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Destroyed by Madness: Fighting Stigma and Building Empathy through the Narrative
Experience

by

Kelley Gladden Walker

Under the Direction of Audrey Goodman, PhD

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2023

ABSTRACT

This dissertation challenges the stigma of mental illness by analyzing 20th century American life narratives written by persons with mental disorders. Focusing on the writing and lives of Zelda Fitzgerald, Allen Ginsberg, Mary Jane Ward, Kay Redfield Jamison, Meri Nana-Ama Danquah, Tennessee Williams, Elizabeth Wurtzel, Cameron West, and Susanna Kaysen, while applying the theories of Michel Foucault, Erving Goffman, Sigmund Freud, William C. Cockerham, and Otto F. Wahl, I contend mental illness life narratives fight stigmatization by questioning the common stereotypes perpetuated by dominant cultural narratives. Through a historical lens, the project explores a variety of sources from 20th-century American literature with complementary psychological and sociological theories in juxtaposition with my personal experiences of stigma in order to prove how dominant cultural narratives perpetuate the myths of mental illness, how mental illness life narratives raise awareness to social prejudices and encourage empathy within their audiences, and why mental illness life writers demand revisions to popular cultural representations of mental disorders. I argue mental illness life narratives foster understanding and inspire empathy, thus encouraging a social mindset change and an end to the stigma of mental illness.

INDEX WORDS: Mental illness, Life narrative, Stigma, American literature, Identity, Madness, Mental disorder, Zelda Fitzgerald, Allen Ginsberg, Kay Redfield Jamison, Meri Nana-Ama Danquah

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2023

Destroyed by Madness: Fighting Stigma and Building Empathy through the Narrative
Experience

by

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December 2023

DEDICATION

This project is dedicated to my husband, Clinton Walker, and my parents, Tracy and Ted Lawson, for their unconditional love, support, and patience. Thank you for believing in me, even when I doubted myself.

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PREFACE

I keep my sweaty palms facedown against my pants to avoid fidgeting with my fingernails. Psychiatrists always notice behaviors like that—those little nervous habits used to self-soothe. Some of them act as if they're genius sleuths, regular ol' Sherlocks detecting and medicalizing behaviors and emotions to find the underlying culprit and diagnose the patient. My heart palpitates anxiously, echoing loudly in my eardrums. I wonder if the doctor can hear it, too. A tremble faintly vibrates through my body, making my stomach squirm, and I feel nauseated. What will my diagnosis be this time?

Dr. E. sits silently behind his desk, perusing my admissions file and medical history like a fact sheet, checking off the list of my symptoms in his mind, tallying them in accordance with the *Diagnostic Statistical Manual (DSM-5)*, reviewing them like a judge and jury would the evidence in a criminal court trial. When he finally looks across the desk at me for the first time, a knot the size of Texas makes its home in my throat. My mouth is too dry from the psych meds to swallow my anxiety. He has the verdict: *Guilty*—one count of Bipolar I Disorder, one count of Post-Traumatic Stress Disorder, and one count of Generalized Anxiety Disorder.

So, Dr. E. added another diagnosis to my psychiatric rap-sheet—Bipolar I—an upgraded version of my previous diagnosis of depression. It feels strangely relieving to hear it though; finally, a diagnosis that explains all my symptoms, including the terrifying periods of psychosis.

“What do you do for a living?” Dr. E. asks in monotone.

“I’m a student. I just completed my bachelor’s degree two months ago, and I’m supposed to start my master’s program in the fall. My lifelong dream has been to earn a Ph.D. I want to be an English professor.”

He scoffs, “Unfortunately, that will never happen. Not with your disorders. I guarantee if you pursue any more degrees, you will only end up back in the hospital. You won’t be able to succeed in that stressful environment, so you need to reevaluate your life goals now and choose something more realistic. Something that’s *actually* attainable; otherwise, you’re destined to fail.” Glowing in his own self-importance and psychiatric wisdom, he continues, “I’ve worked with numerous bipolar patients, and from all my experience, I promise you, your dream is not going to happen.”

I grow silent, madly debating in my mind if he is right—the seed of doubt now sown. I barely listen to the rest of his words about his prescribed treatment regimen with its list of psychopharmaceuticals I would take, the trial-and-error process of finding the most effective combination of medications, the various types of doctors I would see, and the therapies I must try. He will keep me in the hospital for at least a week, maybe longer, depending on how I respond to his prescriptions. He doesn’t mention the unspoken rules of how to get out of the loony bin, but I have been through this before: (1) Don’t be a problem patient. (2) Follow all the nurses’ rules without rebellion, hesitation, or complaint. (3) Take all my meds without debate, swallow them with water, open my mouth for inspection, and show there is nothing left under my tongue. (4) Attend and participate in all activities, therapies, and groups; don’t be late, unless I’m meeting with my doctor.

After eight days, my status changes from in-patient to out-patient, and I reenter the community with a new social identity—as a bipolar mental patient. After several years of struggling to accept my diagnosis and to reject Dr. E.’s prejudiced limitations for me, now I fight against the dominant cultural narrative that stigmatizes mental illness by analyzing and sharing life narratives about personal experiences of mental disorder. I have faced stigmatizing treatment

not only from doctors but also from bosses, peers, coworkers, and ex-friends. I have learned that sharing my story of mental disorder is always a scary risk; however, sharing personal narratives about mental health issues is one way to build understanding and empathy and to fight the stigmas associated with mental illness.

My experiences with this stigma are what began my desperate pursuit to understand why and how my identity changed once I was diagnosed with bipolar disorder. I began to search for answers. How do other people experience mental disorder? Are my experiences similar? Who contributes to the stigma of mental illness? Would I be shunned by some people forever? And the most difficult question of all: Why? Why did my social identity change overnight in a psychiatric hospital, never to return to my pre-patient identity? Was I not still the same person? After more than a decade of exploring these questions, I now know that the stigma forced upon those considered mentally ill is not medical but social. Moreover, because cultural norms and expectations change over time, when social action and advocacy arise, stigmas can be diminished or even abolished. But where does advocacy begin?

The answer may seem simplistic, but it starts with sharing life narratives about personal experiences of mental disorder and stigmatization. Such autobiographical acts shatter the silence enforced by the stigma's shame and challenge dominant cultural narratives about mental illness. Mental illness life narratives foster understanding about these experiences and raise awareness about the negative effects of stigma. These sites of autobiographical performance are where empathy can develop between the writer/artist and the reader/viewer, and with empathy comes hope for a less prejudiced future and a reduction in the demoralizing stigma attached to mental illness.

1 INTRODUCTION

One significant contribution of mental illness life narratives is their ability to take representations of mental disorder out of the academic jargon-filled theories of psychology and present these experiences in an accessible, colloquial language. By utilizing everyday language and literary tropes, mental illness life narratives humanize portrayals of mental disorder; by doing so, they appeal to the sympathies of broader audiences than medical narratives, such as case studies. Theorizing in overly complex language hinders large-scale understanding about mental disorders because it traps knowledge in a cage only accessible to narrow readerships, i.e., academics or doctors. Nevertheless, one may not fully understand the nuances of this stigma and the historical, cultural movements which underpin it without diving into theory. Therefore, by combining the knowledge acquired from both mental illness life narratives and interdisciplinary theories (historical, psychoanalytical, sociological, and literary), a nuanced enlightenment concerning the plight of mental disorder heightens awareness about the treatment and experiences of those labelled mentally ill. By analyzing how the concept of mental illness and its stigma historically change within Western and American culture, one sees how individual experiences of it also alter, depending on the historical milieu. Mental illness life narratives reveal the underlying social construction of the stigma and encourage readers to collaborate with authors to create an intersubjective interpretation of mental disorder. The intimate author-reader relationship developed through mental illness life narratives inspires readers' empathy and demands a social mind-set change that challenges stereotypes propagandized through dominant cultural myths. Only through a collective empathetic change in Americans' perspectives can the stigma be abolished. Ultimately, I aim to demonstrate that the pathos inherent mental illness life narratives appeals to audiences' sympathy and open-mindedness, and when combined with a

comprehension of the social underpinnings of the dominant stigma myths, the audience can develop empathy towards those labeled as mental ill.

Within this project, I analyze a variety of mental illness life narratives from 20th-century American authors through a historical lens, while incorporating interdisciplinary theories from psychology, sociology, literary criticism, and women's studies. In many ways, Foucauldian theory shapes this project: I rely upon a historical lens to trace the repetition of stereotypical narratives and images of insanity within 20th-century American culture; I analyze how these images and narrative tropes negatively influence the identity formation of those with mental disorders; I argue mental illness life narratives are sites of resistance to stigmatized identity; and following Foucault's concept of the aesthetics of self, I call for the deconstruction and recreation of identity through discourse, thereby fighting the power of the dominant cultural narratives that stigmatize mental illness. I interweave my personal experiences of mental disorder, the life narratives by other authors, biographical materials, and literary theory to create an "autobiocritical" interpretation of the stigma of mental illness. I incorporate my personal experiences within the first and last chapters for a variety of reasons. Firstly, I cannot call others to share their life narratives without demonstrating the courage to share my own. Secondly, I want to establish my credibility on this subject not only from a scholarly perspective but also from a lived experiential perspective. Thirdly, and most importantly, I want to emphasize this social problem continues to affect the present; this is not a dead issue of the past but one stuck in a perpetual present, unless purposefully fought. To this end, using a historical perspective to trace the lineage and effects of this stigma, I demonstrate how the cultural narratives of stigma and their associated tropes repeat throughout 20th-century American culture and bleed into today's. I analyze why individual patients experience stigma, diagnosis, and psychiatric

treatments in disparate yet predictable ways, depending upon social factors like gender, race, sexuality, and socioeconomic status. Moreover, I illustrate the cross-disciplinary benefits of studying mental illness life narratives in a multitude of academic and professional fields, such as psychiatry, criminal justice and law enforcement, social work, education, and literary studies. My target audience is not limited to literary scholars. I seek to reach a wider audience because my ultimate goal is to end this stigma, so I appeal to pathos and empathy by recreating scenes from my own life and those of American authors to bring this issue to life. I mix genres between creative writing, biography, and literary analysis because mental illness as a subject and an experience cannot fit into one genre. Mental illness is messy, terrifying, beautiful, divine, confusing, and unforgettable. How could this fit into one genre alone? Instead, this postmodern, hybrid, outlaw project seeks to spark conversations across a variety of readerships from scholars to clinicians to mental patients to caretakers to the American public. Ending this stigma will take a united force, so here I wave these pages to call forth a wide and diverse audience. Together, as Americans, as human beings, we must join to end this stigma. The first step is understanding mental illness, not from a clinical perspective of diseases and symptoms, but from one focused on the lived, personal experiences of disorder and stigma.

Within the first chapter of this dissertation, I explain how stigmatization negatively affects an individual's ego identity and social identity, and I present the major consequences of the stigma of mental illness for individual patients, such as silencing, social exclusion and isolation, self-shaming and self-harm. In addition, I define four significant stigma myths found within American culture—the myths of contagion, divine madness, personal weakness, and dangerousness; all of these myths combine to promote the concept of Otherness, or that neurodivergent individuals are inherently lesser than neurotypical persons. I argue that identity is

created through language and as such is fictional, as are the myths of stigma, so one way to fight the stigma is also through language, particularly through life narratives. The stigma relies upon the dominant cultural narrative about mental illness to perpetuate stereotypes through common tropes found within cultural artifacts (such as art, literature, film, journalism, and other media), which teach Americans how to think about and how to treat individuals with mental disorders. Therefore, the best way to end the stigma is by writing, reading, and teaching mental illness life narratives because this multifaceted, hybrid genre highlights why stigmatizing stereotypes are harmful and how authors fight to deconstruct their stigmatized identities through language. I illustrate how these stereotypes detrimentally influence individual experiences of mental disorder through the mental illness life narratives and biographies of Ghanaian-American author Meri Nana-Ama Danquah, American psychologist and author Kay Redfield Jamison, American playwright Tennessee Williams and his sister Rose Williams, and American authors F. Scott Fitzgerald and Zelda Fitzgerald. As additional support to my claims, I refer to the theories of Austrian neurologist and psychoanalytic theorist Sigmund Freud, French philosopher and historian Michel Foucault, French psychoanalyst and psychiatrist Jacques Lacan, British-Canadian author and scholar Lisa Appignanesi, Canadian-American sociologist Erving Goffman, American sociologist William C. Cockerham, and American sociologist Thomas J. Scheff.

In the second chapter of this project, I examine how the repetition of stereotypical images and narrative tropes allows the stigma myths to seep into the American popular imagination and how this social learning of the stigma myths affects individual experiences of mental illness. The major problems involved in this social issue are, firstly, that the majority of cultural representations of mental illness within the media are highly prejudiced and sensationalized, and, secondly, that the general public believes these stereotypes portray typical lived experiences of

mental disorder. I argue that the repetition of stigma myths within American cultural artifacts influences what audiences believe about people with mental disorders and that the repetition of bigoted images and narratives reinforce and propagandize the stigma. These claims further support my overarching argument that mental illness life narratives are the best method to fight the stigma and inspire empathy within the audience. I analyze American author Mary Jane Ward's novel *The Snake Pit* and Ukrainian-American filmmaker Anatole Litvak's film adaptation of the novel in order to illuminate how stigma myths, stereotypes, tropes, and images function to "teach" American audiences how a "crazy" person looks and acts. The comparison of the autofictional novel and the film together presents the mainstream understanding of mental illness as well as the consequences of these stigma myths. The significant theorists I use to support these claims are William C. Cockerham, Michel Foucault, Sigmund Freud, Erving Goffman, American historian Troy Rondinone, Thomas J. Scheff, and American author and professor of psychology Otto F. Wahl.

The third chapter of this project is the longest because I compare the individual experiences of stigmatization in the biographies and life narratives of Zelda Fitzgerald and Allen Ginsberg. I argue that social factors, such as gender and the presence of social support, shape the experience of stigmatization, particularly self-stigmatization, and greatly affect how an individual reacts to his or her stigmatized identity. Moreover, analyzing the life narratives of Zelda Fitzgerald and Allen Ginsberg demonstrates why the study of mental illness life narratives is crucial to understand the significant consequences of the stigma, to focus on the individual over the disorder, and to encourage empathy within the audience. I use evidence from the theories of William C. Cockerham, Michel Foucault, Sigmund Freud, Erving Goffman, Scottish psychiatrist R.D. Laing, and Hungarian-American psychiatrist Thomas S. Szasz to support my

claims within this chapter. Part I of Chapter 3 examines Zelda Fitzgerald's life, focusing on how her ego identity and social identity change through her marriage to F. Scott Fitzgerald and her experience of schizophrenia. Zelda's gender restricted her creative and intellectual opportunities and relegated her to a muse, i.e., non-artist. The split between her ego identity as artist and her social identity as muse, ultimately, caused a division in Zelda's psyche, which manifested as schizophrenia. Although Zelda resisted self-stigmatizing at first, once enough significant people in her life labelled her as mentally ill, eventually, she believed them and incorporated the concept of "madwoman" into her ego identity. Because Zelda's social support group insisted on labelling Zelda as a madwoman and coerced her into many psychiatric hospitals, she self-stigmatized for the last 18 years of her life. I include evidence from Zelda's autobiographical novel *Save Me the Waltz*, her collected writings, and letters to Scott; I also utilize F. Scott Fitzgerald's autobiographical novel *Tender is the Night* to portray his perspective on Zelda's mental disorder. In addition, I consult Fitzgerald biographers and scholars Sally Cline, Matthew J. Bruccoli, and Nancy Milford. Part II of Chapter 3 analyzes Allen Ginsberg's experience of mental disorder and stigmatization. First, I examine how witnessing his mother Naomi Ginsberg's experience of mental illness taught young Allen about the consequences of stigmatization and the horrors of experimental psychiatric treatments. I demonstrate how Allen, ultimately, rejected self-stigmatization, even after he went to a psychiatric hospital, because he found support and empathy within his Beatnik social group. Through the Beat Movement and his poetry, Ginsberg fought against the dominant cultural narrative that stigmatizes individuals with mental disorder by blaming the hypocrisies within American culture as the cause for the madness of his generation. Because Ginsberg was an unmarried man, he had greater freedom to avoid institutionalization, until court ordered. Moreover, because the most influential people in his life

never stigmatized him as insane, Ginsberg had the social support to believe in himself and avoid long-term self-stigmatization. I include primary source evidence from Ginsberg's journals, letters, and collected poems, with a close focus on *Howl*. I also cite Ginsberg's biographers Thomas F. Merrill, Jonah Raskin, and Michael Schumacher for additional context. The comparison between Zelda's experience and Allen's highlights how the individual experience of stigmatization varies based on social factors that have nothing to do with the individual's mental disorder. However, the most significant contributor to whether an individual will self-stigmatize or not depends on his social support group—such as a spouse, friends, or family members. One reason teaching mental illness life narratives is important is because they help build understanding and empathy within the American audience, which encourages better support systems for individuals with mental disorders.

Finally, in the fourth and final chapter of this dissertation, I reiterate the consequences of the stigma of mental illness within the individual experience, including social exclusion and isolation, silencing and information management, and avoidance of psychiatric treatment. These social consequences harm both neurodivergent individuals and our American society as a whole. I opine that the major goals of mental illness life narratives are to combat and correct stigma myths, encourage understanding and awareness in the audience, and inspire empathy for those suffering from mental disorders; these goals together work toward a more equitable future for Americans. Life narratives present unique, subjective first-person perspectives; this intimacy invokes pathos and appeals to the audience's emotions by focusing on the individual over the disorder. I argue that through the combined perspectives of mental illness life narratives and psychiatric case studies, a holistic understanding of mental illness emerges. One major problem of learning only from case studies is that the patient becomes silenced and dehumanized to an

object of scientific study, but examining life narratives in conjunction with case studies combats this issue by presenting multiple perspectives on mental disorder. To illustrate the silencing common within case studies, I analyze Sigmund Freud's foundational model *Dora: An Analysis of a Case of Hysteria* to demonstrate how a case study narrative silences the patient in order to prove the doctor's interpretation of her. I, then, conclude that, for effective treatment, a doctor and patient must collaborate to work toward the patient's recovery. Life narratives can help clinicians view the patient as a person capable of participating in his treatment plan. Overall, both perspectives—the doctor's and the patient's—are necessary to comprehend the experience of mental disorder, to humanize the patient, and to support collaborative relationships within treatment and recovery. Next, I interpret the common goals life writers pursue when creating their personal narratives about mental illness. By closely analyzing four memoirs from the American memoir boom of the 1990s, I identify five common goals among mental illness life writers as demonstrated through common narrative strategies, tropes, and literary devices. To this end, I interpret the following four memoirs: Kay Redfield Jamison's *An Unquiet Mind: A Memoir of Moods and Madness*; Susanna Kaysen's *Girl, Interrupted*; Cameron West's *First Person Plural: My Life as a Multiple*; and Elizabeth Wurtzel's *Prozac Nation*. The collective goals of mental illness life writers are: 1) narrative therapy to heal the author's identity, as illustrated through the trope of the living dead metaphor; 2) regaining the author's voice to end silencing and to prove herself a reliable narrator, as demonstrated through moments of awakening and personal redefinitions of her disorder through nature metaphors; 3) ending social isolation, as confirmed through the trope of laying claim; 4) protest through narrative, as evidenced in the criticism of doctors and resisting the traditional Recovery Narrative elicited by doctors; and 5) advocacy and activism, as elucidated within apologies and comparisons to

physical illness. Together, these five goals unite to empower the authors and their readers who also struggle with mental disorders. The major theorists and critics I consult to support these arguments are Sigmund Freud, Troy Rondinone, Otto F. Wahl, and American professor of English Mary Elene Wood.

1.1 Terminology

First, I must explain the hybrid genre I term “mental illness life narratives” because its generic parameters are dynamic and adaptable. When focusing on the value of personal narratives about mental illness, the range of possible texts is broad, spanning multiple genres and mediums, including fiction, nonfiction, poetry, drama, performance arts, music, photography, painting, and emerging online mediums. To lay a foundation for this hybrid genre, first consider the term “life writing” as used by English professor Mary Elene Wood. Exploring first-person accounts by writers with schizophrenia in her book *Life Writing and Schizophrenia: Encounters at the Edge of Meaning* (2013), Wood defines “life writing” as written texts (including “memoir, autobiographical fiction, autobiography, case studies”) that “give shape to the lives and identities of those diagnosed with schizophrenia”; these are “stories...written with deliberation, in an attempt to give written form to life experiences” (1). Notice, this broad term of life writing applies only to written texts; moreover, it may include life writing written by authors other than the patient, as in case studies. Thus, to broaden the types of narrative mediums and to limit the authorship, the term “life narrative” becomes more accurate because this opens the scope of the genre to include non-written texts (such as performance arts, photography, painting, illustration, and film) and narrows the authorship to individuals with mental disorders, eliminating the “as-told-to” narratives written by mental health clinicians, sociologists, and anthropologists (Smith and Watson 4). In the second edition of their foundational text *Reading Autobiography: A Guide*

for Interpreting Life Narratives (2010), American humanities professors Sidonie Smith and Julia Watson argue the term “life narrative” better includes the vast nuances between different subgenres of autobiographical acts. The subgenres of life narratives are multitudinous and fluid; oftentimes, the boundaries between these subgenres overlap, creating generically hybrid narratives. I describe the texts within this project as “mental illness life narratives,” but many of these texts combine a variety of narrative structures and rhetorical purposes found within other subgenres of life narrative. Smith and Watson present numerous subcategories of life narratives that could apply to mental illness life narratives, which they term “narratives of mental breakdown or psychological vulnerability” and “recovery illness narratives” (141). Because the concepts of mental illness and its stigma involve more than breakdown and recovery for many individuals, aspects of other subgenres also characterize the experience of mental disorder and stigmatization. For example, “narratives of trauma and survival” or “narratives of crisis” remake the narrator-as-victim into the narrator-as-survivor through “acts of speaking out,” which allow authors both to present personal testimony of trauma or crisis and to expose the sociocultural institutions that contribute to or are complacent toward such traumas (Smith and Watson 282). “Addiction narratives” (like those told in Alcoholics Anonymous meetings), “conversion narratives” (which focus on a narrator’s radical self-transformation), “autie-biography” (autobiographical acts by people with autism), “scriptology” (narrative therapy), “autopathology” (life narratives about disability that protest cultural stigmas), and “memoir” (which focuses on a narrowed topic or limited period of time from one’s life) could fall under the hybrid genre of mental illness life narratives (Smith and Watson 254, 256, 261, 266, 279). Notice, all these subgenres focus on nonfictional texts. However, other types of life narratives that employ fictionalization or poetic presentations also can fall under the category of mental

illness life narratives. For example, Smith and Watson name the subgenre of autobiographical fiction “autobifictionalography” to emphasize the fictionalization of lived experiences in some texts; think of the Fitzgeralds’ competing autobiofictional novels *Tender is the Night* and *Save Me the Waltz* (258). Fictionalization is a safer way to present discrediting lived experiences while protecting other people involved in the events because the ambiguity of which aspects are fictional or not adds a layer of insulation between the author and the social risks of publicizing a mental illness life narrative. Another subgenre of mental illness life narrative could be “poetic autobiography” if such a text focuses on mental illness, such as Allen Ginsberg’s poems *Kaddish* and *Howl* (Smith and Watson 276). Of course, these games with genre could continue into perpetuity, so I shall apply the term “mental illness life narrative” as the overarching genre for the texts within this project, but keep in mind, this hybrid genre incorporates tropes, narrative structures, and plots from a variety of subgenres.

In consideration of the difference between the terms “mental illness” and “mental disorder,” although the policing of language is ultimately ineffective because merely changing offensive diction does not erase the sentiments supporting it, I do present the terms “mental illness” and “mental disorder” differently and purposefully in this project. I use “mental illness” when analyzing the social stigma of and dominant cultural narratives about mental disorders, as well as when discussing individual confrontations with the stigma. Because the word “illness” inherently implies there is also a “cure,” mental illness does not fairly represent the actual experience of mental disorder. In the context of this project, “mental illness” refers to the myths and stereotyped perceptions about mental disorders caused by the deceptions of stigma. In contrast, I use the term “mental disorder” when discussing neurological experiences of neurodivergence, *not* the myths of mental illness. The word “disorder” better represents the lived experience

because it implies a syndrome without a cure. This is more accurate to the reality of mental disorders because most are either chronic or episodic throughout the patient's life, especially from adolescence onward. In other words, mental disorders cannot be cured but only managed. This key difference between my usage of the terms "mental illness" and "mental disorder" is crucial to understand because a part of the stigma of mental illness is that patients should be able to be cured, so when a patient does not find a "cure" for the mental disorder, the perception is that she is choosing not to get better, which places blame on the sufferer and stereotypes mental disorder as a personal weakness. Thus, in order to support the development of empathy, I will use the terms "mental illness" and "mental disorder" strategically to demonstrate the nuance of stigma. However, using the word "disorder," in itself, is controversial in today's cancel culture. Many may argue that the word "disorder" implies pathology and, thereby, is offensive. Supporters of terms, such as neurodiversity, likely would opine that my use of the word "disorder" contradicts my advocacy because such diction denies that neurological conditions, such as autism or mood disorders, are simply normal variations in the human experience and human genetics. I use the word "disorder" not to reject the truth claims of these arguments that support neurodiversity but to *not deny* the mental distress, medical components, and functional disabilities inherent in the lived experiences of mental disorders.

2 STIGMATIZATION OF IDENTITY THROUGH THE CULTURAL MYTHS OF MENTAL ILLNESS

The aim of my writing is to expose the fictional identity of mental illness, to tear down the “absolute truth” of the dominant cultural narrative, and to resist social regimes of prejudiced myths and hierarchical binaries that only serve to marginalize anyone who does not fit into the imaginary image of “the normal,” which, hint, none of us can. As an American society, we must throw off these ludicrous labels that Western culture attaches to us like barcodes and rewrite the cultural narratives of mental disorder to portray actual lived experiences and disrupt the myths of stigma. Within this chapter, I explain how identity and stigma myths form through language and storytelling, which is why exploring mental illness life narratives is crucial in fighting the stigma. I present four common stigma myths within Western culture and illustrate how these myths affect individual experiences of stigmatization. Overall, this chapter highlights why mental illness life narratives are crucial to write and teach in order to deconstruct the myths of mental illness by challenging common prejudicial stereotypes.

2.1 Identity Formation

In order to understand how stigmatization affects individual experiences of mental disorder, one must comprehend how stigmatization harms a person’s identity. The first thing to know about identity formation is that it is, by nature, fictional. Every human being creates an internalized identity, or ego identity, which one imagines best characterizes his most honest self. This ego identity begins to develop during infancy and continues to transform throughout one’s life, often based on personal experiences, interactions with others, and internalized cultural ideologies. Thus, and one’s identity is not stable nor consistent, but ever in the process of becoming. Additionally, the individual is not the only one who contributes to her identity; one's

cultural environment and the corresponding social mores for that historical milieu encourage, if not enforce, certain identity markers for individuals as a means of social control. Taking this into account, every person has an ego identity and a social identity, which may or may not harmonize with each other. When one's social identity contains aspects which are aberrant to dominant cultural norms, such as mental illness, he becomes marginalized and oppressed, even if his subjective ego identity does not align with his imposed social identity and its corresponding stigma.

2.1.1 Ego Identity

First, one's ego identity begins to form during early childhood development. In his pioneering theory "The Mirror Stage as Formative of the Function of the *I*" (1949), later published in his collection of essays entitled *Ecrits* (1966), notable French psychiatrist Jacques Lacan hypothesizes that the formation of the specular "Ideal-I," or an individual's ego identity, occurs initially from a *meconnaissance*—a misrecognition—of the self during the mirror stage of childhood development, which occurs approximately between the ages of 6-18 months (2). Lacan suggests, "We have only to understand the mirror stage *as an identification*...namely, the transformation that takes place in the subject [i.e., the individual] when he assumes an image" (2). The first part of the mirror stage occurs when the infans (without language) toddler first sees a reflection of himself, whether literally in a mirror or reflective surface or figuratively in a child of similar age; the toddler identifies with this image and assumes it to be his ideal self. In other words, this reflection creates a stable, unified visual image that the toddler perceives as himself through "homeomorphic identification" (Lacan 4). This image by all appearances is both attractive and coordinated (in a motor-sensory configuration), unlike the toddler, who is biologically undeveloped (as a human baby), and thereby uncoordinated (Lacan 3). Thus, the

toddler is drawn to this specular other and associates the image of this other as his “self.” Lacan defines this formative image as “the Ideal-I...in the sense that it will also be the source of secondary identifications, under...the functions of libidinal normalization” (2). This visualized, imaginary self, due to the original *meconnaissance*, is divided and eternally separated from the individual’s real experience of human existence. Lacan sustains:

The important point is that this form situates the agency of the ego, before its social determination, *in a fictional direction*, which will always remain irreducible for the individual alone, or rather, which will only rejoin the coming-into-being of the subject asymptotically, whatever the success of the dialectical syntheses by which he must resolve as I his discordance with his own reality. (2-3; emphasis added)

This initial formation of the specular I, or the individual’s subjective ego identity, effectively creates the sense of a fragmented body within the individual’s Unconscious and constitutes the fragility and fictionality of his ego identity. When the toddler sees his own image, the form is nothing more than a “mirage...given to him only as *Gestalt*,” so the whole, organized, and ideal image seems to be greater than the sum of its parts precisely because it contrasts so alluringly “with the turbulent movements that the subject feels are animating him” (Lacan 3). This overestimation of the Ideal-I creates the sense of a fragmented body; Lacan explains that ultimately:

This *Gestalt*...symbolizes the mental permanence of the I, at the same time as it prefigures its alienating destination; it is still pregnant with the correspondences that unite the I with the statue in which man projects himself, with the phantoms that dominate him, or with the automaton in which, in an ambiguous relation, the world of his own making tends to find completion. (3)

This haunting fragmentation between the real, tangible blood-and-bones individual and his symbolic language-dependent ego identity—which is caused by the original *meconnaissance* through Gestalt that reflects his imaginary ideal image—continues throughout an individual's life in his Unconscious.

Thus, the mirror stage, in which all humans (who *must* fall into language) participate, creates an incongruity in the human experience. Lacan postulates the human experience is separated into a triadic distinction between the real (the tangible physical world), the imaginary (thoughts and images), and the symbolic (language). After a baby falls into language during and after the mirror stage, she no longer feels the undifferentiated wholeness with the real around her and, instead, begins her lifelong separation from the real through her fictional identity, which is formed in her thoughts and symbolically expressed through language. When the toddler sees this little object (the image of her reflection) and finds semblance between herself and the object, psychically she merges with this object/image. Then, after the subject learns to understand language (the symbolic) and to use it, she is never again able to merge with the real (the undifferentiated self); she is literally (by the Letter) barred from the real for the rest of her life. American English professor and critic Calvin Thomas further illuminates this aspect of Lacan's theory of the self-fragmentation resulting from language in his textbook *Ten Lessons in Theory: An Introduction to Theoretical Writing* (2013):

The ecstatic "truth of self-division"...involves the irreducible "splitting of the subject," our unavoidable separation and alienation from ourselves *in language*. Linguistic self-estrangement is unavoidable...because (1), like you, I have no "I" to speak of unless I can speak of it, and (2), I can speak and think of myself only by discursively *splitting* myself in two...on the one hand, into the *subject* who performs the speaking and thinking

and, on the other, into the potentially losable object...of my “own” speech and thought...whenever I put myself into words (as I *must*, if I want to participate in human reality); whenever I say, think, or otherwise mean “I,” I inevitably (albeit unconsciously) end up with more than one “I.” (95-96)

Ultimately, when one considers his identity, he is left only with language to create it and to describe it. One cannot point to something physical to show his identity, nor can he draw it or photograph it. Identity can be formed and discussed only on the symbolic level of human experience. Therefore, in essence, identity is nothing tangible; it is nothing real, in the Lacanian sense of the term. Identity is symbolic and fictional because it can only exist in and be interpreted through language. Thus, identity is anti-physical, or against nature, because in order to have meaning in the symbolic order of existence one’s identity must work against her “real” nature, which existed prior to her induction into language. Therefore, one’s identity is fictional precisely because it can exist only in language, and language imposes the negation or the absence of the “real thing” of which it speaks.

2.1.2 *Social Identity*

Additionally, because humans are conditioned to adhere to cultural expectations and libidinal normalizations, from the mirror stage onward the subject’s ego identity also depends upon others, whether others of semblance or the big, culturally determined, ideal Other, which forms from the dominant narratives of a culture, language, and historical milieu. The big Other represents the cultural ideal—the image of perfection and normality—which society demands individuals emulate in order to be socially accepted. Which specific image of the ideal Other and which corresponding characteristics an individual must follow changes based upon social markers, such as gender, race, nationality, and able-bodiedness. Thus, the mirror stage also

functions as the introduction to a sociocultural image that the individual is supposed to follow to be accepted in society as normal, healthy, and valuable. Of crucial relevance to the study of the experience of mental illness, this sense of a fragmented body (which is initiated during the formation of the ego identity) can transmute into the sense of a fragmented, disconnected identity, especially when one's ego identity does not align with one's social identity. This rift can haunt those who suffer from mental disorders and causes many individuals to create a façade or masked persona when in social situations; through the act of passing, they portray an acceptable virtual social identity to avoid becoming socially discredited. Additionally, for some individuals, the unattainable ideals demanded by the big cultural Other can contribute to mental disorders, including depression, anxiety, and eating disorders. Ultimately, the ideal Other shapes what society accepts and expects, so consequently it also determines how mental illness is perceived, including which behaviors, lifestyles, and beliefs constitute pathological symptoms and psychiatric diagnoses. Highlighting the influence of the ideal Other, Calvin Thomas explains the social implications of the mirror stage:

The mirror functions as a sociocultural “apparatus” that “imposes” and “naturalizes” the vision of an always-already sociocultural subject who had *better* get its act together, who had *better* perform its mimicry correctly, and who had *better* turn out *straight*. For Lacan, the subject's eventual concordance with its “own reality” entails a rather large quantum of fear-based *conformity* with the “pacifying” function of the ego ideal; it involves the coerced internalization of the “appropriate picture,” the successful introjection of the image of the parent of the same sex (who, as “successful” parent or effective “prop,” must be presumed to have turned out “straight” him-or-herself), and a perpetual

identification *with* and docile endorsement *of* all the images of compulsory normativity that a given culture proffers. (102)

With this in mind, individuals must contend with socially imposed images and expectations of conformity in order to be accepted in society; thus, one's identity is socially constructed to such an extent that many theorists linguistically separate an individual's ego identity from her social identity. Moreover, one's ego identity and social identity continue to transform based on social encounters and dominant cultural narratives. To renowned American sociologist Erving Goffman, as he expounds in his influential book *Stigma: Notes on the Management of Spoiled Identity* (1963), the ego identity is an individual's "subjective sense of his own situation in his own continuity and character that an individual comes to obtain as a result of his various social experiences" (105). In other words, one's ego identity is her self-concept. Consequently, in the subjective experience of identity, one's ego identity always is intricately connected to and shaped by her social identity.

In essence, one's social identity depends upon how others perceive him based upon appearance, assumptions, and/or prior knowledge about him. Goffman divides the concept of social identity by differentiating between one's "virtual social identity" and his "actual social identity" (*Stigma* 2). Goffman explains, "society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories" (*Stigma* 2). Thus, an individual automatically receives a social identity based on "normative expectations" and social demands for what that specific individual with her particular combination of social markers is allowed to be (Goffman, *Stigma* 2). In other words, one's social identity relies upon the preconceived, socially appropriate choice of labels with which an individual may identify to be considered "normal." Often, these assumptions germinate from

dominant cultural narratives that reinforce normative expectations as a powerful means of social control. In addition, because appearances are not always reliable, not only does one have an “actual social identity” but also a “virtual social identity,” which represents the presumed social characteristics of an individual (Goffman, *Stigma* 2). For example, when interacting with a stranger, an individual’s *virtual social identity* forms based on appearances and preconceived judgments about that person’s social status, occupation, gender, race, and other noticeable personal attributes, whereas an individual’s *actual social identity* pertains to “the category and attributes he could in fact be proved to possess” (Goffman, *Stigma* 2). A problem arises when one’s actual social identity is culturally less favorable than his virtual social identity. Goffman marks this type of individual as “discreditable” because his differentness is “neither known about by those present nor immediately perceivable” (*Stigma* 4). For instance, because one’s virtual social identity changes based upon the specific people within a particular social situation, if an individual participates in a social situation, which includes only strangers and acquaintances, then she may choose to manage and conceal “undisclosed discrediting information” about her actual social identity by playing the part of her virtual social identity (Goffman, *Stigma* 42). This act of passing occurs when one puts on a socially acceptable mask to conform to a more appealing virtual social identity to order to fit into a particular social group or situation. When one’s actual social identity includes mental illness, Goffman explains, “by intention or in effect the ex-mental patient conceals information about his real social identity, receiving and accepting treatment based on false suppositions concerning himself” because having mental illness as an attribute in one’s social identity inevitably leads to stigmatization (*Stigma* 42). Thus, individuals who have mental disorders must practice information management and, sometimes, perform acts of passing to be accepted in many social situations.

2.2 Stigma, Information Management, and Passing

The stigma of mental illness refers to the prejudices and myths held as truths about individuals with mental disorders by a particular society in a specific historical time, place, and culture. Stigmatization occurs externally from the community, family members, doctors, and even larger social systems, such as in healthcare practices as well as in the penitentiary system. In addition, stigmatization can develop internally within the individual's ego identity; this self-stigmatization, engendered by shame and guilt, also grows from pre-established cultural narratives about mental illness. Many individuals choose to pass as neurotypical because they do not want to be stigmatized. This choice is critical and complicated because once a stigma attaches to someone's social identity it can be difficult, if not impossible, to remove, especially if he internalizes the stigma and adds it to his ego identity. For example, when someone internalizes the stigma, he may say "*I am bipolar*," instead of "*I have bipolar*." By identifying *as* one's diagnosis, an individual internalizes the shame, guilt, and stereotypes reinforced by stigma. Moreover, individuals with mental disorders are conditioned to associate their disorders with their identities, perhaps saying things like, "This is just how I am" or "This is how I've always been." These identifications to being one's mental disorder supports the myths that mental illness is a pervasive personal weakness and/or chosen depravity. In consequence, many individuals neither seek treatment nor support because they identify their mental disorders as an intrinsic characteristic of their self-concept. Consider the following example of a physical illness in contrast: an individual diagnosed with cancer does not say "*I am cancer*"; she would say "*I have cancer*" because cancer does not have the same negative stigma that mental illness does. Furthermore, as a physical illness, individuals with cancer usually seek medical treatment in hopes of recovery. A cancer patient likely does not see his cancer as an essential aspect of his

ego identity, nor do others tend to associate it with his social identity. This demonstrates how the dominant cultural narrative works to shame, silence, and marginalize individuals with mental disorders. In *Stigma*, Goffman elucidates how a discrediting stigma, such as mental illness, becomes attached to an individual's social identity: in social situations, when others discover discrediting evidence of an individual's socially aberrant qualities, which signify him as "a less desirable kind—in the extreme, a person who is quite thoroughly bad, or dangerous, or weak," this individual's social identity becomes stigmatized (2). Goffman explains, once others stigmatize an individual, she is "reduced" from a "whole and usual person to a tainted, discounted one" (2). The labelling of an individual as categorically abnormal is a stigma, "especially when its discrediting effect is very extensive" (Goffman, *Stigma* 3). Moreover, Goffman argues stigma marks "a special discrepancy between virtual and actual social identity," but "not all undesirable attributes are at issue...only those which are incongruous with our stereotype of what a given type of individual should be" (*Stigma* 3). Regarding the stigma of mental illness, the dominant cultural narrative says anyone with mental disorder is "quite thoroughly bad, [and] dangerous, [and] weak" because he cannot control his mind (Goffman, *Stigma* 2). In Western culture after the Enlightenment, the control of one's mind and reason marked the fundamental social qualification to personhood; thus, individuals with mental disorders became discredited outsiders. Because the hierarchy of reason over insanity continues to stigmatize individuals today, many people with mental disorders hide their disabilities. Because society conceptualizes mental illness as disgraceful, the stigma attached to persons with mental disorders effectively "disqualifies" these individuals "from full social acceptance" (Goffman, "Preface," *Stigma*). However, because the stigma relies upon the repetition of prejudiced myths within the dominant cultural narrative, one way to fight it is by replacing

sensationalized, stereotypical myths with patient-written life narratives because patient-authors have first-hand perspectives on the ramifications of the stigma; by presenting autobiographical acts focused on the experience of mental disorder, authors re-humanize themselves and others in this marginalized group, proving neurodivergent individuals are not inherently bad, weak, or dangerous. If the American cultural narrative about mental illness changes from one of stereotypes to one that presents first-person lived experiences of mental disorder, the stigma can be demolished because these sites of autobiographical acts encourage the public to understand that the currently held notions about mental illness are bigoted and sensationalized.

Until the cultural narrative changes, however, individuals with mental disorders must decide if, when, and to whom they will reveal their socially discrediting label. For this reason, information management and passing are common experiences, and many authors present these concepts within their mental illness life narratives because the stigma, and the oppression associated with it, can be extremely damaging to one's social identity, which, in turn, may lead to the loss of employment, friends, or opportunities due to cultural prejudices about mental illness. In her memoir *Willow Weep for Me: A Black Woman's Journey Through Depression* (1998), Ghanaian-American author and journalist Meri Nana-Ama Danquah affirms she hid her depression from others in order to pass as mentally stable: "I prolonged the pain with silence, mostly because I was afraid—of being misunderstood or ostracized, of losing friends, of losing respect" (18). These are common consequences of the stigma because many people believe the cultural myths that claim the mentally ill are weak, dangerous, contagious, and/or malingering. During the beginning of her depression, Danquah believes, as an African-American woman, "clinical depression simply did not exist within the realm of [her] possibilities" due to the myth of strength, which is socially imposed upon Black American women and which Danquah

internalizes, as humans are conditioned to do with mainstream cultural imperatives. She presumes that if she admits to others that she struggles with depression then she will appear weak. She explains how this “illusion of strength” presents another problematic cultural narrative—this time with a racial and gendered focus:

The one myth that I have had to endure my entire life is that of my supposed birthright to strength. Black women are *supposed* to be strong—caretakers, nurturers, healers of other people—any of the twelve dozen variations of Mammy. Emotional hardship is *supposed* to be built into the structure of our lives. It went along with the territory of being both black and female in a society that completely undervalues the lives of black people and regards all women as second-class citizens. It seemed that suffering, for a black woman, was part of the package. Or so I thought. (Danquah 19)

Thus, to portray herself as a “legitimate” Black woman, Danquah silences her depression to feign strength. Obviously, this stereotype is detrimental to Danquah’s mental health because it discourages her from seeking support and treatment. Moreover, this stereotype encourages Danquah to believe that Black women do not (or should not) experience depression because socially they cannot; within the dominant cultural narrative and her conscious thoughts, depression is an illness only afforded to White men and women. As American author, professor, and sociologist Tamara Beauboeuf-LaFontant explains in her cultural critique “‘You Have to Show Strength’: An Exploration of Gender, Race, and Depression” (2007), the projection of strength becomes “a performance and a façade rather than an honest reflection of Black women’s experiences” (32). The myth of strength demands Black women disguise or hide their true emotions when those emotions appear weak, such as suffering, anxiety, or depression. Beauboeuf-LaFontant sustains this myth “encourages Black women to adopt an extensive and

potentially self-negating caretaking role to others” because it reinforces the “assumption that struggle must contextualize and validate Black women’s lives” (32). This socially enforced narrative greatly affects Danquah’s experience because she initially refused to accept the possibility of having depression as a Black woman. In her memoir, Danquah recalls how she created a façade to hide her depression in order to pass as “normal” in social situations:

Depression teaches you the fine art of multiplicity. You become adept at wearing the right mask for the right person on the right occasion. I shut my eyes for a second, inhaled deeply through my nostrils and braced myself like an actor preparing to go onstage. After I opened my eyes, I slid my mouth into a perfect Colgate smile. (77)

Her description of pasting on a socially-acceptable persona tangibly illustrates the performance required in the act of passing. After years of denial, Danquah eventually accepts her diagnosis, and, later encouraged by her editor, she decides to write a book about Black women and depression to challenge dominant cultural myths and to help others who have experienced similar struggles with the stigma of mental illness, especially in combination with racial prejudices within American culture. While writing her book, Danquah spoke about the topic with others. To illustrate how pervasive the myth of strength and the disavowal of Black depression are, Danquah presents numerous conversations she has about depression with both Black people and White people, often highlighting their similar reactions. One vivid example from her memoir occurs at a dinner party. When prompted to talk about her book, stigma slaps Danquah in the face when an older White woman smugly says:

“*Black* women and depression?” The woman threw out sarcastically. “Isn’t that kinda redundant?” The people standing around us exchanged abrasive chuckles. “Don’t get me wrong,” the woman continued...There wasn’t a hint of apology in her voice. “It’s just that

when *black* women start going on Prozac, you know the whole world is falling apart.” I was instantly filled with outrage, anger, and hurt. (19-20)

This dialogue drips with the bigoted clichés that reinforce the stigma of mental illness and the imperative of strength; it also shows how pervasive the stigma is because others in the group chuckle in agreement. Danquah fills with righteous fury only because she has accepted her diagnosis at this point and wants to fight the stigma with her memoir. Unfortunately, many people learn this cultural prejudice, internalize its dominant narrative, and self-stigmatize. When individuals, who are ashamed of their mental disorders, hear conversations like this one, they can become discouraged from seeking medical treatment or support from sympathetic friends and family. This is how the stigma of mental illness silences those who are suffering. Perhaps some of the chuckles at that dinner party were nervous laughter used to conceal someone passing—someone suffering in secret.

Certainly, casual social situations, especially among acquaintances or strangers, often require the act of passing as neurotypical, but the consequences of passing are severe, including isolation, self-doubt and shame. In her memoir *An Unquiet Mind: A Memoir of Moods and Madness* (1995), Dr. Kay Redfield Jamison, Ph.D., a White American psychologist, professor, and author, recalls her experiences of passing in high school: “I have no idea how I managed to pass as normal in school, except that other people are generally caught up in their own lives and seldom notice despair in others if those despairing make an effort to disguise the pain. I made not just an effort, but an enormous effort not to be noticed” (39). Much like Danquah and others who work to pass, Jamison feels compelled to mask her mental distress to avoid being stigmatized. Danquah’s and Jamison’s similar experiences demonstrate that the act of passing as neurotypical occurs across American racial groups. As an adult, Jamison learns passing in the professional

world is almost mandatory if she wants to keep her job. She explains why she struggled with the choice to write a book “that so explicitly describes [her] own attacks of mania, depression, and psychosis, as well as [her] problems acknowledging the need for ongoing medication” because she feared the repercussions to her career; she justifies this fear with the fact that “clinicians have been, for obvious reasons of licensing and hospital privileges, reluctant to make their psychiatric problems known to others” (7). By speaking honestly about her manic-depressive illness (now called bipolar disorder), Jamison risks losing her career, so she delineates why she decided to publish her memoir despite the possible consequences:

I have no idea what the long-term effects of discussing such issues so openly will be on my personal and professional life, but, whatever the consequences, they are bound to be better than continuing to be silent. I am tired of hiding, tired of mispent and knotted energies, tired of the hypocrisy, and tired of acting as though I have something to hide.

One is what one is, and the dishonesty of hiding behind a degree, or a title, or any manner and collection of words, is still exactly that: dishonest. Necessary, perhaps, but dishonest.

I continue to have concerns about my decision to be public about my illness, but one of the advantages of having had manic-depressive illness for more than thirty years is that very little seems insurmountably difficult. (Jamison, *Unquiet Mind* 7-8)

Though wary about sharing her personal experiences, Jamison refuses to participate in passing any longer, so her mental illness life narrative acts as both testimony and protest. Jamison experiences stigma and the loss of relationships after sharing this “discrediting” truth about herself, yet she explains how passing becomes especially burdensome in close relationships and why she desires to be vulnerably honest despite the risks:

After some time, I began to feel the usual discomfort I tend to experience whenever a

certain level of friendship or intimacy has been reached in a relationship and I have not mentioned my illness. It is, after all, not just an illness, but something that affects every aspect of my life: my moods, my temperament, my work, and my reactions to almost everything that comes my way. Not talking about manic-depressive illness, if only to discuss it once, generally consigns a friendship to a certain inevitable level of superficiality. (Jamison, *Unquiet Mind* 200)

The desire for honesty in an intimate friendship is common and sensible. However, others' reactions vary greatly when Jamison admits she has manic-depression: "Despite the fact that most people that I have told have been very understanding—some remarkably so—I remain haunted by those occasions when the response was unkind, condescending, or lacking in even a semblance of empathy" (*Unquiet Mind* 199). She dramatizes negative social responses with an anecdote about a colleague she nicknames Mouseheart, whom she believed was a friend. During a nice dinner at a Malibu restaurant, Jamison tells Mouseheart the secret she has been keeping. She tells him of her manias, depressions, and past suicide attempt. The silence that stretches between them creates a "long, cold wait," which ends when she sees "tears running down his face"; at first, she appreciates his seemingly sympathetic reaction (Jamison, *Unquiet Mind* 200). However, "after wiping away his tears, [he] told [her] that he couldn't believe it. He was, he said, 'deeply disappointed,'" and he criticizes Jamison for what he views as weakness, cowardice, and selfishness, especially pertaining to her suicide attempt (*Unquiet Mind* 200). He accusingly asks her, "Do [you] *really* think that someone with mental illness should be allowed to treat patients?" (Jamison, *Unquiet Mind* 204). Of course, Jamison has questioned this herself, based on internalized stigma, so this enquiry adds another layer of injury. Obviously, this prejudiced, unsympathetic conversation ends their friendship. After many experiences like this, Jamison's

hesitancy to speak about her mental disorder is logical. She rationalizes this tentativeness:

I have been very concerned, perhaps unduly so, with how knowing that I have manic-depressive illness will affect people's perception of who I am and what I do. There's a thin line between what is considered zany and what is thought to be—a ghastly but damning word—"inappropriate," and only a sliverish gap exists between being thought intense, or a bit volatile, and being dismissively labeled "unstable." (Jamison, *Unquiet Mind* 202)

Luckily, Kay Redfield Jamison pushed past her fears and published her memoir; as a result, her openness about her experiences with manic-depression has helped countless people—including the patients she treats in therapy, students in her classroom, readers who relate to her experiences, and those who are unaware of the lived experiences of bipolar disorder. The influence of and reference to *An Unquiet Mind* appears in 21st-century mental illness life narratives, such as *Silver Linings Playbook* (2008) by American author Matthew Quick. In fact, when I first was diagnosed with bipolar disorder, a family friend, who also suffers from the disorder, gave me her copy of *An Unquiet Mind*, and Jamison's narrative not only inspired me to share my story but also helped me believe in myself enough to pursue my own Ph.D. and ignore the stigma-marred advice of my diagnosing psychiatrist. Jamison's bravery in publishing her experiences motivated me to be courageous also; this personal example demonstrates the value of mental illness life narratives for readers.

Subsequently, for the most part, I avoid passing because I desperately want to fight the stigma and to start conversations in hopes of planting seeds of empathy and understanding to foster a space for others like me to know we do not have to suffer alone. However, as a result, my refusal to participate in passing often has been to my own detriment. I have lost jobs and

friends when I share the fact that I have mental disorders, which at times incapacitate my ability to function. One vivid anecdote about the consequences of stigma from my life occurred when I was a senior staff writer for a local magazine, where I had worked as a successful, disciplined employee for over three years. Before I go on, I concede that if I had chosen to participate in passing at this juncture, then I would not have faced the repercussions of my honesty. I understood the risks of disclosing “discrediting” information about myself, but I chose to take the chance anyway in hopes of helping others and of challenging the dominant cultural myths about mental illness. My choice backfired, as I knew it might. This stigmatizing event began when the owner and editor of the magazine gave me an assignment to write a second article about mental illness; I had recently submitted a successful piece about the common misconceptions concerning mental illness in the Clayton County community on the southside of Metro-Atlanta. This article was well-received after publication, so for my next article on the topic, I wrote about my personal experiences with mental disorder and the stigma. The editor accepted my topic proposal, and I began to write. The article was rigorously honest. Though nervous when I submitted it, I was proud of my rhetorical purpose. More than a week passed, and there was no response from my editor; typically, I received feedback on my articles within a few days. When I contacted my boss, she informed me that she would not publish my article because she did not like the content. I was disappointed, but that happens as a writer; not everything one writes is published. However, I did not expect my boss to never give me another assignment, effectively firing me without firing me. This was one of those gut-punch moments. I worked diligently and continuously for this magazine for more than three years, earning promotions quickly and rising from copyeditor to senior writer. Then, because of one soul-baring essay about living with mental disorder, I lost my job. What is worse is that I never was fired,

verbally or in writing; my boss simply never contacted me again. There was no big, dramatic scene with prejudiced dialogue or embarrassing public displays of emotion. There was no explanation, not a single word, just dead silence. Maybe, I should have passed for normal, put on the mask, and written about mental illness from a distanced third-person point-of-view. That would have been easier and safer, and I would have kept my job, which I loved. The thing is I do not want to be ashamed of personal characteristics that are completely out of my control. I cannot control my genetic makeup. I cannot change the fact that I have genes that predispose me to mental disorders. I cannot change the traumatic events from my past that triggered my disorders to manifest. I cannot control others' reactions when I tell them I have mental disorders. What I can control is sharing my story, and in spite of the consequences of stigma, I will not be silent because I do not want others to feel isolated, alone, weak, and broken like I have in my past. If enough people with mental disorders share their life narratives, writers and readers together can dismantle the prevailing stigma myths through an "intersubjective exchange... aimed at producing a shared understanding of the meaning of a life" marred by mental illness (Smith and Watson 16). Because both identity and stigma are created and enforced through language, one powerful weapon against this stigma is also language. Mental illness life narratives demonstrate how dominant cultural myths present sensationalized stereotypes of the mentally ill; moreover, these life narratives encourage audiences' empathy and call for social change.

2.3 The Common Myths of Stigma

Significantly, Western society did not always stigmatize mental disorders; in fact, the stigma myths about mental illness we know today developed only over the last 500 years. According to innovative French historian, philosopher, critic, and activist Michel Foucault in his

groundbreaking book *Madness and Civilization: A History of Insanity in the Age of Reason* (1961), before the 17th century and the Age of Reason, madness had no corresponding stigma because it was considered a common aspect of the human condition; madness was “an undifferentiated experience, a not yet divided experience of division itself” (Foucault ix). There was no “caesura that [established] the distance between reason and non-reason; reason’s subjugation of non-reason, wresting from it its truth as madness, crime, or disease” (Foucault ix-x). Before the Age of Reason, Western culture viewed madness as a necessary human experience for understanding life. However, during and after the Enlightenment, madness became unreason or non-reason, and sanity and insanity became diametrically opposed. Because a lack of reason was nearly sinful during this period, those condemned as insane became stigmatized, confined, and disqualified from the newly Enlightened society. Foucault designates this shift as “the transition from the medieval and humanist experience of madness to our own experience, which confines insanity within mental illness” (“Preface” *Madness and Civilization*). As cultural demands for reason, higher thinking, and control of one’s mind progressed in Western history, the need to confine the mentally disordered became paramount to the appearance of a civilized society. Because individuals with mental disorders were a visual representation of what Western society most feared—the loss of control over one’s mind—the mentally ill became stigmatized outcasts, marginalized to the edges of society, hidden in attics and basements, locked away in asylums, and shipped to other countries. In her literary criticism “Memoirs: Rewriting the Social Construction of Mental Illness” (2009), English professor Elizabeth Young explains the cultural logic behind the stigma of mental illness: “if order is so tenuous, if any mind could lose itself, the social structure itself is vulnerable, and so the dominant culture must reinforce its power and stability by marking any mental illness as individual, aberrant, a crime of which one cannot be

acquitted” (64). By producing the myth that mental illness is a personal weakness, as opposed to a natural human experience, the stigma stains neurodivergent individuals, reducing them to problems to be solved and often forcing them to submit to whichever treatment is most fashionable at the time. To do this, the dominant culture “must reinforce its power and stability” through language by propagandizing narratives which spread its own versions of “truth,” which, in turn, influence expectations for behaviors, values, beliefs, and thoughts within a given culture. In his “Two Lectures” from the collection *Power/Knowledge: Selected Interviews and Other Writings 1972-1977*, Foucault explains how the power of the dominant culture constructs truth through discourse to enforce order and control:

There are manifold relations of power which permeate, characterize and constitute the social body, and these relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse. There can be no possible exercise of power without a certain economy of discourses of truth which operates through and on the basis of this association. We are subjected to the production of truth through power and we cannot exercise power except through the production of truth. (93)

Ultimately, dominant cultural narratives (i.e., “discourses of truth” or “productions of truth” created by those with social power) influence the public to internalize these narratives through repetitive dissemination through all avenues of culture (including discourses of psychology, medicine, mass media, art, and literature). These cultural narratives then affect how individuals view both themselves and the world around them. Importantly, the dominant cultural discourse about mental illness produces numerous myths and stereotypes about the experience of mental illness and those who are labelled as insane, crazy, mental, nuts, loony, schizy, mad, psycho,

cracked, certifiable, kooky, screwy, wacko, bat-shit, funny, off, bananas, unhinged, flipped, neurotic, and hysterical. The stigma, created from these discourses of “truth” (i.e., discourses of power), supports narrow-minded assumptions that people with mental disorders are lesser than neurotypical persons because mentally ill individuals are morally corrupt, deviant, and sexually depraved; unpredictable, violent, and dangerous; unintelligent and biologically inferior; contagious; and/or selfish, attention-seeking, lazy, weak, and malingering. These stereotypes support the idea that mental illness is a constant, pervasive, and persistent state of being, as opposed to occasional or episodic. All these myths combine to place persons with mental disorders on the outside of the community in a state of “Otherness.” Their “uncivilized” mental states bring shame upon their families, and this humiliation is often internalized as self-stigma because these stereotypes are culturally pre-established and constantly reinforced.

2.3.1 Contagion

Let us now consider some of the major stigma myths of mental illness. One of the most notable, long-standing myths corresponds to the idea of contagion, which originates from prehistoric concepts of taboo. According to pioneering Austrian neurologist and creator of psychoanalysis Sigmund Freud in his theoretical text “Totem and Taboo: Some Correspondences between the Psychological Lives of Savages and Neurotics” (1913) as collected in *On Murder, Mourning, and Melancholia* (2005), based on data and observations collected from primitive tribes in Australia, America, and Africa, within prehistoric cultures, a negative taboo and its corresponding mana (i.e., magical energy) were transferable through touch: “certain persons and objects possessed a dangerous power transmitted by contact with the object so charged, almost like a contagion” (26-27). Hence, when something—an object or person—is socially taboo,

anyone who interacts with it becomes contaminated with the taboo himself. Freud clarifies further how the mysterious mana attached to tabooed objects and people is “transmissible”:

The strangest thing about this is probably the fact that anyone violating such a prohibition himself assumes the character of the forbidden object, as though he has absorbed the whole of the dangerous charge. This power, then, attaches to...everything uncanny, such as illness and death, and everything that is connected to them by contagion or dissemination. (“Totem and Taboo” 25; 27)

A tabooed object/person taints whomever comes into direct contact with it through the concept of mana transfer. Moreover, the nature of taboo evokes ambivalent social responses precisely because the mana (magical energy) involved seems both divine and cursed. Whether in a primitive tribe or a civilized society, a tabooed object/person becomes “at once holy, elevated above the ordinary, and at the same time dangerous, unclean and mysterious” (Freud, “Totem and Taboo” 27). For example, in primitive tribes, a corpse may be a tabooed object, so anyone who touches a corpse, in any capacity, would automatically receive the taboo of the object, becoming tabooed himself. This same principle of contagion applies to the stigma of mental illness.

In the 20th century, into the 21st century, the idea of contagion remains one of the most common stigma myths about mental illness; correspondingly, cultural mores encourage the avoidance of those with mental disorders precisely because society views these individuals as dangerous, unclean, and mysterious. As American author and activist Susan Sontag argues in her cultural critique *Illness as Metaphor* (1978), “any disease that is treated as a mystery and acutely enough feared will be felt to be morally, if not literally, contagious...contact with someone afflicted with a disease regarded as a mysterious malevolency inevitably feels like a trespass;

worse, like the violation of a taboo” (6). In the 20th and 21st centuries, most people did not and do not believe that mental disorders are literally contagious; however, the disruptive, strange, and/or anti-social behaviors that persons with disorders may display encourage social distancing from them, as if they were contagious. At the same time, the taboo of mental illness can be alluring because it also represents a state of being that is uncanny, elevated above the ordinary, and sometimes even holy. Of course, variances in behavior caused by different mental disorders contribute to how others perceive this taboo within individuals. For example, an individual with schizophrenia or severe depression may be perceived as dangerous or unclean during a mental health crisis, while an individual in a hypomanic state may seem more intoxicating and alluring.

Consider the example of American playwright Tennessee Williams’ hypochondria in comparison to his addictions and severe depression. According to biographers Richard F. Leavitt and W. Kenneth Holditch in *The World of Tennessee Williams* (1978), Williams possessed an “accustomed tendency toward hypochondria,” which manifested itself numerous times throughout his life. For instance, according to Williams’ *Memoirs* (1975), in the spring of 1934, he experienced the onset of what he would later term his “cardiac neurosis”; he convinced himself he was having a heart attack or stroke and checked himself into a hospital (42). The doctor there diagnosed Tennessee with high-blood pressure and “a heart defect of unspecified nature” (Williams, *Memoirs* 39). However, both physical symptoms were likely the result of anxiety and panic attacks, exacerbated by his hypochondria. Not long after, Williams believed he was having another heart attack for which he stayed in the hospital approximately ten days (39). His hypochondria, rooted in anxiety, often led Williams to check himself into hospitals for physical ailments and to elect for surgeries, sometimes unnecessarily. Notably, Tennessee’s hypochondria does not drive others away from him, and he is able to write successfully without

it significantly affecting his work. For example, in 1946 while traveling from New Orleans to New Mexico to visit friends, Williams' appendix burst. After a seven-hour surgery, Tennessee awoke with a belief in his imminent death; according to his *Memoirs*, "it marked the beginning of about three years in which I thought I was a dying man" (Williams 104). He believed wholeheartedly that he "was dying of pancreatic cancer" (Williams 110). During these three years of intense hypochondria, Williams produced three full-length plays—*A Streetcar Named Desire* (1947), *Stairs to the Roof* (1947), *Summer and Smoke* (1948)—and wrote 14 one-act plays. He also had successful relationships with his friends, and in 1947 he met the love of his life, Frank Merlo, with whom he shared an intimate 14-year relationship. Others viewed Tennessee's hypochondria as eccentric but not dangerous; this disorder was less tabooed because it posed no obvious threat to others and did not negatively affect his work.

In sharp contrast, during the late 1950s and 1960s, Williams' addictions to drugs, alcohol, and sex were extremely taboo and created nearly insurmountable problems in his relationships, especially with Frank Merlo. In his *Memoirs*, Tennessee recalls feeling contagious both during this period of severe addiction, which ended his romantic relationship with Frank Merlo, and during his severe depression which followed Merlo's death in 1963: "It is strange how alone you are at times of great personal crisis. Strange is too convenient a term, and too euphemistic. The hard and cold fact of the matter is that nearly everyone who knows you draws back from you as if you bore some terrible contagion" (202-203). Williams consistently tried to outrun feelings of loneliness throughout his life, so despite their break-up, he was never far away from Merlo. Once he learned of Merlo's lung cancer, Williams moved Merlo into his home to take care of him; he recalls his precarious moods during Merlo's illness and after his death: "As long as Frank was well, I was happy. He had a gift for creating a life and, when he ceased to be alive, I couldn't

create a life for myself. So I went into a seven-year depression” (*Memoirs* 194). To cope with this depression, Williams continued drinking excessively, taking Seconals, and traveling from New York to Key West to New Orleans in attempts to escape his despair, but his bizarre behaviors, unpredictable outbursts, and despondency caused most people to avoid Williams altogether during this time, socially distancing from him as if he was figuratively contagious because his mental illness “contaminated” anyone around him through his cruel words, destructive actions, and despondency towards his friends and loved ones. According to Leavitt and Holditch, by 1969, Tennessee’s brother Dakin and his mother Edwina “managed to talk him into entering Barnes Hospital. Once he was there, they signed a furious Williams into [an involuntary] confinement which lasted three months...something he had always dreaded throughout his life” (49). Understandably, his family worried he would die from a drug overdose and believed his hospitalization was critical. Williams’ anger toward his mother and brother after his confinement took time to ease. During his severe depression, Williams pushed away numerous friends and family members. For example, as Leavitt and Holditch illustrate, “Another unfortunate circumstance that developed from this dark period in his life was his final separation from Audrey Wood, who had been his agent for nearly thirty-two years” (49). Williams fired Wood during his depression, and his pride kept him from rehiring her after he recovered. Obviously, the behaviors and symptoms associated with his depression and addictions were the most tabooed and the most problematic for Williams’ social relationships, in comparison to his hypochondria. Although not viewed as literally contagious, his addiction and depression still drove people away as if he were a leper; most of his friends and colleagues disappeared from his life during this difficult time, and eventually, his family involuntarily confined him in a psychiatric ward until he recovered.

Next, consider the complexity of the contagion taboo in American author F. Scott Fitzgerald's experience with bipolar disorder, then referred to as manic depression. According to his personal essay "Early Success" (1937), Fitzgerald completed his first novel during "one desolate spring" of heartbreak; Zelda Sayre had ended their courtship, at the behest of her parents, due to Fitzgerald's lack of financial security and professional prospects (85). During this period of desperation and sadness, he went "home to St. Paul to 'finish a novel,'" working constantly to finish *This Side of Paradise* (Fitzgerald, "Early Success" 85). In "Early Success," he remembers believing, "if I stopped working to finish the novel, I lost the girl" (Fitzgerald 85). So, Scott wrote feverishly, perhaps in a mixed mood state with elements of both depression and mania. Then, with the publication of *This Side of Paradise*, Fitzgerald found himself suddenly catapulted into fame and success; he was experiencing his dream life—marrying Zelda, becoming a professional writer, and making significant money from his work. Fitzgerald chronicles, "All in three days I got married and the presses were pounding out *This Side of Paradise*" ("Early Success" 88). Fitzgerald recalls his emotions and moods during this period in his third personal essay "Handle with Care" from *The Crack-Up* series (1936):

My own happiness...often approached such an ecstasy that I could not share it even with the person dearest to me...And I think that my happiness, or talent for self-delusion or what you will, was an exception. It was not the natural thing but the unnatural—unnatural as the Boom; and my recent experience parallels the wave of despair that swept the nation when the Boom was over. (84)

The ecstatic "boom" of Fitzgerald's mood reflects the hypomanic and manic states of bipolar disorder. This "unnatural" happiness became as intoxicating to Fitzgerald as it did to those who attended Scott's and Zelda's lavish, paparazzi-worthy parties. Indeed, Scott must have seemed

and felt “elevated above the ordinary” for achieving such heights of literary success during his 20s (Freud, “Totem and Taboo” 27). However, for his ego identity, success as a young man would prove detrimental. In “Early Success,” he explains:

Premature success gives one an almost mystical conception of destiny as opposed to willpower—at its worst the Napoleonic delusion. The man who arrives young believes that he exercises his will because his star is shining. The man who only asserts himself at 30 has a balanced idea of what willpower and fate have each contributed, the one who gets there at 40 is liable to put the emphasis on will alone. This comes out when the storms strike your craft. The compensation of a very early success is a conviction that life is a romantic matter. (Fitzgerald 89)

Here, Fitzgerald indirectly admits, when he was in his 20s, he believed in his own romantic, mystical, and holy destiny, which may “at its worst” have been “the Napoleonic delusion.” Such delusions of grandeur are common during the hypomanic and manic states of bipolar disorder, which is likely what Scott experienced during this period. The severest symptoms associated with mania often are not present during hypomania, which is a preliminary, less extreme version of mania. Likely, Fitzgerald was hypomanic while throwing his Gatsby-esque parties, and others flocked to this type of energy and to Fitzgerald—their confident, friendly, generous host. After his sorrowful spring and his almost instant success, Fitzgerald’s mood ricocheted from depression through hypomania toward mania once the sources of his depression—the loss of his relationship with Zelda and his amateurism in the literary world—suddenly vanished. He explains, “with [*This Side of Paradise*’s] publication I had reached a stage of manic depressive insanity. Rage and bliss alternated hour by hour” (“Early Success” 88). The mercurial changes in mood between exuberant joy and dark fury is a common feature of mania. When Fitzgerald’s

mood was blissful and grandiose, others thronged to him and his extravagant lifestyle; however, when his mood darkened into manic rage or severe depression, others avoided him. In other words, sometimes Scott Fitzgerald seemed taboo in an alluringly uncanny and charismatic way; while at other times, he seemed diseased, dangerous, and possibly contagious. When Fitzgerald drank excessively or when his anger flared unpredictably, many people saw him as “dangerous, unclean, or mysterious” (Freud, “Totem and Taboo” 27). Scott recalls others’ reactions to his mercurial moods: “A lot of people thought [the manic depression] was a fake, and perhaps it was, and a lot of others thought it was a lie, which it was not” (Fitzgerald, “Early Success” 88). Fitzgerald’s experience with the stigma of mental illness as contagious illustrates how the taboo of mental illness can be attractively unnatural and above-the-ordinary at times and seemingly dangerous or unclean at other times, often depending upon how socially excusable his behaviors were. Thus, when Fitzgerald acted too blissfully or overly generously with his wealth, he was not ostracized but forgiven for his artistic eccentricities and grandiose ideals; however, when his moods sunk into depressive episodes or rageful manias, or when he drank too much alcohol, which sometimes resulted in his arrest, Fitzgerald became negatively tabooed and ostracized. When analyzing F. Scott Fitzgerald’s life, what becomes clear is the ambivalence involved in his experience of stigma—sometimes his eccentricities attracted others, but at other times, his tabooed behaviors and moods repulsed people.

Within mental illness life narratives, many common tropes demonstrate the persistence of stigma myths within American history and culture. Some of the typical tropes that emphasize the stereotype of contagion include character portrayals of a nurse-gone-mad, settings with physical and social barriers, and allusions to the Ship of Fools. Because I discuss these tropes in greater detail later in this project, I only include a brief explanation here. The character of the “nurse-

gone-mad” within mental illness life narratives occurs often. For example, in Mary Jane Ward’s autobiographical novel *The Snake Pit* (1946), one caring nurse, Miss Sommerville, begins her career at Juniper Hill State Hospital with great dedication and personal care for her patients. However, her friendly relationships and close proximity to mental patients, eventually, contaminates Nurse Sommerville with insanity. By the end of the novel, Miss Sommerville is a permanent patient of Juniper Hill. This stock character appears in many texts about mental illness.

In addition, settings which present impermeable physical and social boundaries are another repeated trope within mental illness life narratives. Think about any film or text you have encountered about mental hospitals. The physical settings often contain gothic features, such as a prison-like building in an inescapable, remote destination, surrounded by fences, forests, cliffs, or water. The physical barriers exist inside the mental hospital setting as well, including locked wards, glassed-in nurses’ stations, and white rooms (solitary confinement). These physical barriers “protect” the outside community from the “contagious” mental patients. The social boundaries within mental hospitals are less visible, but they exist under the authoritative control of medical staff, who tell the patients where to go, when they can smoke cigarettes or use the restrooms, and with whom they may socialize via ward assignments. Narratives about mental illness almost universally include these setting elements because these restrictive boundaries visually mark the difference between mental patients and non-patients, which implies the concept of contagion as well as dangerousness. The myth of contagion opines the mentally ill must be separated from the sane for the welfare of a civilized community.

Finally, allusions to the Ship of Fools occur in many mental illness life narratives because this trope is based in historical fact. In the groundbreaking text *History of Madness* (1961),

French historian and theorist Michel Foucault explains the image of the *Narrenschiff* (Ship of Fools) became commonplace within Renaissance as a literary device, but historically, these ships existed to exile mad people from Enlightened societies (9). Local government officials would gather mad persons from the streets and pay merchants to take them by ship to other countries. Before the Great Confinement of the 17th century when mad persons were confined vastly to asylums, the social ostracism of the mad occurred through relocation to different lands (Foucault, *History of Madness* 9). The Ship of Fools continues to be a literary trope in 20th-century American mental illness life narratives. For instance, in the autofictional novel *One Flew Over the Cuckoo's Nest* (1963) by Ken Kesey, as well as its film adaptation (1975) by director Milos Forman, one scene satirically alludes to the Ship of Fools when protagonist Randle Patrick McMurphy organizes a deep-sea fishing trip for him and the other patients. Within this scene, especially in the film portrayal, the image of the men on the boat resembles the painting *The Ship of Fools* (circa 1490-1500 ce) by Dutch painter Hieronymus Bosch (see Figures 1 and 2). The repetition of these three tropes underlines the cultural power and historical endurance of the stigmas about mental illness, such as this myth of contagion.



Figure 1: Ship of Fools (c. 1500) by H. Bosch.



Figure 2: Cast of One Flew Over the Cuckoo's Nest during the boat scene.

