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Claire's Head and Pain
Beyond the Sign of the Weapon

> Physical pain has no voice, but when it at last finds a voice, it begins to tell a story.
> —Elaine Scarry, *The Body in Pain*

Defined as pain lasting for more than three months, chronic pain is common (Harstall and Ospina 1). A review in 2012 suggested that 15-29% of the Canadian population experiences chronic pain (Fischer and Argento 192). Unfortunately, the outcomes for pain management are poor (Kamper et al. 1). Medical management of chronic pain may even be worsening the problem: globally, Canada is the second-highest per-capita consumer of opioids ("Narcotic Drugs 2012" n. pag.); Ontario has seen a 250% increase in opioid-related emergency department (ED) visits from 2005 to 2011 (*The Way Forward* 4); and some First Nations in Canada have declared a community crisis owing to the prevalence of the harms associated with prescription drugs (Graveland n. pag.). The larger problem of lack of efficacy with pain management costs the Canadian economy an estimated $37 billion a year in lost productivity (Phillips and Schopflocher n. pag.). Why is Canadian society's prescription drug problem escalating? Why is the benefit experienced by patients in medical pain management regimes so modest? Part of the explanation lies in the fact that the responsibility for pain management in Canada largely rests with physicians who overwhelmingly approach illness from a biomedical perspective.

Bad backs, broken bones, burns, arthritis, earaches—as a family physician, I encounter the patient in pain every working day as a cog in the medical machine. For most patients, pain is transient, lasting as long as the average causal illness. For others, pain transforms into a chronic problem that usurps identity. I take a history because a patient's symptoms and signs must be contextualized within a patient's life; otherwise, I treat a disease and not a person. In this way, I resist the dominant Western medical model of "biomedicine" defined by Nikolas Rose in *The Politics of Life*

Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century as "technomedicine, highly dependent on sophisticated diagnostic and therapeutic equipment" that is "fractured by a complex division of labor among specialists" (11). David Morris, in his work on the culture of pain, observes that "our culture—the modern, Western, industrial, technocratic world—has succeeded in persuading us that pain is simply and entirely a medical problem. When we think about pain, we almost instantly conjure up a scene that includes doctors, drugs, ointments, surgery, hospitals, laboratories, and insurance forms" (2). Medical discourse *is* hegemonic in contemporary life, and authority over pain is firmly in the hands of physicians. I work against the dehumanizing processes of diagnostics and therapeutics by talking to patients. I follow in the wake of a small institutional shift away from biomedicine that is reflected in the rise of interdisciplinarity and the medical humanities. It is a shift owed to the recognition that biomedicine strips patients of personhood and thereby works to worsen recovery. As Judy Segal has written, "[n]arrative . . . gives meaning and texture and humanity to what might otherwise be just cases" and is the "corrective to biomedical discourse" ("Interdisciplinarity" 20).

The value of narrative in the health research and clinical arenas is now widely accepted, if not funded by granting bodies at a level even remotely close to that of traditional biomedical research. In *Narrative Medicine: Honoring the Stories of Illness* (2006), Rita Charon, director of Columbia University's Program in Narrative Medicine, writes that "[w]hen we human beings want to understand or describe singular people in particular situations that unfold over time, we reach naturally for narrative, or storytelling, to do so" (vii). Much evidence suggests that when physicians represent illness in narrative, care is improved; representation matters in a practical, measurable way for both patients and doctors (Charon, Hermann, and Devlin 345). Also facilitating the "narrative turn" is a broad engagement on the part of humanities scholars with what Anne Hawkins defines as "pathography": "a form of autobiography or biography that describes personal experiences of illness, treatment, and sometimes death" (*Reconstructing Illness* 1). Hawkins maintains that pathography "returns the voice of the patient to the world of medicine, a world where that voice is too rarely heard, and it does so in such a way as to assert the phenomenological, the subjective, and the experiential side of illness" (*Reconstructing Illness* 12). In *The Wounded Storyteller*, Canadian medical sociologist Arthur Frank describes the problem faced by the ill: "Seriously ill people are wounded not just in body but in voice. They need to become storytellers in order to recover the voices that illness and its treatment often take away. The voice speaks the mind and expresses the spirit, but it is also a physical organ of the body" (xii). Though Frank refers here to actual patients and nonfiction narratives, his principle can be usefully applied to works of fiction in which suffering characters struggle to articulate their stories as means of asserting their identity, but also of healing—to heal that "physical organ of the body."

