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TO GET THE SHOT OR NOT: NARRATIVES, RHETORIC, AND THE CHILDHOOD
VACCINATION CRISIS

A Dissertation

Presented to

The Faculty of Social Sciences

University of Denver

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Katherine M. Hurley

August 2011

Advisor: Dr. Christina Foust

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Title: TO GET THE SHOT OR NOT: NARRATIVES, RHETORIC, AND THE CHILDHOOD VACCINATION CONTROVERSY

Advisor: Dr. Christina Foust

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Abstract

Parents in developed countries like the United States are questioning the need for and safety of childhood vaccinations. Incidences of disease have risen as fewer parents have vaccinated their children. Perhaps the most significant public figure to reinforce the choices of parents not-to-vaccinate is Jenny McCarthy, whose best-selling book details her theory about the cause of, and cure for, her son's autism. As I demonstrate, the study of the narratives is vital for understanding the vaccination crisis, not the least because of the extent to which McCarthy's (2007) story has echoed through parenting communities. I examine whether chosen anti- and pro-vaccination narratives meet the requirements of Fisher's (1984) narrative paradigm. In addition, I examine how the narratives might promote a sense of identification with audience members, particularly in how the narrators deal with a sense of guilt about the condition of their children (Burke, 1969). Further, I concentrate on both the functional nature of these narratives and on the constitutive components. The public is clearly divided on the vaccination issue. As I argue, this division may well come down to the way in which these distinct narratives constitute audiences differently, constitutions that both encourage people to act in particular ways through a sense of identification, and also outline the boundaries of what it means to be a "good" parent, such that one may be more swayed, consciously or unconsciously, by one type of narrative than another. Finally, I examine how the narratives deal with the conflict between personal choice and the public good. This

dissertation also addresses the question of how to make Fisher's paradigm a powerful tool for the rhetorical analysis of narratives. As I argue, focusing more explicitly than has previously been done on the Burkean (1969a, 1969b) concept of identification and including Burke's guilt/purification/redemption cycle in the analysis of narratives, we begin to see why stories that "should" be rejected by readers for failing to achieve the requirements of the narrative paradigm become widely accepted instead. In addition, this dissertation contributes to the field of communication, particularly health communication.

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Chapter One: Introduction

Should we get the shot? Why not?

Vaccinations have been considered one of the greatest achievements of modern medicine, protecting against diseases that once wiped out hundreds of thousands of children and adults worldwide, such as diphtheria, measles, and polio (Judelsohn, 2007). For instance, the small pox virus killed three hundred million people, just in the twentieth century, before the vaccine was invented which eradicated the disease (Specter, 2011). Vaccinations protect millions of children and adults from infectious diseases annually. According to one estimate, the current series of childhood immunizations recommended in the United States “prevents approximately 10.5 million cases of infectious illness a year and 33,000 deaths” (Every Child by Two, 2010b). Internationally, the World Health Organization, UNICEF, and the World Bank estimate that vaccinations currently save approximately three million lives, with that number doubling if more funding is made available for these efforts (Every Child by Two, 2010b).

Aside from the ability to spare suffering and possible death for our children, there is the added financial incentive to vaccinate them, not because of profit (as discussed below), but because vaccinations prevent health care costs that would be paid out to care for those suffering from vaccine-preventable-diseases (VPDs). Aside from the fact that high rates of vaccination protect against the spread of highly infectious diseases which could rapidly spiral into epidemics, vaccines are relatively inexpensive for the amount of

savings they provide in preventing health care spending on treating VPDs. According to one estimate, each individual vaccination saves an average of \$16.50 in treatment and related costs of VPDs for every dollar spent on them (Zhou, Santoli, Messonnier, Yusuf, Shefer, Chu, Rodewald, & Harpaz, 2005). This translates into roughly 43 billion dollars saved annually in treatment and associated costs of VPDs. In light of these statistics, everyone benefits from all of our children being vaccinated—from the prevention of disease and possible death of the children, to the pain and suffering of children and parents, to millions of dollars in tax-payers' money that can be filtered elsewhere to fight diseases that do not have preventions in place.

Yet in many developed countries, like the United States, the United Kingdom, and Australia, vaccinations have come under scrutiny—so much so that now vaccination is no longer the automatic reflex it once was among certain groups. Vaccination protocols are, in essence, suffering from their success. Parents in developed countries have limited or no experience with the diseases vaccines protect against, as in the case of polio (withered limbs, the inability to walk), measles (deafness), and rubella (blindness, mental retardation) (Judelsohn, 2007). However, diseases such as these, once thought eradicated, are still rampant in certain parts of the world (Offit & Bell, 2003). The increase in global travel has allowed VPDs to travel faster and farther than ever before. Developing countries fight to protect their children against these VPDs, with measles alone killing more than a hundred and fifty thousand people each year (Specter, 2011). Yet developed countries are struggling to achieve the necessary levels of vaccination to maintain herd immunity: the majority of people have to be vaccinated in order for everyone to be protected (Children's Hospital of Philadelphia, 2010a). Additionally, no vaccine provides

complete immunity against disease, but herd immunity helps to suppress incidences of the disease enough so that very few people are actually exposed to it.

It is not only the lack of exposure to VPDs that cause parents to question vaccinations, but also parental concern about the efficacy and safety of vaccinations. Those in the US who do not vaccinate their children often cite a mistrust of the government (Salmon, Moulton, Omer, DeHart, Stokley, and Halsey, 2005). Suspicion and distrust of government and medicine are partially warranted by historical incidents like the Tuskegee Syphilis Study, in which patients were subjected to unethical and inhumane experiments at the hands of the government (U.S. Public Health Service Syphilis Study at Tuskegee, 2010). In that infamous study, conducted from 1932 to 1972, poor working class men of African American descent who were infected with syphilis were enrolled in the study so that researchers could examine the progression of the disease unchecked by treatment. The men were unaware they had the disease, and were not treated for it, an especially egregious breach of ethics given that the cure for the disease, penicillin, was discovered in the 1940s. This study continued for forty years, despite changes in informed consent requirements and the creation of Institutional Review Boards to ensure the ethical and humane treatment of human participants in clinical research. The men were subjected to painful, invasive procedures, and many of them died from the untreated disease or complications from it. The study only stopped when its existence was leaked to the press in the early '70s. The fact that such an inhumane study was allowed to continue for so long, and only concluded relatively recently in a country that values equality, democracy, and justice, lends power to those

who raise concerns about the apparently revolving door between government officials and drug companies that manufacture vaccines.

Concern regarding vaccinations seemed to gain momentum in the late '90s with the idea that the Measles-Mumps-Rubella (MMR) shot caused autism, a hypothesis sparked by a study released by Andrew Wakefield and colleagues. This study vaguely linked the vaccination with the onset of Autism Spectrum Disorders (ASDs) (Wakefield, Murch, Anthony, Linnell, Casson, Malik, Berelowitz, Dhillon, Thomson, Harvey, Valentine, Davies, & Walker-Smith, 1998). The paper itself did not fully articulate the possible link. Rather, Wakefield, the lead author, proposed this claim in a news conference he held as the paper was being released. While this paper has since been retracted (Editors, 2010), its influence has been far-reaching, sparking the debate over the safety of vaccinations and causing parents in developed countries to question whether vaccinations are harmful to their children. The controversy started, in large part, by the Wakefield paper has had drastic results, as Specter (2011) notes:

Vaccine-preventable illnesses have made a strong resurgence in the past decade in the United States, fueled almost wholly by fear. There is currently a measles outbreak in Minnesota; last year, pertussis (whooping cough) cases, and deaths, reached a record high in California. (p. 82)

Other events have fueled the concern over the safety of vaccinations. For instance, as a preventive measure, the FDA recommended that a mercury-containing preservative, thimerosal, be removed from vaccines. One of the arguments anti-vaccination advocates make is that the mercury in thimerosal causes autism. This is not, in fact, true, but the FDA decided to recommend the removal of that preservative as a safeguard, with the result that all vaccines, except for the flu vaccine, were free of thimerosal by March 2001 (Gross, 2009). Tony Blair refused to disclose whether his youngest son, Leo, had been

vaccinated, which led many in the UK to question whether there truly was a conspiracy surrounding vaccines, of which government officials were definitely aware. Blair's refusal to indicate whether or not Leo was vaccinated seemed to support this idea (Lewis and Speers, 2003).

A few years later in the US, Robert F. Kennedy, Jr. (2005) wrote "Deadly Immunity," an article which accused the United States government of being involved in a far-reaching scheme with drug companies. He claimed that the government helped to hide evidence that the mercury in vaccines was actually causing autism in thousands of children so that the drug companies would not have to face lawsuits from the parents of injured children. At the same time Kennedy's article was released, David Kirby wrote a book entitled *Evidence of Harm*, which focused on the experience of a small group of parents who were convinced that vaccines had caused their children's autism (Kirby, 2005). In the summer of 2005, Kennedy and Kirby made the rounds in the media. These rhetorical claims seemed significant because, as Gross (2009) indicates:

the major US public health institutions—including the Surgeon General, Department of Health and Human Services (DHHS), and National Institutes of Health—*made no effort* to reassure the public that vaccines are safe and could not cause the complex neurodevelopmental problems associated with autism. (p. 4, emphasis added)

This lack of an official response made Kennedy's and Kirby's claims seem all the more true, and more parents in the US began to believe that there was a link between mercury and autism, even though such a link had been disproved and all mercury had been removed from vaccines at this time.

Kennedy, Kirby, and other anti-vaccination advocates have tapped into the cultural fear that corporate greed motivates many mandated medical interventions, such

as vaccinations. In the late twentieth century, relatively few drug companies were involved in the manufacture of vaccines, and those that were often complained about the low cost and the increased risk of liability (Allen, 2007). However, with the approval of “blockbuster” vaccines in the early twenty-first century, vaccines became big business. Two examples of these money-makers are found in Gardasil, discussed below, and Pediarix, a combination vaccination that includes immunization against the following diseases: diphtheria, tetanus, pertussis (whooping cough), Hepatitis B, and poliomyelitis, and which is given as a series of three shots to infants starting at 6 months of age (Pediarix, 2010). This latter drug garnered over one-billion dollars in profits in 2008 alone (Sheridan, 2009).

The conflict of interest between profits and products for people’s health is clearly outlined in the Merck Vioxx scandal of 2004. Vioxx was a hugely successful, profitable arthritis painkiller that, unfortunately, also caused heart attacks and strokes in its users, even though it had been sent to market as a “safe” drug (Smith, 2006). On September 30, 2004, Merck pulled the drug from market, and the effects were immediate. The company lost two-and-a-half billion dollars in annual revenue from the loss of drug sales alone. The potential losses from lawsuits of former users, numbering almost twelve thousand, are almost incalculable. Despite facing these massive losses, and seeing its stock drop nearly twenty-seven percent in value (Smith, 2006), Merck was able to recover profits quickly, due in large part to the FDA approval of its human papillomavirus vaccination (HPV), Gardasil. This vaccine, which is being marketed as protection against cervical cancer, is projected to generate roughly four billion dollars in annual revenue for the drug company. Parents of young women, who are the main target of the vaccine, report

numerous ill side effects of the three-shot series, such as pain at the injection site, nausea and dizziness (Gardasil, 2010), to more serious complications like a very high fever, weakness, tingling or paralysis, which is sometimes indicative of Guillain-Barre syndrome. These more severe reactions are not cited by Merck in their literature on the vaccine; rather, the literature refers patients to their doctors for more information on the vaccine.

It is hard not to be jaded about a vaccine that is supposed to protect our youth against a potentially deadly disease when that vaccine has been nicknamed “Help Pay for Vioxx” and which generates such a huge amount of revenue for its makers. And even this huge profit is not enough to satisfy corporate investors and shareholders. As Smith (2006) puts it, “even with [Gardasil], Merck will have to scramble for more blockbusters to fill the impending sales gap while maintaining enough growth to keep investors happy” (para. 10). His statement points to the fact that drug companies such as Merck have somewhat competing interests: ostensibly helping people to stay healthy or to treat their diseases, and making a profit to keep their shareholders happy. Given this conflict, it is easy enough to understand why people would be concerned about the safety and necessity of drugs and vaccinations, because their manufacturers seem to be making enormous profits while harming people.

People who advocate against mandated childhood vaccinations have the tendency to believe in a “vast conspiracy of physicians, public health officials, and the pharmaceutical industry” (Jacobson, Targonski, and Poland, 2007, p. 3149); with drug makers like Merck profiting hugely from the required implementation of certain vaccinations, this conspiracy seems more likely. Thus, the distrust of government and

corporations, and the sense that there is a revolving door between pharmaceutical companies and the government agencies meant to police them, runs through many of the narratives that reject vaccination. As Leask, Chapman, Hawe, and Burgess (2006) have shown, those who reject vaccination “align themselves with broad, socially acceptable structures, framing non-vaccination as an informed choice made by parents who are dissatisfied with official assurances, venerate freedom of choice, and are suspicious of government intervention” (p. 7238). Indeed, it is the sense that parents are making smarter, more informed choices by rejecting corporate profit-making vaccines that motivates many parents to question vaccination in the first place.

Perhaps the most significant public figure to reinforce the choices of parents not-to-vaccinate is Jenny McCarthy: The actress, former Playboy bunny, model, and mother, wrote a popular book chronicling her experiences with her son’s apparent autism (McCarthy, 2007). In the following excerpt from her compelling narrative, McCarthy recounts the event she originally believed caused her son Evan’s autism: the Measles-Mumps-Rubella (MMR) vaccination.

Right before his MMR shot, I said to the doctor, “I have a very bad feeling about this shot. This is the autism shot, isn’t it?” And he said, “No, that is ridiculous. It is a mother’s desperate attempt to blame something,” and he swore at me, and then the nurse gave [Evan] the shot...And I remember going, Oh, God, I hope he’s right. And soon thereafter—boom—the soul’s gone from [Evan’s] eyes. (<http://www.oprah.com/oprahshow/Mothers-Battle-Autism>)

Like many parents over the past decade, McCarthy struggled with the decision to vaccinate her child. Despite strong evidence to the contrary, McCarthy originally linked her son’s diagnosis with the MMR shot. Her book also details the ways in which she has “recovered” Evan from the disorder.

McCarthy has spent subsequent years promoting the theory that vaccines have caused autism in countless children, appearing on shows like CNN's *Larry King Live* and the *Oprah Winfrey Show*. For instance, during her appearance in April of 2008 on the *Larry King Live* show, McCarthy indicated that "It's time to start listening to parents who watched their children descend into autism after vaccination...[because] *parents' anecdotal information is science-based information*" (cited in Gross, 2009, p. 5, emphasis added). Here, McCarthy suggests that the stories parents tell detailing their experiences, which seem to show a direct, causal link between the MMR shot and the onset of autism, have real, scientific evidence behind them, supporting their claims. This was a particularly damaging assertion, especially as this rhetorical claim was not refuted by scientists because none were on the show with her; thus, her claim was able to resonate as "truth" with anyone who watched the show. McCarthy's story has changed over the years to reflect less of an outright rejection of vaccinations and more of a concern for making vaccines "safe." However, her narrative against vaccinations has caused significant concern about the safety and need for them, and the possible connection between vaccines like MMR and the onset of autism, even though this claim has been disproved.

As fewer parents have vaccinated their children against common childhood diseases, incidences of those diseases have continued to rise (Burgess, Burgess, & Leask, 2006; Friedrichs, Cameron, & Robertson, 2006; Leask, 2002). For instance, California has suffered from an epidemic of whooping cough (pertussis), with the most recent report in 2010 indicating:

more than 6,700 cases of pertussis (including ten infant deaths)...This is the most cases reported in 63 years when 9,934 cases were reported in 1947 and the highest incidence in 52 years when a rate of 26.0 cases/100,000 was reported in 1958.

Previously, the peak was in 2005 when there were 3,182 cases reported. (CDC, 2010a)

The real number of those suffering from the disease is probably much higher, as the number reported only indicates those who actually have been tested for the disease. As indicated, pertussis is a disease that used to kill literally thousands of children before the vaccine was discovered. And clearly, the rates of incidence of the disease have risen drastically in recent years, suggesting the effects of parents refusing to vaccinate.

The Centers for Disease Control (CDC) reports that “Immunization of children aged 19-35 months old against most vaccine-preventable diseases remains high in the United States, with coverage for most of the routine vaccines remaining at or over 90 percent” (CDC, 2010b). However, while it seems as if parents are still vaccinating their children, parents in certain groups are still questioning vaccines as the best choice. And, as Dr. Anne Schuchat, the director of the CDC’s National Center for Immunization and Respiratory Diseases indicates, “we must continue to educate parents about the importance of vaccination to help avoid future resurgences in serious, preventable illnesses” (CDC, 2010b). Dr. Schuchat’s comments seem to indicate that the crisis must still be addressed in order for parents to feel confident in vaccines. Additionally, “Dr. Schuchat noted that there [is] substantial variation between states in vaccination rates, suggesting room for improvements” (CDC, 2010b). Again, certain pockets of the nation’s population show increased reluctance to vaccinate. These communities tend to be affluent and well-educated, like Boulder, Colorado, Portland, Oregon, and Santa Barbara, California (Rae, 2010; Reich, 2010), believing in “natural” immunity as preferable to vaccines. Other groups who believe non-vaccination is the best choice tend to home school their children or view vaccines as unnatural (Rae, 2010; Reich, 2010). Because

these groups of people continue to tell stories that outline the supposed dangers of vaccination, other parents are influenced to question vaccines as well. Thus, while the national outlook is good regarding high rates of vaccinations, individual states still may be facing concern over vaccinations, leaving their populations vulnerable to epidemics of VPDs, such as those of pertussis seen in California, Pennsylvania, Minnesota, Oregon, and Michigan (CDC, 2010a).

Public health organizations (PHOs) and doctors sometimes have difficulty in conveying important medical information to patients and parents in ways that are meaningful because doctors tend to rely on scientific assessments, technical knowledge, and findings from epidemiological studies; however, parents may be more likely to rely on their own experiences, or those of close family members and friends when making decisions about vaccination risks and benefits (Leask, 2002; Rogers & Pilgrim, 1995). Further, narratives regarding vaccinations seem to draw the attention of the media, and therefore the public (Burgess et al, 2006). When the “voice of medicine” is privileged over the “voice of the lifeworld,” (Mishler, 1984), doctors are not as effective as they could be in responding to concerned parents. Responding to narratives that link vaccinations with the onset of disease solely with scientific discourse tends to be ineffective.

Parents have been more reassured about the safety of vaccines when doctors have indicated that most of them do not believe in the findings of Wakefield et al. (1998), and are in fact vaccinating their own children (Burgess et al., 2006). Conveying these personal facts and narratives helps to put a “face” on the pro-vaccination side of the controversy, rather than presenting a blank, scientific organizational front in response to

public concern. Importantly, while this crisis is reaching, or has possibly reached, its height, we are beginning to see confidence restored in vaccinations, probably because of a multitude of factors: scientific studies disproving the link between MMR, mercury, and autism; a rise in VPDs as a result of non-vaccination, without an accompanying decrease in rates of autism; and most importantly, the spread of pro-vaccine narratives outlining the real and significant concerns about VPDs. Many pro-vaccine narratives are now becoming more widespread, indicating that we are still seeing the effect of people not vaccinating. Because personal narratives are not only fundamental to how we live our lives, but also to this controversy in particular, they are vital to study at both the practical and theoretical levels.

The Rhetorical Study of Narratives Matters

Scholars have approached the vaccination controversy from a variety of fields, particularly sociology (Frank, 1995; Frank, 1998; Hyden, 1997), anthropology (and in particular, medical anthropology) (Casiday, Cresswell, Wilson, & Panter-Brick, 2006; Kaufman, 2010), psychology and psychiatry (Murray, 2000), and the medical and public health fields. Most have considered the history of the crisis and how it has unfolded (Kaufman, 2010). The literature from the medical field concentrates on disproving the links between thimerosal and autism, and vaccinations and autism. A common focus of research is also on who is to blame for the current climate toward vaccinations, with speculation about risk as well as journalism and the media concept of “balanced” reporting (Gross, 2009; Lewis & Speers, 2003).

Further, the narratives involved in the crisis have been examined by scholars who acknowledge the importance of narratives in influencing people to act in certain ways

(Leask, et al., 2006). However, these scholars merely indicate that the stories are powerful but do not examine the ways in which they are powerful, or consider the stories themselves. They look at the effects the stories have (in terms of how vaccination rates have gone down), or at them as one piece in the puzzle of how vaccinations have come under scrutiny (Leask et al., 2006). A study of the narratives told in the vaccine crisis, chiefly those which are published and broadcasted through the media, inherently calls for rhetoric, which allows access to the ways in which persuasion is occurring and how power is being wielded. Narratives are told with potential listeners in mind (Frank, 1995; Murray, 2000), so it is important to analyze how they are structured in order to get particular messages across, as well as how meaning and identification are co-constructed between speaker and listener.

Christina Beck (2001) highlights the fundamental role communication has in discussions about health and well-being: “From infectious disease to family planning to cancer awareness, communication can provide the vital bridge from scientific discovery to impacted lives” (p. 5). In the vaccine crisis, *narratives* have become the means by which science is questioned as problematic or reinforced as necessary and essential. As McCarthy’s (2007) story illustrates, one major component of the childhood vaccination controversy is the narratives that parents tell, whether in support of vaccinations or against them. Narratives seem to help parents make sense of the decision to vaccinate. For instance, Leask et al. (2006) indicate that the reaction of participants upon hearing personal stories about VPDs tended to show the “sacredness with which they held the stories” (p. 7242). The authors also validated the effect of illness narratives shown on television, as participants recalled with horror an advertisement from a national pertussis

vaccination campaign which showed a child suffering from whooping cough. Clearly, narratives about health-related issues, such as vaccines, comprise a large factor in people's decision-making regarding medical treatment.

As Murray (2000) indicates, narratives are “a popular human means of making sense of the world” (p. 338). This has certainly proven to be the case in the controversy over childhood immunization, as one can tell from the description physician and vaccination advocate Dr. Paul Offit gives of why he refuses to go on talk shows with Jenny McCarthy: “Every story has a hero, victim, and villain...McCarthy is the hero, her child is the victim—and that leaves one role for you” as the vaccine advocate (Gross, 2009, p. 5). Stories, particularly McCarthy's, spread the notion that vaccines are far more harmful than helpful.

As I demonstrate throughout this dissertation, the study of the narratives is vital for understanding the vaccination crisis, not the least because of the extent to which McCarthy's (2007) story has echoed through parenting communities across the United States. Stories relating parental experiences of VPDs also powerfully resonate with parents, illustrating the very genuine dangers of not vaccinating children; these stories have received less press, but are equally important in understanding the conflict raging about childhood immunizations. In the dissertation, I focus primarily on stories about those vaccinations given to children from birth to the age of two, as that is the time frame in which most immunizations, such as those protecting against pertussis, Hib, varicella, rotavirus, polio, diphtheria, tetanus, measles, mumps, and rubella, are administered; however, I also look at the stories surrounding the contraction of these various diseases at later stages in a child's life, before children reach eighteen [see Cheri Rae's (2010) story,

cited below, for an example]. In the analysis, I examine whether each narrative meets the requirements of Fisher's (1984) narrative paradigm, particularly narrative probability and narrative fidelity. This includes analysis of the depictions of characters within each story, as well as whether or not the story hangs together as audience members expect it to. In addition, I examine how these stories might resonate with audience members' experiences of the world. I specifically focus on how a narrative might reflect a reader's particular, historically situated perspective, which influences whether a reader would possibly identify with the story; this perspective has a significant impact on a narrative's ability to achieve fidelity.

In addition, I examine how the narratives might promote a sense of identification with audience members, particularly in how the narrators deal with a sense of guilt about the condition of their children (Burke, 1969a, 1969b, 1970, 1984). The concept of identification is woven throughout Fisher's (1984) paradigm; however, he does not touch on the notion of guilt, which is a vital component of these narratives. How the narrators purify themselves of the guilt they feel strongly affects how readers may identify with the narratives, which in turn either helps or hinders the narratives' ability to achieve the requirements of the narrative paradigm.

Further, I concentrate on both the functional nature of these narratives and on the constitutive components. Each story attempts to elicit some response, whether a change or reinforcement of a belief, or the motivation of some action in audience members. The functional element of these narratives is a fundamental aspect of their construction. However, each of these narratives also constitutes different audiences, in particular and contradictory ways. Throughout the stories, we see how each narrator's rhetoric

constitutes what it means to be “good” and “bad” parents,” “good” and “bad” members of the medical profession, and “good” and “bad” members of a community.

Finally, I examine how the narratives deal with the conflict between personal choice and the public good. Intricately connected to this conflict are questions of power and ethics. These concepts are central because decisions about vaccinations not only affect individual children and their families, they affect the larger public as well; this fact tremendously complicates the narratives surrounding the controversy.

Walter Fisher’s (1984) narrative paradigm has shown great promise as a method for analyzing narratives from a rhetorical perspective, but it has become mired in criticism by scholars who either are looking for something the paradigm does not claim to provide, or who focus in on and critique one or two aspects of the paradigm without considering how other elements of the paradigm help to balance them out. Therefore, this dissertation also addresses the question of how to make Fisher’s narrative paradigm a powerful tool for the rhetorical analysis of narratives: how might the criticisms of Fisher’s paradigm be addressed and corrected? As I argue, focusing more explicitly than has previously been done on the Burkean (1969a, 1969b) concept of identification that Fisher originally incorporated into his paradigm helps to revitalize the narrative paradigm as an analytical tool. Further, I contend that by including Burke’s guilt/purification/redemption cycle in the analysis of narratives, we begin to see why stories that “should” be rejected by readers for failing to achieve the requirements of the narrative paradigm become widely accepted instead.

In addition to enhancing Fisher’s narrative paradigm as an analytical tool, this dissertation contributes to the field of communication, particularly health communication,

a relatively young field that has been dominated by an interpersonal, post-positivist approach. The study of narratives has gained prominence within the health communication field, but not from a rhetorical perspective. However, while the general focus on quantitative methods in health communication has come under scrutiny lately (Beck, 2001), a rhetorical approach to the field is still lacking. Thompson, Robinson, Anderson, and Federowicz (2008) indicate that the least commonly used methods in health communication research have “included *rhetorical, narrative*, discourse and conversation analysis” (p. 10, emphasis added) approaches, despite the authors’ indication that these methods have much to offer to the study of health communication.

Rhetoric and persuasion are at the heart of the issues surrounding childhood vaccinations, and health communication more generally. The field of health communication is rife with issues of power, from the mandate of childhood vaccinations, to the treatment of chronic illnesses, to end of life and palliative care. The immunization crisis is being played out on the national (if not global) stage, in the form of media coverage and public health campaigns, as well as in smaller groups. When the question of profit comes into the picture, or the question of safety, the study of the rhetoric involved becomes imperative. This kind of analysis offers access to power and ethics on a grand scale. Power is involved not only in who is speaking, but also in what they are saying, to whom, and for what reasons. Additionally, whenever there are questions of power, there are questions of ethics to be found, because powerful words affect listeners’ beliefs and actions.

Ethically, vaccinations constitute a public health issue which affects us all, particularly because of herd immunity. The choices parents make about vaccinations do

not only affect their own children, they affect everyone else's children as well. One could also argue that the effects go beyond our children—the higher prevalence of disease, the higher the likelihood of other populations, like those who are immune-compromised, succumbing to VPDs. Further, the argument could be made that the higher the rates of disease in our children, the greater the cost of treating and/or containing these diseases becomes, particularly in contrast to the cost of the vaccinations themselves—school closures, travel bans, hospitalizations by those without health insurance, all drive up the cost of VPDs for everyone, not only those who choose not to obtain vaccinations.

Narratives Are a Necessity

Stories infuse our lives; “they provide structure for our experiences as humans and...they influence people to live in communities that share common explanations and understandings” (Burghardt, 2000, p. 289). The stories we tell, about life, death, disease and health “constitute a social *pedagogy*—they teach people who we can expect to be, who we should want to be, and what we ought to do (and not do)” (Frank, 2005, p. xiii).

Many people are aware of a “dramatic” plot line, the way in which many of our novels, literature, movies, and television shows are structured. Indeed, this form of narrative structure is so prevalent, most people are able to understand what the resolution of a conflict presented to the main character “should” be. In this type of plot line, a protagonist, or hero, must overcome some kind of challenge (whether great or small, funny or serious) in order to succeed in some manner. The structure, which is generally linear, has six elements: exposition, conflict, rising action, climax, falling action, and resolution (Schwartz, 2002). During the exposition stage, each main character is introduced to the audience, and the setting and any relevant background is established. In

the conflict, the audience is introduced to the problem, while the rising action details the events that occur while the hero tries to overcome the major conflict. The climax is the high point of the plot, focusing on an event that helps the hero to solve his/her problem and succeed. The falling action entails any action that occurs after the climax, while the resolution of the story shows that most, if not all, conflicts have been overcome. Many of the narratives in the vaccine crisis follow this format, particularly McCarthy (2007), who invokes the structure of triumph over adversity. Her story echoes Fisher's (1984) claim that "the most compelling, persuasive stories are mythic in form" (p. 16). As detailed in Chapter Two, narrative analysis examines how a story is constructed, and what it includes or is about; analyzing the plot structure is an important component of determining how and why certain narratives are powerful and compelling.

The field of health communication is particularly rich for the study of narrative, because people often rely heavily on stories from others, whether doctors, friends, family members or the media, in order to make health-related decisions. People are drawn to and remember information from personal narratives. This has been particularly true of the vaccination crisis, which became such a big issue in the US when McCarthy (2007) published her narrative supposedly linking autism and the MMR vaccine. As we will see, her narrative is easy to remember and forceful, because her message is clear, consistent, and frightening to parents.

Personal stories provide meaning and understanding for an experience that otherwise might be disconcerting (Garro & Mattingly, 2000). As Hyden (1997) indicates, "one of our most powerful forms for expressing suffering and experiences related to suffering is the narrative. Patients' narratives give voice to suffering in a way that lies

outside the domain of the biomedical voice” (p. 49). That is, narratives personalize a health crisis differently than a doctor’s strict medical accounting of it. The latter is often seen as dehumanizing, distancing, and clinical. Ziebland and Herxheimer (2008) indicate that even though people do rely on health professionals to work through health-related decisions, they tend to feel that they get the most useful and applicable information from others who have already experienced the same situation. In the vaccine crisis, parental narratives have an impact on the decisions parents make about vaccinating their children (Ziebland & Herxheimer, 2008). Thus, a focus on the construction and resonance of narratives is crucial for understanding the current crisis regarding childhood immunizations. Narratives allow access not only to “the world of biomedical reality, but also [to] the illness experience and its social and cultural underpinnings” (Hyden, 1997, p. 48). By studying the narratives involved in this crisis, we see how it has evolved and come to be an issue in the first place. We see both the medical and scientific implications as well as the personal, social, and cultural ones.

Further, narratives have come to be a means of accessing power, voice, and reason, particularly for those who may not have had this access before. As psychologist Murray (2000) indicates:

the role of narrative therapy [in psychology] is to undermine the dominant narrative that makes certain experiences problematic and to develop a new story that enhances alternative knowledge...[this] can be a means of strengthening the confidence of the marginalized and underprivileged. (p. 345)

This theme is also prevalent in health communication where the way in which patients tell stories and/or co-construct illness stories with their caretakers has become a focal point (Japp, Harter, & Beck, 2005). Narrative gives the patient or ill-person more control and power than previously was the case in doctor-patient interactions. The sense of

empowerment, or challenging the dominant narrative, is certainly prevalent in the case of McCarthy (2007), whose story seems to represent a David-versus-Goliath struggle. McCarthy characterizes herself as the David taking on the Goliath of the medical professionals, the governments, and pharmaceutical companies who all profit from vaccines even as they harm children. Ironically, this approach to her story is precisely one of the reasons it has been so successful. However, she *is not* a powerless, underprivileged, or marginalized individual. She is a mainstream celebrity with easy access to powerful media sources which widely distribute her story. Even so, the David-versus-Goliath format of her account has been an influential factor in its dispersal, representing how narratives often usurp or upset the dominant voices.

As Hyden (1997) indicates, “narrative’s importance lies in its being one of the main forms through which we perceive, experience, and judge our actions and the course and value of our lives” (p. 49). The narratives involved in the childhood immunization controversy construct each side in particular ways, and publicly play out the conflict that is often seen at the interpersonal level between patients and doctors. These narratives move a private issue to the public domain; through the narrative, “The illness experience is removed from the private sphere and becomes part of an all-encompassing, political and social narrative and context. Through the narrative, the illness experience becomes a collective experience” (p. 59). In the vaccine crisis, doctors and public health organizations, as the “voice of medicine” have been pitted against anti-vaccination parents who want to represent the “voice of the lifeworld” (Mishler, 1995). This trend is shifting, as more doctors and pro-vaccine parents tell stories that represent life experiences rather than merely report facts, statistics, and risk-benefit analyses. A

rhetorical examination allows access to this move from the personal to the public domain. Fisher's (1984) narrative paradigm, reinvigorated with Burke's concepts of identification and the guilt/purification/redemption cycle, provides the perfect tool for the assessment of these narratives. Both Fisher and Burke view narrative as intrinsic to human nature, capable of constituting audiences and individuals in ways that promote identification, and persuasive, able to convince listeners to believe certain things and act in certain ways.

Walter Fisher's (1984) narrative paradigm helps to unpack the force narratives seem to have in this controversy; his paradigm exposes the ways in which the pro- and anti-vaccine narratives are similar and different, as well as how they might be received by parents trying to make decisions about vaccinating their own children. I also use Burke's (1969a, 1969b, 1970, 1984) concept of identification as a necessary addition to flesh out Fisher's (1984) narrative paradigm. In this introductory chapter, I merely outline the basic points of these theories; a much fuller description of each comprises Chapter Two of the dissertation, including a lengthy exploration of the ways in which the two theories complement each other and strengthen narrative theory as an analytical paradigm for rhetorical criticism.

Fisher's (1984) narrative paradigm "presumes that humans are essentially storytellers who act on the basis of good reasons derived from their experience in a world" (p. 8). That is, humans are "*homo narrans*" (p. 6), a metaphor which "is an incorporation and extension of Burke's definition of 'man'" (p. 6). By narrative, Fisher does not mean simply fictional works, but rather a "theory of symbolic actions—words and/or deeds—that have sequence and meaning for those who live, create, or interpret them" (p. 2). Thus, Fisher views the world as created by stories from which we choose those that

match our beliefs and values in order to live. Calling on Burke, Fisher argues that “the materials of the narrative paradigm are symbols, signs of consubstantiation, and good reasons, [and] the communicative expressions of social reality” (p. 8). Here, the concept of consubstantiation means identification—how we choose the stories by which to live depends on how much we identify with, or see ourselves in, the stories told by others. This concept is explored in more depth below.

Fisher indicates that people use the concepts involved in narrative rationality to determine whether a story provides a sound or “truthful” basis for action and beliefs about the world. These concepts are narrative probability and narrative fidelity, which Fisher states “are analogous to the concepts of dramatic probability and verisimilitude” (p. 8). Narrative probability signifies whether a story is cohesive; that is, whether it comes together and stays together in a meaningful way. Different parts of the story must “hang” together without contradicting each other; simply put, the parts of the story make up a coherent whole. The characters act consistently throughout the story, and thus the audience trusts the story, because it is a story like those they have experienced or those they can reasonably expect to occur in their own lives. Narrative fidelity indicates how “true” a story is for the person listening to it; thus, it takes into account the listener’s background and history. If the listener hears a story that does not fit into his/her beliefs or background, that story will not persuade the listener because it is not true to his/her experience of the world. Narrative probability and fidelity help to assess the quality of narratives on both sides of the vaccine controversy, and are the major components by which the narratives are analyzed.

Fisher shows that the narrative paradigm is quite useful for “resolving the dualisms of modernism: fact-value, intellect-imagination, reason-emotion, and so on” (p. 10). The ability to deal with these binaries is particularly useful for the current project because the controversy over childhood vaccinations deals directly with the dualisms of fact-value and reason-emotion. Doctors and PHOs initially responded to concerns about vaccines with incredulity: how could vaccines, one of modern medicine’s most successful inventions, have come under such scrutiny and doubt? These medical professionals then spent much time using facts and traditional forms of rationality, such as risk assessment (Hobson-West, 2009) to reinforce the idea that vaccinations were safe. Parents were less reassured by these types of responses than they were by more emotional and value-laden responses, such as the private views of doctors regarding their own children and whether they personally felt vaccines were safe. In a sense, these individual responses of the doctors could be seen as narratives which address the split between the personal and the public, thus showing how vital the study of narratives is for understanding the controversy.

Further, Fisher (1984) argues that narratives involve the “whole mind in concert with itself” (p. 10)—stories access and play upon many different facets of humanity, including reason and emotion, which often seem mutually exclusive. Fisher’s paradigm is useful also because he indicates that “narratives are moral constructs” (p. 10). They are stories we tell and listen to in order to make decisions about how to live our lives; thus, morality is implicit. The narratives surrounding the immunization debate are rife with moral implications and concerns, particularly those pertaining to parenting and the public/private nature of the controversy. Most parents want to believe that they are acting

in their children's best interests; thus, they hold a self-conception as "good parents," and they are likely to identify with stories that do not counter such ideas. Fisher's paradigm is valuable for examining narratives from both sides of the issue, since one side is arguing that in order to be a "good parent," one *should* vaccinate one's child and the other side asserts that in order to be a "good parent," one *should not* vaccinate one's child.

Fisher's description of narration dovetails nicely with the way in which people make health-related decisions, as reported in the literature, above: people seek out others' stories and experiences to make their own decisions. Far more than solely rational, scientific information, narratives appeal to the broad range of human experiences, "to reason *and* emotion" (p. 10, emphasis added). Additionally, Fisher's three concepts of the way in which narratives work provide an excellent outline for the ways in which both pro- and anti-vaccination narratives might be examined (as I do in Chapters Three and Four): first, narratives "capture the experience of the world;" secondly, stories work in terms of narrative probability (the likelihood of the story actually occurring) and narrative fidelity (whether the story is or could be "true" to their own experience); and thirdly, the narratives may work by identification, whether they "successfully" encourage audience members to act in particular ways. Fisher assumes many of Burke's arguments about identification; however, he does not elaborate on them in any depth. This lack of discussion about identification in Fisher's work points to a need for Burke's perspective in this project as well. I now turn to a brief discussion of Burke's (1969a, 1969b, 1970, 1984) concepts of identification and the guilt/purification/redemption cycle. A much deeper elaboration of these concepts can be found in Chapter Two.

According to Fisher (1984), Burke suggests that our lives are stories that interact with and participate in the stories of those around us, whether now, in the past, or in the future (p. 6). Burke focuses on the concept of identification as supplementary to the traditional focus on persuasion in rhetoric. If we limit the concept of persuasion to the intentional acts of a rhetor to a particular audience, we lack in terms of what we can understand about our world, because our communications with our world are more complicated than that specific relationship of rhetor to audience (Quigley, 1998). Quigley suggests a variety of ways in which Burke's concept of identification helps us to move beyond the traditional concept of rhetoric as persuasion. Identification allows us to focus on a variety of texts, not just on the occasional important speech. Specifically, it draws attention to the everyday experiences with which we identify, and to a variety of audiences, not just the specific, known, and intended audiences who are meant to receive and be persuaded by a specific speech.

