Stylistics as a bridge between literature and medicine:
Embedded focalizers in the nonfictional narrative of *Brain on Fire*

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0. Introduction

In Narrative Medicine the 'unpractical' skill of reading literature is employed for the 'practical' purpose of curing patients. The aim of the current study is to examine how stylistics can contribute to this interdisciplinary field. First, I will explain the essence of Rita Charon's narrative competence training targeted at medical students. According to Charon et al. (2017), the first step of Narrative Medicine is *attention*, in which a doctor learns to pay attention to a patient's words, facial expressions, attitudes, and so on, to elicit potential messages. As an exercise oriented towards this skill, close reading of literary texts is conducted in the classroom. However, there is no reference to stylistics, which shares its principles and aims with close reading, and should have the same pedagogical effect. In this study, I will consider why stylistics is 'excluded' and then consider the potential of stylistics in Narrative Medicine. Finally, I will conduct a stylistic and narratological textual analysis of Susannah Cahalan's non-fictional illness narrative, *Brain on Fire* (2012), by focusing on the presence of embedded focalizers in the character-narrator's single voice, and consider whether and to what extent the language awareness developed by reading and analysing literature can help us to understand an illness narrative and the narrator (=patient) accurately and deeply.

1. Aims and research questions

Medicine is said to consist of both science and art (Charon et al. 2017; Obika et al. 2019). Science has developed so dramatically that it is now regarded as almost self-sufficient. While science is indeed significant, however, individual treatments based on art have still much to offer patients. Therefore, a more patient-centred medicine is needed, where doctors pay as much detailed attention as possible to patients' needs. One approach oriented toward this goal is Narrative Medicine. This study considers the narrative competence training conducted for future practitioners of Narrative Medicine, which has mainly used close reading of literature. Although this is a sound policy, there is some room to improve the methods.

Against this medical and academic background, the current study aims to reconsider the methods of Narrative Medicine, by examining how stylistics can contribute in this field, setting the specific research questions as follows:

1. What are the similarities and differences between close reading and stylistics?
2. Can stylistic analysis help to better understand an illness narrative and the narrator (=patient)?
3. Can the stylistic analysis of illness narratives help to better understand literary texts?

2. Narrative competence training

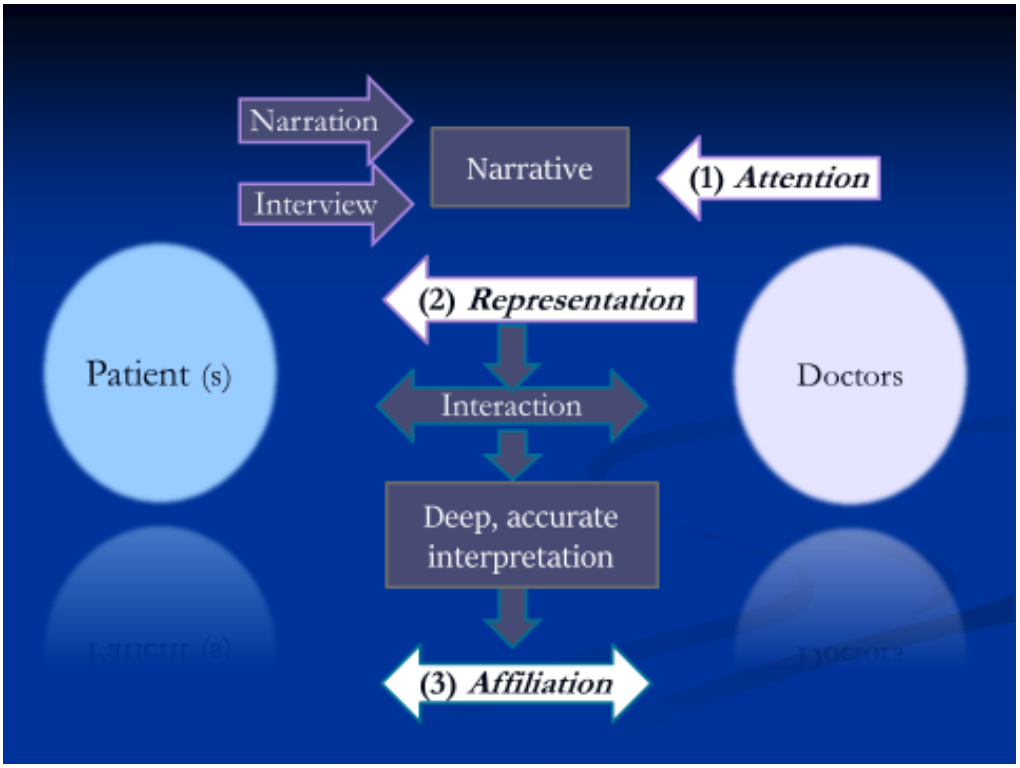
This section explains the current practice of Narrative Medicine. Narrative Medicine has recently been attracting attention from both doctors and patients. It is an interdisciplinary field where literature (narrative) and science (medicine) work together. By paying attention to the stories told by patients, the practitioners of Narrative Medicine try to grasp all the problems surrounding patients, not only with their illnesses but also in their whole lives. This is because the cause of the patients' suffering cannot be identified from symptoms alone, and their narratives may offer some clues to recovery. By considering and analysing problems comprehensively, doctors and patients may find a treatment satisfactory for both. However, finding the best treatment is not always the goal of Narrative Medicine, because some doctors believe that the act of narrative itself can lead to healing.

