

**“A Way of Life That is Not Entirely  
Unfortunate”:  
The Peripheral Cunning of Chronic Pain**  
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*Pain, considered an unsharable, interior experience despite its external expressions, is a phenomenon of the visual tradition and tends to be medically assessed visually. Western biomedicine favors brain scans, facial cues, and palpation signals to configure “authentic” pain as visually locatable, confirmable, and eradicable through targeted treatment. However, these ocularcentric medical techniques account only for acute pain, which is temporary and curable, and not chronic pain syndromes like fibromyalgia, an incurable, non-progressive disorder of unknown etiology. The fibromyalgic subject experiences pain everywhere, constantly, such that pain is normalized, infrequently noticed or made noticeable, excepting unpredictable but anticipated flare-ups that are as interruptive and visible as acute pain. Both contradicting and aligning with the biomedical model of acute pain, the fibromyalgic subject obfuscates the medical gaze and is suspected of hypochondria, malingering, or drug addiction. To receive treatment, she must employ a multisensory peripheral cunning to intuit sensory expectations of how pain should appear and, accordingly, believably, perform the authentic experience of pain she stands accused of faking. Relying on mētis and kairós to deploy new modes of perceiving, knowing, affecting, and being-affected, she must strategically occupy positions that demand the medical gaze embrace multisensory perception over the solidified distance of image-based instrumental mediation outside of the body.*

### Introduction

I want to begin with a scream, a real one, that like the agony of abandoned Philoctetes cannot be suppressed or contained, so that you, auditor, in confronting a body unmade by pain, must also confront how modernity has shaped your perception of pain. I won't lie. I expect you to recoil, and justify your reaction as natural and instinctive, even though revulsion from pain has proved distinctly modern in character, the result of post-anesthetic culture's insistence on eradicating the sensation of pain, which is the same thing as making the sufferer numb, the suffering quiet, maybe still there (Halttunen, 1993, p. 305). The world tells you to interpret the sound as an acute event of such intensity that it rebuffs analgesic erasure. If you keep listening, I expect discomfort to shut down your empathy, and you to excuse it on the grounds that you are not equipped to intervene in a situation that sounds so intractable. Or, in seeking to help, to understand, or to curb voyeuristic spectatorial sympathy, and because hearing presents the scream as not necessarily compresent with its source, and because vision remains the primary sense by which we think the world, you will want the visual confirmation I am trying to evade (Arnheim, 1969; O'Callaghan, 2008).

Look and you'll see why. That's me, post-scream: professor, scholar, writer; inked, pierced, and scarred. I sat silent and stone-faced through four- to six-hour modifications but every morning it takes an hour to prepare my body to stand and meet gravity. My sense of myself is unpredictable and my internal thermostat is permanently broken. If I'm not careful, I weave. I quietly, unwittingly, lived with a ruptured appendix for a month, but I am wary, out of necessity, of every stranger on the subway and every friend's embrace, every possible bump a potential source of torment that will last for days. I have fibromyalgia syndrome (FMS), an incurable, non-progressive condition of constant chronic myofascial pain of unknown etiology, attended by chronic fatigue, affective dysfunction, and depression. Still considered a wastebasket diagnosis, its primary complaint is "Pain, everywhere," an answer that baffles the inquiry of the modern clinical gaze, "Where does it hurt?" (Foucault, 1973). Pain fills me. It is not an unexpected intruder but the medium of my existence, monotonous and mundane except for anticipated but unpredictable intensities, a reality that is marginalized by Western biomedicine, which takes as its basis a distinction between acute and chronic pain and a biopolitical subject that can be reconstituted as autonomous, able-bodied, economically viable (Hardt and Negri, 2000; Morris, 1998). In other words, pain that is medically and socially appropriate—acute, curable, and visually accessible through face, gesture, and sound in keeping with bourgeois civility—admits nothing of my experience and understanding of pain, which is endless, incurable, erratic, and non-apparent.

If fibromyalgia is a disorder symptomatic of the contemporary era, as David Morris (1998) has claimed, the need to visibilize it in order to eradicate it is imperative for the State and imperils the fibromyalgic subject, who requires a long-term managed care approach and not high doses of analgesics or antidepressants. This effort begins with visual assessment, as pain is considered a subjective, unsharable experience despite its external expressions and the biomedical conceit that human vision—which affirms aural and tactile assessments—and technical rendering of the body can verify the authenticity, intensity, and location of pain. The logic of modern medicine overlooks that pain is intersubjective, constructed through shared cultural forces and values as well as interior bodily states. It emphasizes pain as a biochemical response and asserts that locating its biological source is paramount to its erasure. By contrast, postmodern pain opposes the biomedical model, insisting that pain is "not a sensation but a perception dependent upon the mind's ongoing power to make sense of experience" (Morris, 1998, p. 118), exemplified by the daily survival practices of the fibromyalgic subject who must comply with biomedical bourgeois expectations about pain but must remain somewhat elusive to strategically attain increased legitimacy for the disorder as it is experienced and for herself.