Burke's concept of identification is rooted in the notion of division and transcendence—we are divided from others in a myriad of ways, being biologically separate, as well as separated by class, race, religion, sexuality, and other characteristics. These divisions cause us to feel guilt because we are separate from others in ways that create a hierarchy. Our need to identify with others is born out of this separateness from one another. Burke argues that we attempt to overcome these divisions through communication, which helps us identify with each other. We seek things we share in common with others, such as experiences, beliefs, values, and interests. These commonalities help us to be “consubstantial” with them at the same time that we can never transcend the divisions between us. Thus, we are “both joined and separate, at once

a distinct substance and consubstantial with another” (Burke, 1969a, p. 21). We share some qualities in common, but we are never exactly the same as another person or group.

Importantly, we attempt to identify with particular people and groups more than with others. This identification comes via our use of language, which, for Burke (1966), is symbolic action. Burke (1966) defines humans as:

the symbol-using (symbol-making, symbol-misusing) animal, inventor of the negative (or moralized by the negative), separated from his [her] natural condition by instruments of his [her] own making, goaded by the spirit of hierarchy (or moved by the sense of order), and rotten with perfection. (p. 16)

We use symbols, or language, to “form attitudes or induce actions in other human agents” (Burke, 1969a, p. 41). The inherent need to identify with others extends the concept of persuasion: because we are constantly seeking to overcome our separation from others, we are open to those who would influence us through our need for identification with others. Identification can occur by our naming something or someone and indicating they have particular qualities; it can also occur by suggesting that particular groups or individuals do or do not have things in common. Identification can be used unconsciously, as a means to an end, to create a common “enemy.” For Burke, it is vital that we understand the ways in which we use language for good and bad, to achieve social cohesion and peace, or confusion, conflict and war.

Burke’s concept of identification is vital in the study of narratives from both sides of the controversy. It is important to look at the ways in which stories from parents promote group identification, particularly if the attempt at identification is done consciously in an effort to endorse a particular view of childhood immunizations. The various ways in which identification occurs, such as through the creation of an enemy, or through consubstantiality, seem to run rampant through the narratives surrounding this

issue, as McCarthy's (2007) narrative in particular illustrates. Additionally, Burke expands critics' ability to analyze the identification occurring within the vaccine narratives, as it does not limit identification to a rational and instrumental idea as in Fisher's narrative rationality, as critics have argued.

Part of the way in which these narratives generate a sense of identification is through their manner of dealing with a sense of guilt, making the incorporation of Burke's guilt/purification/redemption cycle essential for their analysis. This is especially true because Fisher's (1984) narrative paradigm does not address the concept of guilt at all, and a sense of culpability and remorse certainly appears as an underlying theme in each of the narratives I analyze.

We are guilty not only at the personal, psychological level, but also ontologically, because of the nature of language: symbolic action creates and maintains divisions, as well as transcends those divisions between people. It is human nature to seek order in our world, but the world is full of what Burke (1969b) calls "mystery" (p. 146), or differences. Such mystery is unendurable, thus we seek to contain it by creating social rules and standards, which in turn create a "hierarchy" (p. 146). Some examples of hierarchies are "church[es], political party, labor union, or other such social collectivities" (Brummett, 1981, p. 255). We can belong to many different hierarchies throughout our lives, and they constantly change, crumble, and reform. As Brummett (1980) indicates, "a hierarchy overcomes the natural mystery to which people are heirs by providing grounds for union, for consubstantiality" (p. 65). We feel guilty when we divorce ourselves from one hierarchy or another, which happens both naturally and purposefully. In the case of the vaccine debate, for instance, McCarthy (2007)

deliberately breaks from the hierarchy of prevailing Western medical opinion regarding the importance and safety of vaccinations.

We seek redemption from our guilt through purification, which can occur via mortification or victimage. Mortification occurs when we take the blame upon ourselves in an act of self-sacrifice; victimage occurs when we blame someone or something else for the cause of our guilt. Either way, we seek to purge ourselves of the guilt we feel, and the end result is redemption from this guilt. However, the sense of redemption we gain is temporary; we may have overcome this particular feeling of or cause of guilt, but because life is a continual drama, the cycle of guilt and redemption will continue on.

As an example, McCarthy (2007) feels guilt for “causing” Evan’s autism by agreeing to allow him to be vaccinated. She creates a scapegoat in the form of the medical professionals she interacts with who dismiss, out of hand, the theory that vaccines cause autism. In the pro-vaccine stories, parents display a variety of techniques for dealing with guilt, with the primary coping mechanism being mortification, where they take the responsibility for the guilt and its effects upon themselves, rather than blaming others. How the narratives either create a scapegoat or engage in mortification may resonate with audience members. If audience members recognize McCarthy’s experience with inept and harmful medical personnel as something they have or might experience, they are more likely to identify with McCarthy’s story over one which reflects the medical community as helpful and caring.

In the narratives surrounding the childhood vaccination issue, it is possible to see how different storytellers incorporate Burke’s concepts of mortification and scapegoating into their stories about their children and childhood vaccinations. Indeed, an analysis of

these narratives that did not include an examination of guilt and ways of dealing with this guilt would overlook some of the most powerful and rhetorically moving parts of the stories. Rhetorical critics cannot access the sense of guilt, a vital component of these narratives, solely by using Fisher's (1984) narrative paradigm. By combining Burke's concepts of identification and the guilt/redemption cycle with Fisher's narrative paradigm, a critic is better able to account for the broad range of stories that are told and embraced. The combination of these theories provides a qualitatively rich, in-depth analysis of the narratives on both sides of the vaccine controversy.

Stories Help to Make Sense of the Crisis

Some of the most powerful rhetorical acts in the controversy surrounding childhood vaccinations are stories told by parents on either side of the issue. As noted, I have chosen to examine celebrity Jenny McCarthy's (2007) story. Her narrative has been widely distributed via many different mediums. It can be considered as representative of those who are against childhood immunizations because it is incredibly rich and detailed, describing all of the particulars of McCarthy's journey, from her son's first seizure through the fight to get a "correct" diagnosis, through the challenges of finding appropriate treatment options and struggling against unhelpful doctors, to the joys of successfully curing Evan of his condition. I also analyze a series of parental stories that support vaccines: each of these stories deals with a VPD such as rotavirus (Matthys, 2010), H1N1 (Duvall, 2010), and pertussis (Dube, 2010; Rae, 2010). These pro-vaccine parents are "everyday" parents—that is, they do not share the celebrity status of McCarthy. The difference that celebrity makes in the distribution and reception of narratives is addressed in Chapter Three. Importantly, both anti- and pro-vaccine

narratives not only represent the rhetoric on each side of the controversy, they are also qualitatively rich texts.

Jenny McCarthy is an actress, mother, and outspoken adversary of childhood shots. She is arguably the leader for the anti-vaccination movement—her fame and her bluntness have gotten her far more exposure than other people who believe vaccines cause harmful effects in children. Parents and the public at large are deeply divided by McCarthy, but there is no arguing that she has become the “voice” of those against childhood vaccinations. While the diagnosis of Evan as autistic has recently come under scrutiny (Greenfield, 2010), McCarthy still claims that Evan was autistic, that his autism was caused from vaccinations, and that she “recovered” him through alternative methods.

McCarthy was originally against all vaccinations, believing that the MMR shot caused her son’s condition; she has now amended her stance to argue that children receive too many shots, too close together, and that our vaccines contain harmful elements (Generation Rescue, 2010; Greenfield, 2010). However, her story linking vaccines and the onset of a negative medical condition is a common one from parents who feel that vaccinations, specifically the MMR shot, have negatively affected their children: their seemingly healthy children seem to suddenly develop symptoms of disease, such as seizures or fevers, or a sudden change in personality days after vaccination (Bains, 2008). I include more of McCarthy’s story here to demonstrate its power, as well as give readers a sense of what texts I analyze.

McCarthy discovered her son convulsing, which occurred just prior to his autism diagnosis:

The sound I heard will be imprinted on my soul forever: my son struggling to breathe. I ran to his crib and saw my son fighting to take in air. I grabbed him in my arms and started screaming at the top of my lungs, “Something is wrong with Evan. Oh my God, help me!” I ran his limp body into the living room while his father, John, leaped to call 911. My mother screamed while Evan convulsed and wheezed. I looked into his eyes, which were wide open, and saw that one pupil was dilated and the other was small...I didn’t know what to do. His skin looked white, and his lips were no longer rosy pink. I put my lips next to his ear and said, “Stay with me, baby, stay with me. Mama’s here.” Thoughts of having a brain-damaged child flew through my head. I feared I would never again see him do all his cute little things. I wanted Evan back. I wanted this to *stop*. (McCarthy, 2007, p. 2)

McCarthy’s story resonates immediately with parents; her description is even more powerful because it links Evan’s seizure with neurological damage. Here, the reader gets the sense that McCarthy’s child is slipping away from her, never to return. And when his disappearing “soul” is linked to a particular immunization, the story becomes incredibly compelling for the audience, including parents of unaffected children who are at an age to receive most vaccinations. When a preventive procedure becomes linked, even tangentially, with harm, parents are understandably concerned about that procedure.

While claims linking vaccination with negative consequences such as the onset of autism have been refuted by the scientific community (Afzal, Ozoemena, O’Hare, Kidger, Bentley, & Minor, 2006; DeStefano, Mullooly, Okoro, Chen, Marcy, Ward, Vadheim, Black, Shinefield, Davis, Bohlke, and the Vaccine Safety Datalink Team, 2001; Fleming, Blair, Platt, Tripp, Smith, Golding, & the CESDI SUDI research group, 2001), narratives rejecting vaccinations are nonetheless extremely persuasive. It makes perfect sense for parents to seek an explanation for their child’s seemingly sudden change in personality, and anti-vaccination stories are heartrending for those who hear them, even those who do not believe in a link between vaccines and certain supposed side-effects. In addition, the way in which the media has covered certain stories from parents against vaccinating their

children has led the viewing population to assume that the narratives of the anti-vaccination movement are the “true” story (Offit & Bell, 2003). This may be one reason why Jenny McCarthy’s story has been so influential—her stories are so widely disseminated by media outlets that they are easily accessible to parents questioning vaccination. McCarthy’s narrative thus provides the perfect text to analyze in order to understand the anti-vaccination perspective.

McCarthy’s narrative is clearly gripping, given its wide dispersal through the media. But narratives play a major role in supporting vaccinations as well. In recent years, public health organizations and campaigns have begun featuring the stories of parents who have watched their children suffer, and sometimes die, from VPDs. The Children’s Hospital of Philadelphia has a forum on their vaccination information website in which parents tell stories about their children contracting VPDs. One such example comes from a mother who had two children hospitalized for rotavirus within hours of each other (Matthys, 2010). Her story, like McCarthy’s (2007), moves a reader to tears, particularly if the reader is a parent of small children. I include lengthy excerpts of it here to show the power of this type of narrative as well:

Our beautiful daughter...had been vomiting and suffering from diarrhea for three days. This time we went straight to the emergency room. She was dehydrated and would once again need IV fluids. They attempted to start an IV line in her left arm, but ended up blowing all three viable veins. They then tried her right arm, her hands, her feet and even her forehead, but all 12 attempts failed. She was so dehydrated that starting an IV was next to impossible...I can’t tell you the pain I felt in my heart as I watched my daughter suffer. Weak and scared, all she could do was cover her head with her “blankie” as they stuck her again and again. She was so dehydrated her little eyes couldn’t even produce tears as she cried. There was talk of calling in the NICU team to make an attempt to find a vein, then talk of calling in the vascular team and even talk of hydrating her by drilling directly into her bone marrow. My heart broke as I watched helplessly...Rotavirus is a preventable disease. (Matthys, 2010, paras. 1-3)

Like McCarthy's story, Matthys' is vivid and heart-wrenching; like McCarthy, Matthys links her children's suffering to vaccination; however, this time it is because they did *not* get vaccinated that they are so ill.

The pro-vaccine narratives I analyze all come from public health organizations supporting vaccination, rather than from more popular media outlets such as *The Oprah Winfrey Show* or *Time* magazine. The reasons for the location of these narratives and their relatively small distribution compared to McCarthy's (2007) are addressed in Chapter Four. Two stories come from the Children's Hospital of Philadelphia (Matthys, 2010; Rae, 2010). The stories recounting a six-week old baby suffering from pertussis (Dube, 2010), and a fifteen-year old suffering from H1N1 influenza (Duvall, 2010) come from the public health campaign, *Every Child by Two—Vaccinate Your Baby* (2010). Each is a powerful account from parents whose children have suffered from vaccine preventable diseases; in the case of Luke Duvall, the fifteen-year old recounts his experience with H1N1 flu firsthand. It is especially important to me to examine stories about VPDs because McCarthy's anti-vaccination narrative links vaccinations to a disease (i.e. the MMR shot with the onset of autism); these pro-vaccine stories I have chosen also link vaccines to disease, but in these cases, to diseases that can be prevented through timely and proper vaccination. These stories represent a range of diseases and a range of severity regarding the suffering and consequences for each child. These vary from months of illness and loss of schooling (Rae, 2010), to hospitalization lasting from four days (Matthys, 2010) to a month (Duvall, 2010), and finally to death (Dube, 2010). In addition, these children range in age, from six weeks (Dube, 2010) to fifteen years (Duvall, 2010), as well as in vaccination status (non-vaccinated and vaccinated). Because

of all of these differences, this compilation of stories is a good, representative sample of the pro-vaccine narratives distributed for public consumption.

What is interesting about all of the stories in the vaccination controversy is how convincing they seem to be. Yet there must be differences as well, because the public is clearly divided on the vaccination issue. As I argue, this division may well come down to the way in which these distinct narratives constitute audiences differently, constitutions that both encourage people to act in particular ways through a sense of identification, and also outline the boundaries of what it means to be a “good” parent, such that one may be more swayed, consciously or unconsciously, by one type of narrative than another.

The issue of childhood immunizations may very well be decided by who tells the most convincing story, the story that parents identify the most with, and the one they use to make decisions about whether to vaccinate their children or not. Narratives, powerful tools for reasoning and decision-making, are not only influential in the choices parents make about vaccines; they are also vital in continuing the discussion about public good and private choice. The vaccine crisis affects us all, whether we have children or not—when herd immunity is diminished because parents choose not to vaccinate, we are all at greater risk for contracting VPDs, regardless of whether or not we are vaccinated. Even if we do not suffer directly from VPDs, we suffer indirectly, by having to pay for increased health care and public health costs resulting from the outbreak of VPDs.

Finally, although it seems as if parents are being successfully reassured about the safety and necessity of vaccinations, the role narrative has played and

continues to play in the crisis points to other areas in which narrative may be highly influential, such as other public crises brought about by personal choice. For instance, personal narratives may be more influential in bringing home the real dangers of global warming and encouraging personal action in a way that scientific discourse may fail to do. As our population continues to grow, and we come into closer contact with one another, we are rapidly reaching a point where many of the choices we make as individuals affect the lives of others. As I elaborate in the chapters of this dissertation, the vaccination controversy demonstrates how the idea of the “public good” is being challenged by privatization, to the potential physical detriment of our communities. I conclude this introduction by summarizing the chapters of this dissertation.

Chapter 2 explores narrative theory, particularly as it has been approached in the social sciences. I also examine how a rhetorical approach to the study of narratives provides access to power, reason, and ethics. I outline the theoretical frameworks of Fisher (1984) and Burke (1969) in much more depth, concentrating on the criticisms Fisher’s (1984) narrative paradigm has been subject to. By revisiting the Burkean concepts Fisher originally used in his theory, and by augmenting the paradigm with Burke’s concept of the guilt/purification/redemption cycle, I show how these criticisms of Fisher are a misreading of his paradigm. Finally, I show how this reinvigorated combination of Fisher’s narrative paradigm and Burke’s concept of identification strengthens narrative analysis as a tool for rhetorical criticism.

Chapter 3 includes the analysis of Jenny McCarthy’s (2007) story linking the MMR shot to the onset of her son’s autism. I explore the structure of her narrative,

examining the ways in which it adheres to the traditional plot line of a hero overcoming adversity. I study the functional aspects of her narrative; that is, the ways in which she seems to intentionally structure her story to achieve particular attitudes in her audience members, and to encourage them to take specific kinds of action. I also look at the manner in which she constitutes a particular kind of audience, tapping into the sense of identification a reader may have regarding her portrayal of the medical community. Additionally, I explore how she deals with a sense of guilt for “causing” Evan’s condition, by scapegoating all medical professionals. Throughout, I evaluate how her narrative meets or fails to meet the requirements of Fisher’s (1984) narrative paradigm, focusing on moments when Burke’s concept of identification may “trump” the need for narrative fidelity.

Chapter 4 analyzes the narratives of parents who support childhood immunizations. I examine many of the same components as in McCarthy’s (2007) story; however, each of these pro-vaccine stories is significantly shorter than her book-length narrative. Thus, I do not engage in the same in-depth analysis of the plot structure or narrative elements, such as character development. However, I do examine the ways in which these narratives deal with the guilt the narrators feel regarding the state of their children [or themselves, in Duvall’s (2010) case]. This chapter also continues the discussion regarding the trustworthiness of, and/or suspicion people have, about government involvement in health-related topics, as well as the ethics involved in the choices parents make about vaccinating their children. This chapter looks at how pro-vaccine narratives navigate the difficulty of influencing parents about the safety, efficacy, and necessity of vaccinating their own children, not only for their benefit, but for the

benefit of the public at large. I also examine how these narratives constitute audiences in ways that are different from McCarthy's (2007) story.

The concluding chapter revisits the project in its entirety. In this chapter, I compare McCarthy's story to the pro-vaccine narratives, evaluating how each type of narrative either meets or fails to meet, the requirements of Fisher's (1984) narrative paradigm. I also concentrate on the ethics involved in the issue. I explore the struggle over who has the authority to mandate health decisions. This question of authority is complicated by the private/public nature of this issue and the questions of ethics that this split raises. The conclusion provides insight into how narratives influence people's decisions, and how people turn to narratives as a form of reasoning that draws on but extends our nature as rational beings.

The End is Just the Beginning

The controversy surrounding the issue of childhood immunizations is a complicated one which involves all of our faculties as human beings. Because the issue is riddled with parental concern about harming children, either by vaccinating them and having them sustain a potential side-effect, or by not vaccinating them and having them contract a VPD, emotions run high. Parents turn to a variety of sources for information about the issue; because the issue is so emotional and personal, parents rely in some measure on narratives in order to make their own decisions about whether to vaccinate their children or not. By using Fisher's (1984) narrative paradigm to examine these narratives, we can begin to understand the way in which these narratives rhetorically influence parents' decisions. In addition, Burke's (1969) concept of identification helps

in the analysis of narratives, particularly since it seems as if parents will act similarly to those they most identify with on this issue.

I clearly support the continued vaccination of our nation's children; however, I find the narratives told by those who are against vaccinations compelling and moving, just as much as I find the narratives of those who support vaccinations persuasive and convincing. It is tremendously difficult to hear any of these narratives and not be moved. No parent wants to hear about the sudden onset of a neurological disorder, or about a child suffering from a disease which could have, and should have, been prevented through the use of vaccines. Further, I understand the mistrust some people have regarding corporate and governmental involvement in health-related issues. This is an issue that is dear to my heart; further, if it continues, it has the ability to divide the nation in troubling ways, and if many parents choose not to vaccinate their children, we may find ourselves in the midst of an epidemic of diseases once thought to be eradicated. Thus, while I am sympathetic to the stories from parents who do not believe in childhood vaccinations, I hope the rhetorical study of their narratives in comparison with the narratives of those who support vaccinations will shed light on this very troubling problem, along with some insight into how narratives help us to identify with others.

Fisher's (1984) narrative paradigm, and Burke's concepts of identification and the guilt/purification/redemption cycle help us to understand how this came to be an issue in the first place. Narratives clearly have an impact on how we live our lives. This project contributes to an understanding of how some narratives have come to be accepted, believed, and identified with over others, further illustrating the power of the narrative, while addressing the ethical questions we must grapple with as we tell our own stories

and decide which other stories to live by. We live in a time when we seek out information individually, particularly about medical issues, rather than just relying on the medical professionals to tell us what to do. In this age of increasing global travel and population, our health decisions have begun to have far greater effects: it is not just the stories we tell that affect others' views of the world; the choices we make based on these stories affect the health and well-being of our neighbors as well.

Chapter Two: Narrative Theory

What Is Narrative?

Narrative is, most would agree, fundamental to human communication. Walter Fisher (1984) goes so far as to suggest that story is essential to the nature of humanity itself, characterizing humans as *homo narrans*. As Arnett (1990) indicates,

The notion of narrative attempts to ground communication in something other than the psychological relation between people, without falling prey to the dangers of an absolute. A narrative story invites us to participate in the ongoing telling and in the shaping of the narrative itself, while the narrative also shapes us. Narrative is a paradox characterized by both psychological relation of the individuals and the tradition of the group. (p. 213)

Arnett points to the very usefulness and essential nature of narrative here, which he also locates in Fisher's work. For Arnett, Fisher provides "a *practical answer* to a complex question...how do we offer values, a vision and a tradition without embracing an inflexible set of assumptions that require unthinking allegiance?" (p. 213, emphasis added). Narrative allows us to pass on our views of life and what we find valuable to others in ways that are flexible and change according to the time and place in which we find ourselves.

A wide range of scholars agree to the fundamental importance of narrative itself.

For Roland Barthes (1975), narrative is ubiquitous:

Among the vehicles of narrative are articulated language, whether oral or written, pictures, still or moving, gestures, and an ordered mixture of all these substances; narrative is present in myth, legend, fable, tale, novella, epic, history, tragedy, [drama,] comedy, pantomime, paintings...stained glass windows, movies, local

news, conversation. Moreover, in this infinite of forms, it is present at all times, in all places, in all societies; indeed, narrative starts with the very history of mankind; there is not, there has never been anywhere, any people without narrative. All classes, all human groups, have their stories...narrative remains largely unconcerned with good or bad literature. Like life itself, it is there, international, transhistorical, transcultural (p. 237)

Barthes indicates that many, many things can qualify as narrative, whether visual, written, spoken, “good” or “bad.” Further, he points to the constant nature of narrative throughout the history of mankind. This can be seen as early as Aristotle, who “understood that narratives are often moral tales, depicting a rupture from the expected—interpretive because they mirror the world, rather than copying it exactly” (Riessman, 2008, p. 4). Narratives help humankind to deal with the challenges life poses us, in ways that allow us to shape and form our reality, and interpret and change the world around us.

Yet Riessman makes the important point that while so many things can qualify as narrative, not everything can do so (p. 4). Those things fundamental to the story, such as a storyline developed in some kind of sequential order, details regarding a setting for the action, and characters who enact different roles and perform specific deeds, are not always found in everyday conversation, communicative exchanges, or images (p. 5). A narrative is defined by its structural capacity to arrange and order elements of reality that would otherwise be confusing, random, and meaningless. This kind of ordering and structuring can run the gamut from describing discrete, specific events, to a series of events, to an entire life narrative. Riessman originally argues that a *story* is only one type of narrative among others; but she comes to use the terms *story* and *narrative* interchangeably, as I do throughout this study. As we see in the anti-vaccination narrative of Jenny McCarthy (2007) and the pro-vaccination stories of Matthys (2010), Duvall

(2010), Rae (2010), and Dube (2010), each of these stories has a definite sense of sequence and ordering, as well as the disturbance of each person's everyday life as a result of the disorder (McCarthy, 2007), or disease (Dube, 2010; Duvall, 2010; Matthys, 2010; Rae, 2010).

Narratives are told both by individuals and groups of all types. Echoing Fisher (1984), Riessman (2008) points to both the constitutive and functional nature of stories. She argues that "narratives are strategic, functional, and purposeful. Storytelling is selected over non-narrative forms of communication to accomplish certain ends" (p. 8). Stories are a way of remembering and making sense of the past, of arguing and persuading, identifying, entertaining, misleading, and encouraging action (pp. 8-9). Narratives have a functional component—they are forms of argumentation and persuasion, which points to the need for rhetorical analysis of narratives. Further, particular stories constitute specific audiences and encourage those audience members to engage in defined actions. Additionally, the rhetoric of the authors and narrators of stories often tells us what it means to be part of a specific group or to have a certain identity.

Long ignored or distrusted in the social sciences, narratives and narrative analysis are now becoming central to many social science fields. For instance, sociologists (see e.g. Hyden, 1997), psychologists (see e.g. Murray, 2000), and anthropologists (see e.g. Kaufman, 2010) look at illness narratives in terms of treatment and/or what they reveal about patients and patient-doctor interactions. This is a somewhat novel approach, given the general distrust with which doctors and social scientists viewed patient narratives

until recently. Now, social scientists view narratives as the manner by which we understand and make sense of the world around us (Somers, 1994). A common theme in sociology, anthropology, and psychology literature is that narratives should be taken more seriously as a means to access patient experiences and health, a move which gives patients more control and influence over their health-related decisions. Psychologists frequently look at the ways in which telling stories helps individuals get over a particular experience (Pennebaker, 2000). This is a relatively new phenomenon, one which has come about because many psychologists “[have] become disenchanted with mainstream positivist psychology” (Murray, 2000, p. 338).

I argue that it is possible for Fisher’s (1984) paradigm to become a vital tool for the rhetorical analysis of narratives if one does the following things. First, one must revisit Fisher’s (1984) narrative paradigm in light of narrative analysis in general. Secondly, one must focus on the constitutive nature of narrative, not just the functional aspects. Further, the particular, subjective context within which narratives are situated must be analyzed. Finally, Burke’s concepts of identification and the guilt/purification/redemption cycle must be included in a rhetorical analysis of narratives. By incorporating more of Burke’s key concepts into Fisher’s narrative paradigm, it is possible to address some of the critiques of the narrative paradigm *as a method*. In addition, I illustrate how a combination of the two theories makes a more coherent method than either by itself. As I argue, systematizing narrative as an interpretive tool is important, because a rhetorical approach to narratives allows critics to assess not only what is being said, and how, but by whom, and to what end. Scholars are better able to

evaluate concepts such as power, reason, and ethics when using a rhetorical approach to narratives in lieu of other narrative methods. Rhetorical methods position critics to understand why seemingly “bad” narratives become so persuasive.

Riessman (2008) writes that most case studies/case narratives, such as those done by Freud, Piaget, and Skinner, do not focus on “particular sequences of action, choice of language and narrative style, and audience/reader response [which] are not of analytic interest” (p. 12). It is here that a rhetorical approach lends much to the study of narrative—analyzing the way in which a particular narrative is put together, the specific word choice made by the author to portray certain events or individuals in definite ways, and the response the storyteller may be attempting to elicit all point to the subtle workings of persuasion.

Narrative Theory

Narrative analysis is a vitally important approach to rhetorical criticism, one which has been both productive and controversial. As McClure (2009) indicates, “in rhetorical theory and criticism, narrative and the narrative paradigm have become virtually dead subjects” (p. 189). One of the problems with the study of narrative from the rhetorical perspective is a lack of a clear, concrete method by which a critic can analyze the rhetorical power of a narrative. Fisher’s (1984) narrative paradigm has shown great promise in this respect, but given the criticisms Fisher has sustained, the enthusiasm for narrative analysis as a form of rhetorical critique has blossomed brightly and subsequently wilted on the vine. The narrative paradigm is subjected to the following criticisms: that Fisher argues

for a universal audience with values universal to all humanity which elide differences and create a normative standard; that he positions the critic as the objective expert able to judge these values; that his reliance on a narrative rationality is tied much too closely to traditional rationality, such that it does not escape the problems of the rational world paradigm; and that his narrative paradigm cannot account for the fact that people do often accept very “bad” and even contradictory stories (Hochmuth, 1952; McClure, 2009).

Burke greatly influenced Fisher’s (1984) view of narrative and its role fundamental to human nature. I begin with an overview of Burke’s view, before moving on to explore more specifically how Burkean concepts such as identification and the guilt/purification/redemption cycle form essential components of Fisher’s narrative paradigm.

Burke (1983) writes eloquently of the intrinsic nature of narrative for humanity:

Surrounding us wordy animals there is the infinite wordless universe out of which we have been gradually carving out universes of discourse since the time when our primordial ancestors added to their sensations *words* for sensations. When you could duplicate the taste of an orange by *saying* ‘the taste of an orange,’ that’s when STORY was born, since words *tell about* sensations. Whereas Nature can do no wrong (whatever it is does is Nature) when STORY comes into the world there enters the true, false, honest, mistaken, the downright lie, the imaginative, the visionary, the sublime, the ridiculous, the eschatological (as with Hell, Purgatory, Heaven; the Transmigration of Souls; Foretellings of an Inevitable wind-up in a classless society), the satirical, every single detail of every single science or speculation, even every bit of gossip—for although all animals in their way communicate, only our kind of animal can gossip. There was no story before we came, and when we’re gone the universe will go on sans story. (Burke, 1983, p. 859)

Essentially, Burke makes the same argument that Fisher (1984) will make a short while later—humans are fundamentally storytelling animals, and the only animals who tell stories.

Burke argues “that we constantly shuttle between two very different linguistic modes: logic and narrative. We can translate any set of logical ideas into a corresponding story, replete with plot, characters, and images and framed in time” (Carter, 1997, abstract, p. 343). Thus, we are constantly shifting back and forth between rationality (logic) and narrative (set in time). Our narratives take essential philosophies, beliefs, and values and fix them in time in ways that are personal and unique: “the narrative terminology provides for a *personalizing* of essence” (Burke, 1969a, p. 15). Carter (1997) explains it this way:

I would like to suggest that Burke...has a theory of the narrative structure of the self. He believes that our word-identities, whether individually or collectively, have an unremitting tendency to “go narrative.” We hold a “narrative-ridden” or “time-ridden” view of ourselves, our artifacts, and our world. (p. 344)

That is, we take the mysteries of the universe, concepts and “facts” that seem essential and unchanging, and make them personal via narratives which fix those concepts in time and place. One example is the story of Genesis, discussed below. Fisher’s (1984) narrative paradigm includes this same idea when he argues that narrative rationality includes traditional rationality—we use stories to reason through our lives. We move back and forth between “logic” and “narrative,” with each giving us something different (Wolin, 1998). Both Burke (1970) and Fisher (1984) make this same argument, though using different language.

Further, taking seemingly ungraspable concepts and turning them into a story with a beginning and an ending in order to make sense of them is quite possibly the very reason we tell so many stories (Watts, 1998). Who would not feel the appeal of a story that takes essential, seemingly ungraspable concepts or universal mysteries and distills them down into the here-and-now where they are more accessible, and more than that, *personal*? One can see how this move makes humans feel more significant in the universe than they may feel in reality and allows us to determine how we might act or expect to act. For instance, Burke (1970) writes of the story of Genesis as a narrative which serves as a “reduction of the tautological cycle to a narrative linear progression [which] makes possible the notion of an *outcome*” (p. 217). We are able to interpret the notion of life in such a way that it has a personal beginning and an end, rather than being an endless cycle over which we have no control. Carter (1997) indicates that in the story of Adam and Eve in the Garden of Eden, “the essence of human evil is temporized [narratized] in terms of crimes and punishments meted out down through all human generations” (p. 350). We have a reason for why certain outcomes have happened, something that would not be possible in the tautology of logic. Further, the Genesis story permits a beginning and an end, and thus we are offered a chance to “escape” the cycle.

The personal nature of narratives also invokes a sense of identification that is missing from traditional logic; thus, identification is a vitally important concept to understand for narrative analysis. The concept of identification, which evolved throughout Burke’s career, is difficult to fully understand, because of the many different ways it appears and the many different purposes it seems to serve within Burke’s writings

(Wolin, 2001). Burke (1969b) developed his concept of identification when he became dissatisfied with the conflicting views regarding rhetoric. He argued that all current definitions of rhetoric could be developed from the concept of persuasion, which “involves communication by the signs of consubstantiality, the appeal of *identification*” (p. 62). Identification does not rely solely on rationality or logic, yet it involves persuasion: “You persuade a man [woman] only insofar as you can talk his [her] language by speech, gesture, tonality, order, image, attitude, idea, identifying your ways with his [hers]” (p. 55). Note that Burke does not limit identification to spoken language, but rather expands it to the full spectrum of symbolic action. Unlike persuasion, a concept which almost always indicates intent (on the part of a rhetor, audience, or both), identification is consciously used and *unconsciously* used: “with this term [identification] as instrument, we seek to mark off the areas of rhetoric, by showing how a rhetorical move is often present where it is not usually recognized or thought to belong” (1969b, p. xiii). By invoking identification, Burke (like Fisher) moves beyond the idea of traditional rationality in which we consciously and rationally weigh our options before choosing to act. Burke (1951) indicates:

the key term for the “new” rhetoric would be “identification,” which can include a partially “*unconscious*” factor in appeal. “Identification” at its simplest is also a *deliberate device*, as when the politician seeks to identify himself with his audience...But identification can *also be an end*, as when people earnestly yearn to identify themselves with some group or other. Here they are *not necessarily being acted upon by a conscious external agent*, but may be acting upon themselves to this end. In such identification there is a *partially dreamlike*, idealistic motive. (p. 203, emphasis added)

It is possible to see Burke’s both/and approach to rhetoric, narratives, and identification—rhetoric is both as a means to an end (*as a deliberate device*), and as the

end in itself (*as when people earnestly yearn to identify themselves with some group or other*). However, even the yearning Burke points to here is somewhat intentional by people, indicating that they *want* to identify with others and therefore make a conscious effort to do so. Yet this identification also happens *unconsciously*, as when people see themselves as being part of something else against their conscious wishes and desires. Crusius (1999) argues that identification points to “the very processes by which human societies are created, maintained, transformed, destroyed, and recreated” (pp. 120-21). Both Crusius and Charland (1987) highlight the fact that identification can occur without thinking, reflexively, rather than deliberately, beyond rationality. We are not as rational in our behavior and our choices as we think we are; as Crusius (1999) argues, most of our actions, choices, and identities come from “processes that go on almost entirely beneath the threshold of consciousness”(p. 46). When we focus on the incorporation of identification as a key component of the narrative paradigm, we see how narrative rationality not only moves beyond the realm of traditional rationality, but also how it can explain not only what stories *should* be accepted but also what stories actually are.

Further, identification results in unity (or consubstantiality) at the same time that it maintains distinctions:

A is not identical with his [her] colleague, B. But insofar as their interests are joined, A is identified with B...Here are ambiguities of substance. In being identified with B, A is “substantially one” with a person other than himself [or herself]. Yet at the same time he [she] remains unique, an individual locus of motives. Thus he [she] is both joined and separate, at once a distinct substance and consubstantial with another. (Burke, 1969b, pp. 20-1)

Identification implies division, because as soon as we identify ourselves with some aspect of another person, group, or thing, we are distinguishing or dividing ourselves from

others who do not share that same aspect (Wolin, 2001). Both division and identification are social, owing to Burke's (1969b) ontological view that human groups are, inherently, divided and hierarchical: "If men [women] were not apart from one another, there would be no need for the rhetorician to proclaim their unity" (p. 22).

One of the ways in which identification is achieved is through the guilt/purification/redemption cycle. Guilt is a part of human nature: we seek to contain the "mysteries" of the world by creating order through social rules and standards, thereby establishing a hierarchy (Burke, 1969b, p. 146), which can be defined as different groups or "social collectivities" (Brummett, 1981, p. 255). As Brummett (1980) indicates, "a hierarchy overcomes the natural mystery to which people are heirs by providing grounds for union, for consubstantiality" (p. 65). Hierarchies are welcome, in that they dispel the *mystery* and divisions between people by creating rules regarding social interaction. However, they are also unwelcome in that because, invariably, one or more people in the hierarchy divorce themselves from the group in some way (Brummett, 1980). This violation in turn causes the offender to feel *guilt* because s/he has "opened the door to the lurking terrors of mystery and alienation whether the offense is noticed or not. Guilt, therefore, becomes a motive because it must be removed" (p. 66).

Guilt is exorcised, and the guilty is/are redeemed, via two methods: scapegoating and mortification. Scapegoating occurs when we objectify and project the guilt outward onto something or someone else, the scapegoat, in order to expunge it. The scapegoat must be able to stand in for the offenses of those hoping to escape their transgressions (Brummett, 1980). Scapegoating is a way to create a sense of identification and

consubstantiality, because one sees his/her commonalities in the form of guilt represented in the scapegoat, at the same time one is able to divide the guilt from him/herself. The sense of a common scapegoat provides consubstantiation with those who have the guilt/scapegoat in common. A scapegoat can be used for both personal and social sins, as well as present and past sins. Importantly, it cleanses the past, as it were, and allows the formerly guilty party to go forward with a clean conscience.

Instead of searching for a scapegoat outside of oneself, mortification embodies the sins within the guilty person, thereby making an internal scapegoat (Burke, 1970, p. 248). Mortification is an intrinsic part of humanity and humans' interactions with each other, as Burke (1970) indicates when he states that mortification is essential to human sociality (p. 200), because it helps to guide human behavior and structure groups (Jasinski, 2001). Importantly, Fisher (1984) does not consider the concept of guilt, which may be one reason that the narrative paradigm cannot adequately explain the acceptance of stories that "should" be rejected. As I show in my analysis of the narratives involved in the vaccine crisis, guilt is a constant theme running through the stories; the manner of dealing with this sense of guilt either helps each story to meet the requirements of the narrative paradigm or keeps the story from achieving these conditions. Further, each narrative's approach to guilt, purification, and redemption constitutes what it means to be a "good" parent or member of society such that readers may consciously or unconsciously identify with the community being constituted, thereby helping to explain a narrative's resonance.

In the controversy over childhood vaccinations, stories are told both in an attempt to keep parents from making similar mistakes *and* as a way of being, a way of coping

with tragedy that has stricken one's family. Further the rhetoric of these stories also constitutes what it means to be part of a particular group. In these stories, then, we can see identification being used in order to persuade listeners to act in certain ways, as Burke (1951) suggests when indicating the politician who *seeks to identify himself with his audience*. However, it may also be an unconscious or non-deliberate result of the rhetoric that constitutes specific audiences in particular ways. Thus, a focus on the concept of identification within the narrative paradigm, both at the personal and social levels, helps to strengthen the constitutive perspective of narratives while acknowledging the functional aspect stories fulfill in our lives. This is particularly helpful, as Fisher's (1984) narrative paradigm also seeks to highlight the ways in which our narratives are both intrinsic to our human nature, and purposefully used to achieve some end, though this aspect of his paradigm has been under-valued.

Fisher's Narrative Paradigm

Fisher (1984) broadly defines narratives as “symbolic actions—words and/or deed—that have sequence and meaning for those who live, create, and interpret them” (p. 2). For Fisher, humans are all storytellers, “*homo narrans*” (p. 6). Our ability to understand narratives occurs through “the natural process of socialization” (p. 8). That is, when we live in a society, we inherently gain the ability to create and understand narratives that make sense to ourselves and to others. The narratives humankind tells are not merely confined to fictional works created by writers, but are rather the “basic and essential genre for the characterization of human actions” (p. 2; quoting MacIntyre, 1981, p. 194). In other words, narratives are essential to human communication. This is indeed

how the concept of narrative has been taken up recently in health communication, where narratives are used to supplement medical information provided by doctors and other health professionals, the latter of which fits into what Fisher (1984) calls the “rational world paradigm” (p. 3). Fisher maintains that almost anyone who has common sense can determine the point of a story and whether it provides the basis from which that person can act. For Fisher, every aspect of human life is affected by narratives because each story we tell is done in an attempt, whether realized or not, to have a person believe particular things or act in particular ways.