According to Rita Charon, a medical doctor and literary scholar, Narrative Medicine consists of three movements: *attention*, *representation*, and *affiliation*.

> We early recognized *attention*, *representation*, and *affiliation* as the three movements of narrative medicine that emerged from our commitment to skilled listening, the power of representation to perceive the other, and the value of the partnerships that result from narrative contact. By *attention* we mean the state of heightened focus and commitment that a listener can donate to a teller – a patient, a student, a colleague, a friend. Rare, demanding, and rewarding, attention uses the listening self as a vessel to capture and reveal that which a teller has to tell. *Representation*, usually in writing but also in visual media, confers form on what is heard or perceived, thereby making it newly visible to both the listener and the teller. And *affiliation*, which results from deep attentive listening and the knowledge achieved through representation, binds patients and clinicians, students and teachers, self and other into relationships that support recognition and action as one stays the course with the other through whatever is to be faced. (Charon 2017a: 3)

The following figure visualizes this concept.

[Figure 1: Three Movements of Narrative Medicine]



First, narrative is provided by patients and then *attention* is paid to that narrative. Attention could refer to a variety of things, such as reading, analysing, or interpreting patients' narratives. But the most important point is the listener's sympathetic attitude towards the narrator (patient). In other words, a doctor just encourages patients to tell a story without any intention of examining the story.

Next, the doctors share their interpretation of the narratives with the patients. In this process, doctors may use several media, such as painting, as well as written and spoken texts, so that the meanings of the narratives could be made visible for both doctors and patients. Through the *representation*, doctors and patients interact, so *affiliation* is established. This good relationship may help them find a good therapy, but the most significant idea is that the establishment of a good relationship itself may lead to recovery.

Regarding how doctors acquire the skills needed for Narrative Medicine, Irvine & Charon (2017) wrote:

> Whether we listen to the story of a patient in the office or we read the words of a well-wrought novel, we are taking seriously human beings' capacity to formulate, in words, what they are going through. We used the same narrative skills in both the literary and the clinical contexts. (p, 124)

So, doctors use literary texts because the same narrative skills are needed for interpreting literature and patients' narratives.

Further, the practitioners of Narrative Medicine should pay 'deep and accurate attention to the accounts of self' (Charon 2017b: 157), so they need to learn to interpret texts deeply and accurately. For that purpose, close reading is adopted as a teaching technique in the classroom.

Based on this, my hypothesis is:

Since stylistics also aims to offer deep and accurate interpretation of (any kind of) texts, stylistics can take the place of close reading or collaborate with close reading.

In the sections that follow, I will examine the validity of this hypothesis through the stylistic analysis of a non-literary illness narrative.

3. Text-based approaches: close reading and stylistics

Before presenting my analysis of an illness narrative, it would be instructive to identify similarities and differences between close reading and stylistics.

The two language-based approaches share a basic principle: both the contents and the style of narratives are important in close reading, and this principle is shared by stylistics. Irvine & Charon (2017) argue '[The] literary text exerts ethical force not only in its plot but also in its form' (p 123) while Irvine & Spencer (2017) explain that '[n]arrative medicine [applying close reading] attends to style, voice, rhythm, metaphors, perspectives, temporalities, silences' (p 92).

However, there are some differences between the methods, as summarized in the following table.

