of narrow scientific solutions that exacerbate problems by accelerating the damaging effects of modern science and medicine. Lewontin and Levins provide a broad historical context for this movement and theories of complexity.

The scientific tradition of the 'West,' of Europe and North America, has had its greatest success when it has dealt with what we have come to think of as the

central questions of scientific inquiry: ‘What is it made of?’ and ‘How does this work?’ Over the centuries, we have developed more and more sophisticated ways of answering these questions. We can cut things open, slice them thin, stain them, and answer what they are made of. We have made great achievements in these relatively simple areas, but have had dramatic failures in attempts to deal with more complex systems. We see this especially when we ask questions about health. (Lewontin and Levins 297)

As a critic, I have resisted a fetishistic confidence in science and medicine while avoiding what Latour’s considers the “fairy position” of attacking others for their beliefs in fetishes and the “fact position” of believing in the human power to distinguish the “real” facts from false beliefs—an impossible task, according to Latour, because critics, too, can only perceive the world in the “shadows on the cave” of human life. Instead, I ascribe to Latour’s “fair position” from which

[t]he critic is not the one who debunks, but the one who assembles. The critic is not the one who lifts rugs from under the feet of the naïve believers, but the one who offers the participants arenas in which to gather. The critic is not the one who alternates haphazardly between antifetishism and positivism . . . but the one for whom, if something is constructed, then it means it is fragile and thus in great need of care and caution. (Latour, “Why Has Critique Run out of Steam?” 246)

In sum, then, to dis-assemble the dominant medical factishes for the health care of combat veterans, it is necessary to reassemble the actual networks that veterans, journalists, medical providers, and many others have built to challenge the military-medical establishment. For their part, as persuasive mediators, veterans argue that their suffering can be understood *only if they*

*can fully disclose their experiences in combat and how life has been for them since the war.*

Actually, much like the veterans of the Vietnam War, today's generation of veterans challenges psychiatry to reconsider its aims and its understanding of human nature and political action.

In Chapter 2, my aim is to contribute to the on-going project of peaceful reconciliation accomplished by the work of many other people and publications. *Winter Soldier Iraq and Afghanistan: Eyewitness Accounts of the Occupation* and *Beyond the Green Zone: Dispatches from an Unembedded Journalist in Occupied Iraq* are exemplary in pairing veteran testimonies with testimonies of Iraqi and Afghani civilians.<sup>15</sup> To foreshadow my three case studies, *Fields of Combat* is an example of the (bad) narrative that purifies combat trauma via the medical diagnosis of PTSD and the Veterans Administration EBM treatment programs; *Breaking Ranks* is an example of the (good) narrative that restores the matters of concerns of combat soldiers to augment my new version of PTSD; and *Sparta* is an example of a (good) narrative that allows readers to enter the embodied mind of a veteran with PTSD through the power of the imagination in fiction.

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<sup>15</sup>The epigraph to this chapter is from *Winter Soldier* based on the testimony of an Iraqi mother in a Syrian refugee camp. In *Beyond the Green Zone*, Dahr Jamail provides excellent coverage from the "other side of the war" during the U.S. invasion and occupation of Iraq, in large part because he visits hospitals and clinics to study the health effects on the local people. For example, one day in June, 2004, Dahr Jamail and his associates visited Chuwader General Hospital, the largest hospital in Sadr City. The director of the hospital, Dr. Qasim al-Nuwesri, spoke of the large numbers of wounded due to U.S. aggression. "'We are short of every medicine,' he said, something that had not previously been as severe, even under the economic sanctions . . . . Another problem that all the doctors mentioned was lack of potable water. 'Of course we have typhoid, cholera, kidney stones . . . but we now even have the very rare Hepatitis Type-E . . . it has become common in our area.' Hepatitis Type-E is transmitted primarily via ingestion of feces-contaminated drinking water. I had been in people's homes where they had run the tap to show me the brown water that gurgled out. Water the color of a wet, dirty sock that smelled of gasoline./Inside the hospital, we saw open sewage in the bathroom and crowds of people waiting for medical treatment. The hospital seemed to embody the bleakest peak of poverty and suffering of Sadr City . . . . A twenty-five-year-old resident doctor said that U.S. soldiers periodically stormed the hospital looking for wounded resistance fighters. 'They come here asking for patients, and are very rough, because they shout, curse, and aim their guns at people.'/Driving out of the garbage-strewn street of Sadr City, we passed a wall with the words 'Vietnam Street' spray painted on it. Below it read 'We will mark your graves in this place.'" (Jamail 196-197)

As a medical anthropologist, Erin Finley composes *Fields of Combat: Understanding PTSD in Iraq and Afghanistan* based on 20 months of ethnographic fieldwork in 2007-2008 among 62 recent vets and 71 family members and health care providers in San Antonio, Texas. Finley's stated goals are to understand the social, cultural, economic, and political factors that shape how veterans with PTSD negotiate their lives and, more specifically, whether or not they seek medical treatment from the VA and how they respond to that treatment. Unfortunately, Finley fails to deliver on her promises due to several faults in the book. One major fault is that she packages the first-person testimonies from her interviews into composite veterans that are factishes created by Finley in her purification of the wild psychodrama of the actual veterans. As Finley's make-believe PTSD marionettes, their third-person narratives erase the first-personal moral concerns of the veterans. This reduction is due to an inconsistency between Finley's theoretical appreciation for first-personal testimony as a primary source for social studies and her practical work that translates first-personal testimonials into third-person stories to corroborate that PTSD is a curable illness rather than a chronic disease. Written under the guise of an anthropological research study, Finley voices her own pro-war sentiments to advocate that veterans see PTSD as "part of a warrior's noble burden" in carrying out "the mission" (Finley 159). When she suggests that PTSD is curable, she lapses into a sort of scientific iconoclasm by altering the medical factish PTSD into her own medical fetish: Since PTSD is curable, the VA and the U.S. government do not have long-term obligations to veterans with PTSD. Instead of being an advocate for these veterans, Finley is a pro-military and pro-VA partisan of power whose fairytale narrative is a cover-up for the government's decades-long abandonment of hundreds of thousands of veterans and their families, who, for the most part, have been left on

their own to struggle with PTSD, often in the face of dire inadequacies in employment, housing, food, health care, and the other necessities of life.

In sharp contrast to *Fields of Combat, Breaking Ranks: Iraq Veterans Speak Out Against the War* is an anthropological study written for the stated purpose of understanding the decisions made by veterans of the U.S. invasion of Iraq in 2003 to become anti-war activists. Unlike Finley, Matthew Gutmann and Catherine Lutz do not purify the psychological suffering of these combat soldiers but remain consistent in their practical application of their theoretical valuation of first-person testimonials to benefit anthropological research. *Every* combat veteran in the study is diagnosed with PTSD and testifies that their rejection of the medical diagnosis of PTSD has been integral to “breaking ranks” with the U.S. military. Through these first-person testimonials, Gutmann and Lutz honor veterans who break loose from their ensnarement in the networks of the medical-military establishment to become mediators actively working to change the trajectory of their personal and collective lives. Through a series of epiphanies, these veterans put trust in their moral concerns to draw connections between their psychological reactions and their combat experiences.

Gutmann and Lutz adopt an ecological point of view that is relational rather than isolating and aids in my project of tracing the actual assemblages in the experiences of combat veterans to construct a new version of PTSD. This non-reductionist variety of PTSD demonstrates the proliferation of hybrids in the nonmodern world via ecological thinking about complex networks of interconnectivity. As insurgents on the home front, Gutmann and Lutz support anti-war veterans by providing them with a forum for voicing their beliefs about the factishes of war and their newly-formed identities as anti-war activists. By forging new networks of local and global cooperation to make amends for the war and to reconstruct individual and

collective identities, these veterans demonstrate a different pattern of resilience than that offered by Finley in her model for recovery of the isolated individual soldier whose primary source of support is from the VA system of medical care and a supportive family.

In both *Fields of Combat* and *Breaking Ranks*, two striking features of the psychological reactions of veterans with PTSD are how powerfully these reactions affect the veterans and that they persist for years. In *Sparta*, Roxana Robinson crafts a more direct view of these reactions through the internal focalization of the protagonist, Conrad Farrell, a veteran of the Iraq war. Readers enter the “wild state” of Conrad’s embodied mind as he experiences nightmares, rage, and insomnia and tries to make sense of his bewildering inner world as well as his frightening responses to civilian life. While the unidentified narrator deftly contextualizes Conrad’s story, he is the only direct source of knowledge and expertise about his profoundly disturbing condition; this narrative technique accentuates his isolation and the inexplicable nature of his reactions—no one, not even the heterodiegetic narrator, can explain what is happening. Thus, Conrad is represented neither as the subject of his own making—a myth he himself dispels—nor an object for others to help; instead, he struggles against suicide as the only exit from his entrapment by his internal psychological hybridization. The novel is also strengthened by the abrupt shifts between the time of memory and the chronology of the plot. These shifts recreate the blurred boundaries between the underworld of the war—“night” time—and the unreal world of civilian life—“day” time. The epiphanies in the novel are those moments of desperate awareness when Conrad and his family realize that no matter how hard they try, it’s impossible to purify their lives of the war. Instead, Conrad is caught in the intensifying vortex of his memories and nightmares and his barely-controlled rage and self-destructive shame. In the climax, Conrad confronts his family with the death of his former self—the son they welcomed back from the

war—and their callous disregard for who he is now. In fact, he declares, the man he was died in the war and now his matters of concern are entirely foreign to anything they could apprehend. *Sparta* aids in my project because it presents many of the conundrums that a new version of PTSD will have to appreciate.

*Sparta* is an anti-war novel that offers no reprieve from the war: PTSD is not curable nor can family and civilian life at home be purified of the war; the soldiers bring the war home. In addition, *Sparta* is an exposé of the abandonment of veterans by the VA, leaving Conrad bereft of any hope until his younger brother, Ollie, heroically intervenes. The hope for long-term recovery is ritualized in a final scene when Conrad invites Ollie to a memorial for those killed and disappeared in the war. As a recurring backdrop to Conrad's story, the narrator tells the story of ancient Sparta to ask, what happens when a society is organized around war? The overarching message of *Sparta* is not to forget the wars but to remember them and question the proliferation of the hybrids of war and their ubiquitous mediation in contemporary life.

## 2. *Fields of Combat* as Medical Fiction: Purifying “Wild” Post-combat Trauma into the Clinical Factish of PTSD

Finley introduces *Fields of Combat* with a promising list of research questions about the multiple causes of PTSD; what life is like with PTSD; the cultural factors that affect how vets and their families understand PTSD and when they seek treatment; and how the VA is responding to these veterans, why, and to what effect. While this list gives the impression that Finley will base her conclusions about PTSD on her field research, she clarifies her premise that, unlike the unfortunate veterans of past wars, veterans of today's wars are beneficiaries of major

advances in medical science and the development of effective treatment for PTSD; now there are unprecedented resources for supporting veterans and their families. She concludes the book by restating this claim in terms of her recommendations for streamlining the VA's PTSD treatment protocols. As she advises,

*[e]xpect that all combat veterans and other trauma survivors will remain resilient after a period of normal readjustment and that those with PTSD will recover.*

*Convey these expectations.* As important as it is to ensure that all service members and veterans have adequate access to quality mental health care, it is equally important that Americans not come to believe that PTSD is an inevitable outcome of combat or an inevitable source of disability when it arises. The majority of those exposed to trauma, even combat, will not develop PTSD . . . . Among those who do develop PTSD, the emphasis should remain on providing access to evidence-based treatments and on working toward full recovery . . . . [T]he expectation of recovery should be incorporated into military and VA systems of benefits and compensation as well as into popular and professional understandings of resilience and PTSD . . . . [T]he current system should be stripped of provisions that encourage veterans to remain chronically disabled when they need not be while leaving those who are truly disabled with all the support they require. (Finley 177-8)

In making such sweeping recommendations as well as in her entire analysis of PTSD, I argue that Finley “purifies” the experiences of combat veterans during and after the war to exclude real world complexities.

Finley accomplishes this purification by her blithe acceptance of the scientific understanding of PTSD incorporated into Evidence-Based Medicine treatment protocols (Finley's Evidence-Supported Treatment (EST)).<sup>16</sup> Actually, based on her own beliefs about illness and recovery, Finley reinforces the medical science in her interpretation of the data she collects to fashion her own medical fetish about PTSD. Her efforts to persuade readers about the validity of this medical fetish account for fundamental flaws in Finley's methodology: 1) shifting from her theoretical approach to narratives to a practical approach in alignment with her research assignment; 2) recasting the first-person people whom she interviews as third-person composite figures; 3) severing veterans' moral concerns about the war from their post-war recovery; 4) ignoring the steep budget cuts at the VA and its reduction in services to combat veterans in her evaluation of the quality of care provided by the VA; and 5) tailoring her recommendations for a redesign of the VA's health care system to the fiscal crisis of the VA and the government's decision to continue the war. In sum, as the pro-war narrator, Finley writes a fairytale of false hope and magical recovery that reinforces the purification of the modern world of "normal"

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<sup>16</sup>On the one hand, Finley explains the use of Evidence Based Treatments as an efficient way to respond to the huge influx of veterans with PTSD after the invasion of Afghanistan and Iraq. On the other hand, she argues that the treatment modalities of EBM are based on scientific evidence so they consistently produce positive health outcomes in clinical trials and are superior to the accumulated experience of individual providers or schools of theoretical orientation. *To highlight the importance of not accepting such claims on face value*, I include here the testimony of U.S. Army Sergeant Adrienne Kinne in *Winter Soldier*. Kinne explains the institutional biases structured into scientific research about the health effects of combat. She worked for the VA in 2004-2005 as a research assistant on a study about PTSD and Traumatic Brain Injury

'because the symptoms of these two illnesses are incredibly similar.

The research group wanted to develop a mechanism to screen returning soldiers for traumatic brain injury. There were a lot of incredibly educated, well-informed people establishing this traumatic brain injury screening. Before we could make it happen, I was on a conference call when somebody said, "Wait a second. We can't start this screening process. If we start screening for traumatic brain injury, tens of thousands of soldiers will screen positive. We do not have resources to take care of these people. We cannot do the screening."

Medical ethics say that if you know somebody has a problem you have to treat them, so they didn't want to know about the problem since they didn't have the resources to treat it. But I think it's incumbent upon all VA workers to find every area that we need addressed, and to demand that we get the resources to meet those needs.' (IVAW and Glantz 156)

civilian life at home from the actual proliferation of disruptive and dangerous hybrids in the occluded underworld of war.

Finley's unquestioning support for medical science is a common thread throughout the book and can perhaps best be demonstrated by her summary of one foundation stone for EBM treatment protocols: Cognitive-Based Therapies (CBT). Finley concentrates on the most controversial of these therapies, prolonged exposure therapy (PE). PE is based on the psychiatric theories of Edna Foa and her colleagues that

PTSD comes about as the result of an individual's learning to avoid danger out in the world. When a trauma occurs, the circumstances surrounding that trauma are imprinted on the memory . . . [to] become associated with high levels of physiological arousal and anxiety [neurotransmitters] . . . individuals with PTSD, when confronted with sensory stimuli that remind them of previously encountered dangers, will try to avoid them . . . Exposure therapy rests on the principle that traumatic lessons learned in the past cannot be relearned to accurately reflect the current environment . . . unless avoidance is overcome and there is sufficient exposure to the trigger that the individual 'habituates.' (Finley 123)

Rather than avoiding painful memories, veterans need to revisit traumatic memories from the war until the associated anxiety diminishes because the memories no longer trouble the individual. Finley accepts the testimony of psychiatrists who support PE (and CBT in general) due to its measureable benefits after the standardized treatment time of nine to twelve weeks. She mentions the resistance of many psychiatrists to the widespread implementation of PE and CBT at the VA starting in 2008, but she does not substantively examine the differences in scientific understanding of the human mind that underlie these conflicts.

Finley expects much more progress in the successful treatment for PTSD based on further research between the biology of the brain and culture. She strongly advocates for widespread acceptance of her firm belief in the resilience of veterans to turn their psychological suffering into psychological growth. She lends support to this belief based on the scientific perspectives of Daniel Moerman in *Meaning, Medicine, and the "Placebo Effect"* and R.A. Hahn in "The Nocebo Phenomenon: Concept, Evidence and Implications for Public Health."

Daniel Moerman has written about the extraordinary power of what he calls the 'meaning affect'—that poorly understood process by which human beings get sick or well according to their expectations of what will happen to them. Science has proven time and time again that it is possible to make people well with a placebo, just as it is also possible to make them sick with what is called a nocebo.

(Finley 178)

coming full circle to the beginning of my argument, this is the science upon which Finley makes her recommendations for structural changes in the VA's system of compensation and for cultural changes in popular and professional understandings of PTSD: According to the "nocebo effect," if veterans are told they have a serious problem, they'll act like they have a serious problem and won't recover. According to the "placebo effect," if their problems are minimized as temporary and fixable they will have the "extraordinary power" to recover from combat trauma, their symptoms will disappear, and civilian life can resume as if they'd never been to war. As I will show, the actual "power" of veterans is based on their inability to forget the war and yet their capacity to forge new relations based on those memories.

Now, I'd like to elaborate on the connections between Finley's support for the war and the flaws—more so, the contradictions—in her methodology. In her theoretical approach to

narratives, the psychological suffering of the soldiers is complex and variable, depending on the interplay between “social, cultural, political, and economic factors” in the lives of individual veterans. She takes a “systems approach” to state that PTSD is not a monolithic biomedical category but something fluid and open to interpretation; PTSD is understood in heterogeneous ways across the diverse settings of family, the military, and the VA mental-healthcare system. As Finley explains, the narratives of veterans with PTSD matter because, on the one hand, these narratives

shape how we seek out health care and support, how we decide whether to participate in recommended treatments or abandon them . . . . [On the other hand, these narratives] are also maps, navigational charts for those crossing wide oceans of life and loss. They are detailed, depicting the social, cultural, political, and economic forces with and against which veterans with PTSD must orient in charting a successful course to that most longed-for of destinations: a satisfactory life. (Finley 136)

Unfortunately, in her practical approach to narratives, Finley’s navigational maps charted by her composite veterans are purified to exclude any details that don’t support her research conclusions. As Finley admits,

I have offered a portrait of how veterans of Iraq and Afghanistan experience combat PTSD as they move across time and a series of cultural environments . . . . *We have, however, not yet heard veterans articulate how they understand what has happened to them, what is at stake for them in their journeys, and where they imagine themselves ending up* [my emphasis]. (Finley 135)

Nor do readers ever hear the direct first-person testimony in Finley's interviews with actual people. On the contrary, Finley's composite veterans are rendered by her analytical thinking to purify "PTSD" into an isolate—Finley's medical fetish—severed from the tragic experiences of war and treated as a physiologic pathology of the brain that can be successfully treated by the tools of neurobiological psychiatry.

In Finley's fabrication of narratives, she argues that her use of "composite" veterans protects the identity of the actual veterans while honoring the integrity of their life narratives. Without access to the first-personal interviews, readers have no way to assess the authenticity of the stories she composes. Indeed, Finley's method allows her great freedom to bend the facts to support her claims. I argue that Finley's composite technique is akin to writing fiction—in which characters are imaginary and exist on a different existential plane than that of living people. Although Finley is writing what she purports to be a nonfictional text in which she relies on real-life narratives to develop and substantiate her claims, she constructs a host of factishes about veterans and their families to support her claims about PTSD.

This is a crucial distinction because often health care providers confuse their own constructed factishes about disease with the actual meaning of illness for patients and their families. The ability to make this distinction is a major contribution of literary studies to medicine: Narratives of illness can aid or obfuscate the accurate diagnosis of health problems, depending on one's ability to appreciate that both "facts" and "fetishes" are constructed and that the matters of concern to health care providers can distort and even change the meaning and experience of illness for patients and their families. Finley's mistake is to presume that, based on her fictionalized research narratives, she can offer significant improvements to our understanding of PTSD. The result is her medical fetish that pretends that the wild genie-out-of-the bottle" of

the psychic suffering of veterans can be confined as the “genie-back-in-the-bottle” of successful medical cure.

In her purification of the “wild” psychological suffering of combat soldiers, Finley claims that PTSD is *not* connected to the political and moral views of veterans about the U.S. wars of occupation in Iraq and Afghanistan. In making this claim, she conflates moral concerns with political support for or opposition to the war—a major problem since everyone has moral concerns about the war, regardless of one’s political stance—but the bigger problem is that in the rest of the book, she makes no analysis of the connections between the moral crises precipitated by combat and the development of PTSD. This is curious because Finley’s composite veterans consistently testify to being persistently tormented by memories about their involvement in killing and destruction during the war. In a deft sleight-of-hand, Finley asserts that these traumatic experiences only become traumatic when soldiers come home and tell stories about them; the stories are traumatic, not the experiences of war: Telling stories because they are traumatized is construed as being traumatized because of telling stories. I would like to include Finley’s anecdote about Carlos. While he is *not* one of the six composite veterans listed at the beginning of her book, he does rank among the many “minor” composite veterans that substantiate Finley’s claims. Carlos is an air force security officer who witnessed an innocent Iraqi girl hit by a grenade launched by another U.S. soldier. Finley is puzzled because

*[a]lthough he had nothing to do with the event [my emphasis], Carlos visited the girl repeatedly in the hospital, hiding behind a curtain so she wouldn’t know he was there. After he returned home, he began seeing visions in which she was ‘injured or dead or staring at me or pointing at me.’ (Finley 58)*

Finley's premise that Carlos had nothing to do with the girl's injuries presupposes innocence on the part of individual soldiers for the U.S. occupation of Iraq. This premise is founded on the reduction of individual soldiers to being cogs in the killing machine of modern armies. In Finley's complicity with such objectification, she does not query Carlos about *his concerns* about his moral responsibilities as a member of the U.S. military. What bothers Finley is that Carlos is fixated on this recurrent nightmare, a fixation she attributes to his isolation from friends and family. Thus, this anecdote substantiates Finley's claim that the lack of support given to the veterans by friends and family is "the problem" posed by PTSD, not the actual experiences of the veterans in combat and the moral crises precipitated by those experiences.

Nevertheless, Finley is concerned that veterans who experienced more combat in Afghanistan or Iraq are *far more likely* to report symptoms of severe PTSD. In particular, she is frustrated by the minimization of combat exposure in statistics on soldier suicides. Therefore, she advocates for the statistical standardization and measurement of combat experience in the studies of PTSD and suicide among combat veterans. However, without any supporting evidence, Finley claims that veterans' reactions of anger and rage were not problematic in Iraq and Afghanistan but only became so upon coming home. This, too, is paradoxical because based on the testimony of Finley's composite veterans, their reactions *were* a problem while in combat—they were especially troubled by the demands of their superiors to make aggressive attacks against the Iraqi and Afghani people, oftentimes children and innocent civilians. Finley's mistaken claim is based on the glaring absence in her study of *any* appreciation for the particular relations between the U.S. soldiers and the occupied people. This absence is one of the most consequential purifications in Finley's reduction of the psychological suffering of combat soldiers to the genie-back-in-the-bottle of the clinical factish, PTSD.

Another striking purification in the book is Finley’s complete disregard for the crisis in the VA system of health care precipitated by steep cuts in funding by the government that have sharply curtailed access to care. In Chapter 7, “Embattled: The Politics of PTSD in VA Mental Health Care,” Finley refers to several controversies, e.g. the scandal at Walter Reed hits the press in 2007 while she conducts her study, without providing any substantive details about the controversies. Abruptly, she shifts to a discussion of the current huge improvements being made in the VA’s care in response to the controversies. For example, she refers to the 30% increase in the VA’s budget in 2008 without first listing the cuts made in the VA’s funding since 2001.<sup>17</sup> Next, she excuses the VA because, after all, the institution has been overwhelmed by the flood of new patients since the U.S. military invasions of Afghanistan and Iraq: what is one branch of the government to do when another branch goes to war? Purified of the well-documented crisis caused by the dire inadequacy of health care for the vast majority of veterans, Finley’s study concludes that the veterans—not the VA—are remiss because they do not seek treatment promptly nor do they stay in treatment for more than a few sessions. In her Acknowledgments,

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<sup>17</sup>Finley lauds the VA system as one of the best health care delivery systems in the world, as demonstrated by the Brooke Army Medical Center and its rehab center—both are models of the *government’s* support for the veterans. In glaring contrast, in *The War Comes Home*, Aaron Glantz points out that the *non-governmental organization*, the Intrepid Fallen Heroes Fund, “completed construction of a \$40 million state-of-the-art physical rehabilitation center at Brooke Army Medical Center in San Antonio Texas” (Glantz 68). Glantz provides both statistical and anecdotal information about the long history of cuts in veterans benefits since passage of the GI Bill in 1944. In *Winter Soldier*, Adrienne Kinne testifies that she went through the “out-processing system” from active duty to reserve or retired status before 9/11 and after.

‘In 1998 I received a complete and thorough end-of-service physical. As part of the out-processing system, a VA representative sat with me and reviewed every single page of my medical file and filled out a VA disability claim for me.

In 2003 with thousands upon thousands of Reserve and National Guard service members being deactivated through Fort Bragg, they told us if we wanted an end-of-service physical we would have to wait at Fort Bragg for six to eight weeks or longer, in these run-down World War II barracks out in the backwoods. The message was clear. Don’t ask for an end-of-service physical. In addition, there was no VA representative helping people file a claim or reviewing our medical files. There was nobody telling us that we were eligible or how to get into the system. When a soldier is leaving the military, you have a window of opportunity to get into the VA system, but if you miss that opportunity it’s so much harder to get in afterward.’ (IVAW and Glantz 155)

Finley lists the numerous government offices and agencies that lent her financial support, and then she reassures her readers that “the views expressed in this work are mine alone and do not reflect the position or policy of the Department of Veterans Affairs or the United States government” (Finley ix). In spite of this reassurance, this disclosure further undermines the credibility of her narration and accounts for why she asserts tight control as the narrator of *Fields of Combat* by proscribing what veterans themselves get to say about their experiences and PTSD. This points to a major assumption that underlies Finley’s pro-VA and pro-military rendition of her field research: The “experts” should define what illness is, not those who are ill.

Moreover, Finley’s recommendations for streamlining the Veteran Administration’s system of care are tailored to the ongoing fiscal crisis of the VA and can only be evaluated in that context. Ignoring this crisis, she takes a position on the controversies about PTSD among medical professionals and scholars in the humanities. She summarizes these controversies as the “medicalization of trauma,” various arguments about the reality of PTSD (e.g. Alan Young), and opposing views about whether trauma is rooted in the individual or in social inequality, war, and the greed of nations (e.g. V.A. Das and Arthur Kleinman). For her part, Finley indicates that more research is needed into the neurobiological responses of the brain to stress and the cultural factors that shape how people understand their responses. She attempts to unify all sides in the debates, most of whom would agree that

the essential question is this: does the construct of PTSD provide a way of describing a particular experience of human suffering that acknowledges, helps to identify, and provides a means of offering support and healing for that experience? (Finley 168)

After concluding that it does, Finley contradicts the implied transparency of this “construct of PTSD.” She argues that currently, in 2008, there is a problem of over-diagnosis of PTSD, creating “the potential for PTSD to become an identity as well as an illness” *and* the medical basis for long-term disability compensation (Finley 172). Here, she contradicts her previous emphasis that veterans need to promptly seek health care for PTSD from the VA—the earlier the diagnosis, the more effective the treatment.