2.3.2 *Divine Madness*

Considering the ambivalence inherently involved in cultural taboos, one can understand why some stereotypes about mental illness could be considered positive. For instance, one positive stereotype is that some people with mental disorders are extraordinarily creative artists, geniuses, and/or visionaries; this myth relates to Freud's explanation of taboo as something divine and "elevated above the ordinary" ("Totem and Taboo" 27). This myth supports the concept that divine madness or artistic madness is valuable and a worthwhile trade for one's mental stability because mental disorder becomes a source of inspiration. In her historical analysis of "mad artists" entitled *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* (1993), Kay Redfield Jamison explains this particular cultural narrative about mental illness, specifically as it relates to manic depression (but this also may be applicable to other mental disorders like schizophrenia and autism), by tracing it back to ancient mythology:

A possible link between madness and genius is one of the oldest and most persistent of cultural notions; it is also one of the most controversial. An intimate relationship between the ancient gods, madness, and the creators was described in pre-Grecian myths, most dramatically in the Dionysian struggles between violence and creation, and madness and reason. Dionysus, son of Zeus and a mortal mother, was afflicted with madness while young and episodically subject to both great ecstasies and suffering. As the god of wine, and perhaps hallucinogenic mushrooms as well, Dionysus induced frenzied ecstasies, madness, and savage brutality in those around him. The rituals of worship set up in his honor came to symbolize the emergence of new life and creation from chaos, brutality, and destruction. Renewed vitality, restored sanity, gifts of prophecy, and creative

inspiration often followed the violent, Dionysian blood feasts (which frequently involved the dismemberment of both animals and humans). (50)

Many significant themes about mental illness emerge from the myth of Dionysus. First, consider the context of Dionysus' creation. According to the *Encyclopaedia Britannica*, the sexual relationship between Zeus and Semele, which results in the conception of Dionysus, enrages Zeus' wife, Hera, who devises a scheme to kill Semele by tricking her into viewing Zeus in his true godly form; ultimately, the sight of Zeus in divine form causes Semele to die ("Semele"). Thus, Dionysus becomes motherless before he is even born; Zeus saves him from Semele's womb as she dies and grows the baby in his own thigh until birth ("Semele"). In this way, the myth of Dionysus, an immortal god himself, intimately intertwines immortality, genius, and divine creation with death, chaos, brutality, and madness. Significantly, some of the most influential thinkers in ancient Greece—Socrates, Plato, and later Aristotle—believed madness could be a gift from the gods (Jamison, *Touched with Fire* 51). As Jamison summarizes, Socrates and his young pupil Plato espoused that madness "encompassed a wide range of states of thought and emotion, not just psychosis, but the emphasis clearly was upon a profoundly altered state of consciousness and feeling" (*Touched with Fire* 51). Much like Freud's theory about taboo, these "profoundly altered [states] of consciousness and feeling" become "at once holy [and] elevated above the ordinary" because they allow the individual's understanding of the universe and human experience to expand beyond conventional societal beliefs ("Totem and Taboo" 27). One must concede that there may be some truth in this belief; mental disorder does allow an individual to view the world in an extra-ordinary way—one that is nontypical and possibly even visionary.

This concept of divine madness reappears throughout Western history and literature; it begins in ancient history, lingers through the Age of Reason, becomes exalted by the 19th-century Romantics, reemerges during the mid-20th century's Anti-psychiatry Movement, and remains a popular belief in the 21st century. Reflect upon some of the common examples of exalted artists and genius visionaries with known mental disorders: Michelangelo, Vincent Van Gogh, Lord Byron, Ludwig Beethoven, Winston Churchill, Isaac Newton, Abraham Lincoln, Ernest Hemingway, F. Scott Fitzgerald, Stephen Nash, Sylvia Plath, and Virginia Woolf. Although these historical figures are legendary for their contributions to culture and civilization, the positive stereotypes associated with these figures' mental disorders are both romanticized and oppressive. The notion of divine, creative, or genius madness denies the harsh struggles and debilitating realities of living with a mental disorder, which affects personal functioning, productivity, and cognition. Moreover, this stereotype diminishes an individual's talent and participation in his own creations by attributing his merited accomplishments to divine inspiration. Additionally, this sensationalized view of mental illness influences individuals to avoid treatment because they believe medical intervention will impede their creativity. For example, according to American Fitzgerald scholar James L. W. West III in his critical interpretation "F. Scott Fitzgerald and American Psychiatry: A New Letter" (2011), Fitzgerald refused to go to a psychiatrist, even during his worst episodes of mental disorder, because he thought "his literary talent was a natural gift and that an overly close analysis of his inner psychology would short-circuit his creative apparatus. Even in 1936, suffering from discouragement and depression, Fitzgerald remained arrogant about his intellect and his ability to write" (64). After *The Crack-Up* essays appeared in *Esquire* magazine, Fitzgerald received a multitude of letters from fans, friends, and other writers. In response to one letter from fan Joan

Tyson, who expressed concern for Fitzgerald's mental health and suggested he see a psychiatrist, Scott strikes out like a viper in prideful defense of his own genius, despite his disordered mental state. Fitzgerald authorizes his credibility and superior comprehension of mental illness by referring to his conversations with influential psychiatrists (including as Eugen Bleuler, Auguste Forel, Carl Jung, and Adolph Myer) concerning Zelda's schizophrenia; further, he justifies his credibility with the extensive research of psychiatry which he conducted to compose *Tender is the Night*, his autobiographical novel which explores his and Zelda's experiences of her schizophrenia (J. West, "A New Letter" 62). Through feigned graciousness, he scoffs at the mental prowess of psychiatrists in his letter to Joan Tyson:

I don't want to minimize my respect for any of these [previously mentioned psychiatrists] by saying this: but the fact remains that I never even faintly considered putting the high organized thing which I will refer to as my talent into *their* hands. I would never consider trusting myself to what passes for psychology-psychiatry in this country. How could someone not up to your *ankles* in intelligence + character help you.

By some miracle? Some act of God? (J. West, "A New Letter" 62)

Although Scott insists on Zelda's psychiatric treatment, his own mind (which is equally plagued by mental disorder) is too "holy" and too "elevated above the ordinary" for psychiatry to understand or accurately analyze. Because Fitzgerald believed in the "shining star" of his creative genius as if it were mystically destined or divinely gifted, he refused psychiatric treatment for his manic-depression and alcoholism. Fitzgerald was not alone in his refusal to try the new "talking cure"; in fact, his hostility toward psychoanalysis represented a new fear experienced by many 20th-century artists and writers. In her historical critique *Sad, Mad, and Bad: Women and The Mind-Doctors from 1800* (2007), British-Canadian author and activist Lisa

Appignanesi notes “the twentieth-century artist’s perennial fear [was] that the insights garnered during madness were somehow related to literary talent and might be disturbed by psychoanalysis” (240). This fear is not completely unfounded. Much can be learned from the experience of mental disorder, including gaining new perspectives on oneself, God, and/or human existence and developing empathy toward others’ suffering. However, psychoanalysis does not necessarily destroy one’s creativity and talent, but the concept of divine madness discourages many people, especially artists, from seeking treatment for fear of losing their creativity.

Additionally problematic, this romantic ideal, historically, only applies to White men with mental disorders, and on rare occasions to White women, but never to authors from marginalized racial groups. For example, despite her creative talents in dance, fine art, and literary creation, others never labelled Zelda Fitzgerald’s mental disorder as divine or artistic. Because her talents were not exalted like her husband’s and because she was a woman, not only was Zelda submitted to psychoanalysis but, eventually, was confined to various sanitariums until her untimely death in a hospital fire. Equally important, particularly in Western culture, this concept of divine madness almost never applies to individuals from marginalized races. In *Willow Weep for Me*, Meri Nana-Ama Danquah emphasizes how the stigma of mental illness differs based on race and gender:

Stereotypes and clichés about mental illness are as pervasive as those about race...the mental illness that affects white men is often characterized, if not glamorized, as a sign of genius, a burden of cerebral superiority, artistic eccentricity—as if their depression is somehow heroic. White women who suffer from mental illness are depicted as idle, spoiled, or just plain hysterical. Black men are demonized and pathologized. Black

women with psychological problems are certainly not seen as geniuses; we are generally not labelled “hysterical” or “eccentric” or even “pathological.” When a black woman suffers from a mental disorder, the overwhelming opinion is that she is weak. And weakness in black women is intolerable. (20)

Noticeably, particularly in America, any positive clichés about mental illness are reserved mostly for White men. However, it is important to remember that in the 20th century this one positive stereotype in the collection of all the stigma myths rarely ever applies to anyone at all; most individuals suffering from mental disorders will never be labelled as genius or divinely inspired, no matter their race or gender.

The large assortment of negative aspects from stigma overwhelming overshadows this concept of divine madness; nevertheless, this myth often appears within mental illness life narratives. Sometimes, authors directly state their ideas about this stereotype, while others insert it through the trope of laying claim or through scenes of divine communication. Laying claim occurs when an author refers to famous, accomplished persons who share the same or a similar diagnosis. For example, Kay Redfield Jamison lays claim to this positive stereotype through her exploration of numerous famous artists with manic-depression, including Lord Byron, Robert Lowell, F. Scott Fitzgerald, and Virginia Woolf. By uplifting the extraordinary accomplishments of a select few, laying claim invokes ethos by encouraging the audiences’ trust in the capability of individuals with mental disorders.

Additionally, some mental illness life narratives include scenes of divine communication, during which the narrated I (the protagonist of the life narrative) receives divine inspiration and/or gifts of prophesy during a state of altered consciousness. Allen Ginsberg writes extensively about his prophetic experiences, which directed him toward his purpose in life and a

transcendental understanding of Eternity. Zelda Fitzgerald had moments of prophesy from which she accurately predicted the future on several occasions. Although this concept of divine madness has problematic aspects, it recalls a time in the distant past when madness was valued; for example, Socrates often experienced trance-states during which he heard and saw directions from the divine. Importantly, the historical perseverance of this stereotype highlights the complicated social ambivalences about the topic of mental illness.

2.3.3 *Personal Weakness*

Another common aspect of the stigma of mental illness promotes the narrative that mentally ill individuals are personally and morally weak. Part of this stems from the false idea that mental illnesses are curable, which insinuates that individuals who are not healed are malingering and choosing to stay ill or are too weak-willed to overcome their mental illness. Other contributing factors to this stereotype include the American Eugenics Movement, which promotes Social Darwinism, and Christianity-based notions of moral depravity and sin. Moreover, this component of the dominant cultural narrative supports the social control of individuals deemed mentally ill through marginalization, sterilization, and/or institutionalization. First, one must consider the concept of malingering to understand why stigma narratives about mental illness include the concept of personal weakness. In fact, this particular myth is what Sigmund Freud sought to fight when he created the field of modern psychology. Before Jean-Martin Charcot's work with the hysterics at the Salpêtrière hospital in the late 19th century, physicians considered hysterical individuals to be malingerers. If no obvious physical disease could be identified as the source of the symptoms, these individuals were faking it, according to many leading doctors of the 19th century. Given the prominent medical opinions on hysteria during his time, "it is to Charcot's credit that he did not treat the young women who came to him

with a wide range of florid symptoms either as malingerers or as posturers,” posits Lisa Appignanesi (145). Charcot believed hysteria was a real illness, and he did not believe the hysterical patients he treated were pretending. An influential teacher of Sigmund Freud, Charcot viewed “hysteria as a genuine illness which had a neurological basis in a hereditary degeneration of the nervous system. Its status as a disease was provable by the very fact that it had a clinical pattern...and could be *relieved*...if not *cured*, which was the case for most neurological illnesses” (Appignanesi 145). Beneficially, Charcot’s view of hysteria as a legitimate disease made room for Freud’s birth to modern psychology. At the same time, Charcot’s presumption of cures for mental disorders backfired when individuals were not cured because, then, the question of malingering arose again. Most important to take away from Charcot’s and later Freud’s work is “the underlying logic of psychological distress finding itself converted into bodily symptoms” (Appignanesi 140). This logic becomes the basis for Freudian psychology. However, the pervasiveness of the concept of malingering appears within the dominant cultural narrative about mental illness and remains part of public opinion throughout the 20th century. Malingering (i.e., pretending to be mentally ill for personal gain, such as sympathy or time in bed) contributes to the stereotype of mental illness as personal weakness because it accuses the sick individual of moral degeneracy and insinuates that individuals with mental disorders are morally weak, sinful, and lazy.

Secondly, some Christian beliefs about moral deviancy and sin support myths of mental illness as a moral weakness. As 19th-century Victorian ideals for morality bled into the 20th century, mental illness became associated with sin, moral degeneracy, poor work-ethic, and sexual deviancy. As Appignanesi explains, American culture equated mental breakdowns to sinful weakness based upon “Protestant notions of willpower and duty”:

Just as bankruptcy was a form of sin in the public economic domain, so in the private sphere excessive expenditure which led to breakdown of the nervous system or to madness was tainted, and understood not only as physically depleting but as morally reprehensible. (104)

Accordingly, sinful activities (such as sexual immorality, masturbation, gambling, or alcohol abuse) lead to mental and physical corruption (Appignanesi 104). Ultimately, in Protestant tradition, “excess was an abandonment of willpower,” and madness was the consequence (Appignanesi 104). In other words, the individual suffering from mental disorder was to blame for his own anguish because he must have sinned excessively to deserve such a punishment. Additionally, Protestantism promotes the idea that with a diligent work-ethic and strong willpower through faith, an individual can overcome any obstacle when aided by the strength of God. Therefore, if an individual has a mental disorder, the dominant cultural narrative suggests that she lacks both faith and moral strength. Furthermore, when the 20th century began, sexuality became increasingly problematic because mind doctors (influenced by Christian ideals) pathologized non-reproductive sex. Moreover, as Foucault points out in *History of Madness*, 20th-century psychology and psychoanalysis theorized that all mental illness arose from conflicted sexuality, such as homosexuality, prostitution, and other culturally-determined sexual debaucheries (88-89). Sexual deviancy (whether repressed and unconscious or active and conscious) automatically signaled mental illness and moral degeneracy to psychiatrists and the public. Foucault explains this reasoning by emphasizing the social demand for “family morality,” which places one’s obligations to the family, including sexual reproduction, as tantamount to health and sanity (*History of Madness* 89). The ideology of family morality especially pathologized homosexuality, masturbation, and prostitution. Any excessive sexuality, especially

in women and children, endangered the family and its future. Appignanesi clarifies, in the 20th century, sexuality becomes entangled with how “the Western World made sense of health and happiness, identity and destiny. It becomes a key indicator of the kind of individual one is, normal or perverted, sane or mad” (182). In this way, one’s sexuality indicated whether others labelled that individual as sane or mentally ill, as furthering the family lineage or sinfully wasting one’s reproductive potential. In summary, influenced by Christian morality and swayed by Freudian theories of repressed sexual drives, mental illness became associated with sinful immorality and deviant sexuality.

To illustrate this, the experience of Rose Isabel Williams, Tennessee Williams’ sister, emphasizes the tragic consequences of this stigma in 20th-century America. The Williams household was not a particularly warm environment. The father, Cornelius Coffin Williams, was a frightening alcoholic, often provoked to a mixture of anger and melancholy. The mother, Edwina Estelle Williams, practiced a puritanical Christianity, the principles of which she demanded be upheld, especially by her daughter Rose. Predictably, the parents’ relationship was hostile. Cornelius’ cavalier behavior and excessive drinking provoked Edwina’s disapproval, disappointment, and self-pity, and they often had heated arguments as their ideals clashed. Thus, unhappiness grew like weeds in the Williams’ home, pushing the family members apart and strangling the love that should have been there. This family dynamic—the discord between puritanical mandates and pleasure-seeking instincts—becomes a recurring conflict within many of Tennessee Williams’ works, including *The Glass Menagerie* (1944), an autobiographical play based on the family’s tense home environment and Rose’s descent into madness. As biographers Richard F. Leavitt and W. Kenneth Holditch accentuate:

Basic to the work of Tennessee Williams was the confusion which resulted from the clash between the repressiveness of Southern Calvinism with its flesh-denying attitude on the one hand and on the other the hedonism of the Romantic Cavaliers: flesh denied becomes flesh perverted. The playwright's enormous sense of guilt, the result of his own youthful rebellion against his mother's Puritan code, never ceased to obsess him. (16)

In addition, particularly in childhood and adolescence, unbearable shyness plagued Tennessee. In the 1981 interview "The Art of Theater V" conducted by his friend Dotson Rader, Williams astutely points to his repressed homosexuality during this period as the underlying cause to his emotional distress and unconscious guilt: "I supposed it was caused by an unconscious clash in me between my sexual drives and the puritanism imposed by my mother, and the great fear my father inspired in me. He was a terrifying man. He was so unhappy that he couldn't help but be tyrannical at home" (154). Another contributing factor to Williams' adulthood guilt is that he was able to escape this toxic family environment and to live authentically according to his ego identity, while Rose could not. So, while Tennessee finally found some peace and acceptance away from home, he felt guilty for abandoning Rose, as his mother was especially demanding of her. In the same interview, Williams explains that his mother "was terrified of sex. She used to scream every time she had sex with my father. And we children were terrified. We'd run out in the streets and the neighbors would take us in" (149). Edwina's fear of sex, likely internalized during her own childhood as a minister's daughter, fueled the stern Christian limitations she imposed upon her children. As Williams describes in his interview with Rader, Rose harbored "great inner resentment towards her, because Mother had imposed this monolithic puritanism on her during adolescence" (149). Much like Amanda Wingfield in *The Glass Menagerie*, Edwina

encouraged Rose to pursue an appropriate match for marriage, which would safeguard Rose's sexual purity and secure a traditional future for her. Amanda Wingfield (the character modeled on Edwina) nags her daughter Laura (i.e., Rose) about marriage; her fears about Laura's prospects come to light in a conversation with Tom (i.e., Tennessee):

Amanda: We have to be making some plans and provisions for her. She's older than you, two years, and nothing has happened. She just drifts along doing nothing. It frightens me terribly how she just drifts along.

Tom: I guess she's the type that people call home girls.

Amanda: There's no such type, and if there is, it's a pity! That is unless the home is hers, with a husband! (*Menagerie* 34-35; sc. 4)

This sentiment represents what Edwina believed about Rose's future, and influenced by her mother's demands, during her early 20s, Rose entered a courtship with a young man who worked at the International Shoe Company with Cornelius. Unfortunately, this man only courted Rose because he "had thought perhaps a marriage to Rose would be to his advantage" because he hoped Cornelius, as sales manager, would promote him once Cornelius became the Board of Directors, as was his career trajectory at the time (Williams, "The Art of Theater V" 153). However, Cornelius participated in a scandalous poker-night fight before his promotion. Part of his ear was bitten off during the scuffle, and the reconstructive surgery, which took cartilage from his ribs and skin from his buttocks, made his ear look like deformed cauliflower (Williams, "The Art of Theater V" 153). His coworkers no longer respected Cornelius, who previously was the top sales manager; instead, they laughed at him (Williams, "The Art of Theater V" 153).

Needless to say, Cornelius was no longer eligible for his promotion, so Rose's potential fiancé stopped calling her, effectively disappearing from her life without so much as a goodbye (Williams, "The Art of Theater V" 153). Much like the disappearing gentleman caller, Jim O'Connor, in *The Glass Menagerie*, Rose Williams' hope for a traditional future and marriage disappeared, just as Laura Wingfield's does. Rose was deeply in love with this young man, but suddenly it was clear that he never loved her. In his *Memoirs* (1975), Tennessee recalls that after this disastrous courtship, "Rose was never quite the same. A shadow had fallen over her that was to deepen steadily through the next four or five years" (117). Williams identifies this situation as the triggering cause of Rose's first period of mental decline ("The Art of Theater V" 152).

After this heartbreak, Rose disconnected from the world around her and disappeared into the haunted halls of her mind. In *The World of Tennessee Williams*, Leavitt and Holditch explain Rose escaped her grief, powerlessness, and hostility by mentally retreating to an interior life; this withdrawal—along with auditory hallucinations, religiosity, suicidal and homicidal ideations, and other peculiarities—would lead to Rose's diagnosis of dementia praecox (i.e., schizophrenia): "Williams said of his sister's condition at the time that it was as if she had gone on a journey, yet remained in sight" (19). Rose's disordered behavior continued to grow increasingly bizarre, including a somnambulant-like pronouncement one night to Tennessee that the family should commit group suicide (Leavitt and Holditch 39). Additionally, Rose developed a chronic indigestion, which led her mother to take Rose to the family doctor. This doctor suggested "Rose needed psychiatric attention, the mysterious digestive upset being due, he thought, to psychic or psychosomatic reasons that could be determined only through the course of analysis" (Williams, *Memoirs* 116). This was the first official recommendation that Rose seek psychiatric treatment. According to Williams' *Memoirs*, the family doctor explained to Edwina:

Rose's physical and mental health depended upon what struck Miss Edwina as a monstrous thing—an arranged, a sort of “therapeutic” marriage. Obviously old Doc Alexander had hit upon the true seat of Rose's afflictions. She was a very normal—but highly sexed—girl who was tearing herself apart mentally and physically by those repressions imposed upon her by Miss Edwina's monolithic Puritanism. (119)

So at the behest of their doctor, Edwina sent Rose to Barnes Hospital in St. Louis for psychiatric analysis (Williams, *Memoirs* 116). While at the hospital in 1936, doctors diagnosed Rose with schizophrenia, and Rose's resentment and anger toward her mother grew stronger. In 1937, Edwina moved Rose to Farmington State Hospital for long-term confinement and treatment, but this change in location did not heal Rose's anger (Williams, *Memoirs* 121). In rebellious resentment, Rose enjoyed appalling her mother's conservative sensibilities when she visited, but in 1943, Rose pushed her mother too far; in “The Art of Theater V,” Tennessee explains this provocative conversation that led to Rose's immediate lobotomy:

Miss Rose expressed herself with great eloquence, but she said things that shocked Mother. I remember when I went to visit her at Farmington, where the state sanatorium was. Rose loved to shock Mother. She had great inner resentment towards her, because Mother had imposed this monolithic puritanism on her during adolescence. Rose said, “Mother, you know we girls at All Saints College, we used to abuse ourselves with altar candles we stole from the chapel.” And Mother screamed like a peacock! She rushed to the head doctor, and she said, “Do anything, *anything* to shut her up!” (149)

Tragically, this desperate request to silence Rose's narrative of masturbation, whether true or not, resulted in her lobotomy, a new experimental treatment at the time. Rose was never the same after the procedure, and from that day forward, all hope for Rose's recovery died. Edwina

consulted neither Cornelius nor Tennessee before she made this decision. Her puritanic fear of Rose's sexual depravity, intensified by the cultural myth that mental illness forms from moral weakness and may be familially inherited, led to the hasty decision that effectively ended Rose's possibility for independence and release from confinement. Forevermore, Rose needed a caretaker, usually in an asylum. Tennessee's guilt for not being there to stop the lobotomy haunts *The Glass Menagerie* and, indeed, Williams himself. Mirroring Tennessee's experience, in the ending monologue of *The Glass Menagerie*, Tom Wingfield explains that although he physically left Saint Louis, no matter where he went during his travels something familiar would bring back memories of his sister Laura. Tom speaks to the audience as Laura blows out the candles in the living room at the end of the play:

Then all at once my sister touches my shoulder. I turn around and look into her eyes. Oh, Laura, Laura, I tried to leave you behind me, but I am more faithful than I intended to be! I reach for a cigarette, I cross the street, I run into the movies or a bar, I buy a drink, I speak to the nearest stranger—anything that can blow your candles out! [*Laura bends over the candles.*] For nowadays the world is lit by lightning! Blow out your candles, Laura—and so goodbye.... [*She blows the candles out.*] (Williams, *Menagerie* 97; sc. 7)

The blowing out of the candles, the last image in the play, represents the light and person that blew out of Rose Williams after her lobotomy. Additionally, the candles allude to the reason Edwina demanded Rose's silence. Because Edwina feared the immoral implications of her daughter's schizophrenia and, even more so, of Rose's defiantly sexualized speech, Edwina demanded Rose's lobotomy to silence what she saw as Rose's moral weakness, which reflected poorly upon Edwina and the family because mental illness also implied a familial inheritance of

depravity and degeneration. Obviously, the example of Rose Williams demonstrates the heartbreaking social consequences of the myth of mental illness as moral depravity.

In further consideration of the stigma myth of personal weakness, thirdly, the American Eugenics Movement claimed mental illness was a hereditary moral weakness that should be eliminated through selective sterilization. In the expository article “America’s Hidden History: The Eugenics Movement” (2014), American clinical doctor Teryn Bouche and American biology professor Laura Rivard explicate that “eugenics” as a theoretical term was applied first by Francis Galton (a half-cousin of Charles Darwin) in England in the late-19th century. In England, the Eugenics Movement sought to find a basis for heredity in genetics for the selective breeding of desirable traits, particularly for those of the upper class (Bouche and Rivard). This movement took root in America in the early-20th century, led by Charles Davenport and Harry Laughlin; moreover, in sharp contrast to England, the American Eugenics Movement, sought to remove undesirable traits from heredity, including “pauperism, mental disability, dwarfism, promiscuity, and criminality,” to eradicate unwanted persons from American society (Bouche and Rivard). In order words, the focus of the American Eugenics Movement was to remove negative traits from the American population, and unfortunately, this movement found strong support in academic institutions, government policy, and popular culture. For example, in 1910, Davenport founded the Eugenics Record Office (ERO), which was active from 1910 to 1940 (Bouche and Rivard). The American Eugenics Movement was most popular during the 1920s and 1930s; during this time, the American Eugenics Society was formed, along with many other smaller yet similar organizations (Bouche and Rivard). In practice, eugenicists promoted the legalization of forced sterilizations for America’s outcasts, specifically the poor, uneducated, minority, and especially disabled communities. In 1907, Indiana enacted the first sterilization law in the country, and

California quickly followed with its own sterilization law in the same year (Bouche and Rivard). By 1930, 30 states had enacted sterilization laws, resulting in the forced sterilization of over 64,000 people in America (Bouche and Rivard). This ideology even found support in the Supreme Court! In fact, sterilization laws were upheld by the Supreme Court in 1927 in the case of *Buck v. Bell*. The ruling in this case resulted in the forced sterilization of Carrie Buck for the offense of having a baby out of wedlock, even though the pregnancy was likely the result of rape (Bouche and Rivard). Tellingly, California's sterilization program was "so robust that the Nazis turned to California for advice in perfecting their own efforts. Hitler proudly admitted to following the laws of several American states that allowed for the prevention of reproduction of the 'unfit'" (Bouche and Rivard). The American Eugenics Movement promoted the concept of mental illness as a hereditary moral illness, influenced public policy for forced sterilizations, and enflamed social prejudice. However, this movement quickly lost its momentum in the late 1940s after the atrocities committed by Nazi Germany in WWII. Nevertheless, eugenics ideology did not disappear entirely from the dominant cultural narrative and remains an underlying prejudice against individuals with disabilities.

Unfortunately, eugenics ideology lasts throughout the 20th century and seeps into the 21st century. Individuals with mental disorders often internalize this ideology and decide to forego having biological children. Moreover, by the late 1990s and, definitively, by the 21st century, the heredity of certain mental disorders became undeniable with new technology, such as DNA sequencing, molecular biology, and genome assembly, which aid in the research of human genetics; PET (position emission tomography) and MRI (magnetic resonance imaging), which "visually communicate the location and concrete existence of these [mental] disorders"; and as of 2015, gene editing through CRISPR (clustered regularly interspaced short palindromic

repeats), which allows for the manipulation and removal of pinpointed genes (Jamison, *An Unquiet Mind* 183). As evidenced by CRISPR and current ethical debates about germline gene-editing, some scientists still promote eugenics; this ideology remains within the American popular imagination, promoting the idea that mental illness is something to be snuffed out from individuals and society as a whole. Consequently, many individuals, who have mental disorders or a family history of mental disorder, decide to end their genetic lineage by refusing to have biological children for a multitude of reasons. For example, in “The Art of Theater V,” Tennessee Williams divulges his reason for not having children:

I'm very happy I never had any children. There have been too many instances of extreme eccentricity and even lunacy in my family on all four sides for me to want to have children. I think it's fortunate I never did. Rose, Dakin, and I are the last of two direct bloodlines, the Dakin family, and the Williams. And all three of us are childless.” (184)

Obviously, Rose did not make this choice for herself (due to her lobotomy), but Tennessee remained confident in his reproductive abstinence. Interestingly, the youngest sibling, Dakin, who never suffered from a mental breakdown or diagnosed disorder, also chose not to have biological children, although he did adopt his wife’s two children. This shows how prevalent the eugenics ideology was, even after the official American Eugenics Movement lost its political power. Not only does this stigma affect the Williams family in the mid-20th century but also this ideology continued to affect individuals into the late-20th century. In *An Unquiet Mind* (1995), Kay Redfield Jamison emphasizes: “The fact that manic depressive illness is a genetic disease brings with it, not surprisingly, very complicated and often difficult emotions. At one extreme is the terrible shame and guilt one can be made to feel” (190). To illustrate this, she discusses a

stigmatizing conversation she had with a physician. After asking about her family history, her manic-depressive illness, and her lithium usage, he flatly asks if Jamison plans on having children, and she answers that she “very much wanted to have children” (*An Unquiet Mind* 190). After a few more pointed questions, the physician advises “as though it were God’s truth... ‘You shouldn’t have children. You have manic-depressive illness’” (Jamison, *An Unquiet Mind* 191). Outraged and hurt, Jamison sarcastically asks if his warning is due to “the fact that, because of my illness, he thought I would be an inadequate mother or simply that he thought it was best to avoid bringing another manic-depressive into the world” (*An Unquiet Mind* 191). The physician flatly replies, for both reasons. In her memoir, Jamison’s anger about this doctor’s opinion is palpable because it represents a similar belief held by a large portion of the American population and furthers the stigma of mental illness. Although Jamison never had children, she opines: “Not having children of my own is the single most intolerable regret of my life” (*An Unquiet Mind* 192). Struggling with this stigmatizing eugenics ideology, she considers the consequences of genome detection for mental disorders within fetuses and the possibility of parents choosing to abort fetuses with these genetic markers:

Do we risk making the world a blander, more homogenized place if we get rid of the genes for manic depressive illness...? What are the risks to the risk takers, those restless individuals who join with others in society to propel the arts, business, politics, and science? Are manic depressives, like spotted owls and clouded leopards, in danger of becoming an “endangered species”? These are very difficult ethical issues, particularly because manic depressive illness can confer advantages on both the individual and society. The disease, in both its severe and less severe forms, appears to convey its advantages not only through its relationship to the artistic temperament and imagination,

but through its influence on many eminent scientists, as well as business, religious, military, and political leaders. (Jamison, *An Unquiet Mind* 194)

Jamison's questions about the ethics of eugenics ideology, complicated by her decision to forego having children, highlights how pervasive and complex this stigma is within individual lives and American society.

In my personal experience, the decision to refrain from motherhood has been extremely painful, but it comes from a place of deep love for my unborn child. In my family tree, mental disorder runs through both sides of my parental inheritance. Likewise, my husband has a family history of mental disorder. Much like the physician who spoke so cold-heartedly to Kay Redfield Jamison, I worry about my ability to be a fit mother and about possibly cursing my child with mental disorder. This choice is complicated further by potential risks during pregnancy when I would have to stop taking the medications which stabilize my mood. In seeming opposition to my choice to forego children, I do not regret being born, but, at the same time, I would not wish bipolar disorder on my worst enemy. I know I would live with constant guilt if my child suffered from this disorder because of my own selfish desire to have a biological child. Although my husband and I considered adoption, I still doubt whether I could provide a stable enough influence in a child's life, and I also doubt that an adoption organization would choose me as a potential parent. Much of this comes from internalized stigma, fueled by eugenics ideology and the fear that I would be responsible for my child's mental suffering. I will never know if I made the right decision, but I think I have. All I know is that I love my unborn child too much to risk what feels like dooming her with this mental disorder. Like Jamison, never having a child will always be my greatest regret. Moreover, I respect her reasons for discouraging eugenics ideology and agree that having bipolar disorder may offer certain advantages; however, in my experience,

the disadvantages of living with this mental disorder are too severe, so I fear genetically passing on this suffering to my child. I do not judge other individuals with mental disorders who have biological children; I wish I had their courage and faith. I agree with Jamison, that the world is better with a variety of thinkers, including those affected by mental disorder, but I simply cannot bear the thought of watching my child go through the excruciating experiences of caused by bipolar disorder like I have. So, even with the extensive research I have done and the social activism to which I wish to contribute, still, I, too, am affected by self-stigmatization.

Mental illness life writers engage with the stereotype of personal weakness through several literary tropes. First, to address the concept of personal weakness, particularly focusing on malingering and willpower, authors of these life narratives typically protest Franklinian autobiographical traditions. Benjamin Franklin's autobiography stands as the epitome of the traditional American autobiographical narrative—one that emphasizes self-reliance, self-reflection, determination, and willpower. In Franklinian tradition, one can achieve his American dream through these ideals, which find expression through bootstrap-pulling rhetoric; additionally, individuals must strive to strengthen the American republic through pragmatism and entrepreneurism (Smith and Watson 116). In her memoir *Prozac Nation* (1994), Elizabeth Wurtzel presents conversations in which her friends use bootstrap-pulling rhetoric in their advice about her depression. One friend encourages Wurtzel to “Cheer up! Pull yourself together!” because he believes “Happiness is a choice, you’ve got to work toward it” (10). Unfortunately, happiness certainly is not a choice during clinical depression, so Wurtzel emotionally flinches at this advice because Franklinian logic cannot solve mental disorder. No amount of bootstrap-pulling can lift someone out of depression or schizophrenia or any other mental disorder. The problem, as Wurtzel portrays in her memoir, is that this cultural narrative does not align with the

lived experience of mental disorder. This aspect of the stigma implies that individuals should be able to recover from mental breakdowns with enough sheer willpower, and if they do not, they are personally weak or malingering.

Secondly, considering this myth and its theme of moral depravity, some mental illness life writers include allusions to sin and divine punishment. For example, Christian mental illness life writers often allude to the notion of sin and God's absence or punishment. For instance, Kay Redfield Jamison, a Catholic raised in a conservative military family, questions God's presence in her life during the onset of her manic depression as she endures radical changes in her mood, thoughts, and behaviors: "This was not something that could be overcome by protocol or etiquette. God, conspicuously, was nowhere to be found" (*Unquiet Mind* 121-122). Questioning God and allusions to divine punishment for sin occur within many mental illness life narratives because the myth that mental illness is sinful depravity continues to stigmatize individuals.

Finally, a third common trope within these life narratives are animal metaphors. For example, Mary Jane Ward's autobiographical novel, *The Snake Pit*, employs this trope throughout her narrative. At the beginning, the protagonist Virginia Cunningham mistakes Juniper Hill State Hospital for a zoo and the patients for animals. In another example from the novel, the climax of the narrative occurs when doctors place Virginia on the worst ward with the sickest patients; from this vantage point, Ward describes the hospital as a snake pit, meant to shock patients back to sanity. The imagery of this passage inspired the American public to use the term "snake pit" colloquially as a synonym for poorly run state mental hospitals. Animal metaphors and imagery correspond to eugenics ideology, which dehumanizes mental patients to animal-status. When combined, these literary devices portray and challenge the stigmatizing stereotypes that reduce mental disorders to personal weakness.

2.3.4 *Dangerousness*

Finally, the dominant cultural narrative promotes the stereotype that individuals with mental disorders are highly dangerous because they are unpredictable and potentially violent. This idea of “dangerousness” (an American legal term) is not completely unfounded. As American sociologist and professor William C. Cockerham notes in his theoretical text *Sociology of Mental Disorder* (1981), mentally disordered people “are not less dangerous than the general population (as was previously thought) and may be slightly more dangerous in regard to certain crimes, primarily crimes against persons, such as robbery or assault” (317-318). During the second half of the 20th century, especially throughout the 1960s’ Anti-psychiatry Movement, anti-psychiatry critics argued that mentally disordered people are less dangerous than the general population and are more likely to be the victims of crime. However, by the 1980s, based on his meta-study research, Cockerham found that statistically this counterargument is not wholly valid (318). On the other hand, Cockerham emphasizes that mentally disordered individuals “do not constitute the most dangerous group in society when compared with criminals, ex-felons, or even persons convicted of drunk driving” (318). Despite the facts that mentally disordered people are statistically only slightly more dangerous in certain situations than the general population and certainly are not the most dangerous sociological group, “ex-mental patients, as a group, are arrested more than the general population. And the perception that mental illness can be dangerous influences the extent to which individuals want to interact with them” (318). Thus, the stigma attached to mental illness influences the social belief that individuals with mental disorders are more dangerous and less predictable than the general population, which leads to an increase in the arrests and institutionalizations of these ostracized individuals.

Furthermore, this fear (fueled by stigma) can occur without the actual presence of a violent act but simply from the disclosure of discrediting information about an individual's mental disorder. For example, in *Willow Weep for Me* (1998), Meri Danquah remembers her own prejudiced fear against her friend Jade, which is provoked only by the knowledge that Jade is taking the anti-depressant Prozac. Jade is the first person to whom Danquah admits verbally that she is struggling with depression. This is a crucial moment in Danquah's journey through denial toward acceptance of her disorder. As Jade shares her experiences with depression, Danquah notices many shared similarities, especially regarding moods, emotions, and disordered thoughts. However, when Jade admits she takes Prozac, fear overcomes Danquah as she remembers media stories that contribute to this stigmatizing stereotype:

Suddenly I felt embarrassed and frightened. People on Prozac were said to be unpredictable, even violent. On a television special I had seen, a man on Prozac had shot his wife and three children, then he turned the gun on himself. Another man had deliberately driven his car into a ravine. I wondered if Jade would get out of control. My heart was racing. What if she hurt me or Korama [Danquah's toddler-aged daughter]? The calmer part of my consciousness told me I was being paranoid. After all, she certainly had her chance to kill us all when we were on that dead-end road in Rock Creek Park. (84-85)

Tellingly, the only reason Danquah uses to rationalize her fear as paranoia is the fact that Jade had not killed them earlier that day. This is how deeply the stigma runs through American culture. Though Danquah begins to accept her depression as real at this point in her experience, the dominant cultural narrative sneaks back into her consciousness when she hears the name "Prozac." This illustrates also how mass media contributes to the stigma of mental illness as

dangerous. Think about news stories today. Every time a mass shooting or some other act of excessive violence or terrorism occurs, the media often portrays the perpetrator as mentally ill, whether or not the individual has an actual history of mental disorder; mental illness is usually one of the first hypotheses put forth about the reasons or motives for such violence. These narratives are how stigma seeps into our often-subconscious prejudices. What happens in Jade's experience of depression is not violence toward others but thoughts of self-harm and suicide (Danquah 93). Eventually, she voluntarily admits herself into a psychiatric hospital and plans "to be there indefinitely" (Danquah 196). As Jade's example dramatizes, the concept of dangerousness involves more than a danger to others; acts of self-harm and suicide are common experiences involved in mental disorders. Thus, the social rejection caused by the myth of dangerousness harms the vulnerable individual because others' social avoidance leads to isolation, self-stigmatization, and, sometimes, deliberate self-harm.

However, even without the presence of a violent act, individuals with mental disorders experience stigmatization promoted by the myth of dangerousness from both neurotypical persons and the legal system. In America, legally and psychiatrically, the concept of dangerousness applies to an individual's *potential* to be a danger to oneself or others, and sometimes even property. As Cockerham details, "to determine dangerousness, courts look to the severity of the harm, the likelihood that the action will occur, and the behavior of the person who provoked the prediction of dangerousness" (254). Crucial to understand, the qualification as dangerous (in cases of mental illness), both legally and psychiatrically, relies on *the prediction* of future violence. Obviously, the stigma influences this prediction. In the 1964 sociological study "The Societal Reaction to Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State," American sociologist and professor Thomas J. Scheff found that

psychiatrists tended to overestimate dangerousness and overly recommend involuntary confinement in judicial hearings for mental patients, based on data collected from three large state hospitals (409). The presumption of illness and overprediction of dangerousness by court-appointed psychiatrists in the judicial setting is extremely damaging to an individual's identity and reputation, and upholding this unspoken presumption, especially within court cases, engenders the cultural narrative that people with mental disorders are dangerous. Crucial to comprehend, external factors, besides psychiatric symptoms and a patient's behavior, affect the prediction of dangerousness. In a 1974 study entitled "The Attribution of 'Dangerousness' in Mental Health Evaluations," which analyzes data from the files of the Fulton County Emergency Mental Health Service in Atlanta, Georgia, American medical sociologists Richard M. Levinson and M. Zan York discovered that "extraneous social factors had a significant impact upon mental health evaluators' decisions regarding the necessity to commit or not to commit prospective patients" (329). In America, legally, an individual must be deemed a danger to himself or others to be involuntarily confined to a psychiatric hospital; this was true in the 20th century and still holds today. Levinson and York proved a statistically significant association between the psychiatric label of "dangerous" and the external variables of sex, age, psychiatric history, and the person(s) referring the individual for treatment (333). Nevertheless, their study concluded that the most significant factor in the labelling of dangerousness was the patient's behavior: if the patient exhibited disruptive and disorderly behavior, the psychiatrist evaluating him would more likely label this patient as dangerous. This is logical psychiatric practice when one considers the definitions and categories for mental disorders are based largely upon behavior. As Scheff explains in "The Societal Reaction to Deviance" (1964):

It has been argued that mental illness may be more usefully considered to be a social status than a disease, since the symptoms of mental illness are vaguely defined and widely distributed, and the definition of behavior as symptomatic of mental illness is usually dependent upon social rather than medical contingencies. Furthermore, the argument continues, the status of the mental patient is more often an ascribed status, with conditions for status entry external to the patient, than an achieved status with conditions for status entry dependent upon the patient's own behavior. According to this argument, the societal reaction is a fundamentally important variable in all stages of a deviant career. (402)

Although there are biological components to mental disorder, the ascribed stigma of deviance and dangerousness is socially constructed, and although this label depends largely on an individual's behavior, it also is based upon external factors that the patient cannot control.

Levinson and York prove:

Dangerous will be attributed to a greater proportion of males than females...of younger than older persons...of persons with previous psychiatric treatment then to those without a history of psychiatric treatment...[and] of persons for whom help was solicited by a caller outside the household then those for whom help was brought by a member of the individual's household. (330-331)

The reasons for the first two factors—sex and age—are based upon physical strength and how easily an individual can be physically controlled. The reason why prior institutionalizations affect the labelling of dangerousness is because “the past record serves as a strong cue and suggests a perceptual framework from which to interpret a patient's behavior” (Levinson and York 330). Lastly, if the call for help comes from a source outside the household, psychiatrists

tend to assume that “something must be radically wrong if outsiders have become concerned” (Levinson and York 330). Remarkably, Levinson and York do not study the external factor of race. As Danquah notes, race remains a strong external factor to the label of dangerousness, especially for Black men: “Black men [with mental illness] are demonized and pathologized” (*Willow Weep for Me* 20). Importantly, the attribution dangerousness to mental illness allows for social control through involuntary confinement. As Cockerham highlights, “by linking dangerousness to mental disorder, society is allowed to enact preventative detention against the mentally ill, a practice that otherwise would be unconstitutional because the detention of persons merely presumed to be dangerous is prohibited in the absence of an overt act” (308). Because the mere prediction of dangerousness is enough to confine someone in a psychiatric hospital, the overprediction of it becomes a common stereotype in the dominant cultural narrative.

On the other hand, one cannot deny that there are times when individuals with mental disorders become dangerous to themselves or others; however, certain conditions usually affect whether an individual with a mental disorder will become violent. Cockerham defines these conditions as follows:

Severely mentally ill persons typically become physically violent when they: (1) abuse substances and/or have an antisocial personality disorder, which leads to stressful events and tense situations; (2) have an active psychosis causing bizarre symptoms leading to tense situations; or (3) have an active psychosis that, in interaction with feelings of suspicion and mistrust, leads to threats and ultimately violence in tense situations. (318)

Notably, each circumstance occurs during “tense situations” and is exacerbated by substance abuse, antisocial personality disorders, or active psychosis. Moreover, many mental disorders do not involve these secondary aspects. However, when violence does occur during a severe

psychological episode, the aftermath often leads to social isolation and self-stigmatization. In her memoir, Kay Redfield Jamison recalls her own acts of violence during severe mood episodes and the shame she felt after she recovered:

Violence, especially if you are a woman, is not something spoken about with ease. Being wildly out of control—physically assaultive, screaming insanely at the top of one's lungs, running frenetically with no purpose or limit, or impulsively trying to leap from cars—is frightening to others and unspeakably terrifying to oneself. In blind manic rages I have done all these things, at one time or another, and some of them repeatedly; I remain acutely and painfully aware of how difficult it is to control or understand such behaviors...I have, in my psychotic, seizure like attacks—my black, agitated manias—destroyed things I cherish, pushed to the utter edge people I love, and survived to think I would never recover from the shame...The aftermath of such violence, like the aftermath of a suicide attempt, is deeply bruising to all concerned...living with the knowledge that one has been violent forces a difficult reconciliation of totally divergent notions of oneself. After my suicide attempt, I had to reconcile my image of myself as a young girl who had been filled with enthusiasm, high hopes, great expectations, enormous energy, and dreams and love of life, with that of a dreary, crabbed, pained woman who desperately wished only for death and took a lethal dose of lithium...After each of my violent psychotic episodes, I had to try and reconcile my notion of myself as a reasonably quiet-spoken and highly disciplined person, one at least generally sensitive to the moods and feelings of others, with an enraged, utterly insane, an abusive woman who lost access to all control or reason. These discrepancies between what one is, what one is brought up to believe is the right way of behaving towards others, and what actually happens during

these awful black manias, or mixed states, are absolute and disturbing beyond description. (120-121)

Acts of violence can happen during extreme states of mental disorder, and such violence can be difficult to cope with afterwards, especially when accompanied by feelings of shame, guilt, and powerlessness. Unfortunately, such acts of violence during extreme psychic states provide evidence to support the dominant cultural narrative that the mentally ill are more dangerous than neurotypical persons. What is important to understand, however, is that, typically, certain conditions must be met before an act of violence occurs and that individuals with mental disorders are not constantly unpredictable, violent, and dangerous. Moreover, many times, the acts of violence committed by individuals with mental disorders are self-harming only.

Mental illness life writers address the stigma of dangerousness through a variety of rhetorical techniques. Three common tropes used to illuminate and counter this stereotype include prison imagery, military metaphors, and strategic foregrounding and backgrounding. Authors often include prison imagery when presenting the setting and characters within a mental hospital; the setting may have caged windows, high fences, locked doors, and the characters may have dual-images—doctors/wardens, nurses/guards, and patients/prisoners). For instance, in *The Snake Pit*, the protagonist Virginia Cunningham believes she is in prison for a quarter of the text based upon how the nurses, whom she designates as “guards,” treat the patients, whom she supposes are “criminals.” In addition, prison imagery supports Erving Goffman’s argument in his sociological study *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961); within this text, Goffman claims mental hospitals, exactly like prisons, are total institutions, where patients are dehumanized through the punitive ward system, authoritarian staff, and impermeable physical and social barriers. Prison imagery emphasizes the public’s fear

of mental patients and the patients' fear of the asylum. I will discuss this trope in greater detail within the next chapter.

Secondly, some life writers include military metaphors; however, the battlefield is the mind. In this way, these writers imply the violence involved in mental disorder affects the individual struggling, as opposed to harming others outside the "mind-field." In his memoir *First Person Plural: My Life as a Multiple* (1999), Cameron West uses military metaphors to describe the mental chaos of dissociative identity disorder. For example, when depicting how D.I.D. feels, West compares his head to "a hand grenade with the pin missing" (21). In addition, West discusses his journey to recovery as "a mission" (26). The use of military metaphors challenges the stereotype of dangerousness by alluding to a socially-acceptable form of violence—military service—on a battlefield built for one—the mind. In such a situation, the endangered one is the mental patient, and the stereotypically expected outward violence transforms inwardly into personal suffering and self-harm.

Finally, a third narrative strategy involves the foregrounding of self-harm and the backgrounding of violence toward others. Like the rhetorical purpose of military imagery, this linguistic strategy emphasizes self-harm as the most dangerous aspect of mental disorder, as opposed to violence towards others. By backgrounding violence against others within mental illness life narratives, authors alter the stereotype of dangerousness by presenting the mental patient as a danger to himself, and as such, someone who needs care and support. In most texts within this genre, authors develop the narrated I as a victim/survivor, as opposed to a danger to society. Whether through scenes of cruel psychiatric treatments or memories of traumatic abuse, these life writers present their narrated I as in danger. Rarely does an author present detailed episodes of violence towards others, yet many include vivid imagery of self-harm. This selective

foregrounding of the narrated I as victim and survivor suppresses the stereotype that mental patients are more dangerous than neurotypical people; instead, this strategy supports late-20th century anti-psychiatric arguments that claimed mental patients were more often victims than perpetrators of violence. Thus, even when an author admits to past violence against others, as Kay Redfield Jamison does, detailed scenes of these events remain absent from the narrative. However, most commonly, authors background past violent acts, if they do not remove them altogether. For example, Zelda Fitzgerald famously attempted to run her family-filled car off a cliff by grabbing the steering wheel from Scott. This outwardly violent act terrified and enraged Scott; its haunting effect on him becomes obvious in his recreation of the scene in *Tender is the Night*. However, when Zelda composes her own mental illness life narrative, this violent act is not included; in fact, Zelda never includes this scene in any of her creative writing.

Backgrounding violence toward others may alleviate the writer's shame, and it suppresses the stereotype of violent mental patients by removing evidence to the contrary. Foregrounding self-harm over outward violence reverses the victimhood of the narrative, which appeals to the audience's sympathy for the mental patient and inverts the stereotype of dangerousness.

2.4 Conclusion

In summary, dominant cultural narratives about mental illness negatively impact neurodivergent individuals' ego identities and social identities. However, as an American society, we can change this. One effective way to combat the stigma is by composing mental illness life narratives, which can accomplish numerous goals—including to dismantle one's stigmatized identity by recreating his self-image through creative expression, to present autobiographical acts that challenge stigmatizing stereotypes found in American culture, and to appeal to the audience's empathy and call them to action. Due to the antiphrasis (fictionality) of

identity, mental illness life narratives become an excellent site for an aesthetic rebirth of one's identity and for resistance against cultural narratives crocheted with stigma. At the beginning of his historical critique *The Use of Pleasure: The History of Sexuality: Volume Two* (1984), Michel Foucault defines what he terms the "arts of existence" or the "techniques of self" as "those intentional and voluntary actions by which men not only set themselves rules of conduct, but also seek to transform themselves, to change themselves in their singular being, and to make their life into an *oeuvre* that carries certain aesthetic values and meets certain stylistic criteria" (10-11). To Foucault, these "techniques of self" allow for the dissolution and reformation of one's identity. So, through autobiographical acts, whether in formal mediums or in casual conversation, individuals present their identities to others, and these "arts of existence" can manufacture, revise, or disband identity through language. According to her *Foucault News* article, Claire O'Farrell, a senior lecturer at Queensland University of Technology in Brisbane, Australia, explains: Foucault views "identity as a form of subjugation and a way of exercising power over people and preventing them from moving outside fixed boundaries." In consequence, Foucault supports the dissolution of identity to resist discourses of oppression which naturalize social domination and medicalize notions of normality. Theoretically, we, as humans, are all already different from everything and everyone else because there is no original prototype, no perfect mold for a "normal" human. Thus, if no two people can be exactly alike in every way, because there is no original human to mimic, then it is simply ignorance which drives us to point the finger at those groups of Others, who are "different," when we are all technically different from each other. The only reasons one feels a need to label others as different is out of fear and for social control. Is it too terrifying to acknowledge that there is really no one else exactly like you anywhere? It seems isolating. But if one is to be an anti-essentialist and an anti-identitarian, one

must be able to see all individuals as potentially, if not definitely, different from each other. Thus, arranging individuals into groupings based on a few characteristics only alleviates irrational apprehensions of the Other, but it does not actually mean anything “real” at all. These labels of stigma are socially constructed, and though they may seem like facts, they are only interpretations that reinforce fictional hierarchical binaries, such as normal versus abnormal and sane versus insane. As a nation, we must challenge these social constructions to support each other with compassion instead of tearing each other down in fear. Mental illness life narratives, which reveal the intense suffering involved in personal experiences of mental disorder, evoke emotions of sympathy, if not empathy, in readers. Humanizing mental disorder through mental illness life narratives can change the way our society thinks about mental illness and can alleviate the stigmas that stereotype and isolate these individuals. The dominant cultural narratives about mental illness label individuals with mental disorders as inherently lesser-than neurotypical people, and this broad myth of Otherness allows the stigma to continue because many Americans believe mental illness does not and will not affect them. However, statistical data of the prevalence of mental disorder in America, such as through the U.S. Census, shows one in four American adults will experience a mental disorder within their lifetime. Considering the silencing imposed by the stigma, the precise number of Americans suffering from mental disorder is likely higher than 25% of the population. Building understanding and awareness through mental illness life narratives can inspire empathy and a cultural mindset change, and such a change could embolden individuals to stop passing, to reject self-stigmatization, and to seek effective treatments.

3 WE'RE IN THE MADHOUSE NOW! STEREOTYPES OF INSANITY IN *THE SNAKE PIT*

Suspend your disbelief and imagine for a moment that you're walking toward a mental hospital. The large brick building looms tall and dark against the cold, gray sky. Antebellum oaks stretch gnarled boughs like bony fingers over the path leading to the front entrance. Autumn leaves drift past your feet, breaking the eerie quiet with their rustling. Dread knocks upon your heart when you see the barred windows. Is that a pale face peering down from the second story?

At your approach, the front door automatically slides open, but you know leaving won't be as simple.

The floors are tiled white; the walls are painted white; even the staff dresses in white, as if the entire treatment process relies upon ideals of purity and cleanliness. After a 15-minute evaluation, a nameless doctor agrees to the validity of your illness and recommends your commitment.

"Sign right here, child. We'll take good care of you," the admissions nurse says, pointing to the blank line on a waiver. You draw your name with a sinking feeling, like you just sold your soul to the Devil. Getting into the mental hospital is easy. What they don't tell you is that it is far more difficult to get out.

Now, the nurse takes your bag and hands it to an attendant, who promptly rummages through your belongings, setting aside "restricted items." The nurse explains hospital policies when you begin to question the process:

"No, you can't have this nail file; it's a sharp. No, you can't have that mouthwash; it has alcohol in it. No, you can't have those shoelaces; they're a self-harm risk. You'll have to do without or walk around in your socks like most patients. No, you can't hold onto your cigarettes;

I will keep them in the nurses' station for you. I will give you three when it's time for smoking. You *cannot* have your lighter; it's a risk to the safety of yourself and others. No, you can't have a razor to shave either; it's also a safety risk. Don't worry. None of the patients are allowed to shave, so everyone is wooly. No one will even notice."

At this point, you stop bothering to ask as a gnawing anxiety vibrates up and down your esophagus. What kind of place is this? What kind of hospital takes your belongings and won't give them back until you leave? When the nurse finally gives back your bag, you peer into the nearly empty inside. You have received your toothbrush, comb, deodorant, and clothes. (If you're lucky, they returned your prescription eyeglasses, too, but this may be asking too much.)

The attendant leads you down a long, bleak hallway, then another and another, until you feel lost in the labyrinth. Arriving at a heavy metal door marked Ward 13, he unlocks it and guides you into the open common room. "Wait here," he says before making his way over to the glassed-in nurses' station. You look around the room at the assortment of patients.

The tallest man you've ever seen in person paces back and forth near the corner of the room. Head hung low, he mutters inaudibly at his feet while wringing his ashen hands together. He coughs often, not bothering to cover his mouth. Your eyes wander to a middle-aged woman sitting on an age-beaten couch, brushing the hair of a baby doll, though her own hair resembles a bird's nest with bulbous knots and wispy shoots. She coos to the doll, "Mommy loves you so much, Hannah. Sweet baby, yes, I do." A younger man sits on the other side of the couch, his knees tucked up against his chest while he nervously chews at his fingernails, constantly shifting his eyes to watch the other patients. He locks eyes with you but never moves his hand away from his mouth. His eyebrows furrow, so you look away. Another patient walks closely by you, slightly brushing your arm with hers. She laughs in unpredictable intervals—sometimes in glee,

other times in horror—as she listens to someone no one else can hear. Some of the patients are stone-still and silent, sitting around the room on chairs or couches; they seem to stare endlessly at nothing at all. Suddenly, a woman with tattooed arms and bandaged wrists begins banging on a door that leads outside to a walled-in courtyard.

“Hey, Nurse!” she yells. “Come on, get me a cigarette already! I. Can’t. Wait. No. Longer!” she punctuates each word of the last sentence with a slap on the door. The head nurse gives a nod to the attendants, who quickly move toward the patient. When they reach her, she begins screaming, “No! I just want a cigarette! Get the fuck off me! This is still America, isn’t it?! I have fucking rights, you sons of bitches!” One attendant grabs her arms. “No! Leave me alone!” the patient screams and begins kicking. “Get off me, asshole!” Another attendant helps hold the woman still while the nurse inserts a needle into her arm. “No, no don’t, please, don’t,” her speech slurs into inaudible mutters. Her body relaxes, but the flames of rage in her eyes flicker until she fades into the unconsciousness of a drugged stupor. They strap a straitjacket around her seemingly lifeless body, pinning her arms around her torso. She now resembles a breathing corpse—those dead eyes open but without a spark of light, a slack mouth with drool pooling at the corners, and her limp, mummy-wrapped body—carried away without resistance. The attendants take her through the heavy, locked door, back into the maze of hallways, numbered wards, and caged windows. Wide-eyed and nauseated, you wait for someone to remember you are still standing here.

A younger nurse walks over to you and begins to explain in a sugar-sweet voice, “For the first few nights, you will sleep in this room over here.” She shows you to a spacious room with glass walls. More than a dozen beds line the room. “All the new admissions sleep in here under constant observation. When it’s deemed appropriate, you’ll be moved to one of the patients’

bedrooms, where you will have a roommate. You can put your things on this bed; it's yours for now."

Feeling like a prisoner, you silently place your few belongings on the rough wool blanket that covers the small metal-framed bed. Fear courses through your veins; you can hear your heartbeat thump-thumping in your ears. What did you do to deserve this? They said you were sick, but this place is not like a regular hospital. You can't simply walk out of here. The doors are stainless steel and constantly locked, and the windows are caged and inaccessible. Was your crime so great?

The ward's head nurse finally comes to "welcome" you. "Here's your medicine. Take it now," she hands you a small paper cup containing a colorful assortment of pills and another cup with water.

"What are they?" you ask but immediately regret it. A stifled anger flickers across her face.

"Your medicine. Ordered by your doctor."

"You mean the guy I saw for 15 minutes when I got here?" you ask in disbelief. You see at least five pills in this paper cup! That assessment did not seem long enough for this many pills.

"Take 'em now," the nurse growls. Remembering what happened to the last patient who bucked the system, you swallow them quickly. The nurse takes the paper cups and looks you up and down before walking back to the glassed-in nurses' station.

You take a seat near the window, blending in with the other patients. Seasickness overtakes you as the medicine begins to work. Your limbs feel heavy like your blood has turned to lead. Your whole body becomes a sinking ship, and you think of the quartet who continued

playing as the Titanic sank. Your head becomes groggy. Your vision blurs, and you fall asleep against your will in the middle of the snake pit.

For most people, this scenario is nightmarish, but does it not sound familiar? It should. Many details about the imagery, characters, and setting invoke recurrent cultural images of mental illness. These images correspond to stereotypes about mental patients and psychiatric hospitals. For example, the confiscation of personal items highlights the stigma of dangerousness, which labels mental patients as more dangerous and unpredictable than the general population. Another illustration includes the glassed-in nurses' station, which emphasizes the dangerousness and otherness of mental patients by creating a physical barrier that marks the difference between staff and patients. Other examples involve the specific visual attributes of the patients—wild eyes, disheveled hair, strange movements, self-mutterings, and gaping mouths—and features of the physical setting—barred windows and locked doors. Fine artists and filmmakers have captured madness visually in such ways, and writers have recorded accounts or created fictions containing these images for centuries. Even today, mass media continues to perpetuate these stereotypes.

The repetition of stereotypical images and narratives within American cultural artifacts, (including mass media, journalism, film, literature, and art) perpetuates the stigma of mental illness. Through social learning, as supported by social cognitive theory, American audiences incorporate prejudiced representations of mental illness into their imaginations and belief systems. This social learning—via vicarious experiences presented in cultural artifacts—teaches Americans what to think about mental illness, including how a “crazy” person looks and acts. These stigma myths affect both social interactions and individual behaviors. The major problems involved in this issue are that, firstly, most dominant cultural representations of mental illness are

highly inaccurate to the lived experience of mental disorder, and secondly, the general public believes these sensationalized, stereotyped narratives. Within American cultural artifacts, the dominant reoccurring myths include stereotypes that claim: (1) individuals with mental disorders are more violent, unpredictable, and dangerous than neurotypical people; (2) neurodivergent individuals are inherently lesser than “sane” people; (3) individuals with mental disorders should be hospitalized, often or indefinitely, for their own safety and for the safety of others; and (4) everyone should fear the total institution of the mental asylum, where patients experience the loss of freedom, terrifying treatments, and cruel medical workers. An analytical comparison of Mary Jane Ward’s autobiofictional novel *The Snake Pit* (1946) and Anatole Litvak’s 1948 film adaptation of it illuminates how the repetition of stigma myths functions to teach Americans what to think about mental illness as well as the consequences of this perpetuation. The major consequences of these stereotypical representations cause the public to fear mental patients, encourage social ostracism by reinforcing the stigma, and discourage unwell individuals from seeking medical help due to fears of stigmatization and psychiatric treatments.

3.1 Cultural Stereotypes and Social Learning: A Theoretical Foundation

We all learn stigmatizing narratives and stereotypical images of mental illness in early childhood. For instance, consider characters portrayed as mentally ill in popular cartoons from the late 20th century: Wacko from Warner Brothers’ *Animaniacs*, “Crazy Ole Maurice” (Belle’s father) in Disney’s *Beauty and the Beast*, or any of the characters from *Looney Tunes*. Children internalize these social images into symbolic cognitive models in their early developmental years. In the foundational essay “The Social Institution of Insanity” from his pioneering collection *Being Mentally Ill: A Sociological Theory* (1966), American professor and sociologist Thomas J. Scheff confirms that young children learn stereotypes of mental illness during

elementary school, most often from peers (64). Furthermore, Scheff asserts that “the stereotypes of insanity are continually reaffirmed, inadvertently, in ordinary social interaction,” such as in mass media and personal conversations (67). For this reason, most people learn what a “crazy” person looks like and acts like before ever personally experiencing mental disorder, so when someone begins to display symptomatic signs of psychiatric disorder, the ways in which he acts are culturally determined because he has been conditioned to believe this is how a “crazy” person behaves. Scheff sustains, individuals subconsciously learn to display specific behaviors to represent mental distress in culturally pre-determined ways:

Everyone in a society learns the symptoms of mental disorder vicariously, through the imagery that is conveyed, unintentionally, in everyday life. This imagery tends to be tied to the vernacular of each language and culture; this association may be one reason why there are considerable variations in the symptoms of mental disorder that occur in different cultures. (80)

Hence, when others label a person mentally ill, she displays symptoms found in dominant cultural narratives because they are rooted in the everyday language and imagery she uses in her personal cognitive model of mental illness. Moreover, once an individual enters the social role of a mental patient, she typically performs the expected behaviors and characteristics for someone in this role, based upon the internalized social cognitive model of insanity. As Scheff explains, once enough people consistently label an individual mentally ill, especially when such persons are experts like psychiatrists, traditional cultural stereotypes shape the individual’s presentation of symptoms:

His amorphous and unstructured rule-breaking tends to crystallize in conformity to the behavior of other deviants classified as mentally ill, and stabilizes over time. The process

of becoming uniform and stable is completed when the traditional imagery becomes a part of the deviant's orientation for guiding his own behavior. (*Being Mentally Ill* 81)

Thus, upon entering the social role of mental patient, an individual subconsciously performs insanity through frameworks of preestablished cultural narratives. Scheff theorizes, "the traditional stereotype of insanity becomes the guiding imagery for action, both for those reacting to the deviant and, at times, for the deviant himself" (*Being Mentally Ill* 81). In other words, ultimately, stereotypes from cultural narratives of insanity affect both individual behaviors and social interactions. This perspective dramatizes the substantial effects of sensationalized and prejudiced stereotypes repeated within popular American narratives about mental illness: not only do these images lead to stigmatization, they also influence how individuals experience and express mental distress.

Consequently, stereotypical images perpetuated in cultural artifacts and mass media manipulate how people think and behave, highlighting why sensationalized representations of mental illness contribute to the stigma. Applying social cognitive theory, these images become symbols for our cultural understanding of mental illness. In the sociological article "Social Cognitive Theory of Mass Communication" from the anthology *Media Effects: Advances in Theory and Research* (2002), Canadian-American social psychologist Albert Bandura explains, the psychosociological sway of mass media "influences human thought, affect, and action" (121). Bandura purports, humans learn through symbolization, which acts as "a powerful tool for comprehending their environment and creating and regulating environmental events that touch virtually every aspect of their lives" (122). Moreover, symbolization allows humans to incorporate vicarious learning into their cognitive models of the world without direct personal experience:

Most external influences affect behavior through cognitive processes rather than directly. Cognitive factors partly determine which environmental events will be observed, what meaning will be conferred on them, whether they leave any lasting effects, what emotional impact and motivating power they will have, and how the information they convey will be organized for future use. (Bandura 122)

Bandura asserts, humans translate and internalize experiences (even secondhand ones) by creating symbolic cognitive representations of them (122). These symbolic memory impressions then influence how individuals react to similar experiences in the future. Thus, through the process of cognitive symbolization, humans create “meaning, form, and continuity” in their lives (Bandura 122). Regarding the stigma of mental illness, through vicarious learning, humans cognitively translate and validate stereotypes from cultural artifacts into symbolic representations of mental disorder within their memory. Moreover, because many neurodivergent people remain silent about their experiences, sensationalized images from mass media often become the only material some Americans receive to interpret mental illness. As a result, the repetition of prejudiced representations negatively shapes how people react to individuals with mental disorders. Bandura emphasizes, “people gain understanding of causal relationships and expand their knowledge by operating symbolically on the wealth of information derived from personal and vicarious experiences” (123). Therefore, if a person has no personal experiences with mental disorder, he must rely solely upon vicarious experiences he witnesses through cultural artifacts, so when neurodivergent persons stay silent, stereotypical cultural narratives remain the predominant cognitive models of mental illness within the American popular imagination. Because all people create social cognitive models to “generate solutions to problems, evaluate their likely outcomes, and pick suitable options without having to go through a laborious

behavioral search,” people, who must rely solely upon vicarious learning from cultural artifacts, apply stereotypes of mentally illness to their actions toward and expectations for individuals labelled mentally ill (Bandura 123).

Significantly, stigmatizing representations of the mentally ill are highly prevalent in American popular culture. Some of the avenues which propagate the stigma of mental illness to a wide audience include mass media (such as news reports, television, and social media) and art (such as literature, painting, and film). Examining the repetition of stereotypes within cultural artifacts demonstrates how these images seep into the American popular imagination and affect individual experiences of mental illness. Throughout most of the 20th century, Americans could not avoid encountering narratives containing characters with mental disorders. The prevalence of images of mental illness within mass media interested two researchers in the early 1980s. As explained in the award-winning book *Media Madness: Public Images of Mental Illness* (1995), American professor of psychology Otto F. Wahl and his colleague Rachel Roth joined forces with the National Citizens’ Committee on Broadcasting and community volunteers to monitor how often characters with mental disorders appeared on primetime television programs in the Washington, D.C., area (6). Based on the data collected during February 1981, they concluded:

Out of 385 programs watched during that month, 35 (approximately 9 percent) were identified as depicting mental illness. In the Washington, D.C., area, viewers were able to see 35 mentally ill characters in a single month. If one accepts this as a typical month, it would appear that, on the average, television viewers—even those without access to 100 cable stations—can find at least one mentally ill person on their home screens each and every night of the year. Moreover, other research, using similar ratings of primetime

television, indicate that, if anything, the prevalence of mentally ill characters on television is steadily increasing. (6)

In other words, approximately 9% of daily television programming in the early 1980s depicted mental illness; this prevalence means late-20th-century television consumers likely encountered at least one individual (whether fictional or real) with mental illness every day. This emphasizes the powerful effect mass media has on the public's imagination. Bandura warns about the consequences of stereotyped mass media portrayals: "televised representations of social realities reflect ideological bents in their portrayal of human nature, social relations, and the norms and structure of society. Heavy exposure to this symbolic world may eventually make the...images appear to be the authentic state of human affairs" (137). The critical problems that arise from the prevalence of stereotyped narratives are: (1) most media representations of mental illness are highly sensationalized, and (2) the general public believes these prejudiced images signify actual lived experiences of mental disorder.

Significantly, people inherit common stereotypes of mentally illness from previous generations as shared cultural knowledge, so most people neither question nor revise these narratives within their personal cognitive models. Historically and today, the following dominant cultural narratives shape Americans' understanding of insanity and promote the stigmatization of neurodivergent individuals: (1) Mentally ill people are more dangerous, unpredictable, and violent than neurotypical people. (2) Mentally ill people are inherently different from and lesser than neurotypical people. (3) Because mentally ill people are dangerous and lesser than "normal" people, they cannot take care of themselves. Thus, like children, they need to be closely monitored, told what to do, and assisted in daily living, which is why mentally ill individuals may need to be confined in a hospital "for their own good." (4) Finally, we are taught to fear the

mental hospital because it strips one of her freedom and self-autonomy, and, more horrifyingly, its treatments can drive sane persons crazy and turn insane persons into docile zombies. The mental hospital is a total institution, ruled by authoritarianism, from which escape is difficult. These stereotypical narratives, or variations of them, appear in a wide range of American cultural artifacts, including books, television shows, films, plays, newscasts, videogames, and visual arts. To analyze all the sources which contain these repetitive images would be beyond the scope of this project. However, from the comparative analysis of Mary Jane Ward's autobiographical novel *The Snake Pit* (1946), a pivotal 20th-century American text and its film adaptation (1948) directed by Anatole Litvak, an understanding emerges of how the cultural repetition of prejudiced images, stereotypes, characters, and narrative tropes functions to inform Americans how a "crazy" person looks and acts. Moreover, examining the novel together with its film adaptation is crucial, for films often reach a wider audience because people can consume films faster and easier than books, and far more Americans watch films than read novels. Thus, by analyzing the combination of representations from the novel and the film, the stereotypical images that reach the widest audience surface. What becomes clear is the most frequently repeated images are the ones that sink deepest into the public's perception of mental illness. Although *The Snake Pit* represents only a microscopic view of all the possible mental illness life narratives, the novel and film work together to present the mainstream understanding of mental illness and illuminate the repercussions of stigmatizing cultural myths. The visceral images and their corresponding stereotypes, compounded by the emotional impact and horror elements of *The Snake Pit's* narrative, demonstrate how literary tropes expose cultural myths of insanity that inspire public fear of mental patients, reinforce their otherness, encourage social avoidance of

them, and discourage these individuals from seeking treatment for fear of stigma and confinement.

3.2 The Snake Pit: Historical Background and Social Significance

Atop the front cover of the 1946 Signet edition of *The Snake Pit* flashes the advertisement: “The explosive bestseller that became a classic!” and the connotation in this line is no exaggeration. Surprisingly, Mary Jane Ward’s literary agents—Ivan van Auw, Jr. and the famous Harold Ober, who represented a slew of legendary authors including F. Scott Fitzgerald, William Faulkner, and J.D. Salinger—along with several editors rejected her manuscript; however, encouraged by the unwavering support of her husband, Edward Quayle, Ward did not give up (Lockridge). The couple understood the importance of this story because they had lived a version of it. So, as American professor and historian Troy Rondinone explains in his historical analysis *Nightmare Factories: The Asylum in the American Imagination* (2019), instead of stashing *The Snake Pit* with her other three unpublished works, Ward sent her autobiographical narrative to Random House without her agents’ help (93). Intuitively, the Random House editor saw the novel’s potential and printed it “as a small batch, ‘prestige’ title”; however, soon enough, the novel began selling out everywhere (Rondinone 93). This novel, which almost never made it to print, became a national sensation in a matter of weeks. Apparently, the tale of Virginia Stuart Cunningham—a mental patient at the fictional Juniper Hill State Hospital—enthralled American readers. In his literary analysis “The Story Behind *The Snake Pit*, Mary Jane Ward’s Dark Comic Masterpiece” (2021), American novelist, literary critic, and professor of English Larry Lockridge chronicles the novel’s nearly instant success: “Within weeks of its publication in early 1946, *The Snake Pit* was first on the *Chicago Daily News*’s best-seller list and second on *The New York Times*’s.” Harold Ober and Associates must have been stunned by the novel’s immediate

popularity. As stated in her interpretation of the film adaptation “*The Snake Pit* (1948): The Sexist Nature of Sanity,” American studies professor Leslie Fishbein emphasizes the novel’s booming triumph:

Ward's critical success was matched by financial success: the book...was made a dual selection by the *Book-of-the-Month Club*, reprinted in part in *Harper's Bazaar*, condensed in *Readers Digest*, and disseminated in foreign editions in English, Dutch, French, Swedish, Danish, and Spanish. The book earned over one hundred thousand dollars in its first month, proof of its instant popularity. (645)

Nationwide, *The Snake Pit* became a common topic of social conversation, which enabled this mental illness life narrative to make a significant impression on the American popular imagination.

Due to the novel’s immense success, within two years, Twentieth Century Fox released the film adaptation, which also became an instant sensation for its realistic, sympathetic depiction of the mental patient’s plight. To accomplish its realistic portrayal, “the filmmakers even hired three, well-known psychiatrists to gloss the treatments portrayed in the script, and they all ensured a clear, Freudian diagnosis of Virginia’s illness” (Rondinone 96). Director Anatole Litvak’s attention to detail created a highly popular film. Despite its differences from the novel, the film also became a national success and “one of the top-five grossers of 1949” (Rondinone 98). In addition, the film received 10 awards and 9 nominations (*IMBd*). Further proof of its lasting success, Rondinone observes that because this mental illness life narrative became so hugely admired, the concept and phrase of “the snake pit” became synonymous with the nightmarish state mental hospitals in post-World War II America (4). Ultimately, the novel and film worked together to solidify certain images and perceptions of mental illness and its

treatments into the American imagination as well as to influence public discontent toward state mental hospitals. The combination of the gut-wrenching horror elements (such the authoritarian regimen of the hospital and its status as a total institution or the gruesome electroshock and hydrotherapy treatments) with the sympathetic portrayal of Virginia's experience creates strong pathos within both cultural artifacts. This pathos engenders empathy within the audience, which is why this narrative continues to spark strong emotional reactions and social interest. Moreover, the realism in both portrayals generated national mental healthcare reform; according to Penguin Random House's synopsis of the novel for its 75th anniversary edition, the text and its film adaptation "sparked important investigative journalism and state legislation to reform the care and treatment of people with mental illness" ("About *The Snake Pit*"). Ultimately, *The Snake Pit*'s positive effect on the American imagination emphasizes the powerful potential of mental illness life narratives which realistically portray the experience of mental disorder. Furthermore, Mary Jane Ward tackles the dominant cultural myths of mental illness and emphasizes the stereotypes perpetuated by them.