[Table 1: Principles and Methods of Close Reading and Stylistics]

Close Reading	Stylistics
1. 'Impressionistic', intuitive, and randomised (Barry 2009: 201)	1. Objective and scientific (Barry 2009: 201)
2. Accept any interpretation as long as the reader claims it comes from textual evidence	2 Demystify literary text and its interpretation, and admit the possibility of illogical and unretrievable interpretations
3. Lay-person's terms and concepts (e.g. irony, ambiguity, paradox) (Barry 2009: 202)	3. Specialised technical terms and concepts (e.g. transitivity, collocation, cohesion) (Barry 2009: 202)
4. Isolate the literary text and see it as a purely aesthetic art object (Barry 2009: 201)	4. Emphasize *connections* between literary language and everyday language (Barry 2009: 201)

First, while close reading is impressionistic, intuitive, and randomised, stylistics is objective and scientific. Second, while close reading is ready to accept any interpretation as long as the reader claims it comes from textual evidence, stylistics aims to demystify a literary text and its interpretation, and admits the possibility of illogical and unretrievable interpretations. Third, while close reading tends to use lay-person terms and concepts, stylistics prefers specialised technical terms and concepts. Finally, while close reading isolates the literary text and regards it as a purely aesthetic art object, stylistics emphasizes *connections* between literary language and everyday language.

Based on these features, several contributions of each to Narrative Medicine, and problems raised, may come to mind. While a wide variety of interpretations of illness narratives is encouraged in close reading, for instance, the patients' stories may be distorted in this process. Another problem is that close reading isolates literature as

something special, and in theory does not admit its own applicability to non-literary texts.

On the other hand, stylistics admits *connections* between literary language and everyday language, and so in theory can be applied to illness narratives as well. However, stylistics is largely based on the science of linguistics and may be incompatible with Narrative Medicine, which is basically 'art'. Most basically, some practitioners of Narrative Medicine emphasize that they do not analyse or examine narratives.

4. Stylistic analysis of *Brain on Fire*

To see whether stylistic analysis might help better understand illness narratives, I have analysed *Brain on Fire*. Susannah Cahalan, the author and protagonist (=1st person narrator) of this nonfictional narrative, is a 24 year-old journalist living alone in Manhattan. One day she feels that something is wrong with her body and mind. At first, she does not worry much, but the symptoms keep getting worse. Based on 'evidence', one doctor suspects that it is the symptoms of epilepsy, and another one diagnoses her as mentally ill. However, medicine does not work, and her condition does not stop deteriorating. The doctors are about to give up in despair when Dr. Najar joins the medical team to find the cause of the disease (anti-NMDA-receptor autoimmune encephalitis) and consequently saves Susannah.

4.1. How the narrative is constructed

The author explains how her illness narrative was constructed.

> Because of the nature of my illness, and its effect on my brain, I remember only flashes of actual events, and brief but vivid hallucinations, from the months in which this story takes place. The vast majority of that time remains blank or capriciously hazy. Because I am physically incapable of remembering that time, writing this book has been an exercise in my comprehending what was lost. Using the skills I've learned as a journalist, I've made use of the evidence available – hundreds of interviews with doctors, nurses, friends, and family; thousands of pages of medical records; my father's journal from this period; the hospital notebook that my divorced parents used to communicate with each other; snippets of video footage of me taken by hospital cameras during my stay; and notebooks upon notebooks of recollections, consultations, and impressions – to help me re-create this evasive past. (Cahalan 2014: ix)

Sometimes Susannah as a narrator behaves like an omniscient narrator. Because of this explanation, however, we do not regard it as unnatural. In other words, unlike the analysis of literary texts, it seems meaningless to discuss where this narrator-character is situated, such as inside or outside the story world. On the other hand, some literary stylistic and narratological devices are employed in this work and the problem of focalization is important in order to interpret this work deeply and accurately.

4.2. Focus of analysis

Throughout the narrative, Susannah is very sensitive to her nature or what her true self is. Accordingly, in my analysis I focus on how she loses her identity and how she retrieves or reconstructs it. In this study identity means 'the characteristics, feelings, or beliefs that distinguish you from others' (Shaules et al 2004: 2), more specifically Susannah's self-assessment of what she is or should be and what she is not.

In terms of narratological and stylistic devices, since Susannah assumes a variety of voices and viewpoints in her narrative, it seems that the theory of focalization would be effective in the interpretation of Susannah's state of mind. To grasp the basic concept, let us look at the following sentences from a so-called third-person narrator.

(1) Jim saw Betty. She was beautiful.
(2) Jim saw Betty. She was beautiful!
(3) Jim saw Betty. She was beauuuuuuuuutiful!