To recover what is cunning about fibromyalgia, I intend to trouble the fetish of the visual and the humanitarian sensibility surrounding it, which deems pain eradicable and therefore unacceptable, and, consequently, its expressions titillating, obscene, and barbaric (Halttunen, 1995). I open with a scream to unsettle sight as the primary sense modality by which the body in crisis is perceived, and to unmask anesthesia as a temporary state of relief, an obeisance to the State's project of biopolitical productivity, only for acute pain. In this paper, I will first provide an account of pain as intersubjective, bounded in its expressions by bourgeois norms of civility and propriety, and, as Morris (1998) suggests, more biocultural than biomedical. Subsequently, I will discuss the primacy of vision in the medical assessment of fibromyalgia, which also determines its legitimacy. Finally, I will articulate the *mētis* and *kairós* of fibromyalgia, which extends Tobin Siebers' (2004) notion of

disability masquerade—whereby the disabled subject “passes” by exaggerating the stigmatized identity—exaggerating an identity that commingles the stigmatized expectation with artifices keyed to making invisible processes apparent, to foreground them as the chief (if nomadic) manifestations of pain. I will explore how fascia, a peripheral organ in modern anatomy texts and invisible to the medical gaze, becomes the site of bodily intuition with a complex power to cunningly afflict, relieve, transform, disguise, and navigate. By doing so, I hope to account for some of the ways fibromyalgia may be construed as a physiological expression of disciplinarity, as well as “a corporeal resistance to harmful labor practices” (Alaimo, 2012, p. 31), and in terms of the social distance on which eighteenth-century spectatorial sympathy is predicated. Pain is a biochemical response and a discursively constructed social phenomenon intricately bound up with power. It is immovable but neither monolithic nor useless. Ultimately, I hope to address the provocation Morris (1991, p. 175) raises in his study of pain: “We use pain almost as regularly—and sometimes as cunningly—as pain uses us. The hope lies in learning how to use it to better purpose.”

### **Stare at Pain, and Pain Stares Back**

To understand the perception of fibromyalgia, we must look to cultural understandings of pain. As an experience, pain is a universal quality of the human condition even if it differs in its manifestations, expressions, and meanings. Elaine Scarry (1985) observed in her seminal work on physical pain that it is a personal, private, inarticulate interior state that lacks referential content, easily grasped by the sufferer but inaccessible to sensory confirmation by spectators (p. 4). However, this glosses over its fundamentally intersubjective nature, as pain is historically contingent and cannot be divorced from the interpretations placed on it with other people in specific social contexts. Thus, pain is not solely a biochemical problem but one shaped by cultural forces like gender, race, sexual orientation, and emotional well-being—thus, a biocultural problem (Morris, 1998). As Merleau-Ponty (1962, p. 77) observed, the subject’s ordering of stimuli, and not the stimuli themselves, determine the subject’s perception of sensation, a conception of the body that is comprehensible only if we conceive of it as an embodied entity interfacing with the world through embodiment. For instance, the hermeneutic standards of prehistoric society attributed a headache to the crisis of demonic possession, while the same headache today is a trivial biological fact, easily cured with Advil (Morris, 1991).

It was the search for effective anesthesia in the eighteenth century, coupled with a growing middle-class sensitivity to pain, that began constructing pain as taboo, curable, and best handled from a distance. According to Karen Halttunen (1995), modern attitudes and emotional orientations towards pain can be traced to the emergence of a humanitarian sensibility in the eighteenth century that revolutionized the meaning of pain. Pre-modern, pre-anesthetic cultures recognized pain as inescapable and responded to it with an often religious acceptance (Halttunen, 1995, p. 304). After the reformation of values around pain, disciplinarity led to the privatization of pain, relegating it to institutions of deviance like the asylum and penitentiary (Foucault, 1975). Spectatorial sympathy—the act of witnessing pain, imagining yourself in similar straits, and bodily assuming the sensory torments of the sufferer—was necessarily recast from sentimentalism to a prescribed social and biological distance from the sufferer: in other words, viewing suffering from a careful distance allows us to set a value on our own condition, but in viewing immediate pain you risk absorbing it, making it dangerous in addition to being distasteful (Halttunen, 1995, pp. 307-8).

If I were to create a public spectacle of immediate pain, then I would appear to shamelessly want the prurient gaze and to wantonly, perversely, retain pain instead of numbing it. “Making a scene” through an intense response to nonsevere sensations, like being jostled on the street, signals hysterical or hypochondriac attention-seeking behavior. Additionally, stoicism was cast as an upper-class quality, while being the object of empathy was lower-class, an intra-class language that mandated rigid self-control in public. This coupled with the critique of the infliction of public pain made physicians more sensitive to causing pain in their patients, reflecting and reinforcing the new cultural dread of pain (Halttunen, 1995, p. 310). The sufferer of incurable, long-term pain—whether she “makes a scene” or reveals nothing—is framed as biologically, culturally, and socially dysfunctional: helpless, pitiable from a distance, sadomasochistic close-up, a disempowered nonelite if she makes her pain known. The modern-day legacy of anesthesia and the humanitarian sensibility, thus, is threefold: a revulsion to intense expressions of pain; a skepticism concerning intense expressions over pain that is not life-threatening; and the cultural pressure to keep pain hidden and, in settings like the clinic where its expression is appropriate, to reveal it tastefully.