Initially, Finley states that she will leave diagnostic issues to the clinicians so she can “focus on veterans’ own ways of organizing their experiences.”

For all the clinical and political debates that make combat PTSD such a charged topic, it is in the private space of veterans’ hearts and minds that the illness takes its toll, entering lives that were already in motion, already speeding along rapid trajectories toward an unseen but surely promising future. (Finley 11)

By inserting her vision for a “promising future” into her sensitivity to the “hearts and minds” of the veterans, Finley reveals the depths of her belief in the placebo effect. Needless to say, such reliance is incompatible with the expertise of a medical professional, whose authority cannot in principle depend on taking recourse to placebo cures. Nevertheless, Finley fails to present veterans’ first-personal testimony at the same time she makes specific diagnostic recommendations to health care providers to eliminate the problem of over-diagnosis. Her medical fetish—PTSD revised according to the “most recent and best” scientific research—magically emerges in the purified zone of civilian life at home. Meanwhile, in the actual world, the hybrids of war proliferate at home and abroad to complicate the purified zones of modernity with its empty promises about the future.

### 3. Finley's Composite Veterans

Now, I aim to test Finley's composite-figure technique against my own Latourian irreductionist Actor-Network Theory to show how Finley's technique inhibits follow-the-actor, trace-the-network empiricism and allows her an escape into false substantiation of the dominant evidence-based treatment model for combat PTSD. Finley's composite technique involves the application of scattered anecdotes from each composite veteran to substantiate her claims in her research study. I collated the anecdotes into single narratives about each of the six veterans—the major players whom Finley consistently revisits—to discern a greater coherence and meaning to each composite figure. Instead, my collation reveals yawning gaps in what can be learned about each veteran's experiences with PTSD. Conflicting assumptions underlie this methodological difference between Finley and me. On the one hand, as an advocate of Evidence-Based Medicine, Finley agrees that information can be gathered from diverse individuals and packaged into shared diagnoses and standardized treatment-protocols. On the other hand, as an advocate of complexity theory and narrative medicine, I argue that there is great individual variation in human affairs and to achieve the highest standard of medical care for each individual, first-personal narratives are a necessity for accurate diagnoses and individualized treatment plans. To prove the advantages of my methodology over Finley's, let's take a look at the narratives about Finley's six composite veterans.

The dominant impression I have is that Finley's composite veterans are neatly packaged to represent a typical pattern she identifies among veterans according to whether or not veterans seek medical treatment for their crippling symptoms and respond well to treatment to resume productive lives without further need for services from the government. She includes an

alphabetical “list of characters” (xiii) briefly stating each veteran’s name, military deployment history, and current employment and marital status in 2008. The first two veterans, Adam Baldwin and Brian O’Neil, and the last two veterans, Jesse Caldera and Tony Sandoval, continue to suffer from PTSD, while the middle two veterans, Chris Monroe and Derek Johnson, have fully recovered from PTSD, according to Finley. Chris and Derek are Finley’s role models of the ideal soldier—Finley’s “noble warrior”—and the others exemplify problematic veterans resistant to cure. Since Finley refers to the veterans on a first-name basis, I do, too, to avoid confusion

Chris Monroe’s difficulties are typical of the soldier who early in the war suffered from profound PTSD, but whose symptoms were ignored by his superiors for years. When they do intervene to help Chris, he responds quickly and well to treatment; he is essentially “cured” of PTSD, with only a few proud “scars” from his “heroic” exploits in the war. Chris’s story is archetypal, even mythical, because it shows all veterans that, no matter how hopeless things seem, recovery from the miseries and the dangers of PTSD is possible. Chris is a hero who is injured in war and threatened by self-destruction and abandonment for many years while fellow soldiers commit suicide and homicide. Fatefully, his superiors come to his assistance to help him recover from his wounds so he can safely journey home. Chris’s narrative is the myth of the recovery of the injured soldier. In this myth, Finley substantiates her medical fetish, a PTSD that is temporary and fixable, purified of the real world complexities of permanent loss, incapacitation, and disfigurement.

As Chris’s story goes, he is a medically-retired air force computer specialist who served two tours in Afghanistan in support of army units. Three years after getting home from Afghanistan in 2005, he tells Finley that

[he] remembers too many dead bodies, of friends and strangers, and finds these images superimposing themselves on the living faces around him. ‘Whenever I look at people, I know what they’re going to look like dead. I know what they look like with their brains blown out or jaws blown off or eyes pulled out.’

(Finley 54)

In 2002, after Chris severely beat an Afghan prisoner and broke his arm, a major told him he was too “fucked up” for this war so his officers removed him from the front. For the next three years, Chris drank heavily and fought at local bars, often with the police. His military officers protected him from criminal prosecution while several of his veteran friends committed suicide, sometimes after killing family members. Finally, in desperation, Chris became suicidal, and the military leadership sent Chris to a hospital to get help. Finley asks, why did it take so long for someone to intervene to help him?

During his initial treatment Chris underwent Prolonged Exposure Therapy (PE). During this therapy, he talked about his memories from the war during several taped sessions with a psychiatrist, Dr. Alvarez. After initial resistance to PE, Chris agreed to talk with the doctor, and with his coaxing, Chris says he shifted from sobbing about minor stuff

‘[to] talking about the most gruesome awful things, and I can remember every detail—what I was wearing, the smell, everything such clear . . . diarrhea of the mouth, just vomiting into the tape.’

On the whole, he says, ‘It was very difficult and then it got very easy. Three, four months. Each week I would go from one to the next, and I would think about them, talk about it, listen to it for a few days, and then start thinking about the one for [my appointment] next Friday. So it went real slow at first, then

I got good at being able to bring these things up and stop repressing them' (Finley 133).

In group therapy he learned he wasn't alone or weak, and from "cognitive restructuring" he learned to identify negative thoughts and replace them with "correct" thoughts. Chris was given a combination of medications (Seroquel, Wellbutrin, and Trazodone) and group therapy followed by individual therapy.

By the time he talked with Finley, his way of perceiving the world resembles how he observed his surroundings before the war. While he considers himself to be "about 98%" cured, he occasionally has nightmares and flashbacks, but they are not crippling. He considers them to be part of being human, something to keep as a reminder of the war. In addition to economic difficulties, he still struggles with shame about not being the heroic man he was under fire and with suicidal thoughts. Even though his wife left him, he's alive because of the network of support from family, friends, military leaders, and clinicians. In short, according to Finley, Chris's case is a model for the successful treatment of PTSD. For my part, I wonder what a real life veteran would say about persistent nightmares, flashbacks, suicidal thoughts, shame, and feeling worthless and about his divorce: "cure" or "dis-ease"?

In marked contrast to Chris, Adam Baldwin is typical of those veterans with PTSD who don't accept the VA's prescribed therapy and, instead, work with other veterans as their main support system. Finley offers his example as a warning against such "noncompliance." In Adam's story, after seven months in Iraq, he came home to a hero's welcome. Nevertheless, he was afraid of how much he had changed from the war and how his family and new wife would react to him. He had severe nightmares and insomnia and was drinking heavily for six weeks before he sought treatment at the VA, where he was referred to private providers. His

psychologist diagnosed him with PTSD and major depression and a psychiatrist prescribed Zoloft and Ambien. He tried Eye Movement Desensitization and Reprocessing therapy (EMDR)<sup>18</sup> and hated it with a passion: he didn't need help remembering; remembering was all he did. In the next year, he continued to drink heavily while finishing school and working as a business contractor for good money.

In early 2007, things declined when his closest friend, David, returned to Iraq for a third tour to lead a platoon in combat. Adam's depression, anxiety, nightmares, and guilt escalated. David frequently called Adam for support, and David was disciplined for this infraction of military confidentiality and discharged home. He and Adam spent a day together when they didn't talk much about the war, but after they parted company, both David and Adam became intensely suicidal and checked themselves into different VA hospitals. Without providing any details, Finley simply states that after this, Adam became deeply involved in working with other veterans to help them get through their transition home. She regards this as Adam's failure to live up to civilian expectations to change into civvies and forget the war. Like the veterans he seeks to help, "he is on the water without a sail. Up shit creek without a paddle. Having a map has not been enough to get him to shore" (Finley 146).

Adam is the composite who exemplifies Finley's frustration with veterans who do not find the VA's therapy to be helpful so they seek to support one another as autonomous actors freed from the recommended tools of the military-medical establishment. Specifically, Finley's criticism is that they don't adopt her ideal identity of the "noble warrior" who breaks ties with

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<sup>18</sup>A type of CBT intended to weaken the effects of negative emotions, in an EMDR session, the therapist moves her fingers back and forth in front of the veteran's face with the veteran following these hand motions with his eyes while she asks the veteran to recall a disturbing event from the war. This "triggers" the emotions during the event. Gradually, the therapist guides the veteran to shift his thoughts to pleasant events to train him to replace troubling memories and emotions with comforting ones.

other soldiers in preference for family and friends outside the military. She refuses to appreciate that PTSD is simply the tip of the iceberg of much deeper changes in identity that occur during combat: From lone individuals, combat veterans come to identify themselves with other veterans, and with the occupied people. Moreover, Finley disregards both the paucity of civilian life—where there is no “map” of coherent meaning about individual and collective life—and the acute existential awareness among soldiers that motivates them to seek fellow comradeship in quest of collective survival and deeper human meaning in the underworld of war. Many veterans with PTSD reject their former identities because their experiences in war and PTSD motivates them to establish new relations and new solutions outside the confinement of the VA, an institution that seeks to purify them of their new values and moral concerns—through CBT techniques such as rapid eye movement desensitization—such that they are no longer disturbed by the war.

Like Chris, Derek Johnson is a model of successful treatment for PTSD. He exemplifies a physically injured veteran with a permanent handicap who surmounts the challenges of PTSD in large part because he has an ideal partner in his wife, Laticia. Unlike the other veterans who come alone to their interviews with Finley, Laticia always comes with Derek and is an active participant in the sessions. Derek is an African American army soldier whose left leg was amputated after he was wounded by an improvised explosive device (IED) in Iraq. During Derek and Laticia’s interviews with Finley, he shares his experiences during his eight months in Baghdad, where he served in a patrol unit faced with frequent explosions from IEDs and rocket propelled grenades (RPGs), machine gun battles, the constant threat of death, and extremely long hours of work—until his foot was blown off and he was evacuated. He ends one interview by saying,

The grenade that came through the truck, all of it came through in one chunk and was embedded in my foot . . . . Had my foot been an inch here, an inch there, all that shrapnel would have come through, spread out, and . . . I wouldn't even be sitting here. And then the two guys behind me—it probably would have gotten them right in the neck. So the way I see it, I traded my leg for all three of us in the truck. So that alone really helped me deal with it . . . . I was home and other than missing a leg, I was pretty much intact. (Finley 46)

As Finley reflects on Laticia's avid interest in Derek's combat experiences, she concludes that they have achieved something unique: a shared vision of their own war story that strengthens the bonds between them. When Derek returned home after several months in the hospital, he had the no-blame, let's solve the problem attitude that she appreciates and respects; he has achieved a higher level of love and compassion due to his suffering from the war.

After several months at the state-of-the-art rehabilitation facility for wounded veterans at Fort Sam Houston's Center for the Intrepid, Derek began attending college classes. Only then, after circling campus looking for snipers and bombers before his classes, did he realize that he had psychological problems. His psychiatrist put him on a serotonin reuptake inhibitor (Finley mentions Seroquel, but Seroquel is an atypical antipsychotic, not an SSRI) and he began treatment with Dr. Alvarez. For Derek, his classes in cognitive behavioral restructuring changed how he understood the profound sensory and emotional responses he was having to the world around him. '[Dr. Alvarez] explained that what happens is, when you're in combat, all your senses get picked up . . . . Fight or flight kicks in. And because we've been in [combat] so much, we bring it up and we can't bring it down.' He found it helpful to 'actually cognitively understand the thought

process, the reactions, to see yourself go up and then go down and to realize subconsciously that it's going to be okay.' (Finley 148)

He got involved in the "in vivo" aspect of PE treatment by spending time in scenarios that provoked fear responses and purposefully changing his reactions to normal patterns of life in a safe zone. In addition, he revisited troubling events from the war and taped these memories. Both he and Laticia listened to the tapes and reprocessed what had happened in the war and how it was affecting him now.

Therapy worked for Derek and he has moved on with his life with Laticia, who affirms that yes, life is normal now. In the long-run, what's most important to her is that Derek maintains his financial independence and never lowers his aims for himself. For his part, Derek's Vietnam veteran father with PTSD was an alcoholic who abandoned his family, and Derek shares Laticia's values because of what he learned from his father. His mother and grandparents pushed him to strive to be the best, and Derek holds himself to that standard. Like Chris, Derek and Laticia serve as a role model for veterans and their families in their journey to full recovery from the traumatic effects of war.

Unlike Derek, the composite Brian O'Neil does not have a supportive wife, so he represents those veterans who tread in muddy waters for years after the war, managing to keep home and family together but who are paralyzed in their efforts to swim into fresh water. And Brian differs from Adam, whose problems are due to his reliance on fellow veterans rather than the VA. Instead, Finley poses Brian's stagnation as a family affair: The changes in the veterans' internal landscapes affect the families as much as the veterans. Therefore, families should wholeheartedly embrace the diagnosis of PTSD and seek professional care. This is corroborated when Brian reflects on how the war changed his marriage.

‘My wife and I will never be as close as we were before I—when we were dating and first married. And it’s just because I’ve constructed enough barriers that if anything happens I’m not going to get hurt by it. If she dies I’ll be sad, but I’m going to go on. It’s not going to stop me, whereas beforehand it probably would have stopped me.’ (Finley 61)

Finley claims that social support from other people for practical and emotional help is the key protection against PTSD. Unfortunately, veterans with PTSD are less likely to receive social support, exacerbating their anger, withdrawal, disconnection, and emotional numbing.

Furthermore, the interpretations given to family dynamics change the reactions by the veterans and the support they are given. Spouses give their own, non-therapeutic interpretations to the symptoms of PTSD and very few spouses will go to treatment because they don’t believe in the diagnosis of PTSD. Here, Finley’s sleight-of-hand is to make numerous claims about the views of family members without including any direct testimony from family members themselves; her only corroboration is from another “expert” clinician and the composite testimony from Laticia. Nonetheless, Finley relies on Brian and his wife to substantiate her shift of the burden of responsibility for resilient post-war growth and recovery from the military-medical establishment to the often-impoorished families of the veterans: If only they would be supportive, like Laticia, everyone could recover from the war and life would return to “normal.”

In spite of Finley’s defense of family and friends as the ideal nucleus of personal support, Brian’s narrative poses some challenging reservations about the possible extent of that support. He finds the words to recapture the year of stagnant wandering after he returned home from Afghanistan in a scene in the film, *Band of Brothers*, in which a lieutenant says to a soldier, ‘you have to realize that you’re already dead. Then, you can function as a soldier.’ Brian explains that

this attitude makes coming home very difficult, because now soldiers have to live again in the sanitized world of family and friends with whom they can't share war stories about their actual experiences in combat. For example, Brian recounts a suicide bombing when

[h]alf-living bodies and family members surrounded him, all begging for help . . . . Of all the stories Brian shared in our conversations, this was for him the most upsetting. The trauma was, in part, the ruptured bodies, the gore of flesh raining down from the sky. Beyond the gore, the trauma lay in the families' outpourings of grief for those he couldn't save despite his skills as a medic. He is torn by remembered empathy for his junior medic, who was deeply affected by the two men who died under his care, insisting he never wanted to work as a medic again. (Finley 26-7)

Without acknowledging the validity of veterans' concerns about sharing such morbid facts with non-combatants, Finley shifts the blame to Brian's unsympathetic wife, who calls Brian "an asshole" and puts the responsibility for his recovery squarely on his shoulders, not hers. Not only are the solutions to life's problems much simpler when life is purified of the complexities of actual family dynamics and problematic wives are replaced by ideal types, I suggest that Adam presents Brian with the positive alternative of support from other veterans.

Finley composes Jesse Caldera as a "typical" veteran who is caught in the permanent limbo of reliving his experiences of the war, over and over again, but who does not seek medical treatment until long after the war. When Finley interviews him, he has suffered from his symptoms for many years, and even in therapy, he does not make much progress. Instead, life continues to spiral back to the horrific events of the war. In one war story, time slows when he

overhears a call on the radio about a wounded gunner who slowly bleeds to death fifteen minutes from a hospital while someone on the radio keeps saying, the helicopter is coming.

But as Jesse tells it, ‘A helicopter is never on its way. So finally about an hour passes and [the squad is] like, ‘we can’t wait anymore, we have to get to someplace.’ The squad decides to drive to a medical facility about fifteen minutes’ drive from where they were hit. They don’t make it; the wounded soldier dies along the way. . . . In Jesse’s calculation, the soldier would have survived if the squad had just driven for help in the first place . . . . His whole experience of Iraq seems to be one of wandering across a surreal landscape, passing from one inexplicable event to the next without any sense of order or reason. (Finley 39)

Subsequently, he was sent back to his loading job in Kuwait, where he loaded human remains as well as wounded soldiers onto transport planes. When he briefly describes carrying wounded soldiers who were dying as “awkward,” Finley finds that particular words, like “awkward,” are noteworthy in that they glide over the ellipses in the stories, so veterans repeat the words, again and again. For Jesse, such words pick at the unhealed wounds of his memories. Finley’s bafflement at his recurring memories demarcates the outer boundary of her medical fetish of PTSD.

Finley includes Tony Sandoval’s story to corroborate her major claim that a soldier’s psychological reactions to war are predominantly shaped by his life history before and after the war, not by the events of war itself. Nevertheless, she merely provides a few details about his pre-deployment life in a family with a physically abusive father and an absent mother in a violent neighborhood. Finley does not trace the empirical connections between these childhood experiences and Tony’s psychological responses to the war. Instead, she provides testimony of

his experiences when he fought in the Second Battle of Fallujah—notorious for the slaughter of civilians and insurgents by the invading U.S. army. As I have pointed out, Finley herself argues that the exposure to combat is a major, even decisive, factor in PTSD. In Tony’s case, he didn’t have PTSD before the war, despite his childhood and adolescent experiences, but he does have PTSD after serving in both Afghanistan and Iraq. Furthermore, when Finley interviews him in 2008, Tony is a 30-year old Mexican-American man who looks after his two younger sisters and nieces; unlike his abusive father, Tony has never let them down. Much like Derek’s rejection of his father’s behavior, Tony has successfully refused to be like his abusive father. Both Derek and Tony corroborate the importance of tracing the actual assemblages in the networks of each individual soldier to understand PTSD as they each experience the aftereffects of the war.

My favorite passage from *Fields of Combat* is when Finley suggests that the vets seem to have gotten lost in the space between Iraq or Afghanistan and San Antonio.

It was as if, halted prematurely on the journey home, they had landed on some muddled middle ground of reality and memory from which they embarked on both dreams and waking life . . . a dislocation of experience, rather than one of the body, but the image [of dislocation] seemed to capture something of both the injury and the feeling of being thrown out of one’s place in the world, the order of things disrupted. Veterans described dislocations from a previous sense of self, from others in the world, and from feeling truly present in their lives back at home. (Finley 59)

This and other insightful passages are based on Finley’s strengths as an anthropologist—strengths that shine in spite of the restrictive helm of her research obligations. Notwithstanding these strengths, I will provide a contrast to Finley’s bad narrative with two good narratives in

which veterans struggle with the evolving complexities and the proliferation of hybrids in the nonmodern world of war and peace.

4. *Breaking Ranks: Restoring First-person Matters of Concern and the Non-separability of Trauma from Warfare*

In *Breaking Ranks: Iraq Veterans Speak Out Against the War*, the strengths of Gutmann and Lutz's narration is based on the advantages of their ecological point of view. This perspective is 1) relational rather than isolating; 2) complex rather than reductive; 3) dialectical rather than linear; and 4) open-ended rather than deterministic. Their shared assumption is that veterans with PTSD are key players—active mediators—whose rebellion against the military-medical establishment changes the trajectory of their personal and collective lives. Consistently, Gutmann and Lutz rely on the first-person testimonies of U.S. veterans with PTSD to make connections between their combat experiences and the profound personal crises they have faced since going to war. Moreover, as narrators, Gutmann and Lutz adopt a backseat position to the front and driver's seat position they assign to the veterans themselves. Consequently, much more textual time is allotted to the first-person testimonials than to the narrators' own interpretation of the veterans' experiences. This narrative technique affords readers with direct access to the research interviews—in place of a view, such as Finley's, that is filtered by the narrator. This aids in my project of tracing the actual assemblages in the experiences of combat veterans to construct a new version of PTSD.

Another benefit of the non-reductionist, ecological approach of Gutmann and Lutz can be seen when they place war trauma in the social context of Iraq and the political context of U.S.

corporate interests and military power. They highlight the costs of the U.S. occupation in terms of the loss of human life among the Iraqi people due to violence, disease, and malnutrition, the destruction of Iraqi society, and the refugee crisis during the war. They tie the occupation to policy decisions made by the U.S. government and military that enriched certain large U.S. corporations. The rebuilding efforts of the U.S.-installed government, the Coalition Provisional Authority, did little more than restore some of what was destroyed by the invasion and the looting that followed. This was a *planned transfer of wealth* to the 150 U.S. corporations that received billions for their incompetent and even damaging work in Iraq. This work would have been done by Iraqi government bureaucracies and the Iraqi military had they not been disbanded for just this reason in the immediate wake of the invasion. Gutmann and Lutz draw direct connections between this transfer of wealth and the U.S. military's strategy of occupation and counterinsurgency, a strategy that turned the Iraqi people into the enemies of the invading troops and that accounts for the lack of military rules of engagement that would have protected the Iraqi people as allies to be "liberated" from the "terrible dictatorship" of Saddam Hussein. In pursuing this strategy, the U.S. military leadership is accountable for the traumatic experiences of war in which U.S. soldiers brutally murdered Iraqis and destroyed their capacity to resist the transfer of the national wealth of Iraq into the coffers of the international corporate elite. This context allows for a better understanding of the bewildering situations in which U.S. combat troops found themselves disoriented by the spiraling descent into worsening chaos and violence.

Gutmann and Lutz accept the veterans' assessment of PTSD and its ramification for their lives. Differing sharply from Finley, these veterans argue that: 1) Their experiences in combat account for the psychological sequelae of the war, not what happens when they come home. While family and community support is extremely important to them, for example, it can be

decisive in whether or not they commit suicide, this support doesn't make their nightmares, insomnia, rage, etc. disappear. 2) Although they reject the VA's treatment, this rejection is primarily focused on refusing drug therapy. Many of the therapeutic techniques advocated in CBT, such as recalling traumatic memories, are not unique to CBT. Instead, the veterans do recall their memories and share them with others, but this doesn't make the memories go away nor do the memories cease to bother the veterans. Instead, the veterans in *Breaking Ranks*, much like the veterans in *Fields of Combat*, suffer from the psychological effects of the war for years. Will today's veterans suffer permanently, like many of the veterans of previous wars? No one knows—it's too soon to tell.<sup>19</sup> At the end of the book, the veterans in *Breaking Ranks* are still learning how to adapt to PTSD and expect it to be a permanent feature of their lives. 3) Instead of adjusting to civilian life by relegating the war to the past and to "over there, not here at home," the veterans in *Breaking Ranks* find that the war is still with them because of their ongoing psychological troubles. Betrayed by the military and government that sent them to war, they move from being passive intermediaries in the military-medical establishment to being active mediators determined to find answers to their problems outside dominant institutions; in this moral and existential quest, they form new relations to sustain themselves. 4) These relations are based on a paradigm shift in their thinking and a spiritual crisis precipitated by the war. The veterans understand that their mental struggles are directly connected to what is happening to the

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<sup>19</sup> On July 22, 2015 *JAMA Psychiatry* published "Course of Posttraumatic Stress Disorder 40 Years After the Vietnam War: Findings from the National Vietnam Veterans Longitudinal Study." Based on the results of this congressionally mandated assessment of Vietnam veterans studied 25 years ago in the National Vietnam Veterans Readjustment Study, the authors conclude that "[a]n important minority of Vietnam veterans are symptomatic after 4 decades, with more than twice as many deteriorating as improving. Policy implications include the need for greater access to evidence-based mental health services; the importance of integration mental health treatment into primary care in light of the nearly 20% mortality; attention to the stress of aging, including retirement, chronic illness, declining social support, and cognitive changes that create difficulties with the management of unwanted memories; and anticipating challenges that lie ahead for Iraq and Afghanistan veterans" (Marmar et al. n. pag).

Iraqi people. Capra explains this *psychological connection* by the “deep ecological awareness, or experience, of being part of the web of life . . . [We are] inclined to care for all living nature. Indeed, we can scarcely refrain from responding in this way” (Capra 12). The veterans are deeply disturbed by the destruction of the life-sustaining networks of Iraqi society and face a spiritual crisis about the meaning of their individual human lives in relationship to other humans as well as to the non-humans in Iraq and the world as a whole. As Capra explains,

Deep ecology . . . sees the world not as a collection of isolated objects, but as a network of phenomena that are fundamentally interconnected and interdependent. Deep ecology recognizes the intrinsic value of all living beings and views humans as just one particular strand in the web of life.

Ultimately, deep ecological awareness is spiritual or religious awareness. When the concept of the human spirit is understood as the mode of consciousness in which the individual feels a sense of belonging, of connectedness, to the cosmos as a whole, it becomes clear that ecological awareness is spiritual in its deepest essence. (Capra 7)

The veterans rely on their acute psychological and spiritual awareness for insight into their memories and nightmares about the war and their rage and panic at quotidian life at home. This insight is the source of their capacity to find sustenance and new relations in the aftermath of war.

##### 5. Gutmann and Lutz’s Real-life Veteran Portraits

The veterans in *Breaking Ranks* are from working class backgrounds and enlisted in the military because of the “poverty draft:” unemployment, low-paid jobs, kids to support without a social safety network, and a lack of educational opportunities. Once in Iraq, they scrambled to survive a violent maelstrom of events. During the months and years of the war, they gradually sorted out their own perspectives until a pivotal event brought crystal clarity to their understanding of the war. But such epiphanies were only moments of relief in what turned into a spiritual and existential quest for new meaning and different explanations as they struggled to get through combat. These veterans learned to put trust in their moral concerns to draw connections between their combat experiences and psychological reactions until they turned against the occupation and the military itself. They read voraciously and sought contacts on the internet with like-minded people, often due to the passivity of fellow soldiers and the support for the war of chaplains and other superiors. The war followed them home where their memories and nightmares were incessant, insomnia was crippling, and rage and intolerance for others was startling and frightening. In their testimonies in *Breaking Ranks*, they share their experiences with PTSD and insights about recovery.

I begin with Tina Garnanez because she is one of the three veterans who has been most seriously affected by PTSD. When Tina joined the military after high school graduation in 1999, she was a deeply spiritual young Navajo woman who loved to talk with other people about history and religion. With her deployment to Iraq as an ambulance driver in a large area around Baghdad, Tina immediately found herself identifying with the Iraqi people. When Gutmann and Lutz interview Tina in Santa Fe, New Mexico in 2008, she tells how she returned from Iraq as a changed person. This realization was Tina’s epiphany.