(Sasaki 2017: 184-185)

Considering a context where Jim is seeing Betty, many readers will take it that the second sentence in each pair assumes Jim's viewpoint. As Sasaki suggests, there are differences in the degree of dominance of Jim's viewpoint between the three examples. On the other hand, through this example, we can confirm that the speaker is not always the subject of the consciousness.

So, the problem of who speaks must be distinguished from that of who sees, feels, or perceives; that is, who focalizes. This point has been emphasized by many linguists and narratologists, such as Genette (1980), Banfield (1982), Bal (1985), Fludernik (1993; 1996), Emmott (1997), and Sasaki (2017).

In addition, it is also important to understand that in some cases the identification of the subject of focalization, the focalizer, is not clear. More than one focalizer can exist at the same time in some cases, and the identification of the focalizer is impossible in others. This kind of phenomenon has been identified by technical terms such as compound focalization (O'Neill 1994), poly-focalization, and poly-subjectivization (Teranishi 2007; 2008).

4.3. Analysis

In the current study, by identifying embedded focalizers in Susannah's 1st person narrative, I argue that a variety of people contribute to her identity construction, breakdown, and reconstruction.

In the following passage, Susannah loses her usual state of mind and body due to her illness.

[Passage 1]
From here on, I remember only very few bits and pieces, mostly hallucinatory, from the time in the hospital. Unlike before, there are now no glimmers of **the reliable 'I,' the Susannah I had been for the previous twenty-four years**. Though I had been gradually losing more and more of **myself** over the past few weeks, **the break between my consciousness and my physical body** was now finally complete. In essence, I was gone. I wish I could understand my behaviors and motivations during this time, but there was no rational consciousness operating, nothing I could access

anymore, then or now. This was the beginning of my lost month of madness. (Cahalan 2014: 72, emphasis provided by Teranishi.)

Here I would like to emphasise three points.

(1) She is highly conscious of who she is.
(2) She is losing her true self because of the break between her consciousness and body and she is worried about it.
(3) In this passage, other people are not engaged in her identity construction.

The following are all expressions used in the text that consist of modifiers and 'Susannah'.

'the Susannah I had been for the previous twenty-four years' (p, 72)
'news reporter Susannah Cahalan' (p. 88)
'a new Susannah' (p, 158)
'this strange new Susannah' (p, 177)
'the "old Susannah"' (p, 183)
'the substitute Susannah' (p, 185)
'the "Susannah whisperer"' (p, 185)
'the "normal" Susannah' (p, 187)
'the old Susannah' (p, 187)
'this Susannah' (p, 187)
'that wounded Susannah' (p, 197)
'the earlier Susannah' (p, 197)
'this vulnerable, budding Susannah' (p, 198)
'the carefree, confident Susannah' (p, 205)
'this new Susannah' (p, 211; p, 239)
'the Susannah I know' (p, 211)
'this old Susannah' (p, 239)
'the carefree pre-illness Susannah' (p, 240)
'the other Susannah' (p, 247)

This linguistic evidence suggests that she is strongly concerned with what she is, should be, and is not.

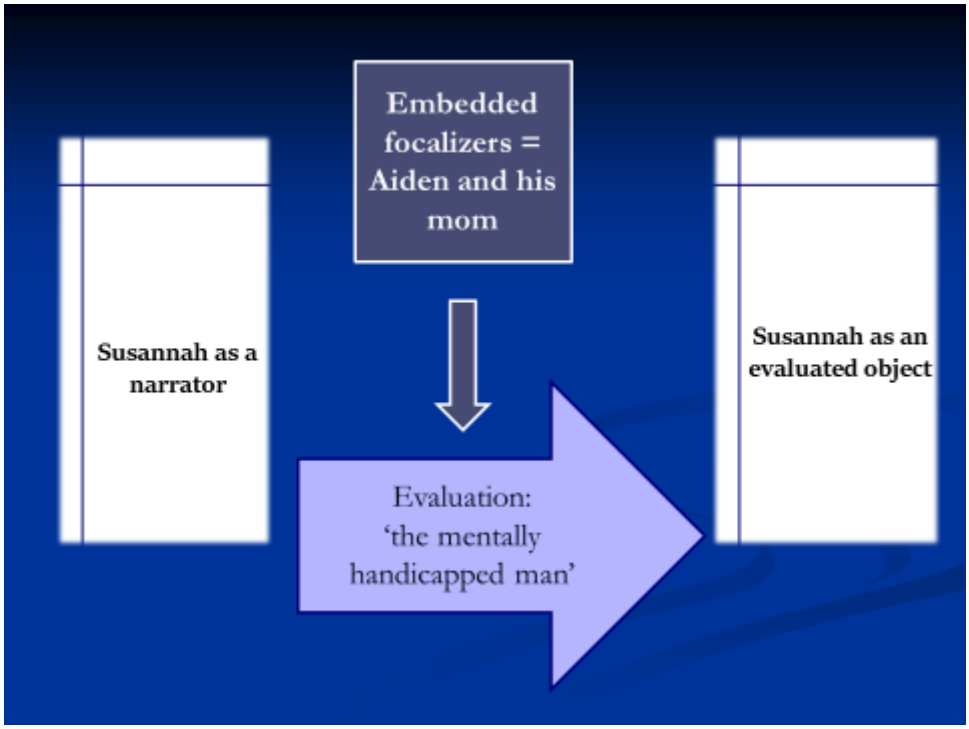
The following passage is one of the examples in which modifier + Susannah is used. Unlike passage [1], her self-evaluation is filtered through embedded focalizers.