Modern understandings of chronic pain emerged in these contexts, despite a history stretching back to Galen’s identification of a diffuse pain condition called *rheuma*. In 1904, Sir William Gowers coined the more resilient term *fibrositis*, and in 1972, Hugh Smythe cataloged its symptoms, including constant, systemic pain and “trigger points,” sites of focal tenderness. This definition evolved in the 1970s, when the name was changed to *fibromyalgia* to describe any widespread, idiopathic musculoskeletal pain of unknown etiology, and diagnostic criteria were refined to normal lab results, the presence of 12 out of 14 trigger points under 4kg of manual pressure, and a history of systemic pain and disturbed sleep. Muhammad Yunus (1981) conducted the first controlled clinical study that supported these symptoms with data. Throughout the 1980s and 1990s, fibromyalgia evolved as a rheumatological, autoimmune, nervous system, autonomic function, and/or affective disorder with potential links to other conditions, including psychiatric issues when serotonergic drugs proved effective and emotional traumas were considered causative as well as comorbid (Inanici and Yunus, 2004; Brennan, 2004). During these past 30 years of development, the contemporary medical community has intensely debated the ontology of fibromyalgia. Although the FDA approval of Lyrica in 2007 for the specific treatment of fibromyalgia lent it credibility, its legitimacy remains highly contested (Graham, 2009). Fred Wolfe (2000; 2009) recognizes that the condition exists but discredits the diagnosis as a socially constructed means to medicalize ordinary, universal states of bodily discomfort to serve the interests of pharmaceutical companies. Additionally, Manfred Harth and Warren Nielsen (2007) question the legitimacy of the trigger point diagnosis given that the minimum number of points for diagnosis is arbitrary and control points also cause pain.

In short, fibromyalgia remains a wastebasket diagnosis for when no one knows what is wrong, and, I would add, even that granted only when it is visible enough to warrant medical attention. This classification is furthered by the biomedical view that pain serves as the body’s alarm system, as well as the cultural rhetoric of conquest in which pain is a sensation to be bested. By contrast, Morris’ (1998) biocultural approach accepts that incurable, chronic pain no longer signifies. When acute pain sounds the alarm in the normate subject, it signals danger to the body, a pressing need for evasive action, before which all other actions pale. By contrast, chronic pain is a continuous

relay of signals that does not signify danger or urgency, although the biomedical view interprets it within the framework of acute pain. I have learned the hard way that chronic pain is a call with no answer, not a biological emergency necessitating medical attention, but sensations to which I ascribe sociocultural, historical, and political meaning. Cultural views of pain and pain perception are entangled with fibromyalgia, which is thought to be exacerbated by nonbiological contributing factors like work-related stress, trauma, financial hardship, interpersonal conflict, or political crisis (Morris, 1998).

A biocultural model of pain considers factors such as those delineated above to offer a model of pain that cannot be private and unsharable, that is historically contingent and intersubjectively constituted at specific cultural moments. The rise in chronic pain not only shapes and defines the postmodern condition but also highlights the problems of contemporary medicine: the blurring of acute and chronic pain, failures to appropriately interpret and classify pain, and the implicit quest for perfection, which must end with a vision of recovery, and which reflects poorly on the physician if it does not (Morris, 1991). By recognizing that there are limitations to standardizing chronic pain solely by medical standards, and by acknowledging that fibromyalgia is intersubjectively constituted in a network of pained and non-pained bodies, we can start to dissolve the fixed distinctions between them and complicate discourses that frame fibromyalgia as isolating, invisible, and therefore unknowable and always suspect.

### Seeing Is Believing—But Shouldn't Be

Despite the apparent effects of culture on sensory perception, the biomedical model implicitly accepts that a seronegative pathology like fibromyalgia can only be diagnosed based on visual assessment. Philosophies of perception recognize that vision dominates how we think about perception, and ocularcentrism is a fact of life in many societies. Rudolf Arnheim (1969) conceives of “visual thinking” in restoring the activity of the senses to the definition of cognition, calling vision paramount in the hierarchy of the senses because it can offer varied data through which to order our world. It may confirm the sensory reality of non-visual modalities, such as a breeze and the fluttering of pages, or a moving mouth and speech. Thus, Arnheim (1969, p. 40) finds visual perception most intelligent, as when the eyes wrestle with a scene by actively scanning, determining, and culling, and not just passively recording sensory stimuli.

Since the 1800s, visualization techniques have been critical to power-knowledge in medical practice (Rose, 2007, p. 14). After the advent of the humanitarian sensibility, Western medical practice was undergoing a revolution in ways of “seeing” and “knowing” the body. Illustration of the diseased body involved an assemblage of actors—physicians, surgeons, artists, and publishers—working closely to represent pathology in the dead. The use of these images in anatomical texts in medical pedagogy indicates their evidential status, despite their also being aesthetically and culturally value-laden. As Johanna Drucker (2010, p. 6, 13) observes about the use of objective images in scientific development, the subjective perception of the viewer is encoded into the production of all images, aesthetic or quantitative, and the act of interpretation is always stamped with subjectivity.

The adoption of mechanical techniques, ranging from *Gray's Anatomy's* lithographies and woodcuts to photographs, further altered the landscape of medical representation. Artists could

foreground or deemphasize parts of interest in the body, whereas the photograph was thought to give equal emphasis to everything in its frame. Although spirit photographs and the like cast suspicion on the neutrality of the photographic images, their alleged impartiality lent itself to an aura of objectivity. Furthermore, photography permitted the mass production of images for indexes and anatomical texts, facilitating the enterprise of collective empiricism and linking the disciplinary medical gaze to a particular form of representation of the dissected body. Their pedagogical use ensured a shared community of principle and practice that standardized methods of observing, comprehending, and treating the diseased body (Barnett, 2014, pp. 20-34; Daston and Galison, 1992). Significantly, in privileging allegedly objective images of the dead patient, biomedical authority was exercising state power over an inarticulate, frequently lower-class corpse, thereby anchoring clinical authority in images of the dead body rather than the living voice.