Offering an autofictional representation, the plot of *The Snake Pit* follows Virginia Cunningham (an author from Evanston, Illinois like Mary Jane Ward) during her treatment at Juniper Hill State Hospital in New York, where she remains a patient for more than a year. Although Juniper Hill is a fictional hospital, Ward bases the setting and characters on her personal experiences during her confinement at Rockland State Hospital in New York, where she stayed for over eight months after suffering from a nervous breakdown (Rondinone 93). The similarities between Ward and her protagonist Virginia Cunningham point to the autobiographical connection in the text. According to American psychology professor Ben Harris in his *History of Psychology* article entitled "*The Snake Pit*: Mixing Marx with Freud in

Hollywood” (2021), “Like Ward, Virginia was a freelance writer from Evanston, Illinois with red hair and a sharp sense of humor, who suffered a breakdown while living with her husband in New York City” (229). Despite the obvious parallels between the author and her heroine, Ward often denied that the novel was pure autobiography. However, many scholars discuss similarities between the novel and Ward’s life to emphasize the social significance of the narrative as an autofictional text; for example, Leslie Fishbein recounts:

The novel's verisimilitude forced the author to state that although “based on personal experience and observation,” the story was not autobiographical and that both characters and settings were fictitious. In fact, the resemblance between author and heroine was striking. Like Virginia, Mary Jane Ward was the author of two novels which had met with limited literary and financial success; both had accompanied their husbands from Evanston to [Greenwich] Village, sharing several lean years before succumbing to nervous collapse and institutionalization. (645)

Whether fictionalized or not, this mental illness life narrative presents a realistic portrait because Ward lived through a similar ordeal. Moreover, because her personal experience inspires the novel, Ward focuses on the protagonist’s disordered point-of-view, which allows the audience to observe the mental hospital from a patient’s perspective. This intimate reading experience offers the audience the chance to encounter this horrible situation vicariously, and because vicarious learning is how many readers/viewers understand mental illness, *The Snake Pit* provides a site for an intersubjective exchange of meaning-making by appealing to the audience’s logical and emotional reasoning and encouraging them to re-interpret stereotypes of madness and to validate the author’s claims within the narrative. As a result, this text affected positive changes in the American popular imagination, and its audience demanded political reforms in mental

healthcare. Whether these reforms were effective or not is another debate entirely; the point is mental illness life narratives can change misinformed minds, public policies, and individual lives.

Within the novel and film, three symbols emerge which influence future mental illness life narratives and the postmodern American imagination—the setting of the overcrowded, ineffectual mental hospital; the horror imagery associated with psychiatric treatments; and the stock character of an incomprehensible Freudian doctor. Furthermore, the imposing hospital and the terrifying treatments in *The Snake Pit* encourage the audience to fear the mental hospital. These narrative tropes reappear in various ways across future American mental illness life narratives, such as *One Flew Over a Cuckoo's Nest* (novel: 1962; film: 1975) and *Girl, Interrupted* (novel: 1993; film: 1999); the historical repetition of these tropes demonstrates the social inheritance of cultural stereotypes through language and narrative and exposes the popular American myths of mental illness.

3.3 An Experimental Narrative Structure

Everything about Juniper Hill State Hospital emphasizes that the American mental hospital is a dreadful place. The novel structurally represents this through modernist techniques which break traditional rules of literary composition. For instance, Ward alludes to Freudian psychoanalytic theory by narrating the story through a first-person stream-of-consciousness, which creates an emplotment interrupted by flashbacks, based upon the free association of ideas and impressions of the narrator (who is also the protagonist, Virginia Cunningham). This disordered emplotment structurally represents the narrator's disordered mind through numerous temporal interruptions and sensory misrecognitions, creating a nightmarish mood throughout the narrative. In contrast, within the film adaptation, Litvak removes Ward's stylistic and structural

ambiguities, replacing her modernist experimentation with realistic imagery and clear transitions within the emplotment, even during flashbacks, yet Litvak maintains the novel's nightmarish mood by invoking horror through visceral imagery and dramatic musical scores. The film relies upon realism, while the novel employs surrealism; thus, one main difference between the two versions of the narrative is the portrayal of mental disorder—either from an external, objective third-person perspective (as in the film) or from an internal, subjective first-person perspective (as in the novel). Despite their differences, both the novel and the film present a sympathetic portrayal of the experience of mental illness in mid-20th-century America.

The novel and the film open in the same way: Virginia Cunningham sits on an outdoor bench and listens to a man's voice coming from somewhere seemingly behind her. The voice, which the reader/viewer later learns belongs to Dr. Kik, asks Virginia if she hears voices, to which she replies, "You think I'm deaf? 'Of course,' she said. 'I hear yours'" (Ward 5). This immediately introduces the miscommunications that often occur between psychiatric doctors and their patients. Although this example does not utilize psychological jargon, the question's implied meaning—does she have auditory hallucinations—is not apparent to Virginia. In fact, this idea does not dawn on her at all because she neither realizes that she is unwell nor that she is in a hospital for the first part of the narrative. Especially in the novel, this misinterpretation of Virginia's situation extends to the reader; the surrealistic experimentation within Ward's narrative dramatizes the bewilderment involved in first-person experiences of mental disorder and the psychiatric hospital. For example, Ward's style complicates the narrative present with Virginia's inner stream of consciousness; this creates a dreamlike atmosphere in which dialogue, setting, and plot events evoke free associations that trigger memories, portrayed as flashbacks, from Virginia's narrative past. In addition, Ward's use of this literary technique, which relies

upon the first-person narrator's stream of consciousness, mimics Sigmund Freud's "fundamental technical rule" for successful psycho-analysis—free association (Freud, "Two Encyclopaedia Articles," 3916). One central modernist technique is the incorporation of psychoanalytic theories, and Ward uses this strategy to establish her ethos as a credible and modernist author and to activate her audience's prior knowledge of popular Freudianism.

By this point in history, American audiences understood many Freudian concepts; though they were often watered-down or misinterpreted versions of the original written texts, popular Freudianism created a general public comprehension of Freud's major hypotheses, such as those on the Unconscious, free association, deviant sexuality, and the Oedipal complex. Thus, by incorporating stream-of-consciousness into the narrative, Ward directly alludes to Freud's ideas about free association and the Unconscious. Within many of his psychological works, Freud explains the history of his development of psychoanalysis. In 1911, Freud gave a lecture "On Psycho-analysis" (later was published in 1913) in which he recounts, "the first psycho-analytic examinations and attempts at treatment were made with the help of hypnotism" (1970). His first experiments with hypnotism worked well enough to convince Freud of the existence of the Unconscious. In "A Short Account of Psycho-analysis" (1924) from *The Complete Psychological Works of Sigmund Freud*, Freud explains this original procedure worked by "restoring to the patient's memory what had been forgotten" so as to ease hysterical or neurotic symptoms (3162). However, hypnotism is not effective for everyone because some people are not as suggestible as others; thus, Freud began looking for a better method. He found "free association" was an expedient substitute because "this modification had the advantage of enabling the procedure to be applied to a far larger number of cases of hysteria, as well as to other neuroses and also to healthy people" (Freud, "On Psycho-Analysis," 1970). This method of

free association allowed Freud to extend the reach of psychoanalytic practice. To engage in free association, Freud (or any trained psychoanalyst following his theories) “pledged his patients to refrain from any conscious reflection and to abandon themselves, in a state of quiet concentration, to follow the ideas which occurred to them spontaneously (involuntarily)” (“Short Account of Psycho-analysis” 4101). In other words, Freud encouraged his patients to begin speaking aloud their stream of consciousness without self-criticism and without excluding any thoughts or details, “even if they felt objections to doing so, if...the thoughts seemed too disagreeable, too senseless, too unimportant or irrelevant” (“Short Account of Psycho-analysis” 4101). Freud believed that the patient’s honest sharing of her free association of thoughts and memories revealed unconscious thoughts, desires, motivations, and repressions because to Freud the Unconscious is “the realm of memory traces” (“Mourning and Melancholia,” 216). In the “Third Lecture” (1910) from his series *Five Lectures on Psycho-analysis*, Freud reminds his audience that “psycho-analysts are marked by a particularly strict belief in the determination of mental life. For them there is nothing trivial, nothing arbitrary or haphazard” (1727). This means that no mental activity is coincidental to a Freudian physician; even if the conscious mind does not understand why, the unconscious mind will have clear motivations or conflicts for the emergence of a particular thought or memory, which can be interpreted by a trained psychoanalyst. Thus, as Freud clarifies in “Determinism, Belief in Chance, and Superstition—Some Points of View” from *The Psychopathology of Everyday Life* (1901), even mental blunders, such as forgetting or slips of the tongue, have important meaning to psychoanalysts because of the determinism of mental life (1029). Through the technique of free association and interpretation, Freud “established with complete certainty the fact that psychical dissociations are maintained entirely by ‘internal resistances’...[and] that the dissociations have originated owing

to internal conflict, which has led to the ‘repression’ of the underlying [unconscious] impulse” (“On Psycho-Analysis” 1970). Following the rule of determinism in mental life and using the technique of free association, Freud further cemented his theories about the Unconscious because he proved that even one’s stream of consciousness, or free association of thoughts, is “unfree” because the Unconscious determines such associations (“Short Account,” 4109). However, Freud highlights a crucial factor for interpreting free association: “This material did not bring up what had actually been forgotten, but it brought up such plain and numerous hints at it that, with the help of a certain amount of supplementing and interpreting, the doctor was able to guess (to reconstruct) the forgotten material from it” (“Short Account” 4109). Within a literary analysis of *The Snake Pit*, a critic must interpret the implied meanings behind many of the images Ward includes within Virginia Cunningham’s stream of consciousness by following the associations Virginia makes to connect these images to the larger conflicts within her Unconscious.

Because Ward experienced psychoanalysis firsthand and researched it for her novel, she understood the basis of free association; this is evident within the text through her experimental style. In many parts of the text, one could practice a Freudian interpretation of Virginia’s stream of consciousness; to demonstrate, consider the following excerpt, in which Virginia conversates with another patient:

“Miss Hart says you are going to P.T. with us this afternoon.”

She had said this as if it were two initials. Parent Teacher Association? But I am neither a parent nor a teacher. “Yes,” she said. I’ll have to write to Hortense. I’ll have to tell her she’s not the only one who goes to P.T.A. Only here in the East, I’ll write, we just say P.T.

Hortense was always writing about the P.T.A. now that Scootie was in school. He had become a problem child. In nursery school he learned to call everyone damn stinks and now, in first grade, he complained about having to dance with the old hags from second grade when he went to dancing class. Hortense was doing something about this in P.T.A. she was working on getting a certain teacher fired and a certain Bad Influence sent to another school. Well, I'll write to her about the meeting this afternoon. I won't need to say just where it was held.

What was Robert telling people? That I have gone away for a little rest? I am not getting any letters, not even from Robert. And when has he ever come to see me?...

Progressive myopia was what you had wrong with your eyes. Was your head trouble progressive? Head trouble. She tried to think of scientific words. There was dementia praecox, but that sounded too young. Precocious. There was maniac something but you were pretty sure you were not a maniac. There was schizophrenia. That was a beautiful word, as a photograph slightly out of focus sometimes is very lovely. It means split personality. When I wrote my book I said that was what my man had. He didn't think he was Napoleon or anything like that but he was aware of being two decided personalities, one very proper and righteous and the other something of a rake.

But that can't be my trouble. I am just me, Virginia Stuart Cunningham. There is only one of me, and it is having a hard enough time thinking for one, let alone splitting into two. (Ward 52)

In this passage, a simple statement from another patient triggers an avalanche of memory associations for Virginia. From the initials P.T., Virginia's mind ventures to P.T.A. and her hometown friend Hortense then to Hortense's troubled son then to her husband Robert

Cunningham. Before beginning a psychoanalytic interpretation of this free association of Virginia's thoughts, one must remember what Freud concluded about the associations' content. In his "Two Encyclopaedia Articles" (1923) from *The Complete Psychological Works of Sigmund Freud*, under the entry "Psycho-analysis as an Interpretive Art," Freud declares, "the patient's associations emerged like allusions...to one particular theme and that it was only necessary for the physician to go a step further in order to guess the material which was concealed from the patient himself and to be able to communicate it to him" (3917). Therefore, the literary critic, like the Freudian doctor, must look at the content material as allusions which work together to point to a specific theme; this theme then represents an unconscious repression of a particular memory or id impulse which provokes a psychic conflict within the patient. To begin, Virginia's associations center around her hometown in Evanston and her marriage. Her associations occur quickly, so the reader must fill in unsaid details; in total, the images from this passage allude to traditional female roles within American society—mother and housewife. Looking first at the content about Hortense, Virginia compares herself to her childhood friend, while admitting her own supposed shortcomings: "But I am neither a parent nor a teacher. 'Yes,' she said. I'll have to write to Hortense. I'll have to tell her she's not the only one who goes to P.T.A." (Ward 52). The idea of the P.T.A. alludes to the theme of motherhood; not being a mother unconsciously bothers Virginia, as is seen in her mentioning this fact. This likely derives from Virginia's unconscious resentment and envy that Hortense has achieved motherhood, while she has not. In an unspoken way, Virginia resents her friend and shames herself for being childless. Additionally, Virginia regrets leaving Evanston, so she constantly recalls the people there. Whether she admits it consciously or not, Virginia longs to return to her midwestern home because the financial and social stresses of living in New York City triggered her nervous

breakdown. This association then leads Virginia's thoughts to wander to her husband Robert, likely from her repressed resentment toward her friend's womanly success and her anxiety about whether Robert will leave Virginia for someone more like Hortense—a woman who is fertile, motherly, and sane. Virginia worries, "What was Robert telling people?" (Ward 52). This quick jump from her husband to other people emphasizes Virginia's fear of stigma. How will people treat her when she goes home? This fear goes unspoken, which further speaks to its repression in the Unconscious. In fact, this contemplation of others' perspective on her present circumstance causes her free association to dynamically shift to a distanced scientific perspective of her condition: "Progressive myopia was what you had wrong with your eyes. Was your head trouble progressive? Head trouble. She tried to think of scientific words" (Ward 52). In this way, Virginia distances herself emotionally from her anxieties about people on the outside. In addition, after worrying about what Robert tells people about her condition, the narration begins switching between the first-, second-, and third-person pronouns. This stylistic puzzlement emphasizes Virginia's anxiety about how others will label her. The quick speed at which Virginia's topics of thought change in conjunction with the dynamic conversions in point-of-view illustrates Virginia's fragile yet chaotic mental state and forces the reader to experience some of her bewilderment and apprehension. Through these narrative choices, Ward uses elements of Freudian psychology because she highlights the connection between repressed unconscious conflicts and consequential mental breakdowns. Ward includes many other similar examples of how word associations initiate memories for Virginia; as a second example, consider this passage:

If I had my glasses I could walk directly to the apartment. It is not seeing that makes me believe I am not thinking. Without my glasses things look so different; hardly look at all.

In connection with the word apartment she thought of the word house and then of a large house where many young people milled around and talked at the top of their lungs. They argued and they sang and they laughed. God in heaven, do we still live with all those young people somewhere outside of Manhattan? This I am not enduring. She closed her eyes. No, we went from there. (Ward 12)

Here, Virginia's thought process begins with one of her repeated complaints—her missing eyeglasses. Virginia's eyeglasses allude to a theme which presents the unreliability of the five senses during the experience of mental disorder. First, one typically determines reality—the physical world, lived experiences, and other tangibles—based on the senses. Thus, along this line of reasoning, the eyeglasses represent the five senses with an emphasis on sight. Naturally, when someone sees an event occur, he believes it is real; obviously, this connects to the adage “seeing is believing.” Therefore, in the text, Virginia's missing eyeglasses make her physically unable to see clearly; symbolically, her semi-blindness represents her psychic bewilderment caused by mental disorder. Ward juxtaposes these two symbols: “It is not seeing that makes me believe I am not thinking. Without my glasses things look so different; hardly look at all” (Ward 52). Here, seeing influences thinking. Much like the missing eyeglasses emphasize her blurry vision, Virginia's mental disorder makes it difficult for her to decide what to believe and what is real because, in both cases, she cannot trust her senses because her perceptions do not align with reality. The symbol of her missing eyeglasses alludes to her unconscious fears about her insanity. She hopes that if she has her glasses then she will think better, but the underlying fear remains: what if the eyeglasses do not return her sanity? In another association, Virginia needs her glasses to find her apartment, which alludes to her desires to escape from the hospital and to be a good wife. The word apartment begins an entirely new allusion: “In connection with the word

apartment she thought of the word house and then of a large house where many young people milled around” (Ward 52). The comparison of an apartment and a house, which becomes a contrast between living solely with one’s husband versus living with roommates or family members, alludes to growing up and fulfilling the role of housewife. Virginia thinks about the apartment first because this is where she most recently lived with her husband before her confinement. Although she is a writer, she spends much of her time working at home; thus, despite not being a traditional housewife, Virginia still works inside the home—as if she is stuck somewhere between the 19th-century’s ideal of the Angel of the House and the 20th-century’s new career woman. A Freudian reading of this immediate switch from apartment (her present home outside the hospital) to a large house (where she and Robert once lived with many other young people before the couple moved to Manhattan) suggests an unconscious conflict concerning her current living situation and her middle age. The large house with many young people represents a family home or a communal living situation, like the one Robert and Virginia experienced while living in a co-operative household at the beginning of their marriage; this house, then, symbolizes youth, idealism, and opportunities. The apartment, on the other hand, symbolizes her marriage, her adult choices, and her middle-age. Notably, Virginia was happy neither in the co-operative house nor in the slew of small Manhattan apartments. However, nothing in the text suggests she does not love her husband or that he is not devoted to her as his wife. However, Ward gives background details which suggest Virginia is unhappy living in Manhattan because Robert is not able to earn enough money through his work in the city. Moreover, Robert begins spending more money than he earns, which endlessly stresses Virginia. Although Virginia sells her writing, she does not earn enough to support them fully either. Ward

ultimately points to these financial pressures as the cause of Virginia's mental collapse, as opposed to repressed feelings about her first fiancé's death, as her physician Dr. Kik believes:

After a year [in New York] Robert announced it was time to Face Facts. Virginia supposed this meant he was going to swallow the Bitter Pill of returning to Evanston, but he had no intention of going back home. He got himself a job in New York. He earned less money at this job than he had earned since his school-day vacation jobs, but that did not bother him. In order to live they had to keep dipping into the dwindling savings but that did not bother Robert. He could not imagine what Virginia was worried about.

Robert, I think there is something the matter with my head. (167-168)

The major conflict is, once the couple moves from Evanston to New York City, they experience severe financial insecurity, which causes Virginia to have a nervous breakdown from stress and fear. Moreover, unconsciously, Virginia does not want to leave Evanston permanently. These financial struggles and repressed desire to return home cause Virginia's collapse. Thus, the apartment represents Virginia's repressed fear that she and Robert have failed to succeed as a married couple (at least by 20th-century American societal standards)—they are childless and cannot afford a small apartment. With the inclusion of Freudian theories through the literary techniques of stream-of-consciousness and free association, Ward establishes herself as a credible author on this topic; thus, even if her narrator/protagonist, Virginia Cunningham, is unreliable, by appealing to ethos, Ward reassures her audience that this autofictional narrative is a trustworthy representation of the experience of mental illness and psychiatric treatments.

Importantly, although Ward proves herself to be a credible source as an author, she establishes Virginia as an unreliable narrator by structurally applying an inconsistent point of view. She does this purposefully to highlight one of the consequences of the stigma of mental

illness: being considered an unreliable witness to one's own experience. Often, healthy people will ignore what persons with mental disorders say by brushing it off as nonsense. This is one reason why many mental patients avoid sharing their narratives—the fear of becoming an unreliable narrator to one's own life is silencing. To emphasize this experience, throughout the text, the perspective changes unexpectedly, sometimes within the same paragraph; for example: “If *I* had my glasses I could walk directly to the apartment...In connection with the word apartment *she* thought of the word house” (Ward 12; emphasis added). Notice within the example above, the perspective switches between first and third person pronouns. As another illustration, consider the following:

You had awakened from a bad dream and almost torn yourself from the memory; the dream itself was obscured by depression which would remain until you were fully awake. But you had no chance. The voice order you back into the horror. What am *I* thinking? The voice has nothing to do with me. (Ward 14; emphasis added)

The perspective switches from the second person to the first person, even though the paragraph only focuses on Virginia inner dialogue. This technique not only makes Virginia seem like an unreliable narrator but also challenges the reader to differentiate between what is real and what is imaginary. This disorientation between the real and the imaginary, and ultimately the symbolic when applied to the literal text, creates one of the best realistic literary representations of the experience of mental disorder. This rhetorical strategy invokes pathos because it encourages the reader to feel some of the anxiety involved in such an essential misunderstanding because he must continually ask himself a series of questions—Is this really happening, or is Virginia dreaming or hallucinating? Who is speaking now? Is that the voice of her doctor or a nurse, or is it a hallucinated voice? Is she speaking about herself in the first person, the second person, and

the third person in the same paragraph? Ward uses these rhetorical distractions to emphasize the disorientation mental patients experience and to challenge the reader to find who the most reliable source is—the patient or the doctor, i.e., Virginia or Dr. Kik. Moreover, because the hospital has not given Virginia her eyeglasses, her misperceptions become even more difficult to resolve because she also must interpret what the blurry shapes she sees are. For instance, in the first scene when the patients move from the yard back inside the hospital, Virginia becomes disoriented: “Blobs rose from other benches and gathered into a large smear. ‘What’s the matter?’ asked Virginia” (Ward 14). Both the modernist structural elements and the absence of Virginia’s ability to visually focus create an almost nauseating effect in the act of reading the text because the audience must constantly question what is really happening as Virginia misconstrues much about her surroundings and situation.

3.4 Dehumanization: Animals in the Human Zoo

The setting and imagery of Juniper Hill encourage the audience to fear psychiatric confinement and treatment. The setting also invokes the stigma myths of dangerousness, otherness, and infantilization. For example, in the opening chapters/scenes of the novel and film, Virginia mistakes the hospital for a zoo then a juvenile reform school then a prison. In fact, she does not realize she is in a hospital until after she receives her first electroshock treatment in “Chapter Three” of the novel. Shortly after the narrative begins, a nurse calls for the patients to form a line to reenter the hospital; this is when the film’s audience sees Juniper Hill for the first time (see Figure 3). One easily can see why Virginia mistakes it for a zoo, a reform school, and a prison. The building is large and foreboding with little personality beyond a monolithic, rigid structure with barred windows. The industrial smokestacks and delivery truck outside the 12-foot fence also suggest the modern mental hospital could be mistaken for a factory.



Figure 3: Hospital Building from The Snake Pit. Directed by Anatole Litvak

This is the first view of the Juniper Hill State Hospital in *The Snake Pit* (1948). Notice the large brick building with barred windows and the long line of patients waiting to enter.

Beginning with zoo imagery, Ward portrays the stigma myth of otherness, which promotes the idea that mental patients are inherently lesser than sane persons. This stereotype affects the social treatment of individuals with mental disorders; one consequence is the dehumanization of mental patients. In Western history, this dehumanization devolves mental patients to the status of feral animals, which contributes to the commercialization of the mad as zoo exhibits—whether in-person or within artistic representations. In the novel and the film, as Virginia moves forward in line, she sees the bars on the windows and first believes she must be touring a zoo:

It was a zoo...At first I didn't notice the cage but then I saw it and I smelled the animals.

There seemed to be no animals in the cage just now. There was a blue-and-white

something but it looked more like a person...The smell of the zoo was unmistakable, and so the animals were not far off. (Ward 14-15)

Virginia sees the cage-like windows and figures peering out from them. Director Anatole Litvak strikingly recreates this image in the film adaptation as the actors hang on the bars like caged monkeys trying to force their way free without success (see Figure 4). Tellingly, Virginia does not realize the caged animals are humans because she is missing her eyeglasses. This zoo



Figure 4: Zoo Imagery from The Snake Pit. Directed by Anatole Litvak
When Virginia sees the mental patients on the second floor peering down through barred windows, she thinks she must be visiting a zoo.

imagery is poignant due to the historical context of madness and the dehumanizing treatment of insane persons in Western history. In *History of Madness* (1961), Michel Foucault explains the imagined connection between animals and insane humans; during what he terms the Classical Age (roughly spanning from the 17th century into the 18th century):

The animal in man was no longer the indicator of a beyond [i.e., supernaturally imposed such as demonic possession or Divine punishment], but had become in itself his madness, with no reference to anything other than itself, his madness in a natural state. The animality that raged in madness dispossessed man of his humanity...[and fixed] him at the degree zero of his own nature. (148)

In other words, during the late part of the Renaissance and into the 18th century, popular Western cultural thought shifts its understanding of madness from supernatural possession to something akin to devolution. In the Classical Age's ideology, madness dehumanizes those suffering from mental disorders and places them on the same level as animals. Consequently, this meant that the mentally disordered were treated like animals. Locked away in large, delapidated dungeon-esque buildings, inmates of mental asylums experienced harsh conditions because society saw them as subhuman:

The animal solidity of madness, and the thick skin that was inherited from the animal kingdom, was a carapace for the insane against hunger, heat, cold and pain. It was common currency until the late eighteenth century that the mad could put up indefinitely with the miseries of existence. Hence there was no need to protect them, cover them or even provide warmth. (Foucault, *History of Madness* 148)

This theory became all the more problematic during the Great Confinement of the 17th century because government entities began confining all the homeless paupers (many of whom were elderly or mentally disordered) to asylums, where they often experienced nakedness, starvation, and physical illnesses. This equation of the mentally disordered to animals promotes the idea that the sickest mental patients do not need the same comforts as healthy persons.

In *The Snake Pit*, Mary Jane Ward illustrates this stereotype most dramatically through Ward 33. On this ward, where the sickest patients stay, patients lack shoes and sometimes socks: “Several of the Thirty-three ladies went barefoot. Sometimes there was snow on the sidewalk when the ladies went to the cafeteria but the barefooted ones padded along as if they did not mind” (Ward 154). This image directly alludes to the lore reported by Foucault, and it comments upon the lasting effects of this particular branch of the myth of otherness. In another example, Ward 33 is so over-crowded that even the supply of toilet paper often runs out: “There had been days when the nurse had said she was sorry, but there was no toilet paper. *She* was sorry” (Ward 152). Despite the lack of toilet paper, restocking it is not a high priority for Ward 33, again, due to the dehumanizing stereotypes of otherness and madness’ animality. The asylums Foucault describes were true snake pits, and Ward 33 draws striking similarities. For a comparative example, in the famous painting *Madhouse* (1812), Spanish romantic painter Francisco de Goya captures the destitution and chaos of the typical late-18th-century and early-19th-century mental asylum (see Figure 5). In this painting, those confined in the asylum must sit and sleep on a stone floor without beds or blankets like animals; most are naked or barely clothed in rags; and the atmosphere suggests chaos and misery and theatricality. Some of the figures in the painting wear costumed hats and crowns and appear to be acting on a stage while others’ faces are blurred and indecipherable as they hunch in corners. Ward 33 presents parallel chaotic images: there are multiple patients who “[have] great red sores on their faces”; one patient who sings all day while wearing a sash made from toilet paper; “ladies who [talk]...[fix] their eyes on things unseen by others and [speak] in animated voices;” many patients scream sporadically, while others laugh inexplicably; and some patients suffer from deranged religiosity (Ward 146; 152). The image from Litvak’s film adaptation recreates an atmosphere similar to Goya’s (see Figure 6).



Figure 5: Goya, Francisco de. *Madhouse*. 1812-1819.



Figure 6: Ward 33 in *The Snake Pit*.

Virginia Cunningham (performed by Olivia de Havilland) stands in the middle of the chaos of Ward 33.

Moreover, this scene emphasizes the overcrowding and chaos of Ward 33 and refers to both the historical and the modern mistreatments of the mentally disordered.

Furthermore, this exhibition of mental patients, as if they were in a zoo, alludes to the commercialization of the mad, which occurred prominently during the Great Confinement when asylums created public viewings of the confined mad persons for paid admission. According to Foucault, this sort of attraction became an especially popular Sunday pastime in London and France; for example, “as late as 1815...Bethlem Hospital [in London] showed its lunatics every Sunday for one penny. The annual revenue from those visits amounted to almost 400 pounds, which means that an astonishing 96,000 visitors came to see the mad each year” (*History of Madness* 143). Welcome to the human zoo! Just as today’s zoos charge admission to view their animals, in the past for a small fee, people could visit an asylum and gawk at the lunatics shackled in chains inside their cages. In the 20th and 21st centuries, the commercialization of the mad changed venues to traveling “freak shows” then to visual representations in film and television. In his meta-study of repeated images and stereotypical narratives of madness within the media, *Media Madness: Public Images of Mental Illness* (1997), American professor of psychology Otto Wahl emphasizes “This sort of parade-of-patients-with-funny-habits can be found in almost every comedy—film, television, or theater—with a scene in a psychiatric hospital” (30). This narrative trope—the parade of patients—emphasizes the public’s desire, or perhaps need, to vicariously experience mental disorder. With all this considered, Virginia’s first impression of Juniper Hill State Hospital as a zoo incorporates centuries of prejudiced thinking about and inhumane treatments of people with mental disorders. In addition, this human zoo emphasizes the concept of otherness—this dominant cultural narrative dehumanizes persons with

mental disorders, claiming they are fundamentally lesser than sane people. In this example, the otherness connects to the antiquated belief that equates madness with animality.

3.5 Infantilization: They Talk to Us as if We Were Children

Another consequence of the myth of otherness is the infantilization of mental patients. Because the stigma encourages society to view individuals with mental disorders as weaker—mentally and emotionally—than neurotypical individuals, many people, including medical personnel, treat mental patients as if they are children, who need constant care and supervision. To accentuate this experience, Ward dramatizes the belittling treatment patients encounter as well as the age regression many undergo, whether naturally through their disorder or induced through infantilizing treatments. Ward switches from the consequence of dehumanization to that of infantilization when Virginia changes her hypothesis about the setting. Virginia realizes there are no animals at Juniper Hill, so she continues to observe her surroundings, albeit without her eyeglasses, to ascertain where she is. As she watches other female patients, she notices how the staff members treat them like children: “They talk to us as if we were children” (Ward 164). This infantilization of mental patients commonly occurs during confinement in a psychiatric hospital. In the sociological essay “On the Characteristics of Total Institutions,” from his collection *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961), pivotal 20th-century American sociologist Erving Goffman observed this type of infantilization while working at St. Elizabeth’s Hospital in Washington D.C. He hypothesizes that the absence of self-autonomy and the totalitarian rule inherent in the total institution causes the doctors and staff to infantilize the patients:

Total institutions disrupt or defile precisely those actions that in civil society have the role of attesting to the actor and those in his presence that he has some command over his

world—that he is a person with “adult” self-determination, autonomy, and freedom of action. A failure to retain this kind of adult executive competency, or at least the symbols of it, can produce in the inmate the terror of feeling radically demoted in the age-grading system. (43)

In consequence of the infantilizing treatment of the total institution, the patients begin to feel like children, so correspondingly, many exhibit childish behaviors. However, this age regression also finds support in Freudian theory, although Freud does not blame the hospital setting. In *Totem and Taboo* (1913) from the collection *On Murder, Mourning and Melancholia*, Freud discusses his observations of “psychical infantilism” in neurotics: “In most cases the neurotic represents to us a piece of psychical infantilism; either he has not succeeded in freeing himself from infantile relations of psychosexuality, or he has returned to them in inhibited development and regression” (19). In other words, patients experiencing mental disorder often display childlike behaviors and thoughts because their minds have regressed to stages of inhibited childhood development. Ward includes many instances of adult patients acting like children in *The Snake Pit*. First, Virginia notices all the women line up in pairs; some even shove others to be first in line, much like elementary school students. Then, once she is in line, Virginia learns there are juvenile rules she must follow: “You mustn’t talk. It’s against the rules” (Ward 14). Virginia further extends this metaphor when she thinks, “Recess was over...How silly...How had you come to be mixed up in a tour? Undoubtedly one of those government things. Adult education. See your city. Study conditions” (Ward 15). The line-up, the puerile rules, and the conditions of the setting remind Virginia of a school; however, she knows she is not a child. These context clues bring her to the conclusion that she must be touring a reform school as research for her writing:

And then Virginia knew where she was. It was some sort of training school for underprivileged and delinquent girls and she had come to study Conditions. I must be doing a novel with Social Significance. All these new friends of ours always pestering me about why don't I write something that has Social Significance. (Ward 20)

This passage alludes to Mary Jane Ward's own calling to write *The Snake Pit*, certainly a novel with Social Significance. This information reminds readers of Virginia's successful career as a writer and demonstrates she knows she is not a child, which incrementally builds her ethos as a narrator even though she is a mental patient. Moreover, Virginia's success in the professional world does not contribute to her mental disorder, nor do her husband or friends discourage her literary pursuits. On the contrary, the last sentence of this quote underlines the social approval she receives for her writing, even if her friends wish for her to elevate her content. In addition, when the novel opens, a patient named Grace Hoover asks, "Virginia... when was it you worked on a newspaper" (Ward 10). This gives the audience further background information concerning Virginia's career as a writer. As the conversation progresses, Grace compliments Virginia's published novel *Afternoon of a Faun* (Ward 11). Later in the text, Ward reveals the title of Virginia's second published novel as *A Little Night Music* (158). Thus, within the first chapter of the novel and the first scene of the film, the audience learns Virginia is a writer, who has worked for newspapers and has published novels. The fact that Virginia has a successful career challenges the stereotype of otherness and emphasizes the ridiculousness of infantilizing her. By including evidence of her intelligence and successful career, Ward makes Virginia a reliable narrator to her own subjective experience of mental illness and the psychiatric hospital.

To reveal this specific consequence of the myth of otherness, Ward juxtaposes examples of infantilization with the silencing of patients. One recurring conflict demonstrates this: the

medical staff's silencing of Virginia's requests for her eyeglasses, which the staff kept after her admission. When she requests her glasses from the Ward 3 nurse, Miss Hart first questions if Virginia actually needs them, as if Virginia may be lying or confused about her own eyesight: "Glasses?" Miss Hart wrinkled her brow... 'I didn't know you wore glasses. You haven't had any since you've been here in Three'" (Ward 37). Virginia assures her that she is "very nearsighted," but instead of helping, Miss Hart sends Virginia to ask a different nurse, Miss Graves (Ward 37). Virginia finds Miss Graves in the office and asks her: "I wonder if I could have my glasses. I'm very uncomfortable without them" (Ward 37). Miss Graves also questions the validity of Virginia's request: "Glasses? I didn't know you wore glasses" (Ward 37). Miss Graves writes the request on a note and says she will "inquire at the main office"; she promises to bring them to Virginia but never does (Ward 37-38). Despite reporting this problem to two nurses, Virginia does not receive her glasses until she asks a third nurse later in the text. The silencing of Virginia through the patronizing questions and the refusal to accommodate this simple, necessary entreaty results from the infantilization of patients. Goffman observes this exact situation within the setting of the total institution:

Especially in mental hospitals..., the statements [the patient] makes may be discounted as mere symptoms, with staff giving attention to non-verbal aspects of his reply. Often he is considered to be of insufficient ritual status to be given even minor greetings, let alone listened to. Or the inmate may find that a kind of rhetorical use of language occurs: questions...may be accompanied by simultaneous searching by the staff which physically discloses the facts, making these verbal questions superfluous. (*Asylums* 45)

The discounting of Virginia's statement about her need for eyeglasses in conjunction with the nurses' discerning gazes and condescending questions substantiate Goffman's observations.

Many mental illness life narratives portray this common experience. In the interpretive meta-analysis “Narrative of Madness, as Told from Within” (2002), American psychologist, professor, and author Gail A. Hornstein explains, “Patients’ complaints about being unheard have often been dismissed as evidence of their illness.” The dismissal of Virginia’s complaint occurs twice before she finally receives her eyeglasses from a third nurse, and this conflict emphasizes the silencing that occurs during and after psychiatric confinement due to the infantilization of mental patients.

This infantilizing treatment likely occurs for many different reasons. First, the total institution of the psychiatric hospital takes away personal freedom from patients, which reduces them to a status similar to children: patients must follow the rules and stay with their assigned groups, or they face punishments. Secondly, mental patients may have difficulty distinguishing reality from fantasy due to psychosis; this can cause patients to participate in fantasy worlds no one else can see, much like children at play. Ward emphasizes this imagery of child’s play in Ward 33, where some patients play cat’s cradle with string or make ragdolls (Ward 146). The inclusion of these images within the narrative alludes to the infantilization of patients; Ward incorporates this theme because it is a struggle that most, if not all, mental patients encounter. The consequences of this may result in lowering the patient’s self-esteem, further stigmatizing the patient as “other,” and creating a challenging journey back to functioning adult living. Ward combats this stereotype by presenting an intelligent narrator/protagonist who has a successful career because having a career usually marks the distinction between children and adults.

3.6 Dangerousness: Lock ‘Em Up

Thirdly, within the first part of the narrative, Virginia mistakes the hospital for a prison. The prison imagery within the setting and the treatment of patients questions the inescapable

authoritarian rule of the mental hospital; Ward presents the asylum as a total institution that relies upon a punishment/reward system, constant surveillance, cruel medical personnel, horrific treatments, and physical and social barriers. Overall, the prison imagery alludes to the stigma of dangerousness and illuminates problems within the mid-20th-century American mental healthcare system. While the female patients push each other to get in line, Virginia notices how strictly the nurse speaks to the women: “She treats them like criminals. Criminals? That is it. The key. The locked door. That cage-like porch through which we entered the building” (Ward 21). At this point, Virginia begins referring to the nurses as guards and wonders what the other inmates’ crimes are. When she learns she has been at Juniper Hill for seven months from fellow-patient Grace, she asks herself, “Was my crime so great?” (Ward 30). Of course, Virginia has broken no laws; she is not a criminal. However, the setting and the way the patients are treated (like prison inmates) lead her to believe she is being punished, as opposed to receiving medical treatment. This prison metaphor appears throughout the film and the novel. Director Litvak includes many shots that emphasize this comparison; for example, Figure 7 shows one frame that highlights this imagery (see Fig. 7). The prison imagery in the text—which includes barred windows, locked doors, guard-like staff, chain fencing around the hospital’s property, and constant surveillance—corresponds to the stereotype of dangerousness, which promotes the stereotype that those with mental disorders are more dangerous, violent, and unpredictable than neurotypical persons. Thus, by the reasoning of this stigma narrative, for the safety of society, mental patients must stay in safeguarded, fortified facilities in order to separate them from the outside world, just like criminals. Then, as a warden does, a doctor must approve a patient’s release. The prison imagery supports Erving Goffman’s hypothesis that the mental hospital is a total institution. In *Asylums*, Goffman explains the term total institution in this way:

Their encompassing or total character is symbolized by the barrier to social intercourse with the outside and to departure that is often built right into the physical plants, such as locked doors, high walls, barbed wire, cliffs, water, forests, or moors. These establishments I am calling *total institutions*. (4)

These types of institutions include prisons, concentration camps, POW (Prisoners of War) camps, and psychiatric hospitals (Goffman, *Asylums* 4). Notably, physical and social barriers are a crucial component of total institutions. Of course, tangible features separate the inmates from the outside world, but other barriers exist that are more difficult to see.



Figure 7: Prison imagery from The Snake Pit. Directed by Anatole Litvak.

Significantly, the physical barricades in *The Snake Pit* promote the mental hospital as a prison and include the restrictive features of the setting previously mentioned; these physical boundaries promote the stigma myths of otherness and dangerousness. In other mental illness life narratives, the physical setting also may involve a secluded location for the hospital, sometimes with hazardous terrains that make escape all but impossible. In *The Snake Pit*, Ward continually

reminds the reader of Juniper Hills' inescapable environment. For example, whenever a staff member guides patients from one part of the hospital to another, an emphasis on locks and keys alludes to the prison ambiance: "Miss Hart took the key that swung from a long chain at her waist. She unlocked the door. She opened the door and they marched into a hall" (Ward 21). These images—the key, locked door, and marching—accentuate the authoritarian atmosphere of the hospital, which insinuates the similarity between prisons and psychiatric institutions. In fact, as Virginia continues following the other patients in line, she questions the validity of the nurses, believing they are guards in disguise: "They halted at a door that was guarded by another woman fixed up to look like a nurse. This one waited until there was respectful silence and then she unlocked the door" (Ward 21). Notice this nurse, like Miss Hart, not only acts as a prison guard but also as a schoolmarm teaching children how to properly behave; in this way, Ward weaves together the stereotypes of dangerousness and infantilization. The physical boundaries within the setting of *The Snake Pit* illustrate a realistic experience of the total institution of a mental hospital, and by equating it to a prison, much like Goffman, Ward ridicules the American mental healthcare system while raising public awareness to this cultural problem.

In contrast to the stark physical boundaries, the social boundaries of the outside world dissolve within the total institution of the mental hospital. Further, this loss of social boundaries fosters the dehumanization and infantilization of mental patients and emphasizes the myth of otherness. In *Asylums*, Goffman expounds, social barriers in the outside world typically separate the realms of where one can "sleep, play, and work"; however, in the total institution, these divisions are lost (4). Instead, patients participate in all these daily activities with the same group of people; this means they eat, work, sleep, and socialize exclusively with each other. Throughout the novel, Ward illustrates this lack of social barriers; for instance, the patients have

assigned seats in the cafeteria, and these rules are enforced by the staff and patients alike. When Virginia sits in the wrong seat during mealtime, another patient “quite...outraged...bawled for Miss Hart. ‘Miss Hart! Virginia will not take her own place. She is on the wrong side again’” (Ward 22). As opposed to the outside world where such frivolity does not matter, such rules in the psychiatric hospital demand patients’ obedience. Again, combining the stereotypes of dangerousness and infantilization, another example is the patients of each ward must use the bathroom at the same time and under surveillance:

There were four booths. The women stood and waited for their turn. Anyhow, that was the idea. Your turn wasn’t necessarily when you thought. It depended a good deal on where Miss Hart was...Virginia changed from line to line but it was no use; none of the booths had a door.

When at last it was her uncontested turn she discovered that an even more vital accessory was missing. There was no wooden seat and the old joke about not falling in was in this case no joke. But she forgot how frightful this was when she saw there was no toilet paper...there wasn’t even an empty container...When she left the booth she peered at the walls of the other three. None of them had paper. This must be reported...She went to Miss Hart to say what is the idea of not providing these women with toilet paper.

When she reached Miss Hart she saw that the woman was providing toilet paper. Miss Hart was the dispenser. If you required paper you asked her for it in advance and she doled it out to you. She was the judge of how much you needed. It was a curious and humiliating procedure. (Ward 26-27)

This scene dramatizes the dehumanizing process of the total institution on the basis that mental patients are dangerous to themselves and others and that they should be treated like young

children because they are lesser than neurotypical adults. Moreover, Ward magnifies Miss Hart's authoritarian power over the patients: she decides when the patients may use the restroom, who goes to which stall, and how much toilet paper each woman receives. Tellingly, the staff does not trust the patients even to choose how much toilet paper they will need. This is not the only instance when Miss Hart flaunts her authority over the patients; throughout the text, her character highlights the ease at which the staff can abuse their power and the defenselessness of the patients. Moreover, this example shows the silencing of mental patients because Miss Hart decides how much paper each patient needs and to which booth she will go; she does not ask them because she assumes their estimations will be inaccurate. Overall, this inability to change social spheres whenever desired and the lack of autonomy to be able to choose which activities to do and at which times emphasizes the dehumanizing process of the total institution. Clearly, these social losses negatively affect one's experience in a mental hospital. Thus, while the physical features of the mental hospital—barred windows, locks, constant surveillance—add obvious barricades, less tangible yet essential social boundaries are lost when one enters the mental hospital.

These physical barricades and social losses ultimately enforce the myths of otherness and dangerousness because they emphasize the necessity of separating the mentally ill from the general population for the public's safety, just as criminals in prisons are. Significantly, Ward continues to emphasize the prison imagery longer than that of the zoo or reform school because the mental hospital is most like a prison. Ward underscores the myth of dangerousness because this stereotype, in particular, causes a lasting public stigma that has been difficult to fight for a number of reasons. According to eminent American sociologist William C. Cockerham in his seminal book *Sociology of Mental Disorder* (1981), "dangerousness is a concept compatible with

the popular stereotype of a mental patient as someone who is unpredictable and potentially dangerous” (308). This stereotypical narrative is prevalent within American society, and it supports the prejudiced belief that people with mental disorders are more dangerous than neurotypical people. Mass media often sensationalizes this stereotype by representing those with mental disorders almost exclusively through negative portrayals. Consider the intensity of public fear during the late-20th century with the burgeoning stereotype of the escaped, violent madman. From the 1980s through today, popular horror movies portray a slew of insane serial killers (like Jason Voorhees, Michael Myers, Freddy Kruger), and these cultural representations flourish in the news media as well (think about the continued interest in Charles Manson, Jeffrey Dahmer, or Ted Bundy). The media, the public, and doctors alike pathologize these characters as mentally ill because it is too terrifying to imagine a neurotypical person committing such heinous crimes. Historically, the news media has sensationalized this stereotype. In “Chapter 5: The Social Institution of Insanity” from his influential sociological book *Being Mentally Ill: A Sociological Theory* (1966), American professor and sociologist Thomas Scheff explains that in the 1960s (and this certainly still applies to today’s media) newspapers followed the “common practice to mention that a rapist or a murderer was once a mental patient” (72). This automatic inclusion of psychiatric history in cases of violence promotes the stigma of dangerousness because journalists rarely balance these stories with positive representations (Scheff, *Being Mentally Ill* 72). Moreover, in news reports, “often acts of violence will be connected with mental illness on the basis of little or no evidence” (Scheff, *Being Mentally Ill* 72). Examples of false diagnoses within the news abound; for instance, consider current news reports: whenever a mass shooting occurs or a foreign dictator invades a smaller country, the news equates such actions with mental illness, whether or not there is substantiated evidence for such claims. Aware of this stereotypical

representation, Ward includes the fact that Virginia once worked for a newspaper but quit to focus on writing novels; this may allude to Virginia's discontent about such misconceptions in news reporting. She wants "to write something that has social significance," and perhaps the common practices of journalism impeded this ambition (Ward 20).

In continuation, the concept of dangerousness allows for the involuntary confinement of individuals with mental disorders, even without the occurrence of a violent act; unlike in the criminal justice system, a person with a mental disorder can be "imprisoned" simply for the possibility of future harm to oneself or others. As Cockerham explains: "By linking dangerousness to mental disorder, society is allowed to enact preventive detention against the mentally ill, a practice that otherwise would be unconstitutional because the detention of persons merely presumed to be dangerous is prohibited in the absence of an overt act" (308). In Virginia's experience, she wonders if her "crime" warranted her lengthy confinement, but in actuality, she never committed any crimes. Neither the novel nor the film suggests that Virginia is dangerous, or even *potentially* dangerous, yet she still cannot choose the amount of toilet paper to use or decide where she wants to sit at mealtimes or, most importantly, leave the hospital by her own free will. Virginia's case criticizes the myth of dangerousness by showing the discrepancy between the stereotype and the actual patient. Like most mental patients, Virginia is not violent or dangerous; she is simply unwell. Ward does not include any overt acts of violence committed by any patients in the entire novel; in fact, the violence comes in the form of psychiatric treatments, such as electroshock and hydrotherapy. This undermines the popular myth of dangerousness. The film, on the other hand, does include one violent patient, Hester, on Ward 33, perhaps to support the media's "common practice" of including this false stereotype.

Another stereotype that falls under the myth of dangerousness has nothing to do with violence or unpredictable behavior; the dangerousness of mental illness also stems from the fear of contagion. In fact, the strong aversion to this taboo continues into the 21st century because many Americans still believe that mental disorders are contagious. This myth encourages the public to avoid mental patients, hence the desire to confine them to hospitals; conversely, it also increases the fear of the hospital for potential patients. Likewise, the taboo of contagion scares away many medical staff members from seeking employment in mental health departments. Ward illustrates these nuances within the novel through the character of Miss Sommerville—a former Juniper Hill nurse who became a Ward 33 patient before Virginia arrived, and Litvak maintains these details within the film adaptation. Miss Sommerville embodies the taboo of contagion and enhances the horror of Ward 33. In her meta-analysis *People Like Ourselves: Portrayals of Mental Illness in the Movies* (2003), American communications professor and author Jacqueline Noll Zimmerman explains the connection between this fear and Miss Sommerville:

The movie does play on some fears about mental illness and mental hospitals. One of those fears is the suspicion that it is a thin line separating sanity from madness and the closely related notion that, like leprosy, madness might be contagious. One of the patients on Ward 33 is a Miss Sommerville, who was once the head nurse of Ward 1 and who still thinks she is a psychiatric nurse. Asylum staff-gone-mad is a standard ingredient of horror movies. (Zimmerman 25)

Sommerville was once the highest-ranking nurse in the reception building, but after years of dedicated nursing, she experienced a nervous breakdown. The insinuation of this example is that anyone working too closely with mental patients, especially if that person cares too much about

the patients, risks falling into madness herself. As a nurse, Sommerville greatly cared about the patients on Ward 1; now, others blame this empathy for her demise. While Miss Vance, a young nurse on Ward 33, helps dress Virginia for a meeting with Staff (these Staff meetings determine whether a patient goes home or remains in the hospital), Vance explains Miss Sommerville's history to Virginia: "She used to be a nurse...Here in this hospital...She felt things too much, though. In this business, you got to have a hide like a rhinoceros...She's been sick a very long time" (Ward 178-179). This horror element emphasizes the fear of contagion because Sommerville becomes a living example of this myth. In fact, because this figure evokes such strong pathos, Sommerville is the last image seen in the novel; after crossing Virginia's name off her "nurse's record," Miss Sommerville remains stuck in Ward 33, a chronic patient living in a world of delusions: "'I should have said good-bye, but it's too late now, of course,' said Miss Sommerville. 'It would be silly to say good-bye to someone who isn't here.' And again reaching for the ghost of her key, the former nurse unlocked a private door" (Ward 192). This last image is poignant because Virginia still stands next to Sommerville when she says this. However, in her disordered mind, once she crosses Virginia's name off her chart, she cannot acknowledge Virginia anymore. Perhaps, somewhere in her Unconscious, Miss Sommerville knows she is unwell, so acknowledging when another patient leaves for home becomes repressed in her Unconscious because it is too painful to accept that she cannot go home like Virginia. Furthermore, by ending with Miss Sommerville, Ward uses this haunting image to engage the reader, even after finishing the novel. The nurse-turned-patient resonates because she anthropomorphizes the fragility of sanity and the fear of contagion. Ultimately, all these images from *The Snake Pit* conjure the myths of dangerousness, otherness, and infantilization and conjoin to belabor the imperative to fear the asylum.

3.7 Fear the Asylum: Torturous Treatments

Ironically and despite its denotation, in American culture, the word “asylum” connotes a hellish mental institution which delivers more torture than healing. The mistreatments observed during the Great Confinement and the resultant public ill-favor encouraged 19th-century psychiatrists to exchange the non-medical term “asylum” with the word “hospital” (Rondinone 9). Of course, a qualifying adjective, such as “mental” or “psychiatric,” always accompanies this noun. Somehow, this change in nomenclature fooled the public into thinking that sweeping positive changes also had occurred within the asylum. Of course, there were changes in procedures and theories; however, the horrors of the asylum simply transformed into newer “scientific” methods of treatment, such as early experiments with lobotomy and electroshock therapy. In *The Snake Pit*, a distinct difference between the public perception of Juniper Hill State Hospital and Virginia’s personal experience there represents the similar discrepancy in mental healthcare during the 1940s. By presenting the mental hospital as disguised asylum, Ward raises public awareness of this social problem and advocates for psychiatric reforms. In the novel, despite the popular opinion that “Juniper Hill has the best doctors,” Virginia experiences a multitude of ineffective treatments ordered by her psychiatrist Dr. Kik, which include shock treatments of “insulin, metrazol, [and] electricity,” hydrotherapy (tubs) and wet packs, psychoanalysis, the oral medication paraldehyde, and various occupational therapies (including sorting, sewing, mopping, polishing, and cafeteria work) as she moves between different wards and buildings, which house patients with varying degrees of mental illness (Ward 175; 150-151). In the novel, the treatment that evokes the greatest fear in the patients is electroshock therapy (also called electroconvulsive therapy or ECT), especially because Ward does not include much imagery of lobotomy. In Ward 8, there is one patient, who has received lobotomies: “Tamara had

had five operations on her head, said the ladies, and was hopeless” (Ward 134). This is the only information included about lobotomy—one hopeless patient. However, the emphasis on electroshock therapy in the novel is understandable given that it was a brand-new therapy in 1938, so the imagery of it was unusual and shocking to the audience (Rondinone 79). According to Rondinone, “Electroconvulsive therapy was still novel in the 1940s, though it was spreading rapidly in mental hospitals. By 1947, nine in ten psychiatric hospitals used ECT” (95). Thus, both the novel’s and film’s audiences alike became fascinated and haunted by Ward’s words and Litvak’s visuals. In the novel, the first time the readers view Virginia’s experience of electroshock therapy accentuates ECT as a horror element and as something to be feared. As a “guard” leads her down one hall then another, Virginia enters “an operating room” (Ward 33). Here, Dr. Kik waits for her. As the doctor and nurses prepare Virginia for the procedure, her fear heightens with her physical discomfort before being validated by the horror and pain of the treatment:

They put a wedge under her back. It was most uncomfortable. It forced her back into an unnatural position. She looked at the dull glass eye that was set into the wall and she knew that soon it would glow and that she would not see the glow. They were going to electrocute her, not operate upon her. Even now the woman was applying a sort of foul-smelling cold paste to your temples. What had you done? You couldn’t have killed anyone and what other crime is there which exacts so severe a penalty?...Dare they kill me without a trial? I demand to see a lawyer. And he—he always talking about hearing voices and never hearing mine...if I say I demand a lawyer they have to do something. It has to do with habeas corpus, something in the Constitution. But they and their smooth talk, they intend to make a corpus of me...

Now the woman was putting clamps on your head, on the paste-smear'd temples and here came another one, another nurse-garbed woman and she leaned on your feet as if in a minute you might rise up from the table and strike the ceiling. Your hands tied down, your legs held down. Three against one and the one entangled in machinery.

She opened her mouth to call for a lawyer and the sully woman thrust a gag into it and said, 'Thank you, dear,' and the foreign devil with the angelic smile and the beautiful voice gave a conspiratorial nod. Soon it would be over. (Ward 33-34)

Virginia's physical discomfort—the wedge, the clamps, the restraints—before the therapy increases her fear of the procedure. Rondinone explains, "before sedatives came into the picture, patients would experience extreme, physical reactions to ECT, often incurring compression fractures of the spine and dislocated jaws" (79). The Juniper Hill staff works to mitigate these possible harmful side-effects by adding a wedge under the patient's back and a gag in her mouth. These additions show that the doctors at Juniper Hill are not using this treatment haphazardly, but the foreignness of the wedge and gag provoke Virginia's panic nevertheless. By including these horror elements, Ward appeals to pathos by invoking the audience's fear and empathy, both of which inspire her audience to fight for reform.

In addition, the ECT scene further illustrates many of the stigmatizing myths Ward criticizes throughout the novel. Firstly, Ward stresses the infantilizing silencing of the patient through this procedure when she refers to Dr. Kik—"he always talking about hearing voices and never hearing mine"—and to the nurse who thanks Virginia for opening her mouth before gagging her (Ward 33). In addition, the narrative perspective changes erratically as Virginia's anxiety builds; the pronouns switch rapidly between first, second, and third person. This emphasizes the stereotype that mental patients are unpredictable and unreliable narrators.

Additionally, Virginia believes the doctor and nurses are going to execute her; this element feeds into the myth of dangerousness and increases the sense of fear within the narrative mood. At this point in the narrative, Virginia still believes she is in a prison. She wants to demand a lawyer, but as soon as she opens her mouth, she is silenced. This alludes to the seemingly unconstitutional practice of the involuntary confinement to psychiatric institutions of persons who have not committed crimes. In addition, the nurse thanks Virginia for opening her mouth, and the doctor nods in approval; to them, Virginia is “actively participating” in her recovery. They misread her intentions and instead infantilize her by treating her like “a good girl.” This scene emphasizes the horrors of experiencing psychiatric treatment and the miscommunications between patients and medical staff; ultimately, this scene vividly illustrates why people should fear the mental hospital.

The combined power of the novel’s and film’s presentations of this narrative demonstrates (1) how stereotypical images and myths of mental illness become implanted in the American imagination through repetition within cultural discourses, and (2) how realistic, empathetic mental illness life narratives influence positive changes in the public’s understanding and treatment of individuals suffering from mental disorders. For example, in 1948, director Anatole Litvak exponentially increases the horror of Virginia’s experiences with ECT because the film adaptation removes the ambiguity of the novel by visually portraying the setting, characters, and plot actions in realistic, concrete images. These images influenced future films dealing with mental illness and became transfixed upon the American imagination. Litvak wanted to create an accurate representation of state mental hospital conditions and of patients’ experiences there, so he shot the film “in a Hollywood studio and at Rockland State Hospital” in New York, the very hospital where Mary Jane Ward received treatment (Harris 232). In fact,

according to American professor of psychology Ben Harris in his film analysis and critique “*The Snake Pit: Mixing Marx with Freud in Hollywood*” (2021), *The Snake Pit* is “the first film to treat the problem of mental illness seriously, not just as a plot device or source of titillation” (233). To accomplish this goal, Litvak encouraged the screenwriters and actors to visit different mental hospitals to best understand the conditions and people there. For instance, Harris highlights, the two screenwriters “[Millan] Brand and [Frank] Partos visited Camarillo State Hospital and talked to patients and staff. They then spent weeks in New York City, visiting hospitals and talking to leading figures in psychiatry and the hospital reform movement” (238). Similarly, lead actress Olivia de Havilland regularly visited Camarillo State Hospital to research for her role as Virginia Cunningham. This diligence to realism creates images within the film that are difficult to forget, especially the ones related to electroshock therapy. For example, Figure 8 shows an image from the film, in which Virginia’s fear is unmistakable—from her furrowed brow to the panic in her eyes (see Fig. 8). Moreover, in contrast to the novel, Litvak creates a montage of four of Virginia’s “dozen or so” electroshock treatments with a guttural musical score, both of which encourage a visceral reaction from the audience (Ward 73). The film’s version of the scene unfolds as follows. First, Virginia sits on a hallway bench crowded with other patients. While waiting, they watch an unnerving cycle—a patient walks into the operating room; the door closes behind her, and the procedure ensues; afterward, a nurse wheels the unconscious patient away on a gurney. When the nurse calls Virginia’s name, she wrings her hands together and freezes; her friend Grace encourages her to follow the nurse’s orders, but Virginia says, “I’m afraid. I’m terribly afraid” (Litvak 0:18:25-0:18:28). As Virginia enters the operating room, an exhausted doctor asks the nurse how many more patients he has for the day, to which she responds “Twenty-three, doctor” (Litvak 0:18:41-0:18:42). This addition in the film

highlights the overcrowding of the hospital and alludes to the psychiatric hospital as a factory line. The novel also supports the theme of overcrowded state hospitals; for instance, in evaluation of the conditions at Juniper Hill, Virginia observes: “There wasn’t enough of anything at Juniper Hill. Not enough doctors, not enough nurses, not enough toilet paper, not enough food, not enough covers for cold nights...there were not even enough beds. There wasn’t enough of anything but patients” (Ward 175). Furthermore, the doctor’s exhaustion due to the shortage of medical staff and the overcrowding of patients increases the horror of this scene because the chance of medical error increases correspondingly with the performing physician’s fatigue. Additionally, the camera’s close focus on the ECT machinery further intensifies the emotional appeal to the audience’s fear. When the nurse directs Virginia to lie down on the operating table, Virginia freezes again as she looks at the ECT machine—a large black box with knobs and buttons and a gauge, which Dr. Kik works to adjust. The temple clamps sit atop the machine. Here, Virginia repeats the line from the novel: “Was my crime so great?” (Litvak 0:19:04-0:19:05). Dr. Kik laughs off the question and picks Virginia up like a child, under her arms, to place her on the table; he tells her, “Dr. Summer and I are just trying to make you well. We’re your friends” (Litvak 0:19:09-0:19:11). This patronizing speech and behavior work to infantilize Virginia and to silence her voice and fears as nonsense. Virginia’s panic is palpable when three nurses hold down her feet; as she opens her mouth to demand a lawyer, another nurse shoves a gag into it (see Fig. 8). Seeing her fear, Dr. Kik tells her not to be afraid in a warm, calm voice. This inclusion of Dr. Kik’s exceedingly tender bedside manner illustrates the filmic version of Dr. Kik as the savior figure, which contradicts the novel’s portrayal. Suddenly, the room goes quiet except for Virginia’s unsteady, fearful breathing. This creates a similar pathos in the audience by heightening the anxiety of the moment before Dr. Kik flips the switch on the ECT

machine. The camera zooms in to focus solely on the machine and Dr. Kik's hand moving toward it. He flips the switch, and the musical score blares in a cacophony of shrieking horns and



Figure 8: ECT Scene from The Snake Pit

This image from the film shows Virginia as she tries to request a lawyer, but the nurse puts a gag in her mouth. Virginia's electroshock therapy begins.

sharp whistles followed by lulls of mournful woodwinds. The deep woodwinds resemble human groans, and these play during the montage when Virginia is in-between ECT treatments. During these in-between moments, the camera focuses on Virginia's patient file as Dr. Kik adds his notes, which do not bode well, with comments like "No essential change" and "Contact continues poor" (Litvak 0:20:29). The shrill brass winds scream again each time Dr. Kik switches on the ECT machine for a subsequent treatment. The montage includes four shock treatments in a row. However, the brief time allotted in the film for this quick series of events

does not decrease the horror of the scene; in fact, the last image is of a wall clock, whose hands move at the correct speed. This demonstrates that despite the quickness of the scene, psychiatric treatment takes a long time, so for a patient like Virginia, the elapse of time feels differently when confined in a total institution. The overwhelming sensory elements juxtaposed with the sense of disrupted time appeals to the audience's fear and empathy, urgently calling them to action to fight the stigma of mental illness and inhumane psychiatric treatments.

Additionally, through its gothic depiction, this ECT scene presents the experience of mental disorder and psychiatric treatments as encounters with the Uncanny through the gothic tropes of temporal in-betweenness, living burials, and ghostly doubles and through allusions to *Frankenstein*. In his essay "The Uncanny" (1919), Freud defines the Uncanny using multiple parameters: 1) something that "undoubtedly belongs to all that is terrible—to all that arouses dread and creeping horror," 2) "something long known to us, once very familiar," and 3) "everything is uncanny that ought to have remained hidden and secret, and yet comes to light" (1-2; 4). Based on these definitions, many elements in the experience of mental disorder and institutional confinement create encounters with the Uncanny. Firstly, because insanity is something long known by humankind, our culture recreates familiar images of madness, which keep it recognizable to most Americans even if they never witness it firsthand. Additionally, the stigma encourages people to remain silent about their experiences with mental disorder, as if insanity itself should remain hidden and secret. These two aspects of madness—both familiar and secret—connect the experience of mental disorder to Freud's definition of the Uncanny. Secondly, the sense that time moves differently when one is confined within a mental hospital is a common theme found within mental illness life narratives because patients experience a feeling of in-betweenness, as if they are suspended somewhere outside of space and time, because they

are hovering within stalled time due to their separation from the outside world, where the people they know continue living, working, and playing. Whereas when one is confined within a total institution, the ability to choose where and how to spend one's time vanishes. After studying conditions at St. Elizabeth's Hospital, Erving Goffman reports this same observation:

Among inmates in many total institutions there is a strong feeling that time spent in the establishment is time wasted or destroyed or taken from one's life; it is time that must be written off; it is something that must be "done" or "marked" or "put in" or "pulled." In prisons and mental hospitals, a general statement of how well one is adapting to the institution may be phrased in terms of how one is doing time, whether easily or hard. This time is something its doers have bracketed off for constant conscious consideration in a way not quite found on the outside. As a result, the inmate tends to feel that for the duration of his required stay—his sentence—he has been totally exiled from living. (*Asylums* 67-68).

This state of exiled in-betweenness marks a place of terror and also symbolizes the primal fear of being buried alive. Within the mental institution, one is locked inside a concrete "box" and left in a dark, solitary, and silent position somewhere between life and death. Thus, in a way, experiencing psychiatric confinement is like being buried alive. The asylum is a terrifying place that fills people with dread and creeping horror because the in-betweenness inherent in the mental patient's situation creates the sense of a living burial. This living burial increases the gothic, horror elements of the narrative and connects to Freudian theory on the Uncanny. Freud claims that "to many people the idea of being buried alive while appearing to be dead is the most uncanny thing of all" ("Uncanny" 14). The elements involved in the symbol of the live burial or living death connect to other instances of the Uncanny: 1) situations which encourage "doubts

whether an apparently inanimate being is really alive; or conversely, whether a lifeless object might not be in fact animate,” such as a corpse; and 2) the theme of the ghostly “double” (Freud, “Uncanny,” 5). Consequently, the sense of a living burial within the asylum divides the patient into doubles—the pre-hospitalized individual and the ghostly shade of the stigmatized mental patient. In Freudian theory, this ghostly double becomes a common image within the human experience; it emerges in childhood from “the soil of unbounded self-love, from the primary narcissism which holds sway in the mind of the child as in that of primitive man” (Freud, “The Uncanny,” 5). Think about this first double as the orienting Ideal-I in Lacan’s Mirror Stage. At first, the double seems like a perfect version of the infant’s wobbly self, but this Gestalt causes a horrible, alienating sense of fragmentation between his real self and his haunting double. Thus, the ghostly double transforms “from having been an assurance of immortality...[to] the ghostly harbinger of death” (Freud, “Uncanny,” 9). Often, when individuals remember the eerie feeling of this division within themselves, they encounter the Uncanny. For example, since the Age of Reason, people in Western civilizations have feared falling into madness. The fear that insanity is just on the other side of sanity provokes two images of oneself—a sane version and an insane version. When taken in combination, these details of the Uncanny easily illustrate themselves in Virginia’s fear of electroshock treatment. For example, on her way to shock, Virginia refers to the other patients as “ghosts,” which equates the patients as the dead doubles of their former healthy selves (Ward 31). This also suggests that experimental psychiatric treatments can cause a living death because they often leave patients in a state of unconsciousness or catatonia, sometimes for a short time and other times forever. For instance, in the novel, Virginia experiences many side effects from ECT, including dizziness, nausea, and temporary amnesia; all these symptoms could make someone resemble a ghost; imagine a patient as she stumbles

around, pallid with nausea and confused about where she is, especially when dressed in a pale patient's gown as she would be at Juniper Hill. The film includes many patients who appear this way. Furthermore, the unconscious patient, wheeled away on a gurney, simulates the appearance of a corpse, which then arouses the uncomfortable doubt of whether this seemingly inanimate object—the zombie-like patient—is alive or dead. Likewise, this ghostly double of one's former self heightens the terror of the situation because the desire to return to one's pre-institutionalized self may be impossible to fulfill if psychiatric treatments go awry. Equally important as a gothic image, the electricity involved in electroshock therapy resembles that used in the electric chair, which further emphasizes the fear of becoming the dead double. Similarly, the electricity and the ECT machine allude to Dr. Frankenstein's monstrous experiments. Like Dr. Kik, Dr.

Frankenstein must flip a switch to start his machine in the classic film version. While Dr. Frankenstein's experiment results in the galvanization and reanimation of a corpse, ECT seemingly does the opposite, at least temporarily. Altogether, this ECT scene utilizes gothic elements within the narrative and portrays the experience of mental disorder as an encounter with the Uncanny. Although Virginia Cunningham experiences other treatments in *The Snake Pit*, including hydrotherapy, wet packs, and physical restraints, both the film and the novel intensify the horror elements of electroshock treatment specifically because it was a new, misunderstood therapy, which only bolstered the modern audience's feeling of terror.

Ultimately, these details appealed to mid-20th-century American audiences' sympathies and affected social and political changes within the mental healthcare system. However, this gothic portrayal of ECT also has negative consequences: because horror elements both increase the social fear of psychiatric treatments and ignore the lifesaving benefits some patients receive, gothic sensationalism in mental illness life narratives can inhibit individuals from seeking

necessary healthcare during times of mental crisis. As Rondinone highlights, “Contemporary evidence indicated that [shock therapies] improved the lives of many patients,” and this continues to be true today (79). For this reason, negative portrayals of psychiatric treatments, especially when sensationalized or anachronistic, are dangerous. For *The Snake Pit*, the gothic portrayal of ECT is effective because, at the time, the treatment still had many problems yet to be resolved; however, the continuation of this gothic trope in the late 20th century and into the 21st century is outdated and socially irresponsible. Nevertheless, the use of ECT as a horror element and the gothic tropes within *The Snake Pit* work to accomplish Ward’s goal to write a novel with social significance because this scene and these literary elements encouraged her audience to fight for changes in the American mental healthcare system.

3.8 Thrown into the Snake Pit

Ward and Litvak further illustrate the mental hospital as a place to fear by criticizing its reliance upon a system of rewards and punishments, instead of best practices for medical treatment. The climax of the narrative and the turning point in Virginia’s recovery highlight the consequences of this system. According to Goffman in *Asylums*, the transfer of patients between wards highlights the privilege system of rewards and punishments (a key component of total institutions):

Inmates are shifted very frequently and visibly from one place to another as the administrative device for giving them the punishment or reward their cooperativeness warrants. The inmates are moved, the system is not. We can therefore expect some spatial specialization, with one ward or hut acquiring the reputation of a punishment place for especially recalcitrant inmates, while certain guard assignments become recognized as punishments for staff. (51-52)

In *The Snake Pit*, the wards with the lowest numbers have the least-sick patients, who are nearly ready to go home. However, if a patient acts out or refuses to comply with orders, her doctor sends her to a higher numbered ward. Throughout the narrative, the doctors shift Virginia between multiple wards and two buildings. They say these transfers are for better care, but the plot demonstrates the staff also uses transfers as punishments. For example, after Virginia bites an overbearing doctor in her first Staff meeting, he transfers her from Ward 3 to Ward 5 (Ward 100). This punitive movement of patients stresses the hypocrisy of the psychiatric hospital because the ward system mimics a system of reward and punishment instead of efficacious medical treatment. Moreover, the wards are drastically different from each other due to the changes in nurses' abilities and care as well as in the patients' degrees of disorder. The climax of the plot occurs when doctors place Virginia in the worst ward—Ward 33 in Building 5—where the chronically insane patients remain, often for life. The reason Virginia moves to Ward 33 is unclear; when she asks why she could not stay in the reception building, a patient named Ruth explains, "Reception. You stay there till you go home, if you go home before a year. Otherwise you have to go to one of the other buildings" (Ward 145-146). When Virginia complains she has not been at Juniper Hill for over a year, Ruth shrugs, "Sometimes they know sooner, I guess" (Ward 146). Not knowing the reason for the transfer makes Virginia frightened and confused; however, the shock from the disturbing sights and chaotic sounds of Ward 33 inspires Virginia's belief that she will recover because she knows she is healthier than the other patients of Ward 33. She compares the shock she experiences on Ward 33 to an ancient human custom involving insanity and snake pits:

Why bother with insulin, metrazol or electricity? Long ago they lowered insane persons into snake pits; they thought that an experience that might drive a sane person out of his

wits might send an insane person back to sanity. By design or by accident, she couldn't know, a more modern "they" had given V. Cunningham a far more drastic shock treatment now than Dr. Kik had been able to manage with his clamps and wedges and assistants. They had thrown her in the snake pit, and she had been shocked into knowing that she would get well. (Ward 150-151)

The cultural phrase "snake pits," which colloquially renames brutal state mental hospitals, comes from this section of the novel. Because this turning point and theme are crucial for understanding Virginia's experience, Ward uses the term as the title of the novel. The film emphasizes this scene by steadily raising the camera's view above Ward 33 until it resembles a snake pit and the patients appear as snakes (see Figure 9). This also connects back to the theme of otherness and the animality of madness as discussed in connection to the narrative's zoo imagery. In addition, this key passage prominently illustrates the incompetency of early 20th-century psychiatry while insinuating that humans have not known how to deal with insanity for a long time, if they ever truly did. The mental shock Virginia experiences is a response to fear—she does not want to be stuck on Ward 33 indefinitely. Nevertheless, this fear catalyzes hope— Virginia believes she will recover because she now knows she is not the sickest patient at Juniper Hill: "the hopelessness that had been hounding her had lessened and for the first time she dared to believe that she might get well...When you realize you aren't the sickest in your ward, it does something for you" (Ward 150). This turning point serves as a stimulus, jumpstarting Virginia's motivation to get well. However, she also realizes the prescribed treatments are not helping her enough, so another crucial aspect of this dynamic change is Virginia's new active participation in her recovery. To conclude, Ward includes these horror elements to compel her audience to act for social reform,



Figure 9: Ward 33 as The Snake Pit

This frame displays the aerial view of Ward 33, which mimics the appearance of a snake pit. Notice this perspective allows for the patients to appear as the snakes in the pit.

and by giving Virginia a new active role in her recovery, Ward inspires hope in audience members who are mental patients by encouraging their active participation in their treatments and recovery.