The editors of *Unfitting Stories: Narrative Approaches to Disease, Disability, and Trauma* acknowledge the proliferation of pathographies over the past few decades:

> Whereas there were relatively few published stories of ill health or suffering twenty-five years ago, in English or other languages, a person visiting any library or bookstore today will discover a wide range of narratives that can be divided into several categories, including accounts of disease, disability, and trauma. (3)

The editors of *Unfitting Stories* broaden their scope of analysis beyond Hawkins' "pathography" concept to include "auto/biographies of disability and trauma" (4) because, as the introduction states and the remainder of the essays make clear, "conceptualizing disease, disability, and trauma as distinct categories was not useful, or even possible, where such stories are concerned" (5), but two elements seem missing from the book: (1) pain is not investigated as a subject in itself; and (2) the genre of fiction is not considered, with the preponderance of analysis devoted to nonfiction.

Twenty-six years after Morris' landmark study, the subject of pain remains ripe for engagement by humanities scholars. Early studies include Madelaine Hron's *Translating Pain: Immigrant Suffering in Literature and Culture*, a text that includes represented body language as a communicant of pain. In addition, Judy Segal's *Health and the Rhetoric of Medicine* offers rhetorical analysis as a useful way to analyze pain (especially her chapter on migraine as disease category). Yet Segal's analysis is rooted in already-present medical rhetoric that constructs "pain" from a position of assumed critique, one based in dyadic interaction between two parties (patient and doctor). Hron and Segal reflect a growing engagement with pain by Canadian humanists.

The small number of studies is unfortunate because pain is an especially pertinent subject of analysis and needs productive intervention by non-clinical personnel. According to the protectionist pact physicians make with their profession so as to not trouble the edifice of medical omnipotence, we cannot tell patients who suffer pain that they are particularly unlucky, for of all the problems facing the human being, pain is one of the most baffling.

Despite the radical improvements made in many other fields, including oncology, cardiology, and surgery, pain medicine is a specialized branch of biomedicine with persistently poor outcomes. These poor outcomes are an intensification of the dehumanizing problems inherent to biomedicine as it meets with the peculiarity of pain experience.

The biomedical definition of pain was first codified by the International Association for the Study of Pain (IASP) in 1979 as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (Merskey et al. 249). A single sentence long, this abstract definition does not convey what pain actually *is*—what it *feels like*—and it is a definition that depends on destruction. Narrative is a way to escape the consequence of such a pathology-connoting definition, but because narrative definitions of pain are not generalizable, dependent as they are on the uniqueness of individual experience, medicine continues to prefer the laboratory-researchable biomedical definition of pain.

That pain can have positive elements is a minority view in Western culture, where pain is always already undesirable, a clinical experience relegated to the discipline of medicine for alleviation. In *The Culture of Pain*, Morris asserts that

> the vast cultural shift that gives the story of pain its hidden plot centers on the eradication of meaning by late nineteenth-century science. . . . We are the heirs of the transformation in medical thought whereby we think of pain as no more than an electrical impulse speeding along the nerves. (4)

The reason medicine is largely unable to provide meaning to sufferers of pain is because *pain is a narrative* and requires contextualization in words that dramatize time and space. The person in pain has hopes, desires, memories, a future, and current human relationships. A clinical perspective that pins pain down into a symptom score fails to recognize the scope and nature of the pain experience.

Because the biomedical definition is expressed in pathological terms, it is understandable that poor outcomes are the lot of patients with chronic pain. But it is not so easy to place the blame entirely on medicine. In *The Body in Pain* (1985), Elaine Scarry suggests that "[b]ecause the existing vocabulary for pain contains only a small handful of adjectives, one passes through direct descriptions very quickly and . . . almost immediately encounters an 'as if' structure: it feels as if . . . ; it is as though . . ." (15; first ellipsis mine). It is this general problem of vocabulary that leads to medical definitions that are problematic because only two kinds of metaphors appear on the other side of the ellipsis, according to Scarry. The first specifies "a weapon that is pictured as producing the pain . . . and the second specifies bodily damage that is pictured as accompanying the pain" (15). Pain described "as if a knife cutting through the belly" is an example of the first kind, and "hurts as if the skin has been completely torn off from head to toe" is an example of the second. By focusing on metaphors of damage and weaponry, we focus on destructive metaphors with destructive consequences.