According to John Tagg (1988, p. 63), the status of photography as a technology varies with the forms of power that invest it. Photography was a key technology of power-knowledge from the 1870s onward in institutions like the hospital that used documentary images to order the conduct of social life. Medical photographs of living patients enacted the intimate observation and subtle control of Foucault's (1975) disciplinary power, and continued to substitute for the patient's voice. Medical photographs were imbricated with contemporary ideologies and preceding art forms, drawing on the codes of the selfsame portraiture and anatomical illustrations they were intended to surpass. Photography was meant to procure with "unerring accuracy the external phenomena of each passion, as the really certain indications of internal derangement" (Tagg, 1988, p. 78) in its physiognomic representations of inmates of the clinic and the asylum. Thus, medical photography linked external manifestations, identifiable with the objective camera's eye, and therefore the human eye behind it, with internal disorders like insanity and syphilis.

With advances in imaging technologies, the camera eye acquired the capacity to broach the body's boundaries before postmortem autopsy. The clinical gaze, which Foucault (1973) acknowledges as imbued with multisensory perception, possessed unrivaled authority after the patient died and was dissected. However, as Donna Haraway (1988, p. 581) observes, disembodiment, which has historical ties to male supremacy and the masculine pursuit of scientific objectivity, is compounded by the mediation of this gaze: visual systems that organize bodily substrates, account for and generalize about pathology, and legitimize conjectures about the subject's future health. In opposition to the Western biomedical narrative about objectivity, the medical gaze is only a partial, situated perspective, and the feminist cunning promoted by Haraway recognizes it as "a god trick"—an illusion that promises to transcend all limits, up to and including the invisible interior substances of life. In a sense, the legitimating power of the gaze is transferred from the moment of dissection to the machine-rendered virtual autopsy, which addresses vision alone. Haraway's (1988, p. 581) feminist objectivity recognizes all vision as embodied, including technological mediation from the medical photograph to internal scoping procedures, diagnostic imaging, microscopes, and enhancement techniques. Although Foucault (1973, p. 164) acknowledges this embodiment of vision in the sensorial triangulation acquired by the clinical gaze, he also suggests that the disembodiment of vision was a necessary moral move, as "instrumental mediation outside the body authorizes a withdrawal that measures the moral distance involved." If the cult of sensibility found pain shameful, the postmortem fact of the body's innards was even more so, and airing that secret prior to death similarly prurient. Diagnostic imaging technologies create a solidified distance

between physician and patient, preserving a veneer of respectability by separating the patient in her state of shameful transparency from the physician's spectatorial appraisal of the most private of bodily depths.

Technical rendering procedures reify the dominance of the visible by limiting the medical gaze—which once embraced more than sight alone—to the realm of everyday vision and the virtual projection of the invisible. As Foucault (1973, p. 165) suggests, auxiliary senses became legitimate methods of inquiry only because they anticipate the visible qualities of the postmortem autopsy. Thus, the multisensory approach remains yoked to the fetish of the visual, with the eyes predominating over perceptual modes that assail the senses only when the body is opened and the invisible made visible. Furthermore, advances in biomedical technology have compounded the sense that the questions to be asked and knowledge to be gained about any given body are innumerable, potentially unnecessary, and tedious. Limiting observation to the intersection of human and technological gazes and patient discourse aligns with a pattern of study in which disease, and especially commonplace events like a headache or a ruptured appendix, is repetitive and recognizable in its repetition (Foucault, 1973, p. 110). Disembodied as it is, the contemporary medical gaze is able to visually isolate systems and sites of interest in the interior organic body through ultrasounds, CAT scans, EEGs, MRIs, and so on. Digital simulation is central to these visualization techniques (Rose, 2007, p. 14). Joseph Dumit (2004) notes that the cultural and visual logics of the digital diagnostic image align personhood with the technologically rendered interior. Thus, if the machine is unable to capture a picture of pain, such as inflammation or injury, it is as though the disorder does not exist. Isabelle Baszanger (1998, pp. 148-149) observes that clinical treatment of pain should draw on diversified knowledge, but patients' words are merely an indication. If it is through "the regular alternation of speech and gaze [that] the disease gradually declares its truth" (Foucault, 1973, p. 112), the patient who complains of distress with no visible symptoms is automatically unreliable, especially in the contemporary biomedical complex where malingering for welfare is a common accusation.

Techniques expected to be more objective, thorough, and knowledgeable about the body take precedence over patient articulations. The detached, scripted, and asymmetrical clinical gaze of medical diagnosis seldom encompasses the whole body but rather the parts where symptoms are expected to appear, in keeping with "the god trick" of Western cultural narratives of objectivity (Foucault, 1973; Haraway, 1988).

The implicit problem here becomes how machine detection and rendering orders the diagnosis, legitimacy, and treatment of fibromyalgia. In this case it is through confirmation of the 18 trigger points "legitimated" by the patient's visible expressions, like a grimace or flinch, on being palpated there—an initial diagnostic measure that employs the sensorial triangulation of sight and tactility. In Emma Whelan's (2009, p. 171) study of pain scale standardization, she argues that, since vision is a selective sense, what it privileges about the pained body is how that body becomes classified and ordered as a result of technical interventions in an attempt to "make pains the same." Accordingly, popular classification systems privilege the location of pain and visual assessment of the patient's reaction to being palpated there over other cues such as vocalization. Additionally, the proprietorial gaze of interpreters like radiologists prevents the patient from fully accessing intimate information about their bodies, exacerbating the experience of dispossession and radical self-estrangement.