3.9 The Efficacy of the Freudian Doctor: The Major Difference between the Novel and Film

The novel and the film differ drastically in the portrayal of the Freudian doctor. While the film shows the Freudian doctor as the hero of the narrative, the novel establishes the patient as the heroine. This disparity questions, upon whom does an individual's recovery depend—the doctor or the patient? The novel suggests the patient must “cure” herself, whereas the film

insinuates that only a “good” doctor can “cure” mental patients. In the novel, after the shock of Ward 33, months of unsteady progress, and ineffective psychiatric treatments, Virginia decides to create her own “private therapy. Thinking Therapy, she called it” (Ward 165). Ultimately, her newfound hope leads to the resolution of the novel’s conflict with the Virginia’s recovery. Virginia explains the importance of Thinking Therapy, or “TT” for short, and contemplates why Juniper Hill does not offer a similar treatment:

Lady, she would say to herself and then she would have her class in thinking. A one-pupil class. It was hard but she felt it was important to learn again how to think. It seemed queer to her that the hospital had no interest in teaching its patients to think. Juniper Hill’s goal was to Keep Them Quiet. Perhaps a group of thinking patients would have disturbed the peace. Let people think and at once they are drawing up petitions and demanding Rights. There simply were not enough nurses to handle thinkers. (Ward 165)

To Virginia, learning to think again is the only way she will save herself. She must relearn how to separate reality from fantasy. When she questions why no such therapy exists in psychiatry, she blames the hospital’s overcrowding and nursing shortage. The film maintains this critique through unequivocal images (see Figure 10). For Virginia’s Thinking Therapy, she assigns herself a topic, such as “The History of the Modern American Novel” or “The Famous Writers I Have Heard Speak”; then, she works to recall all her memories on that subject, sometimes in her mind and other times on paper (Ward 165). In this way, little by little, she reactivates her prior knowledge and begins to cut through the fog of her disorder. Virginia uses her experience as a writer to create lists to stimulate and organize her ideas; this common prewriting strategy ultimately helps Virginia organize her disordered thinking. Crucial to understanding the novel,



Figure 10: Overcrowding at Juniper Hill State Hospital

This frame emphasizes the overcrowding at Juniper Hill; notice there is one nurse, who must care for dozens of patients.

Thinking Therapy does not follow Freudian theory, nor does it rely upon any historical theories from psychiatry. She does not dig into the traumas of childhood nor try to uncover repressed memories. Instead, she works to remember what will help her resume her life as a writer outside of the hospital. In addition to her intrinsic motivation, Virginia receives unconditional support from her loving, loyal husband, Robert Cunningham. Not only does he visit Virginia every visitors' day but also ultimately fights to have Virginia released from the hospital by telling the doctors that he and Virginia are moving back home, out of state, to Evanston, Illinois. The combination of Robert's persistent involvement in his wife's care and Virginia's self-prescribed Thinking Therapy leads to her recovery and release from Juniper Hill. Ward gives little credit to

the doctors for Virginia's improved wellness. Instead, Virginia renames Dr. Kik with sarcastic epitaphs—such as “the Indefatigable Examiner” and “the foreign devil with the angelic smile and the beautiful voice,” both of which could easily apply to Sigmund Freud (Ward 31, 34). In fact, Ward includes many descriptions of Dr. Kik that allude to Freud, such as his voice has “a heavy accent that you had never been able to place. It wasn't German, French, Italian or Scandinavian. Polish, perhaps” (Ward 33). (Freud was Austrian.) These resemblances between Dr. Kik and Sigmund Freud allow Ward to clearly criticize Freudianism by including a Freudian doctor whose therapies are ineffective and whose theories are inaccurate. However, in stark contrast, the film promotes Dr. Kik, and Freud by association, to the status of hero and savior. In the film, Dr. Kik is as much a protagonist as Virginia. To accomplish this, the director of the film removes Thinking Therapy entirely; instead, only Dr. Kik's Freudian interpretation of Virginia's unconscious guilt and his careful explanation of it to her allow for her final recovery.

Thus, the novel and the film differ greatly in their presentations of the Freudian doctor, who becomes a recurring figure throughout the 20th century, and this cinematic modification highlights sociohistorical fluctuations in popular thought, particularly in response to Freudianism, feminism, and the return of America's WWII soldiers. In the 1940s, political imperatives propelled Freudianism back into prominence after it had lost momentum during the Great Depression of the 1930s because Freudian theory aligned with post-WWII political propaganda, particularly regarding the social roles of women. Before America entered World War II, the American public lost much of its confidence in psychoanalysis and Freudianism. As Leslie Fishbein explains, because psychology failed to foresee the stock market crash of 1929 and the corresponding Great Depression of the 1930s, the public no longer trusted Freudian doctors and no longer believed psychology was a real science (641). Despite this loss of faith,

Freudianism experienced a resurgence; after WWII ended, when the American soldiers returned home from Europe, they needed to reenter the workforce to heal from the psychological wounds of war and to restore the household and family unit with their financial support and physical presence. Conversely, this homecoming also meant that many women, who had tasted the freedom of working outside the home during the war, lost their wartime jobs or had husbands who encouraged them to quit. For many American women in the 1940s and the 1950s, this sudden shift back to the role of housewife became psychologically distressing; the house became a pseudo-prison for these women with their husbands as the wardens. Because many American housewives became distraught and angry in this situation, the mass media began propagandizing the idea that American women's patriotic duty was to return to the home and to the roles of wives and mothers. This promoted the exact opposite argument the media propagated during the war when it was women's patriotic duty to join the workforce. Tellingly, this forced migration back to the household applied to middle-class and upper-class women. For impoverished families, women had to work continuously outside the household to support their families before, during, and after the war; in other words, being a housewife was not a luxury everyone could afford. Thus, this propaganda often did not apply to many immigrants, people of color, or anyone living below the poverty line. Nevertheless, the nation became inundated with "a proliferation of anti-feminist tracts" (Fishbein 641). Fishbein illustrates how this anti-feminist movement found support in Freudian hypotheses: whether "consciously or unconsciously," this post-war propaganda promoted "the Freudian dogma that 'anatomy is destiny' to buttress [its] argument that women were static creatures, impervious to historical change, whose very natures would be violated if they were diverted from reproduction and nurturance to the 'masculine' realms of intellect and career" (641-642). In response to this, Mary Jane Ward presents this controversy

and the corresponding anti-feminist consequences that problematize Freudianism as an underlying theme in the novel. The film also includes this historical debate but from the opposite perspective. For example, when Virginia begins to show improvement near the middle of the film, Dr. Kik prescribes her a daily writing regimen. Conflict arises when Nurse Davis promotes late-1940s propaganda about women's expected roles in society because her stereotypical beliefs diametrically oppose Virginia's career as a writer. Fishbein notes, "Intellectual and career women became the *betes noires* (particularly disliked persons) of popularizers of Freudianism in the late forties" (642). Nurse Davis, Virginia's nemesis in the film, illustrates this social prejudice against intellectual women. When Nurse Davis brings a typewriter, desk, and paper to Virginia's bedroom, the nurse sneers down at her as she tries to write; criticizing her ambition, Nurse Davis smirks, "Look Virginia, and I say this only for your own good, being a writer is nothing to be so excited about. It doesn't set you above the other ladies, you know. Now, if you really were a writer" (Litvak 1:17:31-1:17:40) Angrily, Virginia interrupts Nurse Davis: "Do I tell you how to be a nurse?" (Litvak 1:17:41). Although Virginia's question points to the hypocrisy of Nurse Davis' judgment because she is a working woman, too, their career choices are in social opposition. Nurses and schoolteachers were socially acceptable jobs for middle-class women in the early 20th century; on the other hand, American society at that time typically viewed professional writing as a male-dominated field because it was "too intellectual" for women's "sensitive" minds. Nursing and teaching were acceptable choices because they required the feminine qualities of caretaking and child-rearing—these characteristics were part of women's "nature," according to popular Freudian psychology. Nurse Davis emphasizes the social distain for ambitious women in post-WWII America when she replies: "Alright, Lady, I've tried to be patient with you, but you just haven't any spirit of cooperation. All you have is an

exalted idea of your own importance. Let me tell you something, if it weren't for Dr. Kik, you'd never be here" (in Ward 1) (Litvak 1:17:43-1:17:53). These words not only illustrate anti-feminist propaganda but also how many women of the time supported these ideas as well. The major difference between the novel and the film hinges upon the authorial and the directorial political support, or lack thereof, for post-WWII Freudianism.

In continuation, the opposing portrayals of the Dr. Kik character point to the interpretive differences between the female author and the male director. To Ward, Dr. Kik is a fool, but to Litvak, he is a messiah. In both mediums but especially in the film, the doctor infantilizes the patient, often treating her like a child and greatly simplifying his explanations to her about her condition. This power dynamic between the doctor and patient further emphasizes the myth of otherness. The film establishes a clear difference between the patient and doctor because the patient *needs* the doctor to become well again. Without the Freudian doctor, the patient would be lost in the asylum system forever. On the other hand, the novel positions Virginia to be her own savior; she must resist the misinterpretations of her doctor and design her own treatment. As an illustration, near the end of the novel, Robert and Virginia dismiss Dr. Kik's final evaluation based on his psychoanalysis of Virginia. Kik reveals to Robert that Virginia's mental breakdown stems from her unconscious guilt over her fiancé Gordon's death, which occurred 17 years prior to Virginia's commitment to Juniper Hill (Ward 177). When Robert tells Virginia of this conclusion, they find it far-fetched and highly unlikely; Virginia claims, "It's the sort of thing that would be nice in a book" (Ward 177). As the Cunninghams ridicule Dr. Kik in the novel, Virginia draws her own conclusion about him: "'It's embarrassing,' she said. 'I mean, for Dr. Kik. I always think of him in connection with that little room with electricity [i.e., the electroshock room], always the man of science. This changes the picture. I'll have to think of

him as a man of romance as well” (Ward 177). In this passage, Ward criticizes Freudian psychoanalysis for creating only romantic fictions about the patients but not efficacious healing. This criticism becomes even more credible because Ward is a fiction writer, as is her narrator/protagonist; thus, if anyone could recognize how to spin a romantic, fictionalized version of an experience, it would be someone like her. Appealing to the credibility of this claim, Dr. Kik never reveals a specific diagnosis for Virginia’s condition. After months of psychoanalysis, the best he can come up with is that Virginia suffers from “a subconscious feeling of guilt on account of marrying [Robert]” after her first fiancé died (Ward 177). When Robert reveals this “diagnosis” to Virginia, she finds it inaccurate and ridiculous. Moreover, in the novel, Dr. Kik never tells Virginia he is analyzing her, which seems like an ethical misstep. She is shocked when Robert tells her Dr. Kik has been psychoanalyzing her:

“Of course I don’t know a damn thing about psychology,” said Robert after a while, “but I’d stake my life on Kik being wrong. Maybe he’s right according to a book of theories, but he still doesn’t know you. Why, you hear about psychoanalysis lasting over a period of years and he just had a few months of it with you.”

“Months of What!” [exclaims Virginia].

“Psychoanalysis. I suppose it’s important but anyhow he came out with the wrong answer.”

“You mean he psychoanalysed me? You mean when he was hiding somewhere in the bushes and asking those silly questions about did I hear voices...” (Ward 176-177).

Through this dialogue, Ward ridicules Dr. Kik’s methods and the validity of Freudianism. Moreover, the ineffectiveness of Dr. Kik’s various treatments consistently supports Ward’s negative perspective on Freudianism and the field of psychology. The incompetence of

psychoanalysis and other modern psychiatric procedures becomes a central social criticism in Ward's novel; this criticism likely sparked from Ward's personal experiences of such treatments at Rockland State Hospital.

On the other hand, the film removes this distain and, instead, bolsters Dr. Kik and his psychoanalytic prowess as the true hero of the narrative and Virginia's ultimate savior. Director Anatole Litvak completely reframes the portrayal of Freudianism and presents anti-feminist ideas about working women (as portrayed in the Litvak's added scene concerning Nurse Davis' distain for Virginia's writing career). In the film, Dr. Kik is Virginia's savior, there to rescue her from her mental confusion and the turmoil of the horror show that is the state mental hospital. Not only does Virginia never create Thinking Therapy but also Litvak includes new scenes in which Dr. Kik explains how psychoanalysis works to Virginia, and Kik's brief psychology lessons along with his explanation of her unconscious guilt "cure" Virginia. First, the director inserts scenes and flashbacks that are not part of the novel; these propagate Freudian theories and promote the curative power of psychoanalysis. More than halfway through the film, a scene opens to an individual therapy session between Virginia and Dr. Kik in his office. Under a framed portrait of Sigmund Freud, Virginia sits on a one-armed leather chaise lounge, stroking a rag doll for which she has traded cigarettes with another patient. She obviously feels better than before going to Ward 33, but she still does not understand why she had a mental breakdown. Her brows furrow as she listens to Dr. Kik, who paces around her while smoke puffs from his pipe, as he discusses his interpretation of her psychic conflict. In this scene, Virginia is more lucid than she has been in the film up to this point. She accurately describes her relationships with other patients and how she received the rag doll she holds. Mimicking Freud's method of free association, Virginia's words trigger an associated memory from her childhood, pertaining to a

doll her mother took away from her. The scene contains numerous flashbacks of Virginia's childhood, which illustrate Freudian theories of childhood development, including feelings of hatred toward her mother and Oedipal feelings of love for her father. Another scene demonstrates young Virginia's heightened anxiety and anger towards her parents when she learns her mother is pregnant. Young Virginia is so angry that she wishes her father was dead, but when he dies shortly after her wish, her Unconscious represses her feelings of guilt. Remembering her father's death, Virginia confesses to Dr. Kik, "My mother got married soon afterwards. And somehow, I always felt like she didn't like me because I reminded her of father" (Litvak 1:15:17-1:15:24). In emotional pain, she buries her face in her crossed arms as she cries on Dr. Kik's couch; he waits for her to stop, remaining somewhat emotionally distant, which is exactly how Freud encourages psychoanalysts to act to discourage reverse transference. Embodying Freud's example, Dr. Kik does not discourage her crying, but he also does not offer her a tissue either. Dr. Kik does not reveal the root of her psychological disturbance yet, but the flashbacks in this scene emphasize the film's promotion of Freudian theories, which most often trace adulthood neuroses back to conflicts in childhood development. In a scene near the end of the film, Dr. Kik stands behind Virginia as she recites the novel's famous lines about the ancient ritual of throwing insane persons into snake pits. During this conversation, Virginia's condition is obviously improving; she speaks eloquently and makes logical sense in her assertions. Dr. Kik's therapy is working. In her mental clarity, she asks Dr. Kik why she is getting better: "Is it because I'm supposed to know why I got sick?" (Litvak 1:28:55-1:28:57). This line points to Freud's theory that uncovering repressed memories remove psychiatric symptoms by alleviating unconscious psychic conflicts and, thereby, curing the patient. When Dr. Kik questions if she knows the cause of her illness, Virginia says she knows Dr. Kik believes her past traumas caused

her nervous breakdown, but she still does not understand why. Following Freudian theory precisely, Dr. Kik takes this opportunity to explain why psychoanalysis is effective and how Virginia's past traumas contributed to her breakdown. First, he discusses Virginia's early childhood from a textbook Freudian perspective:

Virginia: "Well, I know what you think. It's because of what happened to me years ago, like that doll when I was a little girl."

Dr. Kik: "Well, not quite. You didn't get sick only because of the doll."

Virginia: "Was it because my father and mother were so angry with me?"

Kik: "In a way, yes. Look, it all starts long before you can even talk. It may have started when you were a few weeks old. [A flashback of Virginia's infancy begins; an infant cries in a basinet.] You may have been hungry. And too often, your mother wasn't there to feed you on time. Then, later, still long before the doll incident, you wanted very much for her to love you. It wasn't your fault that you didn't get that love. [Virginia's mother appears in the flashback; she is closing Virginia's childhood bedroom door as she says]: "Virginia, darling, I've already kissed you goodnight. Now, go to sleep."

Kik: "Then, that made you turn to your father, and when he took your mother's side against you, you felt betrayed and unloved. When children feel that way, they get very angry. Often, they want to eliminate the person they feel doesn't love them."

Virginia: "You mean, I wanted my father to die?"

Kik: "No, but unconsciously, you did want to get rid of him. In a sense, that doll [which Virginia destroyed as a child] was your father. Then, when he got sick and died, you couldn't cope with this sense of guilt. And so you began to bury the memory of what had happened in your Unconscious. You pushed it down, deeper and deeper. The years

added layers to cover it up, but it was still there and made you hurt yourself.” (Litvak 1:29:00-1:30:17)

In Freudian fashion, Dr. Kik begins by contextualizing Virginia’s childhood with the Oedipus Complex. In *Interpretation of Dreams* (1931), Freud explains the Oedipus Complex is a foundational part of childhood development and, in dreams, it fulfills two unconscious wishes; using Sophocles’ ancient Greek tragedy *Oedipus Rex*, Freud clarifies: “The Oedipus legend had its source in dream-material of immemorial antiquity, the content of which was the painful disturbance of the child’s relations to its parents caused by the first impulses of sexuality” (162). According to Freud, since the first humans, a child’s initial experience of sexual desire is for his mother because she is a source of love and nourishment (Freud, *Dreams*, 162). This is the first wish of the Oedipus Complex. Secondly, the child’s jealousy and resentment against the father builds, because he is the only person allowed to have sexual intercourse with the mother; thus, the second wish of the Oedipus Complex is the hostile desire for the father’s death (Freud, *Dreams*, 162). In the film, Litvak demonstrates the Oedipus Complex precisely: young Virginia wants all her mother’s love, but she does not receive enough of it. This leads her to love her father more, but when she learns that her father will always choose her mother over Virginia, the typical Oedipal, unconscious, homicidal rage causes Virginia to wish her father to disappear. When this unconscious wish comes true with her father’s death, her unresolved Oedipal guilt manifests into harmful psychic disturbances in her adulthood. Dr. Kik continues to explain his psychoanalytic conclusions on her case:

Virginia: “What did I do?”

Kik: “Well, for example, you didn’t go out with boys. The reason you gave is that you were working very hard trying to become a writer. Actually, you avoided them because you were devoted to the memory of your father.”

Virginia: “But I did go out with Gordon.”

Kik: “That was rather like trying to bring your father back, wasn’t it? Gordon was very like your father in some ways. He was head of a family, wasn’t he? [A flashback occurs of Gordon taking charge of his family—telling everyone where to sit at the dinner table and correcting his sister’s fidgeting.] He was firm, commanding, and you liked it. [Another flashback begins; this one is of Virginia’s father being firm and commanding with her as a child. He tells her to not make him late.] Your father was punctual and meticulous, so was Gordon.” [A flashback of Gordon shows him warning Virginia to be on time].

Virginia: “Sometimes I felt like a child with Gordon, but I thought I really loved him then.”

Kik: “Yet when he asked you to marry him, something deep in you rebelled.”

Virginia: “Well, I just got sick. It wasn’t that I didn’t want to marry him. I did.”

Kik: “Consciously, but your getting ill was the physical expression of your unconscious feeling that you didn’t. Even before you saw that truck, you wanted to get rid of Gordon. [The next flashback shows a tractor-trailer running head-on with Gordon’s car.] And you blamed yourself for Gordon’s death, just as you had blamed yourself for your father’s.” (Litvak 1:30:19-1:31:26)

This part of Kik’s explanation illustrates how the early childhood trauma of losing her father causes Virginia’s unconscious guilt; he also uses these childhood disturbances to illustrate why

Virginia chooses to date Gordon—he reminds her of her father. Moreover, in both the novel and the film, Dr. Kik reveals that Gordon’s death and Virginia’s unconscious guilt for marrying his friend Robert cause her nervous breakdown. Both Virginia and Robert believe this theory to be preposterous in the novel. However, the film greatly expands Dr. Kik’s conclusion about Virginia’s unconscious guilt into a classic Freudian interpretation for the development of neurosis:

Virginia: “It’s horrible, isn’t it?”

Kik: “Again, you needed love and protection, so you went to New York to Robert.”

Virginia: “Robert? You said Gordon was like father, but Robert?”

Kik: “Wasn’t he like the other side of your father?”

Virginia: “Yes, he was kind and thoughtful. He sort of took care of me.”

Kik: “The way your father did.”

Virginia: “Yes, but why after I was married to Robert, why did I want to run away from him? I remember wanting to just before I got sick.”

Kik: “Because you were going back to your original pattern. You couldn’t face being married to Robert, just as you had been unable to face marriage with Gordon.”

Virginia: “Yes, I felt it was wrong somehow. I felt like a child again.”

Kik: “Mrs. Cunningham, sometimes children are afraid to grow up because they can’t let go of the love they felt for their fathers. But they can’t remain with their fathers. They do grow up, and they do marry. Because they learn that husbands and fathers can’t be the same thing.”

Virginia: “What did you say?”

Kik: “I said that husbands and fathers can’t be the same thing, can they?”

Virginia: “No, they can’t.” (Litvak 1:31:27-1:32:37)

This part of Kik’s explanation illustrates how the early childhood trauma of losing her father causes unconscious distress in Virginia and why Gordon’s death further contributes to her nervous breakdown. Dr. Kik’s conclusion becomes an obvious Freudian interpretation. Because of Virginia’s unresolved guilt over her father, she has difficulty separating her father and her romantic suitors; moreover, this childhood trauma causes her to revert to childlike behavior when she is unwell. This scene of the film works to propagandize Freudianism to its audience by carefully explaining Freudian theory in an understandable way and portraying it as the most effective treatment for Virginia’s recovery.

In the film, the only way for Virginia to recover is to understand these repressed memories and motivations through the expertise, interpretation, and explanation of her Freudian doctor. This conclusion incorporates the basic premises of psychoanalysis; as Freud defines in “Two Encyclopaedia Articles” (1923), psychoanalysis relies upon two principles: “first, that hysterical symptoms have sense and meaning, being substitutes for normal mental acts; and secondly, that the uncovering of this unknown meaning is accompanied by the removal of the symptoms” (3913). In other words, once a Freudian physician uncovers and interprets a patient’s symptoms, he must explain these findings clearly to the patient; then, as if by magic, once the patient understands the root causes of her mental disorder, the symptoms will end, and she will recover. Of course, this does not occur in the novel nor in real life. Nevertheless, in the film, when Virginia accepts Dr. Kik’s interpretation with great enthusiasm and gratitude, this resolution appeals to the audience’s sense of logos and ethos because these ideas from Freudian theory were widely accepted. Fishbein supports this assumption of the audience’s prior

knowledge: “Popularized Freudianism had achieved such widespread acceptance that its language and assumptions pervaded many aspects of critical thought” (643). Despite popular familiarity with Freudian theory, Dr. Kik reassures Virginia—and the audience—that it does not matter if she understands the theories behind psychoanalysis; to recover, she only needs to know the Freudian doctor’s conclusions, which pinpoint why her breakdown occurred. Dr. Kik’s character continues to use logos when he gives a metaphorical comparison using the overhead light in his office:

Virginia: “It’s funny.”

Kik: “What is it?”

Virginia: “Everything you’ve said seems to make sense. I feel as though I know it here.” [She places her hand over her heart.]

Kik: “But you don’t quite understand it all here? [He points to his head, and Virginia shakes her head no.] Don’t worry. It doesn’t matter. You may never know why everything happened, but now you do know how and where it started, and that does matter. Look, it’s as though you were in a dark room. Like this one [He walks over to the light switch and turns it off.] now, and you wanted to turn on the light, but you couldn’t because you didn’t know where the switch was. [He turns the light back on.] Now, you do. You may never know why turning that switch makes the light go on, but you don’t have to; as long as you know where it is, you don’t ever have to be afraid of being in the dark again. [Virginia smiles adoringly at Dr. Kik with bright, grateful eyes. He places his hand on her shoulder.] And that, I’m sure you will be able to do very soon.” (Litvak 1:32:37-1:33:22)

This scene demonstrates Litvak's agenda to promote Freudianism along with its undercurrents of anti-feminist rhetoric: ultimately, Virginia must accept her role as a wife and consciously separate the figures of her husband and her father; moreover, the "patriotic" American woman's duty is to return to a traditional female role to preserve her sanity. The novel includes none of these ideas. Additionally, the film has two leading characters—Virginia Cunningham, the helpless female mental patient, and Dr. Kik, the caring Freudian savior whose psychoanalytic detective work rescues her. This difference emphasizes how media attempts to steer the general public's perception of mental illness for political imperatives. Despite the underlying propaganda within the film, Litvak nevertheless presents a sympathetic portrait of the mental patient's experience in a state hospital. According to Rondinone in *Nightmare Factories*, "The studio went to great lengths to portray a 'realistic' mental hospital. The movie came out amidst a sharp rise in attention to the condition of state hospitals and director Anatole Litvak felt it imperative to 'awaken public interest in this vital matter'" (96). Tellingly, Litvak aimed both to raise awareness to the distressing conditions of state mental hospitals and to promote Freudianism. Therefore, the crucial dissimilarity between the novel and the film lies within each text's perspective on Freud's theories—was he a quack, or was he a savior?

3.10 Conclusion

The Snake Pit captured the imagination of American audiences in the 20th century, and it still does today. This mental illness life narrative, in both mediums, presents the experience of mental illness in a realistic and compelling light, which allows this unspeakable topic to enter a widespread social conversation. The narrative calls into question the myths of dangerousness and otherness, shows the infantilization of patients, and illustrates why Americans fear the asylum. However, *The Snake Pit* has a hopeful ending: Virginia goes home with her husband Robert; she

survives the dismal state mental hospital and lives to write the tale. After Mary Jane Ward skyrocketed to celebrity with the success of *The Snake Pit*, she used her new fame to help others experiencing mental disorders by “[participating] in campaigns to destigmatize mental illness and reform psychiatric care” (Harris 232). Ward used her personal experiences to create this moving story, and her realistic portrayal makes this narrative a powerful impetus for fighting the stigma. Importantly, the novel and the film worked together to spark mental healthcare reform during the mid-20th century. Even in the 21st century, *The Snake Pit* remains a consequential cultural text for the beneficial social changes it inspires and for its honest portrayal of insanity. As a text, *The Snake Pit* emphasizes how art can influence the popular imagination and underscores the media’s responsibility to portray mental illness life narratives, as opposed to sensationalized myths, to fight the stigma, promote positive changes in social reform, and inspire empathy in readers and viewers.

4 INDIVIDUAL EXPERIENCES OF STIGMATIZED IDENTITY: A COMPARISON OF ZELDA FITZGERALD AND ALLEN GINSBERG

Individual experiences of mental disorders and stigmatization vary greatly based upon many factors, including the presence of self-stigmatization, outside support from family or friends, types of psychiatric treatments encountered by the patient, and active or passive participation in one's treatment and recovery. A comparison of Zelda Fitzgerald and Allen Ginsberg will serve to humanize the experience of stigma and to illustrate how social attributes affect an individual's diagnosis, treatment, and self-stigmatization. Part I of this chapter focuses on Zelda's experience, while Part II analyzes Allen's. Although they both come from middle-class families, that is where their similarities end as far as social markers. Zelda was a married, heterosexual, White woman, whereas Allen was a homosexual man of Jewish heritage. Ultimately, they reacted oppositely to the stigma of mental illness likely because others treated them and reacted to their mental disorders in vastly different ways because of their genders and the cultural expectations that defined their socially appropriate roles. Zelda eventually incorporated the stigma from her social identity into her ego identity; she participated in self-stigmatization after multiple confinements in various psychiatric clinics. At first, her husband and her family coerced Zelda into treatment, but as their insistence continued, Zelda began to self-stigmatize. Once enough meaningful people in her life—her husband, family, friends, and doctors—labelled her insane, she believed them. In addition, as the number of reoccurrences of her disorder and hospitalizations increased, Zelda no longer needed interventions to encourage her return to the psychiatric hospital because, by the end of her life, she accepted both the presence of her mental disorder and her stigmatized identity. In contrast, although Ginsberg entertained self-stigmatization for a short time, he quickly rebelled against the social identity

which labelled him insane because his close friends did not stigmatize him; furthermore, Allen did not allow the stigma to alter his ego identity (i.e., his self-concept) due to this social support. The differences in the type of social support Zelda and Allen received contributed to these divergent responses to the stigma of mental illness and self-stigmatization. F. Scott Fitzgerald wanted his wife to have the best psychiatric treatment available, so he sent Zelda to numerous sanitariums once her schizophrenia progressed enough to be undeniable. Scott believed Zelda was insane as did her doctors, friends, and family, so eventually, she believed them and accepted her stigmatized identity as true and unalterable. Hence, after years of denial and resistance, once Zelda accepted her diagnosis of schizophrenia, she became a model patient, following the treatment regimens and going to hospitals when required without qualm. Allen, on the other hand, was an auspicious member of the radical Beat Movement—whose members valued madness and countercultural rebellion. Thus, the prominent figures in Ginsberg's life—his friends like Jack Kerouac, Bill Burroughs, Neal Cassidy, and Carl Solomon—did not believe Allen needed to be committed to an asylum and certainly did not stigmatize him. If he was insane then he was in good company with the Beat writers because, to them, madness was holy and transcendental. Seemingly, if enough significant people in a person's life view her as mentally ill, she will add this label to her ego identity, whereas if enough friends and family members reject this label then she may be able to shed it from her self-concept as well.

The sequence of this discussion begins with Zelda's experiences of identity and stigmatization. Part I examines how Zelda's ego identity and social identity change from her childhood in Montgomery, Alabama through her marriage to the famous author Scott Fitzgerald to the last 18 years of her life, which she spent in-and-out of psychiatric hospitals. In her youth, Zelda Sayre had a healthy, confident ego identity and a popular social identity, but she felt

restricted by the gender expectations that limited her possibilities for a fulfilling life. She sought an exciting and influential life, so she married the up-and-coming writer Scott Fitzgerald. At first, the romance was iconic, and Scott made Zelda his muse. However, this new social identity as a muse became more stifling than Zelda expected, so she began searching for an art of her own to reestablish her social identity as a talented, creative woman, which meant resisting her role as muse. Due to these struggles of identity, Zelda experienced a severe split between her self-concept as an artist and her social identity as a muse; eventually, this split experience disrupted Zelda's psyche to such an extent that she developed schizophrenia. The last sections of Part I analyze Zelda's experiences of stigmatization during her later life as well as her persistent pursuit of meaningful art, which she achieves in her autofictional novel *Save Me the Waltz*. Although Zelda did self-stigmatize by the end of her life, she never relinquished the belief that her creative work was integral to her survival.

Part II of this chapter considers Allen Ginsberg's experiences with mental disorder and his ultimate rejection of the stigma of mental illness, which greatly influenced his literary works and later spurred his activism. As a child and adolescent, Allen witnessed the terrible treatments and stigmatization his mother, Naomi Ginsberg, endured. These early observations taught him to question the American society and cultural expectations that drove his immigrant mother to insanity. His unconditional love for his mother also encouraged Allen's empathy for others suffering from mental disorders. By the time Allen had his first personal encounter with mental disorder, he was a member of the countercultural Beat Movement, so he treasured his hallucinations as mystical visions from the Universe. He continuously rejected self-stigmatization because his closest support group—the Beatniks—did not stigmatize his madness. Although Allen briefly entertained self-stigmatization when he was court-ordered to psychiatric

confinement, once he met the brilliant Carl Solomon in the hospital, Allen immediately rejected the stigma again because he believed if brilliant minds are locked up for insanity, then the world itself must be mad. In other words, madness is the only rational reaction to an insane world. The end of Part II analyzes Ginsberg's poem *Howl* through both Freudian and Foucauldian lenses to highlight Ginsberg's final assessments of madness in 20th-century America.

This comparison of two distinctly dissimilar experiences of stigmatization, particularly self-stigmatization, accomplishes several goals. Firstly, this chapter emphasizes how one's gender affects one's experience of mental illness, including confinement, diagnosis, and treatments. Secondly, this chapter humanizes the experience of mental disorder by presenting it within the context of two individual lives. The focus is on the individual, not on the disorder. Thirdly, this chapter highlights why mental illness life narratives are crucial in fighting the stigma; by presenting personal narratives about this topic, a cultural mindset change can begin because of the inherent pathos in such stories of struggle and survival at dire costs. Life narratives humanize mental illness, which lays the foundation for better social understanding and empathy towards those who suffer from not only mental disorders but also the crushing stigma. The stakes of this are life-or-death because the overwhelming repercussions of stigma combined with the agony of mental disorder lead many suffering individuals to commit suicide. Therefore, to help prevent suicides and encourage individuals to seek proper treatment, teaching mental illness life narratives is imperative because it increases awareness and inspires empathy—both of which promote a more equitable society.

4.1 Understanding Self-Stigmatization

First, to understand the individual experience of stigma, one must know the definition and consequences of self-stigmatization. To begin, the way an individual reacts to his

stigmatized social identity contributes to whether he will incorporate negative stereotypes into his ego identity. If one integrates adverse characteristics from his social identity into his ego identity (if he believes the discredit others bestow upon him and identifies himself as “crazy”), then he has internalized the stigma. This is a common occurrence for individuals suffering from mental disorders, especially after hospitalization. In the *Psychiatric Rehabilitation Journal* article “Self-Stigma Regarding Mental Illness: Definition, Impact, and Relationship to Societal Stigma” (2015), American psychiatrists Alicia Lucksted and Amy L. Drapalski define this consequence of social stigma as “internalized stigma” or “self-stigmatization,” which is “the incorporation of others’ prejudices and stereotypes about people with mental illnesses into beliefs about oneself” (99). Whether an individual participates in self-stigmatization often depends upon the opinions of significant people in her life, such as a spouse, family members, and friends, or upon the official decisions made by doctors or the legal system. If enough people around a person label her mentally ill then she likely will entertain self-stigma at least for a while. Lucksted and Drapalski support the hypothesis that self-stigma develops from how others treat persons labelled as mentally ill: “Because of prior experiences of discrimination, individuals with mental illness may come to expect and anticipate that they will be stigmatized, which, in turn, may contribute to believing that the stereotypes involved are true” (99). Thus, if an individual encounters repeated bigotry and enough significant people in his life stigmatize him, then he may question his sense of self-worth and begin self-stigmatizing because he incorporates the negative stereotypes from his social identity into his ego identity. Notably, self-stigmatization can fluctuate in intensity, duration, and frequency. Most individuals entertain self-stigma sometime in their experiences, but this does not mean that they will continue to self-stigmatize indefinitely. In his groundbreaking text *Sociology of Mental Disorder* (1981),

distinguished American sociologist and scholar William C. Cockerham suggests that being labelled as a mental patient may not last forever if others view the symptomatic behavior as transitory:

If former mental patients can act relatively normal for a lengthy period, they probably can shed their label and live a normal life. Yet labels can still be powerful influences on how people are perceived, and former mental patients can find that being considered normal is difficult, even after they have received treatment. (281)

Ultimately, avoiding stigma and the internalization of such bigotries may be infeasible because “much like breathing polluted air, it is very hard to not take in at least pieces of societal prejudices...When one belongs to a marginalized group, internalizing the messages is often impossible to entirely avoid” (Lucksted and Drapalski 99). Nevertheless, how individuals react to this undesirable label often determines how long they self-stigmatize; for example, some people integrate this stigma into their ego identities for life, whereas others reject the social stigma and dismiss the stereotype from their self-concepts. Markedly, the stigmas associated with mental illness affect individuals differently based upon other social factors, including gender, race, sexuality, marital status, and socioeconomic status. Such attributes vary individual experiences of stigma, psychiatric diagnoses, prescribed treatments, and confinement. In consideration of Zelda Fitzgerald’s experience in contrast to Allen Ginsberg’s, although both self-stigmatized, Zelda’s self-stigmatization remained permanently, whereas Ginsberg rejected his short-lived self-deprecation. He rejected then fought the stigma in both his writing and his life.

Although biological sex and gender do not affect the prevalence of mental disorder, one’s gender influences a wide variety of factors, including diagnoses, treatment plans, and

confinements. Crucially, in the experiences of Zelda Fitzgerald and Allen Ginsberg, because Zelda was a woman, she had more difficulty rebelling against the stigma and resisting confinement. For example, it was far more difficult for Zelda to refuse treatment because she did not have the financial autonomy Ginsberg did. Ginsberg supported himself and was unmarried, so he could make whatever choice for his treatment he deemed best. Zelda's freedom often depended upon the decisions and financial backing of her husband Scott Fitzgerald. Analyzing the role of gender, Cockerham highlights:

Most studies of the true prevalence of mental disorder by sex clearly indicates that (1) there are no consistent differences by sex in regard to rates of schizophrenia, (2) rates of mood and anxiety disorders are consistently higher for women, and (3) rates of personality disorders are consistently higher in men....Also, it should be noted that substance-related disorders are more common in men and that dementia is slightly more common among women. (162)

The key difference between the sexes is not that one has a higher prevalence for mental disorder than the other but that diagnoses are gendered, which highlights the bias within psychiatry to guide mental patients back into their prescribed gender roles. This could be particularly vexing for women caught in the 20th-century double-bind between the female roles of housewife versus modern career woman. For the housewife, "sources of gratification are severely limited" because all her joy must come from her home, husband, and children (Cockerham 170). Moreover, many housewives became unsatisfied because that social role "requires limited skill and has low prestige" (Cockerham 170). On the other hand, the 20th-century married career woman often faced a lower income and less opportunities for career advancement because others tended to view her work as merely a "supplement [to] the family income," not an actual career

(Cockerham 170). Additionally, the career woman still had to maintain the household, which effectively created two full-time jobs for her. Thus, women experienced a double bind because neither the traditional female role nor the modern woman role afforded true satisfaction. The major contributor to female psychological distress was “a lack of control” over their lives; this lack of autonomy created a “vulnerability” in the mental stability of many 20th-century women (Cockerham 174). Certainly, this lack of control over her life and over her social identity as Scott’s muse not only affected Zelda’s experience of mental illness but also induced her schizophrenia. Additionally, as Cockerham explains, a double standard exists within the field of psychiatry for female patients: “Even though males may be more likely to be admitted to mental hospitals, females have a particular disadvantage in regard to the stress associated with their gender role and the double standard that influences how their mental health is perceived” (176). When evaluating a woman’s mental health, many people and doctors ascribe certain behaviors and thoughts as mentally ill when they do not align with the social concept of femininity. In the academic article “The Abused Mind: Feminist Theory, Psychiatric Disability, and Trauma” (2001), published in feminist philosophy journal *Hypatia*, Canadian educator and scholar Andrea Nicki highlights that the “norms of mental health are different for men and women. For instance, a woman who displays aggression and ambition, and is not feminine, risks being labelled ‘mentally ill’ or, if genuinely mentally ill, having her illness seen purely in terms of her transgression against her gender” (81). For Zelda, this was certainly true: her doctors and her husband viewed her immense ambition to succeed in the male-dominated artworld (as opposed to remaining solely in the feminine roles of muse, wife, and mother) as the root cause to her insanity. Thus, not only did Zelda’s pursuit of an artistic career encourage others to label her as mad, or at best unreasonable, but also her illness became defined by this unattainable desire and

her rejection of traditional female roles. Conversely, this same prejudice acted against male patients who displayed feminine characteristics or homosexuality during most of the 20th century. For example, until the 1970s, the *Diagnostic Statistical Manual* categorized homosexuality as a mental disorder requiring treatment and conversion. In Allen's experience, many doctors insisted he convert to heterosexuality as the cure to his psyche distress and mental disorder; this prescription emphasizes how most 20th-century psychiatrists promoted conformity to social roles, especially those for gender, as fundamental to successful treatment. In essence, when an individual does not conform to his or her gender role, others often view him or her as mentally ill.

Both Zelda and Allen faced obstacles associated with their rebellion against gender norms. Zelda desired to become an autonomous artist, which was seen as too ambitious and masculine; her limited success and artistic competition with Scott certainly contributed to Zelda's psychic distress and to the split she experienced between her ego identity as an artist and her social identity as a muse. Eventually, this split experience in identity triggered schizophrenia; the onset and diagnosis of which irreparably marred Zelda's identity by labelling her a madwoman. When her self-concept and social identity finally aligned under the pressures of stigmatization, the results were catastrophic. Because Allen was homosexual, which was seen as a mental disorder, his identity had to become countercultural; however, unlike Zelda, Allen could rise above the constraints of stigmatization with the support of his Beatnik friends. However, if Allen had not been part of the rebellious Beat Movement, he may have had more difficulty rejecting the social stigma of mental illness, but because his social group dismissed many American values they saw as hypocritical or prejudiced, they did not stigmatize his mental disorder. Fighting stigmatization in one's personal life and self-concept is not easy, but with the

right support group—one filled with people who do not stigmatize the individual—he has a better chance to avoid self-stigmatization and create a healthy ego identity, even if he has a mental disorder. Moreover, mental illness life narratives encourage audiences to develop empathy for those suffering from stigma and present ways to avoid self-stigmatization through others' experiences.

4.2 Part I: The Individual Experience of Stigmatized Identity: Zelda Sayre Fitzgerald (1900-1948)

Zelda Sayre Fitzgerald experienced mercurial compromises within her identity as a creative woman married to a famous author, and these fractures in her identity ultimately led to her mental breakdowns later in life. Although she established a strong ego identity and vibrant social identity as a bright child and adolescent in her hometown of Montgomery, Alabama, upon falling in love and marrying F. Scott Fitzgerald, Zelda's social identity changed quickly to that of muse and vapid flapper. Although initially flattered to be the fictionalized heroine in many of Scott's novels and short stories, in her self-concept, Zelda strongly knew herself to be creative and talented in her own right. Thus, early into their marriage, Zelda desired to be independent of Scott's fantasy version of her social identity as his lazy muse. Eventually, this insurmountable struggle for an ego identity and a social identity separate from that of Mrs. Scott Fitzgerald became one of the compelling causes for Zelda's mental disorder. Desperately, Zelda searched for an artistic outlet through many mediums—including dancing, writing, painting, and designing—to express her perspective on her lived experiences and to re-assert her identity as valuable and separate from her famous husband, but her artistic pursuits were not enough to save Zelda. Her search for an artistic career of her own was doomed from the start because of the Victorian societal gender rules that were still prevalent in early 20th-century America. In the

Southern Literary Journal article “Art as Woman’s Response and Search: Zelda Fitzgerald’s *Save Me the Waltz*,” French literary critic and biographer of American literature Jacqueline Tavernier-Courbin explains that Zelda “was born in a society where a woman was expected to be charming, witty, entertaining, to rule the household but to leave to men careers and intellectual pursuits” (25). Zelda battled between the traditional Victorian “Angel in the Household” strictures of purity, piety, submissiveness, and domesticity and the progressive goals of the New Woman of the 20th century, who aspired to obtain a career outside of the household and, often, struggled against the constraints of marriage as a result. This bitter struggle for artistic autonomy and the contradiction between Zelda’s ego identity (i.e., her self-concept) as an artist and Scott’s created social identity of her as his flapper-muse-wife resulted in a split within Zelda’s psyche, which expressed itself as schizophrenia. Thus, ultimately, unable to sustain her contrived social identity and barred from openly expressing her ego identity, Zelda experienced numerous mental collapses and hospitalizations in the last 18 years for her life. Zelda’s disordered thinking and schizophrenic symptoms as well as her psychiatric hospitalizations led to a new stigmatized social identity: Zelda became Scott’s mad wife. Although she initially fought incorporating the stigma of mental illness into her ego identity, eventually Zelda began to believe she was insane, self-stigmatizing her ego identity from the pressures of her stigmatized social identity. Zelda’s story is one of consistent struggle hidden behind the glamour of fame and fortune. She resisted many facets of her social identity that conflicted with her ego identity, but eventually, her social identity persisted in breaking down her self-concept. In the end, not only did others only see Zelda as Scott Fitzgerald’s tragically mad wife, but Zelda began to view herself in this way. Zelda’s experience illustrates the severe consequences that can occur when social stigmatization morphs into self-stigmatization. Furthermore, considering the context of Zelda’s social position

in the early 20th century, her gender directly affected how others viewed and stigmatized her personal characteristics and ambitions by associating them with mental illness. The limited options for meaningful intellectual activities and professional ambitions for women in the early 20th century contributed to Zelda's mental collapse and encouraged the social opinion that she brought madness upon herself for attempting to compete in a male-dominated world instead of remaining subservient in her assigned feminine social roles of muse, wife, and mother.

Moreover, because she was a woman during this time, others could coerce her into mental hospitals easier than they could her male husband, who needed treatment for alcoholism and bipolar disorder. Unlike his wife, Scott easily refused psychiatric confinement. As this demonstrates, gender greatly influenced Zelda's diagnosis, treatment, and stigmatization.

4.2.1 A Charmed Southern Childhood: Zelda Sayre's Early Identity

Born to a powerful local family, Zelda Sayre's early social identity became marked by the protection of her father and her light-hearted rebellion against his traditional expectations. Her personal characteristics—courage, charm, beauty, and spontaneity—made Zelda popular from a young age. Zelda was born July 24, 1900 into an old Aristocratic Southern family in Montgomery, Alabama. Her parents, Judge Anthony Dickinson Sayre and Minerva “Minnie” Machen Sayre, were late in life when she was born, so as the youngest child and the only one still living at home, Zelda quickly became her mother's favorite. According to Nancy Milford, one of Zelda's prominent biographers, in her book *Zelda: A Biography* (1970), “Treasuring the baby who would undoubtedly be her last, Mrs. Sayre nursed Zelda until she was four years old. She showered her with attention and praise; her faults were quickly excused” (7). The coddling and loving attention Zelda received from her mother encouraged Zelda's healthy self-esteem and her willfulness. On the other hand, Judge Sayre, though loving, was a distant father, constantly

preoccupied by his work. As a powerful, serious judge, Zelda's father loomed as a protective yet demanding figure in her childhood. Despite his preoccupation with his work, Zelda's discipline relied solely upon Judge Sayre, which meant she often skirted the consequences of her unconventional attitudes and inappropriate behaviors due to the Judge's hyperfocus on his work combined with his local political power. In her autofictional novel *Save Me the Waltz* (1932), Zelda presents an illuminating mental illness life narrative about her experiences and struggles from childhood through her marriage until the death of her father. Interestingly, Zelda never mentions mental illness in the novel, though it is the underlying, unspoken theme of the text; instead, she substitutes a physical illness in the end as the final cause for the heroine's dashed artistic career. Within the text, Zelda names her fictionalized self-character Alabama Beggs, and she illustrates her sheltered childhood and the protection of her father's local power within the first page of the novel:

“Those girls,” people said, “think they can do anything and get away with it.”

That was because of the sense of security they felt in their father. He was a living fortress...Judge Beggs entrenched himself in his integrity when he was still a young man; his towers and chapels were builded of intellectual conceptions...The fact that the state looked indulgently upon his superiority absolved his children from the early social efforts necessary in life to construct strongholds for themselves...By the time the Beggs children had learned to meet the changing exigencies of their times, the devil was already upon their necks. Crippled, they clung long to the feudal donjons of their fathers, hoarding their spiritual inheritances—which might have been more had they prepared a fitting repository. (*SMTW* 9)

Zelda was spoiled from her mother's unconditional forgiveness of her faults, and her father's

political influence kept her from facing consequences; in this passage, Zelda admits that this crippled her from the start because she did not learn the resources necessary to cope with adult life. As she entered adolescence, she became rebellious without punishment, shielded from the local authorities by her father's power. The fortress, tower, and chapel imagery in this passage illustrate Zelda's gendered bind: although she was safe under the fortress of her father's protection, she felt trapped, as if in a tower, by the traditional values of her father's chapel that dictated how she should behave and what she should aspire to be as a Southern lady. Moreover, Zelda highlights how her father acted as a social shield for his children, while still demanding they follow tradition with integrity. For Zelda and her sisters, this meant marrying respectable men and becoming good housewives and mothers—and remaining trapped in a marital tower, like the pedestal the Victorian Angel of the House perches upon in her shrine of purity, piety, submissiveness, and domesticity. In his literary criticism “‘A Very Carefully Orchestrated Life’: Dramatic Representations of and by Zelda Fitzgerald” (2002), American professor of English and theatre Christopher Wixson explains, “Zelda understood life as a performance at a very early age, chafing under the restrictions of traditional roles for women” (32). Even as a child, Zelda wanted more for her life than to stay in her Southern hometown, marry, and have children; she dreamed of a life beyond the social oppression of conservative traditions.

Therefore, from an early age, Zelda worked to construct a different life for herself. Her confidence stemmed from her healthy ego identity and her popular social identity, so Zelda sought courageous ways to free herself from her father's smothering tower. In *Save Me the Waltz*, Zelda recalls: “She already planned to escape on the world's reversals from the sense of suffocation that seemed to her to be eclipsing her family, her sisters, and mother. She, she told herself, would move brightly along high places and stop to trespass and admire” (32). Zelda

emphasizes how stifled she felt from the social expectations for women when describing the “sense of suffocation” as applicable to her sisters, her mother, and herself. This establishes Zelda’s early desire to escape the gender restrictions of her social identity. Early in *Save Me the Waltz*, Zelda presents her childhood self as searching to understand who she is, which emphasizes the fictional construction of identity; Alabama asks her mother, “Tell me about myself when I was little” (11). All her mother says is that she was a “good baby,” but this response is not what Alabama wants to know:

The girl had been filled with no interpretation of herself...She wants to be told what she is like, being too young to know that she is like nothing at all and will fill out her skeleton with what she gives off, as a general might reconstruct a battle following the advances and recessions of his forces with bright-colored pins. She does not know that what effort she makes will become herself. It was much later that the child, Alabama, came to realize that the bones of her father could indicate only her limitations. (*SMTW* 11)

Here, Zelda highlights the construction of identity as both an intentional creation of self through actions (or “what she gives off”) and a battle site, especially for women resisting the social strictures of gender. Her inclusion of military imagery forecasts the war she must fight to establish an identity as independent from her father, and eventually from her husband. In addition, Zelda includes images of skeletons and bones; this foreshadows how Zelda’s efforts to create a self-satisfactory ego identity and a respected social identity will bring about her death—both metaphorically in psychiatric hospitals when her ego and social identities become stigmatized and literally when she eventually dies in an asylum. Moreover, the line “the bones of her father could indicate only her limitations” further underlines the gender role expectations Zelda hoped to escape through marriage, especially if she married an unconventional man. At

this early period in her life, Alabama (i.e., Zelda) searches to create an identity that resists the limitations placed on women in the early 20th century, but her options for how to do so are few.

In contrast to her later stigmatized identity, during her younger years in Alabama, Zelda's fearlessness, charm, and vivacity became legendary in both Montgomery and Atlanta. In her hometown, she was popular, and her ego identity incorporated this social love, encouraging her self-confidence and boldness. In his autobiographical novel *Tender is the Night* (1934), F. Scott Fitzgerald uses Zelda as his muse for Nicole Diver—a mental patient diagnosed with schizophrenia who marries a young up-and-coming psychiatrist, Dick Diver, who fictionally represents Scott. Scott's novel portrays their complicated, contentious marriage while emphasizing Zelda's schizophrenia as the major cause for the couple's downfall. Within this text, Nicole's father describes her as socially well-liked during her childhood, and this illustration accurately portrays Zelda's childhood social identity:

As a child she was a darling thing—everybody was crazy about her, everybody that came in contact with her. She was smart as a whip and happy as the day is long. She liked to read or draw or dance or play the piano—anything. I used to hear my wife [her mother] say she was the only one of our children who never cried at night...She was a perfectly normal, bright, happy child. (*Tender* 126)

This passage highlights how Zelda enjoyed a popular social identity during her childhood and adolescence, and this social acceptance instilled in Zelda a confident, healthy self-concept.

During her debutante years of courting and attending dances, she had enough beaux to make even Scarlett O'Hara jealous. Milford explains, "It was not her beauty that was arresting. It was her style, a sort of insolence toward life, her total lack of caution, her fearless and abundant pride" (2). These qualities would skyrocket Zelda to fame as the first American flapper in the 1920s;

however, later, these same characteristics contributed to psychiatrists diagnosing her as mentally ill.

4.2.2 *Becoming His Muse and Losing Her Identity*

At the height of her debutante debut in 1917, Zelda's world suddenly flooded with thousands of soldiers and aviators training in Montgomery for World War I. In *Save Me the Waltz*, Zelda remembers: "The war brought men to the town like swarms of benevolent locusts eating away the blight of unmarried women that had overrun the South since its economic decline" (37). By September of that year, Zelda had a box full of insignias gifted from soldiers hoping to earn her favor; in *Save Me the Waltz*, she reminisces:

Through the summer Alabama collected soldiers' insignia. By autumn she had a glove box full. No other girl had more and even then she'd lost some. So many dances and rides and so many golden bars and silver bars and bombs and castles and flags and even a serpent to represent them all in her cushioned box. Every night she wore a new one. (37)

Here, Zelda demonstrates her hometown social identity as one of local fame. Before she experienced mental disorder in her thirtieth year, Zelda's social identity was legendary and envied from her hometown in Montgomery all the way to Atlanta. She was rebellious: she chewed gum, kissed young men, snuck out at night when she was grounded, and even wore a flesh-toned swimsuit in a town parade (Milford 19). Without a doubt, Zelda never went unnoticed during this time; she was popular, pretty, and well-liked. As Tavernier-Courbin observes, "Locally, she had become a legend in her own right before she met Fitzgerald, more distinctively famous as Zelda Sayre than she later was as Zelda Fitzgerald" (25). During this time in her early life, both her ego identity and her social identity aligned. Zelda had a confident self-concept. She believed she was destined for an exceptional life, but even as possibilities for

escape circled Zelda's mind, her options were limited. In her analytical comparison of the characters Alabama Beggs and Nicole Diver, entitled "Nicole Warren Diver and Alabama Beggs Knight: Women on the Threshold of Freedom" (1985), American author and literary critic Sarah Beebe Fryer ascertains, "As might be expected of young women raised to believe in their own inferiority in comparison to men, Alabama and Nicole both attempt to escape from overpowering father figures through marriage" (321). Much like the fictionalized versions of her, Zelda believed her only escape from Montgomery was through a marriage to someone with ambition; accordingly, when she met and fell in love with F. Scott Fitzgerald, Zelda believed that a marriage to him would offer her the chance for an exciting future.

In July 1918, Zelda met Scott Fitzgerald at the local Montgomery country club, and from that first moment, their lives changed forever. Zelda, who practiced ballet, performed the "Dance of the Hours" after persistent requests from friends, and her grace and beauty quickly beguiled Scott; this moment marked the beginning of their famous, fantastical relationship (Milford 24). Their love became a whirlwind of possibilities and ambition. Writing to a friend, Scott highlights Zelda's allure despite her notorious social reputation:

No personality as strong as Zelda's could go without getting criticism....I've always known that, any girl who gets stewed in public, who frankly enjoys and tells shocking stories, who smokes constantly and makes the remark that she has "kissed thousands of men and intends to kiss thousands more," cannot be considered beyond reproach even if above it....I fell in love with her courage, her sincerity and her flaming self-respect and its these things I'd believe in even if the whole world indulged in wild suspicions that she wasn't all that she should be....I love her and that's the beginning and end of everything. You're still a catholic but Zelda's the only God I have left now. (qtd. in Milford 60)

Scott sensed the gravity of their attraction to each other, and indeed, their tumultuous love would be the beginning and the end of them. Zelda did not realize that marrying Scott would not save her from the gendered expectations he still would expect her to uphold, despite her courage and “flaming self-respect.” Like Nicole Diver and Alabama Beggs, “although [all three] women attempt to declare themselves adults by marrying, marriage offers no real improvement in their social condition, for, as women, they...remain subservient to men” (Fryer 321). This gendered bind that Zelda experienced was common during this time in American history; Fryer explains,

[Women] were to remain dependent on men throughout their lives, leaving their father’s homes only to become wives and mothers whose success would be assessed solely on the basis of intangibles—housekeeping skills, beauty, charm, and children. Men, of course, were allowed a much greater degree of independence and the more rewarding occupations of work of their own choosing. (320)

Thus, despite her creative talents in ballet, painting, writing, and designing, Zelda soon would learn that her artistic output would become Scott’s property, as would she. Scott’s use of and claim over Zelda’s experiences and words eventually eroded Zelda’s sense of an independent ego identity; eventually, Zelda felt herself disappearing under the guise of Mrs. F. Scott Fitzgerald.

Once married on April 3, 1920, the Fitzgeralds’ social identities intertwined as they consciously created an aura of legend about them; in addition, albeit at first unconsciously, the Fitzgeralds’ ego identities also became dependent upon and enmeshed with each other’s.

After Scott’s major success from his first novel *This Side of Paradise* (the heroine of which is based largely on Zelda, as most of his heroines are), the couple quickly became famous. At first, they relished in the publicity, going as far as putting on acts to create more gossip and

intrigue. As Milford illustrates, “Scott and Zelda discovered that they were being heralded as models in the cult of youth,” so they worked to create an image of themselves as the epitome of the carefree, defiant flapper lifestyle (69). By throwing and attending Gatsby-like parties, becoming spectacularly inebriated in public, flirting with other people, and having garish marital arguments from jealousy, the Fitzgeralds led a performative lifestyle to build a legendary public image. In *Save Me the Waltz*, Zelda illustrates how others expect Alabama Beggs to perform in congruence with their preestablished ideas about her social identity:

“She’s the wildest one of the Beggs, but she’s a thoroughbred,” people said.

Alabama knew everything they said about her—there were so many boys who wanted to “protect” her that she couldn’t escape knowing. She leaned back in the swing visualizing herself in her present position.

“Thoroughbred!” she thought, “meaning that I never let them down on the dramatic possibilities of a scene—I give a damned good show.” (32)

Zelda reinforces the concept of others’ expectations for her to “give a damned good show”: in Montgomery, given the protection of her father, Zelda’s dramatic performances were the harmless rebellions of a spoiled Southern belle—chewing gum, kissing boys, and wearing nude-toned swimwear. In Montgomery, Zelda’s ego identity and social identity aligned well, particularly because she understood life as a performance from a young age. However, as the Fitzgeralds continued their flapper lifestyle with vaudeville-like performances in social situations, Zelda began to feel a disparity between her actual social identity—the confident, talented, and bold Zelda Sayre—and her new virtual social identity—Scott’s vapid, amusing, yet envious muse-wife. In *Stigma: Notes on the Management of Spoiled Identity* (1963), Canadian-American sociologist Erving Goffman defines a person’s “actual social identity” as “the category

and attributes he could in fact be proved to possess,” whereas his “virtual social identity” is the identity others assume he “ought to be”—“a characterization ‘in effect,’” based upon “normative expectations” (2). Due to the Fitzgeralds’ performances and rapid fame, Zelda found her actual social identity dissolving into the virtual identity of Mrs. F. Scott Fitzgerald—the muse.

Tavernier-Courbin asserts, Scott “made [Zelda] famous as *a creation of his*—the flapper—and she was left with the task of living up to the picture of herself perpetrated in his stories and his novels” (26). This feigned yet famous image of Scott’s muse encouraged Zelda to perform this role early in her marriage, especially in public situations; however, this role socially diminished Zelda’s intellect and creativity. In the biographical comparison and literary analysis “The Muse and the Maker: Gender, Collaboration, and Appropriation in the Life and Work of F. Scott and Zelda Fitzgerald” (2015), American professor and literary critic Ashley Lawson explains Zelda’s dilemma in playing Scott’s muse: “The muse is...doomed to be defined as a ‘non-artist,’ not just in relation to those specific works in which her image appears but also those which she has produced herself, no matter what kind of evidence exists to the contrary” (80). Early in her life, Zelda and other people thought she was a talented, creative girl, so this demotion to complacent muse did not align with Zelda’s pre-established ego identity. In *Save Me the Waltz*, Zelda illustrates the loss of self she experiences once she falls in love with Scott, marries him, and moves away from Montgomery to New York City:

So much she loved the man, so close and closer she felt herself that he became distorted in her vision, like pressing her nose upon a mirror and gazing into her own eyes. She felt the lines of his neck and his chipped profile like segments of the wind blowing about her consciousness. She felt the essence of herself pulled finer and smaller like those streams of spun glass that pull and stretch till there remains but a glimmering illusion. Neither

falling nor breaking, the stream spins finer. She felt herself very small and ecstatic.

Alabama was in love. (40)

Here, Zelda demonstrates how she lost her individual identity within her love and marriage to Scott. Her ego identity becomes distorted when she joins Scott in matrimony, so instead of viewing herself clearly, she sees his identity warping and engulfing hers, as if looking too closely into a mirror. In her literary analysis “A Wizard Cultivator: Zelda Fitzgerald’s *Save Me the Waltz* as Asylum Autobiography” (1992), American professor of English, scholar, and critic Mary E. Wood purports that mirrors become problematic within the novel because of Alabama’s search for her lost identity: “It is [the] ability to verify oneself in the mirror that Alabama increasingly finds beyond her reach. For her, looking into the mirror means losing a sense of herself as a separate being. Love for her is not an experience of completeness but one of dissolution (254). Like Alabama Beggs, Zelda’s ego identity became small and fragile under the artistry of her new constructed social identity—the F. Scott Fitzgeralds. Like a fine stream of spun glass, Zelda’s social identity disappears completely beneath Scott’s fame, reducing her to his wife and muse only. Tavernier-Courbin notes, “While he gave her a false public identity, Scott was at the same time draining away her actual identity by appropriating her life experience” (27). Zelda illustrates Scott’s erasure and reinvention of her identity in *Save Me the Waltz*; during the early courtship between David Knight (i.e., Scott Fitzgerald) and Alabama Beggs (i.e., Zelda Sayre), David denies the importance of Alabama’s identity compared to his when he carves their names upon a doorpost:

“David,” the legend read, “David, David, Knight, Knight, Knight, and Miss
Alabama Nobody.”

“Egoist,” she protested.

“I love this place,” he said. “Let’s sit outside awhile.”

...“I want to go inside.” She was a little angry about the names. David had told her about how famous he was going to be many times before...She wondered if David knew how conceited she was. (39)

Because David Knight knows he will be a famous painter one day and expects Alabama Beggs to marry him when he proposes, he erases her last name—her father’s name and his protection—without supplying her any other identity. David reduces her to Alabama Nobody, just as Scott would erase the celebrated Zelda Sayre only to replace it with Zelda Nobody. This example highlights what Tavernier-Courbin argues: “The flapper became Zelda’s alter ego. But such role playing was obviously destructive, resulting in a loss of the self and a grinding uncertainty” (26). Once entangled with Scott, Zelda’s social identity disappeared beneath his. Tellingly, in this reimagined scene, despite Alabama’s protests, which stem from her initial healthy ego identity, David completely ignores her words, thereby denying her separate social identity as valuable without him. Although Alabama wants to flee from this scene and its foreshadowing image of her erasure (she wants to go back to the dance), instead, David decides they will both remain underneath his demarcation: David Knight and Alabama Nobody. Literary critic Sarah Beebe Fryer points to another example of “[Scott’s] absorption of [Zelda’s] identity” within F. Scott Fitzgerald’s autofictional novel *Tender is the Night* when Dr. Dick Diver combines his name with his wife Nicole’s to create “Dicole,” a symbolic representation of their enmeshed social identity (323). In Book I of *Tender*, Dick Diver “left a note for Maria Wallis signed ‘Dicole,’ the word with which he and Nicole had signed communications in the first days of love” (S. Fitzgerald 103). Scott emphasizes the idea that Nicole (i.e., Zelda) participated in this joint social identity at the beginning of their relationship, and this is partially true. However, Lawson

counters, “Despite both Fitzgeralds’ acknowledgements that the artist/muse dynamic was part of their initial attraction to each other, this early stage of their relationship set precedents that plagued their marriage later on, leading to consequential personal and artistic ramifications for both” (80). Zelda’s portrayal of her anger at Scott’s obliteration of her personal identity in *Save Me the Waltz* emphasizes her underlying resistance to the absorption of her actual social identity by the virtual social identity of F. Scott Fitzgerald’s muse-wife. Zelda underlines the fictionality of her famous social identity in *Save Me the Waltz* when Alabama exclaims, “I am a book. Pure fiction,” which emphasizes Scott’s creation of Zelda’s social identity through his novels (70). No longer seen as talented and fascinating in her own right, Zelda began to break under the pressure of assuming a virtual social identity that wholly hid her ego identity.

Eventually, the dissonance between how Scott portrayed Zelda to the world and what she knew to be her true self-concept caused a split in Zelda’s psyche. Ultimately, their marriage proved toxic and psychologically fatal for both Zelda and Scott. Zelda remembers in *Save Me the Waltz*: “Possessing a rapacious, engulfing ego their particular genius swallowed their world in its swift undertow and washed its cadavers out to sea” (49). The emphasis here on one ego for the two of them illustrates how Zelda’s social identity submerged beneath Scott’s until she was nothing to the public but Mrs. F. Scott Fitzgerald; Zelda found her identity “washed” away by their joint identity’s “swift undertow.” Tavernier-Courbin opines, “No human being could allow herself to be used in such a way without resenting it and without paying a heavy toll of self-doubt, reduced self-respect, and loss of identity” (29). Certainly, Zelda experienced these consequences when playing Scott’s muse because he absorbed her identity and subsumed it beneath his; in Scott’s opinion, he would forever be the artist, reducing Zelda to the muse, who only could achieve amateur-artist status at best. In addition, Zelda’s image of cadavers washed

out to sea foreshadows the Fitzgeralds' downfall caused by this enmeshment; it also alludes to the Ship of Fools image from the Renaissance. According to Michel Foucault in *History of Madness* (1961), the Ship of Fools not only existed in Renaissance art but also in practice:

They really did exist, these boats that drifted from one town to another with their senseless cargo. An itinerant existence was often the lot of the mad. It was a common practice for towns to banish them from inside the city walls, leaving them to run wild in the distant countryside or entrusting them to the care of travelling merchants or pilgrims....So the ship of fools was heavily loaded with meaning, and clearly carried a social force. (9-10)

Zelda places Scott and herself on this ship of fools, showing them both as mad and adrift; this also stands as an accurate image of the Lost Generation as a whole as numerous disillusioned expatriates left America after World War I to travel aimlessly abroad, searching for themselves or some unfound wisdom amidst strange lands. Certainly, the Fitzgeralds' extensive travel by ship must have reminded Zelda of this image and of a sense of being lost. By marrying Scott and becoming the figure of his muse and wife, Zelda's sense of an autonomous self soon began to fade. As Zelda confesses in *Save Me the Waltz*, "She had known that no individual can force other people forever to sustain their own versions of that individual's character—that sooner or later they will stumble across the person's own conception of themselves" (56). This idea emphasizes Zelda's loss of self when she plays Scott's muse, and she foreshadows that this loss will be the catalyst to ignite Zelda's search for an art of her own in order to reassert her lost ego identity and demolish her subdued social identity as a muse.

4.2.3 *An Art of Her Own*

Zelda began to yearn for something more, something that could be hers alone. She wanted to create her own art, as opposed to letting Scott use her creativity in his work exclusively. In fact, she wanted to form a social identity, and an ego identity, that did not rely upon Scott or his literary works at all. In *Save Me the Waltz*, Zelda states, “Alabama felt excluded by her lack of accomplishment,” and this sentence emphasizes Zelda’s feelings of missed opportunities and her deflating self-concept (101). Unfortunately, because Zelda’s social identity strictly defined her as Scott’s muse, she faced undefeatable odds in her ambition to become an artist independent of Scott Fitzgerald’s name. As Christopher Wixson explains, Zelda “was constrained by the roles imposed upon her, as both the wife of a famous writer and as a female artist within a decidedly male artistic milieu” (35). Importantly, Scott did not want Zelda to be a professional artist. Zelda was an extremely creative person, and he recognized that; however, he wanted her to remain the amateur, while he reigned as the professional in the family. In *Save Me the Waltz*, Zelda emphasizes Scott’s categorization of the difference between Zelda’s creative pursuits and his own when David criticizes Alabama’s dedication to ballet: “‘You’re so thin,’ said David patronizingly. ‘There’s no use killing yourself. I hope you realize that the biggest difference in the world is between the amateur and the professional in the arts.’ ‘You might mean yourself and me—’ [Alabama] said” (138). Over her life, Zelda danced ballet, painted, and wrote both fiction and nonfiction; however, Scott constantly reminded her that he was the professional, and she merely was an amateur. According to Lawson, Scott Fitzgerald relied upon gendered bigotries to support his stance of their artist-muse relationship: “Within the context of the Fitzgeralds’ marriage, he believed that he held the sole right to define the criteria for what constituted an amateur versus a professional writer” (89). Lawson explains Scott

designated himself as the expert, but his evidence is based upon privileges afforded to him by traditional gender roles: his Ivy League education and his pursuit of a career since adolescence (89). To support this claim that Zelda could never be a professional artist, Scott blames her gender, lack of a college education, limited professional training, and social identity as a flapper-muse (Lawson 89). However, Scott's premises follow warrants outside of Zelda's control: her gender prevented Zelda from attaining a higher education, and Scott perpetuated her "party-girl" persona, even when she no longer participated in the charade. Manipulatively, Scott superficially supported Zelda's creative attempts, while covertly sabotaging her art or pilfering it for his own use, because in his opinion, Zelda illustrates Scott's hardline belief that she never would be a professional artist in *Save Me the Waltz*: "David said he would help her to be a fine dancer, but he did not believe that she could become one" (144). Zelda learned Scott's "help" with her career was superficial and self-serving. As Lawson explains, "At the outset of their relationship, [Scott] was relatively supportive of his wife's career, especially as a means of promoting his own fame, supplementing the family income, or keeping her occupied while he worked on his writing" (85). In his mind, because he was the one who made the most money and supported their lifestyle, Zelda's letters, diaries, and short stories were his creative property, not hers. One example of Scott's appropriation of Zelda's intellectual property occurred during their courtship when Zelda shared her diary with Scott; this marked the first incident when Scott stole Zelda's ideas and written words for his own creative pursuits. Dazzled by her unique style and poetic descriptions, Scott included portions of her diary in *This Side of Paradise*, *The Beautiful and Damned*, and his short story "The Jelly Bean" (Milford 35). In fact, legend has it that Scott later hid or destroyed this diary after an editor-friend read some of it during a party and asked to publish it. To this day, that diary has never been located. Obviously, the similarities between Zelda's diary and Scott's

published works weakened his claims to being the only professional writer in the family, and even worse, the similarities likely uncovered the extent of Scott's plagiarism of Zelda's writing. This would not be the only instance when Scott used Zelda's words in his fiction; he included portions of her letters and diaries in many of his novels and short stories. Zelda not only became his muse but a contributor to his literary work; however, he never wanted the public to know the true scope of Zelda's talents. Tavernier-Courbin emphasizes, "from the very beginning, Scott used her personality, her ideas, her emotions for the creation of his heroines; he also drew extensively on her writing, her letters and her diaries, and he re-created her as his image of the ideal woman" (26). To the world, Scott needed Zelda only to be his muse—an ephemeral, eccentric spirit made purely for his inspiration—not an autonomous artist in her own right. The fact that he often used Zelda's words nearly verbatim destroys the illusion of her as amateur and questions Scott's claim to being the only professional artist in the marriage. If Zelda wanted to write short articles, they had to promote Scott's writing and their public image as a couple, and if she wrote short fiction, he wanted it to "be perceived as an imitation of his own" (Lawson 85). Zelda resented that most people identified her simply as Mrs. F. Scott Fitzgerald. She missed being recognized for her unique self—Zelda Sayre, the most daring and popular girl in Montgomery. So, in a *New York Tribune* review of *The Beautiful and The Damned* from April 2, 1922, Zelda publicly contests her virtual social identity by claiming Scott does not borrow her ideas for his writing; he plagiarizes them:

It seems to me that on one page I recognized a portion of an old diary of mine which mysteriously disappeared shortly after my marriage, and also scraps of letters which, though considerably edited, sound to me vaguely familiar. In fact, Mr. Fitzgerald—I

believe that is how he spells his name—seems to believe that plagiarism begins at home.

(“Friend Husband’s Latest” 388)

Although she partially masks her anger with humor, Zelda publicly accuses Scott of plagiarizing her written material. This battle became a theme within their relationship. Because Scott considered himself the professional writer—the true artist—he believed he owned Zelda and her creativity, experiences, and writing; moreover, although Scott consistently enforced Zelda’s role as his muse, she actively resisted it. Furthermore, Jacqueline Tavernier-Courbin argues, “all the time that he was draining away the product of [Zelda’s] intelligence, he showed no appreciation whatsoever for her accomplishments, not even the stories which she had written but which had been published under his own name” (29). Even when he pretended to support her writing, under his advisement, Scott’s publishers credited him for Zelda’s short stories. Some critics account for this act of altered authorship based upon financial gains, as opposed to the more sinister offense of outright plagiarism. In her scholarly article “An American Dream Destroyed: Zelda Fitzgerald” (1979) published in *Reteaching the Classics: Fiction*, American educator and literary critic Victoria Sullivan rationalizes that many of Zelda’s short stories were published as written by F. Scott Fitzgerald “because they drew higher payments that way: \$500 for a Zelda Fitzgerald story, and \$4,000 for one signed by Scott alone” (34). Nevertheless, even though such an arrangement is a reasonable financial decision, Sullivan contends, “surely such a practice discouraged any sense of [Zelda] as a serious writer” (34). Thus, in practice and in his mind, Scott owned Zelda and everything about her. Tavernier-Courbin explains, Scott “not only felt that he had a right to [Zelda’s] life as his raw material, he also felt that her actual writings were his literary property,” which is another reason many of her short stories appeared under Scott’s name (28). This idea of ownership haunted their future together as Zelda became trapped in the

role of Scott's muse and wife, and forevermore he viewed himself as the only real artist in the family. Within this conflict, Lawson emphasizes, "What was at stake in this struggle between the Fitzgeralds was not just the future of their marriage, but also the right to use their common autobiographical experience as material for their writing" (100). Eventually, this disparity between Zelda's self-identification as an artist and Scott's refusal to accept her as anything beyond his muse contributed to the split experience in Zelda's psyche, later diagnosed as schizophrenia.

Four years into their marriage, Zelda began to rebel against Scott's control over her and his belittlement of her intellect and creativity. Her first major revolt was adultery. While the couple vacationed during the summer of 1924 in the French Riviera (the setting from which Scott famously portrayed their experiences in *Tender is the Night*), Zelda began a brief but torrid affair with a young French aviator named Edouard Jozan. This was the point in the Fitzgerald's relationship when things began to fall apart. Although Zelda's affair ended quickly, it left a permanent scar on her marriage. By early September, the affair ended, and, heartbroken, Zelda attempted suicide by taking an overdose of sleeping pills (Milford 111). Scott found her in time to save her life, but this became her first of numerous suicide attempts. For the next five years, Zelda's behavior became increasingly worrisome and peculiar. Eventually, she entered psychiatric hospitals for treatment, but it took time for the Fitzgeralds to admit that Zelda needed help beyond Scott's abilities. Their five years of denial illustrate the fear of mental disorder and the stigma because the Fitzgeralds, subconsciously or not, did not want Zelda's social identity to be stigmatized, which correspondingly would taint the carefully constructed social identity of The F. Scott Fitzgeralds.