The IASP defines pain as an "experience," but the resources available for sufferers to convey pain experience are limited by the degree of their pain, the lack of vocabulary to describe pain, and their talents as narrators. How can pain experience be rendered? The process that conveys experience is *narrative*, defined in the *Oxford English Dictionary* as "an account of a series of events, facts, etc., given in order and with the establishing of connections between them" (def. n. 2a). Narratives (including literary pain narratives) convey the multiplicity of experience by including the body's emotions, sensations, and memories. This complexity rescues the body in pain from silence and situates it in a context of comprehension. Although narrative skills can help the doctor better treat her patient, narrative competence, where the physician can interpret the story well, is difficult to obtain. Scarry presents the challenge of narrativizing pain as formidable. Pain's "resistance to language" is because of its "utter rigidity . . . essential to what it is" (5). Scarry explains this resistance as follows: "Physical pain—unlike any other state of consciousness—has no referential content. It is not of or for anything. It is precisely because it takes no object that it, more than any other phenomenon, resists objectification in language" (5). Narrative is a good fit for conveying the pain experience because pain is based in inter-human subjectivity. In "Useless Suffering," Emmanuel Levinas explains that the relationships we have with other people are often connections based on sympathy. Levinas contends that a use of pain is forming bonds with others. To know others, we can try to understand if they are in pain—we can listen to their embodied narratives (94). With a focus on the testimony of biology—biomedicine's forte—supplemented by what Mary Ann Elston describes as "a broader embodied, non-reductionist perspective grounded in our being-in-the-world: one which a medicine of the lived body, vis-à-vis a reductionist biomedicine, must actively take up and dwell within" (75), we have the beginnings of a hybrid methodology in which Levinasian ethics and literary studies can be brought to bear on fictional and nonfictional illness narratives.

The pathography genre has been studied (albeit not fully in the Canadian context, despite the ongoing work of disability studies scholars) relatively more than illness novels that deal with pain. The editors of *Unfitting Stories* contend that the "account's form to the story told" is "important," that "the two are inseparable" because "the shape, style, and central metaphors of the narrative govern its interpretation" (28). A key difference between fiction and the nonfiction pathography comes at the level of interpretation: the novel doesn't necessarily have the "storyteller . . . constructed as a persona, and the implied reader . . . encoded as an ultimately sympathetic audience" (28). Though the novelist wishes for an audience much like the pathographist, the motivation is not the same as that formulated by Hawkins: "People write about their experience of illness because they expect to find readers. It does not matter that they do not know who the reader is and will not (in most cases) find out what his or her response was to their book—they write so that others will read what they wrote" (*Unfitting Stories* 125). If, as Helen Buss suggests, the memoir creates a "provisional and contingent subjectivity unable to buy into traditional constructions of the self" (34), the fictional case might also be as invested in creating a provisional and contingent subjectivity, albeit less referential to verifiable truth. With fiction, readers do not require a real-world referent. We can invest our imaginations in the pain experience, which is a particularly creative act that might be the missing ingredient in medicine's biomedically tethered recipes and their ostensibly verifiable truth and existence somewhere in the "real world." If memoir is a direct portal to pain representation because the condition is already part of the narrative—indeed the condition is often the impetus for the narrative—then fiction deals with pain not as "the story" but rather uses pain to tell "the story." In a pioneering paper in *Studies in Canadian Literature,* Laura Moss addresses the relative lack of engagement with fiction in discussions of narrative medicine and points out that fiction could play an important role in teaching narrative competence:

> [M]uch fiction is conditional, based on the question "what if?" . . . A fictional story provides a space to creatively probe uncertainty, to draw out the repercussions of mistakes, to work through the consequences of actions, and to imagine different ends. . . . Because stories allow for polyvocality and a plurality of outcomes, they are potent sites to engage debates about tough dilemmas in medicine. (8)

Pain is among the toughest problems medicine has to deal with. *What if* the writing (and study) of fictional narratives that consider pain could result in a reduction in the number of bodies in pain?