Technical rendering and clinical ownership reinforce the invisibility of fibromyalgia by emphasizing the visibility of the external and internal body, celebrating the triumph of the ocular gaze over the perceptual experience of ear and hand, and substituting partial data for the whole patient (Alaimo, 2012; Dumit, 2004; Foucault, 1973). This is a medical gaze based not on multisensory perceptual experience and analysis but on recognition of a pattern, the picture meant to apportion the visible within the conceptual configuration of the body (Foucault, 1973, p. 113). In a stark departure from sensorial triangulation, the image is absorbed into a complex of practices that seek to generalize about conditions, like fibromyalgia, that tend to differ across individual bodies.

When pain is chronic it becomes so ordinary it ceases to signify. Even with its nomadic irruptions, I have habituated a face that aligns with the cult of sensibility to fit into public society, assuming that my physicians will take my words alone as an indication, instead of pinning their hopes on a visible sign or blaming me for being so foolhardy I ignore what pain is “telling” me, when I know it is telling me nothing. Too much expression, and I transgress against the legacy of the humanitarian sensibility; but without visible expression, I am numb, a gender-marked sensation interpreted as—in keeping with both female hysteria and post-anesthetic culture—the inability to feel instead of a detachment caused by repeatedly being denied the ability to feel (Morris, 1991, pp. 118-124). Confronted with this sensibility and sensory hierarchy in the clinical settings where she seeks help, the fibromyalgia sufferer has little recourse but some form of masquerade. Cunning intelligence allows the patient to use masquerade to destabilize not only the sensory hierarchy but also the biomedical model of pain, to trouble what physicians have habituated about visual assessment and the evidential nature of photography, and restore her ability to express pain without foreclosing empathy in the face of the middle-class dread of pain.

### **How to Win Even With Mediocre Horses**

The ancient Greeks held a special reverence for cunning intelligence, mythologizing it from its namesake Metis to figures officially sanctioned by the heavens, like Hermes, Athena, and Odysseus, and to those who used their *mētis* to outwit Power, like Prometheus and Sisyphus, both of whom were punished by the gods for their actions. The distinction between those with and without *mētis* is significant. Those lacking *mētis* are witless, ritually circumscribed in time or space, and ultimately supportive of the status quo. By contrast, *mētíeta* tricksters are agents of fundamental change, occupying strategic positions to detect the way out from impossible situations (Detienne and Vernant, 1991, p. 144). Whether confronted with ancient gods or the medical gaze, the challenger must possess *mētis* to outwit an all-seeing, all-knowing Power, using creativity, craftiness, fluidity, and opportune timing, or *kairós*, to successfully navigate an inconstant, endlessly changing landscape and enable futures of becoming.

In their landmark study of *mētis*, Marcel Detienne and Jean-Pierre Vernant (1991) deconstruct the role of cunning in 4th century Greek culture, indicating that *mētis* is the only response to powers that bind or capture. The goddess Metis represents crafty wisdom, cunning perception, and technical skill. She is responsible for the deception that caused Kronos to regurgitate his children; her counsel guided the Olympians to victory during the ensuing Titanomachy. Hers is the only mind eternally aware of “all the possible vicissitudes of becoming” (Detienne & Vernant, 1991, p.



279). This *mētis* is diverse, polymorphic, and fertile inventiveness. It is the cuttlefish's impenetrable ink cloud, the pilot's alert adaptability in inclement weather, the blacksmith's technical knowledge, and the warrior's stratagems. It manifests in the fox and the octopus, which rely on dissimulation, camouflage, elusiveness, and unpredictable reversals to find sustenance and evade capture (Detienne & Vernant, 1991, pp. 33-5). In short, it is a fast-moving, adaptable, polymorphous, and many-faceted artificer, characterized by dissimulation, a mastery of finesse and cunning tricks, and a knack for perceiving and exploiting opportunities and paths of egress in seemingly uncrossable territory, visible only to *mētis* (Detienne & Vernant, 1991, p. 19, 43, 147-8).

The semantic field of *mētis* also contains *kairós* as the propitious moment for action and *metanoia*, afterthought, a feeling-state in which reflection, revelation, and transformation influence decision-making in the kairotic encounter (Hawhee, 2004; Myers, 2011). Unlike linear *chrónos* time, *kairós* regards the present as an unprecedented moment of potential crisis, resolvable only by collapsing all present possibilities into a single, incisive decision (Hawhee, 2002, p. 25). *Kairós* collapses *mētis* and *phrónesis*, or practical knowledge that indicates the most appropriate course of action, into a temporal ontology where "propriety of time" intersects with "the ability to say the fitting thing at the opportune moment" (Sullivan, 1992, p. 318). Inseparable from the kairotic decision, *metanoia* is the affective moment of being unprepared for opportunity, including states like regret, repentance, and guilt. If the kairotic moment forecloses advantageous opportunities, *metanoia* is established; if new opportunities appear, *metanoia* is denied (Myers, 2011, p. 10). While *metanoia* that is too strong may stymie future action and transformation, it serves as a painful learning process that may incentivize individuals to be better prepared for future kairotic encounters. Additionally, as Antonio Negri (2003, p. 212, 248) asserts, *kairós* is irreducible to the clock-time of capitalist productivity, suggesting it is ripe for creating meaningful social bonds and overcoming oppression. The kairotic decision, essentially, is the power to innovate on the temporal edge of being as opportune biopolitical resistance. Faced with the seemingly uncrossable territory set for her by the medical gaze, the fibromyalgic trickster must empower herself by intuiting *kairós*, harnessing *mētis*, and enacting *phrónesis* in an attempt to radically transform the grammar of a form of life.