‘I had been the happiest little girl in the world, and then I came home and, “Grrrrrr!” Angry rage. Sleepless nights—I just didn’t want to have nightmares and I’d stay awake or read or go to IHOP and drink iced tea, write in my journal. But I wasn’t feeling safe in a crowd either, really.’ (Gutmann and Lutz 158-9)

At first, she drank too much, self-medicating like many veterans do, and she continued to suffer from insomnia, rage, and panic attacks and from an inability to deal with other people due to irritability and intolerance. She figured out she had PTSD when she was at a conference with other veterans, and the symptoms were listed. It took her three years to prepare her case for disability because of the difficulties of reliving her memories of the war as she filled out the forms.

Tina returned home in April 2005 and soon became involved in the anti-war movement as a speaker and by joining vigils and protests and the IVAW. When peace activists such as the Cindy Sheehan folks in Crawford, Texas found out that Tina was a veteran, they enthusiastically talked with her and invited her to speak. Public speaking at college campuses and town hall meetings around the country changed her life.

‘The support was overwhelming. There were a lot of people who opposed this war, and I thought that was very powerful. I talked to a lot of protesters,’ she says. ‘It was the protesters who brought me home. They were the one thing that inspired me, saved me . . . I would think, Wow, they want us home as much as we want to be home. I was very grateful . . . We felt so isolated, so abandoned. To see some of the American people opposed to this war made us very happy. We felt very loved . . . When I first started I didn’t realize the impact of my own words, my experience . . . But as I started thinking about it more and hearing

other people's stories, I realized I needed to go deeper. I needed to go to the dark scary places inside and use those memories.' (Gutmann and Lutz 170)

She worked a lot with high school students, encouraging them not to join the military and to explore other options for college and travel. Fortunately, with the support of other vets at the Wounded Warrior Retreat in January, 2008, Tina overcame her profound shame about being a vet and accepted her past and her emotional injuries. Subsequently, she helped her family understand great-uncle Willis, a gunner in Korea who suffered from PTSD—Crash Willis was not “crazy” and soon became Tina’s “buddy.”

Thus, over the years, Tina’s friendships with other anti-war veterans have been vital to her spiritual and psychological sustenance. And her mother’s support has been constant. Nevertheless, she explains how most of her days are spent simply dealing with herself to get through on-going panic attacks, insomnia, and nightmares. While she fails Finley’s criteria for success due to her application for long-term medical disability from the government and her refusal to seek treatment from the VA to get cured, Tina serves as an inspiration in *Breaking Ranks* because she has successfully struggled with her inner demons of PTSD to become an influential anti-war activist and part of the long-term healing process with her uncle and other veterans. Furthermore, her story demonstrates that many people do want to know about the war and support veterans in their recovery.

Like Tina, Charlie Anderson has profound long-term effects from his PTSD. He was in Iraq for three months, starting on March 19, 2003 with the U.S. invasion. He describes passing through Sadr City, a major Shi’a neighborhood, and how his troop panicked and started to shoot anywhere and everywhere, deploying massive firepower against the civilians crowding the

streets. During the next few weeks, Charlie found that it was a war in which the enemy was seldom seen but was everywhere and the U.S. troops lived 24/7 with the fear of IEDs and RPGs. As he witnessed and partook in brutality and saw the widespread suffering of the Iraqis, he grew more critical. He felt “schizophrenic,” torn between wanting to believe in the U.S. mission and growing distrust at the dangers for everyone.

His epiphany came one day when he encountered thousands of Iraqi refugees walking along the road. One man carrying his daughter on his back refused the water Charlie offered him, saying

“‘You done enough.’” He turned and I could see that she had a huge shrapnel wound in her head. Obviously she was dead. She’s not sleeping.

‘I was just so upset. You know, my kid is about the same size. And I can’t imagine . . . . We’re here to help these people. Whatever that means . . . . That kid didn’t do anything. That kid wasn’t a threat to freedom.’ (Gutmann and Lutz 111-112)

Seeking the support of his chaplains, they stifled him with their pro-War sentiments—it was a holy war against Islam that Christ would have supported. A devout Christian himself, at this point, Charlie turned against Christianity. He threw away his bible and decided that if God existed, he had a lot of explaining to do—even more than George Bush.

After only three months in combat, he was shipped home with the diagnosis of PTSD. Initially, active-duty group therapy helped, but retelling his experiences in Iraq precipitated vivid, horrific nightmares. For two-and-a-half years, Charlie struggled to adjust, but in December, 2005, a fellow vet and IVAW member committed suicide; and Charlie became intensely suicidal.

‘I was in a really bad state when I finally got to my counselor. He sent me over to the VA hospitals. He wanted to get me some medication, something to help me sleep, something to kind of knock me down a little bit. I get there and I had to register. It’s three o’clock when they finally finish registering me. An hour later, the triage nurse gets to me. I tell her I’m there because a friend of mine committed suicide and my VA counselor told me I should see someone because I got PTSD. She tells me the psychiatrist went home an hour ago, that I should come back to the walk-in clinic the next week.’ (Gutmann and Lutz 142-143)

Several years later, when Gutmann and Lutz interviewed Charlie, he had gone through a divorce and child custody battle, and was living on disability as a college student who was not at peace with himself or the world. Charlie’s story provides direct evidence against Finley’s claims about the superior care provided by the VA. Nor is Charlie’s anti-war activism an effective antidote to PTSD. Instead, Charlie’s story indicates the complex mysteriousness of PTSD—much like the war neuroses after WWI, something new and deeply disturbing happens in the psyches of combat veterans.

Ricky Clousing is the third veteran whose life has been deeply affected by PTSD, and his story points to the connections between his experiences during the occupation, his spiritual and existential crisis, and PTSD. The narrators provide the context for Ricky’s deployment to Iraq in December, 2004. It was *after* the April 2004 revelations about the torture and humiliation in Abu Ghraib—with no subsequent international accountability or even apologies by the U.S. government and with instant and spontaneous mass mobilization of Iraqis against the

occupation—and *during* the infamous Second Battle of Fallujah.<sup>20</sup> Until April 2005, Ricky was an interrogator of low level prisoners swept off the streets as the military tried to clear Hwy 8 between the Baghdad airport and downtown; this was the road with the most IEDs. As an interrogator, Ricky talked with Iraqis all day, and he could describe the details of the widespread incarceration of innocent civilians for weeks and months, without charges and with their families having no idea what had happened to them, and the vicious tactics of many interrogators. As he witnessed murders and brutality, he began to question the war as he watched many Iraqi civilians, including children and women, die from gunshot wounds inflicted by inexperienced troops with no accountability. He reported abuses to his commanding officers, became angry at the false views of the war in the U.S. media, and soon was an outspoken critic, claiming that the U.S. occupation created the resistance, not Al-Qaeda.

Ricky's first epiphany was during an interrogation of one Iraqi man. Ricky broke the rules and let the man, instead, question Ricky. The man asked, do you think you are a terrorist? What is the definition of a terrorist? After four months of

‘seeing firsthand U.S. soldiers shooting civilians, killing civilians, seeing guys in the turret shooting people’s livestock for fun, seeing emotional and physical

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<sup>20</sup>The First and Second Battles of Fallujah 2004 are well-documented. For a view from the Iraqi side, I highly recommend *Beyond the Green Zone: Dispatches from an Unembedded Journalist in Occupied Iraq*. Dahr Jamail also offers a rich historical context for understanding events in the current war.

The crossroad city of Fallujah, which lies on the banks of the Euphrates River, was home to roughly three hundred and fifty thousand Iraqis . . . For thousands of years, Arabs had traveled up and down the north-south desert passageway near the city, which used to serve as a port in the desert where people from Jordan, Syria, Saudi Arabia, and Iraq met, a place held together by longstanding ties of marriage, family, and tribe.

It was in Fallujah that the first rebellion against the British occupation broke out in 1920 . . . To quell the resistance as it gained momentum, the British had sent Lieutenant Colonel Gerald Leachman, who had experience in putting down uprisings against the British empire. Leachman was killed in Fallujah by Sheikh Dhari, a local leader, whose grandson, Harith al-Dhari, was the most prominent Sunni cleric in Iraq and head of the Association of Muslim Scholars. Al-Dhari was instrumental in brokering the deal that ended the April 2004 siege [of Fallujah by the U.S. military]. (Jamail 129-130)

harassment . . . I said, “I know that it’s somebody who uses terror to achieve whatever goal they’re trying to get. It is someone or some group that inflicts terror, scare tactics or violence, on a person or a group of people for some sort of political agenda.” He looked at me and smiled. And he said, “What do you think the American soldiers are doing in my country? What are they doing here?” . . . I just stopped . . . And now I’m seeing why people are responding to our actions, and that whole cycle was really clear to me. I was taken aback. I mean, I got chills on my body. And we just stopped talking.’ (Gutmann and Lutz 119)

Ricky continued to observe the abuses of the U.S. soldiers, including the illegal theft of civilian belongings, when he heard one story about a patrol when the staff sergeant had his soldiers guard a house while he raped the teenage girl inside. This was Ricky’s second epiphany, and now he turned against the war and started to read and question everything.

After six months in Iraq, in April 2005, he was sent home to face himself in peacetime. “‘I was having a meltdown. Iraq had shattered my worldview and the way that I perceived myself and my own identity’” (Gutmann and Lutz 149). He read copiously, but his military counselors didn’t know how to respond when he ranted and raved about the Iraq War, history, and U.S. foreign policy. Since he questioned how he could be a Christian and a U.S. soldier, they encouraged him to talk with a chaplain. The chaplain threw versions of the Old Testament at Ricky about earthly powers of warring Israelites who were ordained by God. When Ricky countered with his own beliefs, the chaplain got angry and advised him to apply for CO status. During these trying months, Ricky was tormented by horrible dreams and recalls the amazing support of his mom, whom he often called in the middle of the night to find a listening ear.

When the mental health people at the VA wanted to medicate him with anti-depressants, Ricky objected.

‘I am reluctant to say I have PTSD . . . . Post-traumatic stress disorder? It’s not a disorder. It’s a natural reaction of culture shock, of being in a combat zone, and the realities and expectations of fighting, and being expected to kill people, and then coming back home to what we have here.’ Far from representing an abnormal adaptation to civilian life, Ricky added, traumatized soldiers were the norm: ‘They’re actually tapped into their human and spiritual and emotional side enough to feel the effects of the war. They’re not numb enough to just blow it off like it doesn’t matter.’ . . . . He was sent to classes on transitioning back from the war zone. ‘But I didn’t need to be transitioned back into reality. I saw what reality with the U.S. in Iraq was now, and I was not okay with it.’ (Gutmann and Lutz 152)

Not against WWII and all wars, all the time, he couldn’t get CO status. After getting support from the GI Hotline, plagued with terrible anxiety and nightmares, at 3:00 a.m. on June 22, 2005, he packed his stuff and deserted the military after taping a MLK, Jr. quote to his door about living by one’s conscience, and drove from Fort Bragg to Seattle.

The context that Gutmann and Lutz provide for his decision is that in June, 2006 Lieutenant Ehren Watada became the first officer to publicly refuse to deploy to Iraq, arguing the War violated the U.S. Constitution and War Powers Act, the UN Charter, Geneva Conventions, and Nuremburg Principles because all of these make “wars of aggression” illegal. For his part, Ricky turns his psychological turmoil into a source of deeper conviction about the purpose of his life. His story amply demonstrates that because combat PTSD is often an indication of alienation

from the values upholding the military, the government, and corporate America, its scientific reduction to neurobiological pathology and cognitive dysfunction is a political act of repression.

The testimony of Garrett Repenhagen confirms this when he voices the common rejection among combat veterans of the diagnosis of PTSD to instead argue that the traumas of war are social and political collective responsibilities and the psychological effects are, ultimately, moral concerns. For Garrett, the connections are straightforward.

‘[The average American soldier] feels like a criminal . . . the killer and the rapist and the thief, and he comes back to America and it’s “Thank you for your service.” But we’re, like, “You have no idea what you’re thanking me for. You don’t know what I did . . . . If we did the things that we did in Iraq, in the streets of D.C., you would go to prison, and sometimes you’d just be executed. These guys aren’t being punished [so] they punish themselves, and they start drinking themselves to death and doing drugs and being abusive to their family and committing suicide because they can’t find redemption.’ (Gutmann and Lutz 145-6)

When he murdered an Iraqi civilian for the first time, Garrett found no consolation in the words of the chaplain that the work of the U.S. military was for God and country. It was hard for Garrett to believe in the mission when most of the Iraqis he fought alongside were against the actions of the U.S. soldiers so they were in the army by day and insurgents by night. As a sniper who murdered Iraqis, Garrett was about halfway through his tour when he turned against the War; he can’t pinpoint any one thing nor any epiphanies that precipitated his antiwar thinking. Three years after the war and over four years after he started his work as an anti-war activist, in his interviews with Gutmann and Lutz, he confides that he continues to have panic attacks and

flashbacks and a lot of guilt about what he did in Iraq. While his activism sustains him, Garrett concludes that the only solution to PTSD and the mental suffering of warfare is to oppose war and advocate for the peaceful resolution of human conflict. From a slightly different angle, I argue that, right now, we need a new version of PTSD to support the hundreds of thousands of veterans who are suffering from PTSD and in acute need for new networks of psychological, spiritual, and activist support. The veterans in *Breaking Ranks* demonstrate that establishing these networks is part of the process of opposing war and creating support for a new social order.

Demond Mullins demonstrates the resilience of poor and working class veterans to regain a certain balance in their inner and outer world after the chaotic psychological disequilibrium of combat. He is a young African-American man from a lower working class family who was deployed to Baghdad with his National Guard unit for 11 months from September 2004 until August 2005. One epiphany for Demond was when a U.S. soldier fatally shot a frightened 14-year old boy in the back as he ran from the soldiers at a checkpoint. Demond's second epiphany was due to Internet access, when one night on a chat room, he and an Iraqi professor began to message one another, and the professor described in detail the constant fear among Iraqis under the U.S. occupation. Demond realized the soldiers were destroying everyone's life—people could not even get to work without risking their lives. He recalls 14-hour truck missions, when he would say to himself, “Dude, I wish somebody would blow this fucking truck up right now and just fucking kill me. Because I can't take this shit anymore” (Gutmann and Lutz 139). This is similar to Tina's story, when she remembers how in Iraq, “I was always afraid. There were times when I would beg, “God, kill me. Just kill me. Because I don't want to live with this stress. I'm tired of being afraid all the time, of dying” (Gutmann and Lutz 131).

Plagued with stomach troubles, Demond's doctor told him he'd be better when he got away from the warzone. When he got home, his stomach did get better, but he was admitted to the VA and diagnosed with PTSD due to his suicidal feelings, impending sense that he was going to die at any minute, and photophobia; he always had to wear sunglasses. Unlike Tina, Charlie, and Ricky, whose spirituality deepened from the war, Demond sought consolation in his nihilist sentiments that there was no point and no structure to life. VA counseling didn't help him, but his immersion in IAW activism, especially in the high schools among black and Latino students, was great for his morale—the best “antiwar therapy.” But working in Senator Obama's office with Walter Reed veterans who came back messed up, Demond suffered from his own symptoms as he helped others with PTSD. So he returned to New York City to concentrate on school and dance and on redefining himself. Thus, Demond's story corroborates my claim that PTSD is directly caused by the experiences of combat and the moral concerns of soldiers.

Chris Magaoay's narrative provides a revealing parallel to Finley's composite, Tony Sandoval. Finley suggests that coming from an abusive childhood made Tony susceptible to internalizing war trauma in the form of PTSD, but she does not substantiate this claim by tracing the empirical connections. On Chris's part, he shares important choices and decisions he faced as a young child and adolescent with abusive and drug-addicted parents. After he enlisted in the military, he figured out that deployment to Iraq or Afghanistan would involve barbarous acts that violated his personal moral standards, so he deserted. Therefore, he was able to avoid the psychological suffering of being a combat soldier. I suggest that from his abusive childhood, Chris developed the maturity to say no at an early age, and this protected him from war trauma and PTSD.

To conclude, the five combat veterans in *Breaking Ranks* have been unable to tame their wild anguish from the war and, instead, they decide their anguish is well-founded and harbors vital lessons about the spiritual and existential meaning of life, both at home and in the war zones. Having become active mediators in their revisionary processes of reflection, these veterans counter the tailored categories of medical concepts and cleansed “matters of fact” of modern warfare with their own moral concerns and first-hand facts about the war. They have established new relationships with their families and communities to find sustenance during their on-going psychological tribulations from the war. These tribulations show the absurdity of Finley’s claim that PTSD is curable and they accentuate the mysterious complexity of the human mind in relation to our nonmodern world.

#### 6. The Power of Fiction to Narrate War: *Sparta*

Thus far in my project, I have fairly well established that the medical factish, PTSD, is a medical diagnosis—a product of the scientific psychiatric laboratory—founded on the purifying work of established polarities—internal/external; subject/object; nature/society; health/illness; etc.. On the other hand, I have challenged this purification with my new version of “PTSD” as a complex hybrid of psychological reactions to the mass slaughter of fellow humans and their homeland by military assault with the high-powered weapons of science and technology.<sup>21</sup> I do

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<sup>21</sup>In *Breaking Ranks*, Demond explains the respect for Iraqi insurgents among his group of soldiers by contrasting the firepower of the U.S. soldiers with the arms of the locals. “[W]e developed a lot of respect for the Iraqis . . . Because in a combat patrol we had four Humvees with at least two 50-caliber machine guns, 240 Bravos [machine guns], and at least sixteen personnel, all with M-4s or M-249s [high-powered rifles]. We got armor and all this stuff. Then you get ambushed by a group of Iraqi insurgents who have a bomb, a makeshift bomb . . . Maybe they have an RPK and a couple of AK-47s. And they’re willing to go head to head. You got to respect it” (Gutmann and Lutz 109).

not mean to assert simplistically that the veterans themselves become hybrids when their psychological reactions to war proliferate in unexpected and uncontrollable ways. Nonetheless, I argue that these psychological reactions are hybrids—internal reactions to high-tech warfare—that develop autonomy and mediate in pivotal ways in the minds and lives of veterans. Since these internal hybrid mediators—actants—can be better understood by entering the mind of a combat veteran—something beyond the capacity of science—I now turn to *Sparta* and the imaginary world of fiction.

In *Sparta*, Roxanne Robinson deploys a variety of techniques to narrate Conrad Farrell's trajectory to suicide due to combat PTSD. The unidentified extradiegetic and heterodiegetic narrator tells the story in a distinct voice to provide background information about Conrad; an occasional account of the history of Iraq and the current war; and the broad historical context of ancient Spartan society. My focus is the bulk of the text in which Conrad is the focalizer. To narrate his indirect interior monologue, Robinson relies on free indirect discourse blended with dramatized memories and flashbacks of the war and direct discourse. Conrad is a thoughtful person who frequently interrogates the meaning of his embodied reactions with questions, hypotheses, and conclusions—he survives outside the “unreality” of civilian life and struggles to make sense of the twilight zone of on-going warfare. During thoughtful moments, his interior monologue has a diegetic quality because he tells himself—and the readers—what's actually happening. Sometimes, the voice of the narrator can be discerned, and readers might be confused: Is a particular point an insight of Conrad's, or is it input from the omniscient narrator? I do my best to make these subtle distinctions in the following, my ANT-assemblage of the networked patterns of organization and dissipative structures in Conrad's psyche during his homecoming from combat in Iraq.

The role Robinson assigns to the extradiegetic narrator prevents *Sparta* from being simply a narrative about the plight of today's veterans, as exemplified by Conrad. Instead, the narrator tells the story of ancient Sparta, a society organized for constant war, to raise fundamental questions about the overall organization of the United States social order. The novel ends with these observations that are externally focalized through the narrator.

Sparta failed, in the end, because the energies of the state were directed only toward war. Robbed of its young men, the country became hollowed out from within, and what remained was a hard, burnished carapace. This repelled the enemy and expanded outward, pushing into the rest of the world, but it had no heart from which to draw sustenance. The costs of war were great, both to the nation and to the soldiers.

Sparta made young boys into warriors; it was left to the warriors to restore themselves to men. (Robinson 383)

As an anti-war novel, *Sparta* is a *bildungsroman* about a young man whose boyhood dreams were shaped by heroic images of Spartan society. In Robinson's novel, the Spartan theme fictionalizes the pro-war ideology and identification such that, as Finley's and Gutmann and Lutz's veterans show, Conrad must come to terms with the incompatibility between the warrior ideal and the real-life atrocities of war. Thus, when Conrad goes to war in the noble cause of serving his nation, he is dishonored by the hideous acts of the military. War is no longer a great myth with higher purpose but an arbitrary killing field where death and destruction *are* the purpose. When he returns home, Conrad still clings to his warrior self, but deeper truths within him emerge in the form of unforgettable memories and relentless nightmares. He is enraged, yet he doesn't know why, and grief makes him cling to his memories of the people killed in the war.

Clearly, these intense psychological reactions do not fit into the purified factishes of neurobiological pathology and dysfunction that define the medical diagnosis of “PTSD.” Instead, according to my new version of PTSD, Conrad’s complex reactions are the broken strands in his psychological connectedness to the people killed and maimed in combat and in his former image of himself and beliefs about the legitimacy of the world order. He longs to forget the war and mourns the loss of his Spartan self-image and worldview. But his psychological reactions are his access to the truths about the war, at the same time they entrap him in the war and paralyze him with shame and horror at what he’s done. Abandoned by the government, Conrad is left on his own to restore his dignity and worth as a man and to establish reasons to live in a society organized for war with people in the rest of the world. In my version of PTSD, that’s what recovery means.

The novel begins on Conrad’s flight home in May, 2006 after his second combat tour in Iraq. Wide awake, Officer Farrell considers his very limited options, since he can’t even remember what his parents or his lover look like. When the soldier sleeping beside him, Private Anderson, wakes up, Conrad Farrell is having a panic attack. As an officer, he “didn’t want to risk speaking, didn’t want to let Anderson know what was happening to him” (Robinson 11). He worries that his loss of memory is post-traumatic stress disorder and wonders if there’s something wrong with his mind, something permanent and unfixable. Readers have access to this free indirect discourse that reveals the cleavage between Conrad’s distant past before the war and his present self due to amnesia. Now, he is preoccupied with strong embodied emotions when his sole concentration has to be to remain calm so he doesn’t lose control to this “thing” inside him. In the following months, his family and lover have little direct access to Conrad’s inner world because he cannot talk about this world. At first, he accounts for this by the stark contrasts

between the luxurious yet seemingly meaningless life at home and the grim, life-and-death world of the war that sets him apart from civilians whom he considers to have no capacity to understand his combat experiences. But in this opening scene, he can't share his inner turmoil with another soldier, and, in spite of their frequent e-mails, this persists until Christmas when Anderson commits suicide in isolation in rural Minnesota.

Soon after he comes home, Conrad's parents encourage him to talk about being hit by an Improvised Explosive Device (IED). He gives them a cleansed account of the explosion with no mention of the death of one of his soldiers, Olivera, from slow hemorrhage, even though vivid memories crowd Conrad's mind. His memory of blacking out after the IED explosion recurs several times in *Sparta*, indicating that Conrad has had a Traumatic Brain Injury (TBI) that, along with his PTSD, is undiagnosed by the military, and yet no direct mention is made of this in the book. Instead, Robinson's technique is to show, not tell, readers, providing the evidence but not the explicit critique of the military; readers are left to do this on their own. On the other hand, in Conrad's inner thoughts, he shares his perspective, and as he gains insight into the war and his adjustment to civilian life, readers are guided in their interpretation of his story.

When his father, a successful law professor at New York University, questions Conrad about going back to school, his chest tightens at the thought of the crowded classrooms, but the higher hurdle is the idea of starting over again, which would mean that the last four years in the military were done, finished. Yet he is still part of that world and any other future seems like "a locked gate." During his first conversation with his younger brother, Ollie, who is a freshman at Bard College, Conrad feels

an unnamed weight attached to his being here. He was here, Olivera was not, and never would be, and how had that happened? And there were those other lives, the

pattern on the wall and the girl, and the man lying in the street . . . . How was he to learn the somber laws of metaphysics that determined who survived and who did not? How could they be tolerated? (Robinson 74)

Still talking with Ollie, Conrad is preoccupied by a long memory of Ali, his Iraqi interpreter and friend, and regrets his rejection of Ali's gift of friendship with another Iraqi who shares Conrad's interest in ancient Greece. But he defends himself as an officer who couldn't talk with every laborer in broken shoes who'd read Homer.

And he couldn't consider every question that arose and challenged his moral right to be in Iraq . . . . He was doing his duty. There was the question of why the U.S. forces destroyed this country. The question of why they were treating their allies—the people they had come here to liberate and protect—with such deep and lethal contempt. The question of whether what they were doing was honorable.  
(Robinson 78)

These inner thoughts disclose Conrad's central conflict between his loyalty to and respect for the military and his awareness of the actual effects of the war on Iraqis. In addition, it's striking that during every conversation, Conrad's mind instantly shifts back and forth between the past in Iraq and the present. Often, when he refocuses on the present, he does so in reaction to this other world in Iraq, and then, reacting once again to the dilemmas in the present, he remembers Iraq. There is a positive feedback loop between Iraq and civilian life such that Conrad's homecoming is directly and persistently affected by the war.

This can be seen in his conversation with Ollie, when Conrad shifts from the above thoughts about Ali and the legitimacy of the war to react to Ollie's disclosure that he is thinking about enlisting in the military. Conrad flies at his brother.

*'Don't you fucking think about signing up.'* He leaned over Ollie and screamed into his face, *'I'll tear your fucking head off'*. (Robinson 80)

In the very next instant, Conrad is back in Haditha where he relives his witness to the murder by U.S. soldiers of an entire Iraqi family, including a little girl who died holding her baby brother in a protective embrace. When Conrad searches the house and finds the dead children, he vomits uncontrollably and is haunted by this memory forevermore. While these memories explain why Conrad doesn't want his little brother to join the military, he can't share these memories with Ollie; only later does Conrad admit to himself that he can't share not because other people won't understand, but because he is deeply ashamed of his participation in the war. At this point, he's back in the present with Ollie, and silently considers that "[t]he thing, the fucking problem, was all this time, this empty time spreading out ahead of him" (Robinson 82-3).

This duality between Conrad's exterior world with other people and his interior world in Iraq continues for the entire novel. Indeed, his actions in the exterior world are a cover-up for his preoccupation with Iraq: Even though he tells his family and himself that he's going to school so he can start a new career, his mind is filled with memories and flashbacks about troubling events from the war involving the deaths and dismemberment of fellow soldiers and Iraqis; he is only excited when he's on-line with fellow soldiers or on blog shows about the war. But being successful in his new civilian endeavors is especially difficult because he is plagued by worsening insomnia. Desperate for sleep, he asks himself,

Wasn't there some kind of therapy that blotted stuff from your memory? Or was that a movie? Wipe it smooth, wipe it all clean of this stuff . . . . How could you make your brain forget something? There must be a way to force it to forget. There must be something. (Robinson 94-95)

As demonstrated in several scenes, such as with Ollie, at the beach with Pink Trunks, and with the couple at the restaurant with his lover, Claire, Conrad has become an overbearing bully whose first reaction is violent domination, if not murder. During his early months at home, he often feels contempt for civilians and justifies his reactions.