I use a narrative-based approach to move beyond destructive representations of pain in order to demonstrate constructive representations of pain. Yet, I face a paucity of novels that deal explicitly with physical and mental experiences of pain in the Canadian context. Other than novels that represent torture (including Karen Connelly's *The Lizard Cage* and Ian Colford's *The Crimes of Hector Tomas*), the number of those representing chronic pain—in which characters have pain, are in relationships with others who also have pain, etc.—is small. However, one novel that stands out significantly in its representations of pain is the second edition of Catherine Bush's *Claire's Head* (2006). I argue that Bush goes beyond destructive representations by using other systems of metaphor to express pain. *Claire's Head* moves beyond the metaphors of weapon and damage described by Scarry in *The Body in Pain* as the novel invokes pain on every page and demonstrates how a novelist can write about pain without resorting to familiar "as if" formulations.

Using a narrative that focalizes on a female migraine-suffering protagonist, *Claire's Head* is the tale of Claire Barber and the search for her missing sister, Rachel. Rachel disappears in the midst of a desperate quest for relief from intense migraines. Claire, too, suffers migraines, but of less severity than those suffered by her older sister Rachel. The novel focuses on Claire while she tries to discover the whereabouts of Rachel, moving from Canada to the US, Sweden, and Italy. Claire's travels are conducted in the context of her own quite substantial pain—pain which, significantly, is not much helped by medical providers. Bush's deployment of biomedical terminology, treatment regimes, and cases could constitute a risk to aesthetics, yet the author's narrativization of the biomedical discourse is ingenious: representations of migraines engage with medical discourse around pain, including pharmacologies and imaging modalities, in order to address power relations between patients and the medical profession. By representing pain in a literary narrative that captures an imaginary human life, Bush resists the biomedical discourse's presentation of pain as a purely negative experience.

After identifying migraine as a "neurological condition" during a promotional interview, Bush admitted that one motivation behind writing the novel was to explore "the ways we use neurological models to help explain ourselves" ("Q&A" n. pag.). Bush presents the discourse around migraine in this interview as a biomedical discourse. In another venue, Bush describes *Claire's Head* as a "neurological mystery," thereby fusing medical discourse with literary genre (qtd. in Richards n. pag). Bush's adoption of biomedical discourse is signalled textually and paratextually. She engages with a broad range of writings on the subject of pain: she thanks David Morris, the cultural studies authority on representations of pain, in the acknowledgements section; epigraphs for the novel come from famous migraine sufferer Charles Dodgson and chronic pain sufferer Alphonse Daudet; she alludes to neurologist Oliver Sacks in the text; and she utilizes anecdotes and theories from medical antiquity.

The challenge Bush faced when writing within the biomedical frame of reference is reflected in the fact that the book has two distinct versions. The hardcover version of *Claire's Head* was published in 2004, but Bush made significant revisions to the softcover, released in 2006. According to Ann Jurecic, a scholar of illness narratives, an imaginative work that tackles non-totalizing pain invites revision:

> Writers who have produced memoirs about such manifestations of pain suggest that the primary problem they face is not how to find language for pain, but rather how to make readers receptive to stories of pain. Their question is not how to find words for pain, but rather, who will listen and what will they hear? (44)

In a piece explaining her motivations for revising the novel, Bush notes that "every writer confronts the difficulty of shoehorning nonverbal experience into those neat little bootlets that we call words" ("Ever Revise" n. pag.). Faced with the difficulty of writing pain, of literally "shoehorning nonverbal experience" into words, Bush felt the first version of the book "could have gone further," that greater "emotional clarity within the characters" could be achieved. With revision, one can improve the fidelity of the rendering. The changes in the second version start on the first page, though the bulk occur in the second half of the book and, crucially, the book has a different ending: as Bush puts it, "same people in same place, different thing happens" ("Ever Revise" n. pag). In a literal sense, the narrative of *Claire's Head* differs over time just as the meaning of pain changes over time. This revision process enacts what non-totalizing pain does to human beings: the story changes as we change. I use the second edition of *Claire's Head* as a substrate for analysis because this version is more explicit about pain behaviours.

Bush exposes biomedical discourse from within by depicting bodies in pain that encounter doctors without real benefit and that ingest pharmaceuticals that provide little relief. Her characters abandon conventional medicine in favour of alternative cures, and the plot of the novel focuses on bodies in pain seeking one another rather than seeking relief from physicians in white coats. The point of encountering physicians in *Claire's Head* is not to obtain relief but rather to narrate the clinical discourse, such as the migraine pain theory (84), and to find clues about the whereabouts of Rachel. Analgesia is not the objective since the pain represented in the novel is intractable.