Passage [2]
Because they were toddlers, Audrey and Grace didn't notice that anything was wrong. But, Aiden, an outgoing six-year-old, kept his distance from me, clearly unnerved by **this strange new Susannah**, so unlike **the one who had played and joked with him only a few months earlier**. (He later told his mom that I reminded him of **the mentally handicapped man whom he often saw at their public library**…) (Cahalan 2014: 177, emphasis provided by Teranishi.)

The theory of focalization clarifies how Susannah is evaluated as 'the mentally

handicapped man'. Susannah is of course engaged in this evaluation as the narrator. However, this evaluation originates in Aiden, who actually referred to the man. Further, his reference was heard by his mother, who probably conveyed it to Susannah. So Susannah's final self-evaluation is in fact filtered through those embedded focalizers. Figure 2 shows the focalizer (evaluator) –focalized (evaluated) relation in this passage.

[Figure 2: Focalizer - Focalized Relation in Passage [2]]



The following two examples show how her identity is disrupted and then reconstructed.

In passage [3], Susannah describes how she was treated as a patient with a rare illness in hospital. In the early stages of treatment, her suffering is harsh. Probably because of this, she is very sensitive to the attentions of others and how she is being seen and evaluated.

Passage [3]

Over the weeks, I had gone from being **a notoriously difficult patient** to **a favorite, the ward's 'interesting consult'** for a host of attending doctors, interns, and residents hoping to catch a glimpse of **the girl with the unknown disease**. Now that we had a diagnosis that had never before been seen at NYU, young MDs, hardly a day older than me, stared at me as if I were **a caged animal in a zoo** and made muffled assessments, pointing at me and craning their heads as more experienced doctors gave a rundown of the syndrome. The next morning, as my father fed me oatmeal and chopped-up bananas, a group of residents and medical students arrived. The young man leading the group of nascent MDs introduced my case as if I weren't in the room.

'This is **a very interesting one**,' he said, leading a gang of about six others into the

room. '**She has what is called anti-NMDA-receptor autoimmune encephalitis**.' (Cahalan 2014: 159, emphasis provided by Teranishi.)