What made him so wild, what made his throat swell with rage, was the fact that no one here knew anything, no one here understood about the real world. No one understood what you looked for on the street (risk assessment), how you cleared a room (always moving as a team, though you had to slip through the fatal funnel one by one), how many shots you fired to kill someone (three), how you identified yourself on the radio (company, platoon, individual), how to establish a perimeter, or what the risks were in a room like this, filled with moving people and noise.

(Robinson 145)

In spite of his defensiveness, he becomes increasingly troubled by his attitudes and behavior. For example, one afternoon he is listening to a blog show about the Rules of Engagement limiting the use of force in the military, and he scornfully rejects the concerns of a call-in by thinking, “[t]hat was what combat meant: lethal force. It meant killing the enemy” (Robinson 174). But suddenly, Conrad flashes back to the war.

It had been bad. The man on the floor was not an insurgent, but a wounded civilian awaiting medical attention . . . . [T]he soldier had come into the room, seen him lying on the floor, and shot him point-blank. It was very bad, very fucked-up. (Robinson 175)

The next sentence is back to the blog show, and, after connecting to this conversation for hours, Conrad is buoyed by his renewed military attitude to life's problems. Marching forward, this was how he'd come back: Step by step.

While his Spartan warrior image reassures him, Conrad's memory of the murder of the wounded civilian challenges his illusion of control over his destiny as an upper middle class white superior, an officer in command of other soldiers and civilians. Actually, Conrad is facing a bifurcation point in his life: He has to vigorously defend his military identity or he has to create new beliefs about manhood and a worthwhile life. He can't stay on the old path because of his combat experiences, which he can't forget because he's experienced deep connections to the people, and nonhuman animals, killed in the war and deep sorrow about the destruction of Iraqi society. Nonetheless, he clings to his identity as an officer in charge because this gives him the self-discipline to make a plan and implement it to the finished task. Instead, he has such horrible headaches and difficulties concentrating that he is unable to follow the lectures in his economics class or understand the preparatory material for his graduate entrance exams. At this point, Conrad is at an impasse, unable to see a new path, and this frightens him terribly: Will things go on like this forever?

Three months after coming home, he and his family are still acting as though family life will resume as before Conrad enlisted, but this is not what's happening. One evening during a family conversation, in response to his mother's interest in "cultural differences," Conrad says that he had Iraqi friends, and then, there were the Iraqis who were trying to kill him, so he tried to kill them. "If you want to know if I killed anyone, yes, I did," he said" (Robinson 203).

Abruptly, he leaves to walk alone on the beach, where there was

no other human presence in the landscape.

But . . . [h]e could sense people over there, shadows sliding between the dark, upright shapes of junipers . . . His heart had begun its crazed clatter again, his chest tight and swollen. He wanted an end to this. He looked back and forth in the darkness. (Robinson 204)

During the next month, Conrad has increasing difficulties in his studies, and, with a desperate fear of failure, he goes to the VA to fill out the paperwork for an appointment. An elderly veteran informs him it'll take at least three months to get an appointment, and Conrad leaves without filing the paperwork.

Indicating a connection between these events at home and Iraq, a new passage begins, and Conrad is dreaming about the IED explosion. Claire wakes him, and he tries to distinguish between the darkness of the IED and Olivera and the darkness where he is now beside Claire.

[H]e was still there in that other blackness, feeling the roaring wind come through his body, feeling the sound all around him, lifting him up into some lost place. He still felt rage that this was happening, an astonishment of grief that it could.

(Robinson 219)

That day, he wanders the streets of New York and carefully remembers the exact chain of events on the day of the IED explosion and Olivera's slow death from hemorrhage. In despair, he has lunch with his father and admits he's doing "shitty" but can't say what will help.

There was too much of everything, too much noise and color and choices . . . .  
 And it was all pointless, trivial, everything people were doing was unnecessary.  
 Going to the grocery store, going to work . . . . *Like I care*: that should be the national motto . . . . Why go through all this every day, if that's how you felt—  
 sarcastic, disengaged, distant, ironic? How about watching someone you're

responsible for die, his chest caved in, blood seeping out of the corners of his mouth? How about him asking you if he's going to die and you lying to him, telling him he'd be all right? What about *Like I care* then?

It seemed this was the way the whole country felt.

So what had they been doing over there for three fucking years and no end in sight, while people in-country were getting their arms blown off and their faces torn apart and losing their wives and girlfriends and their marriages and their lives, and then coming home to people who were all saying, *Like I care*.

(Robinson 241)

But he couldn't share these thoughts with his father because it was his fault that he couldn't forget about the war or feel pride like his father counseled, when his men had died and Ali had disappeared. Would he be like this forever?

In this scene, four months after his return home, Conrad is sorting out his growing conviction that the war was a horrible waste, and because of his youthful investment in proving his worthiness as a young Spartan by going to war, now he blames himself for making the heinous choice to go to war. His memories and nightmares, headaches, rage, and insomnia are intensifying, not lessening, and he's fearful that he's becoming incapacitated by a downward spiral of increasing chaos. At this point, there are no indications that a higher order of self-organization might emerge. That evening Conrad moves in with his sister, Jenny, and she confronts Conrad,

'You don't want anyone to know you.'

'No,' he said, 'that's not what it is.'

But that *was* what it was, as if something had slammed shut deep inside him. He didn't want anyone to come near. But how would he live? (Robinson 246)

The next day, in spite of a sleepless night, he manages to be productive. After studying, he checks his e-mails to touch base with his platoon, especially with Anderson. Finally, readers learn about this most important soldier-friend in Conrad's years in the military, from Conrad's recollection.

The night Anderson had saved Conrad's life, they'd been in Ramadi . . . . Conrad crouched, his back against the wall, to call the CO. The radio jittered with static, and he . . . called in the request [for air support] . . . . [T]hen he was lying on his back on the floor and something heavy was pressing against his neck. He was looking up at a man's silhouette, and he could feel a foot braced against his jaw. A shadowy muzzle was pointed at his head. . . . He waited for what came next: pain or darkness . . . and Anderson was leaning over Conrad, saying, '*LT, you okay?*'

Conrad put his hand up to his face: he was covered in blood. It wasn't his . . . . He scrambled to his knees and picked up the radio . . . . 'Be advised,' Conrad said. 'I have numerous insurgents in a building.' He gave the grid coordinates . . . . The ghostly glow of an infrared spotlight illuminated a building two doors down. It was a cone of pale green nearly white, shining down on the wrong side of the street. It was lighting the building where third squad was holed up.

'Move your sparkle north,' he told the pilot, 'one hundred meters. Other side of the street.' . . . The Cobra let loose with a deafening, triumphant roar,

lengthy and sustained, and the entire building disappeared into a slowly unfurling gray cloud lit by sulfurous red glares. The sound of it enveloped the night. Conrad felt his pulse beating in rhythm with the pounding thunder. His whole body was beating wild survivor's glee.

‘Yes!’ Anderson yelled. (Robinson 262-64)

After this lengthy remembrance, no details are narrated of the hybrid connections that Conrad might have made between the salvaging of his life in exchange for the murder of an entire apartment building of people in one blast from the seemingly omnipotent U.S. military. Instead, Conrad and Anderson share their ecstasy as triumphant warriors who have survived a treacherous attack from the enemy. But at Christmastime, Conrad will tell his family (and readers) the conclusions he has drawn about the war based on the overwhelming evidence from his combat tours in Iraq. At this earlier point, Conrad wonders how he will ever be able to live wholly in the present because, if he was meant to forget it, then what was the point of what happened in Iraq?

In the days ahead, he is crippled by persistent headaches, insomnia, and nightmares. One night, he's lying in bed, unable to sleep.

*Tools, process, opportunity.* The words appeared, crisp and factual, like a phrase from a training manual. He didn't know where it came from, but he knew what it meant. (Robinson 300)

He exchanges e-mails with Anderson, who's also struggling but unable to disclose his own thoughts about suicide. Jenny's doctor boyfriend gives Conrad the gift of a prescription for Ambien. Desperate, Conrad returns to the VA, fills out the forms, and is told he's now on a months-long waiting list. The Ambien mixed with alcohol gives him three hours of sleep, but

things continue to get worse. For the second time, the words come to him. “*Tools, process, opportunity*” and he considers different methods of suicide, interrupted by his reflections.

There were two worlds.

These considerations were part of the lower world. That was the dark, dreaming undercurrent, both nightmare and solace, that ran along beneath this world. That was the world you entered at night, the one that suddenly intruded into your mind, the one of blooming explosions and blood . . . . Where you were embraced wholly, every part of you clasped, water kissing and surrounding you like air . . . your body beloved by the mindless surge.

But the world below was not where you lived. Where you lived was in the upper world, the one where the light came flooding in, harsh and bright and obligatory . . . . Where something angular and unyielding—duty, a moral obligation to a larger metaphysical system—made a labyrinth across the landscape, defining the path. You had no choice but to walk through it . . . there was no backward. And there was no horizon, no reach, no future . . . . Your only choice was to continue the mission. (Robinson 319-320)

He returns to the lower world to work on his plan for suicide.

At Katonah for Christmas, after singing Christmas carols, Conrad starts to drink a lot as the family sits around talking, and when he spills wine on his mother’s carpet, the family conversation changes. His parents try to restore order, and Conrad tells them to fuck their rules.

‘This is like being in the middle of a flooding river. I can’t stop it. I can’t get to shore. I can’t stop to obey the rules . . . . I obeyed the rules when I went over there. But they didn’t work. I ended up doing things I should never have done, by

any rules. I saw other people breaking the rules. I watched my men die. I watched our troops kill civilians. We killed thousands of civilians, and we lost our own men. Young men who should have had their whole lives ahead of them are gone. Or they've come home without arms or legs, or without a face . . . . I'm through with these rules. We went over there for no reason, there were no WMDs. It was a lie. It was a lie. We lost our men for a lie. What is this about rules? . . . . I'm home, and Carleton and Olivera and Kuchnik are not. And Ali is not. And now Anderson is gone. I didn't tell you this.' He closed his eyes for a moment, then opened them. 'But you want to hear my news? I just heard today. Paul Anderson is a guy from Minnesota. He saved my life in Ramadi . . . . He killed himself. He went out to his uncle's barn and blew off the back of his head.' (Robinson 346-7)

What Conrad doesn't tell them is about failing the graduate entrance exams, having nowhere to live now that his sister's kicked him out of her apartment, and his fears that he has no future. He summarizes all this when he says they've lost the man he was, he might as well have died in Iraq because he's not coming home. He's still in Iraq. But Conrad is no longer in Iraq as a proud and loyal warrior in the U.S. military. Instead, he's in Iraq to honor those who have died in a war he no longer supports.

Only death offers Conrad the reprieve of a permanent home in the lower world, where he can be with those who have died. His one remaining sliver of hope for renewed life in the upper world is his appointment with the VA in three weeks; he thinks he can make it until then so when his next college course starts, he'll already be better with the VA's help. After Christmas, Conrad lives in the apartment of his friend, Go-Go, and he only leaves the apartment on cleaning day. One such Thursday morning at a coffee shop,

[h]e read the news: Petraeus had taken over the command in Iraq. Bush had announced a surge of twenty thousand U.S troops. Iraqi civilian deaths in 2006 had topped thirty-four thousand. That fact, the civilian deaths, made Conrad feel very strange. It was a large number. It was the bombs. A captain had been caught on video, talking on his cell phone and saying exultantly, ‘I just killed half the population of north Ramadi! Fuck the red tape!’ He had just ordered a 500-pound bomb. It was the bombs and the artillery. They were turning civilians into pink mist. He thought of the spatters on the wall . . . . [H]e went back to the apartment . . . . *Tools, process, opportunity.*” (Robinson 353)

Here, I point to the connection between this devastating use of hi-tech weapons in mass slaughter and Conrad’s plans for suicide to confirm my claim that PTSD is an internalized hybrid formation in response to modern science and technology that is deeply implicated in the (dis)identification of health with a lack of concern about the atrocities of warfare. That night Claire shows up with Chinese food and spends the night. Conrad has the recurrent nightmare about the man he’d killed in Ramadi chasing Conrad through the streets, and he startles awake, feeling shame and revulsion at himself. Claire tells him she can’t do this anymore, and leaves.

Utterly alone, strangely enough, Conrad begins to have a new kind of hope, a spiritual hope for “peace, redemption, forgiveness.” At first, he knows that these are not for him, not after what he’s done. He can’t ask for forgiveness because he’d acted deliberately, and this gives him a pure sense of sorrow and loss.

If he surrendered, if he asked forgiveness for all he had done, how great were the implications? How much wrong had he done?

Those ideas—of grace and forgiveness—seemed to exist in another part of the world. This was the third part, an upper layer . . . above the great systems of violence and turbulence that stretched over the surface of the world, the systems that composed the weather, the storms of anguish and grief and despair. The storms of guilt and shame. You would be lifted from it, and those things would fall away . . . . He had no real hope for this; it was a kind of dream. What he had done made those things unavailable to him. But still he held in his mind . . . [t]he possibility that he would find a way to that layer. (Robinson 362)

This passage demonstrates Conrad's tremendous inner, spiritual awakening; he worked hard for this awareness in the endless hours of silent anguish since his arrival home in May, 2006. This corroborates my argument for a new version of PTSD not as an object but as a pattern of relations in a dissipative structure with the potential to generate a higher order of psychic organization and complexity.

When the VA cancels his appointment, Conrad asserts his rights by confessing, yes, he is a danger to himself. Exactly 30 days later, he makes it to the new appointment, where his doctor is repeatedly interrupted by phone calls and ends up writing prescriptions for three drugs, Trazadone, gabapentin, and paroxetine—noting that

‘Treating [PTSD] is not an exact science. Some medications work for some people and not for others. We use them variously, separately, and in combination . . . . I’ve given you a prescription for Ambien as well for insomnia. So, start in on these and I’ll expect to see you again in about three months.’ (Robinson 370)

After placing his hope in this appointment, Conrad admits to himself that the doctor's words are meaningless. He looks up the side effects of the drugs: increased risk of suicide. The VA has

abandoned him. *Tools, process, opportunity.* He leaves the apartment to buy a hose to hang himself.

He returns to the hotel to find Ollie waiting for him in the lobby. Ollie confronts him with his fear that Conrad is going to kill himself. Ollie grabs for Conrad's shopping bag with the hanging hose in it. Conrad punches him in the face, giving him a bloody nose.

'You have no idea,' Conrad said, his voice dull. 'It's like I'm a secret criminal. No one here knows what I've done. No one has any idea what it was like . . . . You don't know me . . . . You have no idea who I am. You love the person you knew before. You wouldn't love me if you knew who I am.' (Robinson 380)

Ollie tells him that he's dropping out of Bard and not leaving Conrad's side.

'I know you feel bad about losing your men,' Ollie said. 'Or shooting people, whatever you did. But whatever you did feel about them is how you'll make us feel about you, if you'—he hesitated—'quit. It will mean we've failed you. Whatever Anderson did to you, don't do it to us.' (Robinson 380-1)

Eight months later, in August, Conrad is in Katonah, the family home in Westchester County. It is dusk, and he asks Ollie to go outside with him.

The two brothers walked across the lawn toward the big ash . . . on top of the [stone] wall Conrad had set a small wooden box, a candle, and a box of matches.

He gave Ollie the candle. 'Hold this,' he said, and lit it . . . . 'This is a memorial ceremony,' he said. 'for my good friend and trusted comrade, Ali Sadra. I don't have a photograph of him or his full name. I don't even know if Ali Sadra was his real name . . . . Ali was a brilliant translator, and one of the bravest men I know. He was generous and courageous, curious and intelligent. He was a man of

great dignity and humanity. He was a husband and father. He probably gave his life for our cause.' He paused. 'He helped the human race. This is in his memory, in the memory of Ali Sadra, Ramadi, Iraq, OIF, 2005. With respect and admiration from Conrad Farrell, Katonah, 2007.

And this is also in memoriam for all my other friends in Iraq, for those I met and those I did not. And for my friends from the Marines. For PFC James Carpenter, and PFC Alejandro Olivera, and Lance Corporal John Carleton, and Corporal Paul Anderson, and the others who were there with me, for those who came back and those who did not. And for those who came back but didn't stay. They were good men and I miss them.' (Robinson 382-3)

Conrad has sustained the psychological connectedness he discovered in Iraq and learned from his profoundly troubling psychological reactions to the war to develop a higher order of spiritual connection than he had as a young Spartan warrior. His condemnation of the war is based on his support for people on both sides of the conflict. Conrad's challenge to readers is to set aside the snide cynicism of the privileged in support of the life-and-death situations in which many people are struggling to survive. To move from *Like I care* to *I do care*. Another message of Sparta is the importance of forgiveness in making peace with ourselves and with one another. The narrator looks a year into the future to find Conrad at ease in crowds and no longer overwhelmed by rage and two years into the future when he can sleep through the night.

Finally, I would like to summarize the assemblages in Conrad's PTSD. His nightmares and horrific memories recall the combat experiences that account for his rage and his insomnia. These nightmares and memories are about tragic and unnecessary deaths and human brutality. His entire worldview is shattered in the war, and he returns to the civilian world in an existential

state of homelessness, adrift without the bearings of a legitimate social order; one moment he's grief-stricken and the next moment, he's enraged. His inability to concentrate and his headaches could be from the intensity of these reactions, or they could be the long-term effects of a TBI. Of more significance, Conrad no longer believes that he deserves to live and the boundaries between the world of war and death and the world of life have dissolved; he lives in both worlds and is unable to reconcile them until he comes to understand that they are different places in an even larger universe. In this universe there is a third place, a spiritual place of forgiveness, redemption, and peace. With this discovery, he has a glimpse of hope—not the hopes he had as a Spartan warrior, but the hope for non-violent mutual support among people, who are frail and vulnerable and in much need of care and support. In Robinson's presentation of PTSD, Conrad learns to trust that his psychological reactions are well-founded and reveal the broken webs of life destroyed by war. When he asks Ollie to join him in a shared memorial to the war dead, they are on a new journey in the third place of forgiveness, redemption, and peace. It's not that his PTSD is "cured." Instead, its meaning in his life has evolved into an ecological source of psychological and spiritual connectedness in the webs of life that sustain us.

## 7. Conclusion

To conclude, I would like to extend the parallel between the wars and literature of the early twentieth century and the early twenty-first century. In Chapter 1, I argue that shell shock was a revolt against modern industrial warfare, and in Chapter 2, I argue that PTSD is a revolt against modern high-tech warfare. In my narratives about shell shock, I found that war neurosis was a psychological reaction to the existential crisis precipitated by war, and the solution for

many veterans was authentic-being-toward-death in honor of those killed in the war. Along these same lines, in the narratives about PTSD, I found that PTSD is a psychological reaction to the existential crisis precipitated by war. Furthermore, I offer a new version of PTSD and argue that recovery from PTSD depends on acknowledging the hybrid truths revealed in the psychological reactions to combat and building on these truths to repair the broken webs in the ecological patterns of life to establish stronger networks of sustenance in rebellion against modern war and its twin swords, reductive and destructive science and technology.

Chapter 3: Systemic State Violence and the Discipline of Incarceration and Quarantine:  
Anti-realism as Social Critique of the Biomedical Paradigm

1. Introduction

Saramago's two novels, *Blindness* (1995) and *Death with Interruptions* (2008), narrate how a plague of blindness and the mass suspension of death "reassemble the social." In each novel, respectively, Saramago's white-blindness and death's suspension are fantastic medical conditions that lead to the collapse of traditional society, prompting people to reinvent the "social." *Blindness* and *Death with Interruptions* perform parallel acts of deconstructing the dualities of health/illness and living/dying of modern society. In this way, Saramago's novels show the extent to which traditional society is based on sightedness and mortality: it is predicated on policing the boundary between illness and health—or, in Latourian terms, on the purification of the social from various conditions that are constructed as disease.

At the same time, the specific goals of each narrative are distinct, as can be seen by the following plot summaries, noting first that *Blindness* is a much longer novel than *Death with Interruptions*. *Blindness* begins with the sudden onset of white-blindness in a man driving his car amidst traffic in an unidentified city. A stranger takes the first blind man home, only to be struck blind himself when he steals the first blind man's car. During an ophthalmologist's examination of the first blind man, the doctor puzzles about the anomalies of the condition: Instead of darkness, the blind man "sees" a "luminous whiteness," and there are no obvious signs or symptoms of physical disease. Rapidly, white-blindness spreads to the doctor, the car thief's wife, other patients of the doctor, and many others across the city. Adding to the mystery, the doctor's wife retains normal sightedness, and when the government and medical authorities

respond by putting the first blind people into an abandoned mental asylum to contain the infection, she pretends to be blind so she can accompany her husband. Once housed in the asylum, the white-blind attempt to organize themselves to meet their daily needs of survival, but when many more blind people are delivered to the asylum, pandemonium ensues. Several blind men form a gang of thieves and rapists, demanding first the belongings of the others and then the bodies of the women while hoarding the food so the blind can either starve or acquiesce. The women and their men debate how to resist but are unable to organize effectively against the thugs until the doctor's wife, armed with a pair of sewing scissors she packed in her emergency kit from home, murders the leader of the rapists. In the ensuing scuffle, the asylum is set on fire, killing the blind criminals while many of the internees escape into freedom. The doctor's wife leads her small group of seven from the asylum into the city to discover that everyone has gone white-blind. The group finds refuge in the apartment of the doctor and his wife, which has not been inhabited by other blind people. On their subsequent forays through the city to find food and visit old sites, the doctor's wife and other members of their group witness the attempts of the white-blind to organize themselves and to find food and shelter amidst the excrement, the filth, and the human and animal corpses. Even though the doctor's wife finds sustenance for her little group, living conditions rapidly deteriorate and the group plans to leave the city in search of food. Unexpectedly, the first blind man's sight spontaneously returns, and, in the same order in which they initially went blind, one by one, the entire group regains normal sightedness as others across the city also recover their vision. Abruptly, the novel ends, with no narration of the aftermath of the crisis.

Much like *Blindness*, *Death with Interruptions* begins with the fantastic condition around which the entire plot revolves. The story opens at the stroke of midnight of the New Year at the

deathbed of the queen mother as her adoring relatives eagerly anticipate the moment of her last breath. Instead, she lingers, as do all others on the verge of death in a small, landlocked country of ten million people; mysteriously, in surrounding countries, death is uninterrupted. The first major part of the novel narrates the deconstruction of the social as a consequence of the suspension of death. Initially, while people across the nation celebrate death's suspension, the prime minister, the cardinal, and the king conspire with executives of the hospitals, nursing homes, funeral parlors, and life insurance companies to maintain their positions of power. Doing so becomes more and more difficult as the days and weeks pass and the numbers of the living-dying increase until forecasts are made that their numbers will exceed the healthy-living. Meanwhile, the family of one dying grandfather carries him and his dying infant grandson across the national border to die, and others soon follow in a national reassembling of the social to escape the suspension of death. When the government reacts by closing the once-porous border, a "maphia" (a variety of mafia) is organized to get people safely across the border to die. Mysteriously, mid-way through *Death with Interruptions*, "death" emerges from behind the scenes to appear as a personified character—and a woman—in the story. Identifying herself as the unknown agency behind the unprecedented suspension of death, death introduces her existence to the public with a letter to the head of public national television. The letter states that on midnight of that very day, "normal" death will resume for everyone, though under reformed conditions: advance notice will be given via a violet-colored letter forewarning each person one week prior to the scheduled date of death to allow time to prepare to die. In what follows, people respond in the most bizarre and unanticipated ways to their foreknowledge of death while others scramble to resume business-as-usual prior to the suspension of death. But these events in the second half of the novel are overshadowed by the private drama of the character and

personification of death, who is now the central protagonist. She falls in love with a middle-aged cellist whose violet-colored letter has been bouncing back for inexplicable reasons, in the process magically changing herself from a shrouded skeleton into a beautiful woman. When death finally burns the cellist's wayward death warrant, the novel ends abruptly, closing with the same line as it begins: "On the following day, no one died" (Saramago 236).

As is clear, across their differences, the two novels explore several parallel problems. In *Blindness*, Saramago asks, "what if" everyone goes white-blind, and in *Death with Interruptions*, he asks, "what if" humans are granted their wish for immortality and no one dies. In both novels, the "what if" situations are collective: In *Blindness*, everyone ends up suffering from the same contagious disease, and in *Death with Interruptions*, death is suspended for everyone at the moment before death. By narrating fantastic white-blindness and fantastic immortality as collective, individuals are cast as "social" beings who are intimately connected to one another when white-blindness and the suspension of death become powerful mediators in everyone's life. Furthermore, based on Latour, I argue these mediators are "quasi-objects, quasi-subjects" because they collapse the artificial boundaries between nature and society. Indeed, Saramago's fictional constructs are akin to Latour's "hybrids" that saturate the modern world with human inventions of the natural world—white-blindness and the non-dying are hybrids that disrupt the purification of disease and death from the social in the imaginary worlds of both novels. With collective twists and turns, both novels are allegorical fables: In *Blindness*, Saramago asks, what does it mean to see as human beings, and in *Death with Interruptions*, he asks, what does it mean to die as a species-being. Specifically, I will argue that *Death with Interruptions* allegorizes the modern medical condition of prolonged to infinite dying in critical care units as a result of life-support technology.

In Chapters 1 and 2 of this dissertation, mental illness is directly linked to traditional warfare. In Chapter 3, Saramago's critical perspective connects health and illness and the dying process to nontraditional modes of warfare. In *Blindness*, the government's internment of the white-blind in medical quarantines makes war on the contagious people, not the microbe. In *Death with Interruptions*, the critical care technology that I argue is allegorized in this novel to prolong the lives of the terminally-ill has actually been developed in the context of war medicine, as is well-known in the profession. Although as I argue in relation to *Death with Interruptions*, there is a significant difference between deferring death via life-support technologies and the quarantine in *Blindness*—encampment of the contagious white-blind allowed for their killing—this point is still valid. My allegorical reading of *Death with Interruptions* refers to more general questions about the relationship between the medical technologies of modern warfare and their (mis)applications to civilian life.

Furthermore, both novels are *anti-realist* fables that defamiliarize disease and death as fantastic conditions that are inaccessible to the medical/clinical gaze: *Blindness* narrates a white-blindness that is luminous, unlike the darkness of traditional blindness, and in *Death with Interruptions*, no one dies even when the body is in critical condition. Both novels trouble the dichotomy between health and disease as well as life and death by affording no closure: At the end of the novels, the fantastic conditions of white-blindness and the suspension of death remain puzzling mysteries, as neither condition is soluble by epidemiologists and medical specialists, who turn out to be as helpless as the rest of the population in confronting it. Moreover, and paradoxically, both fantastic maladies turn out to be forms of “seeing” during social crises, when established social reorganization is revealed as the problem (the dis-ease), not the ontological conditions themselves. Ultimately, the fictional maladies achieve their efficacy as mediators

because they destroy the bridge that medicine has built between nature and society: *the sightedness of medical knowledge about disease and the dying process incorporated into medical practice*. Thus, one central concern of this Chapter is that, in both narratives, medical practitioners have no privileged access to knowledge about white-blindness or the mysterious suspension of death.