Fisher (1984) wrote his theory regarding a narrative paradigm in response to the prevailing view of how humans make decisions, which he termed the rational world paradigm. The rational world paradigm asserts that people are basically rational in nature; our rationality comes from our knowledge and our ability to argue. Further, we make decisions based on our and others’ arguments, and we use rational analysis to solve any problem with which we are presented. For Fisher (1985), the types of rationality that fit into the rational world paradigm are deduction and induction, with “rational standards taken exclusively from informal or formal logic” (p. 58). In addition, the type of arguments we make depends on the situation in which the problem has arisen; this appropriate matching of the form of our argument with the environment of the argument (whether legal, political, or otherwise) determines our ability to solve the problem.

Fisher (1984) rightly views the rational world paradigm as too limiting, arguing against it as the *only* way of describing and understanding how humans work together and reason through things in their lives. He takes issue with the idea that “argument as

product and process is *the* means of being human, the agency of all that humans can know and realize” (pp. 3-4). Fisher argues that rationality does not only take place through “argumentative prose or . . . clear-cut inferential or implicative structures: Reasoning may be discovered in all sorts of symbolic action—nondiscursive as well as discursive” (p. 1). We do not only make decisions “rationally,” by weighing evidence objectively and then coming to an impartial conclusion. We really “think things through” sometimes, but not often. Instead, we often make non-rational decisions based on emotions or other forms of reasoning. Fisher does not entirely reject the rational world paradigm, but rather seeks to include it in what he calls the Narrative Paradigm. His intention is not for the narrative paradigm to “supplant the traditional rational paradigm” (p. 3), but for the narrative paradigm to incorporate much of the rational world paradigm in a larger, and for Fisher, more apt description of the way in which humans make decisions about the world. The narrative paradigm is a “dialectical synthesis of two traditional strands in the history of rhetoric: the argumentative, persuasive theme and the literary, aesthetic theme” (p. 2). Our use of narratives coincides with our use of reason and deliberation to help us make decisions about how to live; narratives make rationality more accessible to more people.

In the narrative paradigm, “humans are essentially storytellers” (Fisher, 1984, p. 7), who use “good reasons” (p. 7), which are subjective and historical (p. 2), to decide between many different, competing stories to live their lives. Further, in the paradigm, narrative rationality replaces traditional rationality. Fisher (1985) suggests that narrative rationality “is an attempt to recapture Aristotle’s concept of *phronesis*, practical wisdom”

(p. 350). Narrative rationality is “descriptive; it offers an account, an understanding, of any instance of human choice and action” (Fisher, 1987, p. 56). Further, it operates by “*identification* rather than deliberation” (p. 56, emphasis added). Narrative rationality is broken down into “the principles of probability (coherence) and fidelity (truthfulness and reliability)” (p. 47). When a story meets the requirements of narrative probability and fidelity, it can be considered “rational” (Fisher, 1984, p. 2).

Probability deals with the coherence of a narrative: does it hang together as the audience expects it to? Does it meet standards of “*material coherence*, the comparing and contrasting of other competing stories that may be internally consistent but ignore salient issues, counterarguments, and facts” (McClure, 2009, p. 192)? In other words, does the narrative address other, competing stories in ways that satisfy the audience that the narrative provides the best accounting for certain events? In the vaccination crisis, this type of coherence may be looked at this way: Jenny McCarthy accuses vaccines of causing autism, and argues that doctors are knowledgeable about this side effect but complicit in continuing to administer vaccines. Does her narrative convince readers that hers is the most probable explanation for the rise in autism? Does her narrative address competing stories which detail the very real need for the protection vaccines provide against dangerous diseases, while also being innocent of causing autism, such that McCarthy’s story is more credible? A final requirement for narrative probability is whether the characters in the narrative seem both credible and dependable (Fisher, 1987, p. 47). Can readers trust the descriptions and accounts of events as the characters relate

them to the audience? Or are readers suspect of the “truthfulness” or “reality” depicted by the characters?

Narrative fidelity can be determined by whether or not the story “ring[s] true with the stories [people] know to be true in their lives” (p. 64). That is, does the narrative match those things we already understand and think about our world? *Could* it? For instance, have we experienced a sudden, inexplicable, and seemingly permanent change in our children’s behavior? Have we encountered recalcitrant, unhelpful medical personnel over the course of our lives? Or have we experienced what it is like to have a family member stricken by a potentially deadly disease and felt helpless to stop its course?

Further, Fisher argues that narrative fidelity “concerns the ‘truth qualities’ of a story, the degree to which it accords with the logic of good reasons: the soundness of its reasoning and the value of its values” (p. 88). That is, does the story depict characters, reasoning, and values in ways that we are familiar with in our own lives? For instance, McCarthy’s story depicts *all* medical personnel as intentionally harmful or inept, and blames them for virtually everything bad that happens to her son. Does this seem reasonable or likely to audience members? Additionally, does her story deal with values that we are familiar with or identify with? McCarthy certainly values her son’s health and well-being, which resonates with many people. Does she also consider how her decisions and actions have an impact on others?

Finally, Fisher (1984) argues that narratives must “not negate the self-conceptions people hold of themselves” (p. 15). Consequently, another significant aspect of both

narrative probability and fidelity is the idea of identification—do the characters and events represented in the story resonate with readers or alienate them? In terms of the childhood vaccination crisis, most parents want to believe that they are acting in their children’s best interests; thus, they hold the self-conception of themselves as “good parents.” Fisher’s paradigm is useful for examining narratives from both sides of the issue, since one side is arguing that in order to be a “good parent,” one should vaccinate one’s child and the other side is that in order to be a “good parent,” one should not vaccinate one’s child.

Scholars have critiqued Fisher’s narrative paradigm for positioning the critic as expert; for being too subjective to allow for evaluation and analysis of narratives; too normative in the values it upholds as criteria for judging narratives; and for seemingly not being able to account for which stories actually are embraced. Finally, scholars have interpreted the paradigm solely as analyzing narratives through an instrumental lens. That is, scholars argue that the paradigm only examines how narratives are used as a means to an end, to either motivate people to particular action or to influence their beliefs and values. This interpretation ignores Fisher’s constitutive claims for the paradigm. These critiques can be addressed by taking into account several important factors in Fisher’s construction of the paradigm: that Fisher’s “good reasons” are particular and historically situated, *not* universal in nature; and that these good reasons are influenced by the concept of identification and the way in which a narrative constitutes particular audiences.

Fisher (1984) indicates that a storyteller (and thus, perhaps, a scholar analyzing narratives) should function like a “counselor...his or her contribution to public dialogue is to impart knowledge, like a teacher, or wisdom, like a sage” (p. 13). Many critics have responded to Fisher by taking his statement as reifying the status of the critic as a neutral expert. In utilizing the narrative paradigm, one always comes back to the problem of who is able to judge a story or how to judge it, and to the concept that bad stories are accepted even when unjust and immoral. Fisher argues that “while the narrative paradigm as a worldview of human communication does not provide a specific method of analysis, it does propose a *precise perspective for critically reading texts*” (Fisher, 1985, p. 357, emphasis added). This precise perspective has been taken to mean the status of scholar as expert. Further, this perspective seems to entail a particular, normative view of morality and the good life, which is not viewed in the same manner by all people (Rowland, 1997; Warnick, 1987). What Fisher (1984) seems to be arguing for, then, is the privileged position of the critic who can judge certain moral values apparently inherent in all of humanity, in the “ideal democratic society” (p. 9), such as “truth, the good, beauty, health, wisdom, courage, temperance, justice, harmony, order, communion, friendship, and a oneness with the Cosmos” (Fisher, 1985, p. 363).

While these moral values seem appropriate and desirable, from a Western perspective, they are not necessarily universal; thus, we have the grounds upon which Fisher has been attacked as conservative, normative, and reifying the status of critic as expert, particularly because his narrative paradigm as a method seems to exclude as “good” any stories that do not fit these particular values. Further, critics argue that the

narrative paradigm fails to account for the fact that stories which do not necessarily meet these moral standards have been accepted and embraced wholeheartedly, such as Hitler's *Mein Kampf*. Fisher argues that the narrative paradigm assumes "that the 'people' have a natural tendency to prefer the true and just" (p. 9). Yet, as Warnick (1987) points out, "contrary to Fisher's observation, the 'people' do *not* always prefer the 'true and the just' view" (p. 176). As Warnick indicates, "A narrative such as Hitler's [*Mein Kampf*] is invidiously persuasive precisely because of its narrative fidelity" (p. 176). Fisher (1984) does contend that the narrative paradigm allows for people to be "wrong" (p. 9), which then allows them to accept "bad" stories; but scholars argue that he still positions the critic as the expert who can posit a normative stance on what "good" stories are: "Obviously...some stories are better than others, more coherent, more 'true' to the way people and the world are—in fact and in value" (Fisher, 1984, p. 10).

These particular critiques appear to be a misreading or selective misinterpretation of Fisher's theory. The concern that there is a series of universal values intrinsic to all humanity, which critics interpret as Western, normative standards, able to be judged only by the scholar/expert, seems to ignore the fact that "...the narrative paradigm insists that human communication should be viewed as *historical as well as situational*, as stories competing with other stories constituted by good reasons" (Fisher, 1984, p. 2, emphasis added). The idea that narrative is particular and historically situated infuses the way in which "good reasons" are determined. The seemingly normative, Western values of "truth, the good, beauty, health, wisdom, courage, temperance, justice, harmony, order,

communion, friendship, and a oneness with the Cosmos” (Fisher, 1985, p. 363) must be interpreted according to the historical and situational context in which the narrative occurs. Thus, the values that Fisher lists may be taken as illustrations of “good reasons,” rather than as the universal criteria upon which all narratives in all situations are evaluated. As Rowland (1987) asks:

Would a fundamentalist Christian, or Shiite Moslem, or devoted KGB agent share the same values and endorse the same idealistic stories as does Fisher? It is certainly worth noting in this regard that the interaction of the idealistic stories of Christ and Mohammed has led to considerable conflict over the last thousand years. (p. 271)

Many people would argue that different groups of people clearly do *not* endorse the same values as each other; these seeming differences in values have lead to intense struggle and violence over the years. Yet, Fisher (1984) may not be arguing for a single interpretation of these values. Rather, by arguing that the good reasons through which people judge stories are particular and historically situated, we can see how these same values are embodied differently in different times, places, and cultures. Riessman (2008) makes this same point when she argues that “Narratives are composed for particular audiences at moments in history, and they draw on taken-for-granted discourses and values circulating in a particular culture” (p. 3). Here, the concept of identification, embodied in the idea of the particular and historically situated perspective of the author and audience, allows critics to see how the narrative paradigm both “provide[s] theory and criticism with concepts for the assessment of whether or not a narrative *should* be accepted [and] account[s] for the narratives that *are* constructed, accepted, and believed” (McClure, 2009, p. 197, emphasis added).

Identification is “one’s way of seeing one’s reflection in the social mirror” (Burke, 1957, p. 197). When narratives *speak our language* or reflect our views, we can see ourselves as part of the narrative and the audience the narrative constitutes. Fisher’s narrative paradigm addresses identification when discussing the particular and historically situated respects of narrative—the *social mirror* is different for different people in different times and places. In the case of Hitler’s *Mein Kampf*, people in Germany accepted his story because it resonated with their own particular, historically situated context—this was a Germany downtrodden by the defeat in World War I, its people were suffering hardships such as joblessness, hunger, and lack of money; many were poor and destitute, while others thrived. Into his own narrative, Hitler incorporated this larger story of many in the country in a way that people identified with and then acted upon. He interpreted the values of truth, justice, health, wisdom, and courage, among others, to constitute particular groups of people in particular ways, such that many Germans agreed with his “good reasons,” despite the fact that other groups clearly did not hold the same interpretation of these values: “Stories must always be considered in context, for storytelling occurs at a historical moment with its circulating discourses and power relations” (Riessman, 2008, p. 8). Critics who ignore this vital aspect of narrative are left without a basis from which to make their claims.

The narrative paradigm has also been critiqued as too instrumental in nature, rather than a more balanced blend of instrumental and constitutive aspects Fisher (1984) was attempting to achieve. This is due in no small part to the way in which *scholars* have taken up the narrative paradigm as an instrumental method for analyzing narratives and

their effectiveness in encouraging people to make particular decisions and to act in particular ways (see e.g. Bush & Bush, 1994; Carpenter, 1986; Jameson, 2001; Sharf, 1990; and Warnick, 1987). For instance, Fisher (1985) argues that “No guarantee exists that one who uses narrative rationality will not adopt ‘bad’ stories . . . but it does mitigate this tendency. It engenders critical self-awareness and conscious choice” (p. 349). Here, critics argue that Fisher highlights the use of traditional rationality, which includes the very self-aware processes by which people make decisions and act upon those decisions, something he was trying to circumvent when critiquing the rational-world paradigm (Warnick, 1987).

Further, critics are concerned with the question of evaluation of narratives, particularly when it seems as if two narratives equally fulfill the requirements of the narrative paradigm. That is, how does one determine which of two narratives “should” be accepted, if both seem to achieve narrative probability and narrative fidelity? This question of evaluation, generated by critics, pushes the narrative paradigm to be solely instrumental in nature. For instance, Rowland (1987) argues that:

initially, the most obvious way of evaluating a narrative would appear to be based on its effectiveness. This method would seem to be particularly important, since Fisher emphasizes the great influence that narrative can have on society...the problem is first that a narrative can be effective and yet false...In addition, a story may be effective, but produce horrendous societal effects. (p. 269)

Rowland’s focus on the “effect” of a narrative limits the narrative paradigm to instrumental use. This is a mistake, because much can be learned from the constitutive aspects of narrative, such as how audiences are constituted, whether intentionally or subconsciously, conveying what it means to be part of a certain group for audience members. However, a focus on the effects of a narrative can also lead us to the

constitutive components as well—a focus on identification, infused with the study of the particular context a narrative and its audience is situated in, helps to explain why narratives that are “untrue,” or that *produce horrendous societal effects* have been embraced by audiences. Evaluating narratives by focusing on the sense of identification generated by a narrative, and by examining the type of audience a narrative may constitute, is a more compelling and fruitful approach, and helps to explain how narratives come to be accepted. McClure (2009) argues that this kind of analysis “means assessing critically how a narrative may rhetorically achieve adherence, socially and individually” (p. 201). However, it is virtually impossible to ignore the ways in which stories are used as a means to an end and not just as an end in and of itself. An analysis that combines the instrumental and constitutive elements of narrative captures important details which either approach alone would fail to do.

The early use of narratives by those against vaccinations may have promoted strong identifications, while the use of expert authority and rationality on the part of the pro-vaccine side likely did not. Generally, we may ask of the narratives in the vaccination controversy: if the stories on both sides of the issue seem equally compelling and equally fulfill the requirements of narrative rationality, how does one choose which story to believe? The answer, I argue, comes down to the concept of identification, which is heavily influenced by the guilt/purification/redemption cycle and by the particular, historical, and subjective situation of audience members. As Fisher argues, not all stories are equal for each person, and each human has the ability to determine the value of the stories they hear. As Fisher (1984) suggests, “some stories are better than others, more

coherent, more ‘true’ to the way people and the world are—in fact and value” (p. 10). In the vaccine controversy, narratives deal with parental guilt for acting in ways that contribute to the problems children face, either through scapegoating (McCarthy, 2007) or a combination of scapegoating and mortification (Dube, 2010; Rae, 2010). Each narrative’s manner of dealing with this sense of guilt also highlights very specific, subjective, and historically situated perspectives in ways that promote identification with, or division from, the narrative at hand, either evincing a sense of “truth” or violating that sense of “truth.”

This common ability to determine which stories are “more true” contributes to our sense of “communal identity” (Fisher, 1984m, p. 15), our “way of seeing [our] reflection in the social mirror” (Burke, 1957, p. 195). Narratives are our “communicative experiences of [our]social reality” (Fisher, 1984, p. 8). Thus, they each reflect a different social reality. Groups of people find certain stories to be “truer” than others based upon their own historically situated position, thus allowing for division among different groups, like those who are against vaccinations, and those who support them.

For the specific analysis of stories on both sides of the childhood vaccination controversy, I first consider the narrative probability and narrative fidelity of the stories, because both are “culturally acquire[d] through a universal faculty and experience” (Fisher, 1984, p. 15). We all have the ability to judge stories based on our own social realities and experiences in the world; though, as I have demonstrated above, we do not all judge the same stories in the same way. To account for such differences, I move on to the concept of identification, both in the personal stories and in the larger narratives in

which they are situated, because, “narratives work by suggestion and identification” (p. 15). A sense of identification is enhanced by the manner in which the narratives deal with the concept of guilt; thus, I analyze how each narrative performs the guilt/purification/redemption cycle. Throughout the analysis, I also examine the structure of each of the narratives. I analyze the way in which the characters are described and presented throughout each story, which illuminates how the narratives may achieve a sense of identification with audience members. Additionally, an examination of narrative structure and elements allows a critic to determine how a narrative might fulfill or fail to fulfill the requirements of narrative probability and narrative fidelity. Finally, I examine how the personal stories might “capture the experience of the world [by] simultaneously appealing to the various senses, to reason and emotion, to intellect and imagination, and to fact and value” (pp. 14-15) in a way that promotes personal and group identification, without negating one’s sense of self (p. 14).

Conclusion

Fisher (1989) responded to his critics by saying that the narrative paradigm is “not a rhetoric:” instead, it “is the foundation on which a complete rhetoric needs to be built” (p. 56). By focusing more on what is in Fisher’s (1984) original narrative paradigm, including the concept of identification, and the way in which a person’s particular and historically situated subject position influences his/her ideas regarding what constitutes “good reasons,” we move the paradigm toward theoretical completeness, making it a useful tool. I make no claims that what I have proposed here comprises the “complete rhetoric” Fisher calls for. However, I do argue that revisiting certain of Fisher’s concepts

and concentrating more intently on the Burkean sense of identification Fisher alludes to help to make a move toward a method which is practically useful for rhetorical criticism. The concepts of Fisher I find most significant for this revised method include the importance of narrative not negating one's sense of self to be effective, and narrative as a communicative expression of social reality. This reinvigorated look at the narrative paradigm addresses many of the criticisms previously leveled at it, such as concerns about the positioning of critic as expert, questions about why certain stories do get accepted when they seemingly should be rejected, normativity, and a focus on the instrumental nature of narratives. Chapters 3 and 4 provide illustrations of how this enhanced narrative paradigm helps us to analyze narratives in the childhood vaccination controversy by concentrating on the processes of identification occurring within the personal stories and within the larger stories of which the personal ones are a part.

Chapter Three: McCarthy's Anti-Vaccination Narrative

At that moment I had an overwhelming feeling that I had given birth to a child who was going to make a difference in this world. I even looked at the nurses with amazement and told them [this]. They looked at me kind of like “Yeah, yeah,” but I didn’t care...I looked down at my boy and whispered, “You’re going to be glad you picked me. I’m going to be the best mom in the world, and I’m gonna do everything in my power to make the world a better place and not let anything harm you.” (McCarthy, 2007, pp. 55-56)

If your child stopped speaking, wouldn’t look you in the eye and completely ignored the world around them, what would you do? (Winfrey, 2007)

Introducing Jenny McCarthy

Born in Evergreen Park, Illinois, Jenny McCarthy is the second of four daughters of middle-class parents. She made the move from average girl to household name by modeling for *Playboy* magazine in 1993, a move which changed the course of her life. McCarthy became Playmate of the Month, and then later Playmate of the Year (Playboy.com), and moved to Los Angeles to pursue a career in acting and modeling.

In Los Angeles, McCarthy worked through a series of television jobs; first, she hosted *Hot Rocks* (Internet Movie Database), a music-video show carried by Playboy TV, and then moved on to host *Singled Out*, a dating show aired by MTV. McCarthy was more successful in this position, which added to her growing popularity and led to more acting and modeling jobs. Over the years, McCarthy has starred in some dubious movies, such as *BASEketball* (Zucker, 1998), *Diamonds* (Green, 1999), *Scream 3* (Weinstein, 2000), and *Dirty Love* (McCarthy, 2005), which earned her Razzies for “Worst Actress,”

“Worst Screenplay,” and “Worst Picture.” She has also had numerous guest appearances on successful television shows such as *The Drew Carey Show*, *Charmed*, *Two and a Half Men*, and *My Name is Earl* (imdb.com). Throughout, McCarthy has made a name for herself as being a sexy, seductive woman with a childish sense of humor—her comedy and acting often revolve around crass sight gags, like the advertisement for Candie’s shoes (imdb.com) in which she sits on a toilet with her underpants down. She often would pick her nose on the MTV show *Singled Out*; and her most recent book *Love, Lust, and Faking it: The Naked Truth About Sex, Lies, and True Romance* details “a whirlwind tour of the world of aphrodisiacs and fetishes...and sets the story straight on STDs, man junk and lady bits” (McCarthy, 2010, front flap). However, Jenny McCarthy would say that above her status as a *Playboy* model, above her role as an actress, above her standing as a comedian and celebrity, and even above her role as a spokesperson for “greening” our country’s vaccines, she is a mother.

In her book, *Louder Than Words: A Mother’s Journey Healing Autism* (McCarthy, 2007), McCarthy details the birth of her son, Evan Joseph, on May 18, 2002. From the first, she is in love with him. He develops in a seemingly normal way, “hit[ting] all his milestones” (McCarthy, 2007, p. 56); but looking back, McCarthy determines that the signs of autism are there all along. His first smile comes much later than other children his age; he is able to sit still and concentrate on one thing, like fiddling with a straw, for several hours at a time, which is unusual for a child under one; he engages in self-stimulating behaviors, like flapping his arms, walking on tiptoe, and spinning in circles all day; he is fascinated by door hinges and escalators; and he is able to memorize

and repeat songs in their entirety. It is not until Evan has a series of seizures that McCarthy realizes something is terribly wrong with her child. After a span of several weeks, in which Evan has multiple seizures at a time, McCarthy is given a diagnosis of epilepsy, even though no history of the disease runs in her family. Evan is placed on anti-seizure medication which either makes him behave erratically and violently or turns him into a “zombie” who loses “all speech” and “drools and stays locked in a daydream while staring at the wall” (pp. 41-2).

After being referred to “the top neurologist in the world” (p. 52), McCarthy is given the diagnosis of autism. Now in possession of a “correct” diagnosis, McCarthy feels she and Evan can begin the process of healing. After getting frustrated with the red tape and lengthy waiting lists, some over a year long, McCarthy “decide[s] to educate [herself] on diet intervention” (p. 100), eventually putting Evan on a gluten-free, casein-free, yeast-free diet. This diet seems to work miracles for her son, drawing him out of himself and helping him to interact with her more like a “normal” three-year old:

The fact that he had just blurted out a four-word sentence was honestly a miracle. I knew it was the diet that had helped clear the fog, because within that week Evan responded to my calling his name every time I said it...Mind you, he was in no way cured from autism, but just three weeks prior, he had been locked in a world of spinning toys and ignoring people. (p. 107)

After coming across a website that indicates “Autism is reversible” (GenerationRescue.com), McCarthy (2007) has her “first introduction to the effects of vaccines” (p. 83) and becomes convinced that vaccines have caused Evan’s condition. This “discovery” sparks her crusade against vaccines and becomes the impetus for the book. *Louder than Words: A mother’s Journey Healing Autism* “is the book [McCarthy] hope[s] will shift the world. This is the book [she] was born to write” (p. 85).

Significantly, the book claims not only that vaccines cause autism; it also accuses doctors of knowing this fact and refusing to admit it to parents. “With the diagnosis of her son and the book she wrote about their journey together, McCarthy became the world’s most famous parent of an autistic child” (Greenfield, 2010, para. 12). Greenfield may well add “powerful” given the sensation her book has caused and the massive concern it has sparked in parents in the United States regarding the safety of vaccines.

Parents in the United States have been faced with a troubling dilemma—are the vaccinations they give their very young children safe, and are they even necessary? Or are they actually more dangerous to their children’s development and do they possibly cause autism, a disorder in which a child who previously seemed sociable and interactive becomes withdrawn from the world around him or her, as McCarthy suggests? Many of the questions about vaccine safety have come from vociferous attacks on immunizations via narratives like Jenny McCarthy’s (2007), which “sounds so reasonable” (Greenfield, 2010, para. 7). Even though the link between immunizations, particularly the MMR shot, and the onset of autism has been dramatically disproved (Elliman & Bedford, 2001; Institute of Medicine, 2004; MacIntyre & MacIntyre, 2001; Ratzan, 2004), for some audience members, McCarthy’s story is a compelling competing narrative about the safety of vaccinations and the responsibility of doctors to listen to parents. She wonders how many parents will have to say, ““We vaccinated our baby and something happened”” (Winfrey, 2007), before doctors will pay attention. Her celebrity has had a large impact on the dispersion of her story, but her story would not have maintained its status as a lightning rod for the issue if it did not seem to be credible and likely, at least to some

people. One has to wonder at the strength with which McCarthy's story has affected faith in vaccines—why did this particular story take such hold and cause so much concern?

The answer is complicated by many things, including our faith, or lack of faith, in science, and the power of a gripping tale to affect our beliefs and actions. McCarthy's rhetoric is both constitutive and instrumental. It creates a community, "a ready audience [of those] who [feel] they [are] hearing someone state what they had long suspected" (Greenfield, 2010, para. 13); at the same time, it was composed with the intention to "shift the world" (McCarthy, 2007, p. 85). Her book reads as though McCarthy would like it to be a wake-up call to doctors and the medical community, and to parents of young children who are considering vaccinating their children. Although it is clear that McCarthy concentrates on the functional aspects of her narrative, I argue that the constitutive elements of the narrative are equally important. The crisis over childhood immunizations perhaps would not have been so significant without stories such as McCarthy's; thus, it is vitally important to examine her story in light of Fisher's (1984) narrative paradigm and Burke's (1969b) concept of identification and the guilt/purification/redemption cycle, theories which help us to see why some stories are more gripping than others.

As I show, McCarthy's story meets some of the requirements of Fisher's (1984) narrative paradigm, but fails to achieve others. McCarthy's actions as a mother committed to curing her child, no matter the cost, resonate with many people's experiences of the world and make her character seem credible, establishing narrative probability to some degree. Further, at one time or another, many people have

experienced the desperation and frustration of not being able to help a loved one. The devastation of having your child taken from you, in effect, by a disorder such as autism strikes fear into the heart of parents, such that even if they have not personally experienced this happening, they worry that they *could*. The possibility of such an occurrence for audience members helps the narrative achieve a certain degree of narrative fidelity.

However, the way in which McCarthy depicts members of the medical community stretches the willingness of a critical audience too much to allow the story to attain narrative probability and narrative fidelity completely. Nevertheless, this same depiction of the medical community as harmful bunglers resonates with audience members who identify with this depiction such that they do not question her hyperbolic treatment of these doctors. Therefore, while the story fails to meet narrative probability and narrative fidelity totally, and should then seemingly be rejected by audiences, the strength by which it constitutes an audience which believes in the profit-motivation and harmfulness of modern Western medicine resonates powerfully with people—perhaps even the people who may find her scapegoating of the medical community irrational. Further, as I demonstrate, McCarthy’s manner of dealing with her sense of guilt for “causing” Evan’s autism, by which she creates this seemingly unrealistic scapegoat in the form of these injurious medical practitioners, promotes a sense of identification with sympathetic audience members. Thus, a sense of identification may trump the lack of complete narrative probability and fidelity, and helps to explain the manner in which her story has been embraced by some, rather than rejected by all. Before illustrating these

claims, I briefly revisit Fisher's (1984) narrative paradigm and the concepts of Burke (1931; 1951; 1957; 1965; 1966; 1969a; 1969b; 1970; 1983; 1984) that prove so important for an analysis of this narrative. Because Burke's concept of identification is so essential to the narrative paradigm, I start with a review of it.

Revisiting Narrative Theory from Burke and Fisher

Identification is "one's way of seeing one's reflection in the social mirror" (Burke, 1957, p. 195). Rhetoric which fosters identification is not always derived from a conscious, deliberate choice, though it may be. Burke shows how identification and persuasion are different "by foregrounding the possibility of the *unconscious*, the dreamlike, the nonspecific yearning in speaking subjects seeking to compensate for 'real differences or divisions' that, in turn, prompt further identifications" (Jordan, 2005, p. 269, emphasis added, citing Burke, 1969b, pp. 62-3). Further, identification can deliberately be used as a means to an end, as in "speech directly purposive," as well as exist unconsciously in an "aimless utterance" (Burke, 1969b, p. xiii).

Identification results both in consubstantiality and division: one can identify with another by sharing similar interests, becoming consubstantial with another person. Simultaneously, each person remains divided from the other because each is not exactly the same as the other person. Thus, the two are both the same in some ways, and totally distinct in others (Burke, 1969b, pp. 20-1). Identification deals with sameness and difference, because as soon as we identify ourselves with some aspect of another person, group, or thing, we are distinguishing ourselves from others (Jordan, 2005; Wolin, 2001). As Burke (1957) indicates, identification is "one's material and mental ways of placing

oneself as a person in groups and movements; one's ways of sharing vicariously in the role of leader or spokesman" (p. 195). McCarthy is arguably the leader of the anti-vaccination movement, and her story provides a way for people in similar situations to view themselves as taking action and reclaiming the health of their children, as McCarthy has done. The hundreds of thousands of mothers who were suffering through a similar battle as McCarthy found a story with which to identify, a means to connect them to each other. As one of the founders of the blog *Age of Autism*, Kim Stagliano, who has three autistic girls, says, "Jenny gave us a face" (Greenfield, 2010, para. 13).

The way in which a narrative deals with the concept of guilt (or actions that lead to a sense of guilt) greatly influences the manner in which the narrative both attains a sense of identification and constitutes its audience. Fisher's (1984) narrative paradigm does not deal with guilt directly, which weakens its ability to explain why certain stories get accepted, even though, according to the paradigm, they should be rejected. Guilt is an essential concept to examine because it is part of the human condition: guilt "is virtually identical with the unacknowledged self-hatred that must accompany man's conflict with himself, nature, his fellowmen" and women (Kibel, 1969, p. 422). Because guilt is an intrinsic part of human nature, it cannot be collapsed solely into individual psyches. However, this intrinsic individual guilt motivates us, not necessarily psychologically, but fundamentally because "it threatens to lapse into uncontrolled mystery. Guilt must be expiated, and the person or group must achieve redemption that leads back to a secure hierarchy (reinstatement of the old or establishment of a new one)" (Brummett, 1981, p. 255). Thus, guilt is not endemic to just one or two people, but to all people, which is why

we cannot say that guilt is a psychological manifestation of one person's state of being. It is a way of being that motivates us above and beyond our personal psychologies; however, it does display itself in our behavior, which can sometimes be interpreted as us acting out of specific, personal guilt. As Brummett argues, we must exorcise our intrinsic guilt; this exorcism manifests itself either in mortification, when we take the guilt upon ourselves, or in scapegoating, when we create an outside enemy upon which to heap our guilt. Because McCarthy solely engages in the latter behavior in her narrative, I only review that method of eliminating guilt here.

The scapegoat must be both powerful and representative of the guilt (or transgressions leading to guilt). As Burke (1969a) puts it:

a scapegoat cannot be “curative” except insofar as it *represents* the iniquities of those who would be cured by attacking it. In representing *their* iniquities, it performs the role of vicarious atonement (that is, unification, or merger, granted to those who have alienated their iniquities upon it, and so may be purified through its suffering). (p. 406, emphasis added)

Scapegoating thus also creates a sense of identification: if one sees her or his guilt represented in the scapegoat, s/he is likely to identify with others who also recognize their guilt. A shared enemy creates a common group, because the group is divided from the enemy. And the scapegoat must be powerful enough to hold the sins of the guilty so that when the enemy is destroyed, so, too, are these sins.

McCarthy creates this scapegoat exactly in the manner Carter (1997) discusses: She “utilizes metaphorical identifications of similarity and difference (the victim is first a part of the group, then, having taken on the sins of the group and having been driven away, it becomes something apart from the group)” (p. 370). As I detail below, McCarthy initially listens to her doctors, until she realizes that the information they are giving her is

either inaccurate or incomplete, forcing her to divorce herself from the doctors and strike out on her own. Her research motivates her to act in ways that the doctors actively dismiss as harmful, but which she finds curative. Thus, the doctors become the scapegoats upon which McCarthy can blame her guilt for “causing” Evan’s condition.

Because guilt is intrinsic to human nature, an analysis of narratives that does not examine the manner of dealing with guilt greatly lacks the ability to explain why a story can be so potent. Like guilt, narratives are intrinsic to human nature. Fisher’s narrative paradigm argues that people are inherently storytellers; our entire world is comprised of many different and competing stories, which we must choose among as guides for how to be and to behave. We decide, consciously and subconsciously, which stories to believe using subjective and historically situated “good reasons.” That is, each individual will have his/her own reasons based on his/her experience in the world, which are affected by the time in which he/she lives. The historically situated and subjective nature of our individual reasons is a vital component of Fisher’s narrative paradigm, and one that seems to get overlooked or critiqued for limiting the usefulness of the paradigm to individuals. However, the subjective nature of our good reasons is imperative to the understanding of the paradigm—it helps to explain why some stories are believed, when traditional logic (or even solid narrative rationality) would reject them outright. When a narrative taps into these personal “good reasons,” audience members identify with the story; they see themselves as part of the group the narrative constitutes.

Instead of traditional rationality, we use “narrative rationality” (Fisher, 1984, p. 7) which is comprised of “narrative probability” and “narrative fidelity” (p. 7). Narrative

probability focuses on the coherence of a narrative: does the story hang together as the audience expects it to (i.e. does the action flow in a manner that seems reasonable and not contradictory?) Does it address competing stories in a way that makes it seem the most believable? And do the characters in the narrative seem credible and dependable? (Fisher, 1987, p. 47). In my analysis of McCarthy's (2007) story, I focus most explicitly on the last question, the credibility of the characters depicted, because it is through the characters (particularly McCarthy as a dedicated mother, and the medical personnel she describes as incompetent), that one determines whether her story is believable and coherent. Narrative probability is closely tied to identification—if one identifies with the characters McCarthy depicts, say as the mom struggling against a vast conspiracy of doctors and government officials, the story will seem to cohere more or be more believable than if one dismissed the idea of a conspiracy outright. Further, McCarthy's unwavering depiction of medical personnel as harmful, and therefore the scapegoat for injury to children, resonates with those who identify with her experiences. However, this dogged depiction also makes her story fail to achieve narrative probability for more critical readers.

Narrative fidelity can be described as whether or not a story “ring[s] true with the stories [people] know to be true in their lives” (Fisher, 1987, p. 47). That is, does the story coincide with the reader's experience of the world? Has the reader experienced a crisis surrounding the health of his/her child and fought to cure the child in any way s/he could? Does s/he believe such a thing *could* happen? I also examine the way in which McCarthy's story might have fidelity to a larger story, that of medical callousness and

greed, with which readers may identify. Again, however, it is the extreme nature of McCarthy's depiction of her interactions with the medical community that inhibits the narrative's ability to accomplish narrative probability and fidelity for critical readers.

Like identification, which comprises a significant portion of narrative and the narrative paradigm, narratives are both constitutive and functional. Narratives are a way to make sense of the world; thus, they are structured both consciously and unconsciously to constitute audiences who have similar experiences, such that a story helps both the storyteller and audience members who identify with the story to understand particular events and emotions. In addition, narratives can generate a sense of community, a group of people who "are" a particular way, or tell us what it means to be a part of that community, as reflected by the narrative. Further, narrative is also deliberate—we tell stories to achieve some end, such as persuading the audience to act in specific ways. Because storytelling is inherent in our nature, we do not need to learn how to tell stories or to determine which stories should be believed in the same manner that we need to be taught rational logic. Fisher argues that the inherent nature of narrative allows for greater freedom in who can use it—rather than being limited to those trained in traditional logic, every human being is capable of narrative rationality.

Throughout my analysis of McCarthy's story, I show how her rhetoric constitutes particular groups of people in particular ways—the medical community is destructive and devious, out only for a profit; those mothers who care for their children actively question medical advice and determine their own course of action, relying on "maternal, gut instincts," whether it agrees with prevailing scientific views or not; those parents who do

not “inform” themselves about medical options, but merely rely on doctors to tell them what to do are ignorant and misled. McCarthy creates communities which we either want to identify with or distance ourselves from, decisions which occur at both a conscious and subconscious level on the part of audience members. The way in which she constructs these groups shows why this narrative gets accepted when it “should” be rejected.

Jenny McCarthy: Mother and Mayhem Maker

Because narratives are frequently structured along specific, familiar plot lines, it is useful to explore key elements of a dramatic plot. A dramatic plot line, in which a protagonist must overcome great challenges in order to succeed, generally consists of six elements: exposition, conflict, rising actions, climax, falling actions, and resolution (Schwartz, 2002). In the exposition, major characters are introduced, including the setting and any relevant background, while the conflict establishes the major problem the main character has to overcome. Rising action entails many smaller conflicts that occur as the main character struggles to overcome the major problem s/he is presented with, while the climax represents the key turning point in the story, which helps the main character solve the dilemma. Falling action details those events that happen after the climax occurs; and the resolution is the conclusion of the story, in which most, if not all, of the conflicts have been resolved.

McCarthy (2007) adheres tightly to this dramatic plot line in her narrative. It seems as if she takes advantage of many readers’ knowledge of this kind of plot, in which the hero must overcome great odds to succeed. Even her subtitle suggests the story line: “A mother’s journey healing autism” indicates that she does in fact triumph over the

challenge of her son's autism. While she does include all of these elements, the ones most relevant to an analysis of her narrative include the character depictions she evinces from the very start of her story and which continue throughout, and the perpetual conflicts she engages in with medical personnel.

McCarthy starts her narrative with the major conflict which frames her story: early one morning, she finds Evan seizing in his crib. Within this conflict, she introduces the major characters of the story: Evan as helpless victim; McCarthy as representative of ideal motherhood; and the members of the medical community as inhumane. Their depictions never vary, which lends credibility to the story for some readers at the same time that they make the narrative fail to achieve probability for others because of the exaggerated nature of the descriptions.

McCarthy establishes Evan as a little boy who is suddenly struck down by some condition that makes him "stoned and vacant" (p. 6) instead of the sweet, interactive boy she knew him to be prior to the crisis. Afterwards, he becomes "a bit kooky—and borderline annoying...screaming and tantruming most of the day" (p. 12). This characterization helps her establish the conflict she must overcome—recovering her child from the grips of a condition that leaves him trapped in his own little world. Here, and throughout, she portrays Evan as someone who loves her deeply and who is the center of her world. This characterization aids in establishing narrative probability. Evan is shown as a "normal," cute little boy who then descends into the world of autism, acting very similarly to other children with the same diagnosis. In addition, his depiction helps to fulfill the requirements of narrative fidelity. Parents of autistic children describe

seemingly healthy, normal children who suddenly retreat into themselves and no longer interact with their families or show love and affection (De Giacomo & Fombonne, 1998). The depiction of Evan's crisis, hours and hours of non-stop seizures and comatose behavior, with no concrete, reliable answers from the medical community, strikes horror into the hearts of most people, parents or not. As McCarthy (2007) indicates, "There is nothing worse than seeing a young child being put in the back of an ambulance" (p. 4).