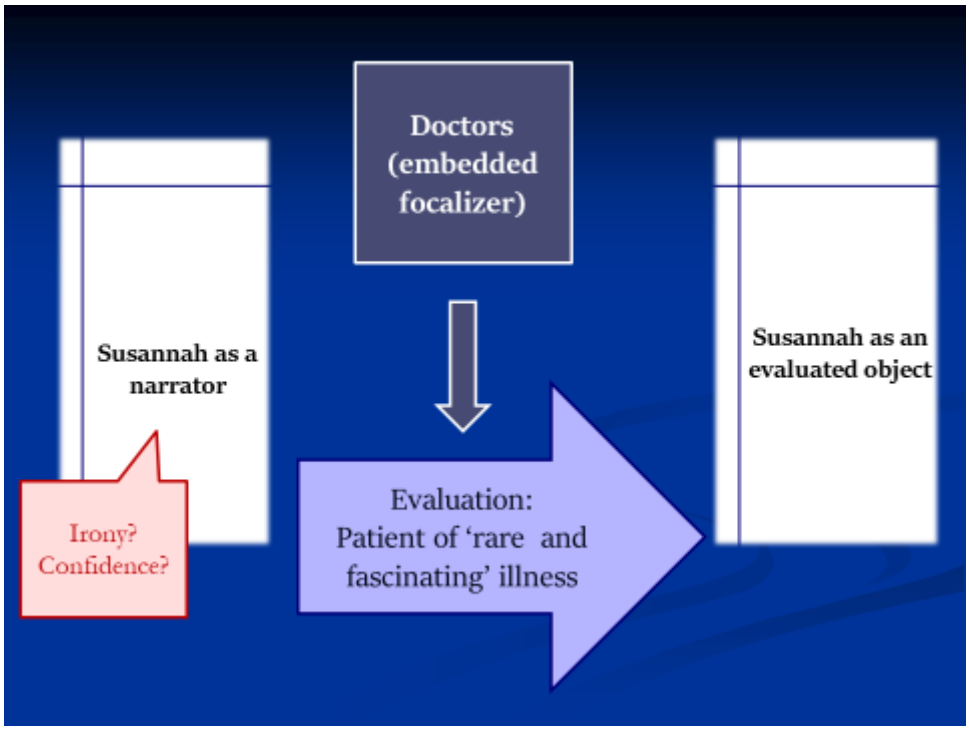
On the other hand, in the next example, while she is recovering, her self-evaluation changes in tone:

Passage [4]
As I recovered more and more of my former functions and personality traits, and began to more fully reintegrate myself into the world, I got used to people asking about **my rare and fascinating illness**. (Cahalan 2014: 207, emphasis provided by Teranishi.)

In this passage, the collocation between 'fascinating' and 'illness' seems unusual and it is instructive to discuss why Susannah uses this deviation here. In passage [3], the young doctor describes her illness as very interesting. There may have been other doctors like him. So, it seems that Susannah in passage [4] assumes those doctors' viewpoints by using 'fascinating' for her illness.

The following figure shows the people who are involved in the evaluation of the illness as 'rare and fascinating'.

[Figure 3: Focalizer - Focalized Relation in Passage [4]]



As a narrator, Susannah is evaluating herself as 'rare and fascinating'. However, there are embedded focalizers involved in this evaluation. So, in fact this seeming self-evaluation assumes the viewpoints of those embedded focalizers.

Considering the context in which Susannah is recovering, we can come up with

several interpretations of this style. One possibility is that Susannah ironically echoes the doctors' cold behaviour towards herself.

This is a summary of the current analysis.

1. The distinction between narrator and focalizer is important if we are to interpret Susannah's state of mind as represented in her illness narrative both accurately and deeply.
2. Susannah (patient) is sensitive to how others look at her as well as how she appears to herself.
3. While based on textual evidence, the interpretation of the style (e.g. poly-focalization) varies (e.g. irony, confidence, emotional (in)stability…)

5. Conclusion

In this study I have stylistically analysed several passages of *Brain on Fire* to discuss the following three research questions.

1. What are similarities and differences between close reading and stylistics?
2. Can stylistic analysis help to better understand an illness narrative and the narrator (=patient)?
3. Can the stylistic analysis of illness narratives help to better understand literary texts?

Regarding the first question, it is obvious that close reading and stylistics are both text-based. On the other hand, they may be different in their degrees of freedom, creativity, and retrievability in interpretation.

Regarding the second question, the analysis has shown that the identification of plural focalizers (evaluators) helps to reveal how Susannah is emotionally hurt by the people around her and how she has recovered from that.

Finally, regarding question 3, the analysis of how Susannah's mind is influenced by other people such as doctors and friends sheds a new light on the same focalizing technique used in fictional narratives, such as Saul Bellow's *Herzog,* in which the protagonist's internal fracture is linguistically and stylistically materialized in different personal pronouns (Teranishi 2007; 2008). So, this finding will help us to read and interpret literary texts as well.

While some findings in the current study are a significant contribution to the study of Narrative Medicine, the study may also make us aware of some problems in this field. First, it is difficult to record and analyse authentic spoken narrative data from patients for a variety of reasons, including ethical ones. Considering this situation, the most suitable materials are at present the masterly accounts of illness written by patients (Charon 2004).

Second, regardless of medical doctors' advice not to examine the text, authentic spoken illness narratives are worth analysing and stylisticians should have much to offer towards a deep and accurate understanding of them. To develop this interdisciplinary field in a healthy manner, interaction between stylisticians and practitioners of Narrative Medicine should be further facilitated.

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