Clinics are presented as irrelevant rather than negative. Doctors are asked to provide a different kind of history, an account of their encounters with Rachel as a person.

Representing pain from within medical discourse resists Scarry's contention concerning the restricted language of pain that is relegated to destructive metaphors and that is inherently language-destroying. An obvious way Bush names pain is to provide a medical "name" or classification: *migraine*. In the first few pages of the book, we learn that Rachel is missing, that she was recently speaking to a medical specialist in migraines, and that the last time Claire had heard from her, she was in the grip of a migraine. The word "migraine" constitutes a disease category, but in our culture "migraine" is a familiar pain code, medical shorthand into which many symptoms and effects are packaged. But Bush resists the dehumanizing medical gaze as formulated by Michel Foucault in *The Birth of the Clinic* (1974) by creating rounded, sympathetic characters that suffer migraines. The linkages characters in pain make with one another constitute inter-human connectivity that imbues pain with meaning, but using medical names for chronic pain conditions is a valid, albeit limited, way to represent pain.

Bush also uses medical discourse to represent pain via pain behaviours. First formulated in W. E. Fordyce's influential textbook *Behavioural Methods for Chronic Pain and Illness* (1975), pain behaviours include moaning and groaning (paraverbal), grimaces and postural positions (nonverbal), and even avoidance of activity. Nonverbal signs of pain are taken up by Hron, who contends that "pain, and even socioeconomic hardships or racial discrimination, are structured as 'languages,' and as such, may be translated into the symbolic language of words" (xvi). Hron believes that one of the "pain languages" is the outward manifestation of "body signs" that constitute "nonverbal neurological, physical, and/or psychological symptoms" (40). Hron encourages literary scholars to move beyond Scarry's influential theorization of the difficulty of representing pain: "The scarcity of a direct language of pain does not mean that there is no viable mode of expression for their pain; rather, like translators, writers must engage in a variety of representational tactics to render their suffering understandable to readers" (41). Bush's solution is to use medical discourse in an aesthetically productive way but also to represent the suffering of characters as visible through behaviour. Claire's pain mannerisms recur throughout the book, providing a visible dimension to otherwise unseen pain. To quote one example from a great number within the text, "Claire pressed her fingers to the point above her right eyebrow that ached, touched the three points across the top of her head" (265). This simple example contrasts with more complex ones in the novel, like the control rituals recounted through analepsis, in which an eight-year-old Claire

> peeled off her socks. The radiator beneath the window was sheathed in an aura of heat. She pressed her right foot against it. Her skin and muscle flinched. She persisted. She counted to ten, pulled her foot back, and examined the pink flush growing on her sole. The stinging swelled and receded. No other sensation existed as she did this. Then she tried the same with her left foot. (25)

The close details here—"skin and muscle" flinching, the chronology of counting to ten, the description of resultant damage with the "pink flush growing on her sole"—all lead to Scarry's "unmaking of the world," the obliteration of consciousness from perceiving anything other than the body. As Claire says, "no other sensation existed" during the ritual. Claire's burning behaviours (reported to be repetitive and ritualistic) are presented by the narrator as ordering, explaining that "the pain was hers, no one's but hers. She controlled when it started and when it ended, and this produced a satisfaction so deep it became exhilaration" (25). Her world is unmade, but migrainous pain is unmade also. The list of pain behaviours—both self-inflicted and not—is lengthy, including avoidant ones like environmental proscriptions and dietary restrictions.

Another obvious representation of pain behaviour in *Claire's Head* involves interactions with pharmacology. In order to get through the day, Claire uses medication: she is depicted taking pills orally; on one occasion she refers to her "vile pharmacopoeia" (207); and in one scene she receives parenteral medication (141). The use and seeking of drugs imply the presence of pain and are a representational strategy that not only signals pain but also represents an active search for relief—and thereby agency. Other pain-relief strategies also signal pain and agency in the novel, such as nonpharmacological treatments like acupuncture or massage therapy. The latter leads to Rachel's romantic relationship with a masseur named Brad Arnason. Thus, Bush complicates the ways she represents pain by tasking those methods with more than just a single function. By including positive romantic relationships as a "side effect" of a character's paramedical treatment regime, Bush suggests that desire might be a way to resist the negativity of the medical discourse.