At the start of 1925, still searching for something to define her social identity as artistically valuable and separate from Scott's, Zelda began painting, which would become "a lifelong pursuit" along with writing (Milford 98). In her literary interpretation "Women's Work: The Case of Zelda Fitzgerald" (1989), American professor of English and literary critic Alice Hall Petry explains why painting became an important medium for Zelda:

Painting was distinctly her own work: her husband could claim credit for nothing but buying her brushes. Then again, unlike ballet, that most ephemeral of art forms..., painting led to something tangible, to something that could be hung on a wall and that would continue to exist long after the painter was gone. Also, it was a purely individual effort, and one in which the end product was the sole consideration for evaluation: there would be no losing one's identity in a troupe or a marriage, and success as a painter did not hinge upon what the painter looked like. (79)

Unlike her writing, Scott could not claim ownership over Zelda's paintings; they were Zelda's creation only. Scott neither could claim he taught her the techniques of her brushstrokes nor her unique perspectives on shape and form. All he could say was that he bought her the materials and time to paint. Turning to painting as a medium, Zelda could create art that was hers alone; moreover, her works did not rely upon her appearance nor her status as Scott's muse. Nevertheless, Scott found ways to diminish Zelda's work; according to Tavernier-Courbin, Scott did not "have any appreciation for her paintings which he helped exhibit, but which he also felt were his to give away as he wished" (29). Although he could not claim any influence over her paintings, Scott belittled them in backhanded ways. He had his friends exhibit her paintings in galleries, but then he gave them away as if they were worthless. Zelda desperately worked to prove her self-concept as an artist was valid and something that Scott could not change nor own.

In a letter written to Scott in 1930 from Prangins Clinic in Switzerland, Zelda explains her drive to create significant art: “I had to work because I couldn’t exist in the world without it, and still I didn’t understand what I was doing. I didn’t even know what I wanted” (“Letters” 455).

Although she also admits to not knowing which work would make her happy—writing, painting, or dancing—Zelda describes her impetus to work as existential—she cannot survive in her life without it, particularly because in her marriage Scott absorbed her identity and appropriated her experiences and writing. By this time, even Zelda’s affair—her first major rebellion and assertion of an independent ego identity—became another part of Scott’s creative property (Milford 112). He retold the story of Zelda’s affair and attempted suicide in countless social situations and in his novel *Tender is the Night*, adding romantic and tragic elements when it suited his audience. It became another performance for him, another conflict to add to his fiction and the legend of the Fitzgeralds. As David Knight tells Alabama Beggs Knight in *Save Me the Waltz*, “If anybody tries to steal you on the train tell them you belong to me” (Z. Fitzgerald 47). Even in her adultery, Scott reminded Zelda that he owned her and her experiences for his pleasure and creative use. Milford explains how Scott materialized his ownership of Zelda’s life experiences:

Scott had helped to fictionalize the affair, thereby giving it a heightened meaning and value, which he, having created, could come to share. It was all of a piece with his having married the heroine of his stories and novels; of his feeling, which by this time, dangerously, had become *their* feeling, that he somehow possessed a right to Zelda’s life as his raw material. (114)

Zelda wanted an individual social identity, not one dependent on Scott’s, but time and again, he reminded her that she was not who she believed herself to be. In his opinion, she never could be

a professional artist because she was a muse, and as cultural traditions emphasize, this is a threshold a muse cannot cross. Ashley Lawson explains this bind that Zelda experienced:

“According to standard notions of creativity, the idea of a ‘self-representing muse’ is practically an oxymoron; cultural expectations do not ask the muse to tell her side of the story through art, nor would it even seem natural that she would want to do so” (89). The problem with this is that Zelda was truly talented, and had she not been designated as Scott’s muse, she may have been able to earn greater respect for her artistic output. In his exploratory article “‘Better That All of the Story Never Be Told’: Zelda Fitzgerald’s Sister’s Letters to Arthur Mizener” (2017),

American professor of English, Fitzgerald scholar, and literary critic Jackson R. Bryer published excerpts from letters written by Zelda’s sister Rosalind Sayre Smith to one of F. Scott

Fitzgerald’s biographers Arthur Mizener; Rosalind corresponds with Mizener to correct falsities about Zelda within his manuscript draft. Of relevance here, Rosalind explains that Zelda “was a person of brilliant gifts, with an unconquerable urge to express herself, and Scott treated her like a child. She called him ‘an Irish policeman,’ resenting his control of her intellectual and artistic occupations” (9). Her “unconquerable urge to express herself” drove Zelda to rebel against

Scott’s oppressive standards for her as muse-not-artist; in fact, Zelda became obsessed with proving she had artistic talent that had nothing to do with Scott. In the preface to *The Collected*

Writings of Zelda Fitzgerald (1991), American professor and Fitzgerald scholar Matthew J.

Brucoli accentuates Zelda’s pursuit of art in tandem with her search for a separate identity: “Her writing during the Thirties was a quest for identity apart from her status as ‘wife of,’ as well as evidence of the rivalry that had developed in the Fitzgerald marriage” (xi). This constant struggle of jealousy, identity, and ambition took a serious toll on the Fitzgeralds’ marriage and on both their psyches. Scott’s desire to possess Zelda entirely and exclusively provoked his jealousy, and

Scott's independence and literary genius incited hers. Despite these resentments, one must remember that Scott and Zelda did love each other deeply, which is why they never divorced; nevertheless, their relationship psychologically damaged them both. For Zelda, constantly being told that she was not an artist, whom she believed herself to be, caused a split experience in both her identity and her daily life. Eventually, this continuous denial of Zelda's ego identity by others caused a split in her psyche, which manifested as schizophrenia.

As she grew increasingly unsatisfied in her marriage, Zelda's inability to create a meaningful, independent career of her own as an artist deeply distressed her and eventually contributed to her mental breakdowns. In her short story "The Original Follies Girl" (1929), Zelda describes the heroine of the story, Gay, as searching to make meaning of her life and to find satisfaction in her successful yet lonely career as an actress. This concept mirrors Zelda's personal struggles to achieve a satisfying and fulfilling life but reverses the available roles for early 20th-century women; Gay has a successful career but an empty personal life, whereas Zelda feels smothered by her personal life because she cannot achieve an independent career:

At this time she was making an awful struggle to hang onto something that had never crystallized for her—it was the past. She wanted to get her hands on something tangible, to be able to say, "That is real, that is part of my experience, that goes into this or that category, this that happened to me is part of my memories." She could not correlate the events that had made up her life, so now when she was beginning to feel time passing she felt as though she had just been born; born without a family, without a friendly house about her, without any scheme to settle into or to rebel against. The isolation of each day made her incapable of feeling surprise and caused her to be wonderfully tolerant, which is another way of saying that she was sick with spiritual boredom. (Z. Fitzgerald,

“Original Follies” 295-296)

In this passage, Zelda mimics her personal quest to create “something tangible” from her experiences and memories. The emphasis on the heroine’s failure to “correlate the events that had made up her life” points to Zelda’s loss of her personal experiences to Scott’s ownership of her life for his creative material and his reinvention of her social identity as his muse.

Furthermore, as the character Gay feels “time passing,” she gains a sense of homelessness and social abandonment—born again “without a family, without a friendly house...without any scheme to settle into or rebel against”; this relates to Zelda’s increasing sense of loneliness in her marriage as well as the loss of her original confident ego identity. In contrast to Zelda, Gay has a successful career but lacks a personal life, whereas Zelda cannot achieve her professional ambitions because of her marriage to a controlling husband. Thus, in either of these available roles—the traditional housewife or the modern career woman—the early 20th-century American woman becomes “sick with spiritual boredom” because she is unable to live her life to its fullest potential; she must choose either a family life or a career, and this choice inevitably leaves her wanting. In the revolutionary feminist text *Women and Madness* (1972), American writer, professor, and psychotherapist Phyllis Chesler argues that Zelda Fitzgerald was “desperately and defiantly at odds with the female role. [She] attempted to escape its half-life by ‘going crazy’” (76). This is a classic feminist argument that purports that some women, especially creative and intellectual ones like Zelda, used insanity to escape oppressive gender roles. However, the concept of malingering for feminist rebellion undermines the legitimacy of Zelda’s mental disorder and spiritual distress. Furthermore, it ignores the stigma stereotypes it invokes: that mental illness is not a *real* illness; that it is a choice, so it is curable. Moreover, escaping a repressive homelife through insanity means entering asylums, and certainly, this does not offer

an improvement. Instead of the husband acting as the domineering patriarchal force, the male-dominated field of psychiatry subjugates and silences the insane woman as an object of scientific study under the male doctor's gaze. Indeed, this "escape" is like jumping into a snake pit—hardly a viable alternative. Significantly, reading her biographies, letters, articles, and fiction, Zelda's mental disorder certainly does not appear to be a choice, and its severe consequences were devastatingly real.

4.2.4 *Zelda's Crack-Up*

As the tension in their marriage grew more oppressive, Zelda's behavior became increasingly more bizarre than eccentric, and Scott became a moody alcoholic, prone to flares of anger and sometimes violence. In her letters to F. Scott Fitzgerald's biographer Arthur Mizener, Rosalind Sayre Smith recalls, "I think [Zelda] was afraid of [Scott] because he sometimes was violent when drunk" (Bryer 9). Although Zelda also became violent on occasion, most often, she was self-destructive, as opposed to Scott, who occasionally became violent toward others. Alcohol and mood swings provoked Scott's negative behaviors, but others easily dismissed certain actions as those of an eccentric, tortured artist. However, because Zelda's social identity defined her as a muse, others regarded her negative behaviors as disturbing and inexplicable. What many of her peers did not understand was that Zelda's social identity and her ego identity were antagonistic to each other, causing a split in both her lived experiences and within her psyche. In her ego identity, Zelda was an artist, but her social identity cemented her as non-artist. Quickly, this internal discord manifested in external symptoms of mental disorder and uncontrollable public displays of insanity.

For one example, in August 1925 while the Fitzgeralds dined with family friends Gerald and Sara Murphy, the famous, retired ballerina Isadora Duncan sat at a table nearby surrounded

by several fans (Milford 117). Zelda recalls this incident in her nonfiction *Esquire* article “Auction—Model 1934,” published in 1934 under the authorship of F. Scott and Zelda Fitzgerald; nevertheless, according to Fitzgerald scholar Matthew J. Bruccoli, Scott “credited [the text] to Zelda in his *Ledger*” (Z. Fitzgerald, *Collected Writings* 433). In this article, Zelda pretends to be selling items the Fitzgeralds collected over the course of their marriage; however, after describing the memories associated with each, she decides not to auction away any of them by the conclusion of the text. In connection with the 1925 incident with Isadora Duncan, Zelda identifies a set of salt-and-pepper shakers in the shape of “two glass automobiles”; Zelda remembers these items as “stolen from the café in St-Paul (Alpes-Maritimes). Nobody was looking because Isadora Duncan was giving one of her last parties at the next table” (“Auction” 434). During this event, when Scott learned who Isadora Duncan was, he immediately went to meet and flirt with her, going so far as kneeling at her feet and kissing her hands (Milford 117). The sight of Scott admiring this lauded ballerina hurt Zelda on multiple levels—rubbing it in her face that Zelda lacked accomplishment in Scott’s opinion and reminding her of his regular affairs with other women. Scott’s public display of admiration and attraction toward a woman recognized as a legitimate artist drove Zelda to commit, what influential sociologist William C. Cockerham calls, a “definitive outburst” (238). Cockerham defines this as an incident when “the mentally disordered person clearly moves out into the open and overtly expresses his or her definition of the situation. This expression is some type of insane outburst that leaves little to no doubt about the mental disorder” (238). Seeing Scott with Isadora Duncan hurt Zelda to such an extent that she became self-destructive. In “Auction—Model 1934,” Zelda remembers, “There were village dogs baying at a premature white exhausted August moon and there were long dark shadows folded accordion-like along the steps of the steep streets of St. Paul” (434-435). As if in

a trance, without warning and in silence, Zelda stood up, climbed atop her chair, and dove across the table, over the seated guests, past the banister, and into the darkened stairwell behind them (Milford 117). Gerald Murphy recalled, “I was sure she was dead. We were all stunned and motionless” (Milford 117). Then, just as abruptly, Zelda reappeared at the top of the stairs, stone-still and silent, as Sara Murphy rushed to wipe the blood off Zelda (Milford 117). Gerald remembered, “I’ve never been able to forget it...They didn’t want ordinary pleasures...they did want something to happen” (Milford 117-118). The Murphys, like many other friends, began to question the Fitzgeralds’ behaviors—were they simply acting, or were they actually losing their minds? Scott was able to mock Zelda’s prior suicide attempt by turning it into part of the Fitzgerald legend; this time, however, was markedly different and undeniable because it occurred in public. Tellingly, Zelda did not speak about her hurt feelings or jealousy; perhaps, she did not feel she had the right (due to her own infidelity), or, maybe, she thought her words would go unheard. Hence, instead of verbalizing her pain, Zelda committed a violently self-destructive act. Despite this second suicide attempt, neither Scott nor Zelda immediately sought medical help for her, which emphasizes their denial of Zelda’s increasingly disordered mind; they worked to insulate her virtual social identity, staving off the stigma of mental illness as long as they could.

But by 1928, Zelda’s behaviors and moods were increasingly mercurial. Her marriage remained contentious and punctuated with Scott’s adulteries, and the damaging cycle of their marital conflicts continued—wild parties inspired Scott’s inebriated jubilation then his cruel insults; Zelda’s maniacal pursuit for her own art resulted in her neglect of her family and increasing isolation; and the emotional and physical distance between Scott and Zelda deepened. Still trying to establish an independent social identity that aligned with her ego identity as a creative and talented artist, Zelda began taking ballet classes during the summer of 1928 when

she was 28 years old (Milford 135). She dreamed of becoming a first-rate ballerina, longing for self-autonomy and a social identity separate from Scott's. Quickly, Zelda became obsessed with ballet. She practiced non-stop and rarely ate or slept, causing her relationship with Scott to deteriorate further. He continued drinking excessively, and they argued often. For the next two years, Zelda worked fanatically to perfect her dancing; Scott struggled to write while drinking excessively; and they grew increasingly silent toward each other. As Zelda withdrew from others to practice ballet, she looked inward; through this medium, she hoped to create a new social identity which would affirm her ego identity, thereby quieting the discord in her mind.

Tavernier-Courbin deduces: "The single-mindedness with which [Zelda] pursued her study [of ballet]...was a massive attempt at expressing herself, at driving out of herself the deep-seated resentment aroused by her situation, an effort to bring meaning and order into her life and to retrieve herself" (30). Zelda wanted to prove to herself that she could be an autonomous artist, and in turn, she also wanted others to view her as the artist she knew herself to be. In *Save Me the Waltz*, Alabama explains that she believes dancing is the only way she can save herself and escape the intolerable split in her experience, identity, and psyche:

At night she sat in the window too tired to move, consumed by a longing to succeed as a dancer. It seemed to Alabama that, reaching her goal, she would drive the devils that had driven her—that, improving herself, she would achieve that peace which she imagined only went in surety of oneself—that she would be able, through the medium of dance, to command her emotions, to summon love or pity or happiness at will, having provided a channel through which they might flow. She drove herself mercilessly, and the summer dragged on. (118)

As her emotions and thoughts became increasingly difficult to control, Zelda turned to physical movement and exhaustion to calm the internal “devils that had driven her” to madness. Zelda recreates her dedication and sacrifice to ballet in *Save Me the Waltz*: “Alabama clamorously dropped her person bit by bit into the ballet like pieces dropped through a mechanical piano” (157). Dancing away the bits of her person, particularly her virtual social identity, Zelda worked to liberate herself from the barbed pedestal upon which Scott placed her as his muse. Even the other dancers in the novel question Alabama’s pursuit of a career when she is married: “‘Oh, but you will be a dancer!’ the girl sighed gratefully, ‘but I do not see *why*, since you already have a husband’” (Z. Fitzgerald, *SMTW* 133). The other women must dance to survive physically (such as paying bills and buying food), so they cannot understand why Alabama also must dance to survive psychically. Alabama exclaims, “Can’t you understand that I am not trying to get anything—at least, I don’t think I am—but to get rid of some of myself?” (Z. Fitzgerald, *SMTW* 133). For Alabama and for Zelda, the ballet offered a site to dispose of the false aspects of her social identity, where she could “get rid of” the identity her husband enforced through his designation of her as muse-not-artist. Tavernier-Courbin attests to Zelda’s motivation in ballet as a rejection and response to Scott’s portrayal of her as vapid muse:

No wonder that [Zelda] drove herself mercilessly, for dancing was the one personal thing she had. The willpower, the self-discipline and the perseverance she displayed show clearly that she was not the self-indulgent and lazy little fool which Scott had described her as being. That she displayed such unbelievable energy in dancing and not in the fields of activity Scott deemed more appropriate, such as housekeeping and extolling his glory, is due to the simplest motive in the world: dancing was hers, the rest was not. (30)

Unfortunately, this strategy did not work because Scott still refused to see Zelda as an artist, no matter how much evidence she created to the contrary. Although Zelda became a gifted ballerina in a short amount of time, despite being considered too old to begin in the first place, Scott refused to consider Zelda's work legitimate. In *Save Me the Waltz*, Zelda demonstrates Scott's belittlement of her pursuit of a ballet career:

David drank with the crowds of people in the Ritz Bar celebrating the emptiness of the city together.

“Why will you never come out with me?” he said.

“Because I can't work the next day if I do.”

“Are you under the illusion that you'll ever be any good at that stuff?”

“I suppose not; but there's only one way to try.”

“We have no life at home any more.”

“You're never there anyway—I've got to have something to do with myself.”

“Another female whine—I have to do my work.” (119)

Zelda presents a typical conversation with Scott through this dialogue. First, she demonstrates Scott's alcoholism with David's annoyance that Alabama will not stay out late and drink with him. When Alabama explains her sobriety supports her ability to dance well, David implies she must be delusional to believe her pursuit can be successful; then, he connects her discontent to gendered expectations—the female artist cannot succeed in the male-dominated world of art, and her desire to try is simply “another female whine.” Nevertheless, Zelda continued to pursue an art of her own to escape gender restrictions and to realign her ego identity and social identity.

However, even as Zelda persisted in her practice of ballet, climbing the ranks from amateur to professional, Scott refused to accept the fact that she, too, was an artist. In the

summer of 1929, the Fitzgeralds went back to the French Riviera, where Zelda “[danced] professionally that summer in brief engagements in the South of France” (Petry 69). Zelda had changed dramatically under the physical strain of ballet and the emotional distress of her marriage; Zelda describes these changes in *Save Me the Waltz*:

Alabama rubbed her legs with Elizabeth Arden muscle oil night after night. There were blue bruises inside above the knee where the muscles were torn. Her throat was so dry that at first she thought she had fever and took her temperature and was disappointed to find that she had none...She was always stiff, and...in pain...Her lessons were agony. At the end of the month, Alabama could hold herself erect in ballet position, her weight controlled over the balls of her feet, holding the curve of her spine drawn tight together like the reins of a racehorse and mashing down her shoulders till they felt as if they were pressed flat against her hips...David was glad of her absorption at the studio...David could work more freely when she was occupied and making fewer demands on his time. (117)

Zelda demonstrates her determination to succeed as a ballerina; she endures and pushes through physical pain. She also compares herself once again to a thoroughbred horse; not only will she “give a damned good show,” this time, she will race to do it (*SMTW* 32). She became a professional ballerina faster than she should have been able to and at an age considered too old to begin. Despite the obvious fact that Zelda was succeeding as an artist, Scott ignored this as best he could, diminishing Zelda’s absence from the home as a helpmate to his creative output.

Still, Zelda persisted through the strain of her grueling ballet schedule and an unhappy marriage, and soon her dreams to be a professional artist were within reach. She was at the precipice of reaffirming her ego identity by recreating her social identity. According to Alice

Hall Petry, on September 23, 1929, Zelda “received a formal invitation to join the San Carlo Opera Ballet Company in Naples, Italy. As her debut with the San Carlo, she was to dance a solo role in *Aida*, with other solo performances as the season progressed” (69). Her hard work had paid off; in two years, Zelda proved her artistic talent and received an offer for a career independent of Scott. He could claim no possession or personal influence over her ballet; this also meant he no longer could classify Zelda as merely a muse. In fact, if she accepted the San Carlo offer, Zelda’s social identity would change from muse to artist because no one would be able to deny her talent and professional success. Predictably, Scott dashed Zelda’s dreams for a career again. In a letter to Scott’s biographer, Rosalind Sayre Smith reports that Zelda confessed to her that “Scott would not allow her to accept [the offer]” from the San Carlo (Bryer 8). Scott refused to admit Zelda had succeeded as an artist, and he denied her the ability to show her talents at a professional level. As reported by Tavernier-Courbin, Scott “made it obvious that he did not think that she was any good as a dancer, and he would never acknowledge the fact that she had received a professional offer” (29). After this heartbreaking loss, Zelda’s mental health deteriorated rapidly. According to Zelda’s biographer Nancy Milford, around this time, Zelda began to “[look] weary and haggard; her complexion, which had always been fresh, was ashen and colorless. Even her speech seemed to have changed” (154). Gerald Murphy, the Fitzgeralds’ friend who had witnessed the St. Paul dinner party outburst, recalled Zelda’s “sudden bursts of laughter for no discernible reason, which came more as spasms of reaction than from enjoyment” (Milford 154). Gerald added, “The laughter was her own, not like a human voice. Something strange in it, like unhinged delight. It was ecstatic, but there was a suppressed quality about it, a low, intimate sound that took one completely off guard” (Milford 154). The split between her ego identity and her social identity, the denial of her artistic talent, and the powerlessness over

her own life caused Zelda's psyche to split. She began to lose touch with reality, and her laughter at aural hallucinations and bizarre outbursts in public were undeniable signs of Zelda's mental disorder.

As Zelda's behaviors grew more peculiar, Scott drank more, aiding in his denial over Zelda's failing mental health and his culpability in her breakdown. However, Zelda committed another definitive outburst that Scott could not ignore. As was their customary reaction to discord, the Fitzgeralds fled the Riviera for Paris in October 1929, but while traveling by automobile along the Corniche, Zelda experienced a serious break from reality and almost killed them and their daughter by grabbing the steering wheel from Scott and attempting to run them off the road and down the mountain's steep cliff. Nancy Milford describes this incident in Zelda's biography:

It was on the automobile trip back to Paris along the Grande Corniche through the mountainous and steep roads of the south of France that Zelda grabbed the steering wheel of their car and tried to put them off the cliff. To her it seemed that the car had a will of its own, that it swerved as though by its own volition. (156)

Zelda adds details to this event in an autobiographical sketch written during her treatment at Phipps Clinic on March 16, 1932: "...it seemed to me it was going into oblivion beyond and I had to hold the sides of the car" (qtd. in Milford 156). Zelda downplays this attempted homicide/suicide in her autobiographical sketch, perhaps, because in her delusions she did not believe she was doing anything wrong or because she later was ashamed. In *Save Me the Waltz*, Zelda never includes this incident, but in the fictionalized version of her life, Alabama accepts the offer from the San Carlo, suggesting that having the option to take the job may have buoyed her mental health and avoided this violent split from reality. This claim is supported in the novel

when Alabama advises her daughter Bonnie “not to be a backseat driver about life” when she visits Alabama at the San Carlo Opera Ballet Company in Naples, Italy (176). In contrast, Scott vividly implants this intense steering-wheel incident into *Tender is the Night* and portrays Nicole Diver as insane, unpredictable, and dangerous:

...as he stepped on the accelerator for a short straightaway run parallel to the hillside the car swerved violently left, swerved right, tipped on two wheels and, as Dick [i.e., Scott], with Nicole’s [i.e., Zelda’s] voice screaming in his ear, crushed down the mad hand clutching the steering wheel, righted itself, swerved once and shot off the road; it tore through low underbrush, tipped again and settled slowly at an angle of ninety degrees against a tree.

The children [i.e., Scottie] were screaming and Nicole was screaming and cursing and trying to tear at Dick's face. Thinking first of the list of the car and unable to estimate it Dick bent away Nicole's arm, climbed over the top side and lifted out the children; then he saw the car was in a stable position. Before doing anything else he stood there shaking and panting.

“You—!” he cried.

She was laughing hilariously, unashamed, unafraid, unconcerned. No one coming on the scene would have imagined that she had caused it; she laughed as after some mild escape of childhood.

“You were scared, weren't you?” she accused him. “You wanted to live!”

She spoke with such force that in his shocked state Dick wondered if he had been frightened for himself—but the strained faces of the children, looking from parent to parent, made him want to grind her grinning mask into jelly. (192)

Scott could not ignore this definitive outburst because it almost killed his family; no longer could he deny the changes in Zelda's thoughts and behaviors. She needed medical help, but still, she did not see a doctor until six months later. In the late spring of 1930, at the age of 30, Zelda voluntarily committed herself to the psychiatric hospital Malmaison near Paris at Scott's coercion (Milford 158). In a letter written to Scott from Prangins Clinic in late summer/early fall of 1930, Zelda describes this moment in her life: "and then the end happened I went to Malmaison. You wouldn't help me" ("Letters" 456). The long blank space that Zelda inserts in this quote emphasizes the end of her pre-stigmatized life and the erasure of her self-concept as valuable and talented; when the text begins again in the letter, Zelda places herself on the other side of that blank nothingness within the asylum, from where she never could return to the ego identity she fought so hard to defend.

4.2.5 *Madwoman in the Asylum*

Numerous stressors accumulated to contribute to Zelda's eventual mental breakdown, including her deteriorating marriage, her increased alcohol use, her struggle to establish a social identity independent of Scott's, and her obsession with becoming a first-rate artist. Firstly, the early-20th-century gender roles created steep obstacles for Zelda to overcome in order to align her ego identity and social identity as an artist; in particular, the designation of Zelda as muse further worked to bar her from realizing her self-concept as an artist in the male-dominated professional art world. These factors are social in nature, and they caused a split in Zelda's lived experience between her social identity and her ego identity. Because others around her refused to see Zelda as individually talented, despite obvious evidence, her social surroundings became unbearable, causing intense psychological distress. Often, the "accumulation of several events in a person's life...eventually builds up to a stressful impact," especially if the life events are

“undesirable,” explains Cockerham (83). At the time of Zelda’s first major breakdown, a quick succession of stressful events took place, which created the perfect conditions for her nervous collapse and diagnosis of schizophrenia. In her analysis of Zelda’s life and work, Alice Hall Petry argues that Zelda’s mental breakdown began when Scott forbade Zelda from accepting the offer to join the San Carlo Opera Ballet Company (69). Petry explains that the steering wheel incident occurred only days after Scott forced her to end her ballet career (69). The third event happened “a few months later in March 1930”: Zelda wrote one of her best short stories, “A Millionaire’s Girl,” and it “was accepted for publication in the top magazine of the day, *The Saturday Evening Post*, and brought the still-phenomenal price of \$4,000” (Petry 69). To Zelda, although Scott crushed her ballet career, she proved with this short story that she could earn as much as Scott. However, when the *Post* published the story two months later, it “had been published under her husband’s name” (Petry 69). Once again, Scott stole Zelda’s work and appropriated it as his own. Imagine Zelda’s emotional distress and self-doubt at this point. All these events occurred in less than one year. Petry opines that these incidents are not “discrete happenings”; they demonstrate “part of larger patterns of cause and effect, of frustration and denial, of thwarted ambitions and usurped achievements that had been the lot of Zelda Sayre from the very beginning of her involvement with Scott Fitzgerald in 1918” (69). For over a decade, Zelda fought to be recognized as a valuable person, separate from the identity of Mrs. F. Scott Fitzgerald; although she excelled in ballet, writing, and painting, Scott’s suppression of her career ambitions and appropriation of her writing consistently disappointed Zelda’s hopes and eventually contributed to her collapse. Thus, if Zelda’s diagnosis of schizophrenia is accurate, this conglomeration of stressors triggered her mental disorder. Cockerham explains, when doctors first diagnose a person with schizophrenia, often:

There was a recent and discernible period—before the appearance of overt symptomatology—during which they were engulfed by a series of insoluble and mutually reinforcing problems. Schizophrenia thus seemed to originate from being placed in an intolerable dilemma brought on by adverse life events largely stemming from intense family and sexual conflicts related to unemployment and restricted life opportunities. (84)

This applies to Zelda's experience: the Fitzgeralds' marriage had become an "intolerable dilemma" with sexual conflicts incited by adultery and emotional abuse; Zelda desired employment as an artist or writer, but her "restricted life opportunities" as a woman in the early 20th century, even with her wealth, made her ambitions unattainable. However, despite what Zelda's family and some feminist critics argue, her marriage to Scott was not the only reason for Zelda's mental disorder, though his oppression over her life and artistic career certainly contributed greatly. Undoubtedly, their tumultuous relationship, which contained physical and emotional abuse by both Scott and Zelda, created a psychically damaging environment, but other factors played into Zelda's mental disorder that were outside of anyone's control.

In addition to the social factors involved, Zelda inherited genes which predisposed her to mental disorder. Moreover, although the collection of social stressors in her life activated these genes, her genetic predisposition to mental disorder cannot be discounted from Zelda's onset and experience of schizophrenia. As highlighted by Canadian psychiatrist and professor Mary V. Seeman in the *Medical Humanities* article "Gendering Psychosis: The Illness of Zelda Fitzgerald" (2016), many of Zelda's family members experienced severe mental disorders:

Zelda's father, Anthony D. Sayre, was hospitalised with a nervous breakdown in 1917; Zelda's brother, Anthony D. Sayre, Jr., committed suicide in a mental institution in 1933; her sister, Marjorie, was institutionalised periodically throughout her life for "nerve"

troubles. Her other sisters also suffered bouts of depression, and her grandmother and great aunt killed themselves. The Fitzgeralds' daughter, Scottie, had problems with alcohol, and Scottie's son, Tim, committed suicide at age 27. (67)

Contemporary science proves that certain mental disorders have genetic markers in DNA; these include but are not limited to mood disorders and addiction disorders. Additionally, suicide can run in families. Seeman asserts, "Although the expression of illness in Zelda's family leans more towards depression and addiction than towards schizophrenia, it is now known that the responsible genes overlap" (67). Thus, despite prior theories which argued schizophrenia was not hereditary, newer scientific findings locate genetic markers for this disorder. All factors considered, the causes of Zelda's mental disorder are both social and biological in nature.

Starting in 1930 and for the last 18 years of her life, Zelda was in and out of sanitariums in both Europe and America. Although their relationship was in tatters, Scott wanted and paid for the best treatments he could find, desperate to obtain a cure for Zelda that would never come. Upon entering psychiatric clinics and being labeled insane, Zelda's identity changed through stigmatization. Her social identity changed first, as whispers of her madness circled amidst her peers. At the beginning of 1930, Zelda became suspicious of her friends and increasingly quiet and withdrawn. In a letter to Scott from Prangins Clinic in Nyon, Switzerland from late summer/early fall of 1930, Zelda describes her growing illness and social anxiety: "I was nervous and half-sick but I didn't know what was the matter. I only knew that I had difficulty standing lots of people...my emotions became blindly involved" ("Letters" 455). Cockerham marks this alienation from family and friends as a common experience that tends to occur before and during the event of psychiatric commitment, especially if the person must be coerced into treatment: "The alienative nature of this situation cannot be overemphasized. Not only is the

insane person likely to reject those formerly close to him/her, but also family members may come to reject the insane person” (219). Zelda’s social identity steadily transformed from muse to madwoman, and when she began hallucinating, her visions further alienated her from others. In a letter from the summer of 1930, Zelda reveals how her grasp of reality faded as her mental disorder intensified, and she begs for Scott’s understanding:

Try to understand that people are not always reasonable when the world is as unstable and vacillating as a sick head can render it—That for months I have been living in vaporous places peopled with one-dimensional figures and tremulous buildings until I can no longer tell an optical illusion from a reality—that head and ears incessantly throb and roads disappear, until finally I lost all control and powers of judgment and was semi-imbecilic when I arrived here [at Prangins Clinic]. (“Letters” 450)

From this description, Zelda’s experience of mental disorder affected her cognitive perceptions—illusion versus reality—as well as her physical senses—her head and ears throbbed and her sight was misleading. According to American professor and literary critic George Soule in his biographical article “Zelda Fitzgerald” (2004), “On Easter in 1930, Zelda...heard flowers talking and other voices” (2). As her behaviors grew increasingly strange, Scott pleaded with Zelda to commit herself to a psychiatric institution, and because she could no longer tell reality from delusion, she consented. On April 23, 1930, Zelda entered Malmaison, a hospital near Paris; she was anxious, restlessly pacing, and slightly inebriated upon admission (Milford 158). The doctors placed her on a rest cure, which was entirely ineffective, so although still psychologically unstable, Zelda left the hospital on May 2 (Milford 158). In a letter to Scott, Zelda explains her voluntary admission to Malmaison and why she left:

To recapitulate: as you know, I went of my own will to the clinic in Paris to cure myself. You know also that I left (with the consent of Proffessor Claude) knowing that I was not entirely well because I could see no use in jumping out of the frying-pan into the fire, which is what was about to happen, or so I thought. (*Dear Scott* 85)

At Malmaison, the doctors prescribed Zelda a rest cure, but in her marriage, Scott already imposed a similar concept when he disallowed her ballet practice. To Zelda, both of her available options—a life without work in the outside world or a life without work confined within a clinic—were equally hellish. Her home life was like living in a frying pan, and the cure for her distress in a clinic was like jumping into the fire. Neither place offered support, comfort, nor security. Thus, she left Malmaison and defiantly returned to ballet with a manic energy, but within two weeks, Zelda again was confused, disoriented, incoherent, and horrified. She began having fainting spells and continued hearing voices. Moreover, her hallucinations increasingly alienated her from reality and from social connections, and her peculiar behaviors and nonsensical speech solidified her new stigmatized social identity as a madwoman.

In his effort to cure Zelda's madness, Scott provided her with the best doctors available at leading hospitals and clinics. While Scott fought for Zelda outside the hospitals, searching for the best care and cutting-edge treatments, Zelda fought her mental turmoil and her changing social identity, which would eventually alter her ego identity through self-stigmatization. According to Mary E. Wood, Zelda saw "some of the most noted psychologists of the age—Oscar Forel, Paul Bleuler, and Adolf Meyer" (249). On May 22, 1930, Scott took her to Switzerland where Zelda entered Valmont for "gastrointestinal ailments," likely caused from undernourishment and psychological distress (Milford 158). Zelda recalls her time at Valmont in a letter to Scott from 1930: "I was in torture, and my head closed together" ("Letters" 456). The physicians quickly

realized Zelda's ailments were psychopathological in nature, so they called in renowned psychiatrist Dr. Oscar Forel from the Prangins Clinic near Nyon, Switzerland on June 3 (Milford 158). Dr. Forel found no organic cause for Zelda's illness; for example, she did not have a brain injury nor a tumor; therefore, he concluded her illness was psychological (Milford 158). After observing Zelda, Forel wrote in his report from Valmont:

It became more and more clear that a simple rest cure was absolutely insufficient and that psychological treatment by a specialist in a sanitarium was indicated. It was evident that the relationship between the patient and her husband had been weakened for a long time and that for that reason the patient had not only attempted to establish her own life by the ballet (since the family life and her duties as a mother were not sufficient to satisfy her ambition and her artistic interests) but that she also [had withdrawn] from her husband. As far as her 8 year old daughter is concerned she expressed herself as follows to the question: "What role did her child play in her life?": [in English] "That is done now, I want to do something else." (qtd. in Milford 159)

Forel captures Zelda's struggle to establish an identity separate from Scott and her extreme discontent within the traditional female role of wife and mother; hence, these were two contributing factors to her mental breakdown. Furthermore, Forel indicates that Zelda's disorder is serious because it requires stronger treatment than a rest cure. Zelda also believed a rest cure was insufficient to dispel her madness. According to Alice Hall Petry, "Zelda did not yet give up on the idea that work was vital for a woman's identity and survival" (79). In a letter to Scott, Zelda opines that the only cure for her mental disorder is work, specifically her work in the ballet if Scott would allow her to take the San Carlo offer:

I at last began to believe that there was but one cure for me: the one I had refused three times in Paris because I did not want it but had persistently kept my eyes for the last three years on the only thing I know which was good and kind and clean and hard-working.

(*Dear Scott* 85)

Although Zelda feigns agency in the decision to reject the San Carlo offer, she often returns to this conflict in her letters, which underlines the intensity of her regret over missing that opportunity as well as her denial of Scott's power over the situation. Dishearteningly, Zelda would not return to the ballet in any capacity as her mental disorder became the new constant in her life. After Dr. Forel's assessment, on June 4, Zelda left Valmont and entered Les Rives de Prangins, a Swiss sanitarium located on Lake Geneva; under Dr. Forel's care, she would stay there for 15 months (Milford 160). While in his care, Scott and Dr. Forel worked together to discourage Zelda's ballet career. Upon Zelda's request, Scott sent a letter to her dance teacher, Madame Egorova, for an evaluation of Zelda's talent as a ballerina; Zelda begs, "*Please* write immediately to Paris about the dancing...just an opinion as to what value my work is and to what point I could develop it before it is too late" (*Dear Scott* 81). However, when Scott received Egorova's response, it was not the news Zelda hoped for, and it helped solidify Scott's judgment that Zelda must quit ballet. In *Dear Scott, Dearest Zelda The Love Letters of F. Scott and Zelda Fitzgerald*, a collection of letters between the Fitzgeralds, the editors Jackson R. Bryer and Cathy W. Barks explain, "Scott and her doctor (who saw her obsession with ballet as contributing to her breakdown and an obstacle to her getting well) were relieved for Zelda to have this decisive evaluation from the teacher she trusted" (81). This moment in her psychiatric confinement marked the end of everything in Zelda's mind: her artistic ambitions were smashed, and her ego identity wilted under the disappointment of this loss.

Soon, Dr. Forel diagnosed Zelda with schizophrenia because, as he saw it, Zelda was “not simply a neurotic or hysterical woman”; her symptoms were more severe (Milford 161). This diagnostic label tainted Zelda’s social identity permanently, and eventually, she incorporated the stigma of it into her self-concept. However, Zelda resisted self-stigmatization at first because she did not associate herself with the other mental patients upon her initial admission to Prangins Clinic. According to Dr. Forel, at the beginning of her confinement, Zelda was afraid of other patients (Milford 162). This fear reveals that in her ego identity she still saw herself as separate and different from the other mental patients. In addition, Zelda’s terror and inability to accept her new identity as a mental patient encouraged her desire to escape from the psychiatric hospital. Thus, miserable and afraid in the sanitarium, by the end of June, Zelda tried to run away, albeit unsuccessfully (Milford 166). This attempted flight demonstrates that Zelda had not incorporated the stigma of mental illness into her ego identity at this point. However, the hospital staff saw this revolt as a sign that her illness was worsening, so they transferred Zelda to Villa Eglantine, the building “where patients were placed under restriction” (Milford 166). Relegated to the restricted ward, Zelda continued to write to Scott about her disorder, but her new surroundings on a worse ward affected how Zelda saw herself. In a letter written in Prangins Clinic in 1930, Zelda explains her breakdown and isolation to Scott with vivid imagery:

Every day it seems to me that things are more barren and sterile and hopeless—In Paris, before I realized that I was sick, there was a new significance to everything: stations and streets and facades of buildings—colors were infinite, part of the air, and not restricted by the lines that encompassed them and lines were free of the masses they held. There was music that beat behind my forehead and other music that fell into my stomach from a high parabola and there was some of Schumann that was still and tender and the sadness

of Chopin Mazurkas—Some of them sound as if he thought that he couldn't compose them—and there was the madness of turning, turning, turning through the decisiveness of Litz. Then the world became embryonic in Africa—and there was no need for communication. The Arabs fermenting in the vastness; the curious quality of their eyes and the smell of ants; a detachment as if I was on the other side of a black gauze—a fearless small feeling, and then the end at Easter—but even that was better than the childish, vacillating shell that I am now. I am so afraid that when you come and find there is nothing left but disorder and vacuum that you will be horror-struck. I don't seem to know anything appropriate for a person of thirty: I suppose it's because of draining myself so thoroughly, straining so completely every fiber in the futile attempt to achieve with every factor against me—Do you mind my writing this way? Don't be afraid that I am a megalomania again—I'm just searching and it's easier with you.... I never realized before how hideously dependent on you I was. (*Dear Scott* 81-82)

In this letter, Zelda displays aspects of her disordered thoughts and hallucinations—everything had a “new significance”: colors were “part of the air,” and “lines were free of the masses they held.” She experienced life in both vast, overarching associations and microscopic details. She also recognized her desire for independence and her high ambitions resulted in the “draining” and “straining” of her “every fiber” but in “futile attempt.” This letter lays bare Zelda’s fear that Scott would be “horror-struck” when he saw her again because, once she was sent to a restricted ward (with sicker patients and constant surveillance), Zelda accepted her label as a mental patient and integrated it into her ego identity, as evidenced by her belief that there was “nothing left [of her] but disorder and vacuum.” This demonstrates the crushing despair that often follows the realization that one has a serious mental disorder. Not only did Zelda’s social identity

negatively change but also she incorporated the stigma of mental illness into her ego identity: effectively, she became “Alabama Nobody” as David Knight nicknames Alabama Beggs in *Save Me the Waltz*.

In a never-ending search to find a cure, Zelda endured numerous traditional and experimental methods of treatment. At Prangins and at subsequent sanitariums, Zelda tried hypnosis; insulin shock; electroshock; ergo-therapies, such as basket weaving, painting, writing, and exercising; and medications, such as morphine and bromides. However, none of these made a lasting impact. When these treatments did not lead to a cure (as schizophrenia is incurable), Zelda’s self-confidence dwindled, and she began to believe she was a hopeless case, imbedding self-stigmatization into her ego identity. She writes to Scott from Prangins in August of 1930: “It’s ghastly losing your mind and not being able to see clearly, literally or figuratively—and knowing that you can’t think and that nothing is right, not even your comprehension of concrete things like how old you are or what you look like—” (*Dear Scott* 89). At this point, fully accepting her new identity as a madwoman, Zelda became an active patient in her treatments, trying every prescription her doctor ordered, but she writhed under the pain of the psychiatric treatments and their harmful side effects, losing sight of the woman she originally believed herself to be. At Prangins in the early 20th century when Zelda stayed there, the most common therapy was known as the Swiss sleeping cure, but the treatment itself was not as peaceful as the name suggests. According to Seeman, the treatment included the following: “Standard medications were bromides, chloral hydrate, hyoscine, paraldehyde, sulfonil barbiturates and morphine. The Prangins treatment...was morphine and bromides administered rectally following an enema. For Zelda, the results were headaches and severe eczema” (68). By mid-June, Zelda developed eczema as a result from her treatment and as a psychosomatic expression of her

mental disorder; the eczema “covered her face, neck, and shoulders” and became exacerbated when she saw or argued with Scott (Milford 169). Her eczema was resistant to the medications at the clinic, so Zelda found no relief from this physical side-effect. Writing to Scott, Zelda describes her pain and begs for Scott’s help:

Please, out of charity write to Dr. Forel to let me off this cure. I have been 5 months now, unable to step into a corridor alone. For a month and a week I’ve lived in my room under bandages, my head and neck on fire. I haven’t slept in weeks. The last two days I’ve had bromides and morphine but it doesn’t do any good” (*Dear Scott* 96).

Eventually, the eczema scarred and disfigured Zelda, and deeply worried, Scott searched for a different doctor. Despite his sympathy and concern, Scott still used her pain and embarrassing side effects in *Tender is the Night*, revealing to the world exactly how insane Zelda had become. In consequence, Scott sealed Zelda’s social identity as a madwoman, while also maintaining her status as his muse. Although not added to the characteristics of Nicole Diver, Scott creates a vivid image of Zelda’s eczema when describing a patient in Dick Diver’s psychiatric clinic:

His most interesting case was in the main building. The patient was a woman of thirty who had been in the clinic six months; she was an American painter who had lived long in Paris....A cousin had happened upon her all mad and gone and after an unsatisfactory interlude at one of the whoopee cures that fringed the city, dedicated largely to tourist victims of drug and drink, he managed to get her to Switzerland. On her admittance she had been exceptionally pretty—now she was a living agonizing sore. All blood tests had failed to give a positive reaction and the trouble was unsatisfactorily cataloged as nervous eczema. For two months she had lain under it, as imprisoned as in the Iron

Maiden. She was coherent, even brilliant, within the limits of her special hallucinations.

(*Tender* 183)

This excerpt serves not only as an example of Scott using Zelda's experience of mental disorder directly in his literary work but also as a demonstration of Scott's sympathy for the drastic changes and intense suffering that Zelda endured. However, this description also illustrates Scott's gendered assumptions about women pursuing careers in the male-dominated world of art.

Literary critic Ashley Lawson argues:

Dick's diagnosis [of the Iron Maiden patient] reflects a larger cultural tendency to equate both gender and mental struggle with constitutional weakness (whether physical or intellectual), and this same rhetoric is apparent throughout Fitzgerald's assessments of his wife's potential, not only as a wife and a functional member of society but also as an artist....While his concern about the effects that any kind of strenuous exertion might have on her overall health are certainly valid, his accusation that she cannot control her creative temperament due to her own mental and emotional fragility does directly connect to the gendered inflection of his comments about her inability to sustain a professional career. Indeed, in his depictions of both his wife and the Iron Maiden, there is something essentially feminine about each woman's failures, as if those who dare to challenge the established patriarchal system by moving from muse to creator are destined to be defeated by their own gender. (97-98)

Certainly, these traditional concepts about female frailty and madness echo throughout Zelda's lived experiences. Her obsession with ballet brought about her physical exhaustion, but "her inability to sustain a professional career" stemmed largely from Scott's interference in her pursuits as well as his appropriation of her work when possible. Zelda's experience of lost

identity, madness, and stigmatization are gendered; if she had been a man in similar circumstances, others would have seen her compulsive work not as insane but as artistic and respectable. Moreover, the coercion to enter confinement would have been more difficult to achieve if Zelda had been a man; this is exemplified in her husband's experience. Although Scott struggled with alcoholism and bipolar disorder, he never entered a psychiatric clinic for treatment, believing that psychoanalysis would ruin his creativity. However, he did not have these concerns for Zelda because he believed her artistic ambitions were mad to begin with based purely upon her gender.

When Zelda did not improve under Dr. Forel's care, Scott demanded another specialist examine her to confirm her diagnosis. Hence, on November 22, at a loss for treatment ideas and on the behest of Scott, Dr. Forel requested a consultation with Dr. Paul Eugen Bleuler, the leading authority on psychosis and schizophrenia (the term with which he renamed dementia praecox) (Milford 179). Both Scott and Forel wanted to validate Zelda's diagnosis to provide her the most effective treatments, and Dr. Bleuler confirmed that Zelda had schizophrenia (Milford 179). Because Bleuler's professional opinion was well-respected in both Europe and America, his diagnosis cemented Zelda's stigmatized social identity as a schizophrenic madwoman. Moreover, according to Nancy Milford, Scott directly quoted Bleuler's diagnosis of Zelda in *Tender is the Night*: "Diagnosis: Divided Personality. Acute and down-hill phase of the illness. The fear of men is a symptom of the illness and is not at all constitutional....The prognosis must be reserved" (Milford 285; Fitzgerald 128). [Note: In Bleuler's diagnosis, when he discusses Zelda's "fear of men" as "not at all constitutional," he is referring to Zelda's temporary homosexual feelings for her ballet teacher Madame Lubov Egorova, which he viewed as only a symptom of her disorder.] Schizophrenia can be a complicated disorder to understand, especially

when diagnostic terms include words like “divided personality.” In 1959, renowned Scottish psychiatrist and theorist Ronald David “R.D.” Laing published his theories on schizophrenia in *The Divided Self: An Existential Study in Sanity and Madness*; in this text, Laing defines schizophrenia:

The term schizoid refers to an individual the totality of whose experience is split in two main ways: in the first place, there is a rent in his relation with his world and, in the second, there is a disruption of his relation with himself. Such a person is not able to experience himself “together with” others or “at home in” the world, but, on the contrary, he experiences himself in despairing aloneness and isolation; moreover, he does not experience himself as a complete person but rather as “split” in various ways, perhaps as a mind more or less tenuously linked to a body, as two or more selves, and so on. (17)

Importantly, schizophrenia should not be confused with multiple personality disorder (or dissociative identity disorder), which became a popular diagnosis at the end of the 20th century. Schizophrenia becomes a divided or split experience because the person feels alienated both from the world and from himself. For Zelda, this divided experience applied to her identity, specifically the split between her ego identity as an artist and her social identity as a muse-not-artist; when she could not prove herself as an artist to those around her, the division between her self-concept and how others viewed her split her psyche and led to her mental breakdown. In the 21st century, according to Seeman, as of 2016, the definition of schizophrenia has changed: “Schizophrenia is currently defined ‘by abnormal social behavior and failure to recognize what is real. Common symptoms include false beliefs, unclear or confused thinking, auditory hallucinations, reduced social engagement and emotional expression, and lack of motivation’” (65). Certainly, Zelda also experienced many of these common symptoms of schizophrenia; thus,

both definitions of the disorder apply to Zelda's experiences—the first outlines the root of her psychological distress, and the second illustrates her outward expression of the mental disorder through symptoms. Milford illustrates Zelda's split experience within the first year of her marriage to Scott, drawing on evidence from letters Zelda wrote to him:

Increasingly, their friends were Scott's friends, the pace of their life was being set by the demands of Scott's work and his success, and Zelda, who had established the tone of their courtship, must have felt their marriage slipping precariously into unknown regions in which she might become lost. The passion of her letter[s], the wild and intense description of her love for Scott, was an indication not only of her need for him but also of her uncertainty about herself within the life they were leading. The woman who realized that she wanted to be two simple people at once was finding the “one who wants a lot to itself” in ascendance in her marriage. Zelda was becoming entangled in the crosscurrents of a complex of opposing roles, making an effort to be both daring and loving, to not give a damn and to care deeply, to be proud of Scott's drawing on her for his fiction while resenting it. (76)

Zelda experienced a double bind in which she wanted both to be independent of Scott's version of her as his muse, which he portrayed again and again in his work, and, at the same time, to be the daring, prideful heroine of his fiction. She wanted to be Mrs. Scott Fitzgerald to an extent, but she longed to return to her legendary identity as Zelda Sayre. The ambivalence Zelda felt from these opposing drives further exemplifies why Zelda's psyche split.

After Dr. Bleuler's confirmation of her diagnosis, Zelda accepted her new stigmatized social identity and incorporated it into her ego identity. She whole-heartedly participated in her treatments because she accepted that she was unwell; thus, she became a model patient. This

mindset change aided in Zelda's periods of recovery, but her new stigmatized self-concept would last for the rest of her life. When evidence of her improvement became clear, Zelda's doctors released her from Prangins on September 15, 1931. However, her prognosis was precarious. According to Milford, as recorded in Zelda's psychiatric medical files, "her case was summarized as a 'reaction to her feelings of inferiority (primarily toward her husband).' She was stated to have had ambitions which were 'self-deceptions' and which 'caused difficulties between the couple'" (191). However, her prognosis was "favorable—as long as conflicts could be avoided" (Milford 191). Obviously, conflicts cannot be avoided in life, so this prognosis presented Zelda's stability as uncertain at best. Unfortunately but predictably, Zelda experienced many more struggles in her life. Cyclically until her death in 1948, she would experience an overwhelming situation or conflict, relapse into mental disorder, and go back to a psychiatric hospital until physicians deemed her mental state as improved. Because of many public outbursts and Scott's reproduction of her disorder in his fiction, Zelda's social identity changed because of the stigma—the power of which only grew stronger with each of her recidivisms. During her first two institutionalizations, Zelda feared the other patients and avoided contact with them, which emphasizes the cultural myth of madness as contagious; moreover, her self-imposed distance from other patients also shows that during her first stay at Prangins Zelda did not relate herself with the other mental patients. She did not self-stigmatize yet, so she did not accept her membership in this marginalized group. According to Erving Goffman in *Stigma: Notes of the Management of Spoiled Identity* (1963), each stigmatized individual undergoes a socialization process or a "moral career" in which she learns about the stigmas associated with her disability and experiences changes in her subjective ego identity; this experience can be characterized by feelings of ambivalence and shame (32). There are a variety of patterns for this socialization

process as described by Goffman, but Zelda's experience aligns with the following "moral career" pattern:

A third pattern of socialization is illustrated by one who becomes stigmatized late in life, or learns late in life that he has always been discreditable—the first involving no radical reorganization of his view of his past, the second involving this factor. Such an individual has thoroughly learned about the normal and the stigmatized long before he must see himself as deficient. Presumably he will have a special problem in re-identifying himself, and a special likelihood of developing disapproval of self. (Goffman, *Stigma* 34)

During her first institutionalization, Zelda viewed herself as part of the "normal" group of persons, not as discreditable; although she believed she was sick, she did not self-identify as a mental patient. However, her perspective and ego identity changed drastically after Zelda received her diagnosis and, especially, once Zelda reentered the world outside the hospital after her first major confinement. Her pre-hospitalization friends and acquaintances treated her differently because Zelda's "stigmatization [was] associated with [her] admission to a custodial institution," i.e., the sanitarium (Goffman, *Stigma* 36). After Zelda left Prangins, the Fitzgeralds traveled to Montgomery, so Zelda could visit her family and her dying father. In addition, the couple entertained the idea of relocating to Montgomery. Friends there remembered Zelda Sayre as a charismatic, beautiful young woman when she left Alabama for New York City, but years later when she returned as Mrs. Scott Fitzgerald, both her physical appearance and her mannerisms had altered dramatically. Zelda looked much older: her appearance was scarred from eczema and dampened under the strain of suffering. Milford recounts Zelda's initial post-patient experience:

Zelda seemed peculiar to her friends, few of whom knew about her recent breakdown, and her appearance startled them. She was haggard and her mouth fell into a slight smile, as if she were permanently amused. The Fitzgeralds had always provided Montgomerians with a topic of conversation and gossip, but now it was no longer entirely out of envy that their names came up.... Zelda began to feel increasingly uncomfortable in Montgomery. (193)

To distract her from these social experiences of stigmatization, Zelda wrote short stories, and she stayed relatively stable for a few weeks, but overwhelming conflict arose again, and she experienced a recurrence of schizophrenia. When her father, Judge Sayre, died on November 17, 1931, Zelda stayed relatively calm during his death and for his funeral; however, by January 1932, she became sleepless, paranoid, and panicked, and her eczema returned (Milford 196-197). When Zelda's mental disorder publicly manifested while she visited home in Montgomery, the town solidified rumors of Zelda's madness, leaving a permanent scar on her social identity, even in the place where she once was the most beloved. On February 10, 1932, after Zelda endured two days of sporadic hysterical fits, Scott wired Dr. Adolph Meyer, the distinguished director of Henry Phipps Psychiatric Clinic of Johns Hopkins University Hospital in Baltimore, Maryland, that he was bringing Zelda to him for treatment (Milford 209). This recidivism further concreted Zelda's actual social identity as a mental patient and caused Zelda to incorporate the stigma deeply into her ego identity. Furthermore, after her diagnosis, others equated Zelda's personality traits with symptoms of schizophrenia; thus, understandably, she learned to integrate "schizophrenia" into her ego identity. No longer did others view Zelda as creative or eccentric; now, they saw her as a deranged madwoman. In consequence, Zelda believed herself to be a hopeless case. Milford depicts Zelda's feelings about her mental disorder: "She remarked later to

a friend that Dr. Meyer wouldn't be able to do anything for her and she thought she'd spend the rest of her life in sanitariums" (213). However, despite her hopelessness for a cure, Zelda showed resilience because she still desired to work and create art. Despite her self-stigmatization, Zelda never stopped believing that she was an artist; neither the stigma nor schizophrenia could take away this piece of self-knowledge.

Luckily, when Zelda entered the Phipps Clinic on February 12, 1932, she went under the care of the young, female resident psychiatrist Dr. Mildred Squires (Milford 210). Dr. Squires was the first doctor who neither diminished nor forbade Zelda's passion for artistic expression. Instead, Dr. Squires' encouraged Zelda to write while she was in the hospital. Likely, because she had succeeded in establishing a career in the male-dominated field of psychiatry, Dr. Squires knew firsthand the obstacles and disparagement that came from challenging the patriarchal status quo. Perhaps, her personal experience allowed Dr. Squires to empathize with Zelda's desire to attain a professional career. With this unexpected support, Zelda finished her autobiographical novel *Save Me the Waltz* by March 9, after working on it for only three months, and she sent it directly to Maxwell Perkins at Scribner's on March 10 without telling Scott (Milford 216). This narrative therapy helped Zelda understand her experiences with mental disorder, and in many ways, it allowed her to recreate her story through a non-conventional narrative structure and a modernist style that both established her resistance to traditional notions of women's intellectual capabilities and demonstrated her ability to create a more experimental modernist novel than Scott could using the same autobiographical material. For example, although both *Tender is the Night* and *Save Me the Waltz* are modernist novels, Zelda's text is far more experimental and expressionistic than Scott's version of the same events. In *The Bedford Glossary of Critical and Literary Terms* (2009), Ross Murfin and Supryia M. Ray explain that modernism was "a

revolutionary movement encompassing all of the creative arts” from the 1890s until the beginning of World War II in the 1940s (307). This movement rejected traditional Victorian conventions for art—such as moralistic themes and narrative realism; thus, artists from all creative fields expressed modernist ideology through “experimental techniques” (Murfin and Ray 307). Murfin and Ray define the modernism movement through historical significances and common experimental strategies employed by writers in rebellion against Victorian artistic traditions:

As a literary movement, modernism gained prominence during and especially just after World War I, then flourished in Europe and America throughout the 1920s and 1930s. Modernist authors experimented with new literary forms, devices, and styles; incorporated the psychoanalytic theories of Sigmund Freud and Carl Jung; and paid particular attention to language—both how it is used and how they believed it could or ought to be used. Their works reflected the pervasive sense of loss, disillusionment, and even despair in the wake of the Great War, hence their emphasis on historical discontinuity and the alienation of humanity. (307)

Certainly, both novels about Zelda’s mental illness are modernist; they both reflect “the pervasive sense of loss, disillusionment, and despair” within their themes, and both experiment with narrative structure and time. However, what truly sets *Save Me the Waltz* apart from *Tender is the Night* in a comparison of modernist elements is Zelda’s style, language, and perspective, which prove the text is an effective expressionistic novel and far-more experimental than Scott’s.

In similarity, both novels illustrate modernist themes of loss, disillusionment, and despair. In *Tender is the Night*, the protagonist Dr. Dick Diver loses his promising career as a psychiatrist because he marries a former mental patient, Nicole Warren. The power dynamic of

their relationship is complicated by Dick's superior status as a doctor, who oppresses his patient-wife, and Nicole's family fortune, which not only establishes Dick's own medical clinic but also checks his megalomaniacal pride. Both husband and wife become disillusioned because their marriage is dissolving from the adulteries both commit and the couple's inability to maintain the feigned versions of their social identities. Scott's novel presents a moralistic lesson about the dangers of transference both in psychotherapy and in marriage. Although transference is a typical part of the psychoanalytic script, Sigmund Freud describes transference as both a powerful and dangerous factor in psychoanalysis. In the instructional text *An Outline of Psychoanalysis*, Freud posits transference occurs when a patient replaces his father (or mother) with his doctor (69). This unconscious replacement allows the doctor to act as a parental figure and to reeducate the patient by establishing trust; in this way, the doctor corrects mistakes introduced by parental education (Freud, *Outline* 69). During transference, the patient fully trusts her doctor, sometimes to the point of believing she "has fallen passionately in love" with him (Freud, *Outline* 69). In *Tender*, Nicole falls in love with Dick, replacing her abusive father with a safer male figure through transference, but the transference in the novel causes Dick and Nicole to believe in false versions of each other. For example, Dr. Dick Diver always sees Nicole as perpetually sick and fragile, and this insistence weakens Nicole's confidence and recovery. One of the reasons Nicole fully recovers at the end of the narrative is because Tommy Barban, Nicole's lover and second husband, refuses to accept Dick's stereotype of Nicole as a madwoman: "Tommy broke in sharply with: 'You don't understand Nicole. You treat her always like a patient because she was once sick'" (S. Fitzgerald, *Tender* 308). Nicole's transference to Dr. Dick Diver originally acted to create a safer version of a father figure; Dick would care for her and not abuse her as Nicole's father did in her childhood. (As an aside, Zelda's father was not abusive, but Scott added incest

to his novel to best support the leading psychological theories by Freud, who insisted that disruptions in the development of one's sexuality led to nervous disorders in the adult psyche.) However, Nicole realizes that Dick is neither a safe haven nor her savior; instead, his consistent labelling of her as a madwoman cripples her:

Nicole relaxed and felt new and happy; her thoughts were clear as good bells—she has a sense of being cured and in a new way. Her ego began blooming like a great rich rose as she scrambled back along the labyrinths in which she had wandered for years. She hated the beach, resented the places where she had played planet to Dick's sun.

“Why, I'm almost complete,” she thought. “I'm practically standing alone without him.” (S. Fitzgerald, *Tender* 289)

By rejecting Dick's assigned social identity for her, Nicole's ego identity blooms and resists Dick's prognosis for her as incurably mad, or as he says in the novel, “She's a schizoid—a permanent eccentric. You can't change that” (S. Fitzgerald, *Tender* 151). By the conclusion, neither Dick nor Nicole can live up to the false identities they created of each other through transference, so Nicole frees them both by divorcing Dick and marrying the French aviator Tommy Barban. The theme of the novel highlights the destructive nature of a marriage in which individual ego identities become suppressed beneath a contrived version of their joint social identity as a married couple. The novel establishes psychoanalytical theories and the profession of psychiatry as the frame for the narrative, which highlights Scott's goal to create a modernist novel by applying Freudian theories to his text. However, by including the moralistic lesson, Scott Fitzgerald upholds the Victorian literary tradition of didacticism and undermines his modernist goals for the novel. Moreover, although incorporating psychoanalytic theories was a common characteristic of modernist literature, Scott incorporates mental illness into his text in

predictable ways because he portrays madness from an external medical perspective; thus, although he complicates the asylum autobiography by dramatizing the Divers' relationship, Scott follows generic conventions for case studies and traditional recovery narratives because the plot follows Nicole's breakdowns and symptoms, her patient history, the various treatments she tries, and her final recovery and departure from her doctor's care. All these plot points mimic case studies written by psychiatrists, like the ones written about Zelda. Thus, Scott's plot is partly original because it utilizes the Fitzgeralds' lived experiences and partly conventional because it follows many generic expectations for case studies and presents mental illness from an external perspective. Furthermore, by mimicking official psychiatric narratives, Scott adheres to Victorian standards for literary realism and verisimilitude. Ultimately, as a text, *Tender is the Night* struggles to suppress the Victorian literary traditions that Scott aimed to rebel against through his modernist experimentation.

In comparison, Zelda's novel *Save Me the Waltz* presents themes of pervasive loss and disillusionment with an emphasis on masked despair, but, unlike Scott, she offers no moralistic lesson at the end—only the portrait of a creative woman crushed and thrown away too early like the cigarette butts in the ashtrays Alabama tosses in the trash in the closing scene. Zelda's novel follows Alabama Beggs' loss of self within her marriage to famous painter David Knight and her devoted pursuit to find an art and a social identity completely independent of David's. The plot portrays Alabama's struggle to survive in a society that devalues the female artist and coerces women to remain in the roles of housewife and mother, no matter how stifling or demoralizing those roles may feel to the individual woman who desires a career. In her biographical analysis "An American Dream Destroyed: Zelda Fitzgerald" (1979), critic Victoria Sullivan outlines three major "thematic concerns" within *Save Me the Waltz*; notice these themes also demonstrate the

overarching modernist themes of loss, disillusionment, and despair: “one, the domestic environment as a negative, alienating, and sometimes dangerous milieu; two, the need to escape through transcendence, flight, dance, and unreality; and three, a recognition that pain and dissociation may be the price that one pays for pursuing a dream” (39). The first theme underlines the pervasive sense of loss Zelda felt within her marriage; moreover, her loss of self alienated Zelda from her others. In the novel, Alabama presents a poem she writes to David after several years of marriage, and it emphasizes Zelda’s loss of self during her own marriage:

Why am I this way, why am I that?

Why do myself and I constantly spat?

Which is the reasonable, logical me?

Which is the one who must will it to be? (Z. Fitzgerald, *SMTW* 68)

This passage illustrates Alabama’s sense that she is splitting into two, which represents the growing division between Zelda’s ego identity and her social identity. She questions which self is most logical—the artist or the muse, the career woman or the kept wife; furthermore, Zelda presents these versions of her identity as in a constant struggle for dominance. The last line questions which identity will win, but by the end of the novel and Zelda’s life, her social identity rules and subjugates her ego identity until it disappears beneath her role as insane muse. The second theme of escape emphasizes the disillusionment many modernist artists felt after WWI and illustrates one woman’s need to escape from the disappointment of her repressive marriage and her consequent loss of self. Mary E. Wood explains how Zelda’s disenchantment with her oppressive marriage, psychiatric labelling, and stigmatization connects to early 20th-century cultural norms that devalued and demoralized women: “Zelda Fitzgerald’s disempowerment during the course of her illness and in her characterization as Nicole bears on much wider issues

of women's relationship to psychiatric authority, the institution of marriage, and the right to authorship" (253). In *Save Me the Waltz*, one way Zelda rejects psychiatric authority over women's bodies and minds is by removing psychiatrists from her narrative entirely. Moreover, she rebels against the restrictions of her marriage and fights for her right to use her own experiences as material for her creative work by penning this novel and advocating for its publication, even in the face of Scott's sabotage and fury. Finally, the third major theme in *Save Me the Waltz* dramatizes the deadening despair felt when the female artist's ambitions are lost forever through injury or illness. Alabama pushes her body to its breaking point to succeed in the ballet, but the end of her career happens almost by chance—an infected blister on her foot results in blood poisoning, which hospital doctors cure by severing the tendons in her foot (Z. Fitzgerald, *SMTW* 181). Thus, despite the absence of psychiatrists in the narrative, male doctors still end Alabama's creative ambitions. Wood connects this theme of despair to cultural male authority over the female body and mind:

In [Zelda's] story of ballet—a story in which mental illness is never mentioned—the diagnosis and control of the female body [is] enacted in an art form. *Save Me the Waltz* reveals the diagnostic sentencing of women not only within the realm of mental illness—the obscured yet always present subject of the novel—but within the wider cultural context of definitions of femininity and of artistic creation and convention. Within these definitions, the female body is the living metaphor for the material of art, the object of the male artist. (254)

Accordingly, the theme of despair in Zelda's narrative alludes to the personal trap she could not escape—Scott's muse. Ultimately, the deepest despair within *Save Me the Waltz* is the heroine's inability to escape the male gaze and its objectification of her as well as her doomed efforts to

become an independent female artist beholden to her husband's fame. Even at the height of a ballet career, female dancers and instructors must bow to the whim of the male director. In *Save Me the Waltz*, Zelda accentuates this power dynamic between the masculine authority of the director and the female dancers' burden to bend beneath it:

Diaghilev called his rehearsals at eight in the morning. His dancers left the theater around one at night....Diaghilev insisted that they live at so much nervous tension that movement, which meant dancing to them, became a necessity, like a drug. They worked incessantly...an allegiance to his genius as strong as a cult determined all their opinions. The quality that set them off from other dancers was his insistence on their obliteration of self to the integral purpose of ballet....They lived for the dance and their master. (135)

This emphasizes the theme of female disillusionment and despair: even in the world of ballet, where female dancers vastly outnumber male dancers, the male director takes credit for female artistic creation. Moreover, because the novel is an autofictional portrait of Zelda's mental breakdown but she does not present this directly, Zelda rejects the traditional recovery narrative plot, which focuses on the protagonist's symptoms and causes of mental disorder, psychiatric treatments, and final recovery, by replacing the mind with the body in her life narrative. In *Save Me the Waltz*, Alabama drives herself mercilessly in ballet, hoping that once she gains complete control over her body, she will achieve control over her identity and circumstances. Certainly, this is true of Zelda's experience in ballet, but what Zelda leaves out of the novel is that she also sought to regulate her mind as it became increasingly disordered by schizophrenia. Unlike Scott, whose novel sharply focuses on psychology, Zelda's approach is unique because she removes the very plot her readers expect to find. What could be more experimental and modernist?

Following another modernist technique, both Scott and Zelda experiment with narrative structure and time in their respective novels. For example, Scott divides *Tender is the Night* into three books, but he orders them nonchronologically. Particularly in “Book 2,” Scott experiments with narrative time because this middle-point of the novel begins as a flashback to 1917 (approximately eight to ten years earlier than the narrative time of “Book I”) when Dick Diver is a new psychiatrist with a promising future. “Book 2” follows the “love story” of Dick Diver and Nicole Warren, starting when he first meets her when she is a mental patient through their courtship and into their marriage. This background section discloses the complications within the Divers’ marriage and the constant power struggle between the husband-doctor and his wife-patient, mirroring the Fitzgeralds’ power dynamic of husband-author and wife-muse. Despite this temporal inversion, the narrative events are mostly straight-forward, even if it takes the reader until the end to see the full picture. Furthermore, by arranging the narrative time in this way, Scott mimics a typical case history—firstly, the doctor meets a patient because symptoms and behaviors have brought the patient to medical attention; secondly, the doctor gathers the patient’s history, looking for clues as to why the patient is psychically distressed; and finally, the doctor prescribes a variety of treatments until the patient recovers. Scott’s use of this Freudian-like framework was experimental at the time for fiction, and it directly emphasizes his modernist preoccupation with psychoanalytical theories.

Similarly, Zelda’s novel experiments with narrative time, especially when the temporal movement of the narrative all but stops when Zelda practices ballet. The first part of the narrative follows a chronological order that presents a forward-moving plot line from Alabama’s childhood through her adolescence and courtship with David Knight, then through their marriage and life in New York City until the birth of their daughter. However, becoming a mother amidst

the riotous lifestyle of the famous couple, Alabama begins to lose herself, and the narrative begins to reject many conventional standards. For example, during a conversation between Alabama and David, once they begin speaking about their daughter, Zelda removes all indicators of which character is speaking for 22 lines of dialogue (*SMTW* 65-66). By doing so, Zelda combines the ideas of Alabama and David in such a seamless way that the reader must struggle to decide which ideas are Alabama's and which are David's. This also imitates Scott's appropriation of Zelda's writing while claiming them as his own production. This collapse of differentiated perspectives implies the reason for Alabama's upcoming pursuit of ballet—she does not want to be swallowed by David's fame. Nevertheless, the removal of dialogue markers illustrates Alabama's disappearing identity, and it foreshadows the structural collapse of narrative time and near erasure of plot movement that occur when Alabama practices ballet. For most of the text, the plot actions begin to circle around and around as Alabama pirouettes. Over and over, the plot finds Alabama at the ballet studio, interacting with the other dancers and strenuously molding her body and movements; when she goes home in the evening, she rubs her sore muscles, stretches, sleeps, then repeats it all again in the morning. Zelda emphasizes this collapse of narrative time by removing most of Alabama's world outside the studio from the plot, especially the figures of her husband and daughter:

By springtime, she was gladly, savagely proud of the strength of her Negroid hips, convex as boats in a wood carving. The complete control of her body freed her from all fetid consciousness of it.

The girls carried away their dirty clothes to wash them. There was heat incubating again in the rue des Capucines and another set of acrobats at the Olympia. The thin sunshine laid pale commemoration tablets on the studio floor, and Alabama was

promoted to Beethoven. She and Arienne kidded along the windy streets and roughhoused in the studio, and Alabama drugged herself with work. Her life outside was like trying to remember in the morning a dream from the night before. (*SMTW* 127)

As this excerpt demonstrates, the passage of narrative time can be measured only by the strengthening of Alabama's muscles, the washing of dirty ballet clothes, and the sunlight moving across the dance floor; everything else becomes like a forgotten dream. To emphasize this temporal collapse, Zelda follows the previous passage with a typical morning after sleeping at home: "Fifty-one, fifty-two, fifty-three—"; the dancers are immediately back at the studio, counting their practice. Zelda includes no mention of Alabama's time at home with her family, nor does she acknowledge her traditional duties of domesticity and childrearing. The only significant time in *Save Me the Waltz* occurs within the count of steps danced in the studio. Occasionally, Alabama's personal life interrupts her time in ballet, and these disruptions serve as distressing reminders of Alabama's expected roles—wife and mother, not artist. In one scene, David and some friends come to the studio to watch Alabama practice, but their intrusion angers her: "My lessons are not a circus," she complains (Z. Fitzgerald, *SMTW* 134). With this insult, David's aghast friends belittle Alabama's drive: "Miss Douglas said indignantly, 'I think it's ridiculous to work like that. She can't be getting any fun out of it, foaming at the mouth that way!' Dickie said, 'It's abominable! She'll never be able to get up in a drawing room and do *that!* What's the good of it?'" (Z. Fitzgerald, *SMTW* 134). These criticisms dramatize the ones Zelda encountered in her life, but this disparagement only drove her ambition for success: "Alabama had never felt so close to a purpose as she did at that moment" (Z. Fitzgerald, *SMTW* 134). The microscopic focus on Alabama's ballet practice encourages the collapse of narrative time within the plot. Only after she is injured and placed in the hospital, only when the dancing

stops, do the narrative time and plot move forward again. Although Zelda's narrative time is chronological, she experiments with the movement of the plot's progression to dramatize the sense of stalled temporality during artistic creation.

Of equal import, Zelda rejects the conventional expectations for autobiography by rejecting realism as an effective method to illustrate mental illness. While Scott presents a traditional recovery narrative that portrays the patient's illness, case history, treatments, and final recovery, Zelda avoids this narrative structure entirely. In her literary analysis "A Wizard Cultivator: Zelda Fitzgerald's *Save Me the Waltz* as Asylum Autobiography" (1992), Mary E. Wood argues, "[Zelda's] choice not to tell explicitly the story of her illness and hospitalization is a strategic one; she writes this novel against the expectations for asylum autobiography, expectations that would shape and constrict her narrative" (248). By resisting literary conventions for asylum autobiography, Zelda creates a greater experimental text than Scott does because he adheres to generic expectations, while she does not. Wood claims *Save Me the Waltz* refuses to follow generic conventions specifically because Zelda rejects the psychiatric objectification of female patients and the patriarchal oppression that supports it:

[The novel] both obscures and reveals a fragmented story of mental turmoil and incarceration. In *Save Me the Waltz*, a narrative about Alabama's bodily experience is substituted for a suppressed story of mental illness. Through this substitution, the novel not only avoids conventional representations of the insane woman—such as the version of Zelda produced in F. Scott Fitzgerald's 1934 novel *Tender Is the Night*—but exposes those representations and the psychiatric discourse surrounding them as dependent upon an appropriation and objectification of female bodies. (247)

Furthermore, by rebuffing the expected representation of herself as both madwoman and muse, Zelda disdains Scott's objectification of her in his novels and his appropriation of both her identity and writing. Despite approaching the structure and temporality differently, both Zelda and Scott create modernist novels through their experimentation with narrative structure and time. Nevertheless, although both novels are examples of modernist texts for their themes, structure, and temporality, Zelda's novel implements more experimentation, particularly in her employment of an expressionistic approach and writing style.