Since the stable foundation of scientific-medical knowledge provides no bearing on white-blindness or the suspension of death, pre-judgments about causality and effective responses prove fruitless. Instead, faced with the crises of white-blindness and the suspension of death, the characters in Saramago's two fables desperately "reassemble the social." Accordingly, Saramago's fiction affords readers with narratives that dramatize the challenge Latour sets forth when he asks,

what sort of collective life and what sort of knowledge is to be gathered by sociologists of associations once modernizing has been thrown into doubt while the task of finding the way to cohabit remains more important than ever? (Latour, *Reassembling the Social* 16-17)

To appreciate the intricate maneuvers of Saramago's characters to reinvent the social, readers are placed in the position recommended by Latour: The best vantage point is not "to glide like an angel" above the social world but to adopt the humble posture of an ANT and "trudge like an ant" on the ground level where it's possible to trace the "tiniest connections" between things (Latour 25). Adopting Latour's ANT vantage point, I will trace the actor-networks in both novels as these social networks are altered by a pandemic of white-blindness and the mass suspension of death.

In parallel but unique ways, Saramago's white-blindness and the suspension of death trouble a central feature of the traditional social: the agency of the free human subject. These fictional collective maladies upset the power of affected individuals, but not due to a loss of "individual freedom" or the imposition of some "structural determination." Instead, white-blindness and the mass suspension of death tear asunder the attachments of individuals to one another, forcing them to form new associations based on the "distributed agency" of multiple human and non-human mediators whose interactions establish new networks. In sum, by challenging modern assumptions about "free" human agency, *Blindness* and *Death with Interruptions* narrate what happens to the "social contract" under conditions of mass upheaval due to illness and dying. On the one hand, in *Blindness*, with the loss of sightedness, people lose the established relations that have sustained life and the social order; nothing can be taken for granted—neither the patterns of daily sustenance nor assumptions about human life in the natural world—and survival depends on establishing new forms of interdependence. On the other hand, in *Death with Interruptions*, without normal death, everyone is trapped in a new limbo of caring for the living-dying. Quickly, society divides into two opposing camps: those intent on maintaining the old order with modifications and those intent on "reassembling the social" to invent new social organizations. Midway through the novel, when death resumes, the conflicts between the two camps persist as the "social contract" has to be renegotiated. With the personal and existential crisis of death herself, death considers the multi-faceted ways in which mortality delimits the existential choices of being human in a social and natural world.

According to Latour, "social contracts" are a form of the "hidden presence of some specific social forces" that traditional social scholars posit to account for social stability. Latour counters,

[i]n [my] alternative view, ‘social’ is not some glue that could fix everything including what the other glues cannot fix; it is *what* is glued together by many *other* types of connectors. (Latour, *Reassembling the Social* 5)

Along these lines, neither novel opens with an introduction to the characters or their milieu; readers learn about each society as particular members respond to events. Specifically, on the first page of *Blindness*, white-blindness strikes a random person who stops his car and relies on a stranger to help him; nothing is narrated about the history of either man or the city in which these events occur. Instead, from the beginning of the novel, the luminous white-blindness acts as a disruptive mediator that makes people act in new and bewildering ways—regardless of their social backgrounds. Likewise, *Death with Interruptions* opens with a simple statement: “The following day, no one died” (Saramago 1). Remarkable for its brevity, what follows does nothing to fill in the missing information about who died or what happened on the preceding days. Thus, both novels confirm the Latourian tenet that at every given moment, “the social is not yet made” (Latour, *Reassembling the Social* 47) because in the novels what’s important is not what’s inherited from the past—the already-existing—but what people do in response to the powerful new actants, white-blindness and the suspension of death.

Actually, Saramago crafts two novels about exceptional situations of disorganization and collapse that reveal what cannot be seen during times of stability. Specifically, white-blindness is a hybrid condition that disrupts the modernist dichotomy between health and disease and insight and madness. It occludes the purifications of normal sightedness while making deeper insight possible when people have to reassemble the social in new networks of organization. Similarly, the suspension of death is a hybrid condition that disrupts the modernist purification of death from life: With the mass proliferation of the living-dying suspended on the verge of death, the

pretense of purification of death from society is no longer possible. Instead, everyone has to confront the prospect of death by making a choice between lingering in artificial suspension in the limbo of the dying process or taking action to provoke a “normal” death by crossing the national border. Consequently, in complementary fashion, Saramago’s narratives fictionalize what Latour considers “a world that is rapidly disappearing” in which “exceptional events” have weakened “*the modern Constitution [that] allows the expanded proliferation of the hybrids whose existence, whose very possibility, it denies*” (Latour, *We Have Never Been Modern* 34-35). Hence, both novels offer a comprehensive critique of the purifications of modern society by tracing the networks of hybrid formation in a world of accelerating disorder and chaos.

Offering a methodology appropriate for tracing these networks, Latour insists that all phenomena, both human and nonhuman, are on the same level plane of “flat ontology.” To distinguish this landscape, he invents the neologism, the “oligopticon,” in part to distinguish it from the panopticon that “feed[s] the megalomania of the inspector or the paranoia of the inspected” (Latour, *Reassembling the Social* 181). To further contrast his approach to the “panoptical gaze,” Latour pays heed to the constant “contextualizing” activity of actors by distinguishing all contextual frames of reference as, quite simply, “big pictures”—the “panoramas” of particular “optical” fields as addressed to particular audiences.

Contrary to oligoptica, panoramas, as etymology suggests, see everything. But they also see *nothing* since they simply *show* an image painted (or projected) on the tiny wall of a room fully *closed* to the outside. (Latour, *Reassembling the Social* 187)

These panoramas are supplements to the oligoptica in that

[f]rom time to time, contexts are gathered, summed up, and staged inside specific rooms into coherent panoramas adding their many contradictory structuring effects to the [local] sites to be “contextualized” and “structured.” (Latour, *Reassembling the Social* 191)

Both *Blindness* and *Death with Interruptions* use an oligopticon method of narration by offering careful details about localized sites and paths of mediation by white-blindness and the suspension of death, respectively. Moreover, both novels provide focalization by both the narrators and individual characters to offer panoramic views that further complicate the overall significance of events. To summarize, in contrast to the panoptical gaze, the oligoptical method records conflicting ways of “seeing” and of “making do” during unprecedented social crises.

This oligoptical method is achieved by the innovating blending of postmodern and realist styles of narration. On one hand, *Blindness* and *Death with Interruptions* resemble postmodern novels in that there is no closure to the riddles that impel the plots at the outset: White-blindness and the suspension of death are puzzling mysteries that remain unsolved at the end of the novels. Otherwise, the novels are written in realist style with varying focalization—some external narrator focalization and some internal/character focalization. Across these strong parallels, there are important differences in Saramago’s narrative techniques in each novel. In *Blindness*, the omniscient narrator is both extradiegetic (superior) and heterodiegetic (third-person); although covert, this narrator has an active and easily identified voice to offer a panoramic perspective on the meaning of events. Distinct from these fairly standard techniques of realist narration, in *Death with Interruptions*, Saramago deploys the innovative technique of intradiegetic collective narration. In my close reading of the novel, I will analyze this construct of an intradiegetic collective narrator more thoroughly. Here, I only want to introduce this narrator to emphasize the

importance of this innovation to the Latourian presentation of society in Saramago's novel. As Latour says in defense of the label "Actor-Network-Theory" for his "sociology of associations,"

I was ready to drop this label for more elaborate ones like 'sociology of translation', 'actant-rhizome ontology', 'sociology of innovation', and so on, until someone pointed out to me that the acronym A.N.T. was perfectly fit for a blind, myopic, workaholic, trail-sniffing, and collective traveler. An ant writing for other ants, that fits my project very well! (Latour, *Reassembling the Social* 9)

In *Death with Interruptions*, Latour's collective traveler materializes as a collective narrator of sorts, who is composed of individual ants who have been at every meeting and in every conversation—not to mention doing the heavy work of carrying the dying across high mountain passes to places of death's reprieve. This narrative technique of intradiegetic collective narration accentuates the reconceptualization of the agency of the human subject at the core of ANT.

Rather than abstract causes for the social crisis precipitated by the suspension of death, Saramago shows that every consequence is due to the actions of individuals, who join together in new assemblages in opposition to the alliances of others. In the novel, the narrator consists of spies in the most fortuitous places—increasing the agency of the newly-organized collectives at the expense of those in established positions of power.

## 2. Beyond State Violence and the Biomedical Paradigm: A New Ontology of Seeing in *Blindness*

*Blindness* is organized into three major sequences that foreground the three primary actants in the novel: first, white-blindness; second, the government; and, third, the small group of

blind people led by the doctor's wife. I will examine these in turn before moving on to more general critical considerations. The first three chapters narrate how individuals are struck by white-blindness, the first primary actant. From its onset, white-blindness is something new and mysterious; it's especially troubling because no one has ever experienced anything like it. During the first moments of blindness, the first blind man tells the people gathered around his car that he can't see.

The blind man raised his hands to his eyes and gestured, Nothing, it's as if I were caught in a mist or had fallen into a milky sea. But blindness isn't like that, said the other fellow, they say that blindness is black, Well I see everything white.  
(Saramago 3)

When the doctor examines his eyes, the first blind man explains that his blindness is "like a light going on" (Saramago 13), but the doctor finds that his eyes appear to be perfectly healthy. Mystified, the doctor confers with a colleague.

[T]oday I dealt with the strangest case, a man who totally lost his sight from one instant to the next, the examination revealed no perceptible lesion or signs of any malformation from birth, he says he see everything white, a kind of thick, milky whiteness that clings to his eyes. (Saramago 19)

Finding no clues to the nature of white-blindness either from his colleague or an extensive search of his medical textbooks, instead, a few hours later, the doctor himself goes blind.

Thus, not only is the presentation of white-blindness unique, but it appears to be highly contagious. The car thief goes white-blind shortly after his contact with the first blind man. The girl with the dark glasses who visits the doctor seeking treatment for conjunctivitis goes white-blind later that same day during her work as a prostitute. The two policemen who separately take

the car thief and the girl with dark glasses safely home to their families, go white-blind. So, too, do the doctor's two other patients, the boy with the squint and an old man with a black eyepatch. When the old man with the black eyepatch is quarantined four days after the others, he tells the first blind group that people all over the nation have gone white-blind. As the narrator describes,

[b]lindness was spreading, not like a sudden tide flooding everything and carrying all before it, but like an insidious infiltration of a thousand and one turbulent rivulets which, having slowly drenched the earth, suddenly submerge it completely. (Saramago 122)

While in the asylum, the “contaminated” go white-blind—all but the doctor's wife. When they leave the asylum, the small group led by the doctor's wife find that everyone in the city is white-blind.

From the explicit references to the passage of calendrical time, the white-blind are quarantined for about three weeks. Once they leave the asylum, they survive for six days until suddenly people regain sightedness and the novel abruptly ends. Accordingly, the pandemic lasts for about a month<sup>22</sup>; white-blindness quickly spreads to the entire population, does its thing, and as quickly as it appears, it disappears. Ironically, when the first blind man regains his sight, he tells the doctor that he can see clearly, with “no traces of whiteness . . . I even think I can see better than before” (Saramago 323).

Thus, as anti-realist fantastic fiction, *Blindness* narrates this mysterious agent that remains beyond scientific explanation: White-blindness is in a third position beyond sightedness

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<sup>22</sup> However, there is one passage that contradicts this. When the doctor's wife and the girl with dark glasses visit the girl's former apartment, they find an old woman who has refused to leave. She is upset by their visit, “as if she were losing her proprietorial rights over this building in which she had been the sole occupant for many months” (Saramago 249).

and traditional blindness. The ophthalmologist is central to this presentation of white-blindness. After the doctor's examination of the first blind man, several pages are devoted to the doctor's medical inquiry into the nature of the strange malady. After talking with his colleague, the doctor

had recovered his scientific outlook, the fact that agnosia and amaurosis are identified and defined with great precision in books and in practice, did not preclude the appearance of variations, mutations . . . . There are a thousand reasons why the brain should close up, just this, and nothing else. (Saramago 20)

But later that night, he decided against agnosia because in psychic blindness, the blind man would continue to react correctly to the luminous stimuli leading to the optic nerve, but . . . he would have lost the capacity to know that he knew . . . . A white amaurosis . . . would also be a neurological impossibility, since the brain, which would be unable to perceive the images, forms and colours of reality, would likewise be incapable . . . of being covered in a white, a continuous white, like a white painting without tonalities, the colours, forms and images that reality itself might present to someone with normal vision. (Saramago 21)

Even though the doctor is perplexed, he clings to his medical knowledge to notify the health authorities of this hitherto unknown form of blindness that appears to be highly contagious, despite its absence of "symptoms of an inflammatory, infectious or degenerative nature" (28).

Strictly speaking, from the perspective of medicine, white-blindness is a functional illness for which no organic explanation is determined. It certainly acts like an infection caused by a contagious microbe that rapidly spreads from person-to-person by an unknown vector. But the entire population goes blind so quickly that the laboratories close before a microbial source

can be identified or ruled out, so no definitive medical diagnosis is ever made. Instead, the people in the city lost hope for a cure

when it became public knowledge that the epidemic of blindness had spared no one, that not a single person had been left with the eyesight to look through the lens of a microscope, that the laboratories had been abandoned, where there was no other solution for the bacteria but to feed on each other if they hoped to survive. (Saramago 242)

As an infection, there is no natural immunity except for the anomaly of the doctor's wife, who retains normal vision.

Nonetheless, there is a magical aspect to white-blindness such that it never quite acts like a disease, perhaps especially in the end when people suddenly regain their vision in the same order that they went blind—(infectious) diseases certainly don't act like that! Alongside the doctor's medical perspective, the invisible narrator provides a non-medical perspective. For example, when the doctor examines the first blind man, the narrator describes the medical equipment as

a scanner which anyone with imagination might see as a new version of the confessional, eyes replacing words, and the confessor looking directly into the sinner's soul. (Saramago 14)

For his part, the doctor is changed by his experiences in the asylum and the city of the blind, as he later comments when their small group finds refuge in his and his wife's home.

If I ever regain my sight, I shall look carefully at the eyes of others, as if I were looking into their souls, Their souls, asked the old man with the eyepatch, Or their minds, the name does not matter, it was then that, surprisingly, if we consider that

we are dealing with a person without much education, the girl with the dark glasses said, Inside us there is something that has no name, that something is what we are. (Saramago 276)

Actually, attempting to follow the path of white-blindness as a Latourian ant intent on discovering its secret source, one is repeatedly confounded by the ironic twists and turns in a montage that never adds up to a coherent etiology. Indeed, “white blindness” is fascinating precisely because it is not any one thing but a montage or “assemblage” of symptoms and mechanics of disease propagation that might not even be a “disease” but a means of higher insight and, consequently, of “health.” Throughout the novel, individual characters probe the mysterious nature of white-blindness. As the woman who can see and lead others, the doctor’s wife adopts an independent position to her husband from its initial onset in her belief that

blindness does not spread through contagion like an epidemic . . . blindness is a private matter between a person and the eyes with which he or she was born. (Saramago 30)

Once in the asylum, she is so troubled by their experiences that she

serenely wished that she, too, could turn blind, penetrate the visible skin of things and pass to their inner side, to their dazzling and irremediable blindness.

(Saramago 58)

Even while white-blindness disrupts every aspect of social life, the condition itself makes people wonder what it means “to see” when they

were for ever surrounded by a resplendent whiteness, like the sun shining through mist . . . blindness did not mean being plunged into banal darkness, but living inside a luminous halo. (Saramago 90)

Often, their group discussions revolve around questions about the nature and causes of white-blindness.

From a Latourian perspective, I argue that white-blindness is Saramago's "factish," carefully crafted as a matter of fact that instantly becomes a major matter of concern to everyone. In my argument in Chapter 2 that "PTSD" is a factish of the military-medical establishment, I summarize Latour's invention of the neologism, "factish," as an inclusive label for scientific facts *and* nonscientific beliefs and values because they are *all fabricated by humans and, once constructed, they achieve autonomy in the real world*. White-blindness is Saramago's invented factish with an autonomous mode of existence: It has the agency to infect people and once white-blind, they have to establish new connections and attachments to survive. One major bridge between the fictional world of *Blindness* and the nonfictional world of Latour is that white-blindness acquires its agency as a mysterious pathogen that acts through a network of associations. Just as Latour's notion of agency is profoundly dialectical, Saramago's white-blindness "makes people do things that make others act;" white-blindness does not exert linear causation but rather mediates in non-autonomous and non-originary ways. Its action is that of a mediator, which Latour describes as

a node, a knot, and a conglomerate of many surprising sets of agencies that have to be slowly disentangled. It is this venerable source of uncertainty that we wish to render vivid again in the odd expression of actor-network. (Latour, *Reassembling the Social* 44)

As will be seen in the following analyses of the two other primary actants in the novel, white-blindness acts via the distributed agency of the actor-networks to which it is attached.

In the fourth through the twelfth chapters, the second primary actant, the government and its medical authorities and military, quarantine the white-blind, ostensibly to protect the sighted from contagion. Ultimately, as long as government officials remain sighted, they can respond to the emergency of blindness according to past protocols, but once they, too, go blind, it becomes clear that members of the government are on the same level plane of flat ontology as all the other actants. Until then, the government attempts to preserve the traditional social. As is clear, the government makes war on the white-blind “in the name of” making war on (contagious) disease. The prime minister comes up with the idea of the quarantine for the “white evil” until a cause and a cure are found,

according to the ancient practice, inherited from the time of cholera and yellow fever, when ships that were contaminated or suspected of carrying infection had to remain out at sea for forty days. (Saramago 37)

As the prime minister clarifies, it could be forty years.

The doctor assumes they will be housed in hospitals where the sighted will care for them. Instead, when they get to the abandoned mental asylum guarded by soldiers, the doctor observes that, “[t]his is madness” to which in an ironic twist, his wife responds, “What did you expect, we’re in a mental asylum” (Saramago 40). Much later, as the small group of blind led by the doctor’s wife find their way through the city streets, they pass the larger theatres that

had been used to keep the blind in quarantine when the Government, or the few survivors, still believed that the white sickness could be remedied with devices and certain strategies that had been so ineffectual in the past against yellow fever and other infectious plagues, but this came to an end, not even a fire was needed here. (Saramago 241)

In this case, the cure is worse than the disease, so to speak, when the government's response treats white-blindness as a modern plague in which the blind are pariahs to be segregated from the healthy and uncontaminated.

From the first day of internment to the last, the government daily airs a recorded message over the loudspeakers that introduces a list of fifteen rules of internment concluding with the following justification:

The Government is fully aware of its responsibilities and hopes that those to whom this message is directed will, as the upright citizens they doubtless are, also assume their responsibilities, bearing in mind that the isolation in which they now find themselves will represent, above any personal considerations, an act of solidarity with the rest of the nation's community. (Saramago 42-3)

In the asylum, medical care and food distribution turn out to be major problems due to the soldiers' fear of contagious contact with the white-blind. When, in self-defense against sexual harassment, the girl with dark glasses kicks the car thief in the leg with her high heel, his leg quickly becomes infected. But when the dying man asks for help from a soldier, the soldier can only see "[t]he face of a blind man. Fear made the soldier's blood freeze, and fear drove him to aim his weapon and release a blasé of gunfire at close range" (Saramago 75). Next, spiraling fear leads the soldiers to murder a large group of approaching internees as they search for containers of food. Following the massacre,

[t]he sergeant's only comment was, It would have been better to let them die of hunger, when the beast dies, the poison dies with it . . . . From now on, we shall leave the containers at the halfway point, let them come and fetch them, we'll

keep them under surveillance, and at the slightest suspicious movement, we fire.

(Saramago 84)

As these examples demonstrate, *Blindness* defamiliarizes the official response to the outbreak of an infectious disease as a form of encampment. Indeed, the internment of the white-blind and the contaminated is aptly characterized by Giorgio Agamben in his study of the origins of the concentration camp in modern society, *Homo Sacer: Sovereign Power and Bare Life*. Agamben locates the origination of encampment in the political status in the state of exception of modernity's sacred man, *homo sacer*.

*[H]omo sacer* presents the originary figure of life taken into the sovereign ban and preserves the memory of the originary exclusion through which the political dimension was first constituted . . . . *The sovereign sphere is the sphere in which it is permitted to kill without committing homicide and without celebrating a sacrifice, and sacred life—that is, life that may be killed but not sacrificed—is the life that has been captured in this sphere.* (Agamben 83)

In *Blindness*, quarantine in the mental asylum is revealed as an encampment in Agamben's sense, where the interned are reduced to the "bare life" of inclusion in the political order solely in "an unconditional capacity to be killed" (Agamben 85).

In another series of ironic twists, the government is aware of the dehumanization of the quarantined, exacerbated by the severe overcrowding with the arrival of new internees. As the Ministry of Health says to the Ministry of Defense,

[t]here is one solution, open up all the wards, That would mean the contaminated coming into direct contact with those who are blind . . . I suppose we'll all be contaminated . . . We have a colonel here who believes the solution would be to

shoot the blind as soon as they appear . . . To be blind is not the same as being dead, Yes, but to be dead is to be blind. (Saramago 107-8)

Later that day, when the colonel himself goes blind, he is reported to have immediately shot himself in the head to escape the fate of internment—of Agamben's *homo sacer*.

The carceral character of quarantine in *Blindness* and its location in an abandoned mental asylum also harkens back to Michel Foucault's argument in *The History of Madness*. As Foucault documents, the asylum was instituted in Europe in the late 18th century in the already-existing houses of confinement for the sick, the destitute, the criminal, and the insane. Rather than eliminate these houses, they were to be neutralized as causes of new disease. Foucault writes:

The great movement of reform that swept through the institutions in the second half of the eighteenth century had its origins there, in the desire to reduce contamination by the destruction of vapours and impurities; quelling the fermentation would prevent diseases, and evil, from permeating the air and spreading their contagion to the atmosphere of the cities . . . . The new dream was of an asylum which, while preserving its essential functions, would be set up in such fashion that disease could vegetate there without spreading, an asylum where unreason would be entirely contained and offered as a spectacle without ever threatening spectators . . . . The idea in short was to build asylums equal to their true nature as cages. (Foucault 359)

The location of Saramago's quarantine for the white-blind in an abandoned mental asylum unmasks the real carceral nature of medical quarantine through this association that links back to the older carceral institution of the asylum. In this way, for the latter-day contagious pariahs that

figure as the distant successors of Foucault's eighteenth century insane, the ostensible gesture of restoring health to the body politic is exposed as the internment of the white-blind in a twentieth century concentration camp, as aptly characterized in Agamben's *Homo Sacer*.

Amidst the chaos and destruction of the quarantine, the Ward One cell of blind internees becomes the third primary actant. This small collective is the birthplace of a new "society of the blind" with their formation of a higher order of cooperation from the ruins of the traditional society of the seeing-healthy. Led by the doctor's wife, this group rejects the logic of exclusion and contagion and their status as blind pariahs. They reclaim their full humanity by demonstrating the greater agency achieved by the healthy and the contaminated joining hands to sustain each other and the group as a whole. Doing so depends on their transformation by the mediation of white-blindness in their lives, and although the doctor's wife retains normal sightedness, perhaps she is the one most changed by white-blindness. She adopts a unique position to the strange condition when the health authorities take her husband to the asylum for quarantine and she pretends to be blind to accompany him, refusing to isolate herself "inside a bell jar to avoid contamination" (Saramago 31). Once inside the asylum, she takes advantage of her ability to see to offset the dehumanization of the white-blind as bare life, as do the white-blind internees themselves in their many small gestures of mutual support.

The need to get organized is immediately raised by the doctor after the government introduces the blind to the asylum with the first announcement of the fifteen rules of internment. Learning from the rules that no one will come to their assistance, the doctor proclaims,

Therefore we ought to start getting organized without delay, because it won't be long before this ward fills up with people. (Saramago 45)

From the initial moments of internment, the doctor's wife is pivotal as the sighted leader, who keeps her normal vision a secret as she constantly awaits its loss, as seen in the opening scene of the fifth chapter:

I must open my eyes, thought the doctor's wife . . . . She opened them the following instant, just like that, not because of any conscious decision. Through the windows that began halfway up the wall . . . entered the dull, bluish light of dawn. I'm not blind, she murmured. (Saramago 56)

As soon as they arrive in the asylum, she guides them to organize life in their small Ward One cell. When a quarrel breaks out between the first blind man and the car thief about the stolen car, the doctor's wife interrupts them with their first collective challenge: getting to the lavatory to relieve themselves.

Due to the problems of the distribution of the food that the soldiers deliver to the forty people housed in the asylum, those from the right wing, who are already white-blind and hence separated from the contaminated on the left wing, gather to discuss a collective solution. Again, the suggestion is made to organize themselves, this time by a woman in the second ward on the right wing, who suggests rationing. A man asks,

[w]ho's giving the orders here, he paused, expecting to be given an answer, and it came from the same feminine voice, Unless we organize ourselves in earnest, hunger and fear will take over here. (Saramago 91)

Before they can come up with a plan, four vans arrive with more than two hundred new internees, exceeding the asylum's capacity of one hundred and twenty beds. Shoved by the armed soldiers through the front doors,

the human mass [of the newly-arrived] swerved towards the wing on the left, carrying all before it, the resistance of the contaminated broken, many of them no longer merely contaminated, others, running like madmen, were still trying to escape their black destiny. They ran in vain. One after the other they were stricken with blindness, their eyes suddenly drowned in that hideous white tide inundating the corridors, the wards, the entire space. (Saramago 112)

In the pandemonium, a band of blind thieves quickly organizes a system of violent exploitation when they demand extortion from the others in exchange for food.

Searching for a means of cooperative opposition, some of the white-blind suggest that they refuse to give their belongings to the thieves.

[E]ither we all hand over everything, or nobody gives anything, said the doctor, we have no alternative, said his wife, besides, the régime in here, must be the same as the one they imposed outside, anyone who doesn't want to pay can suit himself, that's his privilege, but he'll get nothing to eat and he cannot expect to be fed at the expense of the rest of us. (Saramago 141)

When the mass rapes begin, the doctor's wife reconsiders the meaning of her sightedness.

Now, with her eyes fixed on the scissors hanging on the wall, the doctor's wife was asking herself, What use is my eyesight, It had exposed her to greater horror than she could ever have imagined, it had convinced her that she would rather be blind, nothing else. (Saramago 152)

After scouting out the den of the rapists, armed with the sewing scissors that she advantageously packed in her emergency kit, she secretly accompanies the group of women from the second ward on the right wing as they are taken to the den to be raped. There, as the leader of the rapists

ejaculates into the mouth of his victim, the doctor's wife slits his throat. Quickly, she leads the other women to safety as the blind accountant seizes a gun and assumes leadership of the rapists.

In another culminating moment, the victim of the murdered rapist, rather than betraying the doctor's wife, promises to follow her, "Wherever you go, I shall go" (Saramago 197). Mysteriously, she disappears to get her secret stash from her own emergency bag: a cigarette lighter that she uses to set fire to the barricade of mattresses built to protect the gang. Tragically, she is entrapped by the smoke and flames underneath the bottom mattress and is burned to death. But the fire frees the others from the asylum, and the small group from Ward One stays together as they escape to safety.

In Latourian terms, in the hands of the women, the sewing scissors and the cigarette lighter become potent mediators that empower the raped women to change from passive "intermediaries" into powerful mediators who murder their tormentors. Retooled as murder weapons, they are the sort of "hybrid objects" that Latour designates as "quasi-objects, quasi-subjects" because they are both constructed by humans and have powerful effects in the real world, *depending on their precise agency in people's lives*. The events that transpire in the asylum are inexplicable unless these hybrid quasi-objects, quasi-subjects are considered as mediators in the process of the reassembling of the social on the part of the blind internees.