*Phrónesis*, according to Paolo Virno (2008), is the practical action of *mētis*, comprising the "knowing when" and "knowing how" that results from the pedagogical influence of *metanoia*. Importantly, unlike other sets of practical knowledge, *phrónesis* selects a behavior based not on dominant social values but on what is most appropriate to the situation at hand, using *mētis* and *kairós* to do so, in an attempt to change the epistemological grounds that inform predominant norms and values (Virno, 2008, pp. 90-97). The fibromyalgic who has habituated *mētis* may resist the medical classification of musculoskeletal disorder by intuiting and visibly articulating pain vectors that lead the assessor to focus on other implicated organ systems, particularly fascia, which requires senses other than vision to be perceived. This action, like those of the ancient tricksters, seeks to disturb the sensory hierarchy and web of signification that structure the physician's assessment criteria; once the web of signification is divested of its allure, its terms become contingent and revisable, repudiating the fixed end to meanings that is vital to techniques of quantification and massification in favor of stochastic knowledge (Hyde, 2010; Sullivan, 1992).

Most significantly, as it derives from "an unmanly deity," *mētis* is possessed of feminine qualities like prudence and empathy, as Leopoldina Fortunati (2016, n.p.) points out. The gendered

dimension of this cunning, which may be more accessible to women due to the nature of gendered labor divisions, is absent in accounts of wily tricksters like Odysseus—who, significantly, abandoned his wounded comrade Philoctetes because witnessing his pain proved intolerable. The labor of care has been historically placed in the feminine sphere and with it, by extension, a tolerance and empathy for the objects of care, such as those in pain. Challenging patriarchal accounts of *mētis* as masculine cunning recovers a particular form of female cunning, insight and foresight and imaginative creativity that has been censored, in myth and the social order, to consolidate a paternal law contingent on matricide. Metis is disempowered and oppressed through patriarchal consumption, and the cerebral parthenogenesis of her progeny Athena by Zeus strips *mētis* of the essential female creative act of bodily birth, and hence of bodily intuition (Jacobs, 2010). This distinctly female *mētis* parallels the peripheral intelligence intrinsic to the daily survival of the fibromyalgic woman. It may explain how (feminine) persistence, tenacity, adaptability, and patience outwits (masculine) domination in the medical industry, and makes itself available outside of “feminine culture” through a process of habituation that does not dismiss, engulf, or otherwise minimize its matriarchal influence.

### Slipping the Trap of the Biomedical Gaze

The dimension of embodiment is often overlooked in the doctor’s office unless it is visible, but the ontology of fibromyalgia with its non-apparent pain is one of perpetual becoming through corporeal disruption, mandating new forms of attention to others and self that are kairotic, phronetic, and empathic in nature. The management of continuous corporeal disruption speaks to our preconscious capacities for posture and movement, as demonstrated by Steve Paxton’s “small dance,” the incessant and creative “adjustment of orientation, alignments, contractions, relaxations, and balancing” (Dumit and O’Connor, 2016, p. 35). *Mētis* provides a framework by which to understand how the fibromyalgic subject plays with the small dance to comply with the sensory expectations of biomedicine and the humanitarian sensibility to merit treatment while cunningly, simultaneously, occupying the position of the polymorphic “third thing” that exceeds biomedical classification and reorganizes the sensory hierarchy by demanding alternate modes of assessment, ultimately challenging the massified practices of chronic pain treatment.

Siebers (2004) reflects on how public claims to disability must be supported by visual evidence, like a wheelchair, disfigurement, or obvious bodily incapacity. He acknowledges that disability passing, or concealing the disability to appear normate, effectively points to disability identity as one that no one would voluntarily want to assume. It preserves social hierarchies by presuming that disability is lower-class and that disabled individuals desire to rise to the top of the hierarchy, the normative, elite, dominant social group. At the same time, he offers a tricky “third thing,” a strategic, fluid position that defies easy categorization: the disability masquerade, “an alternative method of managing social stigma through disguise, one relying not on the imitation of a dominant social role but on the assumption of an identity marked as stigmatized, marginal, or inferior” (Siebers, 2004, p. 5). Significantly, disability masquerade may inflect private and public space for political ends, to expose false presumptions or make strategic use of them, and to tinker with the social meaning of the particular disability, and disability as a whole (Siebers, 2004, pp. 9-13). Unlike passing, the masquerade makes disability “overvisible,” performing or exaggerating

stigmatizing difference to expose and resist social prejudices, such as a misapplied or absent prosthetic, or an exaggerated limp (Siebers, 2004, p. 19).

Largely non-apparent except during flare-ups of acute intensity, fibromyalgia already passes. Purposefully performing it as disability masquerade merely displays an experience of acute pain. Rather, the fibromyalgic patient must visibly display different experiences of chronic pain in different locations, along the meridians of its referrals, to temporarily confuse the biomedical and cultural norms defining pain: namely, that pain must signal bodily crisis, that it must be visible (but not alienatingly so) to be real, and that it must comply with bourgeois taste and decency. As with minority groups, “overvisible” fibromyalgia subverts hegemonic social conventions by resisting social pressures to embrace the humanitarian sensibility—to hide pain, to designate its public expressions shameful and stigmatizing, to keep it at arm’s length. Fibromyalgia masquerade is visible but only as “civilized” as it must be to keep the physician engaged in the quest for personalized treatment. It is a composite performance intended to appear contradictory and surprising to create the conditions for kairotic transformation, such as costuming to appear able-bodied and expressing pain in posture, gesture, facial expression, and vocalization in close public spaces like an escalator or subway car, or requesting unexpected assistance such as a stool to rest on in a grocery store.