McCarthy also establishes herself as a deeply caring and intuitive mother who aggressively fights to help Evan, as well as a mother seeking to purge the guilt she feels for not being able to "keep anything bad from happening" (p. 56) to him. We see her innate "motherliness" when she becomes instantly concerned that her son is not awake at his normal time on the morning of his first seizures. Likewise, when she is getting ready to accompany Evan to the hospital, she establishes that she cares only about her son by immediately asking to go in the ambulance, without consulting with her husband, and by initially refusing to change out of her "flannel Bugs Bunny pajamas" (p. 3). As a celebrity constantly in the eye of the media, her willingness to go out in public in a pair of pajamas reflects her commitment to her role as a mother. We cannot underestimate the power of her status as celebrity, but it is her "realness" that makes her story seem to resonate so strongly with audiences. She emphasizes throughout how she is just like us, commenting how "shitty my life was. I know people like to think celebrities are immune from problems and have it so easy. Well, we don't. Here's your proof: We all suffer like everyone else. Don't let the designer shoes fool you" (p. 70). In fact, her celebrity status has not protected her from the terrible ordeal of Evan being diagnosed with autism; thus,

in a way, her journey to recover her son seems that much more tremendous because she has to struggle farther to get her life back to where it was prior to the diagnosis. This sense of “realness” strikes a note of fidelity from the very start of the story as well—many parents have been so panicked by the condition of their children as to rush out of the house completely heedless of what they are wearing. Finally, readers have been prepared for this depiction of McCarthy as the “ultimate real mom” by the introduction to her book. Feinberg (2007) illustrates McCarthy as “The Mom” we should all strive to be:

If we called mothers “refrigerator moms” in the past, then Jenny McCarthy is the polar opposite. She is the warm, glowing fireplace burning on the most beautiful winter day...Jenny’s connection to her son is so strong that she practically has a seizure when he does, even when she is miles away. Jenny is affectionate, kind, parental, protective, and proactive in a crisis. Jenny’s *maternal connection and instincts define motherhood*. (pp. xii-xiii, emphasis added)

McCarthy’s rhetoric at the start of her narrative also constitutes the entire medical community as comprised of callous individuals who view patients either as inanimate objects or as potential sources of profit via “unnecessary” and “dangerous” medical interventions, such as vaccines. Her unvarying depiction of this community of people resonates with audience members already inclined to believe in the story of medical malfeasance and incompetence—a cultural plotline which may be more common through health care reform debates. Further, rhetoric allows McCarthy’s creation of this community as the scapegoat for the cause of virtually everything that has happened to Evan, and therefore to all other children subjected to this community’s care. The scapegoat must be powerful: “Its power must be at least equal to the burden of guilt so that the sacrifice of the goat destroys a vessel strong enough to hold the transgressions” (Burke, 1969a, p. 67). Here, in McCarthy’s story, it is particularly those responsible for

caring for children who are deemed the most powerful. These doctors, paramedics, nurses, and specialists seem to control the health and the fate of the delicate, innocent lives they care for. The way in which she describes the actions of the doctors and nurses in charge of Evan reinforces the idea that they care little for any of their patients, and that they are responsible for the harm that befalls them.

This character first appears in the guise of “the paramedics who casually walk [...] up her driveway” (McCarthy, 2007 p. 2), and at whom she has to scream, “Don’t fucking walk. Get over here, run!” (p. 2). Her screams merely encourage them to slightly “pick up the pace;” they then “talk about [Evan] casually, as if they were at the office water cooler” (pp. 2-3). This description of the paramedics reinforces the role of medical practitioners as responsible for a multitude of sins. The portrayal of lazy, insensitive paramedics may resonate with certain readers’ particular view of the world. For others, however, this depiction undermines a sense of narrative probability and fidelity—paramedics are trained to act competently and quickly; further, most of those who go into the medical profession do so because they seek to help people, not to hurt them. Thus, more critical readers are likely to be skeptical of this description of paramedics, and to interpret it as being highly colored by McCarthy’s role as mother in a crisis. For those who see the action of the paramedics as a skewed personal interpretation, this description is likely to undermine the probability and fidelity of the narrative.

McCarthy continues her depiction of the medical community as cruel when she describes Evan’s first visit to the hospital. Here, doctors “stick lights in his eyes and pok[e] and pinch parts of his body to see if that stimulate[s] a response. It [does]. He

start[s] crying” (p. 6). They then want to do a spinal-tap on Evan to determine if he has meningitis, a procedure that requires inserting a needle into a person’s spine and extracting spinal fluid. While doctors normally sedate children who go through this procedure, “they want...to do the procedure on him while he [is] awake and alert” (p. 7). The doctors “give him the same HUGE antibiotic injection they would have given someone with meningitis” (p. 8) even though the test results are negative. We are also presented with a “young Doogie Howser neurologist” (p. 8) who argues that Evan has had a febrile seizure, which occurs when a child has a fever. McCarthy argues that Evan has not had a fever, so this diagnosis cannot be right. The doctor indicates that Evan “could have been getting sick and it went away” to which McCarthy states, she felt “shock and silence because [she] couldn’t think of a polite way to say, ‘You’re a fucking idiot’” (p. 8). Here, and throughout, the medical community almost uniformly is depicted as mean-hearted idiots who enjoy tormenting young children, while McCarthy is the rational, logical, caring, and steadfast mom who will resort to profanity if needed, and will not rest until her son is better, no matter what the doctors tell her. Further, her portrayal of these medical personnel frames them as communicating with *all* parents in ways that suggest that parents are enemies to be beaten because they threaten medical, clinical procedures, and thereby the power of the medical community. McCarthy’s use of profanity here and throughout reinforces the sense of “realness” of her character. Seemingly, she is not glossing over the rougher realities of life, but showing life in all its authenticity, a move which may make her narrative seem more probable and reflective of audience members’ own experiences.

As McCarthy proceeds through the rising action of her story, a reader can anticipate that the medical community will continue to fail McCarthy and her son by being incompetent; and that McCarthy will continue to fight, to help Evan recover. Three weeks pass between the conflict (Evan's first series of seizures) and the next major incident. While visiting his grandparents in Palm Springs, Evan begins seizing again: "He [is] not convulsing this time and [is] not even trying to take in any air. The only thing coming out of his mouth [is] foam" (p. 14). He then goes into cardiac arrest while McCarthy, her husband, and his parents look on in horror. After being rushed from hospital to hospital, seizing all the while and being sedated with repeated rounds of valium, as well as being subjected to many of the same tests he had been given three weeks earlier (including an MRI and a spinal tap), Evan is given a diagnosis of epilepsy.

Throughout these experiences, McCarthy reaffirms her role as a mother determined to get to the bottom of her child's condition. She also confirms the characterization of the medical community as the scapegoat; here, the medical staff seems to be deliberately acting to sabotage Evan's diagnosis and recovery. When Evan is assigned to a bunch of interns, McCarthy acknowledges that "everyone needs to start somewhere, [but she doesn't] want [her] son to be a pop quiz" (pp. 18-9). The interns are portrayed as ignorant, especially in contrast to McCarthy, an untrained layperson who has to help the paramedic in the ambulance to keep Evan from seizing by giving him Valium; further, she seems to be the only one to notice that Evan keeps seizing, even when she is in a room full of doctors (p. 21). She proves her commitment to her son by repeatedly yelling at the incompetent doctors or questioning their ability to help her son: "How

much Valium can a two-year-old take before he ODs?’ Plus, they kept giving him Valium, and he continued to seize. Was that really the best thing for the job?’ (p. 19). She clearly does not think so, but feels unable to get satisfactory answers from the doctors; rather, she must search for answers on her own: “I didn’t care if I ever slept again. I had a big job ahead of me. If the doctors weren’t going to give me answers, I would find them myself” (p. 18).

Further, McCarthy comments that, “It’s amazing how easily medical staff ignores crying, yelling mothers. I understood they had to stay calm, but not on my clock, not while my kid could go into cardiac arrest. They were going to help” (p. 22). Again, we see how she constitutes the distinction between the medical community and the community of parents—the latter is constructed as the dialectical opposite, as medicine’s enemy. Instead of being on the same side against an unknown condition threatening the health and safety of a child, the *medical staff* is fighting against the *parent*, rather than working together with her. McCarthy finally explodes when Evan continues to seize and the Valium does not help; she is further distraught that her son has not seen a neurologist since he entered the hospital:

I screamed even louder. “My son has gone into cardiac arrest and has seized six *fucking* times today, and I still haven’t seen one *fucking* neurologist! Not one *fucking* neurologist has come into this *fucking* room, and my son won’t stop seizing! Find the *fucking* doctor! Go! Find the *fucking* doctor!” I wish I could say that Evan didn’t have any more seizures that night, but he did. I wish I could say that the neurologist showed up that night, but he never did. They kept *injecting him and injecting him and injecting him*. This was supposed to be a well-respected hospital and I felt like we were in a Third World country, being cared for by thirteen-year-olds. (pp. 22-3, emphasis added)

McCarthy is the mother who notices things about her son and questions the appropriateness of a seemingly aggressive and ineffective medical strategy, while the

interns, nurses, and doctors act indifferent to her son's struggle and downright hostile to her as a concerned mother. The repetition of the phrase "injecting him" makes it seem as if the medical staff either do not know what else to do, or are actively engaging in harmful behavior. By building the scapegoat in this manner, heaping doubt and blame upon the medical personnel in charge of treating Evan, McCarthy is able to redeem herself from the guilt of not being able to do anything to help him. She feels guilty for not knowing enough to keep Evan from seizing. By portraying doctors who are supposedly trained and knowledgeable as less well-informed than she is, McCarthy reinforces the characterizations she has set up. For her, "mothering" instincts should and do supersede medical "expertise" every time.

Finally, her invocation of swear words again emphasizes the "realness" of her character and constitutes the audience who would be sympathetic with her plight—she is distraught to the point of cursing in front of professionals and a child, and the situation is so dire that to render it in language that is clean and more neutral would be a disservice. Further, the swearing resonates strongly with audiences because it casts McCarthy as a "real" person with real emotions in comparison to the cold-blooded, emotionless doctors. She may be a celebrity, but she is just a "regular Joe" or "Jane," fighting against highly educated, impassive doctors. It seems as if the narrative coheres based on these consistent character depictions. McCarthy was given unsatisfying answers from her previous trip to the hospital; given the interaction she has with the personnel at the current hospital, particularly the desire to repeat tests Evan had merely hours previous to his admittance or weeks earlier showing no brain tumor or meningitis, it is unlikely that she will receive

any that satisfy her here, or that will make her confident in the ability of the medical community.

This proves to be the case. When the neurologist does show up, he gives McCarthy the diagnosis of epilepsy. She argues with him, indicating there's no family history of the disease, so the diagnosis cannot possibly be right. She says that "honestly, it was my *maternal gut instinct* that epilepsy was not the end of this road. I felt like there was a highway ramp that everyone was not getting on" (p. 30, emphasis added). The doctor merely dismisses her concerns, telling her "You're just having a tough time accepting it" (p. 30). Here, McCarthy is the ultimate mom—she knows her child much better than the doctors, so much so that, without any medical training, she knows that the diagnosis of epilepsy cannot be right. Given her portrayal of the medical community, readers expect that the doctor will dismiss her concerns and send her down a path that will have disastrous consequences, which is indeed what does occur.

The doctor forges ahead with treatment of epilepsy, indicating that they have to take risks to figure out which medicines will help Evan; this is a perilous game because of the possibility that some doses might kill Evan (p. 31). Interestingly here, McCarthy's depiction of the doctor as the scapegoat becomes incredibly powerful, partially because of the authority that he seems to hold—although McCarthy's maternal instincts reject the diagnosis and the treatment options, she portrays the scene as if she has no choice but to do what the doctor suggests. As Burke (1969a) indicates, a scapegoat must be powerful in order to expunge the guilt successfully, and McCarthy creates a very significant representative here. By listening to the doctor and acting as he requests, McCarthy's guilt

intensifies because she *knows* that the diagnosis and treatment are wrong, and her worries turn out to be justified when Evan becomes violent and seemingly psychotic as a result of the anti-seizure medication (p. 36; p. 41).

Evan spends several nights on a blue seizure medicine, “kick[ing] and scream[ing] and shout[ing]” (p. 36). One night, McCarthy wakes up to find “that Evan ha[s] ripped the cords [of the heart monitor] off and [is] on his hands and knees, slamming his head into the headboard” (p. 39). Her son is “hallucinating and batting things away from himself. He [is] screaming ‘Mama’ but [doesn’t] recognize [her]. He [is] hitting [her] as if [she is] a stranger while screaming to find [his mother]” (p. 41). She runs out of her house and “scream[s] and wishe[s] that God would take it all away. [She can’t] bear one more second of it. [She] crie[s] and crie[s] and then [does] what most mothers do. [She] wipe[s] off her face and head[s] back into the house” (p. 41).

McCarthy comes across as a very credible mother here, one who is briefly overwhelmed by the intensity of her experiences, by the lack of control she has over her son’s behavior and treatment, and her devastating encounters with Evan’s new personality. It is no wonder that McCarthy momentarily “loses it” and runs outside to escape the situation.

Her actions enhance the narrative probability of the story—people are less likely to find a character credible if s/he never shows weakness in the face of extreme challenges. McCarthy’s momentary breakdown and subsequent reaffirmation of her commitment to her son also supports the fidelity of the narrative. Many parents know how difficult parenting is in the first place, without any added stress of an undiagnosed or misdiagnosed condition that causes intense struggles. But most parents also know that no

matter how hard parenting may be, in any one particular moment, they will always be committed to caring for their children. This depiction of *what mothers do* does not just promote a sense of identification with audience members. Here, McCarthy's rhetoric constitutes what it means to be a mother. McCarthy hones in on an old stereotype that "mothers know best," that mothers are more committed than anyone to their children. True mothers will always pull themselves together and concentrate on their children. The constitution of "mother" in this way greatly enhances the potency of McCarthy's narrative.

McCarthy continues the development of her character as the ultimate mom, and to cast the neurologist, the representative of the medical community, as the scapegoat when she recounts the conversation she has with him following Evan's night of hallucinations and violence:

Of course, the doctor scoffed that this amazing medicine would cause any reaction like that...the doctor told me I should stick with it. *My emotional guidance system* told me he *was making another terrible mistake*. Sometimes *mothers instinctively know* what works and what doesn't, but *the doctor wasn't interested* in hearing anything I had to say. I hung up and went online and did some research. (p. 40, emphasis added)

McCarthy's *motherly instincts* are so strong that she *knows* that this medicine is causing more harm than good; this knowledge increases her sense of guilt that she is powerless against the doctors and unable to help Evan. This scene also amplifies the responsibility of the medical community as the scapegoat responsible for the horrors she and Evan are enduring because the doctor ignores her more accurate motherly instincts.

However, she does begin to purposively act to address the wrongs, first by researching the medicine online, and secondly by making sure the doctor hears Evan's behavior with his own ears, so that he is unable to dismiss McCarthy's claims:

I put the phone next to Evan and let the doctor hear the sounds this child was making, sounds that would make any person's soul go numb. "We're taking him off the blue medicine immediately," the neurologist said. Sadly, *he had refused to take my word for it*. Evan had had to endure another horrific night for this *idiot* to see what the medicine did to him. (p. 41, emphasis added)

The doctor is an *idiot* who adheres to the status quo until he is forced to believe otherwise. McCarthy, as concerned mom, seems to be right in her anxiety that the medicine is not good for Evan; because she understands this, and the doctor does not, McCarthy feels guilty that she listened to the doctor and gave Evan the medicine against her better judgment. She also begins to transcend this guilt by taking matters into her own hands by forcing the doctor to change medicines for Evan.

Yet even after this change of medicine, the neurologist still seemingly rejects McCarthy's concern about the diagnosis, compounding his status as a scapegoat. She seems worried that Evan has increased in obsessive behavior, behavior that we now know (thanks to McCarthy's retrospective analysis and narration) is closely related to autism. By having the doctor persist in ignoring these seemingly obvious signals, while McCarthy hones in on them, we get a continued rendering of the doctor as the scapegoat who misdiagnoses Evan, thereby causing delays in the "correct" treatment, as well as damage because of the treatments he is prescribing. McCarthy asks the "brain-dead neurologist" (p. 47) if Evan's "flapping... hands and spinning" (p. 48) are normal behaviors. The doctor replies that they are "fine. Completely normal" (p. 49). He ignores McCarthy's concern that "we might be missing something. It's a *gut instinct*. I just don't

know” by saying that “[Evan] looks great to me.’ And with that, he handed me a refill of the zombie drug” (p. 49, emphasis added). Readers know that Evan will be eventually diagnosed with autism, so the doctor’s apparently casual dismissal of McCarthy’s maternal instinct casts the medical community in a very harsh light. It is as if this doctor will maintain a particular course of action, no matter how wrong it may be. This is one small instance of a larger theme throughout the book, which renders McCarthy’s story powerfully political (and not simply a personal tale of one mother’s experience): doctors seemingly know how bad vaccines are for children, yet have convinced themselves that vaccines do more good than harm, and so have a very strong inclination to dismiss anything that might suggest otherwise. At the same time, McCarthy’s story reinforces the idea that parents know best, or that they should not trust the medical community.

When Evan is diagnosed with autism, McCarthy’s narrative reaches its climax. Throughout the depiction of this event, McCarthy continues to portray characters in ways that seemingly reinforce a sense of narrative probability and fidelity. In addition, McCarthy’s rhetoric further defines not only what it means to be a mother, but what it means to be a doctor. Her illustration of the scene in which she receives the diagnosis and the subsequent flashback to Evan’s birth resound strongly with parents of all kinds, whether they identify with her representation of the characters or not. Through her connections as an actress, McCarthy is able to make an appointment with “the top neurologist in the world” (p. 52). Before she meets him, she

hope[s] that this was the doctor I had prayed for—*someone who actually knew what the hell he was talking about*. My *instincts* had always been right about people, and if this guy turned out to be a *bozo* like the last one, I didn’t know what I would do to the medical community. (pp. 52-3, emphasis added)

This man, whom McCarthy “immediately [feels] good about” (p. 53), sits her down and tells her, “I’m sorry, your son has autism” (p. 53), which McCarthy feels is the right diagnosis. Ironically, this diagnosis may also have been incorrect. Some have argued that Evan had Landau-Kleffner syndrome, an uncommon neurological disorder marked by seizures and speech impairment (Greenfield, 2010, para. 11) which is distinct from autism. Yet because his diagnosis seems to *feel right* to McCarthy, she charitably refrains from calling the neurologist a bozo. However, even here and later in the book when describing this moment, McCarthy (2007) critiques this doctor because he merely gives her the diagnosis, says *I’m sorry*, and gives her “a nice shove out the door” (p. 82). Here, even though she feels this doctor is competent in his ability to correctly diagnosis Evan’s condition, he fails miserably to help her beyond this point, confirming the medical community as the scapegoat who must be blamed not only for what causes autism, but for failing to find any “cure.”

Upon hearing the diagnosis, McCarthy comments that “at that moment, I hated everything and everyone” (p. 67). Her sentiments seem to closely coincide with what a person feels when they receive bad news, particularly this kind of news regarding a loved one. It is hard for her to not feel tricked or deceived, as if she suddenly does not know her son:

This was not Evan. Evan was locked inside this label, and I didn’t know if I would ever get to know who he really was. The things I’d thought were personality traits were in fact autism characteristics, and that was all I had. *Where was my son, and how the hell did I get him out?* (p. 66, emphasis added)

Even if readers have not experienced disease, they are surely familiar with similar things happening to people within their sphere or that they’ve heard of; thus, they realize this

could happen to them, which is an important aspect of narrative fidelity. Here McCarthy evidences a sense of guilt: she does not *really know* her son and has been remiss in thinking that his cute behavior showed his personality, rather than a serious condition. Her comment, *how the hell do I get him out*, reflects the dilemma she must face when dealing with this guilt. Will she listen to the medical community, which has disappointed her thus far? More likely, readers realize she will strike out on her own, as her rhetoric has constituted medical professionals as ineffectual, and mothers as far more competent in determining what is best for their children. McCarthy has not been so lucky as to escape the dreaded diagnosis of autism; coupled with her actions upon hearing the diagnosis, her claims as to what causes Evan's condition, and how she comes to "cure" him all strengthen the effect of her narrative.

McCarthy is highly credible when she comments that she does not "want people to think I'm a total idiot for not seeing any signs" (p. 56) in Evan's playing with baby toys when he was two-years old. "I really didn't [see signs] because when I had playdates at my house [the older] kids would play with the baby squeak toys," too (p. 59). McCarthy names the delicate balancing act parents must go through as their children grow up, worrying that they are achieving developmental milestones in a "normal" time frame, while at the same time recognizing that "babies do things on their own clock" (p. 56). Importantly, McCarthy stays in character when revealing that "little signs presented themselves here and there, but as a loving mother who wanted to see only the good, I looked past most of the red flags along the way" (p. 56). McCarthy then retraces many of the signs she should have recognized in Evan as being not-quite-right. He smiles his first

smile much later than other babies; he does not take toys away from other babies, nor complain when they do the same to him; he “play[s] peacefully with a straw for two hours” (p. 57) as a young child; and “when he [gets] excited, his hands...flap like a butterfly or a bird” (p. 57). But, when other people “start to suggest that something [is] a bit off...being the proud mother I am, I could not disagree with them more and made sure they knew it” (p. 61). She even gets one woman fired from her job for questioning if Evan has some sort of developmental delay.

This recounting of the signs of Evan’s condition reflects narrative probability and fidelity, at the same time that it creates a sense of identification. McCarthy’s description of her behavior regarding Evan’s development stays true to the character of “Mom” who only sees the best in her child. Even though she reads an article on autism in *Time* magazine prior to Evan’s diagnosis, she comments how glad she is that Evan did not have that condition: “To me, autism was a closed-off child who allowed no one inside. Evan loved me and he smiled, even though I did have to work a little harder for it” (p. 61). She not only sees her child as perfect, but vigorously defends him against anyone who differs in their opinion.¹

McCarthy clearly feels a sense of guilt for missing the major signs, and thereby failing to get Evan the help he needed sooner. This is especially true since she had

¹ Her experience reflects that of many parents, even those who do not have autistic children—parents almost universally compare their children’s development with others. Not only is she recounting an experience many have had and can relate to in their own lives, thus achieving narrative fidelity, she is also naming this similarity as a way to increase the impact of her narrative. However, a critical reader could argue that given the weight McCarthy places on instincts as of primary significance for the ultimate mother, eclipsing medical expertise, she should have *known* something was not quite right. For more sympathetic readers, she addresses her failure to live up to the definition of the ideal mother by evincing a clear sense of guilt, although questioning readers may not allow her to escape this contradiction so easily, thereby compromising her narrative’s probability.

promised Evan, at birth, to protect him (p. 56). This flashback to Evan's birth helps to constitute what it means to be a "Mom"—a mom is someone who keeps a child from harm, no matter what. Plainly, McCarthy feels she has failed to achieve this identity, and she must work to redeem the guilt she feels for causing Evan harm. We see her guilt again when she comments that, "If I'd had an older child, I might have picked up on some of these signs quicker, but I'm sure most mothers of autistic children would tell you that nothing seemed like a big deal...yet" (p. 59). McCarthy obviously feels guilty for not *picking up on some of these signs quicker*, especially because with autism, early intervention greatly mitigates its effects. Further, McCarthy has to grow into her status as the ultimate mother; she does not immediately become one upon Evan's birth, even though she has all the makings of this ideal given her commitment to be the best, most protective mother who will listen to her instincts.

As I have begun to establish, McCarthy redeems herself by blaming Evan's condition upon the medical community. As soon as McCarthy has welcomed her son into the world and told him she will not let anything harm him, the medical community "whisk[s] him out of [her] arms to begin his welcome-to-this-planet party, consisting of tests and injections" (p. 56). This is McCarthy's first mention of her theory regarding the possible cause of Evan's autism—mandated vaccinations—and it makes perfect sense that she would name the medical community as responsible for the administration of the harmful pathogen she believes caused Evan's condition. She critiques the doctors for missing the typical signs of autism: "You would have thought his pediatrician might have noticed something along the way, mind you, but he did not" (pp. 57-8). McCarthy builds

narrative probability by remembering the medical community's missteps, which she has established throughout the conflict and exposition. Further, she purifies herself of the guilt she feels for allowing Evan to be harmed through *tests and injections* by arguing that the pediatrician, the expert, should have known more than she did about the condition. Again, this argument is complicated, in that McCarthy has constituted the ideal mom as someone who instinctively knows what is wrong with her child, yet she misses the signs herself. Instead of taking on this guilt, she purifies herself by blaming doctors.

Furthermore, here McCarthy speaks to narrative fidelity, for today, we no longer implicitly trust the medical community as we once might have. Now, more frequently, we get second and third opinions on diagnoses, and search out answers on our own via the internet, as McCarthy amply demonstrates throughout her narrative, with her "doctorate" in Google (p. 11). Thus, McCarthy's narrative commands more fidelity and probability than perhaps it would have if coming from a different time, such as the 1950s, when people were more apt to trust the government. Additionally, McCarthy's search for information on her own, thereby divorcing herself from the hierarchy of the medical community, gives her a way to redeem herself by curing Evan and purifying herself of the guilt she feels.

The falling action reflects those things that the protagonist does to achieve the solution of the major crisis which started the narrative, and it leads to the moral(s) of the story. In this section of the book, McCarthy delivers her most damning assessment of the medical community, while at the same time providing parents of autistic children the hope and comfort they need. Throughout the events in this section, McCarthy continues

to act like a mother relentlessly driven to cure her son. Her depictions of the medical community become slightly more nuanced, as doctors are now not only incompetent and crass—they are uncritical sheep who maintain and endorse government vaccination policies that actively harm children and then refuse to admit the possibility of their actions having done any damage. She further portrays medical personnel as purposefully refraining from giving her information that would help her to “cure” her son. The moral McCarthy delivers throughout this section, and through the rest of the book, is that you can only trust yourself as a parent, because you are the one who ultimately knows best.

McCarthy begins divorcing herself from the hierarchy, the medical community, in favor of constituting a group of parents who know better than to blindly follow the advice of doctors. McCarthy, like many people, puts more faith in the anecdotal evidence of someone who has experienced what she is going through, like fellow celebrity and parent of an autistic child, Holly Robinson Peete. McCarthy relies on the personal experiences of non-medical personnel more than on the advice of an objective “expert,” who is far more vested in maintaining authority than in actually helping people. Yet in her journey to cure Evan, she still struggles to divorce herself from prevailing western medicine, since the information she finds on the internet is dismissed out of hand by her doctors. McCarthy doubts the ability of diet and therapy to recover her son, indicating that “the only reason I was still having an inkling of doubt was because no doctor had mentioned it to me” (p. 82). But through further research, and learning to trust her own intuition, McCarthy thinks she pieces together a link between autism and preservatives in food or vaccinations:

Why in the hell isn't this on the fucking news every night if it's true? Why hadn't my *trusted and famous pediatrician* told me it was even a possibility? I felt so torn, wondering whom I could trust since my own doctors weren't telling me about hope...my *emotional guidance* system was telling me I was on to something. (pp. 82-3, emphasis added)

For someone such as myself, who still believes in the efficacy of science, this statement from McCarthy makes her seem more reasonable than I might otherwise suppose her to be. She did not immediately ignore the advice of her doctors, but only turned to alternative therapies when it seemed that traditional methods were doing nothing to help her child. In turn, her initial doubt makes her subsequent experiences seem more powerful. It seems as though her alternative treatment regimen “really works” because McCarthy did not immediately dismiss the scientific narrative. Her comment, which seems to indicate that doctors might know about the possibility of cure resulting from these treatments, continues to portray doctors and nurses negatively. She constitutes good parents, particularly mothers, as those who will listen to their *emotional guidance systems* over the expertise of trained professionals; she also constitutes the medical profession as so invested in traditional methods that it cannot accept alternative theories about causation and cure, nor bring itself to offer patients *hope*.

When McCarthy narrates her flashback of Evan receiving his MMR shot, she illustrates herself as the prophetic mother instinctively knowing Evan is going to be harmed, and the doctor as actively engaging in behavior harmful to children. I include this section in its entirety, to show its impact:

The doctor came into the room, and I said to him, “Evan’s getting the MMR shot today?”

“Yep, it’s that time,” he said.

“Does he *have* to have it?” I said.

He stopped and looked at me and said, “Yes, he has to have it.”
“Isn’t this the autism shot or something like that?” I said.

“NO!” he yelled. “That’s all bullshit. There is no correlation between shots and autism at all.” Then the nurse handed me papers I had to sign before they gave him the MMR shot, stating that if anything happened to him from the shot, it was no one’s fault. I looked at the papers and looked at John. “You’re going to have to sign these, because I’m scared. I just have a weird feeling,” I said. “Why would you have to sign papers to get a shot if nothing is supposedly going to happen?”

John glanced at the papers and signed them.

The doctor assured me yet again that everything was fine and not to worry. Those were just angry moms looking to point the finger because they had no one else to blame.

With that, I watched the nurse depress the plunger on the needle as John held Evan. I watched Evan scream, and that cry hurts me more now than it did that day. (pp. 83-4)

I take this moment as a kind of representative anecdote for McCarthy’s story. First, McCarthy is shown as a mother who seems to be critically thinking about a procedure that her son is slated for. She may have heard some rumors or concerns about the MMR shot, and is asking her doctor for more information before she can, in good conscience, subject her son to the vaccination. This behavior coincides not only with her actions up to this point in the story, but with the actions of any parent who wants to be active in the care of his/her child. No parent wants to subject his/her child to an unnecessary and possibly dangerous procedure, nor do parents want a decision they make to have a negative impact on their children’s health. McCarthy’s behavior resonates with many parents, not just with ones who agree with her assertion that vaccines cause autism: most

parents want to be critical about the decisions that affect their children's lives, no matter what their particular view on vaccines.

Further, the doctor's reaction to McCarthy's seemingly innocent question appears defensive, aggressive, derogatory to parents, and incredibly rude. Personally, I find it surprising that a doctor would curse at a parent, particularly if s/he was trying to convince a parent to do something. McCarthy seems to exercise her poetic license here, but her portrayal is consistent with other episodes in the book. The doctor yells at McCarthy, foreclosing any reasonable conversation on the subject, and it seems that in the next instant, McCarthy is being forced to sign papers indicating the very strong likelihood that something bad will actually happen from the shot. This focus on legal paperwork portrays the medical community as more invested in legalistic ethics than in being ethically responsible to its patients—the doctor is seemingly more concerned about liability than harming people. Two notable events in this vignette build the rhetorical significance of McCarthy's as an anti-vaccination story. First, the doctor seems to assume that a forceful response is all that is required to convince someone who is questioning his medical authority; his response almost seems to indicate irate disbelief that anyone could question the safety of Western medicine as it is currently practiced. Secondly, the immediate and seemingly forced signing of the papers seems to contradict what the doctor has declared just previously. The shouting and hurried consent make it seem as if the medical community is actually quite aware of the danger of vaccinations, and there must be some nefarious, probably financial, reason for the doctor and nurse to continue on as if McCarthy had never spoken. This is a powerful bit of storytelling, as McCarthy stacks

the events so close together as to give this impression of forced hurriedness. It certainly gives the impression of “medicine” as interested more in profit than in the safety and wellbeing of children. Her depiction of the scene hearkens back to a time when medicine and its representatives were seen as all-knowing and powerful, a time when individuals had far less control of their own health than they do now.

In her illustration of husband John casually signing the papers, McCarthy also reaffirms herself as the prescient mother who “just ha[s] a weird feeling” that something is going to go wrong. As she learns to her dismay later, a true “Mom” would have listened to her instincts. She simultaneously casts herself as the overprotective and caring mother who questions the safety of a procedure at the same time that she reflects on the guilt she feels in allowing Evan to go ahead and get a shot she basically foresees as causing him more distress than the mere inconvenience of a prick in the arm. Yet she begins to alleviate this guilt by depicting the doctor and nurse clearly as the cause for Evan’s condition. While she should have known better as a mother, the experts who seem to know the harm the shot will cause Evan are ultimately responsible for the outcome. She finishes out the sequence with irony and with poetry; she becomes one of the *angry moms looking to point the finger because they [have] no one else to blame* for their children’s condition.

This sequence helps the narrative to achieve fidelity because of its placement within McCarthy’s story. Once she has a diagnosis of autism, she desperately seeks answers as to what might have caused Evan’s condition. Her behavior, of remembering incidents which seemed insignificant at the time, reflects that of many audience members.

We are all likely to try and find answers for why certain traumatic events occur in our lives; thus, we search our past experiences to find some cause for them. Within this episode, McCarthy encapsulates the themes of the entire narrative, from the medical community's complicity in harming Evan, to the guilt she feels for not protecting Evan, to her belief in an all-powerful maternity.

The conflict between McCarthy and the medical community advances the falling action section. Here, McCarthy truly begins divorcing herself from the medical community in order to achieve redemption. Aside from continuing to cast doctors as the scapegoat, McCarthy begins to transcend her initial connection with them through research about autism, which makes her "feel better. Not because I was reading warm and fuzzy stories about autism but because I was educating myself on every part of the diagnosis. I felt like I was going to take the driver's seat" (p. 77). And take the driver's seat she does, making diagnostic and treatment decisions on her own, rather than relying on the advice of her pediatricians and specialists.

McCarthy "discovers" special diet books which recommend getting her autistic child off of gluten and casein (wheat and dairy). These books indicate that mothers often "reported huge changes in their children, sometimes even recovery from autism" (p. 104). McCarthy is still somewhat hesitant about believing the books, wondering why she had not heard about the link between diet and autism from her own doctor. But her conversation with her doctor confirms that she and other mothers of autistic children must strike out on their own: Her doctor tells her that the diet-autism connection is "horse shit. [Just] 'another desperate attempt'" (p. 104). McCarthy indicates that she "didn't

know what to believe. All I knew—and I'm going to say it again—was if there was hope in anything, I was going to give it a try” (p. 104). The medical community is, again, intractable and unwilling to do its job of helping to cure people, while mothers are left to rely on their gut instincts and hope to help their children.

It is important to briefly review the information McCarthy relates which seems to link diet to autism, in order to understand McCarthy's course of action regarding her son. McCarthy believes that Evan was born with a weak immune system, and that:

getting vaccinated wreaked havoc in his body, and mercury caused damage to the gut...which caused his inability to process certain proteins...It messed with his little body so much that he wouldn't respond when his name was called, he behaved like a drunk...[by] removing wheat and dairy, some of those behaviors could dissipate or disappear. (p. 105)

McCarthy goes against medical recommendation and immediately takes Evan completely off gluten and casein. She even admits that this is a mistake, but for those inclined to be sympathetic towards her, it is understandable for her to want to see results fast. She says, “it was interesting to see him go through withdrawal, almost like an alcoholic...he tantrumed and gnawed on the back of his fist” (p. 105). Even though McCarthy admits that it was a real struggle to keep on with the diet, she is filled with hope that the diet is working when Evan says “with all of his might, ‘Want... to... go... swimming’” (p. 106). Her son is beginning to talk in full sentences, something McCarthy worried would never be within his grasp.

Parents of autistic children would most likely feel encouraged by the actions of McCarthy and the success she seems to enjoy, even if they have not experienced the same kind of success in their own lives. Thus, while McCarthy's experience may not coincide exactly with their own experience of the world, her accounting of it makes it seem likely,

or at least hopeful, that such a thing *could* happen in others' lives. Here, her narrative has strong fidelity and probability, at the same time that it fulfills all the requirements of a traditional plot line—McCarthy as protagonist is beginning to triumph over adversity, and to overcome her foes even when they actively try to stop her. She continues her portrayal of the medical community as a scapegoat from which she must divorce herself, accusing doctors of being actively negligent:

Even though [Evan's] progress made me so happy, I couldn't help but be pissed off that doctors weren't telling moms to at least try it. They really were against the diet. My thinking is that if the diet works on *some* autistic kids, that would link it to vaccines, and God forbid that happened. Doctors will never admit it, and it's a useless war to try and fight. (p. 107)

Ironically, although she indicates that *it's a useless war to try and fight*, that is exactly what she is attempting to do with this book. Further, McCarthy's rhetoric sets out the parameters of the old group she must transcend, the doctors who support vaccines unquestioningly and who will never admit their complicity in causing autism; and the parameters of the new group she is forming—all those who believe, as she does, that vaccines are responsible for the onset of autism in some children.

Yet, even as McCarthy seems to be succeeding in her quest and overcoming the challenges presented to her, like a protagonist in a heroic novel, the audience continues to hear about the daunting setbacks that she confronts every day. Instead of making the story seem disheartening, these very setbacks, and the way McCarthy deals with them, have the effect of helping the reader to further believe in her journey. The setbacks keep McCarthy's character "real" and within reach of the reader; the setbacks also strengthen the probability of the narrative. For instance, even after McCarthy has taken Evan off of wheat and dairy and he has begun to make fantastic strides toward moving outside of his

anti-social world, McCarthy claims it is difficult for her to see children who have no “problems:” “It’s sad to say, but when I went to parks with Evan, I would watch children his age talking and playing with their moms, and I hated them for their happiness and the wonderful simplicity of their lives” (p. 111). McCarthy is entirely realistic in her jealousy and anger toward children who are non-autistic. Even for someone who does not agree with her standpoint on what caused Evan’s autism, her honesty about how she feels towards other children makes her seem authentic and probable. It is tremendously difficult not to compare one’s children to others’, even when one’s own children have no neurological disorders or other challenges of that nature. Comparison is a natural part of parenting, one that is made so much more traumatic by the onset of this kind of disorder. McCarthy says as much when she indicates that simply spending time with her friends “on the phone and hearing their kids interrupting felt like knives in [her] chest. This is why a huge majority of mothers of autistic children no longer have friends with ‘normal’ kids. It hurts too much” (p. 111). McCarthy’s experience may reflect those of many other parents of autistic children. She also points to the very sensitive nature of childrearing in general when she indicates that, “I know parents who can’t listen to their child’s preschool teacher saying their kid wasn’t paying attention today. Can you imagine hearing that your three-year-old has the comprehension of a one-year-old?” (pp. 94-5). These two statements have a major impact on parents reading the story—those who have “typical children” understand McCarthy’s comment about hearing critiques of their own children; when paired with a devastating realization like the one she received about Evan’s comprehension level, the statements work to encourage a sense of fidelity. By

highlighting her continued struggles, McCarthy reinforces narrative probability, for if McCarthy immediately cured Evan without any other challenges along the way, readers would be much more likely to dismiss the story.

McCarthy employs an interesting narrative technique towards the end of her story, whether intentionally or not, which highlights a sense of fidelity by making her experience realistically echo that of others in similar situations. Evan has begun to progress with his language and social interaction skills, and McCarthy is able to have some time to devote to just herself. She even gets to go on a couple of dates with a “cute boy” and begins “enjoying being a girl on a cute boy’s sofa who looked pretty in her new blouse and wanted to feel liked by him” (p. 158). In other words, her life is getting back to a more “normal” routine, and it is as if she can look beyond the immediate crisis of Evan’s diagnosis to a time when he will be better, or if not better, she herself will be better able to accept his behavior.