To clarify, Zelda's novel achieves a mature expressionist vision of her experience with mental illness, and ultimately, *Save Me the Waltz* achieves a higher degree of modernist experimentation than *Tender is the Night* precisely because of the expressionist elements Zelda displays within her rejection of realism, her poetic yet dizzying writing style, and her focus on the individual, subjective experience, as opposed to an objective third-person perspective like Scott presents. In *The Bedford Glossary of Critical and Literary Terms*, Murfin and Ray explain the basic tenets and techniques of expressionism, a subset within the modernism movement:

Proponents [of expressionism] believed that objective depictions of circumstances and thoughts cannot accurately render an individual's subjective experience. Expressionists reject realism and share (although perhaps with more intensity) the impressionist intention to present a personal vision through art. To render this personal vision artistically, expressionists depict their subjects as they feel or sense or experience them, rather than as those subjects appear from an external viewpoint. To expose the idiosyncratic and often extreme states of human consciousness and emotion, expressionist works tend to oversimplify and distort. In addition, the singularly "unreal" or even nightmarish atmosphere of these works accentuates the gulf between personal

perception and objective reality. (158-159)

Zelda's achievement of these expressionist ideals is obvious in *Save Me the Waltz*, making her novel more experimental than *Tender is the Night*. Although critics at the time claimed Zelda's novel was "excessively verbose and labored" and overly flowery, her "flowery" language is intentional because it creates a "weaving together of dance and writing" through an "arabesque" style, explains French literary critic Catherine Delesalle-Nancy in her analysis "Writing the Body: Zelda Sayre Fitzgerald's Resistance in *Save Me the Waltz*" (2020):

An "arabesque" is a ballet position in which one leg supports the body while the other extends backward, both remaining straight. The term also has connections to writing, referring to any ornamental script whose letters are woven with tendrils, foliage, and other scrolling patterns. Through this adjective, writing becomes, like dancing, a means for Zelda to reappropriate her life and turn it into artistic material. Creating her version of her story is a shaping of the textual body, a shaping which she intends to be her own, not a collaboration with her husband. Her style is obviously very different from his: it is arguably "arabesque" if we think of that word's association with the botanic and verdant metaphors...connotating "flowery." (113).

Zelda purposely employs expressionist ideals: by juxtaposing "flowery" (i.e., feminine) images with violent ones, Zelda portrays her artistic vision and personal defiance of gender norms through the protagonist's sensory and emotional impressions; this establishes a disorienting mood within the text while molding the textual body into an original, unexpected structure in direct opposition to the traditional, objectively narrated, logical plots of the male-dominated American literary canon. Zelda forces the reader to feel the discomfort, denial, and confusion of mental breakdown from a feminine perspective through her verbose descriptions that evoke the

sense of being strangled slowly by the botanic tendrils of her language. For example, consider Zelda's composition of the following expressionistic description of Alabama's subjective experience of the extreme states of emotional distress within her stifling marriage. To frame this passage, this scene occurs at a party where David and Alabama Knight meet the young Hollywood actress Gabrielle Gibbs, who represents the real-life Lois Moran with whom Scott had an extended affair; Scott also portrays Moran in *Tender* through the character of Rosemary Hoyt. When David flirts lasciviously with Gabrielle, Alabama sinks into despair:

In her deepest moods of discontent, Alabama, on looking back, found the overlying tempo of that period as broken and strident as trying to hum a bit of *La Chatte*.

Afterwards, the only thing she could place emotionally was her sense of their all being minor characters and her dismay at David's reiteration that many women were flowers—flowers and desserts, love and excitement, and passion and fame! Since St-Raphael [id est, since her affair with Lieutenant Jacque Cherve-Feuille] she had had no uncontested pivot from which to swing her equivocal universe. She shifted her abstractions like a mechanical engineer might surveying the growing necessities of a construction. (Z. Fitzgerald, *SMTW* 106)

The first part of this passage alludes to Zelda's disillusionment in her marriage and her desperate desire to escape her identity as Scott's muse. Because this social role makes her a "minor character" in her own life, Zelda expresses her female disillusionment indirectly and ironically by repeating David's condescending belief that women are merely flowers, desserts, love, excitement, passion, and fame. By including David's opinion that women are flowers, Zelda hints at one reason she uses such arabesque language: even under the burden of being Scott's flower, she stretches through the pain of ballet and creeps past her husband's belittlement to

create a brilliant piece of writing so “flowery” that no one could claim it was Scott’s.

Additionally, the inclusion of “fame” in this list emphasizes how David uses his wife as a prop to bolster his fame. Next, Zelda demonstrates the silencing regret she feels about her own infidelity, which ultimately also symbolizes her failed escape: “she had had no uncontested pivot from which to swing her equivocal universe.” This sensation of no-escape and self-blame alludes to Zelda’s experience of mental illness, particularly when she writes this novel in the psychiatric hospital because by that point in her treatments she had integrated “madwoman” into her ego identity, thereby participating in self-stigmatization. Immediately following above passage, once Alabama realizes she is stuck in the role of the delicate flower and muse, she shifts into abstractions in a mechanical way:

The party was late at the Chatelet. Dickie hustled them up the converging marble stairs as if she directed a procession to Moloch.

The décor swarmed in Saturnian rings. Spare, immaculate legs and a consciousness of rib, the vibrant suspension of lean bodies precipitated on the jolt reiterant rhythmic shock, the violins’ hysteria, evolved themselves to a tortured abstraction of sex. Alabama’s excitement rose with the appeal to the poignancy of a human body subject to its physical will to the point of evangelism. Her hands were wet and shaking with tremolo. Her heart beat like the fluttering wings of an angry bird.

The theatre settled in a slow nocturne of plush culture. The last strain of the orchestra seemed to lift her off the earth in inverse exhilaration—like David’s laugh, it was, when he was happy. (Z. Fitzgerald, *SMTW* 106)

These abstractions first allude to mythology with the sacrificial procession to Moloch, a pagan demon-god believed to offer success and prosperity to tribes who sacrificed their children to him.

This comparison of the Knights' endless partying and superficial friendships to that of blood sacrifices to Moloch accentuates Zelda's disenchantment with frivolous fame and the Fitzgeralds' Gatsby-esque lifestyle. At this point in the passage, the diction and writing style become dizzying, chaotic with violent images and disproportions; Zelda juxtaposes worldly objects—"the fluttering wings of an angry bird" and "lean bodies"—with nauseating sensory descriptions—"the jolt of reiterant rhythmic shock" and "the violins' hysteria"—and metaphorical abstractions—"The décor swarmed in Saturnian rings" or "a tortured abstraction of sex." Bodies, which also represent the mind in this narrative, become deconstructed into "immaculate legs" and "a consciousness of rib." Zelda then conversely balances Alabama's emotions with David's, as if they were on a metaphorical see-saw, by contrasting her misery with his happiness. Her life becomes theatre, and her "inverse exhilaration" is "David's laugh...when he was happy." This creates a balancing act within the power dynamic of their marriage: if one of them is happy, the other feels the inverse of that exhilaration. In addition, the arabesque language of the narrative mimics Alabama's practice of ballet and Zelda's artistic pursuits. Furthermore, because Zelda uses her subjective personal experience to create her autobiographical life narrative (as opposed to Scott's portrayal of Zelda's experience from his external viewpoint, which mimics official psychiatric narratives written by doctors), *Save Me the Waltz* better portrays the "extreme states of human consciousness and emotion" expressionistically through Zelda's oversimplification and distortion of the narrative's main topic. Alabama's frenzied ballet practice suppresses the shadow narrative of schizophrenia because Zelda purposely oversimplifies mental illness to physical illness by ending Alabama's career with a physical injury as opposed to her real-life mental collapse.

Moreover, to conjure an expressionistic atmosphere, Zelda incorporates scenes of nightmarish pain and physical alteration to represent Alabama's pursuit for an artistic career during a historical time that devalued women's intellectual and creative capabilities. Further, this mood sustains the modernist vision of the novel. For example, during the beginning of her ballet practice, Alabama endures physical pain to mold her body, and Zelda shows this through visceral imagery that challenges stereotypes of appropriate content for female writing:

Madame spread her split satin shoes horizontally. "And you must stretch *so* fifty times in the evenings."

She pulled and twisted the long legs along the bar. Alabama's face grew red with effort. The woman was literally stripping the muscles of her thighs. She could have cried out with pain. Looking at Madame's smoky eyes and the red gash of her mouth, Alabama thought she saw malice in the face. She thought Madame was a cruel woman. She thought Madame was hateful and malicious.

"You must not rest," Madame said. "Continue."

Alabama tore at her aching limbs. (Z. Fitzgerald, *SMTW* 116).

Additionally, this scene illustrates Zelda's attempt to numb her mental and emotional pain by replacing those negative sensations with physical agony—an unstigmatized type of suffering in comparison to mental illness and, sometimes, one that is easier to withstand. Disturbing images, like "stripping the muscles" and "the red gash," combined with negative adjectives, like hateful, cruel, and malicious, promote the mood of a living nightmare. In another example of Zelda's narrative replacement of the mind with the body, Alabama reflects upon her desperation to gain control over her body, which metaphorically connotes Zelda's frantic attempts to control her disordered mind through physical exhaustion: "The human body was very insistent. Alabama

passionately hated her inability to discipline her own. Learning how to manage it was like playing a desperate game with herself” (*SMTW* 118). Substituting “the human body” for “the human mind,” within this quote and throughout the novel, brings to light the real struggle Zelda faced within psychiatric hospitals. In another illuminating scene, while she is recovering in a general hospital room, David breaks the news to Alabama that she will never dance again:

“Poor darling—you’ve still got your foot. It’s not *that*,” he said compassionately.

“But you will never be able to dance again. Are you going to mind terribly?”

“Will I have crutches?” she asked.

“No—nothing at all. The tendons are cut and they had to scrape through an artery, but you will be able to walk with a slight limp. Try not to mind.”

“Oh, my body,” she said. “And all that work for nothing!”

“Poor, my dear one—but it has brought us together again. We have each other, dear.”

“Yes—what’s left,” she sobbed. (Z. Fitzgerald, *SMTW* 181)

Zelda substitutes the real-life psychiatric clinic with this fictional general hospital setting. Instead of including descriptions of her shock treatments, experimental psychopharmaceuticals, and hydrotherapy, Zelda replaces these horrific psychiatric treatments with a surgical cure for Alabama’s physical illness. In either version—whether from mental illness or from physical illness—Zelda’s and Alabama’s ambitions are ruined forever. The repetition of the word “mind” in this passage about Alabama’s body further implies the distortion inherent in Zelda’s mental illness life narrative. As she wrote this autobiofictional novel, Zelda “passionately hated her inability to discipline her own [mind],” but this is too stigmatizing to admit directly, so Zelda distorts the verisimilitude within the narrative to rebel against the conventions for realism within

autobiography and to resist stigmatization (*SMTW* 118). Zelda's distortion of the expected narrative for asylum autobiography also questions whether traditional literary conventions, such as realism, can effectively represent the subjective, first-person experience of mental disorder. This strategy follows a foundational ideal of expressionism. In *A Handbook to Literature* (2009), William Harmon and Hugh Holman describe the key goals of the expressionism movement: "Fundamentally [expressionism] means the yielding up of the realistic and naturalistic method of verisimilitude in order to use external objects not as representational but as transmitters of the internal impressions and moods" (218). To this end, Zelda includes external objects, such as the ballet and the body, as transmitters of her internal impression of mental disorder; this strategy invokes an intimate relationship with her readers because they must collaborate with Zelda to interpret and make meaning of her psychic turmoil through these impressions; her readers expect Zelda to illustrate the experience of schizophrenia directly, instead, she silently portrays how schizophrenia feels through the substitution of the body for the mind because all audiences understand physical pain—it is a socially accepted form of human suffering, whereas mental illness is not. Zelda also uses external objects as narrative mood transmitters through the setting. To demonstrate, Zelda often imbues the atmosphere with morbid qualities; for instance, even the sky becomes monstrous: "The sun bled to death in a red and purple hemorrhage—dark arterial blood dyeing the grape leaves. The clouds were black and twisted horizontally and the land spread biblical in the prophetic light" (*SMTW* 93). In this example, the world around Alabama seems to bleed in biblical proportions, foreshadowing the death of her dreams at the end of her war for recognition and independence. Moreover, the setting reveals impressions of Zelda's mental disorder, connecting it to a spiritual disaster of apocalyptic proportions, and indeed, for Zelda, the onset of schizophrenia marked the beginning of the end. When Alabama fails to

realize her career due to a blood infection from a blister (a physical illness), Zelda oversimplifies her lived experience of losing her career because of schizophrenia. Not only does Zelda utilize such expressionistic distortions and oversimplifications for the difficult topic of mental illness, she also continues to emphasize the modernist themes of “pervasive sense of loss, disillusionment, and...despair”; Zelda spotlights these themes in the tragic conclusion of the heroine’s pursuit for artistic self-expression (Murfin and Ray 307). For all these reasons—the experimental perspective and narrative structure, the rejection of the generic conventions for realism in asylum autobiography, and the expressionistic language and atmosphere—*Save Me the Waltz* stands as an exemplary modernist text and achieves greater literary experimentation than Scott’s portrayal of Zelda’s mental disorder. In addition, Zelda removes the stigma of mental illness from her novel, which allows the reader to focus on her subjective experience as opposed to the objectifying diagnostic perspective of Zelda in *Tender is the Night*.

Notably, Zelda did not send a copy of *Save Me the Waltz* to Scott first, as she had done with all her previous writing. When he received her manuscript on March 14, 1932 from Maxwell Perkins at Scribner’s, Scott was beyond furious (Milford 216). Not only was he jealous that Zelda finished a novel so quickly while he had not completed one in seven years but also he was incensed Zelda used her personal experiences for its content because Scott believed he owned the sole rights to their life as his literary material. As Tavernier-Courbin details, Scott said Zelda “had used material that he had ‘bought’ by keeping her” (27). Moreover, during this time, Scott was “immersing his fresh version of Zelda’s insanity and his own complex reactions to it” into *Tender is the Night* (Milford 217). Scott became irate that Zelda used the same life material for her novel because she always would be an amateur to him, so *his* professional writing and *his* use of their shared experiences always came first. For these reasons, Scott

forbade Scribner's from publishing Zelda's novel until she revised it precisely to his specifications. Reprinting parts of a therapy session transcript between Dr. Squires, Zelda, and Scott, esteemed biographer Nancy Milford (who received special permission to view the original document as well as Zelda's diaries) highlights Scott's specific requirements for Zelda's revisions; not only did Scott want Zelda to stop writing fiction, he also limited the possibilities of topics she could discuss: "If you write a play, it cannot be a play about psychiatry, and it cannot be a play laid on the Riviera, and it cannot be a play laid in Switzerland, and whatever the idea is, it will have to be submitted to me" (275). Scott also wanted Zelda to remove most of her descriptions of him as a character. Literary critic Tavernier-Courbin opines, "Scott was outraged to be submitted to the same sort of psychological and literary dissection which he had performed on Zelda in his first three novels" (27). Nevertheless, Zelda refused to give up writing, but she obeyed Scott's demands and avoided including psychiatry, the Riviera, and Switzerland within *Save Me the Waltz*, which as discussed made her novel far more interesting than his. In addition, following Scott's mandates, Zelda largely erased much of the David Knight character, i.e., her fictionalized version of Scott, from the narrative, reducing him to a flat, static character, who remains off-scene more often than not. Tavernier-Courbin emphasizes why Scott desired the removal of sections about him: "Scott demanded extensive revisions, in particular the cutting out of chapters which portrayed him in a light which did not coincide with the way he wanted to see himself and wanted to be seen by the world" (24). This highlights the fictionality of Scott's and Zelda's social identities and the conflict that arose as Zelda tried to break free of the virtual social identity that the legend of the Fitzgeralds perpetuated. Of course, Scott's restrictions "[left] her only ballet and her youth in Alabama as the experiences from which she [was] 'allowed' to draw for her own literary inspiration. Coincidentally or not, these were the two main

themes of her novel in its published form,” critic Ashley Lawson explains (101). Zelda’s *Save Me the Waltz* hammered the last dagger into the heart of the Fitzgeralds’ tenuous relationship, and the couple never fully recovered from this blow.

However, despite their marital tensions, Zelda’s condition was improving, largely from her sense of pride for creating something she knew was artistically significant. By June 1932, Zelda spent mornings at home with Scott before returning to Phipps for the afternoon and night (Milford 257). This was Zelda’s doctor’s way of testing her ability to cope with the world outside of the hospital, and she did well enough to earn her release on June 26, 1932 though her condition, as noted in her patient file, was “unimproved” (Milford 257). For the rest of that summer, Zelda revised her novel, saw her psychiatrist at Phipps once a week, and argued sporadically with Scott and Scottie (Milford 259). In October 1932, *Save Me the Waltz* was published, but it did not sell well. Some reasons for this include Zelda’s experimentation with high modernist techniques, Scott’s purposeful sabotaging during Zelda’s editing, and Scribner’s limited printing of the novel on suspiciously cheap paper. As Tavernier-Courbin points out:

Though [Scott] was then supposedly helping to edit [*Save Me the Waltz*] for Zelda’s sake, he carefully scrutinized the book for elements which might damage his public image, but he let it go to press unpruned of tangled metaphors and misspellings, of grammatical and typographical errors which obviously weaken it. (24)

Scott never intended to help *Save Me the Waltz* succeed. Coupled with the surface level errors Scott conveniently did not mark for editing, he likely encouraged Scribner’s to print the novel without marketing or quality materials. According to literary critic Victoria Sullivan:

When Scribner’s did publish [*Save Me the Waltz*], the novel appeared with almost no publicity and printed on unusually cheap paper, a rather extraordinary practice for that

prestigious publishing house. It was one more indication of the power of Scott's disapproval, since Scribner's was also his publisher. (35)

This passive aggressivity demonstrates that Scott abhorred Zelda's rebellion against his public image of her as his muse. Moreover, he blamed Zelda and her mental illness for his inability to complete his new novel *Tender is the Night*. In many ways, this is not an unfair claim because to afford Zelda's treatments Scott had to write short stories for quick money to stave off bankruptcy. He did not have the time nor the capital to write a novel while paying for Zelda's treatments; of course, his alcoholism did not help his writing progress either. In addition, Scott continued to insist that he was the professional writer, not Zelda, which is why he earned the right to both of their lived experiences for his creative work. Scott wanted Zelda "to be what he called a 'complementary intelligence'" to his work (Milford 274). This stance illuminates why Zelda sought to become an artist in her own right: if she was not a "professional" like Scott then she could not create a social identity independent of him. What Scott did not take under consideration as a hindrance to his work was his substance abuse of alcohol and Luminal, which he insisted he needed to be able to write though they limited his functioning (Milford 269). In fact, the psychiatrists Dr. Adolf Meyer and Dr. Thomas Rennie at Phipps believed Scott needed psychiatric treatment as much as Zelda did, but Scott refused, calling them incompetent (Milford 269). This discrepancy between Scott's and Zelda's autonomy emphasizes: (1) why Zelda fought to create her own social identity by which she could repair her ego identity, and (2) why Scott could avoid psychiatric treatments easier than she. Following traditional gender roles, Scott made the family's money, which made in-patient treatment for him an impossibility because no one would be able to pay the hospital bills and take care of their daughter. Moreover, because Zelda was a housewife and did not earn her own money, Scott could coerce her into confinement much

easier than the other way around. Only a court order could have sent Scott to an asylum, and although Scott's alcoholism caused his arrest on occasion, a judge never mandated him to a psychiatric institution. This illustrates a key difference between the male and female experience of mental illness in early-20th-century America and highlights how Scott could resist the stigma of mental illness easier than Zelda.

Continuing in consideration of Zelda's experiences with mental illness and the resulting stigmatization of her identity, between the summer of 1933 and the beginning of 1934, Zelda experienced two major conflicts which would trigger another breakdown—the suicide of her brother Anthony and the publication of *Tender is the Night*. Anthony's suicide emphasized Zelda's familial inheritance of mental disorder, which further solidified Zelda's self-stigmatization. In July 1933, Zelda received correspondence from her mother that Anthony had fallen ill with “nervous prostration,” the Southern euphemism for a mental breakdown (Milford 280). After numerous rest cures and ineffective treatments produced no beneficial results, Anthony, feeling desperate and hopeless, committed suicide by jumping out of a window from his hospital room (Milford 280). This was not Zelda's first family member to die from suicide. Having attempted suicide herself multiple times, Zelda must have understood her brother's feelings and empathized with his suffering. Although she held her composure as best she could through her grief, her next breaking point was coming. Beginning in January 1934, the serialization of *Tender is the Night* appeared in *Scribner's Magazine*; Scribner's would publish the novel in four parts, running in consecutive months between January and April (Milford 281). By February 12, 1934, Zelda relapsed and returned to Phipps Clinic in Baltimore (Milford 283). The contributing factors to this collapse were her brother's suicide and, even more so, the publication of *Tender is the Night*, which explicitly detailed Zelda's experiences with mental

disorder to the public. By the time she re-entered Phipps, she had read at least the first half of Scott's novel. Three days into her hospitalization, Zelda confessed how badly *Tender* bothered her. Zelda told her doctor, "[I was] a little upset about [the novel]...What made me mad was that he made the girl so awful and kept on reiterating how she had ruined his life and I couldn't help identifying myself with her because she had so many of my experiences" (qtd. in Milford 286). Seeing herself portrayed in Scott's fiction in a harsh light for the first time, Zelda withdrew into an inner world, and she refused to cooperate with doctors or interact with other patients. Both her ego identity and social identity were shackled securely to the stigma of being a mental patient. Eventually, Zelda revealed her self-identification with other mental patients when she began helping them during exercise and dance classes at the clinic; however, Zelda only assisted other patients who were sicker than she was, remaining wary of patients who were in better health (Milford 283). Her self-imposed distance from the more stable patients is understandable when considering self-stigmatization; Zelda likely felt ashamed when around saner persons because, even within the asylum, she anticipated being rejected by them. The combination of Anthony's tragic reminder of her familial inheritance of madness and Scott's public portrayal of Zelda's schizophrenia concreted both her ego identity and her social identity as a madwoman, permanently scarring the way Zelda would be remembered.

With each new installment of *Tender is the Night*, Scott's portrayal of Zelda's schizophrenia became widespread as did her new social identity—the madwoman muse. Zelda's condition worsened after she read the third installation of *Tender* in the March issue of *Scribner's*, and by May 19, 1934, Zelda entered Sheppard and Enoch Pratt Hospital in Baltimore in a "catatonic state" (Milford 296). By the end of May, Scott tried uplifting Zelda's spirits by offering to have a collection of her short works published. Scott's plan worked temporarily.

Zelda revived enough to work on her collection and design the book jacket, but the collection again was published under both Fitzgeralds' names (Milford 299). Considering one of the root causes for Zelda's psychological distress was her enmeshment with Scott's identity and her burning desire to create her own art, the faux co-authorship on the publication of her works must have exacerbated her mental disorder. Indeed, at the end of the summer of 1934, Zelda was devastated; "the doctors were finding it futile to get her to discuss her illness, and her behavior fluctuated wildly between violence and seclusiveness" (Milford 302). According to scholars Jackson Bryer and Cathy Barks in their edited collection *Dear Scott, Dearest Zelda: The Love Letters of F. Scott and Zelda Fitzgerald*, during this period, "Zelda was deeply depressed, appeared apathetic, and began slipping into a frighteningly disoriented condition in which she experienced aural hallucinations" (198). Due to the intensity of her depression and schizophrenia from the fall of 1934 until the spring of 1936, Zelda did not write much, neither letters nor fiction (Bryer and Barks 198). In the late summer or early fall of 1934, as Zelda's letters became brief, she admits to Scott: "I'm sad because I can't write" (*Dear Scott* 209). In another letter to Scott from October of 1934, Zelda's despair from her long confinement demonstrates Zelda's feelings of ambivalence during treatment: "Darling: Life is difficult. There are so many problems. 1) The problem of how to stay here and 2) The problem of how to get out" (210). With contradictory impulses, Zelda both wants to stay in the Sheppard-Pratt Hospital to recover from her mental disorder, and she wants to escape the hospital. Another implied stay-or-escape problem in Zelda's experience is to stay-or-escape life itself through suicide, a common conflict many individuals face when battling overwhelming mental disorders. By the summer of 1935, Zelda attempted suicide again; Milford recreates the scene:

Once when Scott came to visit her and she was desperate about the hopelessness of her condition, she ran from him toward railroad tracks that separated the grounds of Sheppard-Pratt from La Paix. Scott raced after her and caught her by the wrist moments before she would have thrown herself beneath the rushing train. (304)

For the rest of that summer, Zelda continued to attempt suicide because she viewed her condition as incurable and viewed herself as a burden upon Scott. During the fall of 1935, writing to Scott, Zelda illustrates her depression, hallucinations, and her increasing sense of alienation from place (that is from the social world):

From such an empty world there seems nothing to send beyond the jaunty decolade of turning falling first autumn leaves. From everywhere a vast echo vibrates—strange familiar twang, but one only vaguely distinguishes the sounds. That is because autumn is a sad time and all times are sad from their transience. (*Dear Scott* 216)

The world became empty to Zelda while she remained confined within asylums for years at a time. No longer able to connect to the world outside the hospital other than to Scott, Zelda ponders the transience of time in the background of the “vast echo [that] vibrates” within her mind—voices that sound like a “strange familiar twang.” As the outside world grew more foreign, Zelda receded into her strange yet familiar inner world populated by hallucinations and delusions. According to her biographer Sally Cline, author of *Zelda Fitzgerald: Her Voice in Paradise* (2002), Zelda’s hallucinations soon became hyper-religious and mystical: “Through regular conversations with God, Zelda believed she was in direct communication with Christ, Apollo and William the Conqueror” (358). After seeing Zelda’s deteriorating condition on April 8, 1936, her sister Rosalind Sayre Smith demanded Scott transfer Zelda from Sheppard-Pratt in Baltimore to Highland Hospital in Asheville, North Carolina, a city closer to her family in

Alabama (Milford 308). In a letter written to F. Scott Fitzgerald's biographer Arthur Mizener, Zelda's sister Rosalind explains why she demanded Zelda be moved to North Carolina:

Scott took Zelda to Highlands on my insistence, after I had found her at Sheppard-Pratt weighing only 89 pounds, and fast going downhill instead of improving. (The doctor there told me that Scott, living nearby in Baltimore, interfered so persistently with their care of Zelda that it had been impossible to do anything for her). At Asheville, where much of the institutional atmosphere was lost in pleasant lodgings, but where uncompromising strictness was the rule, and co-operation of the patient was demanded, Zelda bloomed again and on several visits...to me in New York during that period was almost like her old self, beautiful once more, still interested in music, the theatre and art, but toned down to an almost normal rhythm. Any thought of gay life was now far behind her, but she still retained a zest for living that was characteristic of her, and that she retained until the very last stage of her illness. (Bryer 9-10)

Thus, with the approval of her doctors and her family, Zelda entered Highland Hospital in Asheville, North Carolina, where she remained for the next four years; then, she would re-enter Highland Hospital for in-patient treatment periodically for the rest of her life. At this point, Zelda no longer believed she could return to her former self. Nevertheless, she continued to fight for her recovery as best she could, and she became a willing participant in her treatments at Highland.

Upon admission to Highland Hospital, Zelda was placed in the care of Dr. Robert Carroll, whose treatment proved psychologically damaging and sexually abusive and whose unique model for a psychiatric hospital indirectly caused Zelda's death in 1948. Dr. Robert Carroll was always a controversial figure within the field of psychiatry, initially for his experimental

treatments, but later in his career, his infamy heightened when evidence surfaced of his criminal abuse of female patients. Cline accentuates, Dr. Carroll's psychiatric treatment regimen for patients was "controversial, fierce, and frightening"; it encompassed experimental injections into patients' cerebrospinal fluid, regular electro-shock and insulin shock treatments, strict diets and exercise requirements (including a five-mile hike everyday), and ergo-therapy (i.e., occupational therapy or art therapy) (358). Although some of these treatments helped alleviate Zelda's symptoms, she also experienced severe side-effects, including permanent memory loss. Cline details the horrors of Dr. Carroll's extreme experimental treatments:

Carroll was pioneering injections of placental blood, honey and hypertonic solutions, and of horse blood, into patients' cerebrospinal fluid. Horse serum caused aseptic meningitis with vomiting, fever and head pains, but Carroll used it on Zelda because it could induce long spells of lucidity. He also regularly gave Zelda the now standard electroshock and insulin shock treatments, disregarding their known effects of memory loss. Doctor Irving Pine (Zelda's last psychiatrist) said she was given between thirty and ninety insulin shocks, producing convulsions followed by comas that lasted up to an hour. Mary Parker, assistant to Highland's psychotherapist (later Zelda's art therapist)...admitted that "insulin was only supposed to be given to difficult patients because it shocked their brains so that they couldn't be left on their own afterwards without a nurse. Though most recovered, there were bad after-effects." (359)

Most of Dr. Carroll's treatments frightened patients for good reason. Another debatable practice at Highland was Dr. Carroll's recruitment of former patients to work as staff members (Milford 309). Milford claims Highland's "staff was therefore unique: they were compassionate and highly aware of the needs of the unbalanced; they were also extraordinarily devoted to Dr.

Carroll” (309). Though this unorthodox approach to hiring staff seemed beneficial to both patients and former patients, this aspect of Highland Hospital had devastating results in 1948. Finally, the most disturbing fact about Dr. Carroll did not become public knowledge until the early months of 1940. One of Dr. Carroll’s patients filed criminal charges against him for rape; in addition, strong evidence demonstrated he sexually abused numerous patients over his career. Cline reports, “Dr. Irving Pine, Carroll’s colleague [and Zelda’s last psychiatrist], said many years after Zelda’s release but without equivocation: ‘Dr. Carroll treated his women patients badly including Zelda.’ Pine went further: ‘Dr. Carroll took advantage of several women patients including Zelda’” (375). As historical evidence, Seeman reports that “The North Carolina Medical Board records show that Dr. Carroll was convicted in 1926 of ‘gross immoral conduct,’ but that the conviction was overturned in 1928” (68). Because the conviction was overturned, Dr. Carroll remained the psychiatrist-in-charge of Highland Hospital and continued his abuse of female patients. This sexual abuse may have been linked to Dr. Carroll’s theory that deranged women can be mentally healthy *only if* they follow the Victorian ideals of True Womanhood and participate in the traditional role of housewife. This was not new advice to Zelda, for Dr. Forel also encouraged her to re-enter this role. This opinion, put into practice, presented a gender bias in the treatment of female mental patients and created an environment conducive to the abuse of those who did not obey these traditional imperatives. Perhaps rape was another punishment in Dr. Carroll’s power struggle with rebellious female patients who refused to accept his reeducation about a woman’s “proper” place in life. Obviously, Zelda was not the picture of submissiveness, purity, or domesticity. However, Sally Cline suggests Zelda used this sexual trauma to blackmail Dr. Carroll for her release, which highlights her resilience once again (375). Knowing he was at an impasse, Dr. Carroll wrote an unexpected letter to both Scott and Mrs.

Sayre about his approval for Zelda's release and his prognosis for disorder; Milford summarizes the last paragraph of this letter:

The final paragraph stated the precariousness of Zelda's mental condition: her history showed a tendency to repeat itself in cycles. She could be irresponsible and suicidal.

Zelda might well be unable to face what was ahead of her in Montgomery. At present she was gentle and reasonable; her capacity for making mature judgments was, however, permanently reduced. (338)

Interestingly, Carroll mentioned Zelda's inability to make mature judgments; perhaps, this was a result from the excessive shock treatments she received, or maybe this was a safeguard against future blackmailing by labelling her "judgments" unreliable and "permanently reduced." Much to Scott's surprise and worry (as he did not know about the abuse), Zelda was released from Highland on April 15, 1940 into the care of her mother in Montgomery. Zelda finally was free from Dr. Carroll, but she would never be free from her cyclical insanity. Sadly, she would return to Highland voluntarily three more times in her life for treatment. Furthermore, the recurrences of schizophrenic episodes greatly encouraged the stigmatization Zelda experienced both from herself and from others.

Upon her return to Montgomery in 1940, the four years Zelda spent in the asylum had changed her completely, and her social identity became enveloped by the label of madwoman. Zelda desired to secure a job though she knew this would be difficult with the stigma attached to her. In a letter to Scott dated January 1940, Zelda longs for work and asks for his help: "Don't you know *somebody* in Ashville to whom you could give me an introduction and who might give me a job? It would be such salvation to be at work in any possible capacity" (*Dear Scott* 324). Still, courageously, she persisted. Without losing her sense of humor, she planned for her life

outside the asylum with the wisdom that she would encounter stigma: “I will try to find a job. Needless to say I am conversant with the difficulties which will probably confront me: Middle aged, untrained, graduate of half-a-dozen mental institutes. However, there may be something blown in on a box-car or one of those things like that” (qtd. in Milford 337). Eventually, Zelda found part-time volunteer work at the Red Cross; in a letter to Scott from August 1940, Zelda describes her job: “The red-cross is a cool and wind-blown barn where I sew labels in things and watch time passing from the face of the capitol clock. I spend two days a week there” (*Dear Scott* 357). This job gave her something to do, but the rhythm of her life in the outside world had slowed immeasurably compared to her life before schizophrenia. Moreover, finding a job was not the only stigma-fueled difficulty Zelda faced. Zelda’s drastic decline in appearance and mannerism again shocked her friends in Montgomery. Milford explains, “Zelda was nearly forty, and she was largely alone. Friends stopped by to see her the first few days, but not many, and Zelda felt she had little in common with those who did. She was grateful for her mother’s company” (342). In her letters to Scott, Zelda illustrates her social isolation: “People ask about you whenever I see any; though I seldom go anywhere save to church...I don’t know what parties there are because I am not envited to any” (*Dear Scott* 375). The stigma of being an ex-mental patient firmly affixed to Zelda’s social identity, so most people avoided her altogether. Once when walking to town in the early spring of 1940 with one of her few friends Paul McLendon, Zelda wore a strange collection of clothing—“a dress length coat of deep blue wool, with a gray caracul fur about the collar & cuffs—& on her head, a very dark green felt cloche-type hat—from the crown of which were long streamers of green felt, end-tipped at the shoulders with white felt dogwood blossoms” (Milford 378). This ensemble made Zelda stand out because

it was out of season, outdated, and over-the-top. In an interview with Nancy Milford, McLendon remembers Zelda encountered stigma from young children that day:

After only a block & a half, or so, there were three children walking toward us on the sidewalk, two girls and a boy—ages about 9, 11, 12. As they approached...when we were 3 or 4 yards from them we both saw one of the girls punch the other & say, ‘You see there, there’s that crazy woman mamma’s been telling us about!’ and they passed on by us. They continued walking in absolute silence. Zelda had heard the girl and turning to Paul she quietly told him she didn’t feel too well...Together they walked back to the little house. (378).

Tellingly, the children in town knew Zelda as the “crazy woman” because their parents talked about her in a prejudiced way. This example shows how the stigma one carries seeps into the gossip of a community and taints one’s social identity even to strangers. In her youth, Zelda Sayre had a legendary social identity, and everyone, including herself, believed she would lead a successful life. However, as Zelda Sayre disappeared beneath Mrs. F. Scott Fitzgerald, Zelda lost her individual social identity. By the time she returned to Montgomery at the end of her life, Zelda Sayre was gone, and Zelda Fitzgerald was a “madwoman,” both in others’ opinions and in her self-concept.

4.2.6 The End of Everything

By this time, Scott and Zelda were separated but not divorced; Scott never completely abandoned Zelda, but he also understood that they were toxic to each other’s mental stability. Unfortunately, Scott would not be able to help Zelda for much longer, and her care would fall solely upon her mother. In November through December 1940, Scott experienced multiple cardiac spasms, and by December 21, 1940, he died from a massive heart attack (Milford 349).

Zelda's world closed a little tighter that day. Although they rarely saw each other in person, during the last 18 months of Scott's life, they wrote letters to each other weekly. Her life now grew even quieter and slower without Scott. Zelda's life after his death was punctuated by three more stays at Highland Hospital (Milford 371). She also became extremely religious because her evangelical beliefs helped her cope through her grief and accept her experiences with mental illness. Writing to her friend, Mrs. Ober, Zelda explains her newfound peace:

I used to feel desperately sad in the hospital when I thought of time going by and my being unable to turn it to any account, then I reconciled myself and had to accept with grace the implacable exigencies of life. I would not exchange my experience for any other because it has brought me the knowledge of God. Revelations of His Divine presence are a greater honor than any which the world could give; a greater beauty and a more compelling inspiration. (qtd. in Milford 373)

Zelda found comfort through her Christian faith, and this enabled her to appreciate the terrifying experiences of schizophrenia she endured because her journey brought her closer to God. Around this time in her life, Zelda began having premonitions, what she called revelations, which accurately predicted future events. Two instances stand out most impressively. One of Zelda's predictions occurred on the last day of an extended visit with her friends the Biggs. They were all waiting on the front porch, readying themselves to leave for the train station. Milford includes Mrs. Biggs' retelling of that evening:

John [Biggs] mentioned that it was time to catch the train back to Montgomery. Zelda didn't seem to pay any attention and we stressed it a little more obviously. It was late. Perhaps we'd better get into the car, and so forth. Zelda said we didn't need to worry, the train would not be on time anyway. We laughed and said, perhaps, but it was a risk we

didn't intend to take. "Oh, no," she said, "it will be all right. Scott has told me. Can't you see him sitting here beside me?" The Biggses were speechless, neither knowing what to say or do. At last Judge Biggs insisted that they leave. "When we got to the station we had a half hour wait. The train *was* going to be late." It was in an uneasy silence they waited together until it came. (375)

Maybe Zelda's accurate predictions seemed more like coincidence, or maybe they were hallucinations, but perhaps she truly was connected to another aspect of existence—one that was divine or connected to the spirit world. Perhaps the ancient Greeks were right, and mental disorder can allow for divine or otherworldly communication. There is no hard science that proves or disproves the actuality of divine forces. However, Zelda certainly experienced something that connected her to something bigger than herself because her last revelation was of her own death. On November 2, 1947, Zelda returned to Highland Hospital for the last time. Before leaving in a taxi to go to the hospital, Zelda suddenly ran back to her mother and said, "Momma, don't worry. I'm not afraid to die" (Milford 382). Zelda expected her death and knew she would not see her mother again. Sadly, this prediction came true. According to Seeman, "Among Dr. Carroll's more questionable practices was hiring former patients to serve on staff. More than half of Highland Hospital employees at any one time were said to be former patients" (68). In early 1948, Zelda's treatment included a series of insulin shock treatments, after which she and other shock patients were moved to the top floor of the main building to recover from their coma-like states (Milford 382). On March 10, 1948, tragedy struck Highland Hospital; Seeman describes a dangerous staff member who was on duty that night: "Willie Mae Hall, a former patient, who had been described as 'clearly psychotic,' gave patients a double sedative that evening and locked their bedroom doors. She then set a fire in the kitchen. The fire quickly

spread through the building's dumbwaiter shaft to all three floors" and up to the roof (68).

Milford brings the horror to life:

The stairways and corridors were filled with smoke. A pair of stockings pinned to a line on a porch on the top floor could be seen dancing wildly in the wind created by the heat of the fire. There was no automatic fire-alarm system in the old stone-and-frame building and no sprinkler system. The fire escapes were external, but they were made of wood and quickly caught fire. Firemen and staff members struggled valiantly to bring the patients to safety, but they were hampered by locked doors, and by heavy windows shackled with chains. Nine women were killed, six of them trapped on the top floor. Zelda died with them. Her body was identified by a charred slipper lying beneath it. (384)

Zelda's untimely death may be one of the most heartbreaking from the narratives in this project because she still was fighting for her life when she entered the hospital. In fact, she was working on her next novel *Caesar's Things* until her death. Despite prior suicide attempts, Zelda wanted to live, and she consistently fought for her recovery, voluntarily entering hospitals without coercion near the end, and following treatment routines outside the hospital, such as continuing her daily five-mile walk and meeting with psychiatrists as an outpatient. Her tenacity kept her alive through the trauma she endured from almost two decades of experimental psychiatric treatments. Her sudden death in the Highland Hospital fire brought a dramatic conclusion to Zelda Fitzgerald's life, and the image of her burnt body clutching a ballet slipper lingers hauntingly after her story ends.

Zelda's gender, wealth, fame, recidivism, and marital status shaped her experiences of psychiatric diagnosis, treatments, and stigma. Indeed, such factors contribute to how psychiatrists diagnose and treat patients. For example, as published in the medical journal article

“The Attribution of ‘Dangerousness’ in Mental Health Evaluations,” American psychiatrists Richard M. Levinson and M. Zan York discovered extraneous variables beyond the patient’s behavior, including “patient age, sex, marital status, prior hospitalization, and position of person requesting patient evaluation,” influence psychiatric diagnosis and the attribution of dangerousness (334). Although Zelda never was labelled dangerous in the legal sense, which would have resulted in involuntary commitments, factors unrelated to her behavior certainly played a part in where and how Zelda’s disorder was treated. Firstly, as a woman, Zelda sought medical treatment more often than a man may have because, as Cockerham notes, women seek help from doctors more often than men do (164). For example, Scott refused any psychiatric treatment for himself, despite numerous physicians’ recommendations for him to do so. Next, consider the consequences of her fame as well as the privileges wealth afforded her. Her fame caused a dramatic fall in Zelda’s social identity after the gossip of her hospitalizations and schizophrenia became public knowledge. Her identity changed from someone at the height of fame and glamour, who was the envy of those around her, to someone whom people deliberately avoided. However, because of her socioeconomic status, Zelda received treatment at only respected private hospitals in Europe and America; Scott never allowed her to go to a state hospital because he wanted her to have the best treatments possible. Even when the Fitzgeralds were nearly bankrupt, Scott refused to let Zelda have anything but the best modern psychiatric care. Hence, her marital status greatly affected the treatments she received, not only from the Fitzgeralds’ wealth but also because she had an influential helpmate outside the hospital. However, because of the historical time and her financial dependence on him, Scott also could coerce Zelda into hospitals easily because he had the most power in the marriage. Obviously, at times, their marriage was flawed and toxic to Zelda’s mental health, but she received consistent

support from Scott during her treatments. He never let Zelda feel completely abandoned; even when they could not see each other in person, they regularly wrote letters to each other while she was a patient. At the same time, however, her marital status and her biological sex inclined both Dr. Forel and Dr. Carroll to encourage Zelda to immerse herself into the traditional female role of housewife and mother (not autonomous artist) as an imperative for her “cure,” even though this traditional role partially caused Zelda’s psychic distress. Moreover, Zelda’s biological sex left her vulnerable to sexual abuse while in asylums, as was the case under Dr. Carroll’s supervision. Additionally, because Zelda was White, her voluntary admissions to treatment were culturally accepted and encouraged. She did not have a preestablished double consciousness associated with her race, so she did not experience a social stigma until her psychiatric confinement. Often, the double consciousness of race causes many people of color, especially Black Americans, to avoid psychiatric treatment because they do not want to incorporate the additional stigma of mental illness into their social identities, which are already marred by racism. Zelda surely developed a double consciousness once the stigma of mental illness became attached to her identity, but she did not have to endure a triple consciousness as a Black American in a similar situation would. Moreover, because seeking psychiatric help was more acceptable in White American culture, Zelda was comfortable enough to write about her experiences. Her ability and courage to write about her mental disorder allows others to understand her experiences and the treatments she received in the early 20th century as a wealthy, married, White American woman. In Zelda’s individual experience, at first, she fought incorporating the stigma into her ego identity; however, as more people labelled her “insane” due to her public outbursts, numerous institutional confinements, and Scott’s fictionalized portrayal of her schizophrenia, Zelda eventually self-stigmatized by accepting her status as “lesser-than”

because of her mental disorder. Ultimately, what Zelda's experience demonstrates is many individuals accept the social stigma of mental illness and incorporate it into their ego identities, especially when enough important people in their lives view them in this stigmatized way for an extended period of time.

4.3 Part II: The Individual Experience of Stigmatized Identity: Allen Ginsberg (1926-1997)

Allen Ginsberg's relationship with mental disorder is more complicated than most because he saw both the beauty and destruction within madness; moreover, he transformed his experiences of mental disorder into self-transcendence. For Ginsberg, madness is both an religious awakening and poetic inspiration. He did not view mental disorder solely as illness although he certainly witnessed the darkest consequences of insanity all around him; instead, Ginsberg opined, the madness of his generation was the direct result of and a reaction to American materialism, industrialized warfare, and demands for cultural conformity. At the same time, Allen experienced madness' potential to be divinely inspired and holy. For example, Ginsberg linked his hallucinations to prophesy, and they became pivotal moments in his life. When he experienced such visions, he felt connected to a superhuman consciousness and gained a transcendental understanding of his place in the Universe and Eternity. However, the destructive consequences of mental illness, both as mental disorder and the accompanying stigma, encircled Ginsberg throughout his life, affecting him, his mother, and many of his friends. During his childhood, Allen witnessed his mother's insanity and the stigmatization she endured, so he developed empathy for individuals labelled insane when he still was a child. In addition, because he was homosexual, Allen masked his actual social identity until he met his Beat friends in college. By being accepted exactly as he was, for the first time, Ginsberg

encountered peers who appreciated and respected him without judgment, shrugging off his “discrediting” information as if it did not matter. Even after spending time in a psychiatric hospital, Ginsberg carried his countercultural ideals and his friends’ support with him. By having a support group of meaningful people in his life, Allen rejected self-stigmatization quickly, and eventually, he worked as an activist and a mystical poet to fight stigmatization and prejudice stereotypes within American society.

4.3.1 Naomi Ginsberg: A Post-Modern American Madwoman

Allen Ginsberg, born June 3, 1926 in Newark, New Jersey, was the second son of Louis and Naomi Ginsberg (Schumacher 3). Louis Ginsberg, a published poet, taught high school English (Schumacher 4). Naomi, also creative, enjoyed playing the mandolin and piano, singing, painting, teaching, and telling stories to her sons (Schumacher 4). Unfortunately, Naomi suffered from schizophrenia. According to Allen Ginsberg’s American biographer Michael Schumacher in *Dharma Lion: A Biography of Allen Ginsberg* (2016), Naomi Ginsberg’s first nervous breakdown occurred in 1919 just before she married Louis; then, for the rest of her life, recurrences of severe schizophrenia sporadically required Naomi’s confinement to state mental hospitals, until eventually she remained a permanent resident in the snake pit (6). According to Naomi’s grandson Lyle Brooks in an interview by American historian and writer Stephanie Kip for the *Greystone Park Psychiatric Hospital (1876-2008) Oral History Project* (2019), her first hospitalization was the only time Naomi went to a private institution called Bloomingdales because the price of her stay nearly bankrupted Louis. As evidenced in Allen’s journals, poetry, and interviews, Naomi’s schizophrenia punctuated his childhood memories and haunted his adult life. However, his proximity to a loved one struggling with mental disorder allowed Allen to sympathize with his mother and, later in life, to understand his own instances of insanity; he used

these early observations of his mother's experiences to resist self-stigmatization in his life. By the time Allen was nine years-old, Naomi's condition was severe, and to all involved, it seemed her disorder would be permanent. Schumacher details Naomi's illness during 1935 and 1936:

One minute, she would be functioning normally; the next, she would be shouting at Louis, accusing him of entering a conspiracy with his mother against her...She heard voices, but she was uncertain how they were being transmitted into her head. At times, she would walk around naked in front of Allen and Eugene. Naomi was never threatening or dangerous to the family, but her disorder was frightening...For the next year, Naomi was a patient at Greystone, a large New Jersey facility. She was given 40 insulin shock treatments, one of the standard treatments of the day for paranoid schizophrenics. She was also given Metrazol, which altered her metabolism and, combined with the sedate life on the ward, made her soft and flabby. The trim, youthful Naomi...ceased to exist...replaced by a haunted, frightened woman lost in the maze of her own mind, her sharp intellect and happy disposition trapped and invisible in the dark corridors of paranoia. (10-11)

Naomi's paranoia made her distrust her family; she believed that Louis and his mother were plotting to kill her. Naomi's displays of mental anguish, paranoia, and horror made a lasting impact on Allen; watching his mother's mental state deteriorate affected Allen's responses to madness as an adult: he empathized with friends who had mental disorders, but he also feared descending into schizophrenia like his mother.

When Naomi returned home from Greystone in 1936, her condition had not improved, and she remained disconnected from reality. She now complained that "doctors had implanted wires in her head and sticks in her back. In her deluded state, she swore that she received signals

from these implants, messages trying to corrupt her and turn her evil” (Schumacher 12). Sadly, for the rest of her life, paranoia encouraged Naomi to believe these spyware objects remained inside her body. In his poetic autobiography *Kaddish* (1961), Ginsberg recreates snippets of conversations with his mother; in one of these, Allen quotes his mother’s paranoid explanations about the imbedded sticks in her back and conspiracies for her assassination:

‘Allen, you don’t understand—it’s—ever since those 3 big sticks up my back—they did something to me in the Hospital, they poisoned me, they want to see me dead—3 big sticks, 3 big sticks—/ ‘The Bitch! Old Grandma! Last week I saw her, dressed in pants like an old man, with a sack on her back, climbing up the brick side of the apartment/ ‘On the fire escape, with poison germs, to throw on me—at night—maybe Louis is helping her—he’s under her power— (2.16-18).

In this disturbed mental state, Naomi could not be left alone, so while Louis worked, either Eugene or Allen stayed home from school to care for her. By 1937, Naomi became suicidal, and on June 24, she locked herself in the bathroom and cut her wrists (Schumacher 13). Desperately, Louis broke through the door when she refused to open it; luckily, the injuries were too superficial to kill her. In *Kaddish*, Allen includes this incident briefly: “Once locked herself in with razor and iodine—could hear her cough/ in tears at sink—Lou broke through glass green-painted door, we pulled her out to the bedroom” (2.87). In response to her suicide attempt, Louis took Naomi back to Greystone, where she stayed for over two years. Allen witnessed the horrors of his mother’s schizophrenia—the paranoia, hallucinations, suicide attempts, hospitalizations—and this dramatically affected his response to his own hallucinations in adulthood.

Shortly after Allen started high school in 1939, Naomi returned from the hospital. When she arrived home, she immediately went to the bedroom to lie down. She worried her family

would be afraid of her, fully aware of her stigmatized identity. By this point, Naomi had spent more time in Greystone than in the apartment Louis currently rented, especially because he and their sons moved often to afford rent. Because Louis had taken out a large loan to send Naomi to the private sanitarium during her first breakdown, the family had to downsize, so he could pay back the loan slowly. Moreover, because the expense of private mental healthcare greatly exceeded Louis' income, Naomi had to go to overcrowded state hospitals. Upon returning home, Naomi felt uncomfortable in the unfamiliar apartment. For the better part of five years, Greystone had been her home, and reentering the community was not easy. Cockerham explains, the day a mental patient returns to the community can be scary because "discharge often meant a return to an outside world that had long ago lost any real meaning" (269). When Allen sat by his mother that day, Naomi said to him, "Don't be afraid of me because I'm just coming back home from the mental hospital—I'm your mother" (*Kaddish* 2.79). Although Naomi never accepted her mental disorder as real, she recognized her social identity had changed after years of institutionalization. Familiar with the stigma, she worried her sons would fear her. These words deeply saddened Allen, and he reassured his mother that he always would love her. Even though Naomi's social identity was marred, Allen did not care about the stigma; he only cared that his mother knew he loved her. This empathy continued in Allen's later reactions to friends who suffered from mental disorder.

Naomi remained relatively stable until the winter of 1941 when her paranoia returned with full force. One particularly difficult day occurred while Allen stayed home to care for her. Frustrated by Naomi's suspicions, Allen tried to understand her paranoia by asking her questions; he then tried to disprove her delusions, but to no avail (Schumacher 18). Naomi was convinced her life was in danger, and now she accused not only Louis and Buba of the

conspiracy but also Hitler, Mussolini, and Roosevelt (Schumacher 17). According to Schumacher, Naomi begged Allen to take her to a rest home in Lakewood, New Jersey because she was tired and believed a blood transfusion would revive her strength (18). She told Allen that “if [he] loved her, he would help her escape” the apartment (Schumacher 18). Unsure of how to help, Allen called Dr. Hans Wassing, Naomi’s therapist, who agreed to recommend her for treatment at Lakewood (Schumacher 18). Ginsberg relives this day in *Kaddish*:

But you stared out the window on the Broadway Church corner, and/ spied a mystical assassin from Newark,/ So phoned the Doctor—‘OK go way for a rest’—so I put on my coat/ and walked you downstreet—On the way a grammarschool boy screamed, unaccountably— “Where you goin Lady to Death”? I shuddered—/and you covered your nose with motheaten fur collar, gas mask against poison sneaked into downtown atmosphere, sprayed by Grandma—/ And the driver of the cheesebox Public Service bus a member of the gang? You shuddered at his face, I could hardly get you on...(2.6-9).

Taking his mother to Lakewood was anything but easy for Allen, especially because Naomi talked nonstop about the plots against her and the people she saw in public who became part of the conspiracy (Schumacher 19). When they arrived at Lakewood, the staff was not prepared to care for someone in Naomi’s condition, but Allen had no other recourse but to secure her stay there, if only for the night, because Naomi refused to let him call his father for help. Ginsberg remembers this in *Kaddish*: “We got there—Dr. Whatzis rest home—she hid behind a closet—demanded a blood transfusion. /...I shut her up by now—big house REST HOME ROOMS—gave the landlady her money for the week—...[I] sat on the bed waiting to escape” (2.20-22). Allen rode the bus home and worried about his mother. Would she cause problems and get kicked out? Would she be afraid? “Would she hide in her room and come out cheerful for

breakfast? Or lock her door and stare thru the window for sidestreet spies? Listen at keyholes for Hitlerian invisible gas?" (Ginsberg, *Kaddish* 2.25). Allen felt like he abandoned his mother, and he worried what his father would say. Justifiably, Louis was agitated when Allen returned home; he could not believe Allen had taken Naomi to a rest home without notifying him. At 2:00 A.M., Louis received a phone call from Lakewood; they wanted Naomi taken home immediately because they could not calm her. As Schumacher notes, the attendant on the phone recounted Naomi's behavior to Louis as follows:

She had removed her shoes and walked down the hallways of the rest home, knocking on doors, and frightening the residents. When attendants had tried to calm her, she had crawled under her bed, fashioning her suitcase into a barricade. She had demanded a blood transfusion, shouting all the while about Louis and Buba and fascists and death.

(20)

Louis explained he could not come until public transits opened for the day because he did not own a car (Schumacher 20). During this conversation, Allen listened and felt immensely guilty, and forevermore he associated this sense of guilt with his mother. In *Kaddish*, Ginsberg recollects the early morning phone call about his mother, who he "shouldn't have left...Mad in Lakewood":

The telephone rang at 2 A.M.—Emergency—she'd gone mad—Naomi hiding under the bed screaming bugs of Mussolini—Help! Louis! Buba! Fascists! Death!—the landlady frightened—old fag attendant screaming back at her—/ Terror, that woke the neighbors—old ladies on the second floor.../ Her big leg crouched to her breast, hand outstretched Keep Away, wool dress on her thighs, fur coat dragged under the bed—she barricaded herself under bedspring with suitcases./ Louis in pajamas listening to the phone,

frightened—do now?—Who could know?—my fault, delivering her to solitude?—sitting in the dark room on the sofa, trembling, to figure out—/ He took the morning train to Lakewood, Naomi still under the bed—thought he brought poison Cops—Naomi screaming—Louis what happened to your heart then? Have you been killed by Naomi’s ecstasy? / Dragged her out, around the corner, a cab, forced her in with valise, but the driver left them off at drug store. Bus stop, two hours’ wait. (2.34; 2.41-46)

This passage portrays Naomi’s difficult behavior caused by her paranoid delusions, Allen’s guilt for making the wrong decision concerning her treatment, and Louis’ frustration and near helplessness in this desperate situation. Cockerham observes that “mental symptoms can be much more disruptive of social relationships than other forms of deviance can, because they distort and destroy the very core (that is, love, affection, respect, loyalty, responsibility) of what makes those relationships viable” (220). In the above portion of *Kaddish*, Ginsberg insinuates that the destruction of his parents’ marriage stemmed from Naomi’s schizophrenia: “Louis what happened to your heart then? Have you been killed by Naomi’s ecstasy?” (2.45). Her paranoia turned her husband into her enemy. Moreover, Naomi’s social identity became stigmatized permanently by mental illness; even strangers easily saw she was mentally disturbed. For example, upon leaving Lakewood, one taxi driver refused to take Naomi and Louis more than a block, and a bus driver refused to let them ride at all. Within a week of the Lakewood incident, Naomi returned to Greystone. Schizophrenia and its stigma ostracized Naomi, and by association her family members. Moreover, her mental disorder effectively killed the Ginsbergs’ marriage by creating an uncrossable divide between Naomi and her family. Although making mistakes, particularly in moments of crisis, is completely understandable, Allen bemoaned his decision to take his mother to Lakewood. Later, in his adult life, Allen regretted another decision he made

for Naomi's care even, after he authorized an experimental psychiatric treatment—one which he described as Naomi's living death.

Longing to help his mother, in 1947, Allen made a decision that would haunt him forever. Naomi was then a patient at Pilgrim State Hospital on Long Island (Schumacher 88). One day, Allen received an urgent letter from the director of the hospital; Schumacher summarizes the doctor's observations: "Naomi's paranoia had reached such a state that she was now in danger of harming herself. Her blood pressure had risen to such a level that she was in danger of suffering a stroke, and she was so agitated that she would often bang her head against the wall" (88). This news greatly worried Allen, so he carefully considered the doctor's recommendation for Naomi's immediate prefrontal lobotomy. The authorization of this psychosurgery was the responsibility of Naomi's sons because, by this time, Louis and Naomi were divorced (Schumacher 88). The hospital required either Eugene's or Allen's signature on legal documents, which granted the hospital family-permission to perform the lobotomy. The Ginsbergs had long since accepted Naomi's mental disorder; however, this resignation "did not make it any less painful to follow through with the inevitable course of action. This was especially true of Allen, who identified more closely with Naomi than anyone else in the family" (Schumacher 89). In the 1940s, the harmful side-effects of lobotomy were not understood, so only wanting to help his mother and ease her suffering, Allen gave the hospital his legal permission, and the surgery proceeded. At 53 years old, Naomi underwent a prefrontal lobotomy, and when she came out of surgery, she was never the same. Her confusion only intensified, for the procedure severely altered her memory. The results of the lobotomy horrified Allen, haunting him forevermore: "He would always bear an uneasy guilt about being the one who had had [Naomi] committed to Pilgrim State and, ultimately, a lobotomy" (Schumacher 89). This guilt weighed heavily. Although he included

fragments of this incident in his poetry, Ginsberg never fully explained why he chose to authorize his mother's lobotomy, but one can assume he wanted to ease her suffering. This harrowing experience affected Ginsberg's future decisions to avoid psychiatric treatment in hospitals until he was court-mandated to one.

Another distressing shock occurred the last time Allen saw his mother when she was 59 years old. In 1953, Allen decided to leave New York for California, but before leaving, he visited his mother at Pilgrim State. Naomi looked weary, broken, and older than she should have—the price of years of brutal psychiatric treatments and a permanently stigmatized identity. Schumacher explains, Allen had not seen his mother for almost two years, and her rapidly aged appearance horrified him: Naomi's "hair had turned white, and her face, once full and enlivened by her winning smile, was gaunt and lined with age. Her head was scarred from her lobotomy. Partially paralyzed from a stroke, she was weak and had lost all her excess weight, her clothes now hanging on a skeletal frame" (151). Seeing her in this condition, Allen believed Naomi would die soon; he remembers this heartbreaking realization in *Kaddish*:

Naomi stared—and I gaspt—She'd had a stroke—/ Too thin, shrunk on her bones—age
come to Naomi—now broken into white hair—loose dress on her skeleton—face sunk,
old! withered—cheek of crone—/ One hand stiff—heaviness of forties & menopause
reduced by one heart stroke, lame now—wrinkles—a scar on her head, the lobotomy—
ruin, the hand dipping downwards to death—(2.150-152)

As he approached Naomi, seated at a table, she did not recognize him and suspected him of being a spy. Her schizophrenia had not lessened, nor had her suffering; her paranoia, now intensified by memory loss and confusion, remained a permanent fixture in Naomi's mind. By 1953, Naomi had received at least 40 insulin shock treatments, multiple electroshock treatments,

Metrazol as medication, and a lobotomy (Ginsberg, *Kaddish* 2.73). During this last visit, Naomi disbelieved Allen was really her son: “He couldn’t be Allen, she said; Allen would have rescued her from the hospital. He must be a spy, sent by Louis. She was receiving signals, transmitted by the radios in the ceiling to the wires in her back, warning her to beware of this visitor”

(Schumacher 151). As she grew more unsettled, nurses led her away from Allen, back to her hospital bed. She did not take another glance at him; he was a stranger to her now. This incident crushed Allen. He already blamed himself for her treatment and institutionalization, and when his mother did not understand why Allen could not rescue her, he rushed to the public restroom and wept, crying aloud “The horror! The horror!” Ginsberg captures this scene in *Kaddish*:

‘Are you a spy?’ I sat at the sour table, eyes filling with tears—‘Who are you? Did Louis send you?—The wires—’/ in her hair, as she beat her head...I started to cry—She stared—nurse broke up the meeting a moment—I went into the bathroom to hide, against the toilet white walls/ ‘The Horror’ I weeping—to see her again—‘The Horror’—as if she were dead thru funeral rot in—‘The Horror!’ (2.163-166)

This memory remained traumatically distressing to Allen, and it intensified his feelings of guilt and despair for his mother, who was unrecognizable now. Naomi’s social identity became unequivocally equated to a madwoman.

In the summer of 1956, Allen received a telegram from his brother Eugene with sad news. As reported by American professor and scholar Thomas F. Merrill in the biography *Allen Ginsberg* (1988), on June 9, 1956, Naomi Ginsberg died of a stroke while in Pilgrim State Hospital (12). Allen felt a complex ambivalence toward his mother’s death. He was glad her suffering and institutionalization was over, but he grieved the loss of his mother. When he received Eugene’s telegram, Allen was in San Francisco, California. Due to the distance, he

could not attend his mother's funeral because he could not arrive in time. According to Allen's nephew and Naomi's grandson Lyle Brooks, the kaddish—the Jewish funeral prayer—was not performed because it required 10 Jewish men, and there were not enough men at her funeral to give it (Brooks). Brooks also explains Louis and Eugene were not orthodox Jews but agnostics, so the absence of the kaddish did not distress them; however, the lack of this ceremony bothered Allen greatly. Combined with his inability to attend the funeral, the missing kaddish compounded Allen's guilt and grief.

Three years after her death in 1959, Allen immortalized his mother and her mental disorder when he composed his poetic autobiography *Kaddish*, published in 1961. In *Kaddish* and in other poems about Naomi, Ginsberg treasures her madness for its spontaneity, political urgency, and idealism. Naomi served as a muse for Ginsberg, and her mental disorder created a unique connection between mother and son when Allen later experienced hallucinations, which he called his Blake Visions. In *Kaddish*, Allen juxtaposes Naomi's paranoid hallucinations with his visions:

O glorious muse that bore me from the womb, gave suck first mystic life & taught me
talk and music, from whose pained head I first took Vision—/ Tortured and beaten in the
skull—What mad hallucinations of the damned that drive me out of my skull to seek

Eternity till I find Peace for Thee, O Poetry— (2.158-159)

Here, Ginsberg credits his mother for his preternatural visions through the concept of the familial inheritance of madness. Perhaps because his mental disorder was far less severe than Naomi's, Allen found beauty within his experience of madness, and his visions spurred on his poetical mission to elevate human understanding. Unfortunately, nothing was able to save Naomi from her mental disorder, and the treatments she endured eased neither her symptoms nor her agony.

Naomi's schizophrenia and his part in her lobotomy and institutionalizations haunted Allen even after her death, even after he published *Kaddish*. Naomi Ginsberg's experiences encouraged Allen's complete rejection of the stigma of mental illness and planted the seed for his anti-psychiatry beliefs.

Ultimately in legend and in Allen's poetry, Naomi Ginsberg symbolizes the postmodern American madwoman, and her treatment portrays a stark contrast in the gendered experience of madness when compared to her son's. In an interview with American artist, author, and critic Richard Kostelanetz for *The New York Times* entitled "Ginsberg Makes the World Scene" (1965), Allen emphasizes the personal nature of his writing: "Everything I write is in one way or another autobiographical or present consciousness at the time of writing. Whatever travels or psychic progressions I've had are recorded there." This is true of all his poetry, and in this way, Allen recreates Naomi Ginsberg's narrative and mythologizes her as an archetype of a 20th-century American woman driven mad by the evils of postmodern society. As Merrill highlights, "As elegy, *Kaddish* voices its protests not against cruel death, but against insane life—or, more to the point, life that drives one insane by its encouragement of mad idealisms and visions of something more" (74). Naomi Ginsberg certainly struggled against American society; her inability to assimilate to American values created a chaotic world in which she was unable to cope. As a Russian immigrant, Naomi carried her communist idealism with her, but in mid-20th-century America, communist beliefs were considered "insane," if not criminal. In the literary analysis "Subversion of 'Madness' in Allen Ginsberg's Poetry" (2020), American literary critic Rima Bhattacharya reveals, "In an era when Naomi's communism was a sign of official madness, Ginsberg refuses to separate Naomi's political discourses from her schizophrenic ravings. He instead uses Naomi's language to parody discourses of law and order that would

equate madness with criminality” (16). Important to the legend of Naomi Ginsberg, Allen illustrates his mother’s political beliefs as a significant part of her ego identity and as a reason for her mental disorder. Notably, Naomi’s paranoia shifts from family members, such as Louis and Buba, to political figures, including President Roosevelt, Hitler, Mussolini, and the F.B.I. For the Beat generation, “‘Madness’ was a site of sociopolitical and religious debates. Beat poetry, in general, and Ginsberg’s poetry, in particular, aimed to liberate men not only from the machinery of war, government, and industry but also from the mechanism of a purely conceptualizing, abstracting Urizenic mind” (Bhattacharya 16). In other words, what Ginsberg saw as real madness encompassed a government that sent America’s youth to bloody wars, an industrialized military which dropped atomic bombs and caused mass destruction, and the monstrous greed encouraged by capitalism. He also rebelled against a purely Urizenic mind, which relates to one of William Blake’s four Zoas (or divisions of human nature) as the designation of a person who solely relies on conventional reason and law (Bhattacharya 16). Ginsberg asserted that American society put such high values on reason, order, and law that it sacrificed its imagination, feeling, and body (the other three Zoas from Blake’s theory) (Merrill 16). In this way, Allen saw reason as an oppressor in American society: “Reason has become a ‘horrific tyrant’ in Western civilization and created the nuclear bomb which can destroy the body, feeling and intimidate and all but destroy imagination” (qtd. in Merrill 16). Moreover, the exclusive worship of Reason denied the spiritual side of human nature. Ultimately, the Beatniks’ madness burgeoned from “their refusal to accept a nonspiritual view of the world and live in a civilization that has proclaimed God as dead or nonexistent” (Bhattacharya 13). Similarly, when Naomi valued nonconventional feelings and imagination over American-defined Reason, she was institutionalized. This is a romanticized view of her disorder, but there definitely are elements of

truth within it. Schizophrenia often is triggered by environmental stressors or trauma, so perhaps the stress of assimilating to a foreign culture with diametrically opposed ideals to her own sparked Naomi's breakdowns, especially when considering 20th-century American culture labelled her communist values as insane. Much like Zelda Fitzgerald, Naomi's rebellion against society and her alienation from it remained at the core of her mental disorder and served as the foundation for the archetype of the postmodern American madwoman. Ginsberg emphasizes Naomi as this archetype in *Kaddish*: "Back! You! Naomi! Skull on you! Gaunt immortality and revolution come—small broken woman—the ashen indoor eyes of hospitals, ward grayness on skin" (2.162). Like Emily Dickinson's beheaded flower as metaphor for the modern woman, Ginsberg juxtaposes Naomi's feminine "success" of marriage and childbearing with her ultimate demise through mental illness:

Nothing beyond what we have—what you had—that so pitiful—yet Triumph,/ to have been here, and changed, like a tree, broken, or flower—fed to the ground—but mad, with its petals, colored, thinking Great Universe, shaken, cut in the head, leaf stript, hid in an egg crate hospital, cloth wrapped, sore—freaked in the moon brain, Naughtless./ No flower like that flower, which knew itself in the garden, and fought the knife—lost/ Cut down by an idiot Snowman's icy—even in the Spring—strange ghost thought—some Death—Sharp icicle in his hand—crowned with old roses—...All the accumulations of life, that wears us out—clocks, bodies, consciousness, shoes, breasts—begotten sons—your Communism—'Paranoia' into hospitals. (*Kaddish* 1.40-44)

Despite Naomi's traditional triumph as a woman (becoming a wife and mother), she developed mental disorder because her countercultural beliefs were incompatible with postmodern American mandates. Thus, the "idiot Snowman" doctor cut down the flower of Naomi's mind

with a “sharp icicle in hand” when he lobotomized her. In *American Scream: Allen Ginsberg’s Howl and the Making of the Beat Generation* (2004), American writer and journalist Jonah Raskin asserts, “From Allen’s point of view, Naomi was a utopian dreamer driven mad by the insanity of the modern world. There was something fragile about her, something too pure for a world at war, a world wracked by poverty and pain” (30). When she voiced her paranoia too vehemently, she was committed to mental hospitals, and when she became too unruly for the hospital staff, she was lobotomized “by an idiot Snowman’s icy.” By sharing vivid details of Naomi’s tragic life, Ginsberg immortalizes her as the epitome of a postmodern American madwoman driven insane by an uncompromising, unfeeling, and selfish postmodern society and punished with imprisonment in asylums and dehumanizing treatments; ultimately, through his creative use of Naomi’s experiences, Allen fights the stigma of mental illness by inspiring sympathy for his mother.

4.3.2 *Madness as Beat Revolution*

Naomi Ginsberg’s mental disorder was not Allen’s only psychological stressor during his adolescence and young adulthood. In addition, this was a turbulent time for Allen because he feared his homosexuality, which emerged when he was seven years old (Schumacher 15). In the mid-20th century, most Americans viewed homosexuality as a sinful deviance, and most psychiatrists believed it was pathological. This meant Allen’s actual social identity was “discreditable”; if others learned of his homosexuality, his virtual social identity as “normal” would be stigmatized as mentally ill. Schumacher describes this public opinion: “In the 1940s, homosexuality and madness were both regarded in the minds of the American public as aberrations, and homosexuality was actually considered to be a type of madness by a large portion of the public” (69). In other words, the stigma of mental illness encompassed

homosexuality during Ginsberg's lifetime. In fact, according to American psychiatrist Sarah Baughey-Gill in her historical analysis of the psychiatric diagnosis of homosexuality "When Gay Was Not Okay with the APA: A Historical Overview of Homosexuality and its Status as Mental Disorder" (2011), by 1952, homosexuality officially became categorized as a mental disorder in the first *Diagnostic Statistical Manual* (7). Aware of the social stigma and hate-crimes associated with queer sexuality, Allen felt compelled to keep his homosexuality secreted; thus, he lived a double life during his early years. In his ego identity, he believed homosexuality was part of his natural self, but he had to keep this concealed from his social identity to avoid ridicule, hospitalization, and violence. He witnessed many times what happened when his mother acted against social expectations, so he was cautious and attempted to pass as heterosexual. However, when he entered college at Columbia University in 1943, he met others who accepted him and his true sexuality. He no longer attempted to conceal his homosexuality once friends like Jack Kerouac encouraged him to live truly by not hiding behind a socially acceptable façade. His friends fully accepted Ginsberg's homosexuality. The friends he made during the 1940s changed Ginsberg's outlook on life and on the outcasts of American society because they accepted all of him and never shamed him. Indeed, Ginsberg remained friends with these three influential figures until their deaths. The beneficial impact of Allen's friends' social acceptance of him demonstrates how social support fights the stigma of mental illness and how it enables an individual to reject self-stigmatization.