As important, in the dialectics of these momentous events, the women are transformed by their courageous attempts to defend themselves. As the doctor's wife explains after the blind woman suffering from insomnia dies after the night of rape,

it is foolish for anyone to ask what someone died from, in time the cause will be forgotten, only two words remain, She died, and we are no longer the same women as when we left here, the words they would have spoken we can no longer

Speak, and as for the others, the unnameable exists, that is its name, nothing else.

(Saramago 182-3)

After she slits the throat of the leader of the rapists, she reconsiders her personal identity.

She had blood on her hands and clothes, and suddenly her exhausted body told her that she was old, Old and a murderess, she thought, but she knew that if it were necessary, she would kill again, And when is it necessary to kill, she asked herself as she headed in the direction of the hallway, and she herself answered the question, When what is still alive is already dead. She shook her head and thought, And what does that mean, words, nothing but words. (Saramago 192-3)

Here, the doctor's wife voices her acute awareness that human agency is a matter of enacting worlds—bringing forth worlds by doing—and that words are empty representations of those enactments.

After their escape from the asylum, the small group led by the doctor's wife extends the attempts of the white-blind inside the asylum to organize themselves in mutual support of one another. While the other survivors have no idea where the asylum is located and where to go, the small group of seven from Ward One can count on the doctor's wife for guidance, since her sightedness allows her to approximate the asylum's location. Their first act is to organize themselves into an autonomous cell amidst the general confusion by forming themselves into a pattern of concentric circles to safely sleep until morning. With the boy with the squint in the middle, the three women encircling the boy, and the three men encircling the women, "they give the impression of being but one body, one breath and one hunger" (Saramago 219).

Once they leave the asylum, this small society enters a world of chaos and disequilibrium due to the universal spread of white-blindness. During their six days in the city of the white-

blind, there are pivotal bifurcation points when the survival of the group is at stake and yet where a new trajectory to a higher order can be reached. One point is when the doctor's wife finds food in the basement of a supermarket, which the white-blind have yet to discover, only to herself become lost in the once-familiar streets on her way back to the others. At this crucial moment, the sightedness of the doctor's wife seems of no use in the midst of the general collapse of social organization in the city. Miraculously, the "god of crossroads" blesses her with a large map of the city posted by the town council for visitors (234). This pivotal mediator—a quasi-object, quasi-subject much like the sewing scissors and the cigarette lighter—allows her to locate herself and find her way to the pharmacy with the food for her small group of dependents.

Another pivotal point is when they solve the problem of travel through the streets soaking with run-off from rain-soaked corpses and excrement by getting new boots and shoes from an abandoned shoe store. With the food and the footwear, it is clear that the cash economy has collapsed, no barter system is in its place, and instead, the major problem will be an adequate supply of the necessities of life. At the apartment building of the home of the girl with dark glasses, her parents are gone but they find an old woman on the ground floor of the apartment building who has refused to leave after the authorities took her husband, son, and daughter-in-law to the quarantine; since then, she has been living off the raw meat of rabbits and chickens and raw vegetables from the garden in the backyard. Her story narrates the effects on the civilian population of the quarantine as an act of nontraditional warfare, highlighting the mediation of white-blindness in its aftermath. What is pivotal for the small society of white-blind is that the old woman gives the girl with dark glasses the keys to her apartment, so they have a place to stay for the night.

They have reached a critical juncture: Either they can splinter apart by staying in their separate abodes, or they can stay together as a self-organized group. The doctor's wife proposes that they stay together as she points out the lack of electricity, running water, or supplies of any kind. The old man with the black eyepatch comments that they're like primitive hordes,

with the difference that we are not a few thousand men and women in an immense, unspoiled nature, but thousands of millions in an uprooted, exhausted world . . . When it starts to become difficult to find water and food, these groups will almost certainly disband, each person will think they have a better chance of surviving on their own. (Saramago 256)

The doctor's wife offers to be their eyes, and everyone agrees to stay together for the mutual benefits afforded by organizing themselves as a small cell.

When they leave the apartment of the girl with dark glasses, the doctor's wife demonstrates the awareness she has gained of the dangers of their upcoming passage through the streets by organizing them into a file connected to one another via strips of cloth knotted together into a long rope, with the boy with the squint in the middle. The doctor's possession of the key to the couple's large apartment is a pivotal mediator that provides entrance into the flat, a "paradise" where the small society of white-blind form the semblance of a new life together. They bathe for the first time in almost a month, with the women cleansing one another in a heavy downpour of rain, then helping the men bathe in water the women have collected in pans.

These many small attempts at mutual support and survival take place amidst the general disorder and accelerating chaos of white-blindness. On the following day, the doctor's wife, the first blind man, and his wife go into the city to search for food. When they pass the street corner where the first blind man went blind, they recall the fateful day of the start of the pandemic Two

days later, the doctor, his wife, and the girl with dark glasses “survey” the mounting rubbish and animal corpses on the city streets. The doctor says,

the worst thing is that we are not organized, there should be an organization in each building, in each street, in each district, A government, said the wife, An organization, the human body is also an organized system, it lives as long as it keeps organized, and death is only the effect of a disorganization, And how can a society of blind people organize itself in order to survive, By organizing itself, to organize oneself is, in a way, to begin to have eyes. (Saramago 295-6)

He adds that while people have always died from all sorts of things, now they will die of blindness—of their disorganization—the worst form of death since, according to the doctor, they have the capacity to generate higher forms of order that would make such deaths unnecessary.

[W]e shall die of blindness and cancer, of blindness and tuberculosis, of blindness and AIDS, of blindness and heart attacks, illnesses may differ from one person to another but what is really killing us now is blindness. (Saramago 296)

They find the surgery ransacked, probably by the government in setting up the quarantine, again recalling the first days of white-blindness and the war waged by the government against the white-blind. On their way from the surgery to check on the girl’s apartment, they pass a park where the blind are having public debates about everything except how to organize themselves.

When they find the basement of the supermarket filled with the rotting corpses of blind people who fell or were crushed to death on their way down the stairs, the doctor’s wife feels responsible because she mediated their discovery of the basement. For the second time in the novel, she reaches a breaking point, momentarily incapacitated by the heavy weight of responsibility she bears for the well-being of others. Fortunately, with the doctor’s help, the

couple finds refuge in a church across the street, where the doctor's wife regains her strength. Recovering, she is struck by the sight of the white cloths that cover the eyes of the statues and the white paint across the eyes in the church paintings. Her fateful announcement of the white coverings on the icons—which instantly change from a source of religious solace to objects of existential horror—causes the other churchgoers to panic and flee, leaving their small supplies of food for the doctor and his wife, who “left the church without remorse over the theft, their bags half full” (Saramago 320). That night, after sharing the rancid food and facing the prospect of leaving the city for the countryside in search of food, they try to sleep but hunger keeps them awake. As the first blind man dozes, he realizes that he's in the dark. Suspicious at the absence of whiteness, he opens his eyes to see the world. As mysteriously and as suddenly as it began, the pandemic ends.

In summary, key to their survival, the doctor's wife relies on her sightedness to lead them in the formation of new patterns of self-organization. By doing so, she serves as a model to solve the unanswered riddle posed by the abrupt ending of the novel: What will people do, now that traditional sightedness has been restored? Presumably, they will be able to reestablish the necessary conditions for the sustenance of life, but, in addition, will people achieve higher forms of order through networks of mutual support, or will they succumb to the restoration to power of old regimes of exploitation and domination? In their struggles to survive in the city, the doctor's wife and her small group have learned to “see” new modes of organization, both to sustain life and to do so in a cooperative system of higher order. In this manner, the doctor's wife defines a certain form of decentralized leadership advocated by Saramago in *Blindness*. To better appreciate her role as a sighted leader, I recall my model for a new version of PTSD in Chapter

2, where I relied on the ideas of Fritjof Capra in *The Web of Life*. At this point in Chapter 3, I point to Capra's comprehensive new theory of life.

I propose to understand autopoiesis, as defined by Maturana and Varela, as the pattern of life (that is, the pattern of organization of living systems); dissipative structure, as defined by Prigogine, as the structure of living systems; and cognition, as defined initially by Gregory Bateson and more fully by Maturana and Varela, as the process of life. (Capra 160)

In *Blindness*, through establishing new patterns of organization amidst dissipative structures far from equilibrium, both the sighted doctor's wife and the white-blind achieve a higher level of cognition to "see" the world in new ways; this is an ontological process of learning through organizing life in new patterns for mutual sustenance.

Based on the preceding close-reading of how the social is first deconstructed and then reassembled by the pandemic of white-blindness, I now extend my analysis to discuss input from other scholars about the novel and its general themes. To begin, in tracing the networks to which the actant, white-blindness, is attached, violence is not thematized until the public health response to the contagion. The quarantine is an act of nontraditional warfare. Its use and impact on mental health parallels the impact of traditional warfare on mental health (shell shock and PTSD) explored in Chapters 1 and 2. To house the white-blind and the contaminated in these disciplinary death camps, the society of the healthy responds in "fear of the unstoppable plague" by turning the white-blind into "blind pariahs" whose lives are not worthy of protection. As Agamben explains,

The concept of 'life unworthy of being lived' is clearly not an ethical one, which would involve the expectations and legitimate desires of the individual. It is,

rather, a political concept in which what is at issue is the extreme metamorphosis of sacred life—which may be killed but not sacrificed—on which sovereign power is founded. (Agamben 142)

In *Blindness*, the efforts at containment—of the purification of disease from healthy society—fail with the rapid and ubiquitous spread of white-blindness until the pandemic is universal. Hence, the sightedness of the government and its medical authorities turns out to be irrational—a madness that initially passes for reason.

Indeed, white-blindness is a strange malady because it is a pandemic that strikes everyone, the upper- and middle-classes as well as the poor, who, according to the infectious disease doctor and anthropologist, Paul Farmer, are far more susceptible to acquiring and dying from infectious diseases than are those with the privileges of the higher classes. Looking at the incidence of infectious diseases worldwide, Farmer notes that

[a]nalyzes confined within the framework of the nation-state ignore both transnational microbial traffic and the movement of massive amounts of capital in and out of [impoverished nations] . . . . Yet what is missing from the [infectious disease] debate is acknowledgment that the growing inequalities of the global era . . . constitute, in and of themselves, a sort of ‘global Tuskegee experiment,’ to quote Jim Yong Kim. After all, we have the treatments for the afflictions of the poor, and yet for most we do nothing, leaving a vast ‘control’ group of unfortunates to exhibit the natural history of untreated disease. (Farmer, *Infections and Inequalities* 34-5)

In his critique of the purifications of medicine, Farmer argues that infectious diseases are always hybrids of the social. Consequently, he asks,

[w]hat could be less ‘natural’ or more biosocial than an epidemic of, say, drug-resistant tuberculosis spreading from prisons to the civilian population? (Farmer, *Partners to the Poor* 295)

*Blindness* narrates a situation in which a pandemic does spread to the entire population, so the quarantines of encampment fail, and the future as predicted by Farmer becomes imagined. The world that was taken for granted vanishes, and the white-blind grope to “reassemble the social” to survive.

An added contribution that Farmer makes to the appreciation of *Blindness* as a unique account of disease, is the emphasis he places on the pivotal role of women, specifically poor women of color, in changing the dynamics of science and medicine. For example, to explain why the voices of women with AIDS have remained absent from the scientific and popular literature—*it’s not because they are not actively organizing and speaking out*—Farmer points out that

the majority of women with AIDS had been robbed of their voices long before HIV appeared to further complicate their lives. In settings of entrenched elitism, they have been poor. In settings of entrenched racism, they have been women of color. In settings of entrenched sexism, they have been, of course, women.

(Farmer, *Partners to the Poor* 300)

Like these poor women of color, the human protagonist in *Blindness*, the doctor’s wife, a member of the middle class, leads other women to organize themselves against the consequences of disease. As she explains to the girl with the dark glasses,

I don't give orders, I organize things as best I can, I am simply the eyes that the rest of you no longer possess . . . let us continue to live together. (Saramago 256-7)

Thus, in the imaginary world of fiction of Saramago's novel, it becomes possible to narrate the empowered agency of women who, by forming more and more attachments with one another, acquire a voice and make a difference in the real world. The doctor's wife is the voice of egalitarian sharing, a "partner to the poor" in Farmer's sense, central in gathering the women's collective opposition to the system of domination as embodied in the blind thieves.

In *Contagious: Cultures, Carriers, and the Outbreak Narrative*, Patricia Wald also relies on Paul Farmer to critique what she considers to be the paradigmatic story for the spread of infectious diseases: the "outbreak narrative." She explains that this "evolving story of disease emergence" began in the mid-1980s and was popularized in novels and films in the 1990s.

Collectively, [the outbreak narrative] drew out what was implicit in all of the accounts: a fascination not just with the novelty and danger of the microbes but also with the changing social formations of a shrinking world. Contagion is more than an epidemiological fact. It is also a foundational concept in the study of religion and of society, with a long history of explaining how beliefs circulate in social interactions . . . . The interactions that make us sick also constitute us as a community. Disease emergence dramatizes the dilemma that inspires the most basic human narratives: the necessity and danger of human contact. (Wald 2)

Outbreak narratives follow a formulaic plot: 1) identification of an emerging infection; 2) its global spread; and 3) the epidemiological work that contains it.

Microbes, spaces, and interactions blend together as they animate the landscape and motivate the plot of the outbreak narrative: a contradictory but compelling story of the perils of human interdependence and the triumph of human connection and cooperation, scientific authority and the evolutionary advantages of the microbe, ecological balance and impending disaster. The conventions of the paradigmatic story about newly emerging infections have evolved out of earlier accounts of epidemiological efforts to address widespread threats of communicable disease. (Wald 3)

Throughout her book Wald is critical of how outbreak narratives distort the actual pathways of disease emergence and reinforce the illusion that the narrow precepts of science and medicine are adequate tools for the containment and eradication of infectious diseases. In the Conclusion, she summarizes her critique and highlights the need for alternative paradigmatic narratives about infectious disease, such as Farmer's, to counter the outbreak narrative. According to Wald, the problem with outbreak narratives is they encourage preparation for and responses to pandemics based on strategies generated by antimicrobial vaccine and drug development and spatial containment of the "threat" through national border patrols and quarantine; these strategies exacerbate the effects of pandemics on the inequities between diverse global populations—inequities that account for the further spread of infectious diseases. As Wald advocates,

[i]t is possible to revise the outbreak narrative, to tell the story of disease emergence and human connection in the language of social justice rather than of susceptibility . . . [i]n place of the fearful scenario in which monstrous microbes from elsewhere threaten to turn 'us' into 'them' ('thirdworldification') . . . .

Disease emergence, in this [revised] account is an urgent problem in the North not only, or even primarily, because disease may be spread from the South to the North, but because of the role of the North in perpetuating the conditions of thirdworldification worldwide. (Wald 270)

Wald's argument is directly relevant to a central question about *Blindness*: Why does Saramago pose white-blindness as an infectious disease? On one hand, Saramago's fable is an "outbreak narrative" about the sudden emergence of a highly-contagious disease that threatens the very survival of the entire human population and that triggers a quarantine response on the part of the government that is shown to be not only barbaric in its implementation but also entirely ineffective. On the other hand, the fable confounds the basic criteria for an outbreak narrative: 1) the source of white-blindness remains a mystery; 2) its spread is universal; even the experts go blind; and 3) recovery from white-blindness is as magical as its onset; the hard sciences of epidemiology and medicine have no agency and can take no credit for the spontaneous return of normal sight at the end of the novel. As I explain below, I suggest that *Blindness* provides an example, even a model, for an alternative paradigm for narratives about disease emergence.

One of the ways *Blindness* serves as an alternative narrative model is its challenge to the concept of "Patient Zero." Wald details the origin of this concept as a cornerstone to the outbreak narrative, and she points out how misleading the concept has been, especially in the scientific and popular literature about AIDS. As she shows, "patient zero" is a central protagonist in outbreak narratives, considered to be the figure held responsible for the spread of infectious diseases. This characterization started with the AIDS epidemic in the mid-1980s with the French Canadian airline steward, Gaetan Dugas, who was the "AIDS carrier" held responsible for the

spread of AIDS in the gay community and who became known as *the* “Patient Zero” of the AIDS epidemic. According to Wald, the technical inaccuracy of the term—diseases such as AIDS cannot be carried and transmitted—viruses and other microbes cause infectious diseases and are “carried” and “transmitted”—is more than a semantic mistake:

[I]t affects the perception and treatment of both the disease and those who test positive for the virus, with and without the symptoms. The confusion . . . is evident in even the most reputable scientific and journalistic publications . . . . The figure silently witnesses the evolution of the narrative; ‘he’ testifies to its extensions and embodies its consequences . . . with the sinister agency of human retribution. (Wald 215)

After an extensive critique of the vilification of Gaetan Dugas and the ways this vilification has contributed to the failure to adequately respond to the pandemic, Wald concludes,

[b]ut the promised cures and vaccines were not forthcoming. By the 1990s, the disease was considerably more manageable in some parts of the world, but its continuing devastation illuminates social, economic, and political inequities worldwide . . . . [I]t is no longer possible to sustain the apocalyptic language that characterized the spread of the disease . . . . HIV/AIDS is not well suited to the formula of an outbreak narrative. (Wald 216-217)

Instead, the heirs of “Patient Zero” are figured in accounts of other species-threatening outbreaks and bioterrorism in which fictional viruses erupt domestically and are quickly and heroically contained due to laboratory science and the brilliant epidemiological detective work that are the other cornerstones of the outbreak narrative.

In keeping with the outbreak narrative, in *Blindness*, the medical authorities quickly elevate the first blind man to the status of “patient zero.” However, subsequently, the plot diverges from that of the outbreak narrative because the potent mediator, white-blindness, rapidly travels from person to person until it becomes universal, so prompt identification and isolation of “patient zero” and those he has exposed prove to be utterly futile. Unlike an outbreak narrative, *Blindness* narrates how, initially, the first blind man is merely one abject victim among many. However, inside the asylum, the first white-blind change from being abject victims—intermediaries—into active mediators who alter the trajectory of white-blindness by their new attachments to one another, first in their revolt against the band of thugs and rapists, and second during their journey into the city. Thus, *Blindness* serves as a model narrative of the sort advocated by both Wald and Farmer: Cutting across class, racial, and gender divisions, when everyone is inflicted by disease, the “social” has to be reassembled, not according to a “master narrative” such as the “outbreak narrative” but through the distributed agency of the white-blind to reinvent the social through the numerous and the tiniest connections established with one another.

According to Wald, the true identity of “patient zero” is the “viral-human hybrid.” Here, I provide the basic outline of her argument in order to highlight Latour’s distinct concept of “hybridity” and, in turn, the hybridity of Saramago’s white-blindness. On Wald’s part, she argues that in the outbreak narrative, the language jumps from the virus to the host and, along with the incarnation of the threat in gay men,

Haitians, intravenous drug users, and hemophiliacs, designated as belonging to ‘risk categories’ . . . were incorporated into the viral equation, with an accompanying interchange of features for the emerging viral-human hybrid . . .

Promiscuity, the intermingling of bodily fluids of all kinds, created a disease environment that materialized the much-foretold collapse of civilization; ‘risk groups’ were the enemies within. (Wald 225-6)

Tying together the global transformation in U.S. nationalism *and* international travel and contact as a central feature of U.S. imperial influence, Wald shows how the AIDS epidemic turned into “an emblem of national pride” as well as a national threat of the spread of “racialized microbial hybridity” (Wald 241). It follows that the responsibility of the scientists is to isolate and identify the virus responsible for AIDS so that the pathologically deviant viral-human hybrid can be identified and isolated—isolation in the laboratory runs parallel to isolation in the quarantine. Wald’s next step is to connect hybridity to “the mythic features” of the outbreak narrative that legitimate the authority of scientific medicine. Myths

can reinforce or break down social borders. The outbreak narrative registers at once the tenacity and the porosity of national boundaries, among other social borders, and thereby manifests—and medicalizes—the tension of the changing spaces and social groupings of global modernity. Virology supplies a scientific vocabulary for the danger of hybridity. The most dangerous viruses are themselves frequently hybrids: the mutant strains produced when animal and human viruses recombine in animal hosts. In viral terms, hybridity is dangerous because it combines newness and familiarity; in their new incarnations, hybrid viruses can jump the species barrier (be ‘recognized’) and produce outbreaks of especially virulent and untreatable diseases. (Wald 260)

In outbreak narratives, humans themselves become viral-human hybrids due to the “invasion” of microbes into the human body.

In sharp contrast, for Latour, “hybrids” are what they are, not because they look like half-human, half-thing aliens, but because they begin as natural objects or artifacts and then transgress the boundary between nature and society to become mediators in the “assemblages of the social.” More specifically, “hybrids” refer to the products of the laboratory, such as viruses and microbes, that are experimental and fabricated facts not of “nature” but of “human construction” staged in the artificial setting of the science lab. Furthermore, rather than “matters of fact,” Latour argues that these “hybrid” products of scientific research, along with all the natural objects of traditional empiricism, are “matters of concern.” Therefore, to understand these complex hybrids, it is necessary

to learn how to feed off uncertainties, instead of deciding in advance what the furniture of the world would look like . . . . In ‘society’ we learned to distinguish the associations—which we kept—from a substance made of social stuff—which we rejected. Similarly, in ‘nature’ we are going to keep the deployment of reality and reject its premature unification into matters of fact . . . which are nothing more than a dumbed-down version of matters of concern. (Latour, *Reassembling the Social* 115)

In light of Latour, I argue that Wald demonstrates how the hybrid products of laboratory science—“viruses” and “microbes”—become transformed into “viral-human hybrids” in outbreak narratives, according to the deeply-held beliefs and values of the authors, filmmakers, scientists, and government officials. These hybrids are constructed factishes, not “matters of fact” but “matters of concern.” Along these lines, *Blindness* provides another contrast to “outbreak narratives” in that white-blindness does not turn people into alien hybrids of the disease. Instead, white-blindness is itself a hybrid: it’s both a disease (nature) and it infects

humans (society). As a potent mediator, it makes humans do things, and, in turn, the humans make others do things. Each individual human reacts differently to white-blindness; as with all diseases, each character has her own unique journey through illness. Latour explains that

every mediator along any chain of action is an individualized event because it is connected to many other individualized events . . . . [W]e are now interested in mediators *making* other mediators *do* things. ‘Making do’ is not the same thing as ‘causing’ or ‘doing’: there exists at the heart of it a duplication, a dislocation, a translation that modifies at once the whole argument. It was impossible before to connect an actor to what made it act, without being accused of ‘dominating’, ‘limiting’, or ‘enslaving’ it. This is no longer the case. The more *attachments* it has, the more it exists. And the more mediators there are the better. (Latour, *Reassembling the Social* 216-217)

In *Blindness*, human agency is distributed along the attachments that are both tied together and destroyed in the multiple transformations of white-blindness as a hybrid of nature and society. This agency is the opposite of that imposed on the viral-human hybrids in outbreak narratives, who become sinister “agents” dominated by microbial infestation.

According to Sandra Kumamoto Stanley in “The Excremental Gaze: Saramago’s *Blindness* and the Disintegration of the Panoptic Vision,” *Blindness* undercuts grand narratives—such as the outbreak narrative—as well as social hierarchies. In contrast to Camus’s victims, who die of the plague, Stanley argues

that Saramago uses the postapocalyptic narrative and body to comment on both the oppressive and liberating possibilities of the collective, as mediated through the excremental gaze of the plague. Despite the horror it brings, the plague of

blindness and filth, by collapsing socially constructed boundaries, undercuts the social hierarchies and grand narratives that may aid in segregating groups from one another . . . . [T]he plague ‘levels’ society, in its capacity as both destroyer and equalizer . . . . [Saramago] yearns for a postmetaphysical ethics that is based on an antifoundational foundation: one that affirms an intersubjective humanity, which honors the mutual recognition of the communal gaze but at the same time rejects the universal truth claims of grand narratives. (Stanley 295-6)

Stanley points out that while the first blind man is identified as Patient Zero, this knowledge provides no certainty about the mystery of white-blindness; instead, the communal reaction is far more important. Moreover, the first blind man is a representative member of bourgeois society, as are the others encamped in the quarantine, and together they form a new collective. When the entire society goes blind, while social differences were never very strong to begin with, they are leveled to a homogenous group, and “these social actors construct alternative communities as they anxiously survive in the space of the ‘negative.’” (Stanley 302). The doctor’s wife responds to this postapocalyptic necessity by forming a “fragile and contingent vision of social responsibility and morality” most influenced by the

“practice of everyday living,” in which the physical and metaphysical, the domestic and public are not separate, but interrelated, domains . . . . [S]he is in a world without order, with only chaos. The irony, however, is that the “gaze,” especially as a tool of surveillance, has been used as a means of protecting an order that perpetuates exclusionary practices, separating “here” and “there,” keeping the excluded, the contaminated, the impure from the privileged and pure. Despite the suffering it perpetuates, the plague, in collapsing social and economic

divisions, undermines exclusionary categories. The plague has blurred standard binaries between the doctor's wife and others, compelling her to rethink the ethical and "social space of 'being with.'" (Stanley 304)

As Stanley appreciates, *Blindness* narrates the hard work of assembling a common world without the guidance of any master narrative. In doing so, the novel dismantles the entire logic of "grand" or "master" narratives (such as the outbreak narrative), of which Latour is also critical.

In *Reassembling the Social*, Latour points out that "Master Narratives" erase the multiplicity, fragmentation, and little narratives involved in the political task of assembling the common world (189-190). Along these lines, I argue that *Blindness* challenges the master narrative composed about infectious diseases developed at the turn of the twentieth century that Latour critiques in *The Pasteurization of France*. There are two parts to this narrative: 1) Pasteur was the "great man" of science who first discovered the microbes that "cause" infectious diseases; and 2) infectious diseases can be eradicated from human society if the microbe that causes each disease can be isolated and identified in the scientific laboratory so that antimicrobial drugs can be produced and infected people can be isolated and treated with these antimicrobial agents. Latour critiques this master narrative because Pasteur was wholly dependent on the pre-existing, broad-based movement of hygienists and public health officials for the widespread acceptance of his strategy for the laboratory-based isolation of the microbial sources of infection and generation of vaccinations against these diseases. Rather than a great man of scientific discovery, Pasteur's "genius" lay in his strategic practice of recruiting allies to support his research, and then to claim

that everything he did proceeded from "Science." This double strategy bears the stamp of genius, for it amounts to translating the wishes of practically all the

social groups of the period, then getting those wishes to emanate from a body of pure research that did not even know it was applicable to or comprehensible by the very groups from which it came. The “application” became a miracle in the religious sense of the term. (Latour, *The Pasterurization of France* 71-72)

Latour traces the rapid, widespread adoption of this new “religious” belief in the elaborate system built by the French colonial empire.