Pharmacologies also form an image pattern within the narrative. The "medicalized" image pattern comprises pharmacological, neurochemical, and neuroanatomical terms. *Claire's Head* lists a migraine pharmacopeia of the novel's era (drug names include propranolol, Imitrex, amitriptyline, 222's, Zomig, and Anaprox). Central neural structures are named, including the "trigeminal nerve" and "brain stem" (47). Neurotransmitters are mentioned in the midst of a doctor's oration on migraines (84). Theories behind the etiology of migraines are considered. Other medical elements include hospitals, doctors, fMRI and PET scans, the McGill Pain Questionnaire, and famous figures from medical history like Wilder Penfield (81). The frequent use of such references and allusions signals that there is underlying pain that requires recognition, if not treatment; that the bevy of meds and the famous medical pioneers form prestigious entries on a list, but no material relief.

Bush also represents pain in *Claire's Head* by directly adopting biomedical discourse at certain moments in the narrative. These moments concentrate around the character Rachel, who is often depicted as speaking as if she herself were a physician. For example, at one point Rachel tells her mother, "It's not clear what we've inherited, whether the migraines are genetic or if it's some neurological predisposition, something in your physical makeup that's been passed on, and the headaches themselves are a kind of learned behaviour, a body language" (193). If medicine cannot provide relief, then adoption of the language of medicine to describe and theorize one's own suffering is a way to obtain control and, perhaps, relief. Patient proficiency with medical discourse remediates power imbalance, a positive factor in light of medicine's relatively modest ability to ameliorate chronic pain.

Another positive factor in *Claire's Head* is a progressive notion of disability. Rachel, Claire, and Sylvia Barber are three related female characters who find themselves at the high, middle, and low ranges of a spectrum of disability. The *Routledge Handbook of Disability Studies* presents the medical definition of "disability" as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (15). Disability, the consequence of frequent, unpredictable, severe pain, is central to the medical profession's negative conception of illness. Characters who lead lives *with* and not *despite* pain make for a representational strategy of pain that moves beyond the sign of the weapon. Restriction, lack, and impairment all possess negative connotations, but *Claire's Head* resists a totalizing negative claim—Bush represents dis/ability and medical disability in productive contrast with one another.

Rachel meets the medical model's exclusive definition of disability. As a freelance writer, she has a flexible occupation that allows her to complete assignments on her own schedule. Her harrowing, daily pain is described in detail through Claire's perspective—a pain state that worsens as the narrative progresses. Depression, a known complication of chronic pain and disability, is part of Rachel's story (15, 39), as is a former addiction to the barbiturate Fiorinal (110). Yet migraines have more than a *present* occupational impact on Rachel. Her occupational future is diminished by the onset of migraines, as it prevents her from undertaking medical studies:

> Long ago, Rachel had talked about becoming a doctor, even a neurologist—towards the end of high school and during her first two years at university. She had taken a range of science courses and done well but backed away from the idea of medical school in the end because, she said, her migraines were too disruptive. She did not think she had the stamina for it. (71)

Rachel's interest in medicine contrasts with her father, Hugh Barber's. At one point, Hugh was a medical student, but quit before graduating. Hugh's departure from medical school is ambiguously portrayed in the novel—the reasons could either be disillusionment resulting from the traumatic death of a patient or the stress of Sylvia's first pregnancy (100, 232)—but the tension this biographical fact provides is undeniable. If Hugh left school ostensibly because of Sylvia's pregnancy, then Rachel's arrival can be twisted as the "reason" for Hugh's not becoming a doctor. Yet at one point in the narrative, Rachel wants to become a doctor in part to help the family with its migraine problem, making a comment in this regard that is antagonistic to her father. Rachel asks Hugh, "Why didn't you stick it out at medical school? We could certainly have used a doctor in this family" (72). Unlike her father, who had the ability but not the desire, Rachel's frequent, recurring, severe pain episodes were too disruptive to allow her to undertake medical studies, even though she had both the interest and the aptitude. Instead, Rachel works as a popular medical writer, often writing about pain, just as the author of *Claire's Head* has done. The novel resists the institution of medicine by having its characters abandon pursuing the profession as a career; furthermore, the negative implications of the facts of disability are resisted by the positive, affirming lives of the novel's suffering characters who love one another. Rather than dysfunction, people in pain lead meaningful lives when supported by others. They go where they need to go and live largely how they wish to live, with pain.