Allen and his companions—Jack Kerouac, Bill Burroughs, Neal Cassidy, and Lucien Carr—became leaders of the Beat Movement in the 1950s, which fought against social prejudices and hypocritical cultural ideals by promoting a countercultural lifestyle of resistance and endorsing the "New Vision" of the movement's literary geniuses. As the youngest member,

Allen soaked up all he could learn from these open-minded, nonconventional thinkers. As Schumacher explains, the Beat ideology started with Lucien Carr's and Jack Kerouac's creation of what they called the "New Vision":

Like Lucien Carr, Jack Kerouac was looking for a new way to view the world and write about it... as it was originally conceived, the New Vision underscored Carr's belief that self-expression was the highest purpose of art: Rather than be limited by the language and style and morality of established literature, the writer made literature out of his individual mind and experience. Rimbaud, whom Carr admired, had suggested that a supreme reality could be achieved only through a derangement of the senses in such a way that beauty *and* horror we're defined by the individual through his experiences and senses. To Kerouac and Carr, this was the foundation of a new way of approaching art. (33-34)

The New Vision rebelled against established literary conventions and codes of morality to present a truer representation of human experience—a reality that combined the derelict aspects of humanity and the beauty of individual experiences through rigorously honest self-expression. The Beat writers elevated the outcasts in American society and condemned American materialism and the military-industrial complex. Bhattacharya illustrates the Beat ideology as a "countercultural movement":

They were a distinctive group of people who took delight in their socially ostracized position and did not care about being labeled as "Mad." Madness or mental insanity and its consequences were for them a powerful means of resisting social pressures and restrictions. It also helped develop among the Beat writers a spirit of fellowship based on their desire to break away from the normative style of American literature. Often

resulting in exclusion from the mainstream society, madness paradoxically served as a sign of belonging for the Beat generation. (7)

Allen found a sense of belonging with the Beat writers that he never experienced before them. Because he and his friends rebelled against traditional social conduct, Ginsberg no longer felt guilty for his homosexuality; he stopped fearing madness and ridiculed its stigma. Additionally, while pursuing a countercultural lifestyle, the beatniks often experimented with mind-altering substances, searching for a higher consciousness to see past the socially regulated realities of traditional morality, blind patriotism, and tyrannical logic. Much like Bill Burroughs, Allen experimented with drugs for his research into various levels of consciousness; he tried a wide variety of drugs, “including morphine, opium, marijuana, cocaine, codeine, and Benzedrine,” and later in his life, he experimented with hallucinogens, such as psilocybin, yage, peyote, ayahuasca, and LSD (Schumacher 61). However, Ginsberg was careful and methodical about his drug use; he never became an addict, unlike Burroughs who purposefully became a heroin addict for literary inspiration. Allen used substances to invoke altered states of consciousness for the creation of surrealistic writing and for religious awakenings. However, because his friends lived life to the uttermost limits, Allen witnessed how madness, even when purposely induced, could have fatal results.

As the Beatniks continued to seek new levels of consciousness through madness, poverty, and substance abuse, Ginsberg again witnessed the ravages of out-of-control insanity, but instead of stigmatizing his friends, he empathized with them, blaming America’s cultural ideals for destroying the brilliant, creative minds of his friends. Ginsberg opens his most famous poem *Howl* (1956) with “I saw the best minds of my generation destroyed by madness” because he witnessed many friends’ downward spirals into jails, psychiatric institutions, and death (1.1).

Take the following two examples as evidence of the Beat generation's risky behavior, drug-induced madness, and consequential untimely deaths. Firstly, consider William S. "Bill" Burroughs and Joan Vollmer. Bill Burroughs, a mentor, friend, and occasional lover to Ginsberg, purposely became a heroin junkie and interacted with known criminals to research how marginalized individuals survived in America (Schumacher 59). In "Part I" of *Howl*, Burroughs is "suffering Eastern sweats and Tangerian bone-grindings and migraines of China under junk-withdrawal in Newark's bleak furnished room" (Ginsberg 1.21). Burroughs is also the one "who retired to Mexico to cultivate a habit" (Ginsberg, *Howl* 1.64). He was arrested numerous times throughout his life for the possession of drugs and stolen goods and other petty crimes. Burroughs married Joan Vollmer, a bright, bohemian journalism student he met at Columbia. During their relationship, Joan also became a drug addict. Eventually, she was hospitalized in Bellevue for amphetamine-induced psychosis. As recounted by Schumacher, one night, while they were both heavily intoxicated from drugs and alcohol, Bill and Joan decided to play a game of William Tell (137). Burroughs placed a whiskey glass atop Joan's head. She smiled while he aimed his pistol, as confident in his marksmanship as he was (Schumacher 137). Unfortunately, due to his drunkenness, Bill missed the glass and shot Joan in the middle of her forehead, killing her instantly (Schumacher 137). This was just one of the tragic deaths in the Beat generation that greatly affected Ginsberg. Witnessing the destructive nature of alcoholism and drug addiction, although Allen supported his friend Bill Burroughs and did not stigmatize him, Ginsberg learned to take extreme caution when partaking in the drug culture of the Beat movement. For example, Ginsberg avoided using heroin, Burroughs' drug-of-choice, but he did experiment heavily with hallucinogens later in his life. Moreover, to the public, the Beatniks' risky behavior, dangerous stunts, and common drug-use marked them as insane social outcasts; the Beatniks' discredited

social identity continues to discourage the teaching of Beat literature in schools today, demonstrating the lasting effects of the stigma of mental illness and social deviance. Secondly, one of the most tragic examples is Bill Cannastra, another friend of the group. In “Part I” of *Howl*, Ginsberg includes examples of Bill Cannastra’s “crazy” stunts. For instance, Cannastra is the friend “who jumped off the Brooklyn Bridge this actually happened and walked away unknown and forgotten” (Ginsberg, *Howl* 1.57). This death-defying jump resulted in Cannastra walking away relatively unscathed, but this incident was one reason Ginsberg and other friends worried Cannastra was suicidal. He was the one “who sang out of their windows in despair, fell out of the subway window, jumped in the filthy Passaic, leaped on negroes, cried all over the street, danced on broken wineglasses barefoot smashed phonograph records...finished the whiskey and threw up” (Ginsberg, *Howl* 1.58). Although his peers worried Cannastra would kill himself, intentionally or accidentally, they did not stigmatize him or try to intervene because they understood his desperation and mental distress—it was an essential aspect of the Beat Movement. But to the public, such incidents further stigmatized the Beat generation as insane. Cannastra made dangerous attempts to live on the edge—searching for the extremes of human existence—including dancing on broken glass, jumping into strangers’ cars, skipping drunkenly on the ledges of high-rise buildings, and lying in the middle of the road in front of oncoming traffic (Schumacher 130). One night while out partying with friends, Cannastra entered the subway; he planned to sleep off his intoxication at Lucien Carr’s apartment. He waved goodbye to his friends from the window of the train, but as it started to leave, one friend on the platform yelled that they were going to visit a flirtatious barmaid they all knew. Suddenly in jest, a drunken Cannastra made a deadly error. Schumacher vividly paints the incident:

As a prank, Cannastra acted as if he intended to jump out of the train window, supposedly so he could jump back to the platform and return to the bar. He leaned out the window too far and was thrown hopelessly off-balance as the train lurched away from the platform. His friends, hearing his screams for help, tried to pull him back into the car by grabbing onto his coat, but the material tore away in their hands. The train, picking up speed, entered a tunnel, and Cannastra hit his head against one of the tunnel pillars. He was pulled from the car and dragged along the tracks. He died in the ambulance on the way to the hospital. The way Cannastra died might have been horrifying to those who knew him, but few were surprised that his life ended as early and abruptly as it did. In fact, as Allen pointed out in a letter to Neal Cassidy, there was some discussion about whether Cannastra's demise had been an accident at all. He had lived a life that tempted fate on many occasions. If anything, it seemed almost a miracle that he had survived for as long as he had. (130)

Ginsberg, greatly disturbed by this news, includes a line about Cannastra's death in *Howl* "Part I"; although he is unnamed, Cannastra is the one "who chained themselves to subways for the endless ride from Battery to holy Bronx on benzedrine until the noise of wheels and children brought them down shuddering mouth-wracked and battered bleak of brain all drained of brilliance in the drear light of Zoo" (line 14). Despite being an attractive, brilliant Harvard Law School graduate, Bill Cannastra rejected the strait-laced lifestyle that his social station demanded (Schumacher 130). Like the others in his generation who were *beat* down by the strictures of social expectations, Cannastra died attempting to feel truly alive. These are only two examples of Ginsberg's friends dying in mad attempts to live an authentic reality, but they illustrate the Beatniks' full rejection of the stigma of mental illness. They wore their stigmatized social

identity with pride because it demonstrated their belief that the only reasonable reaction to an insane world was madness.

One must remember that after WWII, when word about the American atomic bombs dropped on Japan and the horrors of concentration camps in Germany spread across America, many people, especially young adults, became disillusioned; many Americans lost trust in their government after seeing the global destruction caused by government-sanctioned violence. If those in power could kill millions of innocent lives and still be praised as heroes for ending the WWII then the whole world must be insane, as the Beat writers saw it. Thus, the only sane reaction to an insane world was madness. Merrill explains, “society imposed authority from without, but beatniks obeyed an authority from within. Viewed as a social phenomenon, they appeared ‘fed up’ and recalcitrant—grumbling malcontents and irresponsible hedonists” (2). Because traditional American values seemed like insane hypocrisy when one saw the destruction they caused, so the only way to fight back was to take down the tyrant Reason and fall into madness. Thus, rejecting secular values, the beatniks searched inwardly; they “regarded themselves as pioneers, explorers of interior reality; in this respect, they resembled traditional religious mystics” (Merrill 2). Many Beatniks rebelled through madness in particular, hoping to find something divine within their own experiences; unfortunately, many of them did not survive their quest to find “the ancient heavenly connection to the starry dynamo” (Ginsberg, *Howl* 1.1).

All his previous experiences—witnessing the insanity of his mother and his friends as well as their opposite reactions to stigmatization—taught Allen Ginsberg to approach his first personal encounter with madness with an open mind. Instead of being afraid or self-stigmatizing, Allen connected his neurodivergent experiences to new mystical understandings of the universe and his purpose in life. Ginsberg experienced his first vision in the summer of 1948, and it

changed his life forever. One summer evening, as the sun set over East Harlem, Ginsberg lay in bed reading William Blake's poetry and absentmindedly masturbating, "his mind in a sort of dull postorgasmic blankness" (Schumacher 95). Schumacher ascertains "a combination of Allen's highly conceptual state of mind, his search for another level of consciousness, his reading of visionary theology texts, his intense study of the works of William Blake, and his loneliness led to a *satori* that would influence him for the next fifteen years" (95). Notably, he was not under the influence of drugs or alcohol when this first vision occurred. In his meditative state, Allen suddenly heard a voice reciting Blake's poem "Ah Sunflower." As presented in the collection *The Book of Martyrdom and Artifice: First Journals and Poems, 1937-1952* (2006), edited by American scholars Juanita Liebermann-Plimpton and Bill Morgan, Ginsberg describes the sensation that overcame him in a journal entry: "I felt at that moment a wave of such great sadness pass over me...I stared stupefied with the knowledge of the words written on the page, as if there had been a magical formulation of my own awakening comprehension of joy" (266). As he explains in his journals, at first, Ginsberg identified the voice to be his own but as if it were projected around the room; when the voice continued reciting other poems by Blake, the voice itself changed from Allen's to a deep voice he had never heard but recognized as William Blake's (*Book of Martyrdom* 266). In Ginsberg's interpretation, through poetry and an open mind, the spirit of Blake himself made a direct connection to Allen, defying time, space, and death. In his journal, Allen notes, "I realized...the last and most terrible veil had been torn from my eyes, a final shuddering glimpse through death" (*Book of Martyrdom* 266). Through Blake's voice, Ginsberg felt himself transcend to a place of timeliness, where he could see "eternity in a grain of sand, or the timeliness of the graying sky outside, without feeling foolish or untruthful" (Schumacher 95). During this vision, Allen had epiphanies about poetry and Eternity, and he felt

his consciousness meld with Blake's as he listened to the recited poems. Ginsberg realized poetry is eternal, and "a poet's consciousness could travel timelessly, alter perception, and speak of universal vision to anyone attaining the same level of consciousness" (Schumacher 95). Thus, poetry could deliver visionary content across time and space; Allen now knew his place in the universe: "He was not only a part of a vast presence; he was also part of timeless eternity. Blake understood this, and now, so did he" (Schumacher 96). He knew he must dedicate his life to poetry to share his new consciousness with the world. When the voice stopped, Allen sat stunned for a moment. He believed his vision was part of reality, not mental disorder, but he did not know what to do with these revelations. Neither Bill Burroughs nor Jack Kerouac was in New York at the time, but Allen felt compelled to tell someone of his vision. So, he climbed out his window onto the fire escape and knocked on the window of the next-door apartment; when two women opened the window, Ginsberg announced "I've seen God!" (Schumacher 96). Although they immediately slammed the window in his face, Allen could not displace his jubilation. The neighbors' reaction demonstrates the stigmatization of his social identity as a madman, but Allen did not incorporate this label into his ego identity because he believed his hallucinations were a divine gift. He rushed back to his apartment to pour over other lofty texts by Plato, Saint John, and Plotinus, hoping to invoke another vision (Schumacher 96). To Ginsberg, his first personal experience of mental disorder was revelatory. He did not self-stigmatize or hide his madness; instead, he pursued it like a religion.

For the next few days, Allen tried to induce a second vision; he danced in dizzying shamanic circles, reread sections of his metaphysical texts, and wrote poems about the sensations of his Blake vision (Schumacher 96). Then, while at the Columbia University bookstore, Allen had his second vision, which incited the same physical "shuddering sensation—a feeling that he

was in an eternal place” as in his Blake vision (Schumacher 97). When he looked around him, he saw everyone in the store now had animal faces; for example, the clerk had the head of a giraffe (Schumacher 97). Allen sensed the spiritual torment in those around him. He believed everyone had the ability to experience an elevated consciousness like he was, but they were distracted from it by the hassles of everyday life. Schumacher accentuates Allen’s new understanding of others: “Everybody in the bookstore knew these eternal truths, he felt, but they were so busy going about their daily lives that they did not dwell on their significance in the universe. Rather than face this cosmic consciousness, they hid their intelligence behind grotesque masks of self-deception” (97). Upon consideration, Ginsberg’s perception is astute; most people wear metaphorical masks, perhaps without realizing, because identity is constructed through symbolization and worn much like a costume. By interpreting “normal” people’s social identities as false contrivances, Allen further avoided self-stigmatization because, to him, to live the most authentic existence, one should not hide his ego identity beneath a culturally acceptable social identity. Merrill explains how this vision and, more importantly, the lesson Ginsberg took from it reinforces the major Beat conflict of man versus society: “The vision of people ‘*hiding* the knowledge from one another’ testifies to the beat conviction that people are more real (and presumably better) than society allows them to be and also that collective society has an awesome control over people that transcends their individual wills” (3). With this second vision, Allen reaffirmed and focused his life’s purpose: “Passing along this consciousness was the duty of the poet. It was the Supreme Reality—or New Vision—that Allen had been looking for over the last three years” (Schumacher 97). Ginsberg wanted to help others shed their blinding masks and open their minds to higher levels of consciousness freed from the tyrant Reason and the social restraints placed upon human reality. Thus, his visions initiated a religious awakening that

secured Ginsberg's confidence and spurred his ambition to be a prophetic poet. Merrill explains, "the acknowledgment of reality as an inward experience apprehended through *petites sensations* or 'majestic flaws of mind' is crucial to Ginsberg's conviction of the holiness of everything" (33). Through this higher consciousness, gained through "majestic flaws of mind," he understood that everything real in the universe is connected to the Divine. Thus, in his "madness," Ginsberg gained new wisdom; as he clearly opines in "Footnote to Howl," "Everything is holy! everybody's holy! everywhere is holy! everyday is in eternity!" (line 115). In his biographical analysis "Madness as Religious Experience: The Case of Allen Ginsberg" (1982), American professor of psychology Martin Wasserman describes how a psychedelic experience, such as Ginsberg's, may be the mind's attempt to heal the trauma of alienation (147). Alienation can be an effect of unattainable social expectations (i.e., alienation from place) or the ever-present fragmentation, as described by Lacan, caused by the formation of one's ego identity which is in direct opposition to reality (i.e., alienation from self). Through the psychic experience of his visionary revelations, Ginsberg understood a new reality—one of divinely-inspired proportion. He began to heal from the trauma of alienation from self by connecting to the oceanic feeling of oneness with the Universe and Eternity, and he healed from alienation from place by rejecting society's constructed reality. Wasserman analyzes this type of experience:

When one establishes a new type of psychic reality, he is like an explorer in an unknown world. In a sense, he has gone from the world of the ordinary to the world of the extraordinary. Though the voyager has the opportunity to make profound, intuitive discoveries about himself, it is only natural that he be both confused and frightened by this new territory he has just entered. The confusion and dread, in turn, engender a certain amount of shame when the individual recognizes that he is not viewing reality and the

human situation in an expected manner. Whether this shame is to dissipate and become manageable or progress and ultimately dominate the whole experience is mainly a function of how other people react to the individual. If others see the individual's behavior as part of an ongoing developmental process which has the potential to be a religious awakening, then the shame that the individual feels...will be minimal. (147)

If anything, Allen was an explorer—both as a world traveler and an adventurer into the inner recesses of his mind and spirit. Luckily, Ginsberg and his confidants valued the experiences of the outsider, so his closest friends did not shame or stigmatize him for his visions, even if they did not fully understand them. This unconditional love from his friends further encouraged Ginsberg to avoid self-stigmatization, which emphasizes the importance of social understanding and empathy in the fight against the stigma of mental illness.

Although Jack Kerouac worried Allen was going insane and Bill Burroughs doubted the religious connection to the visions, overall, his friends supported Allen and empathized with his “New Vision” and expanding consciousness. Most crucially, they encouraged his poetic ambitions and newfound confidence in his writing ability, and none of his friends ever suggested Ginsberg should commit himself to a psychiatric hospital. Bhattacharya explains their tolerance:

The anguish of the visionary poet dwelling in exile from a sense of social reality is intensified by a culture that refuses to recognize the validity of such visionary experiences. During the forties and the fifties, the Beats were operating on a definition of sanity that defied the expectations of their time but proved to be potently prophetic for them. (12)

Ginsberg's experience could have been much different if he had not received this support from his social circle. Consider what happened to Zelda Fitzgerald. Her visions were tallied as another

symptom of schizophrenia. Surely, having visions and speaking about them sent Zelda back to the sanitarium more than once. Indeed, if Ginsberg had been at home as a child or an adolescent when he experienced his first vision, his father would have treated the situation much differently than Ginsberg's friends because Louis equated Allen's visions with Naomi's mental disorder. In fact, Louis Ginsberg believed his son's visions were purely mental illness, and if Allen had been younger when his visions occurred, Louis would have hospitalized him. Schumacher explains Louis Ginsberg's understandable reaction:

Tormented by the difficult years he had endured with his wife, Louis reacted to his son's announcement with a mixture of sadness, fear, and pent-up fury. Louis tried to dismiss the visions, but when Allen insisted they were real, father and son quarreled bitterly, Louis wondering whether Allen had inherited his mother's mental disorders. (97)

Likely, if a psychiatrist had observed Allen during this state, he would have diagnosed Allen with schizophrenia, especially if he considered his family history. As replicated in *The Letters of Allen Ginsberg* (2008), edited by American scholar Bill Morgan, in a letter to Neal Cassady dated April 21, 1949, Ginsberg notes how an unnamed psychiatrist pathologized his visions: to Ginsberg, the experience "was gifted, as it seemed, from a higher intelligence of conscious Being of the universe," but "the doctor dismissed it [as hallucination] when I went to arrange for therapy" (32). Because he was an adult and no one could convince him he was mentally ill, Ginsberg did not enter an asylum for these visions; however, under the same circumstances, an individual of a socially less-valued age, race, gender, or socioeconomic class easily could have been confined to a psychiatric ward for the same "symptoms." This is especially the case for women, the elderly, and/or the impoverished.

In the 20th century, because the tyrant Reason ruled supreme, visions became symptoms. In a society that gave science the highest credibility, prophetic visions were not religious or holy but instead were examples of mental illness. Due to this ambiguity in the interpretation of such an experience, one could argue that madness and religious awakenings can occur together; this also dilutes the shame and stigma of mental disorder if a genuine spiritual understanding of the self and the universe helps the individual live a more meaningful existence. Wasserman makes this connection: “The process of madness, therefore, can be considered a religious experience, because the direction throughout...has been toward a search for meaning beyond oneself” (148). Certainly, this was Ginsberg’s quest throughout his creative work and experiences of madness; he found meaning beyond himself and realized how he could help others in this world through his poetry and later his activism, such as his involvement in the Gay Liberation Movement from the 1960s through the 1980s. Allen used his visions to better himself and American society by revealing the eternal wisdoms he learned through these mystical experiences. Instead of internalizing the stigma that he undoubtedly encountered when discussing his visions, Allen refused to absorb the concept of “mental illness” into his ego identity. Instead, he accepted his visions as gifts from a divine source, so his ego identity positively evolved with his experience of madness as Ginsberg cemented his understanding of himself as both poet and prophet.

4.3.3 Allen Goes to the Asylum

Despite his gratitude for the visions, Allen struggled with depression afterwards, which burgeoned from a combination of factors—his love affair with Neal Cassady ended in 1947; Allen was frantic to experience more visions and to put his new knowledge to use; but due to his mental distress, he found it nearly impossible to focus on reading or writing. In his journal, Ginsberg records the turmoil he experienced after his first two visions: “I spent a week after this

living on the edge of a cliff in eternity. It wasn't so easy after that. I would get glimmerings, hints of possibility, secret amazements at myself, at the world, at 'the nature of reality'" (*Book of Martyrdom* 266). Much like a person experiencing schizophrenia or psychosis, Allen began to see patterns of association among a variety of contexts—among the texts he read, the people he met, and the signs he saw in the world around him. When one takes such patterns of association too literally, he is in danger of losing touch with reality and falling into mental disorder. In this setting of "frenzied preoccupation" (as Ginsberg describes it), he allowed Herbert Huncke to stay with him, which would prove to be a terrible mistake—leading to Allen's arrest and his legal confinement to a psychiatric hospital (*Book of Martyrdom* 266).

Herbert Huncke was a figure who came into Ginsberg's life through Bill Burroughs in 1945 after Bill scored dope from him (Schumacher 59). Huncke was a junky and a conman. As a lifelong criminal, Huncke had "been arrested 37 times, and spent several years in jail, usually on short term misdemeanor charges having to do with vagrancy and narcotics" (Ginsberg, *Book of Martyrdom* 270). When Huncke knocked on Ginsberg's door in 1949, he appeared like a "ragged saint" in need of help (Ginsberg, *Book of Martyrdom* 262). Huncke, sick from heroin withdrawals, begged Allen to let him stay in his apartment until he got better, and Allen acquiesced. Taking advantage of the situation, Huncke stayed for several weeks and began running with two other small-time criminals named Little Jack and Vicki. Huncke continuously urged Allen to let Little Jack use his apartment as well. Ginsberg was hesitant, "but Little Jack offered to repaint the place, install a telephone, pay rent and give [Ginsberg] whatever [he] needed (\$30-\$50) to get to New Orleans if [he] would let him have the place for four months" (Ginsberg *Book of Martyrdom* 296). Allen agreed immediately; he had spent all his money on rent and paying for Huncke, who paid for nothing but his heroin addiction. Ginsberg observed

Huncke, Little Jack, and Vicki “bringing things in and out all the time—small things, mostly their own,” or so he believed (*Book of Martyrdom* 297). Foolishly naïve, Allen did not realize the group was moving stolen items into the apartment, and to make quick cash, they sold the stolen goods to pay for drugs. These details are only important because these con-artists’ illegal schemes led to Ginsberg’s arrest and involuntary psychiatric confinement.

In effect, Ginsberg’s apartment became a stash house. In his journal, Ginsberg explains why he did not realize what was happening: “I was in a state of weariness and futility about the absurdity of trying to live and write in such a hectic atmosphere...I wasn’t acting or living with any real sense of purpose except to get out of town and enjoy myself in New Orleans” (*Book of Martyrdom* 297). Thus, obsessed with ending his writer’s block caused by the chaotic apartment, Allen prepared to leave for Louisiana, but he wanted to store all his journals, letters, and manuscripts at his brother Eugene’s apartment for safekeeping (*Book of Martyrdom* 307). On April 22, 1949, needing transportation to Eugene’s, Allen asked for a ride from Little Jack and Vicki, who were taking stolen suits to Long Island to sell; they agreed to drop him off on the way back (*Book of Martyrdom* 307). Allen climbed into Little Jack’s car with his assorted papers in tow, and with Little Jack behind the wheel, the three began their trip. Unbeknownst to Ginsberg, Little Jack had stolen the car the prior month in Washington, D.C. (Schumacher 111). After missing a turn, Little Jack tried to correct the error but entered a one-way street in the wrong direction. Mid-conversation, the trio did not notice the traffic violation until a policeman stepped from the side of the road to wave them down; seeing the officer, Little Jack panicked and pressed the gas pedal to the floorboard (Schumacher 111). Schumacher describes the subsequent chase: “A wild six-block chase ensued. With police closing in, Little Jack tried to guide his car onto a side street at sixty-five miles per hour” (111). Little Jack lost control of the car and accidentally

jumped the curb at high speed (Schumacher 111). Ginsberg recalls, “I felt the car going over on its side and somehow relaxed enough to roll along with it inside the car. My mind was still half tied up with the attempt to hold on to my manuscripts. I felt my glasses being knocked off” (*Book of Martyrdom* 308). The car finally crashed into a telephone pole, stopping upside down (Schumacher 111). Miraculously, no one inside the car was injured, but Ginsberg’s manuscripts and journals snowed down over the street and littered the inside of the vehicle. In addition, the stolen car contained a cache of stolen items. Little Jack and Vicki immediately fled (Schumacher 111). Left behind, Allen climbed out of the wreckage and started toward his apartment on foot, but he worried about the incriminating journals left at the accident scene. Allen stopped at a payphone and called Huncke; he told him about the crash and implored him to remove anything stolen or illegal from the apartment. When Ginsberg arrived home, “Huncke was waiting. He had not done much to remove stolen property but had mostly stowed it away in drawers and bookcases. He had not even thrown out the two opium hashish pipes” (*Book of Martyrdom* 311). Hopeless, Huncke waited for the inevitable while Allen shook with anger and shock, trying to formulate a plan of action. Suddenly, the police pounded on the apartment door, and two detectives entered. They immediately saw drug paraphernalia and began searching the entire place. All four residents—Huncke, Little Jack, Vicki, and Ginsberg—were arrested.

Their arrests made it into the newspapers, and this criminal context publicly soiled Allen Ginsberg’s social identity. Ashamed but caring, Louis Ginsberg travelled to New York City to post Allen’s bail of \$2,500 (Schumacher 112). Additionally, although Allen had caused occasional trouble at Columbia University (once to the point of expulsion though he was readmitted afterwards), some of his former professors came to his legal aid in his consequent court case. Their respected credentials and support of Allen kept him from serving a jail

sentence, but to do so, they had to recommend Allen's confinement to a psychiatric hospital instead. Schumacher details the extent to which Columbia University professors helped by testifying that Allen was an extremely gifted and highly intelligent student, who was suffering from mental disorder; they argued he needed psychiatric treatment, not criminal incarceration:

Mark Van Doren promised to put in a good word for him, but only after he lectured him on his behavior and advised him to abandon his current lifestyle...Lionel Trilling introduced Allen and Louis Ginsberg to Herbert Wechsler, a Columbia criminal law professor, who advised Allen to plead insanity. The Columbia dean, Harry Corman, called the district attorney, a Columbia alumnus, and arranged a plea of psychological disability, on condition that Ginsberg be placed in psychoanalytic therapy. (112-113)

Knowing his case against Allen Ginsberg was weak in addition to the influence from Columbia University, the district attorney agreed to the plea deal, and D.A. Corman arranged for Allen to receive "the services of the Columbia Presbyterian Psychiatric Institute [also known as the New York State Psychiatric Institute] free of charge" (Schumacher 113). Tellingly, the only time Ginsberg entered an asylum was through this court order, which marks a significant difference between Allen's experience as a man and Zelda's and Naomi's experiences as women. Women were easier to force into confinement because of their lack of financial independence and their status as the weaker sex, whereas, typically, men could resist institutionalization, if they desired, unless ordered through a court of law.

After listening to the respected opinions and recommendations of his Columbia professors and the judgments of the legal system, Allen's self-concept wavered; he began entertaining self-stigmatization from the pressure of these social authorities. Just before Allen entered the hospital in June, he questioned whether he actually was insane because "nearly

everyone representing ‘sane’ society seemed to think so” (Schumacher 113). Notably, once enough people around him labelled Allen “insane,” he incorporated this concept into his ego identity because it became a pervasive aspect of his social identity—he was legally judged insane. This highlights how social identity and ego identity are intricately connected as well as how many mental patients experience self-stigmatization upon admittance into a mental hospital. As soon as his social identity changed in the eyes of the media, the court system, his family, and his mentors, Allen doubted his ego identity as a sane individual. This is a common experience, and certainly one that Zelda encountered. Once enough meaningful people in an individual’s life label him mentally ill, especially once he enters a psychiatric institution, that individual likely will self-stigmatize, at least for a while, because the socially reinforced myths of stigma are pervasive and convincing.

Consequently, as his belief in his own insanity grew, when he entered the hospital, Allen looked forward to his upcoming psychiatric treatment; he planned to be an active participant in his therapy. At the beginning of his confinement, Ginsberg fully accepted his new social identity as a mental patient and integrated this label into his ego identity. As evidence for this claim, he wrote in his journal the day before his commitment: “In the hospital I hope to be cured” (*Book of Martyrdom* 316). In a letter to Dr. Wilhelm Reich from March of 1947, Ginsberg outlines his psychological stressors, which he still believed true when he entered New York State Psychiatric Hospital:

My main psychic difficulty, as far as I know, is the usual oedipal entanglement. I have been homosexual for as long as I can remember, and have had a limited number of homosexual affairs, both temporary and protracted. They have been unsatisfactory to me, and I have always approached love affairs with a sort of self contradictory, conscious

masochism. I have had a few experiences with women which were unsatisfactory from the start since my motivation was more curiosity than interest, and I have been pretty consistently impotent when with a woman. I have had long periods of depression, guilt feelings—disguised mostly as a sort of Kafkian sordidness of sense of self—melancholy, and the whole gamut I suppose. (*Letters* 16-17).

Consistent with popular Freudian theory, Ginsberg viewed his homosexuality as a problematic result of “oedipal entanglement.” This demonstrates Ginsberg’s struggle with the social norms that diagnosed homosexuality as mental disorder. He also knew he held resentments against his father and, less consciously, against his mother. So, as a goal for his treatment, Allen wanted to be psychoanalyzed and cured of his homosexuality, periodic depression, and feelings of guilt. His desire to be “cured” highlights Ginsberg’s integration of stigma into his ego identity upon his admittance to a psychiatric institution. However, his self-awareness, even during his psychoanalysis and confinement, establishes his ethos later as a reliable narrator when he creates mental illness life narratives through poetic autobiography.

On June 29, 1949, Allen Ginsberg entered New York State Psychiatric Hospital, where he would remain until March 1950, but his experiences there did not meet his preconceived notions. His time in the institution changed Ginsberg’s perspective on psychiatry, literature, and postmodern American society. These mindset changes burgeoned from Allen’s close friendship with another patient—Carl Solomon, an avantgarde thinker, a student of Surrealist writers, and a suicidal nihilist. Once Allen realized that mental patients can be brilliant, unconventional thinkers, he reverted to rejecting the stigma and cleansed his ego identity of shame once again. Ginsberg’s and Solomon’s initial meeting is now legendary. Standing in a hallway after the admissions process while waiting for his room assignment, Allen watched another patient

wheeled into the ward by a nurse. The man was “bloated from insulin shock treatments” and recently had awoken from the coma such treatments induced (Schumacher 114). Rising from the wheelchair, the man walked over, and Ginsberg prepared to speak to a lunatic. Allen began describing his visionary experiences, perhaps to show he belonged. Unfazed by his confessions, the man said, “Oh, well, you’re new here... Wait awhile and you’ll meet some of the other repentant mystics” (Schumacher 114). This comment interested Allen. Testing the extent of his new acquaintance’s intellect, when asked who he was, Allen responded, “‘I’m Myshkin,’ referring to the gentle but mentally disturbed prince in Dostoyevski’s *The Idiot*” (Schumacher 114). In perfect response, Carl returned the literary volley: “I’m Kirilov”; “In Dostoyevski’s *The Possessed*, Kirilov is a cynical, suicidal character unable to tolerate joy or love” (Schumacher 114). And with this unique meeting, Ginsberg and Solomon became fast friends. Solomon gave Allen the same support and encouragement his other Beatnik friends did, and Solomon’s empathy for Ginsberg emboldened his courage to rebuff self-stigmatization.

While together, Solomon taught Ginsberg about society’s culpability in madness, connecting his ideas to ones commonly held within the Beat movement, including the rejection of dehumanizing social standards and the promotion of madness as the only sane reaction to the insane world in which they lived: “Solomon may have been mad in the eyes of society, but he was also brilliant, attuned enough to himself to appreciate the improbability of society’s acceptance of a person who was both ingenious and insane” (Schumacher 117). Planting the seed of anti-psychiatry, Solomon sarcastically warned Ginsberg, “There are no intellectuals in madhouses” (Schumacher 117). Western culture propagandizes the dichotomy between sanity and insanity; one cannot be both a wise genius and a mental patient because, as Andrea Nicki explains, the main stigma surrounding all mental health opines that “if a person cannot control

her mind—that which allegedly distinguishes persons from animals—the assumption is that she must be mentally defective and so not deserving of full human respect” (95). The flaws in this forced logic became glaringly clear to Ginsberg once he was a mental patient. As he observed the ineffectiveness of prescribed treatments, Allen grew to distrust psychiatrists. As Schumacher explains, “As far as Allen was concerned, Carl Solomon was living proof that the best minds of his generation were being destroyed by madness” (114). Moreover, this destruction by madness resulted from “the post-World War II social and literary environment in the United States [that] was destroying creativity and aesthetics” (Schumacher 114). Post-WWII American culture enforced mass conformity, blind patriotism, and traditionalism. To be a good American, one had to stay within his or her socially prescribed identity, which meant following traditional gender roles, being heterosexual, demonizing communism, and valuing utility over artistic endeavors, but the Beatniks rebelled against these imperatives, seeing them as inauthentic to natural human existence. The conversations shared between Solomon and Ginsberg led to Allen’s rejection of the stigma of mental illness; he fully removed it from his self-concept, which allowed his ego identity to heal.

Together, their rejection of stigmatization changed American poetry when Ginsberg wrote *Howl*. As empathetic intellectuals, Ginsberg and Solomon were inseparable in the hospital, and Allen learned new perspectives from Carl’s cynicism and surrealism. They played ping-pong and spoke of rebellion through art. Ginsberg learned he could fight social injustice and the stigma through the language of prophetic poetry. Thomas F. Merrill explains the significant impact Solomon had on Ginsberg:

Solomon, the “lunatic saint” of *Howl*, introduced Ginsberg to the French surrealists and reinforced his sensitivity to the uses of literature as a political force. An outsider and

antirationalist, Solomon was no doubt responsible for much of the rebellious rage against the system that erupted in *Howl*. (11)

Solomon inspired Ginsberg to use his poetry for political action, and for this reason, Allen mythologizes their friendship in *Howl*, which he dedicates to Carl. In combination with the Beats' New Vision, Solomon's theories inspired Ginsberg, who began a revolution in American poetry with the publication of *Howl and Other Poems* in 1956. *Howl* catalyzed the American postmodern poetic revolution because its content presents a disturbingly honest portrait of the marginalized in America and the problems within post-war American society; furthermore, Ginsberg's use of profane language and lewd imagery within the poem in conjunction with the new form of free verse changed what the literary world would recognize as valuable art. In *Howl*, Ginsberg shows America her own deranged image through his portrayal of the Beat generation's madness, and by doing so, he fights the stigma of mental illness and advocates for mental patients like Carl Solomon.

While in the asylum, Ginsberg received a variety of treatments, but none "cured" him, which contributed to his building anti-psychiatric sentiments, and this attitude becomes abundantly clear in *Howl*. In the "Author's Annotations," Allen makes a list of his treatments from New York State Psychiatric Institute: "hydrotherapy, psychotherapy, occupational therapy (oil painting), and playing ping-pong with Carl Solomon" (*Howl* 131). In comparison to other patients' mental illness life narratives, Ginsberg's treatments were far less harsh than insulin shock or electroshock treatments, and his doctors never recommended psychosurgery. Nevertheless, Allen identified with other patients immediately. In his journal, dated the day he arrived at the asylum, Ginsberg observes:

In the clinic—this is a real madhouse—what a weird feeling—at first I saw the patients’ eccentricities in relief, clearly, but soon these disappeared in a sense; and there appeared to be a secret conspiracy of the great dichotomy—the lunatic vs. society. Solomon...said that they, the doctors, make no attempt (even encourage in sublimation activities) the abstract madness; as long as behavior is socially acceptable. It is only when abstract systems are carried out...in flesh does society object. (*Book of Martyrdom* 322)

This concept of lunatic versus society became a foundational stone in the Anti-psychiatry Movement, which began in the late 1950s and flourished in the 1960s. Ginsberg learned the designation of madness often depended upon socially unacceptable behavior. Moreover, as a Beat writer, Ginsberg’s identity as a poet easily connected to that of a madman because of the long tradition of mad poets, which began as early as ancient Greece with the myth of Dionysus. According to Rashkin, within *Howl*, Ginsberg leans into the persona of mad poet, which “enabled him to fuse his own persona as a madman with his mother’s madness [and Carl Solomon’s], and it infused his poetry with a powerful myth”—that of the lunatic versus society (92). In 1956, “Part II” of *Howl* presented a fuming condemnation of American society and its culpability in the destruction of great minds. Furthermore, as Ginsberg experienced the ineffectiveness of the hospital’s doctors and their treatments, his disdain for psychiatry grew stronger. In a letter to Jack Kerouac, Ginsberg describes the doctors with a variety of negative connotations; he calls them “liberal minded social experimenters,” “fiends,” “absolute Ghouls of Mediocrity,” “seer sucker liberals,” “the bloodless apoetic bourgeoisie,” “squares and ignoramuses” (*Letters* 51-54). During his involuntary commitment, Allen likened the asylum to an Orwellian and Kafkaesque “penal colony in which sadists wore white coats” (Rashkin 93). Ginsberg explains to Kerouac: “You can see what a weird sinister atmosphere here it is, Kafkaian,

because the doctors are in control and have the means to persuade over the most recalcitrant” through punitive treatments disguised as mental healthcare (*Letters* 53). The psychiatrists at the hospital determined Ginsberg was not hopelessly insane, but an average neurotic whose behavior was unusual and disturbing (Schumacher 118). Much in line with the concept of psychiatrists as “the bloodless apoetic bourgeoisie” who enforce socially acceptable modes of behavior and thinking, “the doctors felt that [Allen] had to learn to conform to society’s standards if he ever expected to function normally in it. In essence, that meant finding a job, forsaking homosexuality in favor of a steady relationship with a woman, and following society’s rules” (Schumacher 118). As in Zelda’s and Naomi’s experiences, psychiatrists urged Ginsberg to conform to societal norms and gender roles. Despite his reservations, Ginsberg tried to follow the doctors’ advice to be a “good” patient; he wrote to Kerouac before his release from the hospital: “A turning point has been reached in that I am not going to have any more homosexual affairs” (*Letters* 56). Allen wanted to be cured, but upon leaving New York State Psychiatric Institute, he still felt depressed and psychologically distressed. Furthermore, by repressing his homosexuality, Ginsberg felt more troubled and less authentic. He tried to deny this part of himself, hoping it would heal him, but he would not feel psychologically content until he stopped trying to conform to a social identity that was completely incompatible with his ego identity—his truest sense of self.

After his release from the psychiatric hospital, Allen Ginsberg moved back to Paterson, New Jersey to live with his father. For the next three years, he attempted to live a socially accepted lifestyle—practicing heterosexual dating and working a middle-class job as a book reviewer and market research consultant (Merrill “Chronology”). However, by 1953, Ginsberg found his life in Paterson stifling, so he began travelling across the United States. During his roaming, Allen reinvented his identity; as became a theme within his numerous world travels,

Ginsberg incorporated what he learned into his ego identity as he searched to evolve his consciousness. Ultimately, Ginsberg desired to expand his consciousness to a reality beyond Western culture's worship of reason. When he arrived in San Francisco in 1954, Allen experimented with hallucinogenic drugs in a serious manner; he was on a quest for an authentic inner reality, separated from the tyrant Reason (Raskin 130). Though he tried drugs in college, in 1954, Ginsberg's obsession to expand his consciousness through drug experimentation began. Merrill accentuates the nuances of the Beat generation's exploration for inner truths through altered states of consciousness:

The incessant search for reality within (through drugs, meditation, and intense feeling) was a quest for authenticity that reason...deadened. It called for reconnaissance at the extremes of human experience, as far beyond the limits of reason as possible, thus placing uncommon stress upon subjective moods....Unlike the rationalist they would not attempt to overcome their fears, guilt, dread, and cares; rather, they exploited these feelings in order to reach new levels of truth about themselves. Moods, they passionately believed, were indices to reality. (2)

Rejecting the prescribed social identity recommended by his doctors and father, Ginsberg searched for a way to validate his ego identity and his impassioned experiences with alternative realities. To reach the farthest limits of reality and human nature, Allen pursued mind-altering drugs, searching for different types of hallucinogens in the United States, South America, and Asia. As recorded throughout *Dharma Lion*, Schumacher highlights that Ginsberg visited medicine men in South America, participated in official LSD and psilocybin experiments with researchers from Harvard and Stanford, and sought guidance from holy men in India. If one's identity is a work of art, as Foucault theorizes, then Allen Ginsberg worked obsessively to create

a rigorously honest ego identity by pushing himself to the limits of reality, rejecting psychiatry, and searching for alternative methods of healing and self-awareness in order to live an authentic life that aligned with his self-concept.

4.3.4 *A Howl Heard Across the World*

In April 1955, Ginsberg received upsetting news, but it inspired him to write *Howl*—the autobiographical poem that rocketed him to fame, controversy, and critical acclaim. In a letter from his brother Eugene, Allen learned Carl Solomon had been committed to Pilgrim State Hospital, where Naomi Ginsberg also was (Schumacher 196). Struggling with writer’s block and bouts of depression, Ginsberg had begun psychotherapy with Dr. Philip Hicks in October of 1954 (Rashkin 153). Learning Solomon also was suffering from mental turmoil, Ginsberg felt a spiritual connection to him and an impetus to write. Fortunately, Dr. Hicks offered solid support when Ginsberg heard about Solomon’s commitment. Both the therapy with Dr. Hicks and his immense concern for Carl Solomon served as catalysts to the creation of *Howl*.

For Ginsberg, Dr. Hicks became the first psychiatrist whom he trusted completely. According to Rashkin, Hicks was “a therapist who loved poetry, especially Blake’s poetry, and who had a sense of humor” (153). Thus with Dr. Hicks, Allen finally found a sympathetic psychiatrist who did not want to change Ginsberg’s identity. In fact, Hicks liked Ginsberg and his poetry; moreover, he “refused to take a traditional Freudian approach and scold Allen for his homosexuality as the doctors at the New York State Psychiatric Institute had done in 1949” (Rashkin 154). He did not recommend heterosexuality for Allen as a cure or even an imperative. Rashkin explains, Dr. Hicks “also helped Ginsberg come to terms with the trauma of his childhood and to alleviate his fear of going mad—like his mother, Naomi, and like Carl Solomon” (154). In fact, he confirmed Allen was not insane. Rashkin explains how Dr. Hicks

served as a pivotal person in Ginsberg's life because he helped liberate Allen from his self-doubt: "Dr. Hicks gave his patient the permission he seems to have needed to feel proud of himself as a poet, and to explore, without shame, his own homosexuality" (154). By the end of their time together, Hicks reported that Allen had gained "greater acceptance of himself and began writing more profusely and being able to perform with less anxiety" (qtd. in Rashkin 153). By creating an atmosphere of acceptance and empathy, Dr. Hicks gave Ginsberg the support and encouragement he needed to fully embrace his ego identity without fear, shame, or guilt. By assuring Allen that he was not "crazy," Dr. Hicks helped him gain confidence and lose his fear of descending into an all-consuming madness like his mother and Solomon. This assurance eased Ginsberg's writer's block, and in early August 1955, finally feeling uninhibited, Allen sat down at his desk, and in one lengthy session, he wrote the first and longest section of *Howl* (Schumacher 200). The support of a sympathetic doctor, who assured Allen that he was not insane, aided greatly in Allen's healing; moreover, Dr. Hicks encouraged Allen's confidence in his ego-identity and life's purpose, which helped him silence his doubts and reaffirm his ego identity as a prophetic poet.

An analysis of the poem *Howl* portrays Ginsberg's observations of, experiences with, and theories about madness, and it highlights his protest of the stigma of mental illness. Ginsberg divides *Howl* into four parts, which capture a multifaceted view of madness in mid-20th century America. Ginsberg illustrates in graphic detail his generation's reaction to the chaos of the historical milieu, which encompasses cultural traumas from the aftermath of WWI and WWII, widespread drug abuse and alcoholism, and consequences of capitalistic greed. "Part I" presents a broad overview of the varieties of madness in America during this time from the perspective of a traveling Beatnik. Ginsberg focuses on the derelict and grotesque outcasts. He explores the

socially lowest depths of degeneracy through images of Americans acting in rebellion, protesting through madness, and drugging the chaotic world from their consciousnesses. “Part II” serves as an angry satirical protest of America’s government, excessive materialism, and military-industrial complex. He compares these corrupted American values to the pagan ritual of Moloch, which involves the sacrifice of children to the demon-god Moloch for the tribe’s prosperity and/or victory in war. This part of the poem strongly blames American society for the formation of his generation’s madness. In “Part III,” Ginsberg creates a dedication to Carl Solomon and his torturous experience in psychiatric hospitals. Symbolically, the figure of Solomon represents archetype of the individual American mental patient; Ginsberg creates this character by combining his own experiences with those of his mother and Solomon. His forlorn tone in this section emphasizes the pain of watching a loved one experience psychiatric treatment in the mid-20th century. Finally, the fourth part entitled “Footnote to Howl,” offers a completely different perspective in which “the madman is holy” (line 116). In this footnote, Ginsberg travels, ideologically, to a time in the past when “madmen” were spiritually sacred, when they were neither outcast nor imprisoned but revered as shamans, prophets, and wisemen, when those with sensitive minds were seen as touched by the Divine. This strategy fights the stigma of mental illness as a moral weakness and spiritual punishment; instead, Ginsberg presents mental disorder as a closer connection to the Divine and Eternity.

Within *Howl*, Ginsberg illustrates how madness stems from multiple factors. To best understand a psychoanalytical reading of *Howl*, an analysis using the theories of both Sigmund Freud and Michel Foucault offers an understanding of the internal and external forces involved in the creation of madness and how these function within the text. While Sigmund Freud focuses on the internal psychological conflicts that contribute to madness, Michel Foucault discredits

madness as nothing more than a social construct. Ginsberg certainly was aware of Freudian theories because they permeated through popular culture by this point in American history. In addition, Michel Foucault's anti-psychiatric theories in France, like those of R.D. Laing's in Great Britain, and Thomas Szasz's in America, burgeoned during Ginsberg's lifetime. These leaders of the Anti-psychiatry Movement were part of Ginsberg's generation. The chance of Ginsberg hearing similar ideas to Foucault's is highly likely because a continuous connection and quick exchange of ideas between America and Europe existed during the 20th century as many publishing houses in Europe printed copies of American manuscripts and vice versa.

To explore a Freudian view of *Howl*, one must recall Sigmund Freud believed madness stems from internal conflicts within a person's psyche, specifically concerning battles in the Unconscious between the instinctual drives of the id, the compromising function of the ego, and the imposing moralization of the superego. Freud theorizes symptoms of madness are verbal, behavioral, and/or physical manifestations of unresolved psychical ambivalences within the Unconscious. Thus, a reading of *Howl* through a Freudian lens must interpret the free association of ideas from the narrative to analyze the essential disturbances within the Unconscious that cause the symptoms and development of a particular mental disorder. The most relevant theories from Freud for the interpretation of *Howl* are about the death-drive and the sexual function beyond the pleasure principle.

Significantly, the death-drive and the sexual function operate toward opposing goals within the Unconscious. Freud explains this dichotomic relationship between the death-drive and the erotic drive in his 1932 letter to Albert Einstein entitled "Why War?" as presented in *On Murder, Mourning, and Melancholia* (2005): "This drive works within every living creature, and then endeavors to bring it to destruction, and to bring life back to a state of inanimate

material...it merited the name of a death-drive, while the erotic drives represent drives to life. The death-drive becomes the drive to destruction” (228). Within *Howl*, Ginsberg illustrates these two opposing instinctual drives in explicit details throughout “Part I.” Beginning immediately in the first line, he creates his overarching theme: “I saw the best minds of my generation destroyed by madness, starving hysterical naked” (Ginsberg, *Howl* 1). Markedly, destruction is linked directly to madness, and the examples within the poem of the death-drive are plentiful. These best minds are “burning for the ancient heavenly connection to the starry dynamo” and, thereby, desiring to return to a state of undifferentiated wholeness within the infinite, inanimate, oceanic nothingness before birth, which from a Freudian lens, as theorized in *Beyond the Pleasure Principle* (1920), suggests the “first instinct”—“the instinct to return to the inanimate state” (Ginsberg, *Howl* 3; Freud 46). The illustration of this death-drive continues throughout “Part I” as Ginsberg portrays “a lost battalion of platonic conversationalists jumping down the stoops off fire escapes off windowsills off Empire State...who vanished into nowhere Zen” (*Howl* 17; 20). This idea of “nowhere Zen” alludes not only to Ginsberg’s blossoming interest in Zen Buddhism (introduced to him by Jack Kerouac and encouraged by holy men he later met in India) but also to Freud’s explanation in *Beyond the Pleasure Principle* of the “Nirvana principle”; Freud explains that the Nirvana principle shows “the dominating tendency of mental life, and perhaps nervous life in general, is the effort to reduce, to keep constant or to remove internal tension due to stimuli...a tendency which finds expression in the pleasure principle”; additionally, this Nirvana principle lays the foundation for the belief in the existence of the death-drive (67). Ginsberg juxtaposes images of the drive to destruction with images of erotic drives, or drives to life; however, the portraits of the erotic drives in *Howl* betray the sexual function because the sexual acts included are not for the purpose of procreation. This not only subtly announces

Ginsberg's homosexuality but also challenges social mandates that scorn nonreproductive sex and value heterosexuality only. In some of the most shocking lines within the poem, and certainly the ones which served as evidence for the prosecution in the *Howl* obscenity trial, Ginsberg describes the members of his generation as those:

who howled on their knees in the subway and were dragged off the roof waving their
genitals and manuscripts, / who let themselves be fucked in the ass by saintly
motorcyclists, and screamed with joy, / who blew and were blown by the human
seraphim, the sailors, caresses of Atlantic and Caribbean love, / who balled in the
morning in the evenings in rosegardens and the grass of public parks and cemeteries
scattering their semen freely to whomever come who may, /...who copulated ecstatic and
insatiate...with a vision of the ultimate cunt and come eluding the last gyzym of
consciousness. (36-41)

Firstly, based on his work *Inhibitions, Symptoms, and Anxiety* (1926), Freud would have interpreted these as examples of how “the sexual function is liable to a great number of disturbances” (13). Moreover, a Freudian reading of the “vision of the ultimate cunt” connects this image to “a phantasy of returning into his mother’s womb,” which symbolizes the fear of castration and the death-drive (Freud 65). Certainly, Ginsberg feared his mother’s sexuality. On one occasion when Allen was a young man and Naomi was delusional, she tried to sexually seduce him while naked (Schumacher 89). This incident had lasting effects on Allen though he scarcely discussed the psychic consequences of this event. Freud likely would have associated Ginsberg’s homosexuality with this sexual disturbance from his adolescence. In other words, Naomi’s invitation to return to her metaphorical womb through sexual intercourse effectively castrated Ginsberg’s ability to feel sexually aroused by women. Secondly, corresponding to the

dynamic, conflicting relationship between the death-drive and the erotic drives, after nine lines of graphic descriptions of sexual exploits, Ginsberg switches back to a focus on death and the drive to destruction by highlighting those “who created great suicidal dramas on the apartment cliff-banks of the Hudson...who cut their wrists three times successively unsuccessfully...who jumped off the Brooklyn Bridge this actually happened and walked away unknown and forgotten into the ghostly daze” (46; 54; 57). Interestingly, these situations present failed suicide attempts much like the homosexual acts present failed reproduction; this illustrates how the drive to death and the drive to life struggle against each other with equal strength within the human experience.

In stark contrast to Freud’s theory that internal forces within the psyche contribute to the development of madness, Michel Foucault orients the concept of madness entirely within the social constructs of the historical cultural milieu. External forces create the designation of madness based on social demands for conformity, and if an individual does not submit to his assigned social role, then he is labelled insane and often removed from the community. In his early theoretical work *Mental Illness and Psychology* (1954), Foucault explains: “For a long time now, one fact has become the commonplace of sociology and mental pathology: mental illness has its reality and its value qua illness only within a culture that recognizes it as such” (60). Therefore, each specific culture assigns “the possibilities that form the anthropological constellation of man,” and when a person acts in violation of these socially acceptable possibilities, “each culture is seen as producing an image of mental illness whose lines are drawn by the whole set of anthropological possibilities that it ignores or represses” (Foucault, *Mental Illness* 61). In addition, the historical cultural milieu influences the definitions of mental illness. For example, as illuminated in *Madness and Civilization: A History of Insanity in the Age of Reason* (1961), until the mid-17th century, Western culture considered madness a natural aspect

of human existence: “generally speaking, madness was allowed free reign; it circulated throughout society, it formed part of the background and language of everyday life, it was for everyone an everyday experience that one sought neither to exalt nor to control” (Foucault 67). However, with the rise of the Age of Reason, suddenly madness became “the world of exclusion,” specifically madness became the exclusion of reason (Foucault, *Madness and Civilization* 67). This dualistic concept of madness continued throughout the 20th century, placing mental illness outside the acceptable constellation of rational man. From this place of social exclusion, Foucault claims “madness forged a relationship with moral and social guilt” (*Madness and Civilization* 69). From the 18th century through the 20th century, madness held “at the center of itself a primitive nucleus of guilt and aggression” (Foucault, *Madness and Civilization* 69). Foucault strengthens this theory by criticizing psychology’s claim of discovering the “true nature of madness,” for any contemporary theory of mental illness is “simply the sedimentation of what the history of the West had made of it for the last three hundred years. Madness is much more *historical* than is usually believed, and much *younger* too” (*Madness and Civilization* 69). In Allen Ginsberg’s poem *Howl*, numerous images and authorial accusations affirm Foucault’s theories of madness as a social construct and of madness as the representation of society’s moral guilt and aggression.

A Foucauldian reading lends itself perfectly to Ginsberg’s *Howl* because each of the four parts relates to different aspects of Foucault’s understanding of madness. This close relation in ideas is understandable because these two authors were alive at the same time in Western history; thus, their ideas often align due to the “sedimentation” of historic knowledge within their shared Western culture. The first part of the poem, which appeals best to a Freudian reading, is only the beginning for a Foucauldian analysis. In “Part I” of *Howl*, Ginsberg focuses on the

degenerates, those placed in a “world of exclusion” outside the socially acceptable norms. Ginsberg presents portraits of those in “poverty and tatters,” of those who “drank turpentine” or “purgatoried their torsos night after night...with drugs...alcohol and cock and endless balls,” of those high on “Peyote...wine drunkenness...on benzedrine...stale beer,” and of those “suffering Eastern sweats and Tangerine bone-grindings and migraines of China under junk-withdrawal” (2; 10; 13-15; 21). Ginsberg’s degenerates wander aimlessly by boxcar trains, by highway, by ship, or by foot; they “sat in boxes breathing in the darkness under a bridge”; they “crashed through their minds in jail...demanded sanity trials...and subsequently presented themselves on the granite steps of the madhouse” (49; 63; 65-66). These images of madness as degeneracy align with Foucault’s description of the 20th-century’s concept of mental illness in *Madness and Civilization*: at the beginning of the 20th century, “madness belonged to social failure, which appeared without distinction as its cause, model, and limit. Half a century later, mental disease would become degeneracy. Henceforth, the essential madness, and the really dangerous one, was that which rose from the lower depths of society” (259-260). In “Part I” of *Howl*, Ginsberg focuses on madness as degeneracy by representing those within the lowest strata of society—the junkies, the suicidal intellectuals, the criminals, the homosexuals, the outcasts, and the nomads—but he does not allow American society to go unaccused.

In “Part II” of *Howl*, Ginsberg condemns American capitalism and the materialistic greed it inspires as the primary social failure which caused the degenerating madness of the 20th century because it led to political corruption and an industrialized military. The symbol of Moloch represents American capitalistic bloodthirst for material gain and alludes to the living sacrifices of American citizens for the success of the American economy —through foreign wars and insatiable labor demands for industrial progress. Moloch as a mythological figure can be

seen as either demonic or godlike; similarly, capitalism as a social institution can be considered as either evil or beneficial. Ginsberg, however, creates strikingly negative connotations for both Moloch and capitalism. As he repeats the name Moloch 39 times in 14 lines, Ginsberg leaves no question about his anger toward American authoritarian institutions. In *Howl*, Moloch becomes “Solitude! Filth! Ugliness! Ashcans and unobtainable dollars! Children screaming...Boys sobbing in armies! Old men weeping”; it is a “loveless” “nightmare” and “the heavy judger of men” (Ginsberg, *Howl* 80-81). Moloch embodies “the incomprehensible prison,” “the soulless jailhouse and Congress of sorrows,” “the stunned governments,” and “Robot apartments! invisible suburbs! skeleton treasuries! blind capitals! demonic industries! spectral nations! invincible madhouses! granite cocks! monstrous bombs!” (Ginsberg 80-82; 88). In this part of the poem, Ginsberg directly blames America’s culture and societal structure for the mental, physical, and spiritual ills of the masses. This indictment applies Foucault’s belief that works of art about madness must show the world its own guilt, as he explains in *Madness and Civilization*:

Through madness, a work that seems to drown in the world, to reveal there its non-sense, and to transfigure itself with the features of pathology alone, actually engages within itself the world’s time, masters it, and leads it; by the madness which interrupts it, a work of art opens a void, a moment of silence, a question without answer, provokes a breach without reconciliation where the world is forced to question itself. What is necessarily a profanation in the work of art returns to that point, and, in the time of that work swamped in madness, the world is made aware of its guilt. Henceforth, and through the mediation of madness, it is the world that becomes culpable...in relation to the work of art; it is now arraigned by the work of art, obliged to order itself by its language, compelled by it to a

task of recognition, of reparation, to the task of restoring reason *from* that unreason and *to* that unreason. (288)

This definition of a work that “drowns in the world” to reveal the world’s non-sense, of a work that charges the world as guilty in the division between reason and madness, applies perfectly to *Howl*. Because *Howl* blaringly forced American society to examine its own culpability for the agony, chaos, and disillusionment spreading across the country, this poem became increasingly controversial, leading to illegal seizures of it by the San Francisco Collector of Customs, arrests of the publishers, and an obscenity trial in 1957.

After showing America her guilt in “Part II” for the chaos illustrated in “Part I,” Ginsberg’s focus takes another dynamic shift in “Part III.” Narrowing from his macroscopic perspective of madness in American society, Allen illuminates the individual’s experience of madness. By combining biographical material about Solomon, Naomi, and himself, Ginsberg creates a metaphorical bridge that connects him to others suffering in psychiatric institutions. Dramatically changing his tone from “Part I” and “Part II,” Ginsberg loses his fury and replaces it with sorrow, empathy, and fear when he focuses on the confinement of his beloved friend Carl Solomon. Ginsberg’s disdain for psychiatry and fear of confinement stems from his personal experience at New York State Psychiatric Hospital and from his observations of the treatments Naomi Ginsberg and Carl Solomon received while confined in various mental institutions. Schumacher highlights why Solomon served as a muse to Ginsberg:

Carl Solomon...was at the center of the poem, not only in terms of Allen’s frequent recitation of the events of Solomon’s life but also in terms of inspiration. Allen had been troubled for weeks by the news of Solomon’s admittance to Pilgrim State Hospital, and Ginsberg’s concern for his friend, along with his strong feelings of guilt over his signing

the legal documents granting permission for his mother's lobotomy, catalyzed his compassion and sympathy for the lives mythologized in *Howl*. (202)

After the initial dedication to Carl Solomon, every line of "Part III" begins with "I'm with you in Rockland," which refers to the psychiatric hospital in Rockland County, NY. Although Solomon never received treatment at Rockland, Ginsberg uses "Rockland" because this name creates a stronger negative connotation than Pilgrim State does ("Author's Annotations," *Howl* 130). The image of a rocky land implies a harsh, barren, and inhospitable environment; thus, the asylum becomes a Rockland because it offers no sanctuary, only hardship. In this reimagined Rockland, Ginsberg presents terrifying images of psychiatric treatment imbued with allusions to his own traumatic experiences with psychiatry and his fear of confinement: Rockland is "where you imitate the shade of my mother," where "you scream in a straightjacket," "where fifty more shocks will never return your soul to its body again," "where you accuse your doctors of insanity," "where there are twentyfive thousand mad comrades all together," and "where we wake up electrified out of a coma" (96; 104; 106-107; 109; 111). Ginsberg's disdain for the field of psychiatry echoes Foucault's (the heralded leader of the Anti-psychiatry Movement) when he denies that "truth" can be gained through psychiatry because madness is inherent in human nature, not something that must be cured but something that is innate in the human experience. In *Madness and Civilization*, Foucault declares, "the madness of desire, insane murders, the most unreasonable passions—all are wisdom and reason, since they are a part of the order of nature"; this reinforces his stance that "madness is ultimately nothing" because it is an aspect of human nature (282; 107). Ginsberg uses this concept within the "Footnote to Howl," except he transforms "madness as nothing" to "madness as everything."

In “Part IV” entitled “Footnote to Howl,” Ginsberg re-envisioning a past when madness was holy (Foucault locates this historical time before the Middle Ages) while simultaneously creating the present as a time for holy madness to be reborn. After beginning the “Footnote” with the repetition of “Holy!” 15 times, Ginsberg begins listing everything that is holy, including “the world,” “the soul,” “the skin,” “the nose,” all the way to the “asshole” (113-114). Eventually, he announces, “Everything is holy! everybody’s holy! everywhere is holy!” (Ginsberg, *Howl* 115). Allen names his friends with mental disorders—Peter Orlovsky, Carl Solomon, Lucien Carr, Jack Kerouac, Herbert Huncke, Bill Burroughs, Neal Cassidy—and crowns them all as holy. In this part of *Howl*, Ginsberg transforms the madness of his generation as seen in “Part I” to the holiness of Eternity: “The madman is holy as you my soul are holy! / Holy my mother in the insane asylum!... / Holy the crazy shepherds of rebellion!... / Holy the supernatural extra brilliant intelligent kindness of the soul!” (116; 119; 122; 127). Within these lines, Ginsberg creates a clear depiction of madness as the closest connection to a supernatural, divine intelligence, not one to be denied and excluded but one to be exalted. Madness can be both everything, as Ginsberg imagines, and nothing, as Foucault argues, because it is natural within the human experience; therefore, the dichotomy of “sane versus insane” is ultimately meaningless.

Although in his youth he believed the medical model of mental illness, Allen Ginsberg’s view of madness changed after his numerous experiences; by the time he wrote *Howl*, he valued the anti-psychiatric model. According to Cockerham, the anti-psychiatric model “rejects the notion that mental disorder qualifies as illness” (89). The foundation of this model argues that what qualifies as mental illness is socially established subjectively based on historical cultural milieus. In his pivotal theoretical text, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (1974), Thomas Szasz, M.D., an American leader in the Anti-psychiatry

Movement, claims “the phenomenology of so-called mental illness” relies upon “manifestations [which] depend upon and vary with the educational, economic, religious, social, and political character of the individual and the society in which it occurs” (49). Ginsberg supports this concept in *Howl*; the poem becomes political because it shows America her liability in the destruction of its brightest minds. Ginsberg’s perspective on mental illness did not stray from the beliefs presented in *Howl*; he continued to craft *Howl* for the rest of his life, adding extensive footnotes and end notes for his readers.

Unsurprisingly, *Howl* became controversial almost immediately following its publication in 1956. In the introduction, “‘Howl’ at the Frontiers,” of the historical overview *Howl on Trial: The Battle for Free Expression* (2006), edited by American scholars Bill Morgan and Nancy J. Peters, Lawrence Ferlinghetti (the publisher of *Howl*) opines, the poem became a legal matter not for its obscene language but for the accusations it hurled at American society: “The ‘Howl’ that was heard around the world wasn’t seized in San Francisco in 1956 just because it was judged obscene by cops, but because it attacked the bare roots of our dominant culture, the very Moloch heart of our consumer society” (xi). Moreover, *Howl* became the epitome of the Beat’s New Vision and their call to action. Ferlinghetti explains:

“Howl” became a catalyst in a paradigm shift in American poetry and consciousness. The Beats were advance word slingers prefiguring the counterculture of the 1960s, forecasting its main obsessions and ecstasies of liberation, essentially a “youth revolt” against all that our postwar society was doing to us. (xii)

Ferlinghetti recognized the potential *Howl* had to shock American audiences and disrupt traditional standards for art, so before its official publication, he asked the American Civil Liberties Union (ACLU) in San Francisco if they would legally defend Ferlinghetti and Ginsberg

if the poem's content proved problematic (Ferlinghetti xiii). The ACLU agreed to defend *Howl*, and their support could not have been more effective. Bill Morgan and Nancy J. Peters note: on November 1, 1956, the first printing of 1,000 copies of *Howl and Other Poems* was published in London (2). The second printing shipped to the United States via San Francisco on March 25, 1957, but the "San Francisco Collector of Customs Chester MacPhee [seized] 520 copies...on the grounds that the writing is obscene"; MacPhee publicly commented, "You wouldn't want your children to come across it" (2). Unbeknownst to MacPhee, 1,000 copies secretly passed through Customs undetected, and they spread across the city, the country, and eventually the world. Ferlinghetti remembers, "When City Lights published *Howl and Other Poems* in 1956, the holy unholy voice of the title poem reverberated around the world among poets and intellectuals, in countries free and enslaved, from New York to Amsterdam to Paris to Prague to Belgrade to Calcutta and Kyoto" (xii). Ginsberg conjured enthusiasm for *Howl* through live poetry readings—the first and most famous was the Six Gallery reading in October of 1955 (Morgan and Peters 1). Ginsberg continued passionate readings of *Howl* across Europe and Asia while a censorship battle boiled over in America. Luckily, the ACLU immediately began contesting the Customs Office's seizure of the text. By June 6, 1957, Captain William A. Hanrahan of the San Francisco Police Department's Juvenile Bureau arrested Ferlinghetti; the ACLU posted his bail of \$500 (Morgan and Peters 3). The obscenity trial of *Howl* began at the end of August 1957 and lasted into October (Morgan and Peters 3). Judge Clayton W. Horn presided over the trial as the prosecution argued the text was obscene both for its language and for its lewd sexual content. The defense included nine witnesses who "[testified] on the literary merits" of the poem (Morgan and Peters 3). Ferlinghetti recalls, Professor Mark Schorer of the University of California, Berkeley, defended *Howl* as "an indictment of those elements in

modern society that, in the author's view, are destructive of the best qualities in human nature and of the best minds. Those elements are, I would say, predominantly materialism, conformity, and mechanization leading toward war"; in addition, Schorer claimed, "the picture which the author is trying to give us is of modern life as a state of hell" (qtd. in Ferlinghetti xiii). The witnesses who came to the poem's defense proved far more convincing than the prosecution's, who crumbled under cross-examination.

As this was not a jury trial, Judge Horn made the final legal decision in the case. Bill Morgan and Nancy J. Peters include Judge Horn's written decision in *Howl on Trial*; Judge Horn states, "I do not believe that *Howl* is without redeeming social importance" (197). Horn clarifies that "the theme of 'Howl' presents 'unorthodox and controversial ideas.' Coarse and vulgar language is used in treatment and sex acts are mentioned, but unless the book is entirely lacking in 'social importance' it cannot be held obscene" (Morgan and Peters 197). Thus, despite its controversial themes and diction, Judge Horn ruled that *Howl* had social importance and, thus, was not obscene. Moreover, he exposed the mutability of the concept of obscenity: "No hard and fast rule can be fixed for the determination of what is obscene, because such determination depends on the locale, the time, the mind of the community and the prevailing mores" (Morgan and Peters 197-198). Horn also confronted the prosecution's attack on Ginsberg's language as an assault on freedom of speech:

There are a number of words used in *Howl* that are presently considered coarse and vulgar in some circles of the community; in other circles such words are in everyday use. It would be unrealistic to deny these facts. The author of *Howl* has used those words because he believed that his portrayal required them as being in character. The People state that it is not necessary to use such words and that others would be more palatable to

good taste. The answer is that life is not encased in one formula whereby everyone acts the same or conforms to a particular pattern. No two persons think alike; we were all made from the same mold but in different patterns. Would there be any freedom of press or speech if one must reduce his vocabulary to vapid innocuous euphemism? An author should be real in treating his subject and be allowed to express his thoughts and ideas in his own words. (Morgan and Peters 198)

Ultimately, Judge Horn found the defendant not guilty because the text is “protected by the First and Fourteenth Amendments of the United States Constitution and the California Constitution” (Morgan and Peters 199). Lawrence Ferlinghetti points out the ironic consequences of the obscenity trial: due to the trial’s widespread media attention, *Howl and Other Poems* began selling out everywhere, so “to meet the demand created by the trial, a fourth printing of 5,000 copies” was produced in October 1957 after Judge Horn’s verdict (3). According to *National Public Radio* news report “After 50 Years, Ginsberg’s ‘Howl’ Still Resonates,” American reporter Robert Siegel notes that as of 2006, over 1,000,000 copies of *Howl* have been sold, and the poem has been translated into 24 languages. Obviously, its social importance continues to hold weight even in the 21st century because its themes about madness and the adverse effects of certain American values remain problematic in today’s American society.

Ultimately, Allen Ginsberg believed 20th-century American society, ruled by the tyrant Reason and the Moloch-like worship of capitalism, drove great intellectuals and creatives to madness because the demands for conformity denied truths gained from imagination and emotions. In effect, nonconformists became marginalized and confined to prisons or insane asylums. When viewed from the Beatniks’ perspective, the only sane reaction to the insanity of America was madness. In addition, Ginsberg saw madness not as illness but as an innate human

ability that allows for a transcendent connection to a superhuman consciousness, the Divine, and a timeless Eternity. What is most extraordinary about Allen Ginsberg is that he rejected the stigmatization of his social identity; instead, he used his experiences as an impetus to portray “madness” in a humanizing light and to advocate for the acceptance of others labelled abnormal or insane. In his poem “On Burroughs’ Work” (1954), Ginsberg urges others to be nakedly honest and true to themselves: “Don’t hide the madness” (line 6).

4.4 Comparison Conclusion

The differences between Zelda Fitzgerald’s and Allen Ginsberg’s experiences of mental illness stem from factors involving gender roles, autonomy, and self-stigmatization. Ultimately, Allen triumphed over the stigma by rejecting a social identity that conflicted with his ego identity, while Zelda fell victim to the social stigma and incorporated it into her ego identity through self-stigmatization. Ginsberg believed external factors created by an uncaring, hypocritical society contributed to madness, whereas Fitzgerald assumed her mental illness stemmed from internal factors, placing the blame for her madness primarily upon herself. This key difference occurred for numerous reasons, including the variance of historical time and the burgeoning Anti-psychiatry Movement during the mid-20th century as well as the level of self-autonomy Ginsberg’s gender role afforded him. During Zelda’s generation, Freudian theories reigned supreme; thus, the general population as well as psychiatrists situated the causes of mental disorder internally. In contrast, the Beat generation fought against this principle by placing the construction of madness in the hands of psychiatrists and Western society. Another crucial dissimilarity is the discrepancy between Ginsberg’s autonomy and Fitzgerald’s lack of it. Zelda’s fate depended upon others’ decisions for her treatments and confinements, whereas Allen had more freedom to choose his treatments or avoid confinement; the only time he

experienced “involuntary” confinement was still by choice—he could take the deal plea and enter a psychiatric hospital, or he could go to prison. Although technically she entered hospitals “voluntarily,” her husband or her family usually coerced Zelda into treatment whenever they decided her unacceptable behavior was more than they could handle. This highlights the disparities between the treatment of male patients and female patients in 20th-century America were based upon assigned gender roles and stereotypes. Under such assumptions, women were considered frailer and more codependent than men, which meant others had to be involved in the decisions made for them. For example, when Scott Fitzgerald finally decided Zelda warranted time in an asylum, he arranged her confinement, whereas although Scott certainly needed psychiatric help himself, he had the autonomy to refuse medical treatment. Because Ginsberg was a man, only law enforcement and a court trial could force him to enter an asylum. Finally, Ginsberg rejected self-stigmatization while Fitzgerald fell prey to it because their social support groups differed dramatically. Zelda’s peers stigmatized her schizophrenia, whereas Allen’s peers celebrated his madness. This disparity emphasizes the necessity of empathetic social support to fight self-stigmatization.

Nevertheless, Allen’s and Zelda’s experiences are similar in two ways. First, they took courage and wrote about their mental disorders. By sharing their mental illness life narratives, they allow for others to gain a deeper understanding of the consequences of stigma and the pain of mental disorder. Secondly, both Allen and Zelda, eventually, equated their experiences of mental disorder with religious awakenings. Zelda believed God sent her revelations near the end of her life, and this idea brought her peace. Allen coupled his experience of madness to the Divine upon his first visions, and he used this connection to spark higher levels of consciousness. Ultimately, both Zelda and Allen wanted their lives and suffering to have meaning beyond

themselves. By writing honestly about their struggles with mental illness, they allow for empathy to grow. Through their life narratives, they present their subjective understanding of mental disorder, and they fight the stigma by challenging the stereotypes that those with mental disorders are malingering, weak, unintelligent, morally corrupt, dangerous, and inherently “other.”

5 A CALL TO ACTION, A CALL FOR EMPATHY: COMMON RHETORICAL GOALS OF MENTAL ILLNESS LIFE WRITERS

As lightning cracks in the distance, you smell the impending rain on the wind. The boat rocks over the throws of salty-water swells that smash against the starboard and shower down in great bursts onto those still on deck, though most of the passengers now hide in the dry cabins below. Suddenly, a surge heaves the vessel to the port side, and a stranger topples overboard into the dark, churning waters. Those left standing rush to search for the man in the waves.

“There!” a woman yells, pointing to the white caps several yards away. You see his hands punch at the surface as he fights for air, but the swells continue to push him back down.

“He needs help!” a man shouts. The passengers on deck look to each other, deciding who will aid this dying man. You spy a lifesaver nestled in a pile of rope nearby. Now is the time to decide: will you throw the buoy into the sea to save his life? Will you lend him your strength to pull him back to safety? Now, imagine this buoy is metaphorical; in reality, it is a kind word of support or time spent listening to his life story. What if that stormy body of water was actually the riptide of mental disorder? Would you help? If you could save a life by letting someone know that she is not alone, that there are people who care and can help, would you do it? Or would hearing a label like schizophrenia cause you to keep your distance?