Where disability masquerade readily calls attention to the disabled organ, fibromyalgia takes the whole body as the disabled organ, and must enact masquerade in a way that insists to modern medicine and society that the entire body is afflicted. As such, fibromyalgia masquerade centralizes fascia, the lubricating and supporting membrane that envelopes and interpenetrates the whole body, an “active, intelligent, communicative, and sensory organ; sometimes three, sometimes many and sometimes one, liquid, solid, and mucus” (Dumit and O'Connor, 2016, p. 36). Fascia is the only whole-body organ, and may be critical to managing fibromyalgia but invisible to biomedicine. The mechanical techniques in *Gray's Anatomy* captured fascia as a prominent organ, but modern-day clinical textbooks and pedagogy present fascia as an organ to be cut through, a barrier between the surgeon and the treatable body, and not a treatable organ in its own right. While it is enjoying increased attention, until recently fascia was considered the scraps of cadavers and the snake-oil cure of alternative therapeutic practices like myofascial massage, rolfing, and movement training. As fascia is invisible except during dissection, its absence in modern anatomy texts is a particularly significant exclusion that has inhered in social and cultural norms. Foregrounding touch and fascia challenges the Western anatomical vision of reality as musculoskeletal, a concept that emerged after dissection revealed muscularity as the agents of structure and function and was documented as such by Galen and, later, Vesalius. Under this view, despite coincided myofascial pain, fibromyalgia is biomedically considered a musculoskeletal disease and is assessed and treated as such. However, evidence suggests fibromyalgia is fascial in origin. Unlike joints and muscle, fascia possesses continuity, nervous system investments, and vascular relationships throughout the body and heavily influences functional unity, and is impacted by processes such as habitual sitting posture, stress, trauma, and surgical intervention (Lewit, 1979; Myers, 2009; Schultz and Feitis, 1996). If fibromyalgia is a disease of fascia, which can only be encountered through touch, it must be assessed not with the eyes, but by how the body feels.

Phenomenologies of touch have pointed out that vision is not necessarily the superior sensory modality. Merleau-Ponty (1962) has recognized that touch is extremely difficult to deceive, as contact conveys both form and content of reality around which other sensory meanings can occur, and that we should celebrate the function of the invisible. He notes that “the body is the vehicle of being in the world, and having a body is, for a living creature, to be involved in a definite environment” (Merleau-Ponty, 1962, p. 94), which can and does include ambivalent presences such as phantom pain as part of “an I committed to a certain physical and inter-human world, who continues to tend towards his world despite handicaps and amputations and who, to this extent, does not recognise them *de jure*” (Merleau-Ponty, 1962, p. 94). In other words, the embodied world sets the conditions for our existence, and we experience the world as embodied subjects, largely through our fascia, which habituate our emotional and physical reactions and project our future bodily responses. As such, fascia may be conceived as an “organ of form” changing to accommodate and memorize our habitual movements to reduce our expenditure of effort when we assume our usual postures but also, potentially, trapping us in them (Rolf, 1989, p. 37). This in and of itself is suggestive of the physiological cost of the postures encouraged by disciplinary power and ideologies of productivity.

Fibromyalgia causes a heightened interoception, or awareness of internal bodily processes like sliding, sticking, or pain in the fascia, leading to disordered pain processing. However, this may also be read as a tactile cunning, as it channels an awareness of how our bodies become trapped in our habits, and how the innumerable crises of our modern embodied world may contribute to that entrapment. A reliance on peripheral sensing and high interoceptive sensitivity, both characteristic of chronic pain sufferers, has been correlated with an increased ability to affectively and cognitively empathize with others, especially with their pain (Grynberg and Pollatos, 2015). Empathy, a feminine quality of *mētis*, can be thought of as a “feeling into,” the ability to project yourself into another. Arguably, the *mētis* of fibromyalgia urges a reciprocal sensation in its witnesses, encouraging the intersubjective construction of pain and a collective turn to empathizing with bodies evincing pain instead of shying away, castigating them, or presuming they are “faking it.” Fibromyalgia masquerade effects a temporary restoration of the sufferer’s voice, compelling its witnesses to see and sense the body differently and, potentially, to retrain their own mode of being.

Finally, as a richly sensory organ that interfaces with both the visceral body, the skin, and the external environment, fascia is the organ best equipped to deal with contingency and being in a threatening, unpredictable world made even more so by fibromyalgia. Dumit & O’Connor (2016, p. 40) suggest fascia models a “thinking in our edges,” a peripheral, tactile intelligence that mimics the aspects of a feminine *mētis* invested not only in cunning, deception, and evasion but also prudence, empathy, and (self-)care. The *mētis* of fibromyalgia aims to reveal to the medical gaze how our bodies are physically random and mechanically disordered, as we unconsciously modify, solidify, or liquefy our fascia and tend to keep our postures and postures-in-action unless forces alter these for us (Myers, 2009). This bodily knowledge suggests that fibromyalgic assessment must be, to some degree, hands-on and felt. If the fibromyalgic patient is to focus medical attention to this end, she must intuitively, creatively perform her pain into visibility that directs the physician to feeling whole possible meridians of referred pain rather than specific sites, thus overcoming the humanitarian/biomedical reluctance to witness pain in treating it. Made visible through masquerade, the *mētis* of fibromyalgia is a lived, embodied, ceaseless effort to “strip the civilized

disguises from pain” (Morris, 1991, p. 118) a finding of ways in a pain-repressed world to feel and express both pain and numbness with contextual overtones that dissolve binaries like stoic/weak, masculine/feminine, caring/apathetic.