Pain takes on an emplotment role in the novel. Bush has written paratextually that "part of the specific challenge of the novel was making the experience of headaches central to the narrative, not occasional but woven deep into the fabric of the characters' lives" ("Ever Revise" n. pag). During an interview, she stated: "I wanted to write a novel in which migraines were not only an aspect of character but also were integral to the plot and to the actions of the characters at many levels" ("Q&A" n. pag.). To meet this challenge, *Claire's Head* tasks pain with *agency*, making it positive and productive. Pain makes things happen.

The first example of the plot-moving aspect of pain occurs at the start of the novel. Brad Arnason meets Rachel through his work and the novel is set in motion with a phone call from Brad to Claire about Rachel's disappearance. Without pain causing Rachel to seek physical relief by massage therapy, Brad would have no need to call Claire. Another important example occurs later in the novel when Claire enters Rachel's apartment to obtain clues as to her sister's whereabouts. Upon entering, Claire interrogates Rachel's environment from a pain perspective: "Her pillows lay one atop another the way she piled them when she had a headache so that she could lie with her head raised" (31). After investigating the medicine cabinet and counting its drugs, Claire decides that there might be "some premeditation—a determination, even before setting out for Montreal, not to return . . . While careless about some things, Rachel would never let herself get caught without medication" (34). The reader learns crucial information from Claire's investigation of the environment from the perspective of pain: yet another way pain is represented beyond the sign of the weapon. Rather than read how the body is hurt, we learn of the travels of the body as it survives pain.

These travels are painstakingly described. Scarry argues that pain is unshareable, but Bush's novel contests the popular understanding of Scarry's thesis through credible, convincing narrations of being in pain. The first overt description of pain comes early in the novel and does much to support Scarry's idea: "As Claire hung up the phone, the right side of her temple began to pulse. A point in the centre of her scalp. A second one at the base of the bone above and behind her right eye. Another point at the base of her skull, beneath the occipital bone, on the right" (19). Though this description of pain has precision, it is *limited.* Localization is all it attempts. Bush soon pushes past that limitation by lingering with pain, paying close attention to not only location but also character and severity. In this way, she is attuned to medical discourse as expressed by the McGill Pain Questionnaire, a powerful and widely used tool invented by Ronald Melzack and Warren Torgerson in 1975 that assists patients in describing their pain. Bush embeds her precise descriptions within narrative, thereby enhancing the descriptions of pain by providing context, ultimately crafting *pain-state narrations.* These narrations permit a reader to move past location, character, and severity into emotional and situational contexts of the pain, thereby aestheticizing the medical discourse. Consider the following:

> Everything outside her was reduced to surface. Suitcase. Floor. Thatched roof. She didn't experience auras but there were other forms of sensory distortion. Bright objects were spiked, sunlight an anathema. Odours heaved towards her: smoke, the miasma of car exhaust. She could identify things but was incapable of providing any context for them or making their relationships clear. Heat. Sky. Stefan's back. The burning point behind her right eye. Walk to the van. Part of her remained mute. (140)

Such narrations slow time down to an excruciating, ever-present moment replete with perceptual disturbance, sensory overload, and an overmastered body. We move beyond adjectives and adverbs, beyond metaphors of weapons and damage, and into a rendered world of space, time, and motion.

Bush also writes pain on the level of the inter-human. In his essay "Useless Suffering," Emmanuel Levinas calls suffering a "passivity," "precisely an evil," and a "pure undergoing" (92). Initially proposing that suffering is "intrinsically useless" and "for nothing" (93), he then links suffering with pain. Like Scarry, Levinas prefers to focus on intolerable situations by mentioning "intolerable lumbagos" and "the tortures experienced by certain patients stricken with malignant tumours" (93). As in medical discourse, Levinas uses terminology that is negative in connotation. Pain is presented as a closed loop, a hell of pain-without-exit. Yet, Levinas does not end with the closed loop. He suggests that the actual purpose of pain is to present the "possibility of a half opening, and more precisely, the possibility that wherever a moan, a cry, a groan or a sign happen there is the original call for aid, for curative help, for help from the other ego whose alterity, whose exteriority promises salvation" (93). "The other" becomes audience, promise of relief, and chief benefactor of the call because "the other" is sought for the benefit of "the other." Levinas writes that "pure suffering, which is intrinsically senseless and condemned to itself with no way out" (93), can be remediated when "a beyond appears in the form of the inter-human" (94). When observed in another, suffering finds its real subject and empathy becomes an imperative. Pain itself becomes the "bond of human subjectivity" (94) theorized by Levinas.