However, a subtle threat underlies the success story McCarthy is narrating, and she becomes worried about Evan’s increasing allergies and his:

sudden...obsessive-compulsive... behavior and demands...that experts say happens with a lot of autistic children. But I wasn’t buying the fact that it had happened on its own and so intensely...My *motherly instinct* told me that something was wrong, that I was missing a sign. And I was determined to figure it out for Evan. (p. 159, emphasis added)

McCarthy “start[s] to become scared of [her] own child” because of the “angry and psychotic” behavior he suddenly begins evincing towards her (p. 161). Evan becomes “crazy and [will] not stop screaming, sometimes for hours” (pp. 161-2). All the progress that McCarthy has made comes screeching to a halt, and she has to put her life on hold to figure out, once again, what is troubling Evan. McCarthy reinforces the dual roles she

has set up. First, the doctors are arguing that Evan's behavior is "normal" and just something that spontaneously *happens with autistic children*, an argument that seems to dismiss McCarthy's concern as a mother and which seems to reinforce the idea that doctors actually care little for their patients as people. They refuse to explore potential causes for Evan's behavior, thereby obstructing any treatments or possibility of a cure, actions which reinforce their role as scapegoat. Secondly, McCarthy's *motherly instinct* overrides the expertise of the doctors. Because she refuses to accept the guidance of her doctors, she begins to divorce herself from the hierarchy and achieve redemption. Further, she is the representative of essential motherhood because she refuses to give up on Evan, even though she is scared of his *crazy, angry, and psychotic* behavior. While others may banish their children to an institution, McCarthy's commitment to her child reaffirms her characterization as the "ultimate mom."

The way in which this series of events is depicted highlights an effective and engaging narrative technique: the heroine seems as if she will not be able to defeat her enemies and conquer the crisis that has been placed before her. From this standpoint alone, McCarthy's narrative resonates with readers, most of whom are familiar with this plot structure. Her experience coincides with readers' experience of the world, perhaps not in exact particulars, but structurally through narrative. And readers' expectations are fulfilled, as McCarthy recounts the manner in which she begins to triumph over her challenges.

McCarthy discovers, through the help of a doctor who is sympathetic to her plight, that Evan's system has become overloaded with yeast as a result of taking too

many antibiotics over the course of his lifetime. This doctor argues that, “many of Evan’s OCD behaviors [are] side effects of severe candida [yeast] overgrowth, which [is not] uncommon in an autistic child” (p. 165). However, McCarthy still plays the protagonist as a mother who will not accept the answers she is given by the doctors, even when those doctors agree with her outlook. When she is told that Evan’s immune system can only come back with “Time, maybe. [And that] sometimes it doesn’t come back very much at all” (p. 166), McCarthy says, “I sure as hell wasn’t going to listen to that. I wanted to know how this had happened. I was going to make sure Evan’s immune system got better” (p. 166). Even here, a seemingly neutral or positive member of the medical community is accused of not doing enough to help Evan recover. The doctor is complicit in maintaining Evan’s condition. McCarthy’s role as mother supersedes even the medical expertise of those in the medical community who agree with her viewpoint about the cause of Evan’s disorder. McCarthy works hard to thoroughly place “motherly instincts” as of paramount importance: she may not know the exact science behind what is happening, but her motherly role allows her to “truthfully” sense when a diagnosis is right, when it is wrong, and what to do about it.

McCarthy raises our sympathies as a mother trying to do what is best for her child, even when the treatments seem to make Evan worse before they make him better. After all she has suffered, we feel for her when she describes Evan’s behavior during the yeast die-off period:

He went full-blown Exorcist on me...His eyes were bulging with rage, and he was grinding his teeth so much when he slept that I thought he would have none left in the morning. He also threw up, and his pee was cloudy and painful...I had

sympathy for Evan's pain, but after starting my heavy research online, I knew that this extreme reaction meant I was absolutely on the right track. (p. 167)

Here, we feel her reality resonate with our own experiences. We might have had similar experiences of our own with trying to wean ourselves from something like smoking, or with our own children, when doing something "for their own good" such as taking away something that is very valuable to them in order to teach them a lesson. The point is that her story echoes our own experiences of the world, creating a sense of narrative fidelity. Additionally, her character stays true to how she has depicted herself all along—despite the difficulty of dealing with an obsessive-compulsive child or one who is going through an extreme yeast die-off that is causing him to act like the child from the movie, "The Exorcist," McCarthy remains committed as a mother. Even though she has been *scared* of Evan because of his behavior, and his reaction to her anti-yeast diet seems so extreme that it might threaten his health and well-being, McCarthy's unwavering conviction in her mothering instincts again constitute what it means to be the definition of motherhood. We leave the falling action section of the narrative sure that McCarthy will triumph in the resolution of her story.

The resolution section of a traditional plot line contains the solution to the problems the protagonist has been presented with, and the moral of the story which audiences may take to invoke in their own lives. By the end of her narrative, McCarthy has divorced herself from the hierarchy, purged her guilt by consigning it on the scapegoat of the medical community, and cured Evan of his many ills. She also creates a new group with which to identify—parents who believe as she does and who will act in the ways she suggests. This group believes

that the medical community is a nefarious collection of people who view patients as possible profit-makers, rather than individuals. These parents have faith that they are at least equally as competent as doctors and nurses, and equally able to determine the best course of action for their health and well-being. Thus, they pursue their own research about health issues and make their own decisions, sometimes in concert with doctors, but often in contrast to them, as McCarthy demonstrates throughout her narrative.

Throughout the resolution of the story, McCarthy's character of "devoted mother" remains at the forefront, and it is at the end of the narrative that we see the rewards of the consistency of this character. These rewards reinforce a sense of fidelity—again, we are familiar with many stories of this kind, and since we know at the start of the book that this is a story of overcoming adversity, we know that the story will end "happily" with the protagonist's triumph. The effects of the no-yeast diet, which we see in the resolution of the narrative, seem miraculous. Further, Evan's recovery vindicates McCarthy, who divided herself from the hierarchy and forged out on her own. Suddenly, after being locked in his own little world, where words and concepts worked differently for him and where social interaction was only minimal, Evan "giggle[s] at a joke on the TV...[this is] HUGE!...It mean[s] he [is] understanding subtext and emotion...It mean[s] he [is] no longer in a confused daze but [is] growing mentally and emotionally" (pp. 169-170). McCarthy is understandably thrilled about this breakthrough, and readers are delighted for her. Parents of autistic children would be encouraged by

what they read here, and though they may not have experienced exactly the same thing in their own lives, this story gives them hope that something similar *could* occur with their children. Even parents who have “typical children” cheer for McCarthy because she seems to have succeeded against impossible odds, and in the face of the medical community enemy.

Though she is ecstatic that Evan is “recovering” from autism, McCarthy is not content. She “decide[s] to find out the connection between yeast, immunity, and autism...[She is] inspired and excited about the possibilities for our future. And [she is] a woman in search of answers” (p. 171). McCarthy has “healed” her son through her dedication and incessant quest for answers, as well as through her refusal to accept explanations that did not make sense to her. And herein lies the moral of McCarthy’s narrative. McCarthy makes her most damning assertions about vaccinations, and she couches them in a way to make it seem as if this is only her opinion: “There are many points of view out there, and [this] is mine” (p. 173). The story’s construction of medical-community-as-villain and mother-as-hero gives the statement a great deal of force. More impartial medical and scientific proof cannot compare to her story, even if it is just her *point of view*.

McCarthy (2007) uses the resolution of her book to detail the moral of her story: vaccine companies and the government are complicit in the growth in autism diagnoses, and pediatricians everywhere “will not...give you this information” (p. 174). Thus, she charges her readers to always ask questions: “It was my dedication to asking questions and researching—WHY his immune system was damaged, WHAT happened as a result,

and HOW we can fix it—that led us down the road to recovery” (p. 177). Her message, delivered at the end of a heart-wrenching, believable journey, has more impact because readers have gone on the adventure with her. Her message also speaks to how we have to take more ownership over our own lives, bodies, and health, as we rely less frequently on the advice of “experts:” McCarthy enjoins us to “Figure out the *cause* for all your kid’s issues, and don’t settle for the doctor’s Band-Aid” (p. 178). She is very clear about what she wants parents, especially mothers, to do:

My solution can manifest only with help from moms. Strength in numbers, right? Moms are the only ones who can make a difference when it comes to vaccines. If we all said, “I’m going to wait to vaccinate my kid until you test him for immune problems or give me some proof he won’t turn into Rain Main,” I have a feeling the government would get on it pretty quickly. Many moms I talk to believe too much of what their pediatrician says and still want to vaccinate. (p. 175)

Here we see both the instrumental and constitutive natures of McCarthy’s narrative. A main thrust of her story is to directly influence how people feel about vaccines and the medical community; moreover, she clearly hopes to influence readers’ opinions and to encourage particular kinds of actions on their part. From a functional perspective, McCarthy not only wants vaccine protocols halted completely, until there is some sort of validation of her theory on the cause of autism and some sort of test to ensure that vaccines are safe for *all* children, she also wants parents to take more responsibility for their children’s health. Her book is basically a call to arms for parents to rise up against the medical establishment and demand “safe” vaccines, as she views unsafe immunizations as the cause of the apparent upswing in autism diagnoses. McCarthy states her intentions for writing her book, hearkening back to her strong feeling and declaration that Evan would change the world:

That is what I would love to have happen from this book. The government can keep giving their vaccines, just give us the test to make sure our babies can handle them... Like I said before, I'm all for having vaccines in today's world; I just believe that the government is obligated to offer a test to help moms know which child can take them—and which child can't. (pp. 174-175)

McCarthy makes no secret about her deliberate purpose in writing the narrative in very specific detail. While the story encourages identification and sympathy between her and her readers, it most definitely hopes to accomplish a radical shift in the way that parents approach standardized, accepted Western medical practices such as routine childhood vaccinations.

Yet, even as McCarthy concentrates on the very deliberate ways in which she wants her book to be taken up, the constitutive components of her narrative are of extreme importance in indicating why this story has been so powerful—and, in helping readers consider its potential impacts, the negative side effects which McCarthy does *not* consider in telling her story. She reinforces the idea of a mother as someone who has the power to *make a difference*, to hold dominant institutions accountable for their actions, especially regarding children. And the ideal mother will use her power to change the course of history and the way in which medical communities and the government are held liable for the actions they impose on innocent children. Any woman who aspires to be this ideal mother will not *believe too much of what [her] pediatrician says and still want to vaccinate*, nor will this ideal mother *settle for the doctor's Band-Aid*. In many ways, McCarthy's story is cathartic, helping her to find closure and healing after a devastating but ultimately rewarding experience; in addition, it encourages empathy and identification with other people in similar situations.

Throughout her depictions of Evan’s behavioral therapy treatment, she constitutes an audience of parents, mostly mothers, who are experiencing the same thing she is and who need a voice to spread the “truth” about vaccines. These women “greet...[her] and start...telling [her] ... how [she] need[s] to be the one to spread the word about autism being an epidemic. [She tells] them probably in due time, but [she] just want[s] to fix my boy right now” (p. 126). McCarthy is a part of this kinship of mothers of autistic children: “We all were suffering so badly. We all were watching our kids struggle to do basic stuff, and it was killing us” (p. 118). These mothers, who are all aware of the autism epidemic but powerless to do anything to stop it, need an “ideal” mom to represent their story. McCarthy does not break from her role as ultimate mother, even in the face of other mothers’ needs for an ideal spokesperson, until Evan has shown marked improvement and has become a much more “typical” child. McCarthy is sympathetic to these women, knowing that eventually she will be able to help them:

I prayed for all the mothers like me across the country that God would give them a message through someone or something. I knew someday I would be a messenger, but in the meantime, I prayed every autistic child was getting the help he or she deserved. (p. 97)

McCarthy reinforces her purpose while maintaining her role as the ultimate mother: “I always knew Evan was in some way going to change the world. I had a very strong feeling about this one. I just didn’t realize that it would have to be through me” (p. 85).

By the end of her narrative, McCarthy has divided herself completely from the prevailing hierarchy and has established a new order for herself, one comprised of mothers and parents who believe as she does about the causes and treatments for autism. From the mothers whose children go through behavioral therapy at the same time as

Evan, to the parents reading the book (likely hoping for answers and possible solutions to their own children's condition), McCarthy creates a new group of people who do not blindly accept doctors' "expert" guidance, but rather seek out information on their own, trusting their gut instincts to guide them. Doctors, as scapegoat, come to represent the intrusion of government and corporations into our lives, forcing us to become "experts" ourselves so as not to be misled by the ulterior motives of these representatives, such as profit. McCarthy has found redemption in being responsible for recovering her son herself. We see her coming to this sense of purification as she moves through the narrative, and as she comments on it directly herself towards the end of her story:

I started to feel a shift in me. I was accepting what *was* and not hating the world for what should have been. I came to my own conclusion—that acceptance does *not* mean giving up. Nothing was going to stop me from pulling Evan out of this window. I just simply loved him and was proud of who he was no matter what. I found myself loving his flapping, his tiptoe walking, his love of fans, door hinges, and escalators. I thought, "So what. If he grows out of it someday, great; if not, he comes here after the prom with his girlfriend and they ride the escalators till the sun comes up. Evan *is* perfect." (p. 155)

The way in which McCarthy ends her narrative both evokes a sense of triumph in her readers and encourages them to act in particular ways to achieve their own version of success. These two reactions hearken back to Fisher's (1984) blend of the constitutive and functional aspects of narrative.

Does McCarthy's Story Measure Up?

In many ways, it seems as if McCarthy's narrative fulfills the requirements of narrative probability and fidelity. McCarthy's depiction of herself as the ultimate mom, which never varies throughout the story, helps to achieve probability. Additionally, many of the experiences she recounts (from her interactions with her son, with other parents,

and with members of the medical profession), resonate with audience members' own lives. Yet her narrative fails to meet the requirements of the paradigm in full: her radical actions and her illustration of every medical professional she meets as deliberately causing or exacerbating Evan's condition, claims I elaborate on below, may lead some readers to reject her story. However, her narrative clearly has been taken up and embraced by many parents in the United States, contributing to the lack of faith parents have regarding vaccines. How is this the case, if her narrative does not meet Fisher's requirements completely? I argue that the manner in which McCarthy's story achieves a sense of identification, particularly through her method of dealing with guilt, and the way in which she constitutes an audience of "good parents" who reject medical advice as the only answer to a problem, explains the success of her narrative.

From early in the exposition and conflict of her narrative, it is clear that McCarthy is attempting to address competing stories—a critical component to achieving narrative probability, as Fisher argues. The medical community provides one explanation of why Evan is acting the way that he is, and it is clear, given her depiction, that this is not the "right," or believable story. By establishing the protagonist and antagonist characters early, McCarthy's story seems to achieve one aspect narrative probability—that of dependable characters who act in ways we come to expect. McCarthy's depiction of herself as a mother willing to do anything to help her child, including fighting the odds, against an unhelpful medical community, likely resonates strongly with readers who may have found themselves in similar situations, whether in a school-setting, a medical setting, or a family setting. However, there are times McCarthy acts in ways that stretch

the credibility of her character, and her credibility as a narrator. Notably, her representation of the medical community is so extreme at times that these character depictions weaken the narrative's probability for more critical audiences. I turn first to an examination of how her representation of herself as the ideal mother strains the critical reader's willingness to accept her character as reliable, thereby weakening the probability of the narrative.

After the neurologist is convinced that the blue seizure medication is making Evan psychotic, the doctor switches him to a yellow seizure medication, which makes "the psychotic portion of Evan disappear completely. He [sleeps] full nights on this new yellow medicine, which mean[s] [McCarthy] finally [sleeps], and he never again [fights] away invisible demons" (p. 41). However, this medication also seemingly causes its own set of negative side effects. Evan:

lose[s] all speech...He also drool[s] and stay[s] locked in a daydream while staring at the wall. I called the doc and told him now I had Ozzy Osbourne for a child. I told the doctor that Evan had been a very happy boy who liked people, but now he was a zombie. The doc told me to hang in there, because it was a really good medicine. I got upset. (pp. 41-2)

It is understandable that McCarthy gets upset that the doctor continues to ignore her concerns and to value scientific theories over maternal experience. At this point, McCarthy's character still seems credible, and the audience is likely to be sympathetic to her frustrating plight. Yet McCarthy's next series of actions strains her trustworthiness as a reliable source for medical advice. She indicates that she:

decided to do what I'm sure many would say is a really dumb thing and take Evan's seizure meds to see how they made me feel. I needed to know if it was the medicine making him like this or something new. About an hour after taking the medicine, I swear to God, I could barely hold the saliva in my own mouth. My thoughts were confused, and I couldn't stop daydreaming. I didn't know what to

do. Did I take psycho kid, or did I take zombie kid? I settled for zombie kid until I was able to figure out some more on my own. (p. 42)

While some may argue that McCarthy was merely taking her role as the ultimate mother through the logical steps, more critical readers would see her actions here as downright stupid, as she notes, as well as incapable of actually proving anything. When someone takes medication that has not been prescribed for him/her, and which is meant to treat a condition s/he does not have, the results are unpredictable and most likely dangerous. Further, this kind of “test” will not prove anything regarding how the drugs are affecting Evan—it merely shows how this drug affects an adult without the condition it is meant to treat. McCarthy mentions that she knows her actions will be judged *dumb* by many, but the way in which she frames this scene makes it clear that she finds valuable knowledge in the experiment. Her underlying message indicates that Evan must not really be like the child she sees before her, and it is clearly the medication that is causing this reaction. She is forced to choose between two evils, both created by the medical community (the *psychotic kid* and the *zombie kid*), until she is able, as mother-expert, to determine a better course of action. Even if these seizure medications do affect children in the way McCarthy describes, a more critical reader is far less likely to believe her claims about other medical interventions, such as vaccines, since she clearly does not understand how medicine is designed to work.

Her actions regarding the seizure medication also point to the extreme nature of her conviction that “mother knows best.” Critical readers see this at several points in the narrative, most particularly when she begins to make treatment decisions on her own, without medical advice. When she drastically removes gluten, casein, and yeast from

Evan's diet, she sees his behavior as proof that she is doing the right thing. Yet more critical readers may acknowledge that she could achieve the same effects more gradually, as suggested by medical practitioners, without causing the extreme reaction and suffering Evan experiences. Her reliance on her motherly instincts cause her to act in ways that may actually damage her son, reminding readers of the vulnerability of children not only to medical practitioners, but to their parents as well. While parents can be the most protective and loving caretakers, they are also in the position of greatest power to harm their children. It is ironic that McCarthy is hoping to avoid this kind of harm by protecting Evan from medical procedures she does not believe in, yet her own behavior can be seen as equally damaging. That Evan ultimately seems unharmed by her choices makes a critical reader breathe a sigh of relief that McCarthy has done no lasting damage, though more sympathetic readers would see her "accomplishments" as further reason not to trust the medical establishment. Her radical actions as "ultimate mother" severely impair her narrative's ability to achieve fidelity, probability, *and* identification—critical readers are not likely to identify with someone who takes such harmful actions in search of a cure for her son.

Similarly, the excessive nature of McCarthy's portrayal of the medical community strains the willingness of many audience members to believe in it to the point of making her narrative fail to achieve probability and fidelity. For instance, the second time Evan is in the hospital, and the neurologist fails to appear, McCarthy comments that, "I knew that the day before had been Easter, but I didn't want to believe that some asshole would rather stay seated at a dinner table with his ham and potatoes than come

save my two-year-old” (pp. 25-6). She also indicates that finally, after two full days in the hospital,

Dr. I Can Fix Any Brain Except My Own...just strolled in the door with a big smile. As a mother who had been to hell and back, I couldn't decide whether to tear him a new asshole or bite my tongue so hard it bled, in order to get some help for my son. (pp. 29-30)

Readers sympathetic to McCarthy would feel that she is acting as many parents would—she is furious that it has taken as long as it has for an expert to see her son, particularly given his condition in which he seized eight times during one night. No one wants to believe that a doctor would selfishly concentrate on her/his own wants when s/he possibly has the life-saving skills and information that a child needs. McCarthy's statements seem credible in that she is a mother driven to extremes given the state of her child and the inability of the medical community to give her any answers or to help her son in any meaningful way. However, her suggestion that the neurologist would have deliberately avoided his duties, allowing a child to suffer just so that he could enjoy his Easter dinner, is patently absurd and seems to reflect a misunderstanding of the oath doctors take to help their patients and *do no harm*. McCarthy is understandably upset, but rather than taking her evaluation of the doctor's behavior at face value, a reasonable reader would see this interaction more as an example of McCarthy's panicking behavior, and less a realistic indictment of the medical community.

Further, McCarthy's embellished depictions of the members of the medical community appear more like her attempt to reinforce her status as all-knowing, committed mother, than an accurate reflection of the behavior of nurses and doctors. For instance, when she and Evan are being discharged from the hospital for the second time,

she indicates that “The nurses all waved goodbye, and out of the corner of my eye, I thought I saw a nurse give me the finger. That’s all right by me. I was just looking after my boy” (p. 32). Although this representation of nurses’ behavior seems to make the narrative more coherent for the sympathetic reader, more critical readers may have a hard time believing that medical personnel would be so unprofessional. Rather, this scene seems to reflect McCarthy’s public persona as the crass loudmouth willing to do anything for attention, so much that a judicious reader would dismiss it as unrealistic, thereby undermining the probability and fidelity of the narrative.

Another example of the embroidered portrayal of the medical community arrives in McCarthy’s recollection of Evan receiving the MMR shot, which was discussed previously. The fact that her doctor would swear at her, yelling that the supposed connection between autism and the MMR shot is “*bullshit*,” seems totally unrealistic. How would swearing even begin to address parental concerns about the safety of vaccines? McCarthy argues that doctors are so vested in vaccines that they cannot objectively examine evidence that suggests these shots are not as safe as they seem. Why, then, would the doctor have to resort to childish measures, such as shouting and cursing, in order to “convince” a parent that vaccines are safe? If anything, to the rational reader, it seems as if the doctor’s behavior would be more likely to cause McCarthy to run from the room, rather than allow Evan to get the shot. The doctor’s supposed response seems just a little too convenient for scapegoating.

Further, while she attempts to make her case against the medical community stronger by questioning why parents need to sign release forms allowing doctors to

administer immunizations “if nothing is supposedly going to happen,” the attempt falls short for an audience member less inclined to blame the medical community as McCarthy does. In this day and age, it would be utterly astounding if there were not some sort of release form for a parent to sign, indicating that in the very unlikely event something adverse was to happen to a child upon receiving a shot, the doctors and nurses who administered it would not be considered liable. As parents, we have to sign release forms for virtually everything that involves our children, from liability statements for sports and even for birthday parties held in a gymnasium or at a pool, to release forms for children to play on a trampoline at a friend’s house, to statements indicating whether or not we agree to have our children’s pictures used in promotional materials for their schools. In her effort to blame the medical community for what she sees as the cause of Evan’s disorder, McCarthy strains her credibility too much for more critical readers.

Additionally, one has to wonder why McCarthy would continue to have her son see a doctor who does not listen to parental concerns in any meaningful way, but rather curses at her and sabotages her attempts to help her son by calling all of her research on alternative treatments “*horseshit*.” Further, her obvious attempt to make medical professionals the scapegoat for Evan’s condition impedes the narrative’s ability to address competing stories in such a way that they are dismissed in favor of McCarthy’s.

Critical readers get the sense that she is trying too hard to make the evidence fit her theory; while they may be sympathetic to her plight, they remain unconvinced that her narrative is the only explanation for what has happened to Evan. Most readers have encountered one, two, or even several medical practitioners who seem callous—indeed, it

would be surprising if readers had not. Yet, the way in which McCarthy depicts every single representative of the medical profession as acting in this manner seriously stretches the reliability of her narrative. If every reader had only negative experiences with doctors, the medical profession would have had to change long ago; thus, McCarthy's narrative lacks the ability to achieve complete fidelity with readers' own experiences in a vital way.

Conclusion

McCarthy's story has enjoyed widespread distribution. The affecting tale of a mother searching for cause and cure, struggling to reclaim her child from a disorder that makes him retreat into his own little world, has been embraced by many. Yet, her claims that vaccines caused her son's condition have been thoroughly disproved by the scientific community, which has absolved vaccines of any connection with autism. Her narrative meets some of the requirements of Fisher's (1984) narrative paradigm, but fails to achieve others, a failure which would suggest that the narrative should be rejected outright. Why, therefore, has her narrative been so successful in causing such extensive concern among parents?

The answer lies in the sense of identification she creates with her audience, and the manner in which she constitutes the role of ideal parent who will seek out "correct" information on his/her own, rather than blindly trusting in experts. Her portrayal as the ultimate mother resonates strongly with audience members, creating narrative probability and fidelity to some degree. As I have shown, her manner of dealing with the guilt she feels over "causing" Evan's condition by trusting the advice of an "evil" medical

community, strains the willingness of astute readers too much to meet the requirements of narrative probability and fidelity entirely. However, this derogatory depiction of the medical profession may be precisely what resonates with those audience members who either already identify with her story's values; or who worry that her accounting of these professionals *might* be correct, thereby necessitating preventive action so as not to endure the same dreadful trial as McCarthy. Her narrative so powerfully constitutes an audience which believes in the primacy of parental gut instincts over the profit-motivation and expertise of Western medical professionals, that many audience members may identify with it.

Using McCarthy's narrative as an example, we see how narrative analysis using Fisher's (1984) narrative paradigm and Burke's (1969a; 1969b) concept of identification, as well as a concentration on the instrumental *and* constitutive nature of narratives, reinvigorates the narrative paradigm as an analytical tool and helps to explain why certain stories are embraced with such vigor. We are also left with the question: What are the potential impacts of McCarthy's tale, particularly when it so virulently dismisses medical expertise? If all readers were to identify with McCarthy's narrative, what might be the outcome, particularly for the public good in the case of vaccinations? A series of counter-narratives has emerged, to which I attend in the following chapter.

Chapter Four: Powerful Pro-Vaccine Narratives

Introduction

Despite the fact that vaccines have been deemed safe and absolutely necessary, even as recently as 2009, health officials have attributed considerable measles outbreaks in the United Kingdom to the concurrent drop in MMR vaccinations (Eggerts, 2010); further, the first five months of 2011 have seen double the number of people suffering from measles than the United States normally sees in a year (Cool, 2011). Jenny McCarthy has been the lightning rod for the autism-vaccine debates, with staunch supporters on one side and harsh critics on the other. One example of such criticism is the website *Jenny McCarthy Body Count* (Bartholomaus, 2010), which maintains a count of the number of VPDs and vaccine-related deaths that have occurred since McCarthy started her anti-vaccination rhetoric (Bartholomaus, 2010). From June 2, 2007 until April 2, 2011, the number of VPDs that have occurred is 77,177, and the number of preventable deaths has been 712; the author also indicates that the “number of autism diagnoses specifically linked to vaccinations” (para. 8) in that same time period is zero. Bartholomaus takes the statistics from the CDC’s Morbidity and Mortality reports; it is argued that the number of diseases and deaths is underestimated because the CDC’s reports only include measles, mumps, rubella, polio, tetanus, Hib, the flu, and diphtheria. Many other deaths come from pediatric flu, a disease that is preventable via a vaccine. While McCarthy is not “directly responsible” (para. 7) for each of these occurrences, “as

the unofficial spokesperson for the United States anti-vaccination movement she may be indirectly responsible for at least some of these illnesses and deaths and even one vaccine preventable illness or vaccine preventable death is too many” (para. 7).

The debate over the safety of vaccines still rages because certain pockets of the country continue to question vaccines, arguing that natural immunity is better (Rae, 2010, para. 29; Reich, 2010), or that the studies discrediting a link between vaccines and autism reflect a conspiracy. These beliefs still persist, even though there have been more and more outbreaks of VPDs in communities like “Ashland, Oregon; Pocatello, Idaho; Madison, Wisconsin; and...Santa Barbara,” California (Rae, 2010, para. 2), as well as San Diego, California (Gordon, 2010). However, the concern over the safety of vaccines has ebbed some because parents of children who have suffered VPDs are now telling their stories. These stories powerfully counteract the narratives and misinformation of the anti-vaccination movement by showing the real, inherent dangers in not vaccinating.

The initial response from the medical community about the safety of vaccines was not necessarily effective: doctors reassured parents about the low risks associated with vaccines, and of the safety and necessity of immunizations, but did not directly address concerns about the link between the MMR vaccine, or the preservative thimerosal, and autism. This lack of a personal story from doctors about vaccines seriously neglected one of the major ways humans make sense of the world: narratives. We listen to other people’s stories and experiences about similar health situations, and feel more confident in what our doctors are telling us if they also indicate that they are following their own advice (Ziebland & Herxheimer, 2008). This issue is not simply one of stories versus

science, but how stories complement science, because narrative is such a powerful tool for identification and decision making. As Ziebland and Herxheimer tell us, “Patients’ experiences are not an alternative to the evidence base—they are part of it” (p. 439).

Although it is difficult to argue a direct cause-and-effect relationship between stories about VPDs and the upswing in confidence about the safety of vaccines, it certainly seems likely that stories detailing the very real risks and effects of non-vaccination would have an impact on whether or not one chooses to vaccinate one’s own children. Thus, I move to examine powerful stories about VPDs: from a parent who chose not to vaccinate or neglected to vaccinate her children and suffered the consequences in the form of twin bouts of rotavirus (Matthys, 2010); from one teenage boy who suffered from H1N1 because he and his parents had not gotten vaccinated against the disease (Duvall, 2010); from a parent who vaccinated her child, but whose child contracted pertussis because the community in which the family lived did not have herd immunity (Rae, 2010); and from the parent of a child who suffered pertussis because he was too young to receive the appropriate vaccine (Dube, 2010).

As in the analysis of McCarthy’s (2007) story, I analyze whether these narratives meet the requirements of Fisher’s (1984) narrative paradigm and encourage a sense of identification with the audience. I also examine the authors’ approach to dealing with guilt, again using Burke’s (1969a; 1969b) concept of the guilt/purification/redemption cycle. I argue that unequivocally, these pro-vaccine stories meet the requirements of Fisher’s narrative paradigm, particularly those of narrative probability and narrative fidelity. The characters depicted within these stories are realistic and credible, far truer to

our experiences in the world than some of those in McCarthy's (2007) story. Additionally, by constituting specific communities in particular ways, these stories strongly address competing narratives. For instance, these four stories create communities that both value personal choice and the public good in a reasonable, thoughtful manner. They constitute what it means to be a "responsible" parent or member of the community in which they live—someone who is scientifically minded, realistic, and informed by evidence rather than nebulous, unproven theories. Further, this community seeks protection for *all* children from VPDs by believing in the importance of vaccination as a safeguard, thereby choosing the public good (though these stories also thoughtfully consider the right to private choice). Even for parents who are not swayed by the manner in which these pro-vaccine stories deal with the issue of vaccination, the sense of identification created within these stories, of parents and children struggling to survive devastating and life-threatening illnesses, helps to overcome this obstacle. Further, the manner in which the narrators deal with the concept of guilt helps readers to identify with the larger story of medicine as necessary savior, rather than harmful menace. Specifically, these narrators take the blame on themselves through the purification process of mortification, or by gently and subtly creating a scapegoat in the form of parents who choose not to vaccinate.

Why Narrative? Which Narrative?

Fisher (1984) argues that we make sense of the world around us through "narrative rationality" (p. 7), which is comprised of "narrative probability" and "narrative fidelity" (p. 7). Narrative probability concentrates on how a story "hangs" together as

listeners anticipate, while addressing competing stories and having characters act as we expect them to, making them credible and reliable (Fisher, 1987, p. 47). Narrative fidelity deals with whether or not a story “ring[s] true with the stories [people] know to be true in their lives” (p. 47). Do readers feel that the story matches their own experiences; importantly, do they feel as if the story *could* happen to them? For instance, does a reader of a pro-vaccine story think that a VPD could occur in his/her own life or the life of his/her children, based on the story s/he is reading? As I have established throughout the dissertation, the concept of identification is vital to narrative probability and fidelity—if a reader identifies with characters in the story, that story is more likely to seem believable to that audience member. Further, s/he is much more likely to see a connection between the story and his/her own life and therefore be influenced by the story, either to feel sympathy or to act in particular ways, or both. Thus, stories can be a way of sharing an experience, calling forth a certain kind of identification through the creation of particular audiences. Stories can also function as an impetus or call to action, as in the case of VPD stories, which encourage parents to vaccinate their children.

Burke (1969b) argues that identification occurs when you act like someone, meaning that you mirror another’s ideas or attitudes, which in turn is persuasive and can encourage action (p. 55). Identification leads to both a sense of consubstantiality, and a sense of division: as soon as you identify with one group or attitude or idea, you are inherently dividing yourself from another. Identification in the pro-vaccine stories often comes about through the communities the narratives create; the narrators are touching on concepts, feelings, and beliefs that constitute a particular sense of identity, which in turn

makes one more sympathetic towards these stories, and perhaps antagonistic toward those arguing against vaccination.

Intricately linked to the concept of identification is the guilt/purification/redemption cycle. Guilt is endemic to humanity: in our basic need to understand and feel secure in the world, we form groups and social orders. However, not everyone will belong to every group, creating division among us which then causes us guilt. While such divisions are inherent in our nature, and thus ontological, our guilt also manifests itself in our individual behavior, particularly in our actions to rid ourselves of this guilt. As we saw in the last chapter, scapegoating involves the creation of an external entity upon which we can blame our guilt. Rather than searching for a scapegoat outside of oneself, mortification embodies the sins within the sufferer, thereby making an internal scapegoat (Burke, 1970, p. 248). Importantly, mortification “must be real; false flagellation cannot replace the symbolic value of real sacrifice” (Brummett, 1981, p. 263). The person experiencing mortification as a method of purification must truly feel remorseful in order to be able to successfully purge the guilt. In the pro-vaccine stories, there is an interesting mix between mortification and scapegoating tactics, with the creation of the scapegoats often implied rather than direct (as in McCarthy’s narrative). The effect of these enactments of the purification and redemption tactics strongly encourages a sense of identification between readers and the authors of these narratives. These tactics constitute a community many people would want to belong to: parents who thoughtfully consider the choices they face surrounding their children’s health, and who reflect on how their choices will affect others. This community enacts the “Golden Rule”

of “do unto others as you would have done unto you,” evincing a sense of responsibility that extends beyond the seemingly self-interested actions of those who do not vaccinate. At the same time, these stories address what it means to have personal choice and to worry about harming one’s children, but gently approach the issue in a reasonable way. The manner of dealing with guilt and the identification this engenders all strongly reinforce the narrative probability and fidelity of the stories and help them to address competing stories.

Rotavirus: When Intestinal Distress Becomes Dangerous

Rotavirus, an intestinal virus, is responsible for the majority of severe gastroenteritis (GE) cases in the United States and around the world (Rotavirus center, 2011b). Prior to the vaccination protocol that began to protect children against the disease in 2006, virtually every child under the age of five was likely to contract it. This resulted in “2.7 million cases of rotavirus, 410,000 outpatient office visits, up to 272, 000 emergency department visits, and up to 70,000 hospitalizations” (para. 3). One estimate for the cost of the rotavirus disease prior to 2006 was “approximately \$1 billion yearly” (para. 5).

The disease manifests itself differently from child to child, and the severity of the symptoms depends on whether it is an initial or subsequent infection. However, common symptoms start with vomiting and then move to recurrent diarrhea (Rotavirus Center, 2011a). Almost a third of patients suffer from a temperature greater than 102 degrees Fahrenheit (para. 2). Vomiting and diarrhea caused by rotavirus “is more severe...and more often results in dehydration, hospitalization, and if not treated, shock and electrolyte imbalance” (para. 2) than other causes of gastroenteritis (GE). Prior to 2006, during “the

peak rotavirus season, rotavirus was responsible for approximately 70% of all hospitalizations for GE among children aged [less than] 5 years in the United States” (Rotavirus Center, 2011c, para. 2). The virus is responsible for a vast majority of cases of GE severe enough to require hospitalization; thus, a vaccine preventing this disease was highly sought after and has proven to be incredibly effective.

Yet rotavirus still persists as a threat to young children. Of those who contract the disease, infants and toddlers are still most often affected, and are more likely to suffer from “clinically significant disease” (para. 3), meaning that they get the sickest, particularly because they are the most susceptible to diarrhea and its serious side effects, like severe dehydration and electrolyte imbalance. And, “without rehydration, an infant can lose 10% of his or her body weight and experience shock within 1 to 2 days” (para. 4). The disease is transmitted via touch/oral contact, as when a child touches an object that has rotavirus germs on it, and then puts his/her hands in his/her mouth. Because it is difficult to disinfect every surface a toddler or child touches, and because the virus remains stable for long periods of time, transmission and re-infection can occur frequently (Rotavirus Center, 2011c). Rotavirus is clearly a dangerous disease, particularly for infants and toddlers; further, it is easily preventable via its vaccine, which is one that is on the recommended list of routine childhood vaccinations.

At the start of her story, Brooke Matthys’ (2010) two-year old daughter, who is not named, has been suffering from vomiting and diarrhea for several days; she is also listless and has become dehydrated. Her parents first take her to urgent care, where she receives intravenous (IV) fluids which seem to perk her up; however, the next day her

condition is worse, necessitating a trip to the emergency room. Once there, doctors try unsuccessfully to start another IV; she is so dehydrated that all 12 attempts fail. She is transferred to a children's hospital, where a cardiovascular team is finally able to start an IV. While Matthys' daughter is suffering through her bout with rotavirus, Matthys' eight-month old son, also unnamed, comes down with the disease. The two children are kept in the hospital for four days before they recover enough to be sent home. Matthys indicates that she had neglected to get her children vaccinated against rotavirus because it had seemed like just one more of the many vaccines that are recommended for children.

Matthys' story undeniably completes the prerequisites of the narrative paradigm and constitutes what it means to be a good parent throughout. Here, a good parent is one who preferences a child's health over convenience and who takes the responsibility for what happens to his/her children upon himself/herself, rather than seeking to blame others. This parent admits mistakes s/he has made and is humbled by them. Further, s/he learns her/his lesson so as not to make the same mistake again, and shares his/her parental experience and knowledge to help others avoid the same fate. Her story details the major repercussions of not vaccinating children, and the guilt that one feels over being the one responsible for not protecting her children by getting this simple vaccine.