He chooses the work of Alexander Emil Jean Yersin, a Swiss bacteriologist who worked from Paris for many decades as a research scientist, as a heroic medical figure who typifies “the subtlety and elegance of Pasteur’s style of action” (94). In Yersin’s influential article, “The Bubonic Plague at Hong Kong,” published in 1894 in the *Annales de l’Institute Pasteur*, Latour points out that there’s nothing original in the article; it’s simply one of many examples of how the “state defends its frontiers with soldiers against large-scale enemies and with doctors against small-scale ones” (Latour, *The Pasteurization of France* 95). In the article, Yersin studies an epidemic of bubonic plague in Hong Kong in May 1893 that is deadly to the population. Spreading from its endemic sites in the high plateaus of Yunnan along newly established commercial routes of the French colonial armies, Yersin is given the task of preventing the plague’s further spread from Hong Kong into Indochina. He sets up a temporary field laboratory in Yunnan province, where he follows a Pasteurian program to grow the culture medium necessary to propagate the plague bacillus. In his article summarizing his research findings, Yersin includes photographic proof of his “discovery” of the microbe that “causes” the bubonic plague (now known as “*Yersinia pestis*”). In these photographs, Latour explains:

It is all there. We can see the centers [of disease concentration] on the map of China; we can see the poor classes in their hovels; we can see the tumors on the

armpits of the sick; we can see the dead rats in the houses of the whites; but even better, we can see the curds along the wall of the [laboratory] tube. Certainty grows when the judgments of perception become simplified. The five [photographs] . . . show neither the Chinese nor the sores nor the dead nor the rats but [only] the colonies under the microscope. (Latour, *The Pasteurization of France* 98)

As demonstrated by Yersin's work, in Pasteur's master narrative, the scientist sees nothing but the microbe. As such, in Latourian terms, the disease of bubonic plague is constructed as a factish purified of everything that contributes to its spread. Following Pasteur's model, Yersin's sole focus is on developing a vaccine against the microbe. Latour elaborates,

Yersin was not involved in politics, he did not treat patients, he did not help the poor, he did not rebuild the drains, and he did not advise the European, yet he moved the positions of fleas, rats, colonial administrators, army doctors, Tonkinese, the poorer classes, and bacilli. (Latour, *The Pasteurization of France* 100)

Furthermore, Latour traces the new constellations of disease clusters and the public health responses in subsequent efforts to reassemble the social according to the Pasteurian grand narrative, no matter how ineffective these efforts were in the actual eradication of infectious disease from human society. While Wald does not refer to Latour's study, she argues that the "outbreak narrative" of the 1980s and 1990s is shaped by basic tenets of epidemiological science developed in the late nineteenth century. For Latour, Pasteur's master narrative has had enduring significance because of the active work of many actors to extend this narrative in their on-going, quotidian activities of social and scientific construction.

In *Blindness*, one of Saramago's most effective techniques for undermining master narratives is that there are deep layers of irony and double, even contradictory, meaning in almost every major statement in the novel. All key claims are refracted by multiple layers of meaning. Always, there is a literal, obvious meaning, which is usually undercut or redirected by a hall of echoes with secondary meanings; some meaning indicates a deeper truth and other meaning lays false traps. It can go both ways: The literal meaning can be the false trap and the ironic secondary meaning can be the actual truth, and vice versa. Two examples are especially telling. First, when the blind leave the asylum, they are terrified and unsure of where to go because, as the narrator remarks ironically,

there is no comparison between living in a rational labyrinth, which is by definition a mental asylum and venturing forth, without a guiding hand or a dog-leash, into the demented labyrinth of the city. (Saramago 217)

Second, when the doctor has regained his sightedness, he and his wife reflect on their nightmarish experiences. The doctor's wife asks him,

Why did we become blind, I don't know, perhaps one day we'll find out, Do you want me to tell you what I think, Yes, do, I don't think we did go blind, I think we are blind, Blind but seeing, Blind people who can see, but do not see. (Saramago 326)

Thus, to see is to be blind and to be blind is to see, and this adds an ironic twist to the next and final scene: The doctor's wife sees white and expects to go white-blind, and yet, when she can still see, there's a lingering uncertainty—since she can see, is she blind?

Saramago's technique of ironic layering of meaning is aptly summarized by Patrícia Vieira in "The Reason of Vision: Variations on Subjectivity in José Saramago's *Ensaio sobre a Cegueira (Blindness)*."

Even though the novel seems to propound a return to reason, this facile interpretation is thwarted by the narrative's questioning of the very meaning of thought. The luminous blindness portrayed in the text is presented as the point where reason and unreason intersect and the corporeal dimension of the plague of blindness that triggers the events in the novel further indicates a rejection of an abstract universal rationality and the recovery of the material individual who is exposed to the workings of ideology and of power . . . . Yet, it also opens the path for . . . the possibility of agency predicated on collective subjectivity. (Vieira 98)

Saramago's adroit play with language is an effective tool for narrating disease as a great equalizer when, as Vieira notes, universal blindness ends the panoptical control of the authorities and the "subject's subversion of domination" can only be fully achieved by isolated individuals at the level of the collective (Vieira 116).

In her analysis of Saramago's luminous blindness, Vieira addresses another central question about *Blindness*: Why does Saramago pose disease in the form of blindness—specifically, of white-blindness? While blindness is typically associated with darkness and the absence of color, leaving the essence of things unchanged, Vieira explains that white-blindness is an excess of brightness [that] precludes a straightforward articulation between the plague and unreason . . . . The novel postulates the existence of two kinds of light, or two modalities of the rational, namely the rationality of the blind and that of those who see, as the white luminosity seen by those afflicted by the plague of

blindness contrasts with the light of reason. A second divide arises between those who were already metaphorically blind when they still possessed the physical ability to see, and an equally metaphorical enlightened vision . . . . This proliferation of concrete and figurative light seems to indicate . . . a split within reason itself, which is one of the features of modernity inaugurated by the Enlightenment. (Vieira 102)

In other words, *Blindness* troubles the dichotomy between the Western hegemony of sightedness as a metaphor for knowledge, insight, and reason versus blindness as a metaphor for irrationality and the lack of insight. This ironic twist is immediately considered by the first blind man in his reflections that his strange condition belies thinking that

the darkness in which the blind live was nothing other than the simple absence of light, that what we call blindness was something that simply covered the appearance of beings and things, leaving them intact behind their black veil. Now, on the contrary, here he was, plunged into a whiteness so luminous, so total, that it swallowed up rather than absorbed, not just the colours, but the very things and beings, thus making them twice as invisible. (Saramago 6)

Actually, Vieira's presentation of Saramago's white-blindness as a blend between "reason" and "unreason" is similar to Michel Foucault's presentation of madness during the classical period of the Enlightenment. In *The History of Madness*, Foucault suggests that classical madness can best be described by the words "blindness," "unreason," and "reason dazzled."

Dazzlement is night at noon, the darkness that reigns at the heart of all that is excessive in the radiance of light. Dazzled reason opens its eyes to the sun and

sees nothing, i.e. it does not see, for in dazzlement . . . [a]t the very instant when objects disappear into light's secret night, sight sees itself at the moment of its disappearance . . . the madman sees the day, the same day that rational men see, as both live in the same light, but that when looking at that very light . . . he sees it as nothing but emptiness, night and nothingness. (Foucault 243)

In *Blindness*, Foucault's "dazzlement" and "unreason" become universal when everyone goes white-blind, and, in another ironic gesture, the disease is a path to deeper insight, rather than a form of madness. Thus, whereas the "healthy sighted" are passive intermediaries in the spread of the epidemic, the "diseased blind" are the ones who take action to mediate the effects of the pandemic.

In summary, I argue that by narrating disease as white-blindness, Saramago's novel challenges vision as a primary means of ontological reductionism in modernity. In his Introduction to the anthology, *Modernity and the Hegemony of Vision*, David Michael Levin argues that Foucault sees in the Enlightenment project constitutive of modernity an increasing tendency

toward conditions of totalization, normalization, and domination. If modernity is, as it seems, dominated by vision, earlier times may indeed have been ocularcentric; but the hegemony of vision at work in modernity is nevertheless historically distinctive, and functions in a very different way, for it is allied with all the forces of our advanced technologies. (Levin 7)

In the opening chapter to the anthology, "Light as a Metaphor for Truth," Hans Blumenberg shows the centrality of vision during the Enlightenment, in marked contrast to the Middle Ages.

Of primary concern to Blumenberg is the change from a “general medium of visibility” to “coerced vision” due to the occluding and distorting effects on light of modern technology.

The connection between vision and freedom is being dissociated. Due to the dominance of the prefabricated and of technologically pre-cast situations and aspects, the modern extension of sensory spheres has not become a source of freedom. [Instead] [t]he structure of this world of optical prefabrications and fixations of the gaze is once again approaching that of the ‘cave.’ (Blumenberg 54)

While Saramago troubles sightedness as “unreason,” a further irony in *Blindness* is that the character with the greatest insight is a “woman who can see”: the doctor’s wife never loses her traditional sight. And yet, her sightedness is not that of “coerced vision” controlled by a panoptical gaze and technology but the sightedness of being responsible for the well-being of others. Often, this sightedness depends on touch as a way of “seeing” the world. Such positively-engaged embodied forms of knowing are presented by Maurice Merleau-Ponty in *The Phenomenology of Perception*.

[E]ach sense organ interrogates the object in its own way, and . . . it is the agent of a certain type of synthesis . . . . Spatiality cannot be excluded from touch, in the sense of grasping coexistences. The very fact that genuine vision is prepared for through a transition phase and through a sort of touching with the eyes could not be understood if there were no quasi-spatial tactile fields into which the first visual perceptions could be inserted. (Merleau-Ponty 232)

In one culminating scene of her leadership, the doctor’s wife demonstrates how she is guided by her genuine vision of touch. She tells the other women,

Stay here, I'll be right back. She knew what she wanted, she did not know if she would find it. She needed a bucket or something that would serve the purpose, she wanted to fill it with water, even if fetid, even if polluted, she wanted to wash the corpse of the woman who had suffered from insomnia, to wipe away her own blood and the sperm of others, to deliver her purified to the earth, if it still makes sense to speak of the purity of the body in this asylum where we're living, for purity of the soul, as we know, is beyond everyone's reach. (Saramago 183-4).

In Saramago's deft shift—in narrating the doctor's silent thoughts-- from the past tense and third-person to the present tense and first-person, he includes his implied readers, also housed in the greater asylum of the modern world and also dependent on the body to guide the eyes in protecting and caring for one another.

### 3. To Purify or Hybridize: Reassembling the Social along Contested Borderlands in *Death with Interruptions*

*Death with Interruptions* is Saramago's existential rumination on death. He establishes the theme with two epigraphs:

We will know less and less what it means to be human. –Book of Predictions

If, for example, you were to think more deeply about death, then it would be truly strange if, in so doing, you did not encounter new images, new linguistic fields.

–Wittgenstein (Saramago, *Death with Interruptions* n. pag.)

Like *Blindness*, *Death with Interruptions* is a postmodern novel without closure: It begins on a day when no one dies, and months later, it ends on a day when no one dies; the mystery of

death's interruption is never solved. At the same time, the novel is written in realist style of narration. This realist style is realized in an experimental fashion, by Saramago's innovative technique of narration via a plural first-person narrator ("we"), who narrates what happens to the nation as a whole when death is suspended. At once collective and homodiegetic, this collective narrator is also reliable in recounting how a wide range of groups and characters are reassembling the social. For example, the narrator describes a meeting of the "maphia" organized to transport the dying across the national border.

At the precise moment when we [the narrator] entered the room, the debate was focused on how they could make optimum use of the work force that had been left idle since the return of death, and although there was no shortage of suggestions from around the table, some more radical than others, they ended up choosing one with a long proven track record and which would require no complicated mechanisms, namely, the protection business. (Saramago 130)

As can be seen in this example, the narrative follows the formation and activities of groups of people; even when the decisions of individuals are narrated, the significance is connected to the consequences for other actors. The narrator observes the bizarre and unexpected events from an intradiegetic position to offer commentary, often humorous and extensive. The focalization varies between this collective narrator and individual characters. The important point is that the narrative itself is constructed by the oligoptical gaze of an entire community that comes together to narrate as it experiences a social crisis—like a colony of ANTs that coalesces into a new group and recounts the story of how the social is reassembled when death is suspended.

In the second part of the novel, to narrate the private romance between death and the cellist, for the most part, this collective homodiegetic narrator recedes, only appearing

occasionally, while being supplemented by a traditional objective (extradiegetic and heterodiegetic) narrator. Here, focalization varies between external (narrator-focalization) and internal (character-focalization) filtered through the prism of the persona of death. In addition, Saramago shifts from past tense to the present or even the future tense. For example, when the cellist's violet-colored letter and death warrant is returned for the second time, the scene is rendered in extra- and heterodiegetic narration:

Poor death was clearly beside herself, distraught, and would soon start beating her head against the wall out of sheer distress. In all these thousands of centuries of continuous activity, there had never been a single operational failure, and now, just when she had introduced something new into the classic relationship between mortal and their one and only *causa mortis*, her hard-won reputation had been dealt the severest of blows. (Saramago 158)

In contrast, the third return of the cellist's death warrant moments later prompts an abrupt shift from past to present tense and a reappearance of the earlier collective first-person narrator:

Obviously, we have no reason to feel sorry for death. Our complaints have been far too numerous and far too justified for us to express for her a pity which at no moment in the past did she have the delicacy to show us . . . . Due to some strange optical phenomenon, real or virtual, death seems much smaller now, as if her bones had shrunk, or perhaps she was always like that, and it's our eyes, wide with fear, that make her look like a giant. Poor death. It makes us feel like going over and putting a hand on her shoulder and whispering a few words of sympathy in her ear. (Saramago 158 - 9)

With the collapse of the old divisions between the living and the dead as a result of the fantastic suspension of death, the first part of *Death with Interruption* tracks how the social is reconfigured in its wake. As an ANT, I follow the actions of the characters with their distributed agency to “make do” in response to the deconstruction of traditional social life with the proliferation of the dying. The networks that emerge are formed as much by the movements of the dying and their families as by the moves of the government, the church, and the medical authorities. Moreover, events show the fluidity of group formation and dissolution due to shifting alliances and disruptive interactions. As Latour explains,

By definition, action is dislocation. Action is borrowed, distributed, suggested, influenced, dominated, betrayed, translated. If an actor is said to be an actor-network, it is first of all to underline that it represents the major source of uncertainty about the origin of action . . . . It’s precisely because the social is not yet made that sociologists of associations . . . should paradoxically take all the uncertainties, hesitations, dislocations, and puzzlements as our foundation.

(Latour, *Reassembling the Social* 46-7)

*Death with Interruptions* is a fast-paced novel in which one thing always makes someone do something else new in a rapidly-changing, interlacing chain of events.

Much like *Blindness*, when *Death with Interruptions* opens at the stroke of midnight at the bedside of the dying queen, no background information about the characters is given, and the plot hinges on the suspension of death as a new mediator in the deconstruction of the social. But unlike in *Blindness*, where the tone is acerbic and the style tragic, in *Death with Interruptions*, the narrator maintains a mocking tone and comic style. By moving swiftly across the country to present society as a fluid assemblage of interconnected individuals and groups, the collective

homodiegetic narrator forms at the outset as a panoramic aggregate of various narrow oligoptical viewpoints. For example, after the prime minister delivers the first press release about the “crisis” that cannot be a crisis, the cardinal calls him on their private line and explains, “Without death, prime minister, without death there is no resurrection, and without resurrection there is no church” (Saramago 10). Considering the future, the prime minister asks,

What will the church do if no one ever dies again . . . Let me turn the question back on you, what will the state do, The state will try to survive, although I very much doubt it will, but . . . [w]hat will the pope say, If I were the pope . . . I would immediately issue a new thesis, that of death postponed. (Saramago 12)

Such conversations among powerful players are interspersed as the plot unfolds. Meanwhile, *en masse*, people are celebrating

a unique and marvelous life without the daily fear of parca’s creaking scissors, immortality in the land that gave us our being. (Saramago 14-15)

When a recently-widowed lady expresses her new joy about her own immortality by hanging the national flag out her balcony window, in less than forty-eight hours the “colors and symbols” of the flags are flapping throughout the country in celebration of their special status as a nation.

Among those opposed to the suspension of death are undertakers, who, like the prime minister and the cardinal, want death back. Alarmed, since they are

faced by the prospect of a catastrophic collapse from which no one in the funeral trade would escape, they called a general meeting . . . after heated discussions . . . [they] ran up against the indestructible wall of death’s refusal to collaborate. (Saramago 17)

Desperate to make up for their plummeting loss of business, they agree to petition the government to make obligatory the burial or cremation of all domestic animals, carried out by the funerary industry, and to give financial support to the industry for the transition from handling human corpses to animal ones (after, all, disposing of “a circus elephant or bathtub crocodile” presents unique challenges).

Because hospitals and nursing homes are overflowing with the dying, like undertakers, the directors and administrators of state-run and private hospitals and the “eventide” (nursing) homes petition the government with proposals about how to reassemble the traditional social. Given dire prospects of a future with the dying vastly outnumbering the healthy living, they propose

building from scratch vast new edifices . . . starting out with districts, then cities, then metropoli . . . cemeteries of the living where fatal and irrenunciabile old age will be cared for as god would have wanted. (Saramago 24)

For their part, the life insurance industry emerges triumphant in devising a “win-win” plan in response to the thousands of letters received in the first few days, “as if they had been copied from one draft” (Saramago 25), demanding renegotiation, or else cancellation, of policies. The industry leaders propose an addendum to the policies crafted by their lawyers.

[T]he companies would receive the premiums as normal until the date when the happy policy-holder celebrated his eightieth birthday, at which time, now that he . . . was virtually speaking, dead, he would be promptly paid in full sum . . . .

[C]ustomers could renew their contract for another eighty years, at the end of which they could register a second death. (Saramago 26-27)

Countering these conservative attempts to turn back the clock before fantastic immortality, “poor country folk” are the true leaders in the innovations to reassemble the social. The protagonists are the small family who live near the national border and respect their dying grandfather’s wishes to be carried across the border to die, as I detail below. What’s important here is that others quickly follow suit. When the government intervenes to stop the national border crossings, a “maphia” is formed that soon numbers in the hundreds of newly-employed. These conflicts between the government and this mass movement fill the next two chapters. In sum, the first half (roughly speaking) of the novel is divided between the first thirty-two pages of textual space that narrate the deconstruction of society and about thirty-five pages that narrate these conflicts over the reassembling of society. In between, there is one middle chapter devoted to the transport of the first hero and his dying infant grandson across the border. Thus, the conflicts over the borderlands are central to the plot of Saramago’s mysterious invention, the suspension of death, with the ironic twist that the common people have the solution to the social crisis and those in power are united in their opposition.

In the seventh chapter, almost midway through the book, the suspension of death suddenly ends. The director-general of television receives a violet-colored envelope in which the resumption of death is announced by a character who introduces herself as “death.” This marks a major contrast with *Blindness*, which abruptly ends with the spontaneous return of sightedness. In *Death with Interruptions*, substantial textual space narrates the “resumption” of traditional assemblages of the social, which are now clearly visible and not-to-be-taken-for-granted as they are reassembled. In addition, the novel shifts from its earlier focus on the collective plot of the cessation of death (and the resulting explosion of the population of mortally-ill on the brink of death) to the private romance between death and the cellist. Here, death’s metamorphosis into a

beautiful woman demonstrates why Latour borrowed the word “actant” from literary theory to replace solidity with uncertainty about group formation.

Because they deal with fiction, literary theorists have been much freer in their enquiries about figuration than any social scientist . . . . [F]or instance in a fable, the same actant can be made to act through the agency of a magic wand, a dwarf, a thought in the fair’s mind, or a knight killing two dozen dragons . . . . ANT has borrowed from narrative theories . . . their freedom of movement . . . to gain as much inventiveness as the actors they follow. (Latour, *Reassembling the Social* 55)

Saramago’s personified death is an extremely inventive figure from the moment she reveals herself as the agent behind the suspension of death to her departing gesture of burning her violet-colored death warrant to the cellist. When her ancient friend, the silent scythe, protests that she can’t change the date of the cellist’s death, death announces herself as a free agent in this fable. “That’s where you’re wrong, I have all the power and authority I need, I’m death, and never more so than from this day forward” (Saramago 184).

Having shown how the suspension of death “reassembles the social” in *Death with Interruptions*, I now offer my analysis of the novel as an allegory about the modern purification of death from the human condition<sup>23</sup> as a result of medical technology: The fable replicates the ontological condition of prolonged dying on the life-support machines of modern medicine for terminally ill people. This analysis has three parts: 1) an allegorical reading of the novel that

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<sup>23</sup> In *How We Die: Reflections on Life’s Final Chapter*, Sherwin B. Nuland emphasizes this aspect of today’s medical care. “Nowadays, the style is to hide death from view . . . Eighty percent of American deaths now occur in the hospital. The figure has gradually risen since 1949, when it was 50 percent . . . The solitary death is now so well recognized that our society has organized against it, and well we should . . . [T]he goal of each of [these efforts] is the same: a restoration of certainty that when the end is near, there will be at least this source of hope—that our last moments will be guided not by the bioengineers but by those who know who we are” (Nuland 254-5).

establishes parallels between Saramago's imaginary world and modern end-of-life medicine; 2) a Latourian approach to conflicting conceptions of temporality that underlie scientific medicine and end-of-life debates; and 3) additional points from Latour's *Laboratory Life* to better understand what's at stake with both laboratory science and *Death with Interruptions*.

First off, I concede that there is a tension in my allegorical interpretation of the novel. After all, Saramago pays scant attention to doctors and makes no mention of life-support technology as the means of prolonging death; instead, the suspension of death is magical and the magician is the skeletal figure, death. To be sure, Saramago defamiliarizes death by taking a short-cut past medical science straight to the existential situation of the suspension of human mortality. Nonetheless, there is a striking parallel between events in the novel and the quotidian events in Critical Care Units: At the moment of death—the heart has stopped beating and the lungs are no longer breathing—humans intervene to revive the person's life. And yet, parallel to Saramago's suspension of death, it's not that people stop dying and start living functional lives, again. Instead, in both the novel and the real world, the dying linger in a suspended state, in the former via magic and in the latter via the administration of life-support technology. In Saramago's fable, when the suspension of death ends, people simply die. In parallel, in the real world, at the decisive moment when life-support is withdrawn, the person simply dies, because their bodies are no longer supported by machines doing the breathing, the work of the kidneys, and administering the potent neurotransmitters to keep the heart beating and the vasculature toned to perfuse the vital organs. Suddenly, those present face the utter futility of medicine to regenerate life for the terminally-ill. As anti-realist fiction, *Death with Interruptions* satirizes the suspension of death as a mysterious condition that remains beyond reductive scientific

explanation, and this parallels the non-realistic pretense of reductive scientific medicine that presumes the human condition can be purified of death by life-support technology.

In offering an allegorical interpretation of *Death with Interruptions*, I do not assert that Saramago composed it to give its apparent sense the other, allegorical sense that I give it.

According to *The New Princeton Handbook of Poetic Terms*,

To interpret allegorically (“allegoresis”) is to explain a work as if there were an “other sense” to which it referred . . . . While interpretive allegory is implicit in the design of work composed allegorically, it is not limited to works intended to be allegorized. Allegoresis has a momentum of its own. (Brogan 7)

Accordingly, even though the novel makes no mention of the prolongation of dying via scientific medicine, there is strong textual evidence for my allegorical interpretation of Saramago’s suspension of death: 1) the main plot hinges on the conflicts over the borderland between the suspension of death and a normal death; 2) the device of two parallel dying grandfathers, one who is comatose and unable to express his thoughts or wishes to his family and the other who is fully conscious and directs his family concerning his dying process; and 3) the metamorphosis of death from a living-dead hybrid into a woman in love.

First, Saramago figures the national border as the geographical point of passage from the suspension of death to “normal” death. While and the main plot centers on the mass movement that develops to escape the suspension of death by crossing the border to die and the resistance to that movement. This may allegorically reference the broad-based “death with dignity” or “right to die” movement, which has developed since the 1980s to give patients the legal right and autonomy to die without medical intervention, including that of life support technology—a movement that initially met vehement and concerted resistance. In the fable, when death is

suspended, people quickly learn that by crossing the border, normal death occurs. Immediately, one dying grandfather asks his daughter to convince the entire family to carry him and his dying infant grandson across the border so they can die peacefully. Countering the daughter's objection that according to the doctor no one dies anymore, the grandfather asserts,

The doctor doesn't know what he's talking about, ever since the world was the world, there has always been an hour and a place to die, Not anymore, That's true, Calm down, papa, you'll make your fever worse. (Saramago 33)

Respecting the grandfather's wishes, the family carries him and the child across the border to die. With many others following their example, the national border, according to the narrator, now figures as a

new guillotine, whose blade, if you'll forgive the very free comparison, was the slender line of the frontier invisible to the naked eye, each vehicle carrying those poor unfortunates whom death, on this side of the line, had kept in a state of permanent dying. (Saramago 44)

Further, the dying "crossed the frontier, feet first so that the head would be aware of what was happening to the rest of the body" (64). The government in turn responds by closing the border, which then becomes an openly contested borderland between life and death, or between the grassroots demand for "death with dignity" in the mode of mass emigration in quest of the right to die, and the government's restriction of this movement. Saramago literalizes and magnifies the natural and dignified end of life as a national border that the terminally ill now have to travel across in order to obtain their natural right: the allegorical "other" sense of the end of life is this far out of reach—as distant as the national border—because natural death for the terminally ill has been made near-impossible by end-of-life technology.

In contrast, the second grandfather becomes the icon of those opposed to ending the suspension of death by border crossing. This camp has vocal spokespeople, both in positions of power and among the “popular movements that arose among the masses.” The narrator laments that since the human condition is fathomless but ponderable, it’s unfortunate that people adopt the attitude of certainty—of faith and belief. Such is the case during the first days of the suspension of death, when a daughter announces on television that her grandfather doesn’t die because he changed his mind, and millions agree. A large group comes together based on their conviction that with the simple application of will-power they, too, can conquer death and that the undeserved disappearance of so many people in the past could be put down solely to a deplorable weakness of the will. The second dying grandfather becomes the icon of the mass movements of “mistaken interpretations.” According to the narrator,

[a]s far as anyone knows, no particular importance would be given to the fact that grandpa remained in a state of profound coma, which everything seems to indicate is irreversible. (Saramago 6)

Representing the opposing factions in the conflicts over the border crossings, the two dying grandfathers are allegorical personifications of spokespersons for and against end-of-life medical intervention with life-support technology. Especially striking is the accuracy of the parallel between Saramago’s fictional world and the medical reality outside the text: In both worlds, when the dying can express their wishes, often, they choose the border crossing, but when they are unconscious, making decisions becomes much more complicated because of conflicting beliefs and concerns among their relatives. The murky waters of end-of-life decision-making further substantiate two prongs of Latour’s thinking that this dissertation addresses throughout:

1) beliefs have autonomous agency in the real world and 2) “matters of fact” are actually “matters of concern.”

The metamorphosis of death into a beautiful woman provides further textual evidence for my argument about *Death with Interruptions* as an allegory of end-of-life medicine. In figuring out that she has the choice between continuing to exist as a living-dead hybrid or to accepting the gifts of love as a beautiful woman, death is given a choice between death and life that echoes the life-or-death choices confronted by two grandfathers. Granted, the existential condition of death is at some distance from the terminal illness of the grandfathers, but herein lies the secret to the allegory: Death stops and asks herself what has she gained from “thousands of centuries” as a living-dead hybrid but endless loneliness and misery. So, too, patients and/or families come to moments of realization when they ask themselves, what has been gained from being entrapped between life (society) and death (nature), as a hybrid connected to machines, but endless suffering.