Inter-human connection between characters in narrative is another way pain can be represented beyond the sign of the weapon. Characters in pain and characters who recognize the pain in others create the matrix of inter-human connection that need not be represented in destructive metaphors, but rather in an unfolding narrative. As Rita Charon writes in Narrative Medicine: "fundamental aspects of living as recognizing self and other, connecting with traditions, finding meaning in events, celebrating relationships, and maintaining contact with others are accomplished with the benefit of narrative" (vii). Using this framework, the experience of pain need not be almost wordless, as per Scarry, but rather ready for unlimited dramatization and development.

Excepting the postmodern, most stories have an end. As Charon writes in her textbook for physicians, "[t]he plots we encounter and create in medical practice are very practically and irrevocably about their endings. They point to human ends, using their geometries to understand or to imagine the vectors of life, the plottedness of life . . . and the narrative connections among us all" (51). Bush states that pain is integrated into her plot, and plots must end or "exit" ("Ever Revise" n. pag.). Pain has an exit in the novel—it works between people outside of a framework of pure suffering and makes a bold statement at the end of the book. In both the hardcover and softcover editions, the prose changes slightly when Claire ultimately finds Rachel. But a substantial change occurs in the second edition, in which Claire observes Rachel from a distance after finally finding her: "Rachel did not seem to be in pain. She did not look anguished (no finger rubbing the skin beneath her right eye)" (317). This additional piece of data demonstrates that Claire is assessing her sister for pain behaviours, which has important implications for the "vectorless end" of the novel's second version.

At the end of the first edition, Rachel notices Claire watching her. Rachel touches Claire wordlessly, and then drives away from the retreat. This is a less satisfying ending because the lack of communication between the two sisters in this circumstance is implausible—the open ending is a thwarted one. The second edition, however, features an ending in which Claire, rather than being noticed by Rachel, simply observes her sister. Claire then makes a choice—she decides to leave Rachel in a place where Rachel seems to have found "a certain calm" (317). This ending is sanctioned by Claire's earlier identification of Rachel's pain-free state and her resultant satisfaction that Rachel is behaving pain-free. Claire, having spent the entire novel looking for her sister, can now leave her sister with a partial answer to the question, "[w]hat is the place of pain?" (169). The place of pain is not as much with Rachel anymore. The place of pain is where pain takes Claire as a result of her decision not to make contact with Rachel, the place of "a deeper sensation, as of something letting go" (318). Claire lets go, and in so doing, a different book is made.

In this circumstance, "letting go" is a wholly positive act, yet medicine's negative concept for "letting go" is palliation. The human end to this narrative is one of pain that is opened up to an unknowable future. The open (and positive) end presented by *Claire's Head* resists the negativity of medical discourse via an unresolved conclusion in the new space of the spiritual healing centre in Mexico.

Doctors inclined to read novels like Bush's will not revolutionize their understanding of the physiology of pain, but by learning that pain is a narrative, they might be better able to address the pain of patients and possibly alter physiology. For their part, patients would see themselves represented in narrative as people who live with, and in some respects transcend, negative stereotypes about disease/disability. Novelists would discover the richness of pain as theme and subject and write more narratives involving pain. Scholars might take on the many guises of pain in Canadian fiction and generate comprehensive inquiries that consider pain in terms of gender, sexuality, race, class, and faith over the course of the entire history of Canadian literature. Privileged definitions like the IASP's may change to include cultural dimensions, and, as Simon Williams has written in *Key Concepts in Medical Sociology*, "other more positive renderings of pain" could become "possible" (74). Research could then proceed with biomedical researchers and humanities scholars working collaboratively. Reshaped in this way, pain transcends negative sensation, symptom, and disability, and instead becomes a story about inter-human connection.

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