Matthys' story definitely meets the criteria of narrative probability. First, her story hangs together from start to finish—her children are sick and suffering as a result of her actions, and luckily enough, they recover from this disease, but not until they have gone through serious distress and discomfort. Secondly, throughout the story, Matthys depicts the characters (mainly herself as guilt-ridden mother) in realistic and consistent ways. As

Matthys writes, “I can’t tell you the pain I felt in my heart as I watched my daughter suffer...My heart broke as I watched helplessly” (para. 3). She has just witnessed the doctors attempt *twelve times* to start an IV in her two-year old daughter, but her daughter is so dehydrated, “weak and scared, all she [can] do [is] cover her head with her ‘blankie’ as they [stick] her again and again...her little eyes [can’t] even produce tears as she crie[s]” (para. 3). Matthys comes across as a good mother trying to make up for her mistake in not getting her children vaccinated against the disease. She clearly feels guilty about her “child...paying a high price for [her] foolish decision and unfortunately, she wouldn’t be the only one” (para. 5). Matthys also knows “instinctively” (para. 6) that her son “[is] suffering from rotavirus as [she has] been splitting [her] time between home and the hospital” (para. 6). She concludes: “I now had two children suffering *because of me*” (para. 6, emphasis added). Not only does she feel guilty for not vaccinating her children in the first place, an ordeal that “[is] totally preventable” (para. 7), she also feels guilty for transmitting the disease from her daughter to her son. Throughout her narrative, Matthys never breaks from this character of guilt-ridden mother trying to do the best she can to help her children recover from something she should have prevented. This consistency not only makes her character credible, but it also fosters a sense of identification with audience members, who most likely have either been in a similar situation to Matthys, or realize that they could easily be in her place; this identification helps the narrative achieve fidelity.

In addition to the consistent depiction of her characters, Matthys’ narrative also implicitly addresses competing stories, lending the story narrative probability. The most

significant competing story would be the one which argues that vaccination is not only not necessary, but downright harmful, as McCarthy (2007) contends. Yet here, instead of seeing the possible negative side-effects from vaccinating, we see actual, concrete results of *not* vaccinating. Additionally, we see her story address the competing one which argues that natural immunity is preferred to vaccine-induced immunity. Families who believe in the preference for natural immunity cite incidences of disease as times that bring them closer together as a family, and of the choice not to vaccinate as an informed choice that reflects a healthier lifestyle (Evans, Stoddart, Condon, Freeman, Grizzell, & Mullen, 2001; Rae, 2010). Matthys (2010) is in a unique position to comment on the desirability for natural immunity because her “older children had suffered from rotavirus, but they had never been this ill” (para. 5). Matthys is not clear about why her older children did not receive the vaccine, though one can speculate that the vaccine was not available to her older children during the time they would have been slated to receive it.² In Matthys’ case, her experience shows the dreadful course of the disease and the tremendous pain and suffering her children went through because she had failed to get them properly vaccinated. After reading her story, it seems difficult to believe that others would want their children to suffer in this manner, deeming the illness a healthier and

² It is recommended that infants receive at least two doses of the oral vaccine, with the first dose being administered at two months of age. The vaccine was not available until 2006; thus, given the age of Matthys children, it is just possible that the vaccine was available for all four children (assuming that she had the first in 2006 and one every year after that, in order to account for having a two-year old and an eight-month old who could have received the vaccine.). The greater likelihood is that the vaccine was not available for her older two children, and since she had previous experience with the disease, it is possible that she thought the vaccine was not necessary. However, this is speculation, as she does not indicate that as a reason for not vaccinating; rather, she indicates that she was annoyed at the idea of having to make an extra trip “for yet more vaccines” (para. 5). Matthys can be seen as someone who is able to comment on both sides of the vaccine debate, and she clearly comes down on the side of vaccinating children against this disease, indicating as she does that “If I had taken the time to have my children immunized against rotavirus, this could all have been avoided” (para. 7).

more natural alternative to a vaccine that could have prevented all of the suffering her two small children endured during their bouts with the disease.

Further, the manner in which Matthys writes about this experience tends to reinforce her character's credibility, and thus the probability of the narrative. Matthys does not seem to embellish upon what happens to her children; rather, she seems to be reporting the facts, augmented by moving personal responses to the events, especially regarding how it felt to see her children's distress and the guilt she feels knowing that she could have prevented her children's suffering. Readers get the sense here that "good parents" are honest about their own experiences and encourage others to act upon these experiences, but also allow others to make their own choices, compared to more elaborate accounts meant to scare people.

In addition to meeting the requirements for narrative probability, the story also easily meets the conditions for narrative fidelity: clearly, a story like this could happen to parents of young children, or parents can imagine that it might. This story relates a parent's nightmare—that a seemingly "common" ailment such as diarrhea or vomiting, which is often attributed to "bad food" or a "stomach bug," could transition suddenly and drastically into a much more serious condition which necessitates ambulance rides, and IVs possibly administered "by drilling directly into [the] bone marrow" (para. 3) after attempts to start a line in a child's "left arm...right arm, her hands, her feet and even her forehead" (para. 2) all fail. Matthys' recounting of "the four sleepless days and nights" (para. 7) she and her husband spend in the children's hospital with their two severely ill

children “just five rooms apart” (para. 7) resonates with parents, regardless of whether they have actually experienced a situation like this themselves.

By establishing the extent of her daughter’s torment, Matthys exposes the depth of her own guilt. Matthys engages the guilt/purification/redemption cycle and constitutes what it means to be a “good parent.” Matthys employs mortification by critiquing her own behavior and relating it to the audience in a way that shows how embarrassed and humbled she is by the experience. For instance, she comments that she remembers “sitting in my doctor’s office rolling my eyes at the thought of taking my children to the Platte County Health Department for yet more vaccines” (para. 5). Matthys’ comment about rolling her eyes shows how she looks back on her decision not to vaccinate her children as a lazy, irresponsible choice. This comes through again when she comments that “the worst part was that...if I had taken the time to have my children immunized against rotavirus, this could all have been avoided” (para. 7). She seems truly shamed by the fact that she “now had two children suffering because of me” (para. 6) and by the fact that “watching your children suffer is awful, but knowing you could have prevented it is much worse” (para. 7). She seems to suggest that a good parent would do everything in his/her power to avoid the situation in the first place. Further, a good parent knows to take responsibility for his/her actions instead of seeking to blame others: this kind of parent acts like a *parent* and not a child. This responsible parent realizes the humbling nature of parenthood, with all its pitfalls and uncertainties, but still tries to do his/her best to protect his/her child and allow them to flourish.

In Matthys' story, the medical community is sort of a non-entity—they do what they can to help the children recover, but the focus of the story is really on the mother's guilt and mortification. By indicating that she alone is responsible for the mess the family is currently in, Matthys also provides a path for redemption. She is sharing her story with others so that they may avoid the same fate for their own children. While her children are saved by her decision to take them to the hospital for treatment, thereby providing a measure of redemption for Matthys, she expresses hope that other parents will vaccinate their children as a result of her story. If this were to happen, Matthys would find further redemption, knowing that her story had a purpose in saving others from the same needless suffering.

One could argue that, even though the narrative fulfills the requirements of the narrative paradigm, one's decision to act upon a story such as this and get his/her children vaccinated depends on the sense of identification s/he has with Matthys. A reader who identifies more with a community which believes that vaccinations are more harmful than helpful, and that natural immunity is far preferred to the negative effects of vaccines, might be less inclined to identify with Matthys. After all, one could reason, her eldest two children did not suffer cases of the disease that were nearly so severe, indicating that perhaps a vaccine is not always necessary. And none of Matthys' children seem to have suffered grave and lasting consequences from their bouts with the disease. However, the very fact that her two youngest children had such drastic cases of rotavirus and needed hospitalization seems to suggest that the natural immunity they acquired, which would still need another round of the disease to be completely effective, came at quite a cost,

one which very few parents would be willing to pay if a painless and successful alternative were readily available. Matthys' story meets all the requirements of the narrative paradigm and encourages a sense of identification with audience members by constituting the community of good parents who are responsible, care for their own children and those of others, are humble yet knowledgeable through experience, and are capable of sharing their important knowledge in honest, thoughtful ways with other parents.

H1N1—Seasonal Flu's Dangerous "Younger" Cousin

The H1N1 virus, also sometimes referred to as "swine flu," caused much concern during the 2009-2010 flu season, particularly because it was the predominant flu virus of that season, because it was a "new and very different" strain, and because it "spread worldwide causing the first flu pandemic in more than 40 years" (CDC, 2010c, para. 2).³ In the United States, H1N1 appeared first in the spring of 2009 and then again in the fall, with the most people infected by the end of October, which is when Luke Duvall, whose story I analyze, experienced the disease. The disease has symptoms similar to the seasonal flu, ranging from "fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills and fatigue, [and sometimes] vomiting and diarrhea" (para. 8). Notably, "severe illnesses and deaths have occurred as a result of illness associated with this virus" (para. 8). While seasonal flu is a deadly disease, killing 36,000 people on average a year

³ While the disease is not making the same kinds of headlines during the 2010-2011 flu season, this may be due partly to the fact that the seasonal flu vaccine for this year includes H1N1 as one of those against which it will protect, whereas during the 2009-2010 flu season, one needed a separate flu shot to guard against the disease. Anyone who received a flu vaccine this season, and it is recommended by the CDC that everyone 6 months and older get vaccinated, would also be protected against the H1N1 strain. Intuitively, this indicates how well vaccination works; presumably most people get vaccinated against the seasonal flu, which would mean they were protected against the H1N1 strain as well, one very probable reason we are not hearing much if anything about this virus this season.

in the United States, most of those who die are older than 65 (para. 15). H1N1 can be more severe in those under 65 years of age, with “approximately 905 of hospitalizations and 88% of estimated deaths from April through December 12, 2009 occur[ing] in people younger than 65” (para. 16). This is a significant change from seasonal flu, and the fact that younger, healthier people are more seriously affected by this disease contributed to its status as pandemic. President Obama declared the disease a national emergency in October of 2009 (Hinckley, 2009), and international travel became restricted in an attempt to stop the spread of the disease around the world.

Luke Duvall is a fifteen-year old high school athlete when he contracts H1N1 in October of 2009. At first he thinks it is the seasonal flu and that he will just “work through it,” but after two days he realizes something is very wrong. After being told that there is nothing that can be done for him (for his doctors and family assume he has contracted seasonal flu), Luke goes home, only to begin spitting up blood the following day. His parents take him to the emergency room, where doctors discover his bodily systems are beginning to fail. Through a series of fortunate circumstances, Luke is airlifted to a children’s hospital, where he is put into a medically induced coma, connected to 11 IVs, and intubated. He “crashes” two times while in the hospital—his blood pressure becomes so low that doctors have to pump him full of fluid to keep him alive. After 12 days, he wakes up; he remains intubated for another five days, until he is well enough to begin to recover on his own. He stays in the hospital for a month before he recuperates enough to go home. While in the hospital, he remarks that he saw other

children with H1N1, many of whom did not make it. He ends his story by urging that everyone get vaccinated against this disease.

Duvall's story meets the requirements of narrative probability and fidelity, especially considering Duvall is a fifteen-year old recounting his experience in his own words. Characters are credible and reliable, and he is realistic in his portrayal of them. He does not deal with a sense of guilt over what has happened to him, or look for someone to blame for the onset of the disease. Rather, his depiction of two sets of medical personnel, one useless, the other capable, reflects a realistic sense of relief that he find skilled doctors and paramedics who save his life. This realistic rendering of both kinds of medical practitioners reinforces the probability and fidelity of his narrative and increases an audience's sense of identification.

This depiction also constitutes what it means to be both a "good" and a "bad" medical professional: good members of this community are up to date on the latest diseases and treatments; they accurately diagnose illness and prescribe the appropriate treatment, while incompetent members are uninformed about illness and proper remedies. Good doctors know what will work for some patients, and not others, and will uphold their oath to "do no harm," while ineffectual ones do more harm than good. Skilled medical professionals also do not assume a person is healthy because s/he is a young, fit athlete—they will treat everyone with the utmost care and professionalism, and will work tirelessly to save someone's life, while inept medical practitioners make assumptions that cost people their lives. The constitution of what it means to be a competent or incompetent doctor/nurse/paramedic is far more important to the understanding of

Duvall's story than the functional aspect of encouraging others to get vaccinated, although this factor is certainly a vital aspect of the narrative as well. Duvall argues that the entire crisis could have been avoided by his getting vaccinated, and he encourages everyone to do so. This functional message is incredibly powerful given the ordeal he goes through. However, within the narrative, we see the significance of concentrating on a constitutive approach to the study of narratives, and how this aspect can outweigh the instrumental message in terms of explaining a narrative's resonance.

Duvall's story meets the requirements of narrative probability because it hangs together as listeners expect it to; we know from the outset that Duvall will survive, first because of the title of his story, "Beating the Odds," and secondly because he is the one telling the story. His characters are depicted consistently throughout. This is particularly true in Duvall's own case, as he acts like many fifteen-year olds do: the vocabulary he uses, including sayings and slang, and his tone of voice are consistent throughout. For instance, he is beginning to get sick, but chooses to play in his high school football game anyway, indicating that later he knew "that [he] had no business playing that game" (para. 1), and that he "woke up feeling like ten pounds of trash in a three pound sack" (para. 2). Despite this, he "force[s] himself to get up and go work for [his] grandpa. [His] grandpa being the slave driver he is [doesn't] cut [him] any slack all day" (para. 2). In typical teenage fashion, Duvall tells himself "that [he is] ok and that [he] just [has] a little headache and nothing [is] the matter" (para. 2). Later, he realizes he is truly unwell: Duvall is "panting like a dog saying call 911 please get me an ambulance and get me to a hospital NOW" (para. 5).

Duvall's own character seems very realistic, which reinforces the narrative probability of his account. Duvall's representation of the members of the medical personnel he comes into contact with also seems accurate: we see how Duvall's rhetoric constructs what it means to be a "good" doctor in comparison to what it means to be an "inept" one. Unlike McCarthy (2007) who only constitutes the medical community as ineffectual and harmful (and therefore to blame for all the ills that befall Evan), Duvall (2010) shows both perspectives. All those medical professionals he deals with prior to being transferred to Arkansas Children's Hospital are ineffectual and cause more harm than good, representing what it means to be a "bad" doctor. However, the medical evacuation team and the members of the Pediatric Intensive Care Unit at Arkansas Children's Hospital seem like very competent professionals who heroically save his life not once, but many times, characterizing what it means to be a "good" medical professional.

Throughout his encounters with medical professionals prior to being airlifted to Arkansas Children Hospital, Duvall has a series of experiences which paint a vivid picture of doctors and nurses who fail to do their jobs. By the time Duvall sees his family doctor, he has been suffering for four days. At his appointment, the doctor concludes that Duvall has "the flu and that [he] ha[s] had it long enough that there is nothing they can do for [him] except give [him] diarrhea and nausea medicine" (para. 4). Duvall is "sent home with a dinky med and a lot of frustration because [he] can tell things are still not right" (para. 4). His words convey his frustration at not being given more help. In addition, he notes that this doctor also "misse[s] the ticking time bomb that [I] call my

left lung. At this time, it was slowly filling up with mucus as we later found out” (para. 4). A short while later, Duvall starts “spitting up blood,” (para. 5), which was a previously unknown symptom for H1N1. While it is unfortunate that the doctor would have missed that Duvall’s lung was filling up with fluid, it does seem understandable that the doctor would not have diagnosed Duvall with H1N1. At the time of his bout with the disease, H1N1 had not been in this country very long, and cases such as Duvall’s (in which a healthy, young athlete contracted the disease) were quite rare. Duvall acknowledges as much: “the news hadn’t yet started putting bloody mucus as a sign of H1N1, but because of my case they started listing it as a symptom” (para. 5). However, this lack of knowledge on the part of the pediatrician helps Duvall constitute a “bad” doctor, and conversely, a “good” one. Even given the newness of the disease and the rarity of cases like Duvall’s, he seems to suggest that an adept doctor would know not only about the disease, but would also keep abreast of the latest symptoms of it. Here, his pediatrician fails miserably to achieve the status of a “good” doctor. Yet, even this “poor” doctor is not actively out to harm him (as in the case of other narratives which scapegoat the medical community).

Duvall’s characterization of the doctors and nurses at St. Mary’s emergency room and intensive care unit continues to construct a community of unskilled medical professionals. Although these doctors discover that Duvall’s “immune system is shot and [his] lungs are packed concrete tight with bloody mucus” (para. 5), his “night at Saint Mary’s is the worst night of [his] life” (para. 6). According to Duvall, after being admitted to the intensive care unit, his “care consist[s] of oxygen and a pat on the back.

They do nothing for [him]” (para. 6). His condition is steadily worsening, yet these doctors do not determine this. They have no idea that his “bone marrow [is] dying, [his] kidneys [are] shot, and [his] liver [is] shutting down” (para. 5). Not only are the doctors ignorant of the true state of his body, he also receives little attention from the staff at St. Mary’s; the attention he does receive does him more harm than good. He is very uncomfortable, restless, and agitated; when his dad asks that he be given something to calm down, a nurse finally injects him with Ativan. However, rather than calming down and being able to sleep, “about an hour later [he] begin[s] hallucinating, [and] later [his] dad finds out that Ativan given at a fast rate to a minor can make them hallucinate. So instead of sleeping for the next 4 hours [he] see[s] and hear[s] crazy things” (para. 6). Again, Duvall’s rhetoric constitutes incompetent, harmful medical practitioners: the nurse should know better, and the hospital staff should not assume that just because Duvall is a strong young athlete ostensibly suffering from flu he would pull through on his own. A good medical staff would have been fully aware of the effects and limitations of the drugs they were administering, and they would have made absolutely sure Duvall was not suffering from something more severe than the flu. Further, Duvall’s characterization of these medical professionals helps maintain the probability of his narrative because it is entirely in keeping with his role as a fifteen-year old who has suffered a major ordeal. It would be amazing if he did not express some sort of contempt or anger at his treatment at St. Mary’s because he endured so much and nearly lost his life there.

In contrast to the manner in which Duvall’s rhetoric creates “harmful” doctors, the description of the medical staff from the larger, more specialized Arkansas Children’s

Hospital is positively glowing, particularly that of the medical team accompanying the evacuation helicopter, Angel One.⁴ Within the description of these medical professionals, Duvall constitutes the ideal doctor. Duvall seems in awe of the evacuation team and describes their arrival like a scene out of a movie:

My dad said that when they arrived everyone just stopped and stared as they walked down the hall. They were in *complete control* of the situation and the hospital. *The only thing that could have made it any cooler was if they had played Clint Eastwood background music when they arrived.* He said that when the air medics asked for something that the Saint Mary's nurses didn't just go get it, but they ran and brought back two, no questions asked. That's exactly what I needed because I was still dying, but now, much faster. (para. 8, emphasis added)

This rendering is quite in keeping with Duvall's character as a fifteen-year old who has most likely seen many movies or television shows depicting just such an emergency situation. Duvall adds his own take on the air evacuation team when he writes that:

all the Angle One team came and stood around my bed and told me exactly what was going to happen in a calm voice...I remember thinking, 'Wow, these guys are cool!', and they were...they knew exactly what they were talking about. (para. 8)

These paramedics epitomize what it means to be "good" medical professionals—they talk directly to the patient, including him in their discussions of what will happen, and they do so in a calm, able way. Additionally, they *know exactly what they are talking about* just like they should. They understand the severity of Duvall's case, and more importantly, know just what to do to help him live: they intubate him before the helicopter ride, and "cram [him] full of fluids to keep [him] stable" when his "blood pressure bomb[s] out," threatening to kill him (para. 8). Duvall's description of this team not only constitutes what medical experts should be, but also reinforces the credibility of his character. He is

⁴ Duvall calls this helicopter "Angle One" throughout his narrative. The true name of the helicopter is "Angel One" (Arkansas Children's Hospital, 2011).

upset that he will not be awake for the helicopter flight, yet still comments on how cool it was to “fly in an \$8 million medically decked out Black Hawk” (para. 9). Here, and throughout the rest of his story, Duvall comes across as a believable character—he is a fifteen-year-old full of wonder and admiration for the flight team, their respectful treatment by others, and the fact that they take immediate action to save his life.

Like the air-evacuation paramedics, and in contrast to the medical staff at St. Mary’s, the staff at the Arkansas Children’s Hospital is fully capable: “I had hardly entered the door before I had IV’s and all kinds of tubes running into me. My dad remembers counting 11 IV’s running into me at once. I was almost as connected as a person can get” (para. 9). At this hospital, they “fight and battle to save [his] life and eventually succeed” (para. 9). These doctors represent absolutely what it means to be “good” at their jobs. They take immediate, life-saving action, which must be repeated several more times before Duvall is fully stabilized. They interact with both the patient and his parents in respectful and meaningful ways. Here, Duvall’s narrative not only constitutes good doctors, it achieves narrative probability through these characterizations.

The credibility of Duvall’s story is enhanced by the fact that it is presented, without editing or changes made to it, on a public health organization website (VaccinateYourBaby.org). This organization seems to have left Duvall’s (2010) story intact as he wrote it, a fact which can be assumed not only because of the editorial errors contained within the story, but also because the narrative contains descriptions of the actions of some members of the medical community which are not flattering. If Duvall had been uniformly complimentary of the treatment he received both at St. Mary’s

Hospital, in the intensive care unit, and at Arkansas Children’s Hospital, given some of the events that happened during the course of his treatment, one may be less inclined to believe in this as a realistic portrayal of events. Rather, one may feel that this story was solely being used by the medical community as a tool to encourage vaccination—it would lack sincerity, or worse, become the propaganda McCarthy accuses the medical community of spreading.⁵

The H1N1 virus is particularly interesting in terms of vaccines because the vaccine has not been around for very long and people were initially concerned about side effects like Guillain-Barre syndrome, which had been a side effect the last time a vaccine was “rushed” through the approval process (Dugdale, Hoch, & Zieve, 2010). People may still identify more with the community that argues there are more vaccine risks than there are rewards and thus choose not to identify with Duvall’s (2010) story. His case was the exception, rather than the norm, and people could reasonably assume that they do not need to get vaccinated because what happened to Duvall is not necessarily likely to happen to them. However, Duvall’s case was so severe that if one was questioning the need to get vaccinated, this story could go a long way toward convincing her/him of the necessity. This brings us to the question of whether the story meets the requirements of narrative fidelity.

⁵ While one less inclined to feel sympathetic toward the medical community may doubt my claims that this account has not been tampered with, it is important to note that there are other mistakes contained within his account that show that it has been left unedited. For example, Duvall refers to the helicopter responsible for airlifting him from St. Mary’s to ACH as “Angle One” (para. 8), but a quick search on the ACH website shows the name of the helicopter is actually “Angel One” (Arkansas Children’s Hospital, 2011). While this might seem like a small discrepancy between Duvall’s account and the actual name of the transport he received, it shows that his story is fully his own, without any editing from a self-interested public health organization.

Does Duvall's story ring true to people's own experiences? *Could* it? Again, this situation is as close to a parent's worst nightmare as one can get, except that the story ultimately ends well with Duvall recovering and living, even though by the time he leaves the hospital, he "[is] coming off of drugs, still fighting pneumonia, battling depression... [and] having therapy and relearning to eat and drink...[he is also] now 36 pounds lighter, much weaker, and very fragile" (para. 12). And unfortunately, this story does ring true to many people's experiences, whether their own personal experience or via their experiences through media reports of disease, which make it seem more likely that such a story could happen in their own lives. In the fall of 2009, the World Health Organization (WHO) was issuing a pandemic warning and travel advisories and restrictions were put in place to stop the spread of this deadly pandemic very much because Duvall's story could happen to others.

Readers are likely to identify with Duvall throughout his story. This is especially true since his story was broadcast on national television, on an episode of *60 Minutes* (CBS News, 2009). As Duvall (2010) indicates, "the whole town, and the whole Nation as a matter of fact was thrilled I was home. People kept up with my story like I was their own son" (para. 12). He seems like a typical teenager who really just wants to concentrate on football (para. 2) and baseball (para. 12), but who has been thrust into a life-threatening situation instead. His story, in his own words, as well as the *60 Minutes* version, really brings home the reality of the deadliness of H1N1. This reality shocks readers because Duvall is a healthy athlete who succumbs, quickly and dramatically, to

the vaccine-preventable disease. His story achieves narrative fidelity because of this—if it can happen to him, then it can happen to readers or their children.

In addition, one may identify with Duvall because he is a fifteen-year old telling his story and urging vaccination on his own; neither his parents nor public health officials, but a young adult who has suffered from it directly, is writing the story to warn people about the perils of non-vaccination. This first person accounting from a young person perhaps reinforces the pro-vaccine message particularly as this is a disease that can be very dangerous to younger people. Duvall does not come across as someone who is promoting vaccination for any reason other than the terrible suffering he went through, which he hopes to spare others: “while [he] was at ACH there were many kids that had H1N1 who didn’t make it. I can’t help but think how different things could have been for me and for them if we had all been vaccinated” (para. 13).

Importantly, Duvall’s story shows how significant it is to analyze both the functional *and* the constitutive aspects of narratives. His narrative is a powerful motivator for getting oneself and one’s children vaccinated in order to greatly diminish the possibility of enduring an ordeal such as this. Yet Duvall’s constitution of what it means to be a “good” or “bad” representative of the medical community is almost more important. Duvall’s dualistic treatment of the medical community can be compared to McCarthy’s one-sided scapegoating of other members of the same community such that his story shows a more balanced, realistic approach, making his story more credible. One would certainly want to avoid falling ill if possible, by getting vaccinated, yet one is

likely to identify with Duvall's experience because of the way in which he constitutes good medical care.

Pertussis: Not Just the Common Cold

Pertussis is a sneaky condition whose beginning is often disguised as the common cold. The disease starts out with symptoms like a “runny nose; a low-grade fever . . . ; a mild, occasional cough; [and] apnea—a pause in breathing (in infants)” (CDC, 2011c, para. 4). It is during the initial stage of the disease, when it appears to be a common cold, that the patient is most contagious; in addition, the diagnosis of pertussis at this stage is unlikely. Rather than getting better after a week or two, the “paroxysmal” stage of the disease begins in which patients suffer from severe coughing; these fits can continue for one to six weeks, sometimes lasting as long as ten weeks (CDC, 2011c).

During the “paroxysmal” stage, the traditional signs of pertussis begin to appear: patients begin to suffer “paroxysms (fits) of many, rapid coughs followed by a high-pitched ‘whoop;’ vomiting” and “exhaustion . . . after coughing fits” (para. 7). This stage can last so long that the disease is called the “100 day cough” in China (para. 8). Once the paroxysmal stage is over, the recovery stage begins. The cough begins to diminish in frequency, strength, and duration, although it can recur with other respiratory infections, which pertussis patients are more susceptible to. This recovery stage lasts for two-to-three weeks, but the susceptibility to other respiratory infections can continue for many months after the convalescent stage is over.

Pertussis is so communicable that even children, teenagers, and adults who have been vaccinated for it can contract it, although vaccination significantly reduces both the

chances of coming down with pertussis, and the length and severity of the disease if contracted. While people of any age can suffer from pertussis, infants are most susceptible because the disease is transmitted via adults and older children who bring it into the house. The CDC and public health organizations now recommend that anyone who comes into regular contact with infants under one year of age be vaccinated against pertussis. This includes giving new mothers the Tetanus, Diphtheria, and Pertussis (Tdap) vaccine in the hospital after birth, although this practice varies from hospital to hospital (CDC, 2011b). The vaccine protocol that provides the most protection against the disease is a series of five DTap (diphtheria, tetanus, and pertussis) shots; a shot is given at 2-months, 4-months, 6-months, and between 15-18 months of age, with the final shot given between 4 and 6 years of age (para. 2).⁶

Pertussis is most dangerous for infants: over fifty percent of babies under the age of one who contract the disease end up hospitalized (CDC, 2011c, para. 2). Additionally, the younger an infant is when s/he contracts the disease, the higher the likelihood of hospitalization and other serious complications:

Of those infants who are hospitalized with pertussis, about: 1 in 5 get pneumonia (lung infection); 1 in 100 will have convulsions (violent, uncontrolled shaking); half will have apnea (slowed or stopped breathing); 1 in 300 will have encephalopathy (disease of the brain); [and] 1 in 100 will die. (CDC, 2011a, para. 2)

⁶ Importantly, the ability of the vaccinations to protect against these three diseases diminishes with time, and prior to 2005, the vaccine booster only provided protection against diphtheria and tetanus, not pertussis. This booster was intended to be administered every ten years; there is now a booster, the Tdap shot mentioned above, that is recommended during the pre-teen years, and again as adults, particularly for those who have regular contact with young children, such as new parents or caretakers of infants (CDC, 2011b, para. 3).

These are grave statistics, representing the dangers of the disease to children who are too young to be vaccinated or those who have not been vaccinated because of parental choice. While infants are more at risk for contracting the disease and for suffering serious side effects from it, young children also endure great distress from pertussis.

Pertussis strikes a vaccinated seven-year old

Cheri Rae (2010) lives in Santa Barbara, California, one of several communities in which pertussis has made a dramatic comeback in recent years because of the high population of unimmunized children.⁷ Rae's seven-year-old son, Daniel, comes down with what seems like a common cold toward the end of his school's winter break. He becomes easily tired, has a runny nose, and a dry cough. When he does not get better, Rae "[takes] him to the pediatrician, who diagnose[s] a sinus infection and prescribe[s] a course of antibiotics" (para. 3). Even on antibiotics, Daniel does not improve; rather, his cough becomes worse. Rae becomes alarmed that he is not getting better, and insists that the pediatrician help her to determine what is happening. The doctor decides to test Daniel for whooping cough; the test comes back positive. Rae begins investigating levels of immunity in her son's school, and begins hearing stories about the deadliness of the disease. Meanwhile, Daniel gets worse. He develops the characteristic "whooping" cough

⁷ Rae's (2010) story, like Duvall's (2010), was publicized in more than one place: the *Santa Barbara Independent*, as well as the Children's Hospital of Philadelphia website. Specifically, the story was produced and distributed in the environment in which she lives. This is significant because she understands that people she knows will be reading her story, and will have personal reactions and interactions with her based on this fact. The fact that she is in close contact with the readers of her narrative probably tempers her portrayal of what happened and how she feels about it. Rae is also a reporter with the *Santa Barbara Independent*, which may help to explain why her narrative addresses the conflict between individual choice and public good more than other pro-vaccine stories analyzed.

in which he cannot breathe and eventually vomits. Rae spends the next few weeks helping Daniel through serious bouts of coughing that keep him up at night. Rae ends her story by indicating that after three months, their lives are finally getting back on track. Daniel is beginning to heal, but the process is slow, and he is far behind in school. Finally, Rae tells how the family celebrates this return to health by going out to a movie, a seemingly fun and low-risk event, until she indicates that she and Daniel hear a cough:

And not just any cough. There in the dark, somewhere far behind us, over and over again, a child was coughing loud, hard, and long. Between coughs we heard that familiar struggle to take a breath, and then more coughing. It was the unmistakable sound of an old-fashioned disease taking hold in an unexpected place. (para. 34)

This is a chilling end to the story, one that reinforces the possibility of catching a VPD such as pertussis.

Rae's consistent character descriptions and the coherence of her story allow the narrative to meet the requirements of narrative probability. Further, her narrative closely mirrors the experiences of other parents, or seems highly probable, thereby achieving narrative fidelity. Finally, her narrative constitutes what it means to be a good parent, as someone who works with doctors to achieve the best care, informs herself about medical practices such as vaccines from a variety of sources, and who ultimately chooses to honor the public good in ways that also achieve personal interests by protecting children. Rae's constitution of the good parent starkly contrasts with those parents who choose not to vaccinate their children, thereby spreading disease. The narrative also constitutes what it means to be a "good doctor:" someone who will work with a patient and assist parents in achieving the greatest possible success.

Through her illustration of her son as a bystander suffering from the debate that rages among adults regarding vaccines, Rae's narrative achieves probability. Daniel is an innocent little boy afflicted by an entirely preventable disease. He seems to handle the situation well, "camp[ing] out on the futon in the guest room...look[ing] at the stars...reach[ing] out...to grab at the rain...discover[ing] the late-night fun of watching Jon Stewart and David Letterman...[and] consum[ing] popsicles in the middle of the night" (para. 17-18). Rae indicates that "clearly, this disease had put him in touch with his kinder, gentler nature. It also awakened his sense of vulnerability" (para. 19): when he overhears a neighbor worrying that pertussis can kill children, he "refuse[s] to eat, drink, or speak for the rest of the day" (para. 19). Daniel is suffering from a disease that his parents tried to protect him from, but which he contracted because others were not as responsible.

Doctors in Rae's narrative are always depicted as concerned for children's welfare and willingness to work with parents, rather than against them, as in McCarthy's (2007) case. For instance, Daniel does not improve after a few days on antibiotics (following the sinus infection diagnosis); "his cough sound[s] worse—dry and deep, and it seem[s] to come in waves...all the coughing [is] affecting his ability to get to sleep, so he beg[ins] each day exhausted from the night before" (para. 4). Rae insists that her "son be seen immediately" (para. 5). Instead of dismissing Rae as an overwrought and paranoid parent, the doctor treats Rae's concerns with respect. Together, they "discuss his condition, [go] over his recent records, and [try] to piece together what might be going on with this miserable-looking little boy, who had been perfectly healthy during his physical

that was conducted just a month earlier” (para. 5). Through discussing the family’s recent movements and contacts, the doctor determines that there is a chance Daniel might have contracted pertussis, though it does not seem likely, and tests him for the disease, “just in case” (para. 6); this does, indeed, turn out to be the case. The doctor acts with alacrity and insight, correctly diagnosing Daniel by exploring all options, even unlikely ones. This doctor is willing to work with Rae even when she can be seen as a pushy parent whose maternal instincts are trying to supersede medical expertise, especially when she realizes her child is sick from something more than a sinus infection and must be seen immediately. The doctor honors Rae’s maternal instincts, instead of ignoring them.

In Rae’s story, doctors come across as highly critical of those who choose not to vaccinate their children; they also act concerned and caring for those who do vaccinate. Rae has to call her pediatrician’s office after-hours when Daniel is suffering from a severe bout of coughing: “Daniel [is] hacking so loud, [Rae cannot] even hear the dispatch nurse when she answer[s]” (para. 12). When the on-call pediatrician comes on the line, “and listen[s] as [Rae] describe[s] this whooping cough crisis” (para. 13), she immediately chastises Rae, ““This is why you must immunize your child”” (para. 13). Rae’s account of this doctor’s behavior points to the divisions inherent in the vaccine controversy, divisions which are an outcome of constitutive narratives. The doctor’s comment clearly reflects the belief that immunizations are a necessary preventive measure to protect children against disease. The doctor belongs to a community which includes most pediatricians, and which believes that immunizations are necessary and beneficial. When she finds out that Daniel ““is immunized, but he got it anyway,”” (para.

14), “the doctor then bec[omes] a model of kindness and calm reassurance” (para. 15). Rae has portrayed herself as a reasonable, responsible parent thus far, and takes offense when she is not recognized as such by the doctor. However, the doctor’s attitude represents what it means for a doctor who practices traditional medicine to live in a place where some residents actively reject these practices. This place is Santa Barbara, California, a community that has seen a decrease in rates of vaccination and a rise in VPDs in recent years. The realistic accounting of this doctor reinforces a sense of probability within the narrative.⁸

Through her self-depictions and her portrayal of the interactions she has with doctors and other parents, Rae reinforces the probability of her story. Her characterizations of parents, including herself, constitute what it means to be a “good” parent. A good mother is one who stays attentive to her child’s condition, and takes action to help him get better. She works in concert with her doctor, acting as an equal partner rather than as either an unquestioning follower or critical know-it-all who rejects the doctor’s medical expertise. When Daniel first gets sick, she thinks he is suffering from the common cold and works to help him get better by giving him “increased rest, plenty of fluids, and a couple of batches of homemade soup” (para. 3). When this does not seem to help, she takes him to the pediatrician who prescribes antibiotics. Rae, ever

⁸ I live in a similar environment to Santa Barbara, in Denver, Colorado. I have had comparable experiences when calling my own pediatrician after-hours. Depending on the symptoms I describe in my own children, the doctors immediately ask if they have been immunized. Further, many doctors are now refusing to have non-immunized children be a part of their practice, with the reasoning that they do not want to have to explain to a child that they could have prevented the suffering the child is going through if the doctors had been able to convince the parents to vaccinate. Thus, the description of this doctor’s action also achieves a sense of narrative fidelity for some audience members.

vigilant regarding her son's condition, realizes that he is getting worse, not better, and she "becom[es] alarmed. [She drives] to the pediatrician's office and insist[s that her] son be seen immediately" (para. 5). Throughout the narrative, Rae evinces the persona of an ideal parent in her care of Daniel as he suffers and then slowly recovers from his illness. As she states, "For the next couple of weeks, the whole focus of [her] life [is] keeping Daniel breathing through one coughing spell after another" (para. 16). But her characterization of the responsible parent goes beyond just caring for her child—she spends time and effort to become knowledgeable about VPDs, immunity, and vaccines so that she can understand why Daniel got sick in the first place and what to do about it.

Rae's character continues to act realistically (and thus credibly) through her encounters with the medical community. Further, Rae's character persists in constituting a responsible parent as one who works with medical practitioners but does not blindly accept everything they say. For instance, Rae is critical of the on-call doctor when she indicates that Rae should remain calm and help Daniel to breathe using techniques that will help him get through the major coughing fits. Rae relates her disbelief that she will be able to stay calm and:

not panic when [her] little boy coughs until he vomits, coughs for 10 minutes straight and struggles to take a breath. While he expects [her] to help him, and [she] knows [she] cannot, [she] will be calm, rub his back, and repeat [her] new mantra, "Breathe through your nose, honey, and it will get better. Just relax; I'm here and you're going to be fine." (para. 16)

In her sarcastic representation of this doctor's advice, Rae is highly credible, reinforcing a sense of probability and fidelity. Rae's character is willing to do as the doctor asks because she knows there is some merit in the suggestion to stay calm so that Daniel will stay calm. In many ways, this is just sound advice that carries through to many different

parenting situations. But her incredulous reaction also resonates with many parents because it seems to ask the impossible—how can a parent stay calm when her *child coughs so hard he vomits* or *coughs for ten minutes straight* without being able to take a breath? Yet like McCarthy (2007), Rae does it—she stays calm and focuses on her child, though inside she is panicking, because that is what a responsible parent does. While Rae can be critical of the medical community at times, the nature of her interactions with them supports the probability of her narrative, both through her depiction as mother and the medical community as real people and not self-interested fools. If her portrayal of the medical community was less nuanced, but rather reflected a universally flattering image, readers would be far less convinced of the narrative’s probability and fidelity.

Though Rae constitutes what it means to be a responsible parent throughout her narrative, her manner of dealing with guilt maintains the credibility of her character, enhancing narrative probability, at the same time that it further constitutes a community of responsible parents. Rae touches on the guilt/purification/redemption cycle in a unique way, by engaging in both mortification and scapegoating. Even though she has vaccinated Daniel against VPDs, she still feels a sense of guilt over not being totally informed about immunizations, and what is required to fully protect children against diseases. Her guilt regarding Daniel’s condition is evident when she talks about her research regarding rates of immunization in the children with whom Daniel goes to school. She mentions that she has learned “firsthand...the limitations of believing in immunization as an invincible protective shield...I still feel like I failed to protect my son by not knowing all the facts about immunizations and herd immunity” (para. 32). Here,

Rae employs the mortification tactic, taking the blame upon herself for failing to fully protect Daniel and to prevent his disease. She also feels guilty for possibly exposing other children to “this extremely contagious disease” (para. 9) by having Daniel interact with them prior to his diagnosis: “A sense of responsibility mixed with a feeling of embarrassment washed over me as I made the initial calls informing friends and neighbors about their exposure” (para. 9). Not being fully informed about herd immunity and immunizations, Rae feels responsible for the exposure and possible infection she has subjected others to because of her lack of complete knowledge. By admitting to her own imperfect knowledge about vaccines, Rae redresses her actions through the method of mortification. Here again, Rae constitutes what it means to be an “ideal” parent—the ideal is someone who is well-educated and informed about the issue at hand, from herd immunity in general, to specific rates of vaccination in one’s community.⁹ Further, this ideal parent is a responsible one, not only for his/her own children, but for those of others as well.