This is what the fibromyalgic woman of *mētis* works towards. As Fortunati (2016, n.p.) observes, *mētis* is more culturally instinctive for women, such that women are more likely to possess *phrónesis* when it comes to communication strategies and social masquerade to “make their message incisive.” Managing affects and emotions already inheres in the feminine labor of care, bestowing on women a cunning intuition about others’ emotional wellbeing in the sphere of social reproduction. Women, then, already understand that “emotions work like multipliers of energy”; thus, the fibromyalgic woman grasps without much struggle that emotions place costly demands on energy as well, and can intuit how to coax energy investments out of others around them: for instance, an empathy that quietly insists on touch and human connection, as opposed to the depersonalized tactics of massified healthcare. Ultimately, the scream on palpation is this woman’s pain cunningly made visible, literally restoring her voice and the conditions of her lived experience, offering physicians willing to attend yet another clue in the puzzle of a so-called wastebasket diagnosis, attempting to further the disorder’s acceptance and legitimacy.

The reductive biomedical model of pain asserts that pain is danger. As a chronic pain disorder, fibromyalgia insists that the sufferer replace this meaning with a paradoxical and personal one: “Pain signifies nothing” (Morris, 1998, p. 117). Where acute pain teaches avoidance of the offending stimuli, fibromyalgia instructs its sufferer in rewiring her beliefs about experiencing and appropriately responding to pain. Fibromyalgia is incurable, and, unlike the able-bodied subject, fascia training does not offer a cure so much as a system of management that replaces the biomedical model of pain with a biocultural one that recognizes both body and mind as implicated in sensory processes. This constitutes a management of instinct, a union of intuition and cognition, accepting that pain of varying intensities signifies nothing, but attending closely enough to tell when it does. Like *mētis*, this cannot be taught; it must be learned as bodily knowledge, habituated, like the fascia it seeks to make the visible locus of this form of chronic pain.

## Conclusion

In “The Myth of Sisyphus,” Albert Camus (1955) considers the Greek myth of Sisyphus, whose *mētis* outstripped that of the gods, and who is best known for temporarily rearchitected the laws of mortality by briefly capturing Thanatos and, after his own death, deceiving Hades to revive. For this he is punished with endless labor that knows no culmination. However, Camus considers that the eternal, futile task is not a source of torment for this man of *mētis* but a source of satisfaction and ultimately a reason for resisting. Sisyphus must embrace as a reason for living a consciousness of the absence of remedy for the absurd unfairness of existence, and living for it is synonymous with finding a way out. Selfish a figure as Sisyphus is, we can extract the common from this, just as folkloric Trickster slips the traps set for him not just to escape but to reveal the trap for what it is and preemptively thwart its future iterations, performing what Hyde (2010) calls “dirt work”: moving the taboo exclusions of polite society into the places of its exclusion. In doing so, Trickster seeks to introduce a “third thing” to disturb the webs of signification that create and reinforce the binaries that bind us. By channeling *mētis*, the fibromyalgic patient can transform the eternal, futile

task of daily survival into finding a way out, can become adept at using parts of her body that are invisible to human and mechanical eyes to subtly challenge the efficacy of visual assessment.

Healthcare is a complex of commercial practices that support the project of quantification for massification; fibromyalgia, with its personalized fascia arrangements, regardless of standardized trigger points which already seem arbitrary, inherently resists these practices. To this end, the fetish of the visual in biomedicine is stubbornly persistent, even regarding imaging techniques that are problematic or questionable at best: for instance, the injection of contrast material into joints or bloodstream or the digestive use of nuclear medicine to measure gastric emptying and potential correlations with disorders like fibromyalgia or irritable bowel syndrome; or the metrics offered by wearable technologies that claim to monitor physical fitness or mental acuity, while problematically reducing experience to a biochemical model, and not a biocultural one. Like the lineage of Ouranos, each all-seeing, all-knowing son matched only by Metis, “this eye fucks the world to make techno-monsters” (Haraway, 1988, p. 581) characterized by unregulated, devouring vision. Chronic pain is so resistant to ocularcentric biomedical thinking that effective treatment depends on the physician’s willingness to assess in more ways than one. *Mētis* is perhaps most significantly exhibited in the fibromyalgic subject’s ability to present herself, based on fascia training and interoception, to the medical gaze in ways that align with the biomedical model of pain as treatable and musculoskeletal in origin, but diverge enough to compel physicians to perceive her body differently, necessitating other sensory modes of assessment: dialogue rather than symptom listing or one-sided interrogation; and, notably, palpation of a pressure that potentially inflicts pain, which is anathema to post-anesthetic cultures. The *mētis* of fibromyalgia further acts on language and secondary expressions of pain, awaiting the opportune moment to strategically, cunningly express pain in ways popularly presumed authentic without extending it so long it becomes, *a la Philoctetes*, alienating under the humanitarian sensibility or the biomedical impetus to rehabilitate—to instead show that aurality and a firm touch where touch is not a minor mode of assessment can create a generative connection between bodies, opening new avenues for communication, empathy, potentially affecting the form and space of all bodies involved and qualitatively altering their relations (Manning, 2007).

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