What is at stake here is aptly explained by the physician and professor of medicine, Sherwin B. Nuland in *How We Die: Reflections on Life's Final Chapter*. In summarizing the lessons he has learned, usually from his mistakes and from decades of surgical practice, Nuland explains that one promise health care providers can keep to patients is they won't die alone, a promise that cannot be kept if the knowledge of death's certainty is withheld.

Unless we are aware that we are dying and so far as possible know the conditions of our death, we cannot share any sort of final consummation with those who love us. Without this consummation, no matter their presence at the hour of passing, we will remain unattended and isolated. For it is the promise of spiritual

companionship near the end that gives us hope, much more than does the mere offsetting of the fear of being physically without anyone. (Nuland 243)

After recounting a story about an old woman who wanted to die but accepted aggressive medical intervention at Nuland's insistent medical advice, much to his later regret, he extends her experience to that of others kept alive on life-support machines.

The beeping and squealing monitors, the hissings of respirators and pistoned mattresses, the flashing multicolored electronic signals—the whole technological panoply is background for the tactics by which we are deprived of the tranquillity we have every right to hope for, and separated from those few who would not let us die alone. By such means, biotechnology created to provide hope serves actually to take it away, and to leave our survivors bereft of the unshattered final memories that rightly belong to those who sit nearby as our days draw to a close. (Nuland 254)

These problems with critical care medicine are allegorized in the moment in *Death with Interruptions* when death is mystified by her power to suspend death even though she is powerless to do much more. When the cellist's death warrant is mysteriously returned to her, death contemplates that the cellist is

[i]nfringing on the harshest of nature's laws, the law that imposes on us both life and death, which did not ask if you wanted to live, and which will not ask if you want to die. This man is dead, she thought, all those being doomed to die are already dead, all it takes is for me to flick them lightly with my thumb or to send them a violet-colored letter that they cannot refuse. (Saramago 171)

Deeply torn by her new longings and confusion since her secret visit to observe the cellist and his dog, death resumes her skeletal form to study the volume of death's ordinances. Now more sympathetic to the dead and the living, death studies the cellist's card kept in the "archives updated over millennia" to record births and deaths (180). Inexplicably, the cellist has outlived the predicted date of his death, as stated on his card. Further confounding her belief in the infallibility of these archives and "nature's laws," from her secret observations of the cellist, she realizes that to be alive is not to be "already dead." By acknowledging the hubris of her belief in power that she never had, death is able to act on the power she does have: to live a life of love rather than one condemned to an existence of solitary seclusion as the skeletal harbinger of death. Ultimately, she figures out that her hope is to exchange her lonely isolation for a loving relation with the cellist. Likewise, I argue that in the real world of end-of-life medicine, by facing impending death uninterrupted by intervention with life support technology, we exchange a lonely death of solitary confinement for death surrounded by those we love.

In more general terms, my allegorical reading is based on central concepts in *We Have Never Been Modern*. Latour stresses that according to the "modern Constitution," a sharp division is maintained between purification and hybridization. Along similar lines, I argue that with life-support technology, hybridization becomes the hoped-for means of the purification of death from life. In short, when the terminally-ill are kept alive on life-support technology, they become living-dying hybrids under the scientific pretense of the agency to regenerate new life, and to do so indefinitely by always putting off the moment of death. The confusion of the personified character of death about her powers over life, thus allegorizes the quandary presented by modern science and technology when health care providers, patients, and families are faced with the essential question: Are we prolonging "life" *or* are we prolonging "death"? I argue that

the pretense of having the capacity to regenerate life is founded on the revolutionary notion of temporality of the moderns: empowered by scientific hybrids, humans can make a revolutionary break with death. Latour points out that the modern form of temporality as irreversible rupture with the past and new birth is actually founded on scientific innovation and the proliferation of nonhuman hybrids. Based on the official modern view,

the history of the moderns will be punctuated owing to the emergence of the nonhumans—the Pythagorean theorem, heliocentrism, the laws of gravity, the steam engine, Lavoisier’s chemistry, Pasteur’s vaccination, the atom bomb, the computer—and on each occasion time will be reckoned starting from these miraculous beginnings, secularizing each incarnation in the history of transcendent sciences . . . . The present is outlined by a series of radical breaks, revolutions, which constitute so many irreversible ratchets . . . [O]n to this line . . . the moderns . . . project the multiplication of quasi-objects and . . . will trace two series of irreversible advances: one upward, toward progress, and the other downward, toward decadence. (Latour, *We Have Never Been Modern* 71-2)

The modern advance toward progress through revolutionary breaks with the past is integral to reductive scientific medicine. *In Writing at the Margin: Discourse Between Anthropology and Medicine*, Arthur Kleinman argues that

[b]iomedicine instantiates the Western tradition’s idea of progress. The profession’s self-portrait is of a scientific, technological program that is continuously progressing in acquisition of knowledge and especially in deployment of powerful therapeutic operations. Even in spite of limited progress over the past decade in the treatment of the chronic diseases . . . biomedicine’s

self-image emphasizes awesome technological capacity . . . . [L]ife-support systems even ‘prevent’ death. It is not surprising, then, that therapeutic hubris is commonplace. Physicians are not educated to feel humble in the face of sources of suffering that cannot be reversed or to place limits on the utilization of powerful technologies. (Kleinman 34)

Latour critiques the revolutionary idea of progressive time via scientific advancement. According to his alternative “nonmodern” view, actually the world

permits scarcely anything more than small extensions of practices, slight accelerations in the circulation of knowledge, a tiny extension of societies, minuscule increases in the number of actors, small modifications of old beliefs. When we see them as networks, Western innovations remain recognizable and important, but they no longer suffice as the stuff of saga, a vast saga of radical rupture, fatal destiny, irreversible good or bad fortune . . . . Another field—much broader, much less polemical—has opened up before us: the field of nonmodern worlds. (Latour, *We Have Never Been Modern* 48)

*Death with Interruptions* is a comic parody about these “small” changes that humans can make when people journey across the national border to die and when death chooses a life of love over a perpetual state of death.

I conclude with further reflections on the scope of my allegorical interpretation of *Death with Interruptions* as a fable about end-of-life medicine. In this regard, I’d like to distinguish my own concerns about life-support medicine from Agamben’s. According to Agamben, modern medical technology is a symptom of the “politicization of death”:

The hospital room in which the neomort, the overcomatose person, and the faux vivant waver between life and death delimits a space of exception in which a purely bare life entirely controlled by man and his technology, appears for the first time. And since it is precisely a question not of a natural life but of an extreme embodiment of *homo sacer* (the comatose person has been defined as an intermediary being between man and an animal), what is at stake is, once again, the definition of a life that may be killed without the commission of homicide (and, that is, like *homo sacer*, ‘unsacrificeable,’ in the sense that it obviously could not be put to death following a death sentence). (Agamben 164-5)

For Agamben, end-of-life medicine is another instance of modern encampment—“the fundamental biopolitical paradigm of the West” (181)—that produces its own variety of bare life—life that is “devoid of value” (139). He explains,

Karen Quinlan’s body is really only anatomy in motion, a set of functions whose purpose is no longer the life of an organism. Her life is maintained only by means of life-support technology and by virtue of a legal decision . . . . A law that seeks to decide on life is embodied in a life that coincides with death. (Agamben 186)

But in fact, Agamben’s analogy hinges on the equation of “being killed” with “not being allowed to die.” Countering Agamben, I insist that the gap between “being killed” and “not being allowed to die” is too significant to be elided, and that Agamben’s conflation of modern scientific medicine with “encampment” as a generic term indicating commonality with the concentration camps of the modern state is problematic. The good news is that Agamben’s flawed analogy affords a fresh look at parallels between *Blindness* and *Death with Interruptions*. But its fallacies also measure the distance between the state quarantine of the white-blind in the first novel

(whose purpose is killing) and the interruption of death in the present case (whose gist is not being let to die). Instead, the problems posed by modern medicine are problems common to the proliferation of scientific hybrids in the modern world, as Latour elaborates. With the development of medical technology, health care providers, patients, and families are confronted by entirely new decisions about medical care. And, it takes awhile for humans to figure out what these powerful new nonhuman actants are doing and to decide what to do in response to their introduction into the world of health care.

On this note, some additional points are in order about the problems of the proliferation of scientific hybrids exemplified by medical technology. In *Laboratory Life*, Bruno Latour and Steve Woolgar show how scientists rely on “inscription devices” to translate the collated data of “laboratory life” into obscure charts, graphs, and waveforms that are used to generate scientific knowledge according to a refined semiotic system known only to the very few highly-trained specialists in each particular research field. According to Latour and Woolgar,

Our argument is not that facts are not real, nor that they are merely artificial. Our argument is not just that facts are socially constructed. We also wish to show that the process of construction involves the use of certain devices whereby all traces of production are made extremely difficult to detect. (Latour and Woolgar 176)

The next step shows how scientific hybrids go from this obscure world of the laboratory to become the “facts” of ordinary life.

A fact is a fact, one could say, because it works when you apply it outside science . . . . [However] [i]n no instance did we observe the independent verification of a statement produced in the laboratory. Instead, we observed the extension of some

laboratory practices to other arenas of social reality, such as hospitals and industry. (Latour and Woolgar 182)

Latour and Woolgar's comments gloss how the extension of laboratory practices to health care facilities involves the development of an extensive system of "inscription devices" for use outside the laboratory to reproduce the facts constructed in the laboratory. Such devices are necessary mediators in the application of scientific hybrids produced in the lab, such as potent neurotransmitters like norepinephrine and dopamine, to living human beings. Reading these inscription devices and interpreting the semiotic meaning of the waveforms and numbers is a highly-complex form of specialized exegesis that requires fully-trained and experienced health care providers.

Unfortunately, in making medical decisions, the work of hybridization and purification goes hand-in-hand: Patients are purified of their life stories in their reduction to scientific objects by the nosological gaze. When medical providers look at the multiple numbers, waves, graphs, and images, they form a view of the organism according to medical purification that hybridizes patients as dependent intermediaries of scientific technologies. A vital step is often missing: the translation of the semiotics of medical technology into plain, ordinary words so that patients and their families are the ones making the decisions regarding the application of high-tech medicine. Here, Latour's argument that matters of facts are actually shaped by matters of concern is particularly relevant. The precise translation of the semiotic "facts" produced by medical technologies are made according to the beliefs of health care providers about life and death issues and values. *Even the language of explanations given to patients and their families about the meaning of these facts is clarified or clouded by these concerns.*

End-of-life medical practitioner Nuland elucidates how the concerns and beliefs of medical providers affect their clinical advice to patients and families. Foremost, with the astounding advancements in the technological capacities of late-twentieth century medicine, the challenge for doctors is the intellectual pursuit of a diagnosis and a cure—which Nuland dubs, “The Riddle.” To account for why physicians encourage “patients to undergo diagnostic or therapeutic measures at a point in illness so far beyond reason that The Riddle might better have remained unsolved” (Nuland 249), Nuland points to studies that indicate that

medicine is the [profession] most likely to attract people with high personal anxieties about dying. We become doctors because our ability to cure gives us power over the death of which we are so afraid . . . . Every time a patient dies, his doctor is reminded that his own and mankind’s control over natural forces is limited and will always remain so . . . . The greater humility that should have come with greater [scientific] knowledge is instead replaced by medical hubris: Since we can do so much, there is no limit to what should be attempted—*today*, and for *this patient!* (Nuland 258-9)

In accordance with Nuland, *Death with Interruptions* challenges reductive scientific medicine. This is precisely because Saramago bypasses the special problems of medicine to get right to the existential condition of human mortality. Much of the fable is devoted to meandering conversations among various players as they puzzle over matters of life and death. For example, the germinal conversation between the “spirit of dignity” and the “apprentice philosopher” begins at the moment when a goldfish rises from the dirty water of its aquarium that the philosopher has neglected to change, to gasp for air. As the narrator explains,

the most impassioned and thrilling controversy ever known in the whole history of this country where no one dies . . . [is started when] the spirit [of dignity] hovering over the water of the aquarium asked the apprentice philosopher, Have you ever wondered if death is the same for all living beings, be they animals, human beings included, or plants . . . will the death that kills a man who knows he's going to die be the same as that of a horse who never will. (Saramago 75)

Having neglected to tend to the ontological conditions necessary to sustain the life of the goldfish, the apprentice philosopher learns from the spirit of dignity to question the hubris of epistemology in philosophy's failure—even its inability—to adequately contemplate “another death, the last, supreme death that will destroy the universe, the one that really deserves the name of death . . . [the other, natural deaths] are nothing but tiny, insignificant details” (Saramago 77). In the interlude of this conversation, a spirit—that of dignity—attempts to restore to philosophy what is lost to humans in the modern world. Saramago's strength is his capacity to explore mysteries without the expectation of their resolution. Instead, in appreciation of the hubris of human knowledge, the enduring message of the book is to chuckle at ourselves as often as possible and to proceed with caution, always—and, I add, especially when end-of-life decisions are made. While technological hybrids complicate these decisions, the challenge is to follow Saramago's example and bypass the science to get right to the patients and their families. *What do they want? What matters to them?* After all, end-of-life health care providers are merely the maphia, responsible for carrying people safely across the borderlands to death.

#### 4. Conclusion

Both white-blindness and the suspension of death precipitate social crises of accelerating chaos and destruction. I have shown how Latour's sociology of associations and ANT contribute to understanding Saramago's inventions of white-blindness and the suspension of death as "factishes" on the plane of flat ontology and distributed agency in the nonmodern world. Conversely, *Blindness* and *Death with Interruptions* exemplify what Latour calls "good accounts" of "reassembling the social"—accounts that themselves do well at "performing the social." Furthermore, Saramago's novels contribute to the on-going work of the composition of narratives of illness and health and death and dying and of modern war. These contributions are complementary: In the fabulous imaginary worlds of his fiction, Saramago has the liberty to invent new possibilities and take down the old things that get in the way, even as he resuscitates much of what has been threatened and even lost in modernity. In both books, the social is reassembled to reveal the corruption of the old world and to indicate new collective assemblages amidst disintegration and chaos. Perhaps most inspiring, the heroines and heroes in the fables are authentic: they are leaders, not because they have answers but because they are inventive and compassionate on collective journeys through treacherous territory.

## Conclusion

Beginning with the power of narratives, I have deployed a wide variety of methodologies to investigate nonfictional and fictional representations of illness, death, and survivorship in modern war. To draw this dissertation to a close, I am ending with promising questions for further study that will tend to areas that have been overlooked and to new lines of inquiry. In the following, I indicate three broad directions for such study.

First, I hope that the contributions this dissertation makes to the on-going critique of modern medicine, in particular of Evidence-Based Medicine and the (mis)application of medical technologies of warfare to civilian life, exemplify the bridge-building necessary to elaborate an alternative model for medicine and for nursing. To continue my work on the power of narratives, of particular interest is how fiction can supersede the boundaries of individual illness pathographies to narrate the tragedies of war: How can literary experiments with representations of subjectivity bridge the separations between the self and others to narrate wartime suffering and forge shared instruments for healing and reparation? In particular, I am interested in the aesthetic creativity of survivors to express their profound insights about the crippling and suicidal effects of grief and melancholia.

To study these experiments in fictional representation, one project is to explore literature that has been overlooked. For example, from the modernist burst of aesthetic activity after World War I surrounding shell shock, promising novels include *The Unpleasantness at the Bellona Club* (1929) by Dorothy L. Sayers and *Her Privates We* (1930) by Frederic Manning. *A Fable* (1950) is William Faulkner's long-overlooked allegorical novel about shell shock among mutinous soldiers in the trenches of France during World War I. Since the United States war

against Vietnam, experimental fiction holds particular promise. One instance is *House Made of Dawn*, a novel in which N. Scott Momaday blends traditions of oral storytelling with modernist techniques of writing to express the grief of the Native American protagonist about the European invasion of the Americas compounded by the long-term psychological effects of fighting as a U.S. soldier in WWII and by alcoholism. Demonstrating the “world-historical” nature of this project of gathering literature about war and medicine, *A Constellation of Vital Phenomena* (2013) is a novel about the Russian war against Chechnya in which a doctor becomes personally implicated in the refugee crisis of the war. In *The Mehlis Report* (2012), Rabee Jaber writes a complex war thriller about the collective psychological effects of living in a permanent state of warfare in civilian Lebanon.

In addition to literary experiments in fiction, much like Vera Brittain’s *Testament of Youth* in this dissertation, several first-personal memoirs about war and its suffering deserve inclusion in further research. While I have not found novels to complement *Sparta* as fictional representations of the U.S. war in Iraq and Afghanistan, there are many memoirs of the war by returning soldiers. Of particular note, in *Road From Ar Ramadi: The Private Rebellion of Staff Sergeant Camilo Mejía*, the author points to the direct links between the psychological suffering and the moral concerns of soldiers suffering from PTSD. Even as I am interested in such exceptional memoirs written from the side of the invading and occupying military, I am especially interested in memoirs from the “other side” of the war. For example, Qais Akbar Omar shares his memories of his family’s repeated displacements by war at the turn of the twenty-first century in *A Fort of Nine Towers: An Afghan Family Story* (2013).

To complement the power of narratives, further studies in the phenomenology of illness are integral to the development of an alternative model for medicine and nursing. To provide an

umbrella for this model, I suggest that the works of many “old-timers” need to be reexamined. For example, the writings of Kurt Goldsmith and Georges Canguilhem and, more recently, of Richard Zaner, Hans-Georg Gadamer, and James Aho and Kevin Aho offer rich fields for germinating fresh ideas based on their deep erudition. This dissertation asks the question, what are fruitful ways to put these phenomenologists in conversation with leading innovators in systems thinking about life, such as Fritjof Capra, Richard Lewontin, and Richard Levins. Along these lines, one of my immediate projects is to revisit Maurice Merleau-Ponty’s *Phenomenology of Perception* in light of Hubert R. Maturana and Francisco J. Varela’s *Autopoiesis and Cognition: The Realization of the Living*. Based on this research, I hope to expand my “new version of PTSD” begun in Chapter 2 of this dissertation so as to engage a host of related considerations about the embodied mind, structural coupling, and the creation of higher order from the chaotic disequilibrium of mental illness and social crisis.

The second direction for further study is indicated by a recurring question in my dissertation: How to replace hierarchies of domination over others with another kind of power: the distributed agency to collectively learn “to see” the world in new ways? Even as asking this question is requisite for a new model for medicine and nursing, more generally, it supports a transition from ocularcentric and anthropocentric ecology to the alternative systems thinking envisioned by Fritjof Capra as “deep ecology.” Capra presents this paradigm shift as

a new scientific understanding of life at all levels of living systems—organisms, social systems, and ecosystems. It is based on a new perception of reality that has profound implications not only for science and philosophy, but also for business, politics, health care, education, and everyday life. (Capra 3)

To create a new understanding of life, the important concept of the network offers fresh perspective on the organization of natural hierarchies in a complex “web of life;” if this system is dissected, the properties are destroyed. As Capra explains,

[t]he great shock of twentieth-century science has been that systems cannot be understood by analysis. The properties of the parts are not intrinsic properties but can be understood only within the context of the large whole. Thus the relationship between the parts and the whole have been reversed. In the systems approach the properties of the parts can be understood only from the organization of the whole. Accordingly, systems thinking concentrates not on basic building blocks, but on basic principles of organization. (Capra 29-30)

In *Order Out of Chaos*, Ilya Prigogine and Isabelle Stengers share their research on these principles of organization more specifically in dissipative structures in living systems. While Prigogine and Stengers study chemical structures, their work has been extended to considerations about the “structural coupling” that constitutes the dissipative structures of life, in general. This general approach to systems thinking next needs to be applied in detail to work out the promised changes in health care. Broadly speaking, one question raised by my dissertation is, how can survivors create higher forms of order out of the chaotic destruction of warfare? To generate variegated responses to this question, I will turn to additional studies in systems thinking and deep ecology, such as that offered by Lynn Margulis, Dorion Sagan, and Niles Eldredge in *What is Life?* (1995) and by Isabelle Stengers and Robert Bononno in *Cosmopolitics I* and *Cosmopolitics II*.

The third direction for further study is indicated by my work in all three chapters, where, as a Latourian scholar, I investigate the value of illness narratives to represent relations of

geographic scale in tracing hybrid global networks across distances and segregated domains. One broad question I ask is, given that, as Farmer and others argue, disease is inseparable from global social, economic, and political inequalities, how do illness narratives trace the networks and connectivity between local and global? The innovative work of many scholars is relevant to pursuing answers to this question. To invent new ways to talk about the local/global, in “A Global Sense of Place,” Doreen Massey proposes a shift from geographies of place in self-contained, static, and bounded centers to de-centered localities inserted into trans-local networks and flows. To move from the enclosure of “inside/outside” in parochial localisms, she presents the g/local “here” as entwined with the global “elsewhere.” According to Massey,

[W]hat gives a place its specificity is . . . that it is constructed out of a particular constellation of social relations, meeting and weaving together at a particular locus . . . . It is, indeed, a meeting place. Instead then, of thinking of places as areas with boundaries around, they can be imagined as articulated moments in networks of social relations . . . . [T]he point is that there are real relations with real content—economic, political, cultural—between any local place and the wider world in which it is set. (Massey 154-5)

In short, the task is to jump from one geographic scale to another to interconnect the local with the national and the global.

Two exemplary texts that narrate Massey’s concept of a “global sense of place” are *What Is the What* by Dave Eggers and *Rings of Saturn* by W.G. Sebald. One question to ask about both narratives is, to what extent do the respective settings—of the escape on foot from civil war of the “lost boys of the Sudan” and Sebald’s narrative of a walking tour in England—illuminate transnational sites and de-centered places? For instance, these texts bridge disruptions in

geographical place, on the one hand, and war, disease, and extermination, on the other, to make visible connections between the local and global. In *What is the What*, the refugee crisis precipitated by a geopolitical war waged in one locale is experienced as a plague of starvation, dehydration, disease, and violence narrated through the internal dialogue of the central African protagonist. Based on his trans-global dislocation, he is able to connect the psychological effects of high-level warfare in central Africa to the mental suffering caused by the low-level warfare endemic to the lives of black men in the United States. Indeed, this novel is a telling example of an “illness narrative” that extends the boundaries of individual pathography to the collective crises of modernity. Moreover, the novel experiments with the challenges to represent the “routes” that map the diaspora of an entire population “uprooted” by war, in the parlance of James Clifford’s assessment of new anthropological challenges in the late twentieth century.

Diaspora discourse articulates, or bends together, both roots and routes to construct what Gilroy (1987) describes as alternate public spheres, forms of community consciousness and solidarity that maintain identifications outside the national time/space in order to live inside, with a difference. (Clifford 251)

In particular, in his internal dialogue, the protagonist of *What is the What* expresses the diasporic language that, according to Clifford, “gives a strengthened spatial/historical content to older mediating concepts such as W.E.B. Du Bois’s notion of ‘double consciousness’” (Clifford 255).

Furthermore, the repeated breaks in the narrative between the past and present and distant places and the current locale debunk the myth of the “imagined community” of the nation-state. In *Imagined Communities*, Benedict Anderson examines the underpinnings to this myth in

an idea of ‘homogenous, empty time,’ in which simultaneity is, as it were, transverse, cross-time, marked not by prefiguring and fulfilment, but by temporal coincidence, and measured by clock and calendar. (Anderson 24)

In sharp contrast, in *What is the What*, diaspora “communities” appear as collective formations of disparate people oftentimes desperate to find places of safety and hiding during violent and tumultuous times, when, clearly, there’s no such time as “empty, homogenous time.” Moreover, the protagonist of the novel challenges the “invisibility” of the Sudanese war refugees to the dominant communities in the nations where they relocate. Mary Louise Pratt understands such invisibility from the perspective of “contact zones” as a way of understanding

how social bonds operate across lines of difference, hierarchy, and unshared or conflicting assumptions. Such an approach would consider how differences and hierarchies are produced in and through contact across such lines . . . . [T]he ‘invisibility’ of colonized and subaltern groups to the consciousness of the dominant group would be understood not as what it declares itself to be, that is, invisibility . . . but as a form of copresence . . . . Invisibility names the subaltern’s presence for the dominant party. (Pratt 88)

Often, in *What is the What*, starvation, dehydration, exposure to the elements, disease, and death are narrated as profoundly life-altering, in similar fashion to how pathographies, in general, narrate the erasures of personal identity and drastic shifts in time of life-altering illnesses. Indeed, there are many parallels to explore between the diaspora communities of war and diaspora communities among the ill; in particular, of the power of narrative to make visible the invisible and to reimagine communities.

*Rings of Saturn* is of especial interest because of Sebald's Neobaroque techniques of narration. In my original plan for this dissertation, I intended to examine the Baroque/Neobaroque/New World Baroque as a mode that counters the modern logic of dualism and rupture and that constructs interconnections between supposedly segregated realms. While I was unable to accomplish this, a central concern for my future work is to study how the innovative narrative techniques of Baroque/Neobaroque/New World Baroque literature reveal hidden historical continuities between illness and health; war and survivorship; the local and the global; and past and present. To highlight this potential, I want to briefly mention Sebald's resuscitation of the seventeenth century Baroque melancholic scholar in the figure of the late twentieth century melancholic narrator in *Rings of Saturn*. This narrator recovers Sir Thomas Browne's seventeenth century "quincunx" model as the blueprint for his treatment of the dark side of modernity with its colonial expansion, wars, and environmental devastation. In addition, he adopts Browne's bird's eye view to connect distinct yet distant sites—separated by both time and space—to reveal hidden historical continuities. In particular, I am interested in Sebald's alternative approach to melancholia and grief, with its sharp contrast to reductive biomedical science that isolates mental suffering from the tragedies of real-world events and traumatic loss.

Another, related question is, how could Baroque/Neobaroque/New World Baroque aesthetics contribute to the above-mentioned project of creating a new understanding of life? This question is grounded in scientists' increasing appreciation of the metaphorical nature of scientific language. For example, in the opening lines to *The Triple Helix: Gene, Organism, and Environment*, Richard Lewontin says

It is not possible to do the work of science without using a language that is filled with metaphors. Virtually the entire body of modern science is an attempt to

explain phenomena that cannot be experienced directly by human beings, by reference to forces and processes that we cannot perceive directly. (Lewontin 3)

As an aesthetic mode of “more is more,” the Baroque/Neobaroque/New World Baroque abounds with metaphors, such as “metaphysical conceits,” that are rich with promise for science. Indeed, these might be the metaphors needed to replace current medical metaphors, ranging from infectious “secret agents” and microbial “foreign invaders” to cancer-causing “mutants” and the suppression of “T-killer cells.” Furthermore, the critique of modernity presented from multiple perspectives in this dissertation is founded on a rejection of Cartesian philosophy and science. As a contemporary of Descartes, Sir Thomas Browne subscribed to an alternative worldview of interconnectivity in pattern, structure, and process among all forms of life and even among the non-living. There is a striking similarity between Browne’s quincunx model of connectivity for the entire universe, which merits explicit analysis, and many of the ideas in contemporary considerations about a new understanding of life. Along these lines, in *Looking for Spinoza: Joy, Sorrow, and the Feeling Brain*, neuroscientist Antonio Damasio recalls the Baroque refusal to separate mind and body and humans and nature to instead integrate the body and mind, thought and emotion, the individual and evolution, and nature and society.

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