However, Rae also uses scapegoating subtly, rectifying guilt by blaming parents who do not vaccinate their children and thus expose everyone to the risks of VPDs. As mentioned above, she is “shocked” to learn that rates of immunization in Daniel’s school are only about 66%, not nearly high enough to provide herd immunity, which would suppress incidents of disease. She also implicitly creates a scapegoat when she writes

⁹ Doctors and public health officials have certainly maintained the belief that the reason parents choose not to vaccinate is because of a lack of knowledge about the risks and rewards of vaccinations, a belief that is not only mistaken, but which is being eroded by the strength of narratives that seem to better resonate with parents on a personal level, regardless of the information contained. Rae’s story reflects a blending of these ideas, with a reliance on scientific information coloring the personal narrative throughout. As C. Foust (personal communication, June 1, 2010) notes, “I question whether or not ‘information’ is going to really help protect our children. What we need is for others to make behavioral changes and build up the herd immunity.”

how, “*as a responsible parent*, I don’t ever want anything bad to happen to my children—or *any other children*” (para. 31, emphasis added). Her implication here is that other parents who choose not to vaccinate their children are *not* being responsible parents, either toward their own children, or towards others, particularly since vaccinations need herd immunity in order to work. And Rae reinforces this faint scapegoat when she indicates how easy it is for parents to opt out of the mandated vaccination laws for school attendance, indicating that parents can choose not to vaccinate “because of medical conditions or due to religious or personal belief” (para. 35).

Rae reaches out to her community to hear other people’s views and experiences with VPDs, especially pertussis. Some parents have had children who suffered from the disease:

more than one mother reported that it took their un-immunized children more than a full year to get back to good health following their ordeals with whooping cough. [Rae] learn[s] that three babies in California died from whooping cough last year, (para. 27)

including an infant in the area in which Rae and her family lived. Rae reports on the attitudes of parents who choose not to vaccinate in fairly objective terms, indicating only that “a sizable number of parents these days choose not to inoculate their children for various reasons that run the spectrum of medical, religious, and political beliefs” (para. 28). Other reasons are “fears about side effects, an overall distrust of Western medicine, and concern about government intrusion in matters of personal health” (para. 28). She includes comments from anti-immunization parents, some of whom indicate that “I just want my children to get strong and develop their immunities on their own...we don’t

have much risk” (para. 29); others indicate that they “look at the disease as a gift. It brought us closer, helped us become more aware of our bodies” (para. 3).

Here, though she refrains from commenting on these beliefs, Rae clearly constitutes the anti-vaccination parents as irresponsible. Anti-vaccination parents are irresponsible not only because they are not accurately informed, but also because they choose to allow their children to suffer, ignoring the risks that VPDs present, risks that can kill children, rather than merely allowing them *to get strong and develop their immunities on their own*. She also constitutes anti-vaccination parents as selfish, forcing children to endure illness because of a mistaken understanding of how disease travels, as in the parent who argues that her family *does not have much risk*. They are also selfish because they do not consider how their personal choices affect the lives of those around them, favoring personal choice above public good (a point which is discussed in greater detail below). Rae’s combination of purification methods lends credibility and force to her story—were she to come out directly and attack those who did not vaccinate their children, without making any allowances as to the reasons for their not doing so, it is far more likely that her story would be rejected outright by those who think vaccinations are dangerous and unnecessary.

Rae’s narrative is very strong in terms of narrative probability. Her characters are all credible and act as we expect them to, and she addresses competing stories in such a way that we are likely to believe her narrative over others. The fidelity of her story is also very strong—this story *could* happen to us because it *is* happening. She points out how people are not vaccinating in various communities around the US, and highlights the ease

with which families may get out of vaccination mandates for school: “Contrary to what many believe, immunizations are not required for children to attend public schools” (para. 35).

Importantly, in Rae’s story, like the other pro-vaccine stories, we see both the functional and constitutive elements of narratives. From a functional perspective, Rae’s depiction of Daniel’s bout with whooping cough seems to reinforce the magnitude of vaccines. Daniel’s case, though “considered light,” (para. 32) is certainly not insignificant. He has to live with the disease for “nearly three months” (para. 33), and suffers,

strained ligaments in his chest...[and] his stamina isn’t back yet. He recently suffered a two-week setback when he developed a secondary viral infection that attacked his vulnerable bronchial tubes. He’s lost five pounds...[and] countless days of school. (para. 33)

Clearly, Daniel suffered a tremendous amount, even for a *light* case. As Rae comments, “I don’t want to imagine a bad case of the disease in a non-immunized child” (para. 32). It would be hard to identify with anyone who said that Daniel’s case was not that bad, and that his suffering was normal and natural, and therefore justifies others making decisions that affect the health of everyone. Were the situation reversed, with Daniel causing illness in other people’s children, especially those who were not vaccinated, it is hard to believe that those same parents would be accepting and forbearing of Daniel’s contagiousness. Rae seems to be arguing that a responsible parent would vaccinate because s/he does not want anything like this to happen to her/his own *and* others’ children, thereby making it hard to identify with parents who, by not vaccinating their children, seem to reject this sense of public responsibility.

The instrumental component certainly comprises an important part of the narrative; however, the constitutive elements help to more fully explain why these stories might resonate so strongly with readers. Rae's narrative at least pushes people to question their decision regarding vaccinations and to look at their sense of identification and community. Do they identify as part of a group which defines itself as comprised of "good parents" because they refuse to vaccinate based on reasons like the superiority of naturally derived immunity, breast-feeding as providing all the protection needed, or vaccines as harmful, unnatural pathogens (akin to pesticides or food additives)? Do they make their decisions based solely on what they believe is right for them and their children? Or do they identify with a group which defines itself as being responsible both toward their own children and others by ensuring that VPDs are kept in check, which in turn ensures herd immunity to protect everyone? Rae's view, while carefully considering both sides, identifies most closely with the latter group. Given the manner in which she presents these choices, without direct attacks on the opposite view, one is likely to believe her narrative and to want to identify with her community of "responsible parents." When her story is read beside one depicting a child who is not vaccinated and who ends up dying from the disease, as in Carter's case (Dube, 2010), audience members want even more to identify with the community of responsible parents Rae's story creates. Audiences are more likely to believe in the safety and worth of vaccines, and the necessity for *all* parents to do the right thing and vaccinate their children.

Pertussis: The 100-day hack turns deadly

Carter Dube is born a few weeks early, but is a healthy baby boy (Dube, 2010). At his six week check up, his parents express concern that he is fussy and spitting up; the doctor recommends changing formula and that seems to solve the problem for a few days.¹⁰ However, he becomes even fussier and cannot be put down without crying, so his parents take him back to the doctor. Once there, medical personnel become concerned about his breathing and rush him to the hospital in an ambulance. Over the next few days, Carter's condition worsens while his doctors treat him for everything from pertussis to respiratory infections to fungal infections. He is put on an ECMO (lung and heart bypass machine), and then given a last-chance medication as his condition becomes steadily worse and the organs in his tiny body cease to function. After ten days in the hospital, Carter passes away from pertussis. He was a week too young to receive his first pertussis vaccine.

Overall, the story of "Carterbug" (para. 1) is a heart-wrenching narrative of a VPD and its devastating effects on a small child and his family. Unlike the stories of Matthys (2010), Duvall (2010), and Rae (2010), Carter does not recover from his illness. Dube's (2010) story of Carter's experience hangs together throughout, achieving

¹⁰ We know from the story that Carter is not breast-fed. This would be a significant red-flag for many who do not support vaccination. Breast-feeding is often cited as providing enough protection, protection that is natural and therefore superior to vaccination (Reich, 2010). Interestingly enough, breast feeding does provide some protection in the form of anti-bodies against disease, at least in the first few weeks of life, so there is some merit in this argument. However, breast-feeding does not provide the same levels of protection as vaccination does, nor does the protective barrier of breast-feeding last as long as some people assume. Indeed, one study indicates that parents who cite breast-feeding as protection enough against disease, and the reason they do not vaccinate their children, often overestimate the time and strength of the protection breast-feeding offers (Reich, 2010). Perhaps more importantly, especially given the cartography of this issue provided by Rae (2010), the immunity afforded by breastfeeding is individual, and cannot build the herd immunity afforded by vaccinations.

narrative probability. It is a moral tale about the dangers of disease, especially diseases once thought suppressed or eradicated through widespread vaccination protocols. It unfolds in the way we expect it to, though we are unprepared for the suffering Carter goes through and his ultimate death. Further, the way in which Dube details her character as mother clearly outlines what it means to be a good parent—love your child, do everything you can to protect him/her, but be able to let him go, and share your experience to help others. Her narrative also constitutes doctors as doing everything they can to help, rather than harm, children.

Narrative probability is established most thoroughly through the depictions of the characters, particularly Carter, his parents, and the medical staff they encounter. At only six-weeks old, Carter is not so much a personality as a victim—an infant suffering from a deadly disease before he even really has a chance to enjoy life. At birth, Carter is a good size, at “six pounds, six ounces and...18.5 inches long” (para. 1). At six weeks, some babies have not even cracked their first smile yet, but rather concentrate all their time on sleeping, eating, and growing. This lack of background or details about Carter’s personality make the disease, its symptoms and side effects, all the more terrible, because Carter has not even had a chance to really begin to interact with his family.

The way in which Carter’s mother depicts her role as parent and the medical community as capable and helpful helps to reinforce the sense of probability and fidelity for readers. For instance, Carter’s parents express love and wonderment that they are blessed with Carter in the first place: “‘Carterbug’ [is] three weeks early...[is] born breach, and [has] a head full of red hair; he [is] the spitting image of his daddy” (para. 1);

though he does not gain weight at first, he soon becomes a “little chunky monkey” (para. 3), a description that shows affection and love on the part of his mother. His parents are knowledgeable about the risks of illness in infants, and they “[are] careful who [they] let...hold Carter, [and] where [they take] him because of the cold weather in South Carolina and the fear of the flu or swine flu” (para. 2). The Dubes have another child, Zach, who is ten-years old; thus, they are not first-time parents. Still they worry over Carter, since he “ha[s] been spitting up a little and seem[s] to be cranky at night” (para. 3). When he does not seem to get better and begins to run a low-grade fever, they take him to the doctor, “joking about how over-protective [they are] acting and how it [is] probably just a little cold” (para. 6). Carter’s parents act throughout like loving, caring parents who are concerned about the health and well-being of their son, and who want the best for him, even if that means losing him:

We asked our preacher to pray with us and Carter for God to hold him close and not let him be afraid. I talked to Carter and told him how much we loved him and how excited we were when we found out we were pregnant with him. There was so much we wanted him to see and so many people that he hadn’t had a chance to meet yet. I held his hand, the only thing I could touch that wasn’t wired to a machine, and told him that I loved him very much. I told him how brave he was and how he had fought a great fight, but if he was tired and wanted to go to heaven, he should go. I told him that momma and daddy would miss him, but we would see him again one day. (paras. 22 and 23)

Their infant is only six weeks old, yet they want so much for him, including for his suffering to stop, even if this means he must leave them. Dube’s language reflects the overwhelming emotion she feels regarding her son—she is the ideal parent making the ultimate sacrifice.

The doctors and medical personnel are depicted in the background, rather than as central characters, yet their portrayal is realistic and balanced. The doctors here are

shown as helpful and doing everything they can to save Carter's life. This representation makes their characters plausible and convincing. This realism and evenhanded approach lends strength to the narrative probability of the story, as well as demonstrates a sense of what it truly means to be a doctor—someone who cares about the development and well-being of a child almost as much as his/her own parents. When Carter's parents initially take him to the doctor for his six-week check-up, the doctor is “excited Carter ha[s] gained a little over a pound” (para. 3), since he had been slow to gain weight at first. Both the pediatrician and Carter's parents think the cause of his fussiness is either colic, or that he is not tolerating a particular brand of formula all that well. Once they switch formulas, Carter seems to get better, and they are pleased with his progress. Yet when they realize that perhaps all is not well, the nurse practitioner whom they see at the doctor's office takes swift action, as she is “immediately concerned with Carter's breathing rate and [thinks] he may be a little dehydrated. The next thing [Carter's parents know, they are] in an ambulance, heading to Levine's Children's Hospital in Charlotte, North Carolina” (para. 7). The nurse practitioner does not dismiss their concerns as inconsequential, but acts competently to get them the best help they can have, as quickly as possible.

Once in the hospital, doctors jump into action, attempting to figure out what is wrong with Carter. Despite a day-long respite in which Carter seems to be getting better, his condition worsens and doctors send him to the Pediatric Intensive Care Unit (PICU) “for better care and observation” (para. 10). Carter's mom reflects on how this move makes her feel better, because Carter is getting direct, constant interaction and observation, and she is able to hold him and talk to him: “It was wonderful for Carter to

have his own nurse who made him her priority. I was even able to cuddle with him and tell him about all of the things we were going to do once we got home” (para. 10).

The medical personnel are shown as caring, concerned, and honest with Carter’s parents, trying to help Carter even as they are “confused as to why Carter’s heart rate [is] extremely high and his blood pressure [is] so low” (para. 12). Carter’s mom details the number of doctors and specialists who are involved in his case, showing that many people are trying to help Carter recover from this deadly disease: “By this time, Carter [is] the talk of the floor. We [have] three Pediatric Intensive Care Specialists, an Infectious Disease doctor, a Hemoglobin/Cancer doctor and enough residences and interns to fill a football field” (para. 12). Many, many people are working to help Carter get better.¹¹ In concert with Carter’s parents, the doctors discuss the last few medicines

¹¹Some people who are inclined to think that the medical profession regards patients as experiments rather than people might argue that this amount of interest is because he seems to be a medical mystery and anomaly, rather than a very sick little boy who needs all the help he can get. Although there may be some component of this aspect in the interest in Carter’s case, one gets the overall picture of doctors and nurses who are trying to do everything they can to save this infant’s life because he needs their help, not just because he is a medical mystery. This more charitable reading of the doctors’ actions can be seen as they discuss options with Carter’s parents. The doctors are depicted as honest about the chances of Carter’s survival, working with the wishes of Carter’s parents to ensure the best treatment and the least amount of suffering. For instance:

Around noon on Tuesday, the doctors discussed the idea of putting Carter on an ECMO (heart and lung bypass machine), as a last resort. We were told that if it was decided to put Carter on the ECMO machine, there would be a 60-40 chance that he would leave the hospital with us. We discussed our options with the doctor and made arrangements for Zach [Carter’s brother] to come and see Carter before the procedure was done. (para. 13)

From this detail, it is clear that the doctors are working with Carter’s parents to determine the next move in Carter’s treatment. At the same time, they do not give Carter’s family false hope that Carter will fully recover, or that the ECMO is a miracle machine that will definitely save Carter’s life. Despite the fact that Carter suffers expected side-effects from being put on the ECMO machine, his condition does seem to stabilize:

Carter held his own on Wednesday, January 27 with no sudden changes to his condition. It was the first day [his parents] relaxed a little and talked about a long term plan. They didn’t sugar coat it, we were still looking at a month or more in the hospital before we could take him home. When we went to bed Wednesday night, it was the first time I didn’t feel like I was carrying the weight of the world on my shoulders. (para. 15)

they have available to treat Carter, remaining honest about his chances for survival: “We had asked the doctors to always be honest and to let us know when it got to the point that they were doing things *to* Carter and not *for* him” (para. 17). His parents always have the final say in whether or not they approve of the treatment plan the doctors have created, indicating both control over the situation and the willingness of the doctors to listen to and work with the family, as in Rae’s (2010) case, instead of completely overriding their concerns, as in McCarthy’s (2007). Although Carter’s mom indicates concern over the medicine, because signing the release forms acknowledging the side effects “[is] like signing our lives away because the doctors [have] told us the medicine [will] tint his blood and skin blue” (para. 20), the family makes a joint decision to proceed.¹²

The depiction of the doctors and medical staff throughout the narrative maintain this respectful working relationship, making their characters reliable and credible, and the narrative achieve probability. Although the disease ultimately kills Carter, a reader gets

The doctors want Carter’s parents to be fully aware of the risks and long-term struggle ahead of them, yet they convey this information in such a way that his parents feel aware of what they face and relieved that Carter seems to be stabilizing and improving.

¹²Someone who identifies more strongly with the view that medicine is invasive and sometimes causes more harm than good might be likely to see the drastic measures the medical community takes as insidious and destructive. One could argue that all the life-saving measures Carter was subject to, like the ECMO and medicine that would turn his skin and blood blue, or the fact that he was eventually being treated “for everything: whooping cough, fungal infections, pneumonia, anything they could think of” (para. 19), were actually causing more harm than good. Each of these medical interventions resulted in some negative side-effect that needed to be counteracted by even more medical treatments. Even if Carter’s family would not be likely to be able to save him, if they had kept Carter at home, someone may argue that he would have died a much more peaceful death without all the invasive medical interventions that ended up not saving him anyway. These readers may view the treatments as worse than the symptoms of pertussis. This seems to be much the same argument McCarthy (2007) is making when she contends that vaccines (the “treatment”) are worse than the diseases they are meant to prevent. McCarthy seems to be attempting to get readers to make this leap in logic by generating a sense of identification with her audience. In Carter’s case (Dube, 2010), vaccine-induced immunity, via herd immunity, would have been far preferable to the disease, which necessitated such drastic treatments. The fact that he lost his life from pertussis speaks very strongly to the story of vaccines as saviors, not harmful pathogens.

the sense that it is less because the doctors are incompetent or harmful and more because pertussis is so insidious and lethal. The realistic portrayal of doctors as knowledgeable and compassionate, but stretched beyond their skill by a relentless and deadly, yet preventable disease, highlights the supreme importance of everyone's getting vaccinated in order to prevent pertussis from claiming the lives of more innocents like Carter. At the same time, the narrative constitutes medical professionals as truly caring for their patients.

Not only does Dube's narrative meet the requirements of narrative probability through the reliable depiction of characters, and by addressing the competing story of vaccines as unnecessary and unsafe, it also meets the requirements of narrative fidelity. The events depicted in this story, and stories just like it, have been happening around the country as parents decline vaccination and rates of VPDs are on the rise. Every few months, there are news stories of disease outbreaks, particularly pertussis; not only, then, is this story currently happening, but it definitely *could* happen to audience members. In addition, Carter is too young to receive his first series of vaccinations when he gets sick. Anyone with a newborn experiences the concern of how delicate and fragile these babies are and how susceptible they are to illness and disease that older children are better able to tolerate. Not only does this narrative show the substantial effects of VPDs in ways that likely resonate with a reader's experiences, it is certainly not difficult for a reader to imagine that such a story *could*.

Imagine looking at your own infant child, barely six weeks old, with giant tubes running down either side of his neck, while his body “[swells] to nearly twice his original size” (para. 17). Further, your baby is

under a heat lamp and two huge medicine trees [hold] all of the medicines that [are] working to keep him alive. It is difficult to forget the machine that [is] also monitoring his heart and blood pressure which [is] constantly chiming, alarming [you] that something [isn't] right. (para. 17)

As Carter’s mom indicates, “It was like a bad dream where we just couldn’t wake up” (para. 17). This narrative, more than the other stories analyzed, constitutes the VPD pertussis as such a tremendous threat that doctors are powerless to interrupt its course once it has taken hold. It is difficult enough to merely read this story about someone else’s child suffering and dying. It is easy to picture this kind of thing happening in one’s own life, particularly if one has an infant child who is too young to be vaccinated against disease, regardless of one’s feelings toward childhood immunization. Indeed, the fidelity of this narrative heightens its functional component: if a reader is in the position of having an infant child, reading a story such as this one would probably go a long way toward encouraging that parent to vaccinate his/her infant. Additionally, it would be likely to encourage that parent to make sure that everyone who came into close contact with his/her baby gets the vaccination against pertussis in order to create a cocoon of protection that Carter obviously lacked. And this story would likely persuade parents to keep their infant child as isolated as possible from others until s/he could begin the series of vaccinations which would help to protect them against this deadly disease.¹³

¹³ Interestingly, the first-person account from Dube’s mother does not address the issue of vaccination at all; the crisis is addressed in the version of her story that is written in the third-person point of view on the website *Vaccinate Your Baby*. This account indicates that “despite this tragedy, Carter’s family is adamant

The narrative probability and narrative fidelity of the story is reinforced by the manner in which Dube writes it, which implies a sense of guilt about Carter's death. She worries about travel and allowing others to handle Carter. And she is concerned that "the whole family had allergy issues and mild colds, but we were all being treated for them; I had even been on antibiotics for seven days" (para. 7). Her mention of illness in the family may be an understated way of acknowledging guilt she feels for possibly causing Carter's deadly sickness. It is also possible to see guilt reflected in the subtle references to the fact that they do not know how Carter contracted the disease, or whether they might have caused it themselves. It is possible to argue that Mrs. Dube engages in mortification tactics by detailing how much Carter suffered and how little they could help him—they tried to protect him from illness, but failed. Through the portrayal of this story as one of extreme sadness at the loss of a child, with the implied message that it could have been prevented via vaccines and herd immunity, she not only attempts redemption by helping others avoid this fate, but also establishes the constitution of good parents: the Dubes did everything they could to protect Carter from disease, by isolating him from family members and bad weather, while seeking medical attention for a seemingly mild common cold. Implicit in their description is the dialectical parent—one who does not

about sharing their story with others, in an effort to prevent other children from suffering from vaccine-preventable diseases" (para. 7). While this message and language comes from the public health organization and not from Carter's own mother, one can assume that she feels this way because she has written her account of her child's death to be published on a website created for the purpose of encouraging vaccinations. Parents who are worried about the supposed negative side effects of vaccination or are questioning whether vaccines indeed are necessary at all have their concerns and questions forcefully addressed in this very real, unembellished accounting of the toll pertussis takes on infants. Carter's story not only illustrates the serious need for protecting one's own children from VPDs by getting them vaccinated, but it also highlights how important vaccination is as a barrier to the transmission of VPDs for children and immune-compromised individuals who cannot get vaccinated. Carter's story speaks to the necessity of vaccinating without his mother needing to say those words.

vaccinate themselves or their children, thereby failing in their responsibility to others. This sense of conflict and guilt resonates so strongly and elicits such a sense of identification that it helps to accomplish the functional goal of the narrative—to encourage vaccination—at the same time that it constitutes a community of parents who want desperately to protect their children from this kind of harm.

Conclusion

The stories relaying encounters with VPDs, such as those from Matthys (2010), Duvall (2010), Rae (2010), and Dube (2010), clearly meet the requirements for narrative probability and narrative fidelity. The stories flow in expected, though heartbreaking, ways and characters are represented realistically. Across the spectrum of stories, we meet children who suffer through painful ordeals, dire circumstances, and threats to their lives, with one child who actually dies from his encounter with a VPD. We meet parents who are intent on helping their children any way that they can; who also feel guilty that their kids are suffering, whether or not they are the cause of this suffering. We also meet members of the medical community, who are depicted throughout as believable people who sometimes make mistakes, sometimes act in unprofessional ways, but who always have the interests of the patients and their families at heart. The illustration of these characters, arguably, more accurately reflects the realities of most people, far more than the caricatured, scapegoating version of doctors and nurses that McCarthy (2007) describes. And, in the narratives, we are exposed to the diseases themselves—to the methods of transmission and protection, and to the very real threat they present to children across ages, stages, and levels of vaccination. Further, each of the stories hangs

together from start to finish. As I have demonstrated throughout the analysis, all of these stories also meet the requirements of narrative fidelity—if audience members have not directly experienced these same situations, it is very easy for them to imagine that they *could*, which is equally as compelling as whether or not these experiences actually have happened to readers.

Each of these stories has an instrumental purpose. They all either tangentially or directly address the question of whether or not vaccines are safe and necessary. Matthys (2010) indicates that she could have prevented the suffering of her two children if she had not been lax and refrained from getting them vaccinated. Duvall (2010) indicates that he, too, could have avoided his life-threatening encounter with H1N1 if he and his family had been vaccinated. Rae (2010) addresses the issue of vaccination obliquely—her son was immunized against pertussis, but contracted the disease anyway because of the high numbers of non-immunized, or not fully immunized, children living in the Santa Barbara area. Dube (2010) shares her experience so that others may avoid losing a child to a VPD by getting themselves, as well as their children, vaccinated. Yet while these stories have an important functional component, the constitutive nature of their rhetoric is at least equally important to their analysis, not only because it illustrates what it means to be part of a particular community, but also because it helps to explain why certain stories are accepted, while others may be rejected.

These pro-vaccine stories tend to create audiences whose members are more likely to identify with the view of medicine as necessary or even a savior, rather than a threat to our health and safety. Importantly, the constitutive elements of these stories

create a community many people would want to be a part of: these stories create audience members who plainly want to protect their children against pain and suffering, and sympathize with the experience of the narrators to such a degree that they would not want the same thing to happen to anyone else's children either. In one sense, people in the pro-vaccination camp are "regular" folks who run the range in terms of income, education, and outlook. They may see breastfeeding and organic foods as necessities, *along with* vaccinations, for providing their children with the best possible start in life—though such discursive markers are not prominent in their stories. Rather, in these stories, the community that is created is one which is informed about the necessity of vaccination through the incidence of disease. While members of this community also may value personal choice, as is suggested by Rae (2010), they likely believe that the best personal choice regarding vaccinations is also the best choice for *the public good*.

In addition, the members of this community do not necessarily believe unquestioningly in everything the medical community suggests, nor are they uniformly flattering in portrayals of medical personnel. Rae, for instance, showed no qualms about insisting that her son be seen again by a doctor, even though he has already been diagnosed with a sinus infection. However, instead of viewing doctors and medical professionals as the "enemy," who are trying to trick them into something, as in McCarthy's (2007) story, members of the pro-vaccination community are likely believe that the doctors and medical personnel are experts in their fields, and ultimately that they know what is best. This does not mean that the parents are not informed or uneducated; rather, they work with the medical personnel instead of innately distrusting them. In fact,

those people who would actually consider the question of whether to vaccinate or not are likely to be more highly educated, with time to consider such a question. They may weigh all the evidence, both scientific *and* personal, and decide that vaccination is something that is necessary to prevent real, physical harm. They too, would view themselves as caring parents interested in preserving the safety and health of their children.

Undoubtedly, the pro-vaccination authors and McCarthy are coming from two different perspectives, either supporting vaccinations or adamantly rejecting them. Both types of stories appeal to a sense of identification of “good parents” who want what’s best for their children. However, there is a major distinction in the creation of a particular audience who would identify with the story—pro-vaccine stories constitute good parents as those who would vaccinate their children to achieve the best of both the private and the public good. In comparison, McCarthy’s story constitutes good parents as those who take on “big medicine” to change the status quo, with the individual right not to vaccinate affecting the public good in positive ways by making pharmaceutical companies and the government “green” our vaccines.

In constituting what it means to be a part of the pro-vaccine community, as well as the anti-vaccination community, these narratives deal with the conflict between public good and private rights. Rae’s (2010) narrative most directly addresses the public/private nature of the vaccine controversy, and she does so in a way that also constitutes what it means to be a responsible parent. In the end, her story illustrates that while she does not want to infringe upon personal choice, the right and responsible thing

to do is to vaccinate one's children in order to protect everyone. Within her narrative are strands of the debate, making her story one that is both very apt and affecting in terms of swaying parents towards vaccinating their kids; and also more easy to dismiss because her personal choice of vaccinating Daniel kept him from having a much more serious bout of pertussis. Her story illustrates how vaccination is a public responsibility, not just a personal choice, and Daniel's illness might make others who are questioning the need for immunization realize that it is not just the health of their own children they are dealing with. She does not comment on her own feelings about the reasons that parents do not immunize directly, but rather does so in a more general sense, by wondering how we allow for individual choice, while at the same time making sure all people are protected against deadly, frightening diseases:

As an independent spirit, I'm typically inclined to support alternative lifestyles and philosophies. As a responsible parent, I don't ever want anything bad to happen to my children—or any other children. As a neighbor, I'm still unwilling to make a welcome-baby visit to the 2-month-old across the street. As a citizen, I am deeply concerned about the impact of health choices made by individuals on the overall health of other individuals and the public at large. Still, the question continues to haunt me: How do we reconcile the issue of maintaining personal beliefs with the devastating reality of communicable diseases? (para.31)

Her comment regarding her refusal to visit her neighbor's new baby shows how much she considers the ways in which her behavior will have an impact on another person—a two-month old baby is still extremely vulnerable to VPDs like pertussis, as the first series of shots is not completed until the baby is six-months old. As an informed parent, Rae knows how VPDs such as pertussis are spread, and thus refrains from engaging in behavior that might result in a child contracting the disease from her. Given her experience with a VPD, and the likelihood that her son caught the disease from a non-

immunized child, it is possible to see that she wishes everyone would be responsible for themselves and others, and vaccinate their children.

Rae establishes this message through the very subtle references she makes to vaccination rates throughout the story, particularly upon the discovery that Daniel was suffering from pertussis. Rae researches the rates of immunization in her community and is “shocked to learn that the rate of un-immunized children in the herd of Daniel’s schoolmates was 24 percent, and that another 10 percent were under-immunized—immunization levels comparable to some Third World countries” (para. 10). Her vocabulary drives home her personal views about the private/public issue—she is *shocked* that others are not vaccinating, and that the vaccination rate in her well-educated, affluent community is lower than in many struggling, disease-ridden, developing countries. Many of these countries are toiling to bring their vaccination rates up and to suppress incidences of VPDs, while members of certain communities in one of the most powerful and wealthiest nations in the world are *choosing* not to vaccinate their children against deadly and preventable diseases.

At the same time, Rae reifies the dialectical communities constituted through vaccination narratives. She reflects on the desire to have personal choice in how we live our lives, a value exercised by anti-vaccination communities who view science and medicine as invasive and unnatural. She also elicits a pro-vaccination community, which values medicine as not only necessary, but helpful; as one who identifies with this community, Rae rejects the anti-vaccination narrative in favor of the public good. Carter’s story (Dube, 2010), like Rae’s (2010) telling of Daniel’s ordeal with pertussis,

shows that vaccination is not just a private choice, for everyone is affected by the herd immunity afforded by vaccinations. If the consequences of non-vaccination are serious illness and death, whether in your own child or in those of others, then the competing story of non-vaccination as the “informed choice” of “good parents” becomes far less powerful and compelling.

The pro-vaccine stories illustrate how an analysis using both Fisher’s (1984) narrative paradigm and Burke’s (1969a; 1969b) concepts of identification and the guilt/purification/redemption cycle help to augment the study of narratives from a rhetorical perspective. Further, the concentration on both the instrumental and the constitutive aspects of these narratives highlights how narrative analysis can move beyond the boundaries of the narrative paradigm to explain why a story might be accepted by audience members. Yet in a conflict involving competing persuasive narratives, how is one to choose between stories? We are left wondering how the pro-vaccines narratives might compare to McCarthy’s (2007) story in their ability to fulfill the requirements of the narrative paradigm. Further questions remain about how the narratives involved in the controversy over childhood vaccinations affect people’s opinions and actions, and constitute audiences with whom readers identify. How might the rhetoric of these narratives affect issues such as power and public health? The concluding chapter turns to an examination of these questions.

Chapter Five: Conclusion

Introduction

One unfamiliar with the controversy surrounding childhood vaccinations may wonder how we even came to a place where vaccines, arguably one of the most effective, simple, and relatively painless medical advances known to humankind, have come under such scrutiny and suspicion that people no longer trust them. Why are people questioning such an important safety measure that protects them, their children, and loved ones—as well as the community at large—from the devastating effects of VPDs, including death? Much of the answer stems from the rising rates of autism. This “mysterious” condition, with no definable cause and no certain treatment, has left parents demanding answers as to why their children are suffering from a disorder that makes them withdraw into themselves and virtually disappear. Parents are filled with guilt, worrying that they did something to cause their seemingly “normal” child to stop talking, smiling, and interacting with people in typical ways. People have looked to vaccinations as the “common-sense” cause of this condition because most parents notice symptoms of the disorder in the second year of life, typically when children begin to develop speech (Sivberg, 2003), and seemingly after their children receive the MMR shot between fifteen- and eighteen-months of age.^{14,15} As narratives like McCarthy’s (2007) show,

¹⁴ Interestingly, scientists have determined that most children suffering from Autism Spectrum Disorders (ASD) actually show signs of the disorder within the first year of life, whereas a far fewer number of

parents may have heard about “dangerous” preservatives in the vaccines, and they may be concerned about the number of immunizations given to a child, and the frequency with which a child receives vaccinations in the first two years of life. Parents of autistic children want answers to the cause of their children’s condition, and a course of action which may help cure them. Jenny McCarthy is a minor celebrity who has become a major influence on how people feel about the safety and necessity of vaccination. Questions have arisen as to whether McCarthy’s son actually had autism in the first place [with some now believing Evan had Landau-Kleffner syndrome, a rare neurological disorder with similar symptoms (Greenfield, 2010)]. McCarthy has also been awarded the James Randi Educational Foundation’s Pegasus Award in 2008 as the “Performer Who Has Fooled the Greatest Number of People with the Least Amount of Effort in that Twelve Month Period” (James Randi Educational Foundation, 2009). However, McCarthy (2007) has had an almost incalculable effect on parental confidence in vaccines.

McCarthy offers parents of autistic children hope, detailing not only how she cured her own son, but also what caused his condition in the first place. She presents parents with concrete actions that they can take, like refraining from vaccinating their children and changing them to a casein-free, gluten-free diet. As one of the founders of the blog Age of Autism and the mother of three autistic children indicates, “I have yet to

children are symptom free in that same time frame (87.5% versus 12.5% respectively, of 40 participants). (Maestro, S, Muratori, F., Cesari, A., Cavallaro, M.C., Paziente, A., Pecini, C., Grassi, C., Manfredi, A., & Sommaro, C., 2005). Most first-time parents of autistic children miss out on these signs and believe their autistic child is developing “normally.” The symptoms become severe enough in the second year of life that parents become aware of the disorder.

¹⁵ Most parents of autistic children (roughly eighty percent) become aware of the atypical behavior of their children by the age of twenty-four months (Landa, 2008). These symptoms usually involve language development (De Giacomo & Fombonne, 1998) and social and play skills (Charman, T., Baron-Cohen, S., Swettenham, J., Baird, G., Cox, A., & Drew, A., 2000).

really get one actionable piece of assistance from my pediatrician. They offer nothing. Nothing...these treatments are filling a vacuum”” (Greenfield, 2010). Beyond McCarthy’s (2007) celebrity status, as I have demonstrated through this project, her story does have rhetorical resonance which helps explain its power. As I have personally experienced, it is difficult to maintain faith in the safety and necessity of vaccinations when faced with the worrisome details and absolute conviction with which McCarthy presents her tale.

Doctors and scientists have failed to address McCarthy’s rhetorical claims, and those of other representatives of the anti-vaccination movement such as Kennedy (2005), and Kirby (2005), in ways that matter to parents, potential parents, and the community at large. Instead, they have relied on risk-benefit analysis and on reinforcing the scientific evidence that substantiates the safety of vaccines. It is only as doctors realize that their individual status as parents who personally dismiss the claims of the anti-vaccination movement and immunize their own children, that their pro-vaccine rhetoric becomes more convincing (Ziebland & Herxheimer, 2008). And when parents of children who suffer from VPDs begin to tell their stories of suffering, we begin to see a powerful counterpoint to the narratives from the anti-vaccination movement.

The vaccination crisis has been fueled by stories regarding immunizations because narratives come closer to capturing our experiences of the world than do dry statistical facts and figures (Fisher, 1984). As Fisher aptly points out, we reason through narratives, which do not exclude traditional rationality, but rather subsume it. The continuing controversy surrounding vaccinations has really been fuelled by the narratives

that parents tell, first linking immunizations to the onset of autism, and later, to the terrible effects of *not* vaccinating one's children. We are now left with the question of which story to believe and why. We are still seeing the effects of the anti-vaccination narratives, which scare parents into questioning the need for vaccines in the first place; we are just beginning to see the effects of pro-vaccine narratives regarding VPDs. However, we now have a sense of what both kinds of stories entail, and how they fulfill or fail to fulfill the requirements for Fisher's (1984) narrative paradigm. Having analyzed both kinds of stories, we are now positioned to be able to evaluate which may be more compelling and create a greater sense of identification with audiences

In this final chapter, I evaluate how McCarthy (2007) and the pro-vaccine stories compare in their ability to fulfill the requirements of the narrative paradigm. I also consider how each side of the controversy constitutes communities, which I consider instrumentally (as audiences with which a reader would want to identify, and therefore act like) and constitutively (as the outcome of rhetoric which has significant impact on questions of ethics and the public good). Based on my analysis, I believe that the pro-vaccine stories of Matthys (2010), Duvall (2010), Rae (2010), and Dube (2010) all fulfill the requirements of Fisher's (1984) narrative paradigm more fully than McCarthy's (2007). McCarthy's depiction of the medical community seems too exaggerated for readers to take at face value, but rather makes them wonder what underlying motives may be encouraging the caricature in her descriptions. Further, the pro-vaccine stories deal with the guilt/purification/redemption cycle in such a way that their stories are strengthened rather than detracted from, as in McCarthy's case.

Certainly not all readers would find the pro-vaccination stories more compelling than McCarthy's. The pro-vaccine stories constitute their ideal audience as someone who is reasonable, rational, and considers all the facts, both scientific and personal, in order to make an ethical decision regarding a procedure that affects not only their children's health, but the health of everyone in the community of which they are a part. Importantly, the "reasonable" nature of the audience constituted by the pro-vaccine stories is a rhetorical effect which resonates with people who identify with the definition of reasonable as informed and knowledgeable from a variety of sources. In its own way, McCarthy's story also constitutes what it means to be "reasonable;" McCarthy's rhetoric constitutes an "ideal" audience in the form of those who question mandated medical intervention as a dangerous imposition on personal rights, and who share a sense of guilt (or want to avoid a sense of guilt) for causing a terrifying behavioral disorder in their children. Her narrative has been so effective because of this constitution of her ideal audience, which is "reasonable enough" to encourage people to identify with her, thereby helping to achieve her instrumental goals of changing the public's view about the safety of vaccination.

However, by considering the nature of narratives constitutively, one can see that the rhetoric of the pro-vaccine narratives seems to better address questions of ethics and what personal choice means for the public good. While readers would not want to harm their children, as McCarthy believes she has done by agreeing to have Evan vaccinated, readers are likely to see the harm that befalls children by not vaccinating them as more

compelling, not the least because it is not only their own children who will suffer from the consequences of the decision not to vaccinate.

This conclusion also addresses the contributions to the field of communication made by this study. There are three major ways that the dissertation enriches communication scholarship. First, it brings a rhetorical approach to the study of health communication, which has been called for in the past, but which is a goal that has yet to be fully realized, though strides have been made in that direction (see e.g. Shugart, 2011). Further, the rhetorical approach to this issue allows us to access ethics, power, and reason, all elements which are generally elided or ignored in the traditional approaches to health communication. Finally, this analysis reinvigorates Fisher's (1984) narrative paradigm and strengthens it as an effective tool for rhetorical analysis. By revisiting Burke's contributions to Fisher's theory (especially identification), and by incorporating other Burkean concepts, Fisher's paradigm is strengthened. In addition, the incorporation of these Burkean concepts allows us to realize how important the constitutive elements are for the narrative paradigm, especially since critics have emphasized the functional approach of the paradigm while ignoring its equally important constitutive elements.

Summary and Evaluation of Narratives

There are some superficial comparisons that need to be made between McCarthy's (2007) story and the pro-vaccine stories I have analyzed prior to comparing them in detail. While surface-level, these comparisons are not insignificant. First, McCarthy's story is a "popular" one in that she is a celebrity who seems to be taking on a "vast conspiracy" of professionals, the government, and vaccine manufacturers (who

represent “big business”) as they threaten the nation’s children. In contrast, the pro-vaccine stories are not widely distributed, nor are their authors “famous.” One deliberately has to go looking for them, rather than being bombarded with them on talk shows and interviews, as in McCarthy’s case. Further, these stories appear on the websites of public health organizations which are clearly pro-vaccination, which makes the stories somewhat more suspect if one is inclined to believe the conspiracy theory put forth by anti-vaccination believers. From the conspiratorial view, McCarthy’s story seems like she’s uncovering some truth about vaccines, which she reveals in order to protect others. Conspiratorial audiences may view pro-vaccine stories as a tool used by the medical community to reinforce its message about the safety of vaccines, and to scare parents into vaccinating without question. The pro-vaccine stories are distributed by the very “powers that be” in a sense, meaning that they reinforce the status quo.

However, while one may be suspicious of the pro-vaccine stories because of their location on websites promoting vaccination, one could be equally suspicious of McCarthy as embellishing her story in order to make the conflict and medical “enemy” appear worse than might actually be the case. While pro-vaccine stories seem much less vitriolic about the medical community, and rather concentrate on how horrible the diseases are, McCarthy spends more of her time creating the enemy, reinforcing the idea that she is just looking for someone or something to blame, whether or not that someone or something is truly culpable. Readers may become suspicious of McCarthy’s motives in creating such an exaggerated depiction of the medical community; this, in turn, makes readers doubt the credibility of her as narrator and the reliability of her tale, injuring the

narrative's probability and power. In contrast, pro-vaccine narratives reflect a more even-handed depiction of the medical community, reinforcing the fidelity of the stories such that we doubt their motivations far less. The end result thus is that, for many readers, the pro-vaccine narratives tend to be more believable, and therefore, more motivating to readers. It is very difficult to read these stories of intense suffering that could have been avoided, and not feel moved to protect one's own children and those of others.¹⁶ For instance, my own personal response to each of these pro-vaccine narratives is to cry each time I read them (though the impact diminishes as I read, and re-read them)—I am horrified by the helplessness of the parents and at the suffering the children go through. Thus, while I sympathize with McCarthy and her plight with Evan, I cannot help but think with dismay about the ordeals of the children and their parents in the pro-vaccine stories, especially the Dube family, who lost their six-week old baby boy. As a mother of two young children who is expecting her third child, my sympathies ultimately lay with the pro-vaccine narrators. The pro-vaccine narrators seem to reflect an ethic of genuine care for others because they are sharing stories of such pain and grief to keep others from experiencing the same thing. The ethos of McCarthy's story seems more doubtful because she seems to want to get revenge, though this motivation is masked by a rhetoric which attempts to convince audience members that her actions and story are ethically motivated. Thus, even though the pro-vaccine narratives are distributed on websites that support vaccination, for audience members who identify with the ideal parent that pro-

¹⁶ I have personally known people who believed in anti-vaccination claims and did not vaccinate their children *until* they saw brief stories on the tangible effects of VPDs. In one instance, a pair of parents saw a thirty-second spot on television merely showing an infant suffering a round of coughing brought on by pertussis, after which the parents immediately had their children vaccinated (B. Freeman, personal communication, 2008).

vaccine stories constitute, the merits of the pro-vaccine stories outweigh McCarthy's more exaggerated narrative.

Another major difference between these stories and McCarthy's is that these pro-vaccine stories chronicle acute, potentially life-threatening such as H1N1 (Duvall, 2010), pertussis (Dube, 2010; Rae, 2010) and rotavirus (Matthys, 2010). McCarthy's (2007) story chronicles a (perceived) battle with the heart-wrenching, life-changing neurological disorder of autism. One of the major differences between these narratives, then, is that people can die from diseases such as H1N1 and pertussis. These pro-vaccine stories are warranted through the fears, or horrifying results, of not vaccinating children; whereas McCarthy's story is warranted through fairly nebulous, mysterious conditions like autism, and their specious connection to childhood immunizations. While there may be serious side effects associated with autism, and while I do not mean to make the condition seem trivial or easy to endure, autism is not likely to cause physical death—particularly a death as sudden and terrifying as the pro-vaccination narratives describe.

Importantly, from a Burkean perspective, death can be symbolic or metaphorical, not just physical: we can suffer social death (Hyde & Rufo, 2000) when we are ignored or mistreated, or experience a symbolic death when we lose an identity we once laid claim to. This kind of symbolic death can be absolutely devastating. Autism can be interpreted as representative of this kind of death, as it is a disorder that can slowly take away a vibrant, loving, interactive child, leaving us to mourn our loss at the same time we try to “revive” this child by discovering what has caused this death and how to fix it. Yet, from a rhetorical perspective, the symbolic death from autism is qualitatively different

from the physical death depicted in the pro-vaccine stories. In the pro-vaccine stories, physical death is described in concrete detail, from the medical interventions to the manifestation of symptoms in a child's body.¹⁷ The symbolic death of autism, while terrible, at least has the possibility of resurrection—the child is not *physically* dead and parents can hold out hope that someday, their child will come back to them. The physical death from VPDs offers no such consolation.

Unfortunately, despite the millions of dollars that have been poured into finding a clear causal agent or “cure” for autism, we are no closer to finding answers about this devastating disorder. However, we know, without a doubt, what causes VPDs like rotavirus, H1N1, and pertussis; and more importantly, we know how to prevent these

¹⁷ Dube's (2010) story of her son's death from the VPD pertussis highlights the graphic nature of the physical death. Initially, the disease starts out somewhat innocuously, making Carter cranky and a little harder to console at night. However, it quickly becomes more serious as he is rushed to the hospital and “put on nasal oxygen...taken for chest x-rays and [has] his nose and lungs suctioned” (para. 8), as well as being started an IV “to supplement his lack of milk intake” (para. 8). He starts coughing, “lo[s]es his breath and turn[s] blue” (para. 9); “become[s] fussy and inconsolable” and descends into a coma because “by early Sunday morning, the decision was made to put Carter on a respiratory machine...that was the last time we saw our Carterbug awake” (para. 11), five days into his illness. His body is not “strong enough to handle the respiratory machine” (para. 12), so he is put on an Oscillator instead. By “Tuesday, Carter start[s] going downhill. Doctors were confused as to why Carter's heart rate was extremely high and his blood pressure so low” (para. 12). That same day, Carter is put “on an ECMO (heart and lung bypass machine), as a last resort” (para. 13). This machine, which Duvall (2010) indicates he was lucky enough to avoid, makes Carter's chances of leaving the hospital with his parents only “60-40” (Dube, 2010, para. 13). It takes three hours to transfer Carter onto this machine, and Carter is almost unrecognizable because of it: “My sweet baby boy had huge tubes in the sides of his neck while blood pumped in and out of them. The ECMO machine itself required two people to run it at all times” (para. 14). Carter is clearly in deadly peril. As Carter's mom recounts, he “started to swell and wasn't putting out enough urine for the fluid he was taking in. The doctors told us it was related to the stress on his body for being so sick. Now we had to worry about kidney failure and other issues related to the swelling” (para. 14). Finally, Carter is given one last medicine that “would tint his blood and skin blue” (para. 20). And “at this point, Carter's condition had gotten worse. His IV in his foot was blown and they were not getting a good reading of his blood pressure. His kidneys had completely stopped working and his body was too fragile to handle dialysis” (para. 21). When this last medicine does not work, the Dube's begin “to let our family go back to say their goodbyes to Carter. It was the longest walk to take over and over again with our family, as their hearts broke along with ours” (para. 21). After ten days in the hospital, Carter “received his angel wings. He went peacefully on his own terms to the arms of Jesus. [His mother] truly believes that [his family] will see him one day and that his spirit carries with [them] everyday” (para. 24). Carter's suffering, which comes on so suddenly and which is clearly so drastic, brings home the true cost of VPDs.

diseases from occurring. Pro-vaccine stories show the definite effects of not vaccinating children, through neglecting to vaccinate (Duvall, 2010; Matthys, 2010), having the child be too young to vaccinate (Dube, 2010), or not having enough children immunized to maintain the necessary levels for herd immunity (Dube, 2010; Rae, 2010). While McCarthy's (2007) theory linking vaccination to autism may make a certain amount of sense, scientifically this cause-and-effect reasoning has not been proven despite massive amounts of research and money spent on testing this supposed link.

Another difference, and a seeming strength of the pro-vaccine stories, is that three of these pro-vaccine stories have multiple versions available, two of which are those specifically provided by the website on which they are found (Dube, 2010; Duvall, 2010). As previously noted, the first-person accounts do not seem to have been edited in any way, with Duvall's story in particular reflecting a less complimentary view of some of the medical professionals than one might assume the public health organization would want to share. The fact that these stories have both a personal, first-person accounting and a more neutral, third-person report makes it seem more likely that what is being described is the "whole truth," thereby reinforcing both a sense of probability and fidelity. The different versions reinforce a sense of coherence for the narratives and we are more likely to believe in the credibility of the characters.

McCarthy has told her story in numerous places and in numerous ways; however, hers is the only voice heard. We do not hear from the doctors and medical personnel involved in the controversy or in her narrative, except from those who support her point of view. This one-sided nature of her story, combined with the absolute vitriol with which

she treats anyone who disagrees with her, may make people less inclined to see it as reasonable and credible. Further, her tone may make readers doubt her motivation and challenge the narrative's ability to meet narrative fidelity; not only will audience members likely have come into contact with medical professionals who do not meet the description McCarthy provides of them, they will also be suspicious of the complete lack of a dissenting voice, particularly as the claims of her narrative are so controversial.

When combining Fisher's narrative fidelity with Burke's identification, the constitutive elements of these stories create a community many people would want to be a part of: these stories constitute audience members who plainly want to protect their children against pain and suffering, and would not want the diseases and experiences narrated in the stories to happen to anyone else's children either. However, between the two types of stories there is a major distinction in the creation of a particular audience who would identify with the story: pro-vaccine stories constitute good parents as those who would vaccinate their children to achieve the best of both the private and the public good. McCarthy's story constitutes good parents as those who take on "big medicine" to change the status quo by privileging the individual right not to vaccinate. We may view the individual choice to avoid vaccinations as promoting the public good by making pharmaceutical companies and the government "green" our vaccines—a direction which McCarthy seems only recently to have taken. But, on its face, McCarthy's story privileges personal rights to protect children from autism by refusing to vaccinate, a course of action that is ineffective in preventing autism and downright harmful because it exposes children to the very real risks of VPDs.

Contribution to Communication Studies

The field of health communication has been dominated by a quantitative approach, though qualitative methods have recently begun making significant contributions to the field (Beck, 2001). For instance, in her review of how the health communication field came to be, Thompson (2003a) points to a call from David Smith (1989) in the initial issue of *Health Communication* to favor “theoretical and methodological pluralism” (Thompson, 2003a, p. 3). She continues, “‘Messy’ research, a focus on narratives, and consulting with research participants, all of which [Smith] advocated, are also recurring themes” (p. 3). Five years later, Thompson et al. (2008) indicate that “we see more work focusing on the roles of narratives in health communication...and using discourse or conversational analysis to examine health-related interaction” (p. 14). While this move toward qualitative methods has been rich and productive, the field of health communication still lacks focus on other, equally illuminating methods, such as “rhetorical, narrative, discourse and conversation analysis” (p. 10), despite indications that these methods have much to offer to the study of health communication (see also Miller, 2003).

Rhetoric brings much to the study of health communication that quantitative and qualitative methods cannot or do not address. The study of rhetoric has become epistemic, “focus[ing] today on the question of the source and status of knowledge” (Bizzell & Herzberg, 1990, p. 14). We know the world through rhetoric. This is certainly a different perspective than that taken by quantitative methodologies, and different as well from strictly qualitative works. Qualitative research tends to focus on the way in

which meaning and knowledge come about through phenomenon, through social interaction in given situations and communities. Language creates reality through interaction, and since all language is inherently persuasive (Burke, 1945, 1950; Richards, 1923), rhetoric encompasses the phenomena that are studied by qualitative researchers. While qualitative methods focus on the immediate situation in which the researcher is involved (e.g., on the phenomena as they occur in that moment), rhetoric permits researchers to explore not only at the context of the immediate situation, but also across time. If one follows Burke's argument that rhetoric is very encompassing, including written and oral discourse, (Bizzell & Herzberg, 1990), rhetoric allows access to concepts that qualitative research, with its focus on the immediate, specific situation, cannot detect.

Unfortunately, much of the work done so far in health communication that could be considered rhetorical relies on the transmission model of communication, and thus the view that language is neutral. In her introduction to media issues in health communication, Parrott (2003) suggests that public health campaigns are best designed by "careful formative research" (p. 445), such as that done by Salmon and Atkin (2003) in which "their review provides a framework for understanding how to develop campaign objectives...[such as] the characteristics of campaign audiences [which] guide message, source, and channel selection" (p. 445). This clearly reflects the assumption that language is a neutral medium for communicating knowledge about the world, a theory of rhetoric that has fallen out of favor with many rhetorical critics. The preference for a post-positivist outlook still prevalent in health communication continues to dominate the rhetorical studies that have been done in the field. Parrott again demonstrates the post-

positivist view of rhetoric, when she lauds scholars for highlighting “the important relationship between audience segmentation principles and message design in order to predict and explain and influence outcomes” (p. 446). This terminology clearly reflects a post-positivist ontology; a more constitutive view of rhetoric such as that represented in this dissertation adds to the field of health communication research and takes it in the direction that many health communication scholars have been attempting to go with their call for more qualitative work. Such a perspective shows that scholars need to examine language as more than a neutral tool to be used to transmit knowledge, but rather as a way to create knowledge and discourse communities (Bizzell & Herzberg, 1990).

The cohesion which rhetoric creates in a community, and the way in which rhetoric is used to keep discourse communities separate, is clearly apparent throughout the study of health communication in general (though it is not often referenced directly as rhetoric) and in the childhood immunization crisis specifically. Rhetoric is used to create sides (those who are for vaccinations and those who are against them), and is used by each side to maintain distinctions between the discourse communities. Interestingly, the rhetorical cohesion and division largely contributes to the crisis—with neither side listening to the other and with both dismissing the concerns of the other. The pro-vaccination advocates often write off those against vaccination as “crazy, uneducated hippies” or religious fundamentalists; those against vaccination reject the pro-vaccination group as government or corporate “stooges” who are intent on “making a buck” at the expense of their children’s health. A truly rhetorical approach, which views language as the means by which situations, knowledge, and power are created, spotlights the ways in

which language may create division and cohesion, with serious material consequences. Because the issue is being played out on the national stage, in the form of media coverage, public health campaigns, and disease outbreaks, as well as in smaller groups, taking a rhetorical perspective is vital to access power and ethics on grand scale. Power is involved not only in who is speaking, but also in what they are saying and to whom. Ethics is equally found here, because powerful words affect listeners' beliefs and actions.

If, as Bizzell and Herzberg (1990) argue, "Our learning comes from interpretation, our disciplines grow by argument, our communities cohere through discourse, our ideologies are structures of persuasion; reality itself is a function of the way we use language" (p. 14); then how can continue avoiding the contributions of a rhetorical approach to the field of health communication? The view that language constructs the world around us, so prevalent in modern scholarship, calls for rhetorical analysis of a situation so fraught with tension and conflict. As we have seen, a rhetorical approach allows us posit and explore questions like: who has the power to decide what is right or necessary regarding childhood immunizations? What does it mean to be a "good" parent? How does one resolve an issue that is at once both private and public?

In addition, rhetoric helps address the question of how something comes to be known as "true," which is important for the vaccination crisis because facts that were once thought to be true, such as the absolute need for vaccinations, have come to be questioned through powerful narratives such as McCarthy's (2007). Truth and knowledge are constituted in discourse, and there is a great deal of power embedded in the ability to "create" truth and knowledge. Things come to be known as "true" because of the

persuasiveness of the discourse wielded by powerful actors who have the ability to make their voices heard. Thus, a study of the rhetoric of health communication, and of the childhood immunization crisis, reveals not only how we create and know reality, or determine what is “true,” but also who has the power to create this knowledge and truth.

Rhetorical analysis of language and discourse helps to reveal how power is created, maintained, and wielded, particularly by institutions, authorities, celebrities, and ordinary people, who all have the capacity to speak and to suppress others’ speech. The question of power, of who can express their viewpoints, runs rampant through health communication in general, and the childhood vaccination debate in particular. Speaking generally about his own health crisis, Canadian sociologist Arthur Frank (1998) writes about illness narratives in a way that addresses the power involved in the telling and hearing of stories about health. In writing about his own story of cancer, he asks: “How was my story—and the stories other people tell—produced by power, and how was my story reproducing power?” (p. 330). Using a Foucauldian perspective, Frank examines whether illness narratives, including his own, are an opportunity for patients to deal with their illnesses and take control of their lives, or whether they replicate the patterns of power already existing in society. Anti-vaccination narratives empower individuals to question the dominant voices and discourse surrounding medicine, health, and well-being. They encourage parents to reject the heavy hand of the government and profit-motivated corporations in favor of a seemingly more healthful, and more individual lifestyle in which a person is solely in charge of how s/he lives her/his life. However, these narratives replicate inherent power structures: At least in McCarthy’s case, they are

told through a sensationalistic voice of the media and celebrity that garners disproportionate public attention, and rhetorically shouts down any dissenting voices, whether reasonable or not. Pro-vaccine stories empower parents to address the issue of public good versus private rights in ways that are personal, rather than as seeming mandates handed down from all powerful governments and corporations. These personal narratives give voice to the patients and their families in ways that powerful medical and science discourse has not done in the past (Hyden, 1997; Murray, 2000). These narratives empower discussion in reasonable ways and counteract scare tactics with thoughtful engagement while still honoring the power of the personal narrative. They enable people to stand up to frightening, rancorous rhetoric which threatens our health and challenges the notion of public good. They also reproduce power by reinforcing the message of public health officials in a far more effective manner than the scientific language used by powerful governmental institutions to address the issue.

From a broader perspective on the childhood vaccination controversy, one could argue that the issue is, in essence, about challenging institutional power, which is created and maintained in discourse; and about seeking ways to gain access to power by people who have not traditionally been granted authority. The issue encompasses questions of power because doctors (and the scientific and medical communities, generally) have enjoyed ultimate authority over medical and health decisions for many years, a position which has come under scrutiny as of late (Hyden, 1997; Murray, 2000); rhetoric thus is at the heart of the matter, since it is through language and discourse that power is generated and preserved.

While a rhetorical approach helps to analyze concepts such as power, knowledge, and reason, that emanate from the use of language (specifically, in the form of story), it also highlights the manner in which ethics infuse the vaccination controversy. Burke (1969b) argues that,

the rhetorical concept of “identification” ...does make clear the fact that one’s morality as a specialist cannot be allowed to do duty for one’s morality as a citizen. Insofar as the two roles are at odds, a specialty at the service of sinister interests will itself become sinister. (p. 31)

The behavior one engages in as an “expert” on a subject must be held to the same standards as the behavior and morality of that person as a private individual.¹⁸ This concept is important here because one must consider the ethical and moral implications of one’s rhetoric as it constitutes a sense of identification with the instrumental purpose of encouraging particular actions. One must also consider how one’s rhetoric will have an impact on the public good. McCarthy (2007), as a celebrity, creates for herself the role of a “specialist” on autism, including its causes and treatments. She generates a sense of identification with her audience, highlighting her role as a mother and as an advocate for the safety of children. Yet McCarthy does not seem to consider how her rhetoric will affect the public good in a way that indicates a reasoned sense of the outcome. She seems to believe so strongly that she *knows* about the vaccination-autism link, that she is not reflexive about the drastic consequences of her rhetoric on the public good should she prove to be wrong—consequences which, as I have demonstrated, may include rising

¹⁸ Thus, he argues, one cannot engage in immoral behavior under the guise of its being one’s job, while at the same time rejecting that behavior in one’s personal life. For instance, a scientist who engages in animal experimentation and justifies it by saying that animals do not have feelings and emotions, cannot then go home and anthropomorphize his/her dog. The more ethical behavior evidenced in the private life of the scientist would need to carry over into his/her professional life.

rates of VPDs in communities across the world. Again, a question of motivation comes into play for McCarthy's narrative—she ostensibly wants to promote change for the greater safety of the public, but readers may question whether she herself does not have a vested interest in making sure her book is sensational enough to attract attention.

Johannesen (2001) argues that human communication inherently deals with ethics, regardless of whether or not we even recognize the ethics involved, let alone come to terms with them. This is true especially if we agree that we may face these issues any time we are making a “conscious choice of means and ends, whenever the behavior could have significant impact on other persons, and whenever that behavior is subject to judgment of standards of right and wrong” (p. 202). It would seem that McCarthy (2007) never considers the effect her claims might have on children and their susceptibility to VPDs when she argues that vaccines cause autism. Rather, it would seem that she focuses solely on insisting that her views are right, and that we can begin to vaccinate our children only once we determine that they actually are safe and whether all children can handle them; she seems, then, to ignore the information that shows, scientifically, that vaccines *are* safe and do not cause autism. From an ethical standpoint, McCarthy would have done better to think before she spoke, about how her words would affect people's confidence in vaccines and cause serious harm to children.

Examining the actual language used in these narratives reveals ethical meanings and consequences of that discourse, something that is particularly seen in Rae's (2010) case. In depicting the story of her son, a young boy who contracted pertussis even though he was vaccinated, Rae directly addresses how personal choices are more than an

individual's right to decide something for themselves. Rae not only recognizes the ethical issues implicit in the controversy, she actively seeks out differing viewpoints to explore the moral implications further. The decisions of those in the Santa Barbara community to not vaccinate their children affected even those whose personal decision was to vaccinate. Much like smoking, vaccination is an ethical issue because of the private *and* public nature of our choices. Through Rae's rhetoric, we can begin to come to terms with the moral implications of this crisis. Importantly, McCarthy's (2007) narrative does not address this concept, or addresses it obliquely in a manner that makes one question her "selfless" purpose. It is important to access these ethical premises in the childhood vaccination debate in particular, because health issues are not only individual in nature, but rather affect the public at large.

Finally, as Hobson-West (2003) indicates, mass immunization:

is usually argued to be beneficial to individuals, but the benefit to the community is the main concern and may be greater than the sum of individual health benefits, and more important than any individual costs...So, the question then follows: Why isn't the social benefits argument prioritized as part of promotional campaigns in the UK? One answer could be related to the reported dominance of the language of choice, empowerment and individual responsibility in current public health discourse. (p. 277)

Hobson-West both summarizes the ethical issues involved in this controversy, and hints at the ways in which a rhetorical approach compliments the study of the issue. Since vaccination is a topic with such far reaching consequences, it clearly has garnered national and international attention, with broad media coverage and intense public health campaigns. As Hobson-West indicates, the current discourse dominating public health issues, at least in the US and the UK, is one privileging individuals rather than community. This is a mistake, however, because in order to function, vaccination relies

on herd immunity, a concept which is clearly community-centered. As Hobson-West notes, “One of the driving ethical rationales behind these historical and contemporary policies [mandated vaccination] is the prioritization of community benefits over individual costs, whether these ‘costs’ are understood as health risks or a restriction of individual liberty” (p. 277). In the case of childhood vaccines, the cost to individuals is not an increase in risk of autism, as anti-vaccination advocates claim, but rather a higher rate of the population’s susceptibility to damaging and deadly diseases. Thus, immunizations are beneficial both for the individual and for the community. Approaching the issue from a rhetorical perspective helps scholars to access how the individual decision to vaccinate one’s child has become an issue of public import via media coverage and public health campaigns.

A rhetorical approach to the issue highlights communication ethics in such a way that a critic can understand and evaluate the controversy surrounding childhood immunizations. Because this is an issue in which people on all sides are attempting to persuade their listeners to arrive at particular beliefs and actions, and because individual actions have repercussions that extend far beyond the individual who acted, ethics is at the heart of vaccination. By examining the rhetoric and narratives involved in the issue, one can begin not only to understand what is occurring, and how it is coming about, but also begin to make ethical judgments about the communication involved. Murray (2000) argues that telling stories, particularly illness narratives by patients, especially “when established wisdom is questioned...is part of a general social responsibility” (p. 341). How we tell stories, how we construct them either consciously or unconsciously, how we

change them to suit different audiences, what we hope to get out of them, all implicitly include ethics, particularly communication ethics. Our stories affect others, whether intentionally or not, thus, as Frank (1995) indicates, storytelling is “the core morality of the postmodern” (p. 17). The ethical implications of narratives are of supreme importance, particularly as we come to understand how much narratives may be a part of our lives, influencing our behavior and our way of being in the world. When we ignore the ethical implications of the stories we tell, either intentionally or inadvertently, we do a serious disservice to others. Here, in the vaccine crisis, we see how significant stories are for making immunizations a controversial topic in the first place. While lively debate over such issues is fine, and even welcomed, when our narratives motivate us to actions that begin to actively threaten the lives of other people, we are guilty of creating narratives that harm others.

Fisher’s (1987) narrative paradigm argues that all humans tell stories and use “good reasons” (p.7) to make choices about their world; these good reasons are both subjective and historical, meaning that each reason reflects a person’s particular time, place, and standpoint, rather than some universal value. Further, people judge the soundness of a narrative, and decide among the many competing narratives that make up our world through the use of narrative rationality, which is comprised of narrative probability and narrative fidelity. Narrative rationality is “descriptive; it offers an account, an understanding, of any instance of human choice and action” (Fisher, 1989, p. 56) and it works through “identification rather than deliberation” (p. 56).

Scholars criticize Fisher for elevating the role of critic as an “objective” arbiter of “good” narratives, surpassing the ability of non-experts to judge narrative quality for themselves (see e.g. Bush & Bush, 1994; Carpenter, 1986; Jameson, 2001; Sharf, 1990; and Warnick, 1987). Related to this, critics argue that Fisher creates a set of “universal values” that impose normative, Western ideals on all narratives, and that only the critic is able to adequately judge whether a narrative meets these criteria. Finally, Fisher’s paradigm has been criticized as only illustrating what narratives should be accepted, and not explaining those that actually are accepted (McClure, 2009). If one returns to Fisher’s (1984) original narrative paradigm, as well as focuses on the ways in which Fisher incorporated Burkean concepts such as identification, many of these critiques are addressed.

Fisher (1989) argues that “‘people’ have a natural tendency to prefer the true and just” (p. 9), a claim which many have critiqued as untrue and which many have argued impose Western, normative ideals on the evaluation of “good” narratives (see McClure, 2009, for an elaboration of this claim). For instance, Warnick (1987) cites Hitler’s *Mein Kampf* as an example of a story that was neither true, nor just, but which was embraced by many German people. What Warnick leaves out of her critique is an important component of the narrative paradigm, that the “good reasons” people use to embrace particular stories over others are subjective and historical (Fisher, 1984, p. 7). When one concentrates on the “good reasons” the German people might have had to accept Hitler’s story, reasons which were grounded in their own, particular, historically situated perspectives, it makes perfect sense that they would see Hitler’s story as “true and just.”

Their perspective would have allowed them to see Hitler's story in this light, and to accept the story as a guide by which to make choices. Warnick (1987) alludes to this when she says that "Hitler's [story] is invidiously persuasive precisely because of its narrative fidelity" (p. 176). The story resonated with the German people because it reflected a view that seemed to reasonably explain why things were unfolding in the manner in which they were, despite the fact that others from other countries would not accept that story, because they came from different perspectives. Hitler's story reflected "the most compelling, persuasive [types of] stories [which] are mythic in form" (Fisher, 1984, p. 16). Hitler created a story that relied on a David versus Goliath theme. From a more constitutive view on Fisher's theory, *Mein Kampf* was so effective because the narrative created a sense of identification within audience members—Hitler was constituting an audience of German people who had been ruthlessly treated by other countries after World War I, and he created a scapegoat for their treatment and current situation in the form of Jewish people who seemed to be flourishing, while the rest of Germany struggled. When we look at the narrative paradigm in whole, and focus again on the Burkean concepts of identification and the guilt/purification/redemption cycle that resonate with Fisher's original construction, we see that it does in fact explain not only what stories actually do become accepted, but also provides critics (and audiences) with tools to distinguish between what stories *should* get accepted in a particular time and place.

By revisiting the Burkean concept of identification that Fisher had originally incorporated in his narrative paradigm, we also see how the seemingly normative,

Western ideals Fisher touts, such as “reason and justice” (p. 16), can take different forms based on the historical and subjective perspective of the narrator and his/her audience. For many Germans, Hitler’s story was reasonable and reflected a sense of justice, or a way of correcting the injustices many Germans felt they had been subjected to. Yet, its resonance through the guilt/purification/redemption cycle may offer critics a capacity to evaluate it, for its harmful effects. Here we see how narrative is both instrumental and constitutive: through his powerful evocation of a sense of guilt about the state of Germany, which could then be blamed on the Jewish people as a potent scapegoat, Hitler provided an instrumental way for the German people to achieve redemption. He encouraged specific beliefs and actions through the sense of identification. At the same time, his rhetoric constituted communities which had significant impact on moral and ethical questions regarding the public good.

Fisher (1985) also argues that it is impossible to ensure that people “will not adopt ‘bad’ stories and rationalizations” (p. 349), but that “narrative rationality...does mitigate this tendency. It engenders self-awareness and conscious choice” (p. 349). Warnick (1987) takes this to mean that Fisher still insists that narrative rationality guides us to make better decisions about which stories to accept. Again, the Burkean concept of identification “rescues” Fisher’s narrative paradigm from rationalism; while we cannot ensure that people will not adopt what seems to be a “bad” story, we can figure out which stories certain people are more likely to accept based on their situation and beliefs, and whether these beliefs coincide with those reflected in the story. For instance, McCarthy’s (2007) story is likely to be accepted by those who already believe that there is a vast

conspiracy between the government and drug manufacturers to make a profit at the cost of children's health and safety. This kind of audience member may not believe this particular claim, but may believe something similar, which then allows McCarthy's story and claims about vaccines to make sense because the reader identifies with the type of audience member McCarthy constitutes in her narrative. Another reader who does not come from that particular historically situated perspective may reject McCarthy's story as a "bad" one because it does not coincide with his/her experience or perspective on the world. The narrative paradigm and identification go hand in hand—without a sense of identification, a narrative may not be viewed as meeting the requirements of the paradigm, and therefore may be rejected. Moreover, through the concept of identification, we may come to understand the rhetorical *telos* of certain stories, and, as critics, evaluate the ethics of competing visions of community. In the case of vaccinations, identification allows us to distinguish between the ethics of a community-of-individualists-attacking-institutional/corporate-authority, and a community-of-informed-parents/patients/practitioners-protecting-themselves-and-the-public-good.

While some may argue that this view of Fisher's narrative paradigm reflects too much subjectivity on the part of the reader to be useful, it is important to understand that this very subjectivity explains why certain narratives are accepted. Fisher gets out of the criticism of "universalism" by appealing to Aristotelian *phronesis* and context, two equally important components of why a story might be accepted. He seems to argue that, in general, people are moral individuals who will honor similar values of justice, peace, and harmony; and that they achieve rationality in ways that particularly suit them,

reflecting their subjectivity. Though a critic can never situate him/herself in the exact same context as someone reading a story (s/he can only account truly for his/her own experience), one can begin to understand the context, which in turn, helps the critic evaluate why certain stories are accepted. In the case of the childhood vaccine controversy, we can see why McCarthy's (2007) anti-vaccination narrative has been taken up by so many people—not only are parents of autistic children desperate for some kind of answer about their child's condition and possible treatments, but parents who do not have autistic children are worried about doing something that would harm their child, as we now feel compelled to find our own answers about health issues. The Burkean concept of guilt is vital here as well: as parents, we want to avoid any possible harm to our children; when something like a neurological disorder such as autism, or a deadly, yet preventable disease such as pertussis strikes, we inherently feel guilty for either “causing” their condition, or failing to protect them from it. When narratives such as McCarthy's and the pro-vaccine stories tap into this lurking sense of guilt, the stories gain far more traction than they might have otherwise.

Fisher's (1984) reinvigorated paradigm fruitfully addresses why McCarthy's (2007) narrative, which has virtually no basis in scientific fact and which *should* be rejected by audiences, has instead been embraced with enthusiasm by some. Her narrative demonizes medical professionals, which challenges her narrative fidelity; yet, her story also resonates strongly with audience members who see their own experiences reflected in her narrative. These audience members identify with the embellished characterization of medical professionals as uncaring or incompetent, willing to jeopardize the health and

well-being of our nation's children for a profit. They may also see themselves in the type of audience member McCarthy's narrative constitutes as receptive to her story—willing to take on these menacing giants and uncover the conspiracy that is at the heart of the vaccine controversy, all the while having to fight to make their voices heard. This community has an ethic of private rights, defining “being informed” as enlightened by sources outside big government or corporate entities; they question motives of recommendations from other groups, such as medical professionals; they value the purity of the body and the superiority of the “natural;” and they prefer individual choice because they feel most capable of evaluating risks.

Pro-vaccine stories better realize the conditions of narrative probability and narrative fidelity through reasoned, yet personal accounts of VPDs, and their constitutive rhetoric generates communities more mindful of the ethics involved in the childhood vaccination crisis. Pro-vaccine communities evince an ethic of personal *and* public protection through informed choices; they work *with* health professionals, critically examining decisions and possible motives; and they ultimately prefer the public good while honoring private choice (as much as they might). It remains to be seen whether the pro-vaccine narratives will be taken up with as much strength as the anti-vaccination narratives have been, particularly since these pro-vaccine narratives have appeared more recently. Regardless, pro-vaccine narratives better accomplish the conditions of the narrative paradigm, indicating that they *should* be accepted by audiences. Further, they create a stronger sense of identification within the audience members, particularly because they constitute the kind of person many parents aspire to be—caring parents who

will do what they can to protect their children from real, actual harm, as well as being responsible and ethical members of society who will also act to protect others. When buoyed by the fact that science has found vaccines to be safe and free from the blame of causing autism, these narratives should be accepted by the majority of those who read them. And the manner in which they detail the real, significant harm that can befall children who are not vaccinated, or who are exposed to VPDs, goes a long way toward convincing parents that vaccination is not only safe, but necessary. Given the strength of these narratives on all these counts, it is likely that pro-vaccine stories are and will continue to be accepted by the majority of people, and used by them as guidelines for their own actions and beliefs.

The issue of vaccination as constructed by the anti-vaccination movement seems to be one of making a choice between a dreadful disorder which robs a parent of his/her child or risking the inconvenience of a VPD. Pro-vaccine narratives address the question of “whether to get the shot or not” as a choice between the mistaken belief that vaccines are unnecessary and their essential nature as protection against deadly diseases, for individuals and communities. Again, while the link between vaccinations and autism has been soundly disproved by rigorous scientific studies, anti-vaccination proponents claim that these studies merely further the “conspiracy” surrounding vaccines, rather than clearing them of complicity in causing autism. The choice one makes, and the narrative one chooses to believe, depends on how strongly the communities each type of narrative creates resonates with readers. Pro-vaccine stories depict characters acting in reasonable ways as they consider the results of not vaccinating their children—their rhetoric is

moving and compelling, at the same time that it reflects balanced consideration of honoring private rights to the detriment to the health and well-being of the community.

Moreover, pro-vaccination stories tap into a Burkean sense of guilt in ways that intrinsically resonate with parents, as much as McCarthy's story does. Further, and of critical importance to the power of these narratives, pro-vaccine stories eloquently address the concerns of parents who may be swayed by the rhetoric of the anti-vaccination movement, an achievement the more clinical, technical story has been unable to do. These stories fill the void left by a lack of faith in medical expertise, and encourage identification in ways that the more sterile risk/benefit rhetoric has failed to accomplish.

Speaking personally, as one who believes in the efficacy and necessity of vaccination, and who felt her confidence in the safety of vaccines shaken when reading McCarthy's story, I can attest that reading the pro-vaccine stories went a long, long way toward reassuring me of the necessity of vaccination to protect children against deadly and preventable diseases. Again, I empathize with McCarthy's plight, and that of the thousands of others who face the trial and ordeals of autism, and I hope that the true cause and possible cure to this disorder is found. But I do not believe that refraining from vaccinating our children is the answer. It may be that people who are firm in their beliefs either way will not be swayed away from those beliefs, no matter what they read. However, I believe that the pro-vaccine stories have a more forceful impact and a more ethical course of action than McCarthy's story. Given the real and devastating portrayal of disease wreaking havoc on families, people who are undecided on the issue of

childhood vaccination may very well be swayed toward vaccinating their children once they are exposed to these pro-vaccine stories.

Parents of autistic children are searching for an answer about the cause of their child's disorder; they also want a real, actionable treatment that will help their children recover, and they may be wracked with guilt if they believe actions they have taken have caused autism. Other parents worry that they may cause a condition such as autism if they listen to the medical community and vaccinate their children. Still other parents wonder if vaccinations are even necessary anymore. Narratives such as Jenny McCarthy's (2007) undoubtedly have had an impact on parental views concerning vaccination, and until recently, members of the medical community have done little to effectively reassure parents about the safety and imperative nature of vaccines. Now that more parents are telling stories of their perilous encounters with VPDs, we further see how narratives can have a powerful impact on our lives. Thus, analyzing the narratives involved in the crisis not only highlights how integral stories are to our nature as human beings, but also why certain stories come to be believed over others.

The controversy over childhood vaccinations demonstrates the power of rhetoric, and particularly the power of narrative, above technical-rational knowledge. Further, as this analysis has shown, Fisher's (1984) narrative paradigm is a crucial tool for the rhetorical study of narratives. This is particularly true if one focuses on a sense of identification within the narratives, and includes an examination of the sense of guilt, a concept which is intrinsic to our nature as humans. The concept of guilt helps to explain why certain stories which "should" be rejected by the narrative paradigm are accepted,

sometimes widely so. By incorporating these two ideas into the narrative paradigm, the paradigm becomes reinvigorated and is better able to address the criticisms it has been subject to. Further, these ideas allow rhetorical critics to access how the rhetoric of a narrative constitutes what it means to be part of particular audiences or groups. Fisher has been critiqued for being too instrumental in nature, meaning that the narrative paradigm seemingly focuses on the ways in which stories are deliberately used to achieve some end. Yet as this analysis has shown, the constitutive aspects of narrative are equally important for an understanding of how stories come to be accepted, even if they violate some of the principles of the narrative paradigm. By focusing on both of these aspects, rhetorical scholars are better positioned to understand how stories become so powerful, affecting the issues in our lives on a local, national, and global level.

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