5.1 Consequences of Stigma

Unfortunately, many people actively avoid those suffering from mental disorders because of the dominant stereotypes of mental illness. As if the agony of mental disorder is not excruciating enough, the social consequences of revealing one’s diagnosis create steep obstacles. As Otto F. Wahl affirms in *Media Madness: Public Images of Mental Illness* (1997), “Stigma is burdensome. Added to the weight of already painful, and sometimes overwhelming, psychiatric

disorders is the hurt of other people's disdain, dislike, and avoidance" (99). The gravity of this stigma often discourages people from seeking treatment, which diminishes the probability of their successful recoveries. Furthermore, even if a person seeks mental healthcare and recovers through a treatment plan and outpatient care, the stigma still encourages him to hide a history of psychiatric treatment. Ultimately, remaining silent becomes a social imperative.

Initially, I did not understand the magnitude of this social stigma when I first entered a psychiatric hospital for treatment. I was naïve, to put it mildly. Consequently, upon my release, I immediately crashed against the stigma like a football player running through a homecoming banner made of cinderblocks. When I returned to my community after the hospital, I learned my boyfriend had a new girlfriend because he did not want to date someone like me. I discovered I had lost my nanny job because the parents did not want a bipolar person around their children, and my roommate moved out because he now feared living with me. Have you ever had to start your life over again? New friends, new job, new home? I have, more than once, because of this stigma. I never hurt anyone else. I was not violent. I did not damage property. Yet I still lost so much because of a hospitalization and a subsequent diagnosis. Can you imagine this happening to someone who went to the hospital for heart disease? What about for someone diagnosed with kidney failure or diabetes or cancer? Wahl explains the social rejection that ex-mental patients frequently encounter "is based not on any real knowledge of the individual's specific disorder or psychiatric symptoms, but simply on the knowledge that the person had an unspecified 'mental illness' or even that he or she had been to see a mental health professional about an unspecified problem" (98). In my experience, this ostracism materialized seemingly overnight. Before I entered the hospital in the summer of 2010, I had an abundance of friends and often participated in social events. During that summer, although I did not understand it then,

I began experiencing symptoms of hypomania—increased energy, excessive generosity, amplified self-confidence, and impulsivity. My grandiose thinking and exuberant emotions made me feel like anything was possible. All these attributes drew new friends to me, and when I left the hospital, I still expected them to accept me. Now, I cannot say I was abandoned by everyone because I have more than a handful of unconditionally loving, supportive friends and family members, but many people, whom I mistook for friends, no longer wanted to see me. I was still the same person, but my social identity changed dynamically through stigmatization. Sadly, my experience is not unique. Most likely, everyone diagnosed with a mental disorder has dealt with the consequences of stigma in one way or another.

Furthermore, these prejudicial obstacles in the community have detrimental effects that extend to the emotional, social, and financial spheres of a person's life, and often, they emerge the moment a person reveals she has a mental disorder, especially if it is a misunderstood diagnosis like schizophrenia, bipolar disorder, or dissociative identity disorder. According to Wahl, the common social obstacles that ex-mental patients face have injurious results, such as social exclusion, rehospitalization, and homelessness:

Once people do leave psychiatric hospitals—people whose need for support and acceptance may be particularly acute—they are likely to be met instead with suspicion and fear. Moreover, when they encounter those who believe that people with mental illnesses are as dangerous as media presentations suggest, any behavior, however objectively harmless, that clearly suggests a mental illness (for example, hearing voices) will likely frighten others, who may then seek the ex-patient's rehospitalization in order to protect themselves and their communities. The end result is that large numbers of people with serious mental illnesses either remain unnecessarily in isolated hospital

environments or add to our growing homeless population because there are too few communities or too few affordable residences in which they are allowed to live. (95)

The stigma makes finding employment and affordable housing extremely difficult once patients leave a psychiatric hospital. Can you imagine a patient leaving dialysis being ostracized and shamed? How dare he have kidney failure! No, of course not. But what about a person struggling with depression? How many times have you heard someone say, “Everyone’s got problems. Everyone gets sad. She should just get over it”? This disparagement remains commonplace because dominant cultural narratives stereotype mental illnesses as less authentic and devastating than physical illnesses. In her memoir *Girl, Interrupted* (1993), Jewish American author Susanna Kaysen illustrates her experience of public shaming in the 1960s when she recalls the challenges of reentering the community after her confinement at McLean Hospital in Belmont, Massachusetts:

The hospital had an address, 115 Mill Street. This was to provide some cover if one of us were well enough to apply for a job while incarcerated. It gave us about as much protection as 1600 Pennsylvania Avenue would have...In Massachusetts, 115 Mill Street is a famous address. Applying for a job, leasing an apartment, getting a driver’s license: all problematic. The driver’s-license application even asked, Have you ever been hospitalized for mental illness? (123)

For Kaysen to successfully function in life outside the hospital, she must complete applications for a driver’s license, employment, and housing. However, in Massachusetts, her current address at McLean Hospital is as famous as the White House’s at 1600 Pennsylvania Avenue. Nevertheless, Kaysen must use the hospital’s address to secure a job because it is the only permanent address she has. When she applies to “a sewing-notions shop in Harvard Square,” the

prospective employer asks how long she has lived at 115 Mill Street with a dark grin on his face (Kaysen 123). Embarrassed, Kaysen replies, “oh, a while” (123). The consequences of stigma stare Kaysen in the eyes as the man smirks back at her, ““And I guess you haven’t been working for a while?’ He leaned back, enjoying himself” (123). Kaysen does not get the job, but as she leaves the shop, the most haunting part of this encounter occurs: “My glance met his, and he gave me a look of such terrible intimacy that I cringed. I know what you are, said his look” (124). Although this man has only just met Kaysen, his expression implies he believes all the stereotypes about mental patients—that they are inherently bad, weak, lazy, and broken—because this is what the stigma teaches. Regrettably, Kaysen’s experience is not exceptional. Such loss of employment opportunities, even if one is qualified, occurs often for people living with mental disorders, whether others ever see their symptoms or not. Wahl further highlights, “The general public sees those with mental illnesses as so undesirable as to warrant avoidance and exclusion” (98). Within his meta-analysis, Wahl showcases one study in which “less than half of the participants indicated that they would be willing to work with an individual identified as having a mental illness” (98). This data illustrates the obstacles to employment ex-mental patients face. More vividly, using a second study, Wahl shows, “one out of five residents of a rural community indicated that they agreed with the advice that ‘it is best not to associate with people who have been in mental hospitals’” (98). Clearly, the challenges of securing employment and housing often stem from a lack of social sympathy within local communities. Although Wahl’s data comes from the 1990s, sadly, the resonance of his findings apply to the consequences of stigma that stretch as far back as the Enlightenment in Western history and continue to occur today.

In my 21st-century experience, others have refused to work with me after learning about my stigmatized identity. Perhaps it is my stubborn optimism and unfailing hope in the potential goodness of others, but I found myself caught off guard while working with a classmate for a group research assignment in graduate school. (I have changed this classmate's name to Brittany for anonymity.) The professor of the course paired us together because we both were analyzing *Tender is the Night* through a psychoanalytic lens. I felt encouraged when Brittany and I discussed our ideas about the text and about theorists we had read. She and I were getting along well, and it seemed we would be able to learn from each other. After class, as we walked back to the parking deck, Brittany asked me why I was interested in psychology. It was a simple question, but I suppose I did not answer it in an expected way. Instead, I revealed the truth: "I'm interested in abnormal psychology because I have bipolar disorder." Upon hearing my words, she put more physical space between us, as if I might spontaneously combust at any moment. The rest of our walk was nearly silent. My next few comments fell flat because she no longer was interested in getting to know me. Brittany never sat next to me again in any class. According to Wahl, her response is a common one; he stresses that this social ostracism stems from the stigma of mental illness: "Not only is it difficult for those with mental disorders to face a world that misunderstands and devalues them, but it is isolating. Strangers and casual acquaintances keep their distance, and even friends may reduce their availability when they learn of one's psychiatric label" (99). This treatment was shocking to me because I thought I would be safe from stigma in an institution of higher learning, in a place which encourages people to be open-minded and to appreciate different ways of viewing the world. That is the real gut-punch about stigma—it is everywhere, even amongst the highest educated.

Ethically, this tendency to avoid people who suffer from mental disorders is problematic because those sufferers need compassion, understanding, and patience to recover. In her literary analysis “Memoirs: Rewriting the Social Construction of Mental Illness” (2009), American English professor and literary critic Elizabeth Young condemns the stigma as life-threatening: “Cultural assumptions and discourse about mental illness...are potentially dangerous and threaten to further mental illness rather than limit or treat it” (53). Moreover, the consequences of stigma exacerbate the psychiatric symptoms: especially when considering that suicidal ideations and suicide attempts are characteristic of many mental disorders, living in a society that is hostile towards such suffering may encourage negative self-esteem and deliberate self-harm. What remains clear is the social rejection of individuals with mental disorders causes harm not only to individuals but to American society as a whole. Without developing understanding and sympathy for each other’s diversity, working together toward a more equitable future becomes nearly impossible.

5.2 Ending the Silence and Humanizing Patients

So, what can be done to fight the stigma? As an American society, we should incorporate mental illness life narratives into popular culture—within the media, the arts, the classroom, and our communities. Mental illness life narratives are especially moving because they come from a place of subjective truth at the outside edges of human experience. From this site, the author invites the reader to an intersubjective collaboration; together, they must create meaning from an experience outside the domain of reason. According to Sidonie Smith and Julia Watson in *Reading Autobiography*, this “intersubjective exchange” between the audience and the author/narrator establishes “autobiographical truth” within life writing; instead of reading a life narrative as “a story to be proved or falsified,” the intersubjective process moves “the emphasis

of reading...from assessing and verifying knowledge to observing processes of communicative exchange and understanding” (16). This approach interprets life writing as a narrative mode that “resides outside a logical or juridical model of truth and falsehood” because this mode relies upon intersubjective meaning-making of remembered experiences, which never can be perfectly narrated considering the fallibility of memory (Smith and Watson 16). Smith and Watson explain, “narrated memory is an interpretation of a past that can never be fully recovered” because memory itself is “never isolatable fact but situated association” (22; 24). This concept applies beautifully to mental illness life narratives, whose stigmatized authors already must battle for credibility. When approached as sites for collaboration, where emotional impressions become more critical to meaning-making than veritable facts, mental illness life narratives allow authors to unite with audiences to create empathetic understandings of these experiences.

Furthermore, the mental patient’s first-person perspective is valuable precisely because it appeals to the audience’s emotions more effectively than a distanced third-person perspective, such as that of a case study. Typically, in case studies, a doctor presents an analysis of the patient’s symptoms, past traumas, and psychic conflicts to interpret, diagnose, and treat the patient. He may note specific words she says or behaviors that seemingly point to psychic disturbances. Then, in the end, the doctor will give his final interpretation of why this patient became ill followed by his official diagnosis and prescribed treatment regimen. From the doctor’s external perspective, the patient becomes an object—specifically a broken object requiring repair. Psychiatric case studies make it easy for readers to forget the patient’s humanity by presenting her as an object under a scientific gaze. Consider Sylvia Plath’s telling metaphor in *The Bell Jar*; the title of her autofictional novel emphasizes her open criticism of psychiatry’s diagnostic medical gaze and its dehumanization of mental patients. Contrastingly, mental illness

life narratives from patients' perspectives reveal subjective nuances, giving greater insight into the internal suffering involved these experiences. The patient as narrator-protagonist creates an intimate relationship with the reader/viewer; this personal dialogical exchange often uncovers relatable moments, from which empathy can grow. And, ultimately, empathy defeats this stigma.

Like other art forms, literature humanizes others' experiences through the shared emotional event which the text creates between the author and the reader. Mental illness life narratives allow audiences to gain new understandings of mental disorder, and because the pathos within these narratives encourages social empathy, this genre creates a site of resistance to protest the stigma. Wahl supports this assertion: "Books, magazine articles, and newspaper pieces that provide personal stories of mental illness are seen as particularly valuable in correcting the public image of mental illness" (152). Mental illness life narratives have the power to fight stereotypes about mental illness, which is why these stories are crucial to write, to share in the media, and to teach in the classroom. Within the study of mental disorders, students typically review case studies and psychological theories from physicians like Sigmund Freud. Case studies are valuable because they demonstrate how to apply psychological theory to the analysis of mental patients. These texts certainly aid psychiatrists and psychologists in diagnosing and treating patients. However, as American psychologist, professor, and author Gail A. Hornstein emphasizes in her psychoanalytic literary analysis "Narratives of Madness, as Told from Within" (2002): "Psychiatrists have not simply ignored patients' voices; they have gone to considerable lengths to silence them." (An example from one of Sigmund Freud's case studies illuminates this trend in the following section.) The problem of relying solely upon case studies is these texts often dehumanize and silence patients. As Hornstein further explains, Narratives written by doctors are "often stereotypical in tone" because they represent their patients as their

diagnoses; this rhetorical foregrounding “reduces with everything else in their lives...to evidence supporting [the diagnosis].” Hornstein notes the narrative climax of case studies is “the patient’s arrival at the hospital”; from there, the emplotment follows the doctor’s interpretation of the patient and her history (the diagnosis), his prescribed treatments, and the patient’s recovery.

Obviously, presenting patients in terms of their diagnoses allows the doctor-author to focus on treating the disorder and teaching other practitioners how to analyze a patient. Thus, case studies certainly have a benevolent purpose; however, because confidentiality must be maintained and the narrative focus is scientific, case studies reduce the patient to a flat character, often removing the texture that humanizes her; the patient becomes an object of the physician’s gaze, reduced to a lab specimen and a problem to be solved. Moreover, in Freud’s case studies, when a patient disagrees with his interpretation about her unconscious conflicts or the origin of these conflicts, Freud dismisses these rejections as the patient’s psychic resistances, thus setting the standard of patient silencing in psychiatric narratives and real-life treatments.

5.3 Freud’s Silencing of Dora: The Unreliable Narrator in Case Studies

Using one of Freud’s case studies to exemplify physician-written life writing illustrates how the founder of modern-day psychology compiled a model case study; his generic foundation still influences how mental health professionals compose case studies and conceptualize their patients. In the case study *Dora: An Analysis of a Case of Hysteria* (1905), Freud claims patients resist psychiatric interpretation through verbal negations; however, because this type of life writing relies upon an “as-told-to” framework, his silencing of patients’ negations creates a shadow narrative within the text. The patient’s shadow narrative, hidden beneath the doctor’s, begs to be heard, but the power dynamic of the doctor-patient relationship allows the doctor to background the patient’s protests of his diagnostic interpretation. As highlighted in the literary

analysis “Narrative Strategies and Hermeneutic Desire: Constructions of a Case Study” (2018), Freudian scholar Daniela Finzi’s states, the *Dora* case is “Sigmund Freud’s first independently published case history and his longest on a female patient”; moreover, it is one of the three “founding texts” of Freud’s psychoanalytic theory (17). This case study continues to provoke responses from readers today; as Finzi exclaims, this case “has never ceased to appeal to subsequent generations and to elicit retorts” (17). Critics have discussed many nuances within this case study, including concepts of female sexuality, complexities of adolescence, the Oedipal complex, transference and countertransference, and Freud’s abandonment of his earlier trauma theory (sometimes called seduction theory, although not by Freud himself). I will focus on Dora’s trauma-induced symptoms and her experience of silencing during psychiatric treatment. Notably, this case lasted only three months because Dora left treatment before Freud’s “appointed end” (Freud, *Dora* 9). The most compelling reason for this is Dora disagreed with Freud’s analysis and no longer believed he was helping her. Ultimately, Freud’s continuous silencing of Dora contributed to her choice to terminate their therapeutic relationship because he refused to see her as a reliable narrator to her lived experiences.

The story unfolds at the turn of the 20th century when 18-year-old Dora (a pseudonym for Ida Bauer) entered Freud’s care (Freud, *Dora* 17). Although she had displayed lesser hysterical symptoms in her childhood (mimicking those of her mother), the traumatic instigator of her adolescent psychological disturbances began when Dora was 14 years old; during this time, she encountered unwanted sexual advances from her parents’ friend Herr K. (a pseudonym for Hans Zellenka). On at least two occasions, Herr K. attempted to seduce Dora. The first sexual event occurred when Dora was 14 years old; she and Herr K. were alone together in his shop, preparing to depart for an upcoming church parade (Freud, *Dora* 24). Although flattered by his

prior attention and small gifts, when Herr K. “suddenly clasped [her] to him and pressed a kiss upon her lips,” she was horrified (Freud, *Dora* 24). During this erotic event, Freud hypothesizes, Dora “felt not merely his lips upon her lips but also the pressure of his erect member against her body” (*Dora* 26). This was the first traumatic event Dora experienced from Herr K. Two years later, while on summer vacation in the Alps with her family and the K.s, Herr K. made a second sexual advance toward Dora as they walked around a lake near the vacation property (Freud, *Dora* 22). What seems most likely is Herr K. sexually assaulted Dora during at least one, if not both, of these traumatic events. Freud explained later in the case study: “The experience with Herr K.—his making love to her and the insult to her honour...—seems to provide in Dora’s case the psychic trauma which Breuer and I declared long ago to be the indispensable prerequisite for the production of the hysterical disorder” (23). Here, Freud directly alludes to his work *Studies on Hysteria* (1895), co-authored with Josef Breuer, in which they present numerous theories on hysteria. In her critique “The Analytic Denial of Freud’s Struggle with the Understanding of Dora: Simplifying the Oedipus Complex and the Process of its Adoption” (2018), British professor and psychoanalyst Rachel B. Blass claims Freud’s allusion to *Studies on Hysteria* emphasizes “in no uncertain terms that this case history is being presented to substantiate the views of hysteria that he put forth in 1895 and 1896” (36). To validate his prior theories, Freud carefully describes his interpretation of Dora’s symptoms and their precipitating causes. According to Freud, after the unwanted sexual encounters with Herr K., Dora developed hysterical symptoms, including a nervous cough, migraines, exhaustion, eating disturbances, and melancholy (Freud, *Dora* 20). Distressed by these symptoms, Dora’s mother encouraged her daughter to confide in her, so Dora told her about what happened at the lake. After this confession, Dora’s father and uncle required Herr K. to answer for his actions; both Dora and her

father described this confrontation to Freud (Freud, *Dora* 22). Unfortunately, as often happens in such circumstances, Herr K. refuted everything and said Dora was lying: “He had denied in the most emphatic terms...He had then proceeded to throw suspicion on the girl...it was most likely, he had added, that she had been over-excited by...reading [Mantegazza’s *Physiology of Love*] and had merely ‘fancied’ the whole scene” (Freud, *Dora* 22). After Herr K.’s explanation, Dora’s father chose to believe him instead of his daughter, likely because he was having his own affair with Herr K.’s wife. Afterwards, Dora’s mental state deteriorated, and she developed a strong contempt for her father, whom she now saw as a willing participant in the horse-trade of her maidenhood as compensation for her father’s affair with Frau K. Freud recalls, “When she was feeling embittered she used to be overcome by the idea that she had been handed over to Herr K. as the price of his tolerating the relations between her father and his wife” (*Dora* 31). Dora’s case history involves the powerful men in her life—her father, Herr K., and Freud—and their manipulation and silencing of her. These are some of the major details of the events which led to Dora’s mental breakdown and the key plot points Freud reveals in his case study.

Although Freud believed Dora about Herr K.’s sexual advances, he still reduces her to a broken lab specimen, and sometimes to a criminal on trial, within the case study because his primary rhetorical purpose is to prove his psychoanalytic theories through a real-life example. Daniela Finzi claims, “case histories are always written with the aim of signaling a further development of theory—and are thus intentional texts,” and, for this reason, “the [*Dora*] text is dominated by a legitimizing tone” (26). Freud found in Dora a compelling example to imbue with his psychoanalytic interpretations and promote his developing theories. As a clinical physician, Freud worked to find reasons for Dora’s psychic disturbances to “cure” her, but as a theorist, he focuses on substantiating his still-evolving philosophies on hysteria and

psychosexuality; in consequence, this rhetorical purpose dehumanizes Dora within the case study and submerges her version of events into a shadow narrative. Thus, first and foremost, Freud explains her reactions as pathological, founding this determination primarily upon the disgust Dora felt during the sexual encounters with Herr K. Freud bases his analysis on the premise that Dora's negative libidinal reaction to Herr K.'s sexual advances is hysterical; he argues, "I should without question consider a person hysterical in whom an occasion for sexual excitement elicited feelings that were preponderantly or exclusively unpleasurable" (*Dora* 25). Here, Freud alludes to the trauma theory developed in *Studies on Hysteria*, which posits:

External events determine the pathology of hysteria to an extent far greater than is known and recognized...In cases of 'traumatic' hysteria what provokes symptoms is the accident. The causal connection is equally evident in hysterical attacks when it is possible to gather from the patient's utterances that in each attack he is hallucinating the same event which provoked the first one. (7)

In the case of traumatic hysteria (as Dora's is), an external traumatic event causes hysterical symptoms especially when the patient experiences another similar event. For Dora, the original trauma occurred in Herr K's shop, and the second event at the lake retraumatized her, exacerbating her psychological distress. Dora re-lived these traumas, not only in real experiences but also in her psyche. This traumatic repetition is common in war neuroses as well as in post-traumatic stress disorder (although PTSD is a late-20th century term). In *Studies on Hysteria*, Freud and Breuer explain how a traumatic event continues to inflict psychic harm on an individual long after the event's actual end; for this reason, trauma can induce mental disorder:

The causal relation between the determining psychical trauma and the hysterical phenomenon is not of a kind implying that the trauma merely acts like an *agent*

provocateur in releasing the [hysterical] symptom, which thereafter leads an independent existence. We must presume rather that the psychological trauma—or more precisely the memory of the trauma—acts like a foreign body which long after its entry must continue to be regarded as an agent that is still at work. (9)

The lasting consequences of a traumatic event haunts the patient's psyche and becomes evident in the disordered symptoms she displays. In *Inhibitions, Symptoms, and Anxiety* (1926), Freud describes traumatic repetition as a psychological defense mechanism which aims to undo the damage caused by the initial trauma. This obsessional repetition occurs as a psychic repetition of the traumatic event itself, whether literally through images in psychic flashbacks or metaphorically in dream-images or through object-substitutions within the mind of the survivor. This haunting repetition provokes anxiety and psychic distress. In her critical analysis of trauma narratives *Unclaimed Experience* (1996), Cathy Caruth describes trauma as a "crying wound" within the psyche, for it never heals because traumatic repetition continually reopens it. Applying Freudian theories on trauma, Dora's sexual assaults are the logical triggering events that unmoor her fragile adolescent psyche. Incredibly, in this case, Freud completely ignores his prior theories on trauma, which seem most applicable to Dora. The likely cause for this theoretical desertion is Freud's primary rhetorical purpose to prove his newly developing hypothesis that errant sexuality disturbs the psyche and results in hysteria or neurosis. (As an aside, one should note the labels of hysteria and neurosis are gendered; even when presenting similar symptoms, doctors typically diagnosed female patients with hysteria and male patients with neurosis. Otherwise, the disorders are very similar.) In her literary analysis "Dora, the Un-Ending and ever Unraveling Story" (2018), American professor and psychoanalyst Jeanne Wolff Bernstein examines Freud's rhetorical purpose for the text and his neglect of trauma theory:

Freud's theoretical zeal to prove that sexuality was the key to explain hysterical symptoms and the problem of psycho-neuroses, renders him blind...to his earlier theory of trauma which had not emphasized sexuality in a similarly strong manner, but had privileged the back and forth movement of *Nachtraglichkeit* [afterwardness/deferred action of traumatic repetition] as an internal psychic process that re-invests an earlier (possibly unlived, unsymbolized) experience with a newly discovered sexual sensation. (96)

By ignoring his ideas about *Nachtraglichkeit*, Freud silences Dora's lived experiences and his prior wisdom. One symptom Dora displayed logically illustrates the traumatic repetition inherent in her hysteria and emphasizes the idea that Herr K.'s sexual advances went farther than mere proposals and kisses on the lips: Dora often experienced a "sensory hallucination" "upon the upper part of her body" which mimicked "the pressure of Herr K.'s embrace" (Freud, *Dora* 26). Rape victims often experience sensory hallucinations during traumatic repetition; colloquially, the term "flashback" applies to this experience. The pressure Dora felt upon her chest likely was her muscle memory of Herr K.'s weight atop her during the rapes, although keep in mind she never admitted this precise violation. Of course, at that time in history, if she told she was raped, she would have been considered unmarriageable, except perhaps to her rapist, so it is unlikely a young woman from a wealthy family would admit such a violent desecration. According to a meta-analysis conducted by American clinical psychologist and professor Emily Dworkin and her co-researchers at The University of Washington in 2021, "81% of sexual assault survivors had significant symptoms of post-traumatic stress (PTSD) one week after the assault. One month afterward – the first point in time that PTSD can be diagnosed – 75% of sexual assault survivors met criteria for the disorder" (Dworkin, et al.). Although the significant symptoms of post-

traumatic stress can decrease over time, even two years later, Dora clearly displayed symptoms of traumatic repetition. Dworkin et al. describe the most common symptoms of PTSD “as reliving a traumatic event in nightmares, intrusive thoughts, or flashbacks; avoiding being reminded of the event; increases in negative emotions and decreases in positive emotions; self-blame; and feeling ‘keyed up’ or on edge.” Importantly for Dora’s case, sensory hallucinations occurred as flashbacks. In the literary and historical analysis “From Dora to Conchita: Recent Views on Gender and Sexuality in Psychoanalysis” (2018), German psychotherapist and author Ilka Quindeau emphasizes that within *Studies on Hysteria* Freud argues, “actual sexual assault can result in trauma or be processed as a trauma” (119). Understandably, Freud’s refusal to apply trauma theory to Dora’s case has puzzled critics for generations. Why did Freud not view Dora’s illness as trauma-induced? Why, instead, did he accuse her of malingering?

Two compelling reasons account for Freud’s ineffective treatment in this case. One explanation for Freud’s diminishment of Dora’s trauma and Herr K.’s attack was his social acquaintanceship with the Zellenkas and the Beuers, which encouraged his countertransference and identification with Herr K. and Dora’s father. Jeanne Wolff Bernstein details this personal conflict of interest:

Freud appears to be blinded by his strong identification with Herr K. (Herr Zellenka, whose sister he had already treated and whom he may have known from vacations spent in the same resort town as the Zellenkas and Bauers...) when he attempts to prove beyond any single doubt that repressed sexual wishes and desires resided behind each one of Dora’s bodily symptoms. (90-91)

Freud’s personal relationship, however tenuous, to the families involved served as a motivation, whether intentional or not, to silence Dora. It was socially easier for Freud to reduce the rape to a

lesser encounter or to a fantasy that never actually occurred. Secondly, Freud's misinterpretation of Dora's case supported the new ideas he was developing during this time. Circa 1897, Freud turned away from his theories of seduction and "began interpreting the accounts of his female patients not so much as descriptions of real sexual experiences but as manifestations of unconscious fantasies," explains Quindeau (117). This change in theoretical understanding is a second plausible reason for Freud's diminishment of Dora's lived experiences as exaggerated fantasies. Socially, this revision Freud avoid repercussions from persons accused of wrongdoing by his patients. By translating (possibly) real experiences into imagined fantasies, Freud protected psychoanalysis against public scandals, but by doing so, his theory now gaslighted traumatized rape victims, situating them as unreliable narrators driven mad by overactive imaginations. To Finzi, "Freud's interpretation of the case study reveals more about his own hermeneutic desire—that is, to demonstrate the validity of psychosexual aetiology—than about what Dora really experienced and suffered" (28). Because Freud viewed Dora's case as a compelling example to prove his theory that hysteria stemmed from repressed sexual desires, "he constructed the account towards a preconceived outcome or result, at least in terms of the textual representation" (Finzi 27). Because this rhetorical goal was Freud's primary motivation in the case study, Dora's actual recovery, experiences, and self-awareness became nearly irrelevant to him. The combination of Freud's social connections with the Zellenkas and the Beuers and his primary rhetorical purpose for the text are two plausible causes for his silencing of Dora. Freud's practical model in this case established a foundation for the silencing of patients in psychiatric practice today.

Indeed, Freud went to great lengths to silence Dora through his accusations of malingering and his reduction of her negations to symptoms. In the case study, Freud first introduces Dora as an intelligent young woman, who regularly "[attended] lectures for women" and "[carried] on more or

less serious studies” (*Dora* 20). Freud describes Dora as having “natural gifts” and “intellectual precocity” (*Dora* 17). And, most tellingly, Freud begrudges, she was “a mature young woman of very independent judgement, who had grown accustomed to laugh at the efforts of doctors, and in the end to renounce their help entirely” (*Dora* 19). Freud needs his audience to understand Dora as fully capable of manipulating others because this lays the groundwork to substantiate his later accusations of malingering. These descriptions also appeal to the audience’s sympathies for Freud when the Dora character abandons treatment. In many ways, Freud presents Dora as an attorney might introduce a criminal to a jury—the audience must be careful not to believe everything Dora says because she is both intelligent and educated, which insinuates she is more than capable of manipulation. Bernstein argues:

[Freud] takes on the position of an attorney who cross-examines a witness rather than a psychoanalyst who treats a patient when he insists that Dora was only seeking revenge against Mr. K. Freud falls into the role of “the one who knows” and the one who uses his subject, in this case Dora, to benefit his own cause and to serve his own theoretical ambitions. (91)

Often, Freud claims Dora’s symptoms and bouts of illness were “a clever tour de force” because “she had an object in view which she hoped to gain by her illness” (*Dora* 39-40). What was her vengeful objective? According to Freud, Dora desired for her father to end his affair with Frau K. and dissolve the family’s friendship with the K.s (*Dora* 40). This aspiration is reasonable when one considers that without this separation Dora was forced to see Herr K regularly. How many rape survivors do you think want to spend time around their rapists? Is it not reasonable to desire avoiding that situation? Additionally, although Freud believed Dora experienced something untoward from Herr K., he never questioned if Herr K. raped her. Instead, he told Dora that she

was in love with Herr K. before these incidents occurred, so she should have had a positive sexual response. Blass aligns Freud's interpretation here to his theory of the hysteric's repressed love for her seducer: Dora's "forbidden longings" for Herr K. manifested her symptoms as "symbolic expressions of these longings and libidinal wishes" (37). Blass argues, "this proposition in many ways resembles Freud's formulation of hysteria as a result of the repression of 'incompatible ideas'" (37). Although Dora denied loving Herr K., Freud insists on the truth of his conjecture based on Dora's repressed incompatible ideas—her love and hate for Herr K. In support of this claim, Freud purports another hypothesis about the meaning behind a patient's "no": "It is of course not to be expected that the patient will come to meet the physician half-way with material which has become pathogenic for the very reason of its efforts to lie concealed; nor must the inquirer rest content with the first 'No' that crosses his path" (*Dora* 21). This was Dora's first of many "Nos" in response to Freud's interpretations of her psychological conflicts; nevertheless, Freud continued to dismiss Dora's disavowals as natural responses to her unconscious desires. Freud then explained to Dora that she removed her love from Herr K. after the lake scene substituted her object of desire by falling in love with her father—who became a safer alternative (*Dora* 55). Of course, Dora denied this as well, but Freud uses her "no" to launch into another of his emerging theories—the Oedipus Complex: "I have learnt to look upon unconscious love relations like this (which may be recognized by their abnormal consequences)—between a father and a daughter, or between a mother and a son—as a revival of germs of feeling in infancy" (*Dora* 55). Again, this evidence highlights Freud's purpose for this case study is to prove his psychoanalytic theories as much as, if not more than, treating his patient. Thus, even as Dora vehemently denied being sexually in love with her father, Freud silenced her by belittling her self-awareness: "The inference is obvious that her affection for her father was a much stronger one than

she knew or than she would have cared to admit: in fact, that she was in love with him” (*Dora* 55). Freud uses this assumption to segue into his hypothesis about the Oedipus Complex in greater detail, and by doing so, the reader sees his strongest motive is to substantiate his theories. It leads one to question if Freud was more interested in helping the patient recover or in demonstrating the validity of his new science, at least when considering the rhetorical purpose and goal for the *Dora* case study. Freud’s apparent purpose is to establish the credibility of psychology, and ultimately, he silences his patient many times to accomplish this. Despite Dora’s repeated “Nos” to many of Freud’s conclusions about her supposed unconscious sexual desires, Freud only tried to convince her that he was right; he did not second guess himself, as perhaps he should have. Dora’s continual negations and his disregard of her words and ideas illuminates how a mental patient often becomes a silent object in case studies because, even when she explains her perspective, her words vanish, as if unheard, into a shadow narrative. Furthermore, by silencing Dora, Freud archetypes mental patients as unreliable narrators in their own lives. Finzi examines this aspect of *Dora*:

The patient’s narrative, to paraphrase Freud with narratological terms, is “unreliable” as it is imperfect; the motives given for this include deliberate reserve or dishonesty; unconscious dishonesty and amnesias. Here we can make out an aim of the treatment: ultimately, to survey “an intelligible, consistent, and unbroken case history.” That this endeavor comes at the expense of the sublimation wishes, needs and fantasies of the Dora figure comes as no real surprise. (29)

The repercussions of Freud’s representation of the mental patient as unreliable and dishonest materializes within the sentiments of 20th- and 21st-century psychiatrists and psychologists; moreover, the generic conventions he established for case studies continue to encourage the silencing of patients today.

Eventually, Dora abandoned her treatment with Freud likely because he consistently silenced her by denying her personal conclusions about her own experiences. Freud rarely questions if his assumptions are flawed, at least not in the published manuscript. Instead, he posits, the patient must be mistaken due to her lack of self-awareness and ignorance about the complexities of the Unconscious and its psychic defense mechanisms. Finzi concludes, “We can interpret Dora’s termination of treatment as showing that the narrative uncovered or constructed by Freud and his normative male expectations of female sexual response did not tally with her story or her self-constancy” (30). Ignoring the patient’s perspective and silencing her words are especially problematic when physicians misdiagnose patients or when they ignore patients’ complaints; this can harm the patient’s sense of self-awareness, or it can persuade her to leave treatment. Additionally, as Hornstein explains,

Efforts to silence patients' voices have taken subtler forms as well. By allowing patients into psychology literature only as case illustrations, never as authors, physicians have severely restricted the audience for the patients' works. Some doctors openly distort patient experience to fit their own rules.

Freud took great care to dismiss Dora’s repudiations of his inferences as further evidence of her illness because his rhetorical purpose was to prove his psychological theories and teach other physicians how to “cure” patients of their insanity. By doing so, he distorts Dora’s experience and silences her voice in the text, reducing her to an inaudible lab rat under his medical gaze and her personal story to a shadow narrative.

5.4 When Silencing Almost Killed Me

Although no mental health professional has accused me of being in love with my father, I have experienced psychiatric silencing like Dora. Dr. TW was my doctor for three years, and

under his care, I took a combination of psychotropic medications, as is widely recommended for the treatment of bipolar disorder. During the last year of my treatment with him, Dr. TW increased the dosage of the antidepressant I took because I was experiencing symptoms of depression. After this increase, I quickly encountered a slew of harmful side effects, but I did not realize these new physical health problems emerged from the toxic combination of psychopharmaceuticals I took to stabilize my mental health. My muscles and joints became sore all the time, and I bruised easily from the slightest touches. Before I knew it, my skin was thinner and frail, often tearing away like tissue paper. I had bruises in varying degrees of healing all over my body—splotches of dark indigos, swampy greens, and rancid yellows. In addition, my gastrointestinal system revolted; I experienced vomiting and diarrhea nearly every day. I eventually lost my sense of taste, other than hot sauces, and I could no longer eat red meat without becoming violently ill. I soon noticed my pupils were dilated often, even in bright places, with each eye displaying a different pupil size. I felt like I had aged 50 years in a matter of months.

When I went to my next appointment with Dr. TW, I told him about these new symptoms and asked if they were side effects of my medications.

“Doctor, something isn’t right with my medication. I’m having a lot of awful side effects,” I explained. He eyed me suspiciously. “I feel sick all the time. I’m nauseated all day, and I’ve been getting headaches. I have no appetite. Food only tastes like bland cardboard now. I feel anxious constantly and I’m still depressed. I’m tired all the time. I have these bruises that keep showing up all over my body. My skin is so thin now. Something is wrong! I’ve never experienced side effects like this before.”

“It’s not your medicine. You most likely have the flu. Go see your general practitioner for those symptoms,” Dr. TW responded.

“No, you don’t understand. This is not the flu. I’ve been experiencing these symptoms for months without any relief. Couldn’t it be related to the increase in my dosage? That’s around the time these symptoms started.”

“No. It isn’t your medication. Plus, I’m sure if it was *that* bad, your husband would be here with you. Keep taking your medicine and go to your family doctor for the flu symptoms,” said Dr. TW, as he wrote an unaltered refill for my prescriptions. Feeling defeated, I took the paper and left his office. As I started my car to drive home, tears streamed down my cheeks; I felt powerless.

When I told my husband, Clinton, about my appointment, he became furious at Dr. TW’s belittlement. He assured me he would go to my next appointment to speak with this doctor.

In the meantime, attempting to verify Dr. TW’s assessment that my symptoms were not caused by medication, I went to my general practitioner, but I did not test positive for any virus or bacterial infection. The flu was not causing these symptoms, but something was seriously wrong. Not only was I suffering from physical side effects, my mood continued to sink into the quicksand of depression.

Concerned over the deteriorative changes in my health, Clinton sought help from my therapist JD, who had helped me for a decade. JD had recommended Dr. TW when I left my previous psychiatrist, Dr. E—the one who guaranteed that I would never succeed at completing a Ph.D. Hoping that JD would have a solution to my medication problems or would be able to talk to Dr. TW on my behalf, Clinton began listing his worries about the changes in my mood as well as the strange physical symptoms I was experiencing.

“She isn’t doing well. Something’s got to change with her meds. She’s isolating and doesn’t want me to touch her anymore. She’s either angry or crying most of the time. Something’s not right, and I need your help.”

At first, JD became somewhat defensive, likely because our therapist-patient relationship involved a bit of transference on both sides. After working closely together for years, our relationship began to mimic a father-daughter association. This kind of transference is very common; however, at this moment, it created an obstacle.

“This is just how she is sometimes. You knew when you married her that there’d be issues and that you’d need sympathy during times like this,” said JD.

“No, you’re not listening to me. Of course, I have sympathy for her, but there’s something seriously wrong. She bruises whenever I touch her. She bruises when anything touches her. You *have* to do something! Help her! Dr. TW won’t listen to her and refuses to change her prescription. He’s poisoning her, JD,” Clinton desperately explained.

“Okay, I promise I’ll look into it. Just be patient with her. I know you love her. Just be patient,” JD said.

Frustrated and angry, my husband left, and together we waited for my next psychiatry appointment. Clinton would go with me to Dr. TW’s office—that he guaranteed as sparks of fury danced in his eyes.

Approximately two months later, my next scheduled visit arrived, and sure enough, Clinton sat by my side in the uncomfortable waiting room chairs. Anticipating the nurse’s arrival to escort us into the doctor’s office, anxiety vibrated in my chest, and anger radiated from Clinton. The seconds ticking by on the wall clock slowed almost to a stop. The room felt unseasonably hot for December, even for Georgia. Finally, the nurse opened the door. “He’s

ready for you now, Mrs. Walker.” The hallway seemed to elongate nauseatingly as we walked toward Dr. TW’s open door.

The doctor’s eyes widened ever so slightly when he saw my husband walk in behind me. Clinton is not a small man. When Dr. TW stood to shake his hand, Clinton, scowling, sat down without taking it. Unsettled, Dr. TW abruptly sat behind his desk, and I took my typical seat across from him.

“So, how are we doing today?” Dr. TW asked, looking at Clinton instead of me.

“Not good, Doc. Not good at all,” he began. “First off, I heard about your last appointment. You remember. You said my wife’s concerns didn’t matter unless I was here, right? Well, guess what, Bubba, I’m here today, and I’m pissed! How dare you belittle her! You deserve to be hit in the face. What so, if I’m not here, you don’t have to take her concerns seriously? You fucking idiot! My wife is far smarter than me and probably smarter than you, so if she tells you something’s not right, you *will* listen to her. I’m no doctor, but it seems like you’re poisoning her with this crapshoot combination of meds you got her on. All this started after you increased her dosage. This’s been going on for months! Are you stupid or something? Do something about this. Today.”

“Okay, Mr. Walker, I need you to calm down,” Dr. TW began.

“Listen here, motherfucker, I am calm. But since you think only a man’s opinion matters, *I need you* to help my wife,” Clinton fired back.

“I am helping her. Mrs. Walker, keep taking your medications. It takes time, but you’ll adjust to them,” Dr. TW continued.

“Doctor, I take my medicine like clockwork—same time every day. They’re not working; something’s been wrong for months. I feel worse than ever. You *have* to change my prescription.

I feel sick all the time. I don't have the flu! I saw my general practitioner. Please believe me! Please change my medications," I implored.

"Your medication just needs more time to work," Dr. TW said, handing me an identical prescription refill.

"This is fucking horse shit! This is exactly what's wrong with your profession! You're nothing but a glorified drug dealer." Sucking his teeth, Clinton snatched the prescription from the doctor's hand, and we walked out of the office. My hands trembled from fear, from side effects, from an overall sense of impending doom.

The following week, Clinton and I went to speak with my therapist again. I listed my negative symptoms to him. I showed him the litany of bruises covering my arms and legs. Then, I explained how Dr. TW would not listen to my complaints.

"I've never experienced side effects this severe. Have you ever heard of anything like this happening?" I asked.

"After I spoke with you last, I did some research," said JD. "From what I've found, I think you're suffering from serotonin syndrome." He explained serotonin toxicity to me in detail, and the following sources demonstrate similar information. In the medical article "Serotonin Syndrome," American psychiatrists Penny March, et al., define this syndrome as "a constellation of signs and symptoms, some of which can be life-threatening, that occur in patients taking serotonergic drugs (i.e., drugs that increase brain serotonin levels)." Moreover, according to the Cleveland Clinic, not only the combination of serotonergic drugs but also the increase in dosage can cause serotonin syndrome (SS) to develop. The increased dosage amidst the mixture of serotonergic medications elevated my cerebral serotonin levels to a toxic concentration. As March, et al., explain, "high serotonin levels produce CNS [Central Nervous System] and

smooth muscle (e.g., GI tract, uterus, vascular endothelium) hyperactivity, causing SS's neurologic and neuromuscular effects." Disruptions in the CNS and the smooth muscle system in my body caused by high levels of serotonin triggered harmful side effects, but because my psychiatrist ignored my complaints, I suffered unnecessarily for months. In the online article "Serotonin Syndrome," the medical writers at the Cleveland Clinic list the following as symptoms of SS:

Nervousness, nausea, vomiting, diarrhea, dilated pupils, tremor, agitation, restlessness, muscle twitching, involuntary muscle contractions, muscle spasms, muscle rigidity, sweating, shivering, abnormal (side-to-side) eye movements, confusion, disorientation, delirium, rapid heart rate, high blood pressure, high body temperature, seizures, abnormal heartbeat, passing out, [and] fainting.

Clearly, many of my symptoms are known effects of serotonin syndrome, yet my doctor viewed me as an unreliable narrator to my experience, so he silenced my complaints. He never bothered to research my symptoms or consider he was mistaken. After describing SS to us, my therapist said he would contact Dr. TW immediately to advocate for a change in my prescription.

The next week, my husband and I sat across from Dr. TW.

"I spoke with JD," he said. "He expressed his concerns about the side effects you're experiencing, so I've decided to change your medication. You'll now take the antidepressant Wellbutrin, instead of Lexapro." He briefly discussed the possible side effects of Wellbutrin before handing me the new prescription.

Was he finally making changes *only because* another mental health professional contacted him? How many other patients had Dr. TW gaslighted? The relief I felt for the change in my medication only made room for my anger. What happens to his patients who do not have

supportive spouses or do not have a therapist to call on their behalf? How can this man be considered a real doctor when he is causing so much harm without remorse?

I took the new prescription and left his office. Promptly, I began searching for a new psychiatrist, hoping to find someone who would listen to me. Dr. TW's silencing could have killed me because, if left untreated, serotonin syndrome causes seizures and death. Part of the problem is many psychiatrists do not trust their patients' accounts; the stigma labels them as inherently unreliable narrators, even about their own experiences and especially if they exhibit delusions, hallucinations, or denial. However, for effective psychiatric treatment, doctors and patients must work together for the patients' recovery; thus, mutual trust is required.

Of course, trusting someone who silences you nearly to death is impossible, so I searched for a new doctor. I filled my new prescription and started taking Wellbutrin. The symptoms of serotonin syndrome began to dissipate, and I physically felt better, but my mental state remained overwrought. Over a month later, I began seeing a new psychiatrist, Dr. JT. After the normal introductions concerning my patient history, current diagnosis, and medications, I explained I was still experiencing bipolar depression, although evidence of the serotonin toxicity had diminished. Learning I had taken Wellbutrin for approximately four weeks but without improvement to my depression, Dr. JT supposed the dosage needed to be increased. So, he doubled it. Now, I do not want to demonize this new doctor. As a new patient, he had never seen me in a stable mood, so he had no baseline for comparison. He could only take me at my word and read through my patient chart from Dr. TW's office. Unfortunately, this was the wrong choice in the trial-and-error process of prescribing psychopharmaceuticals. The die had been cast again.

Within three days, I was living through full-blown mania, which induced psychosis; I

became highly delusional and experienced vivid auditory hallucinations. Within three days, I lost myself: I lost my ability to read with any kind of comprehension, and I no longer could write anything that made sense. I became confused and disoriented. I could not sleep more than an hour or two. I never experienced the onset of mania happen so quickly. The Wellbutrin catapulted me out of the tarpit of depression and rocketed me toward the blazing sun of mania with nothing to help me fly but wax wings. There was no hypomanic phase, as typically happens, so there was no warning, no subtle signs that my mood was ramping up too much. I took the Wellbutrin as prescribed and lost all sense of myself. Much of what happened during this time and immediately following I only remember in flashes because my mind, indeed, was gone.

By February, I voluntarily admitted myself to a psychiatric hospital, where the doctors changed my medications and took me off Wellbutrin. I slowly recovered through 2017 and 2018. My thoughts incrementally became clearer. I could sleep again; I could speak clearly again; and most importantly, I could read and write again. The relief I felt upon my sanity's return is indescribable. It was the kind of feeling that vibrates through the body until it quakes the soul. Can you imagine losing yourself so completely that you can no longer do what is most important to you? I feared I would not make it back from the murky swampland of insanity this time, and that fear still lives deep down in the core of my being. Will that day come—the day I lose my mind and cannot find my way back?

Personal experiences like these are nearly impossible for me to bear remembering, much less speaking aloud or committing to this page, due to the shame I have inherited from the stigma of mental illness. This stigmatizing shame is almost too much to overcome, but that is exactly why I am writing this dissertation—to fight this stigma the only way I know how. I do not know

if I will ever fully escape every consequence of it, especially those stemming from self-stigmatization, but I keep trying every day. What I do know is if sharing my experiences of mental illness helps even one other person to release a piece of his shame or one other person to develop sympathy for someone she sees suffering—then this was all worth it—every single painful part.

Fortunately, I now have a psychiatrist who listens to me, instead of silencing me; the doctor-patient relationship I have with Dr. JT is one built around teamwork—we work in partnership to maintain my mental wellness. This teamwork exemplifies what could be done in psychological literature. Instead of looking at mental disorder from a “doctor versus patient” power struggle or giving greater credence to case studies over patients-written narratives, a cooperative interdisciplinary approach creates fuller insights into this complicated topic by erasing historical silencing and challenging preconceived stereotypes of madness, while also respecting proven psychological theories and effective psychiatric treatments. The combination of multiple perspectives humanizes mental patients and fosters a greater understanding of mental disorder. For these reasons, the value of mental illness life narratives cannot be exaggerated because this hybrid genre is crucial in the fight against stigma.

5.5 The Value of Mental Illness Life Narratives

As a genre, mental illness life narratives can resemble other American autobiographical traditions by applying common generic conventions and literary tropes; these shared aspects appeal to American audiences through their familiarity with similar narrative structures and figurative language. According to the literary analysis “The Genre of the Mood Memoir and the Ethos of Psychiatric Disability” (2010), American author and activist Katie Rose Guest Pryal highlights the similarities between mental illness life narratives and early-American captivity

narratives, spiritual autobiographies, and American slave narratives by exposing recurring narrative conventions like the inclusion of an apologia and a moment of awakening (485). Because the experience of mental disorder transcends the body and the mind to include the soul and because the stigma of mental illness adds seemingly insurmountable odds to recovery, mental illness life narratives engage in several American autobiographical traditions by describing the downfall of an individual, often from sources outside of his control; the seemingly impossible odds of escape or recovery; and the individual's final return to his community with new insight and an altruistic purpose, which inspires the composition of his narrative. The power of mental illness life narratives lies in the foundation they create as sites of intersubjective meaning-making between authors and readers; this collaboration allows authors and audiences to raise awareness and inspire empathy together. Moreover, these personal narratives offer a glimpse into the edges of existence, which may be otherwise unavailable to neurotypical people. Hornstein argues this genre offers a unique perspective:

Patient narratives...mark off the extremes of human experience. Just as Olympic athletes define the boundaries of human physical ability—how high it is possible to jump, how fast 200 meters can be run—so do mental patients show us how much terror or suspicion it is possible to feel before collapsing under the weight or committing suicide. We may be frightened as we read such stories, as we are frightened by other survivor accounts, but they do show us the extraordinary resilience of human beings, as well as the lines we cannot breach.

Mental illness life narratives demonstrate what it is like to live with mental disorder, and the authors' struggles against stigma emphasize their tenacity to survive even in the face of seemingly insurmountable obstacles. Perhaps, this is why mental illness life narratives appeal to

a wide audience. In the 1990s, America experienced what many have termed the “memoir boom” (McLennan 223; Torres-Quevedo 207). During this decade, publishing houses printed a multitude of memoirs about a variety of topics, including mental illness. Since the 1990s, Wahl reports, “the number of such publications—and their success in attracting audiences and returning profits to their publishers—is...increasing, meaning that more...people are reading true life stories of experience and recovery that can counteract the problematic stereotypes found elsewhere” (153). As the publication of mental illness life narratives increases, the likelihood of successfully battling stereotyped stories also rises.

To end the stigma, mental illness life narratives should be taught in higher education, especially in medical school, because first-person accounts offer insights into the human mind that are unapproachable from any other viewpoint. Mental illness life narratives should be added to the curriculums of psychology departments and English departments in juxtaposition with case studies. In this way, students learn to view the complexities of mental disorders from two crucial vantage points—from within the subjective personal experience and from the distanced scientific perspective. In her medical literary analysis “On the Borderline? Borderline Personality Disorder and Deliberate Self-Harm in Literature” (2008), British professor of mental health Charley Baker stresses the value of patient-written literature for doctors and medical staff, but these advantages could reach other areas of society, such as law enforcement, social work, and education: “Exploring these highly individualized networks of meaning through the relatively safe medium of literature can be a valuable tool for clinicians seeking to understand a group of patients who are often thought of as distressing and challenging” (22). Despite the advantages mental illness life narratives offer, history demonstrates the medical field’s resistance to using patient-written narratives. Hornstein pinpoints the doctor-patient power dynamic as the influential reason for the

diminishment of patients' accounts: "Doctors' viewpoints, of course, have always been given more weight than rival accounts by patients, not so much because they are more insightful as because doctors are in control." During treatment, doctors have more power than patients, and this dynamic creates tension within their relationship. As previously demonstrated, when a doctor disagrees with a patient, or vice versa, typically, the doctor's opinion is difficult to refute, and the patient becomes silenced. However, the authority of the doctor becomes subverted in mental illness life narratives—the patient gains complete control, and the doctor becomes the powerless, silenced character. For this reason, mental illness life narratives intrinsically are acts of protest because, through discursive resistance, they challenge not only medical authorities but also hegemonic narratives of stigma. For example, a typical antagonist in mental illness life narratives is the "bad" doctor, which presents another reason why physicians often dismiss patient-written narratives as unbelievable. Hornstein illuminates this conflict and its consequences:

Patient memoirs are a kind of protest literature, like slave narratives or witness testimonies. They retell the history of psychiatry as a story of patients struggling to escape doctors' despair. Again and again, patients talk of having to wrest control of their treatment or cure themselves after some physician had given up on them. It isn't surprising that psychiatrists ignore this literature; physicians in every branch of medicine discredit patient accounts, and madness, by definition, further calls into question what patients say. But that attitude terribly limits our understanding of mental illness, and blinds us to the many contributions that mental patients have made to art, science, and literature.

This antagonism between doctor and patient often exists in individual therapeutic relationships and certainly occurs within the medical field on a large scale. One effective way to resolve such

deeply-rooted opposition is to find common ground, which involves locating values and goals with which both doctors and patients can agree. Patient-written narratives can serve as a tool to explore common ideals and treatment objectives, especially when studied in conjunction with case studies. Ultimately, patient memoirs offer another perspective on mental illness, and by combining patients' and doctors' viewpoints, a nuanced comprehension of this complex issue emerges. Moreover, when both doctors and patients feel valued and heard, the therapeutic relationship functions better, increasing the probability of a successful treatment plan.

Furthermore, the act of authoring a personal narrative is therapeutic in itself; the writer gains control over his experiences, reestablishes his identity as valuable, and counters the stereotypes that stigmatize him. In "Memoirs: Rewriting the Social Construction of Mental Illness," Elizabeth Young recognizes the therapeutic benefits of creating memoirs:

[A memoir is] a way in which writers refute the cultural ideology of mental illness as personal weakness, as something shameful, utterly destructive, and permanent... None of the writers is weak or lost or all that different from the reader. The dissonance between the hegemonic story and the writers' experiences of mental illness serves as the first step in the therapeutic benefit of writing about mental illness. (58)

In other words, by writing about their personal experiences with mental disorder, authors fundamentally challenge pre-established stereotypical narratives by showing where and how their stories differ from the hegemonic ones. This allows the individual to reconstruct his fractured identity and dispel the myths reinforced by the stigma. Finally, mental illness life narratives intimately connect the author and the reader; together, they must interpret the remembered events to understand the author's experiences, fears, traumas, and motivations. Through this collaborative meaning-making, mental illness life narratives encourage readers'

empathy. Young explains these narratives affect the writer and the reader by encouraging both to challenge common stereotypes:

The memoirs confirm...that language in the form of narrative can simultaneously *contain* traumatic experiences in ways that are therapeutic for the writer and *shape the meaning* of those experiences for both the writer and the readers... [The] narrative sets up a reciprocal relationship between writer and reader in which each is affected by the other. Reading the narratives of people with mental illness and incorporating them into our own life stories is an act of inclusion and empowerment that challenges the dominant story of mental illness as something shameful and isolated. In that way, the acts of writing and reading narratives of mental illness contribute to the incremental but essential shift in the social construction of mental illness. (67)

The social impact of these narratives is what makes the discomfort of writing them worth it. Ultimately, mental illness life narratives are acts of empowerment when the writer regains her voice and ends her feelings of isolation. In an interview conducted by Dr. Freda C. Lewis-Hall as included in the “Reader’s Companion” of *Willow Weep for Me*, Meri Nana-Ama Danquah discusses the emotionally painful but rewarding experience of writing her memoir:

Many people have asked if writing the book was cathartic for me. My answer has always been “no.” Writing the book was painful. Had I known how much raw pain would have come from the whole process of revisiting my past and putting it down on paper, I doubt that I would have taken on the task. I was too busy looking at the dents on the trees to take note of the beautiful forest. Now that the book has been published, I can see, and say, that *having written it* was indeed cathartic. I was able to let go of all the pain, of all the hatred, the bitterness and fear. I was able to move forward with, and in, my life. (274)

Although the process of committing one's trauma to the page can feel like psychological bloodletting, the therapeutic benefits and psychic peace that come from the finished text should encourage others to share their mental illness life narratives. According to Mary Elene Wood, "who is doing the writing is key" (1-2). Thus, first-hand accounts of mental disorder are paramount in countering the silencing imposed by case studies and protesting the derogatory stereotypes propagandized by the media.

5.6 Shadow Narratives that Demand to be Told: Common Goals of Memoirists

In consideration of the American memoir boom of the 1990s, I analyze four memoirs from this decade: *Girl, Interrupted* (1993) by Susanna Kaysen, *Prozac Nation: Young and Depressed in America, a Memoir* (1994) by Elizabeth Wurtzel, *An Unquiet Mind: A Memoir of Moods and Madness* (1995) by Dr. Kay Redfield Jamison, and *First Person Plural: My Life as a Multiple* (1999) by Dr. Cameron West. Susanna Kaysen recreates her adolescent experience from the 1960s during her confinement in McLean Hospital, where she received the diagnosis of borderline personality disorder; she rebels against the rigid social standards that elicited her confinement and protests her diagnosis and treatment there. Elizabeth Wurtzel illustrates her childhood and adolescent experiences with atypical depression in the 1990s, emphasizing the disillusionment of Generation X, her parents' hateful divorce, and the trending cultural reliance on psychopharmaceuticals. Both of these authors come from middle-class Jewish backgrounds in New England. Dr. Kay Redfield Jamison constructs her memoir about manic-depressive illness from the vantage point of both a patient and a clinical psychologist; she comes from a New England, Catholic, White, middle-class, military family. Dr. Cameron West recounts his experience with dissociative identity disorder (formerly termed multiple personality disorder), and he composes his narrative from the perspective of both a patient and a professor of

psychiatry. West comes from a White, middle-class New England background. Kaysen and Wurtzel protest psychiatry and traditional Recovery Narrative expectations more fiercely than Jamison and West, who imitate Recovery Narrative conventions, for the fact that Jamison and West are doctors in the field of psychology, while Kaysen and Wurtzel are professional creative writers. Analyzed together, these texts illustrate common rhetorical goals and narrative tropes within mental illness life narratives.

These memoirists share five common rhetorical goals, which become apparent through their collective use of repeated narrative tropes and literary devices. Typically, the decision to compose a personal narrative about mental illness begins with the desire for personal healing. Because the consequences of mental illness touch every aspect of a person's life, the need to restore one's sense of self becomes a deep yearning. One way to heal from this trauma and recreate one's identity is writing about these complicated, confusing experiences. Composing a mental illness life narrative becomes therapeutic by allowing the author to re-form his identity through narrative coherence. As Wood explains, "Acceptable identity is tied to narrative coherence, the ability to tell a story that makes sense" (2). By creating a narrative that "makes sense" of the chaotic experiences of mental illness, the memoirist also reconfigures her fractured ego identity back into a coherent whole. Young confirms, through life narrative, authors "represent and affirm a self that, though bruised by mental illness, is characterized by strength and confidence and hope" (67). Thus, the first common goal among such writers is narrative therapy. The repeated metaphor of the living dead illustrates this objective by emphasizing the writer's loss of self during mental disorder.

In the same spirit of recovery, the second shared goal is to regain one's voice. Once a person becomes labelled mentally ill, his credibility nosedives because now everything he says is

second-guessed, especially if he has stayed in a psychiatric hospital or has suffered from hallucinations and delusions. These factors reduce a person's social credibility and his rhetorical credibility. Pryal explains, this lost reliability results in silencing: "In short, the psychiatrically disabled are not trusted to exercise reason or judgment; as a consequence, civic exclusion often yields rhetorical exclusion as well" (479). However, composing a mental illness life narrative proves the archetype of mental patient as unreliable narrator is wrong. Wood agrees that "life writing is an undoing of that erasure" which silences the voices of those with mental disorders (20). Undeniably, the act of writing creates a permanence to the ideas the patient-author communicates. No longer are her words ephemeral or ignored. In this creative space, no doctor can silence the patient-author; therefore, through life narrative, she not only rebuilds her identity but also rescues her voice. These writers illustrate this purpose through two narrative tropes: moments of awakening, which invoke ethos, and redefinitions of their disorders in non-scientific, personal terms, which inspire pathos and ethos.

Continuing, the third frequent purpose is to end the sense of isolation the stigma causes. Due to the adverse effects of stigma, many people suffering from mental disorders remain silent and secluded, and this isolation whittles away their hopes for recovery. If someone feels truly alone and misunderstood, he starts to believe no one can help him or that no one cares about his survival. Moreover, if that person does not know anyone else has experienced a similar mental disorder, then his loneliness can intensify. To combat this, some authors write mental illness memoirs specifically to readers with mental disorders, allowing both to feel less deserted. Young explains memoir writing fights the loneliness caused by stigma because "it normalizes many aspects of the experience of mental illness by permitting the writer to establish parallels between their experiences and the reader's experiences, drawing people with mental illness out of

exclusion and otherness and into interaction with the larger society” (67). Thus, in addition to reaffirming one’s identity, sharing one’s experiences connects the writer to his readers. By having conversations about mental illness, writers and readers work together to understand this difficult topic. Moreover, readers with similar experiences may be encouraged to share their own stories, and if more people are willing to have these conversations, our society can become more empathetic because these autobiographical acts challenge the stigmatizing stereotypes that isolate. The narrative trope of laying-claim (through name-dropping and statistics) illustrates this goal to end isolation.

Oftentimes, the fourth typical objective is one of protest: because mental illness life narratives confront this controversial social issue, these texts often become a form of rebellion against the stigma, against unfair treatments or unjust laws, and against the doctors who discourage or harm. Young argues, the memoir “gives the writer the opportunity to publicly refute and correct the social construction of mental illness that we all—including people with mental illness, the general public, and mental-health professionals—carry in our heads” (67). Examining mood memoirs as a genre, Pryal confirms these narratives are “a form of political activism” because they act as testimony of the patient’s experience with psychiatry: “the narratives written by mood memoirists should...be read as...political counter-narratives to the dominant psychiatric narratives about mental illness” (483). While Pryal focuses on mood memoirs specifically, this concept also applies to the broad genre of mental illness life narrative. For example, Wood finds this protest through the life narratives by memoirists with schizophrenia, who “find ways to make their voices heard, writing with and against psychiatric and popular narratives that describe them as different beings whose language is at worst unintelligible and at best unreliable, tainted by incoherent sentences of their psychotic episodes”

(2). Here, Wood highlights writers act against dominant stereotypical narratives by manipulating traditional psychiatric narratives, protesting the stigma inherent even in case studies. Two narrative tropes expose this common goal: criticizing doctors and resisting conventions of the traditional Recovery Narrative. Both tropes emphasize the power reversal between doctor and patient within these narratives. Again, *who is writing* matters because authorship gives patients a site to challenge dominant stigmatizing narratives and to protest unfair treatments, cruel doctors, and social exclusion.

Frequently, this protest manifests from a desire for compassion that is not readily given, which emphasizes the common fifth goal of advocacy for the civil rights of people with mental disorders and activism to fight the stigma and raise public awareness about the realities of living with mental disorders. Ultimately, this fifth objective aims to help others suffering from mental illness. The narrative tropes that illustrate this goal are the inclusion of an apologia and comparisons to physical illness. The writers demonstrate selflessness and altruistic purposes in the apologia and argue for the same level of treatment and sympathy for mental illnesses as offered for physical illnesses. These tropes emphasize how the stigma affects not only individuals but American society as a whole: because anyone can experience mental disorder, as a society, we must develop empathy for each other. Wood explores the relationship established between the reader and the writer within mental illness memoirs:

These memoirs thus bring the reader face to face with those defined as mentally ill, regardless of their diagnosis or supposed neurochemical condition. Within their pages, the answer that emerges is, yes, it could happen to anyone, and thus as a society, we need to rethink the ways that mental institutions respond to and house the human desires, thoughts, and feelings of their most affected inhabitants. (72-73)

These texts emphasize that mental disorder emerges from both external and internal factors—both nature and nurture—which, in many ways, establishes mental disorders as a natural human response to unbearable circumstances and traumatic events. This fifth goal appeals to the readers' empathy because anyone could experience a mental breakdown given the right conditions.

With these goals combined, the ultimate purpose of mental illness life narratives is the empowerment of the authors and others within this stigmatized community. Young illuminates how creating a memoir undermines the stigma, especially the myths of weakness and otherness, by empowering the author:

The dominant cultural interpretation of mental illness focuses on intransigent exclusion and loss due to personal weakness, and indeed for many people who have internalized these cultural values (consciously or not), the diagnosis of a mental illness is a terrifying doom. In the memoirs of mental illness, however, we see a different plot emerge as the writers describe their experiences in ways that show them confronting and then resisting the dominant story, and ultimately offering a new narrative of empowerment. (64)

By sharing her mental illness life narrative, an author can accomplish numerous goals that heal herself, challenge the stigma, and help others struggling through similar battles. Now, I will analyze these common goals in closer detail.

5.6.1 *Goal 1: Narrative Therapy*

During my time in psychotherapy, my favorite therapist often recommended for me to write about my experiences of trauma and mental disorder to better understand my emotions, suffering, internal conflicts, and diagnoses. Using writing as a therapeutic tool is a frequent suggestion in psychotherapy because of its potential benefits to the patient. In the literary

analysis “Narratives of Mental Illness: The ‘Autobiographical Manifestos’ of Kate Millett, Susanna Kaysen, and Kay Redfield Jamison” (2008), American autobiography scholar Leah White explains how writing about personal experiences can aid in the healing process:

“Autobiography offers the option to create one's own understanding of self, as opposed to accepting an external construction of self, and in turn offer that understanding to others” (4).

Because the stigma of mental illness causes a fractured sense of identity, especially immediately following a diagnosis, writing personal stories is one act of defiance against the myths that claim those with mental illness are weak, unintelligent, and illogical because the finished manuscript proves the opposite. By rewriting the stigma's hegemonic narratives, the author presents an alternative account based on experience as opposed to stereotypes. As Wood emphasizes, “The ex-patient needs to tell yet another story of who she is, this time, a story that reconstructs her identity as a person capable of living in the non-hospital world” (71). In other words, by writing one's story of mental illness, an individual fights the stigma, which says she is incapable of such a feat, and heals her ego identity. White agrees that autobiographical writing is both “a way to proclaim [one's] experiences with mental illness, while at the same time reclaiming [one's] sense of self” (4). Ultimately, this narrative therapy works by exposing where and why the stereotypes of stigma are false in relation to personal experiences, which then allows for the author to release some of the pain caused by the stigma and to understand the context of her disorder. Young supports a similar conclusion to White's about the personal advantages of autobiography: authors “write the memoir for their own benefit...they write about their experience as a means of expunging the pain and suffering the illness has caused...to cull the traces of [their] identity into some sort of self...[and] to make meaning out of [their] devastating experiences” (65). Narrative therapy heals the author through “a process of resolving ambivalences” (Young 65). Oftentimes,

resolving psychic ambivalences is a primary goal of psychotherapy, which is why many therapists encourage patients to write about their past experiences.

Elizabeth Wurtzel illustrates this first common goal within her *New York Times* best-selling memoir *Prozac Nation* (1994), in which she describes her experiences with atypical depression from childhood through young adulthood. She reflects upon her parents' combative divorce, her father's eventual absence from her life, the disillusionment and despair of Generation X, and her final diagnosis. Wurtzel uses two dominant metaphors to accomplish the first common goal of narrative therapy. The first metaphor is a comparison of her untold narrative of depression to a palimpsest; this metaphor emphasizes Wurtzel *had* to write her memoir for healing and peace. The second metaphor—a comparison of the mentally ill and the living dead—is an extended metaphor, which repeats throughout the text; this image illustrates the way depression fractures Wurtzel's ego identity, effectively killing her former self-concept. To examine the palimpsest metaphor, first one must know the term “palimpsest” has two definitions; according to *Merriam-Webster Dictionary*, a palimpsest is: (1) “writing material (such as a parchment or tablet) used one or more times after earlier writing has been erased,” and (2) “something having usually diverse layers or aspects apparent beneath the surface” (“Palimpsest”). The first definition is historical and refers to antiquity when writing materials were scarce; during this period, scribes reused tablets and parchments by erasing prior writings and marking over them. Because the erasure never completely removed the previous words, prior texts faintly remained under newer writings. This first type of palimpsest visualizes why Wurtzel's unwritten personal narrative of depression called to her beneath whichever article she was writing at any given time. She uses this metaphor to explain why she initially decided to compose her memoir—to quiet the shadow narrative that demanded to be told. The second

definition of palimpsest applies to Wurtzel's memoir as a whole; she includes "diverse layers [and] aspects beneath the surface" of her narrative by including epigraphs from literature and popular culture as well as political critiques of psychiatry, the Community Mental Healthcare Movement, and the capitalism of psychopharmacology. In this way, her memoir is not simply a retelling of her experiences with depression; it is a social critique of late-20th-century America. Focusing on the first definition of palimpsest, although she had written magazine articles about depression before her memoir, in the "Afterword" of *Prozac Nation*, Wurtzel explains her compulsion to write about her experiences in vivid detail:

I would...say that I had tried to write other books about very different topics, that I had tried to be a regular journalist, that I had tried to be an arts critic, that I had tried very hard to get away from thinking or feeling depression in all my professional endeavors, but it just kept creeping up, over and over again, like a palimpsest, a text hidden beneath whatever else I was working on that refused to remain submerged. Finally, and, I guess, inevitably, I gave in to the obsessive hold that my experiences with depression seemed to have on me, and decided to just write a whole book, all by itself, about that very subject and nothing else. Get it done and be done with it. (355)

Although she initially avoided writing her memoir, Wurtzel needed to write it to mentally free herself. Unresolved ambivalences have a way of continuously pecking at the psyche, and the need for resolution often becomes an impetus to commit one's deepest thoughts and darkest experiences to paper. White claims, "the very nature of offering the world your story in an autobiography is a liberating move," and Wurtzel certainly seems to agree (8). To free herself from the stigma and reconstruct her identity, Wurtzel published her shadow narrative that "refused to remain submerged" (355). In essence, mental illness life narratives help resolve

psychic contradictions that constrain one's ability to heal and function, so a primary goal of this genre is narrative therapy.

The second metaphor, used not only by Wurtzel but also by Jamison and West, is the image of the living dead. This common metaphor illustrates the death of one's prior identity—both ego and social—after the experience of mental illness. Because mental disorder affects one's mind, brain, body, and soul, the equation of mental disorder to a metaphorical death emphasizes the all-encompassing destruction of such experiences. Jamison describes this mind-body experience using the metaphor of a corpse: “Now, all of a sudden, my mind had turned on me...[I was] virtually inert, with a dead heart and a brain as cold as clay” (*Unquiet Mind* 38). In fact, many writers include this metaphor, which suggests the death of one's former self-concept is a regular consequence of mental illness. Moreover, this metaphor highlights the individual's feeling of disconnection from the world around him, underlining the difference between his stigmatized identity and those of neurotypical people. In *Prozac Nation*, Wurtzel extends this metaphor throughout the first half of the text, varying between images of ghosts and zombies. Within her first chapter, Wurtzel describes her experience with depression as a living death:

In my case, ...I was certain, quite certain, that I was already dead. The actual dying part, the withering away of my physical body, was a mere formality. My spirit, my emotional being, whatever you want to call all that inner turmoil that has nothing to do with physical existence, were long gone, dead and gone, and only a mass of the most god-awful, excruciating pain, like a pair of boiling hot tongs clamped tight around my spine and pressing on all my nerves, was left in its wake. That's the thing I want to make clear about depression, it's got nothing at all to do with life...Depression is in an altogether different zone because it involves a complete absence: absence of affect, absence of

feeling, absence of response, absence of interest. The pain you feel in the course of a major clinical depression is an attempt on nature's part...to fill up the empty space. But for all intents and purposes, the deeply depressed are just the walking, waking dead. (22)

For Wurtzel, depression is the death of her spirit, which connects this genre to that of spiritual autobiographies. Like authors in spiritual conversion narratives, mental illness memoirists often present themselves as spiritually dead near the beginning of their narratives. Losing one's spirit and self becomes a central conflict within this genre, which is why a typical goal is to heal the author's self-concept. In another example, Wurtzel describes feeling like a body without a spirit, invoking a zombie image: "People talk about the way disembodied spirits roam the world with no place to park themselves, but all I can think is that I am a dispirited body, and I'm sure there are plenty of other human mollusk shells roaming around, waiting for some soul to fill them up" (49). At this point in the memoir, Wurtzel feels disconnected from her classmates and her parents, but she intuits that she must not be the only person who feels this way, particularly in her generation when divorce became extremely common and broken families seemingly created broken people. In her last use of this metaphor, Wurtzel compares herself to both a corpse and a ghost: "I can watch myself, sit alongside this vacant corpse of mine, and watch the roll of tears, but there is no sense of release because there's no one inside. I'm gone. *Knock-knock?* I've disappeared" (176). This dissociation—feeling disconnected from her body—occurs during the moment of awakening in the text, which is when she accepts she cannot overcome depression on her own and decides to seek professional treatment. Moments of awakening most often occur at the climax of the plot action, which I explain in greater detail in the next section. Cameron West also uses the metaphor of the living dead, referring to himself as "a fetid and festering corpse covered in sticky blackness, still mired in putrid shame and scorching self-hatred," even during

his psychiatric treatments and while completing his Ph.D. (261). Unlike Wurtzel—who stops using this metaphor after receiving effective treatments, i.e., Prozac, other medications, and psychotherapy—West ends his memoir with the living dead metaphor, but he reverses the pathos in it. Throughout the memoir, West’s uses the living dead to inspire sadness for his lost ego identity, but his last inclusion of it encourages hope and empathy through the recreation of his self-concept: “Remember all those pirates you read about when you were a kid? Blackbeard and Long John Silver and all those guys? Well, they were wrong about something. Dead men do tell tales. And I’m the living proof” (319). West does not abandon the living dead metaphor because he still considers his former self (before his symptoms of dissociative identity disorder emerged) to be gone; however, he conforms to the traditional Recovery Narrative resolution—recovery and reentry into the world as a functioning, capable adult. Overall, this living dead metaphor accentuates the destruction of identity during the experience of mental disorder. To recover from this loss, mental illness memoirists resolve their broken identities by reconstructing their experiences and foregrounding a new self-awareness through narrative therapy.

5.6.2 *Goal 2: Regaining One’s Voice*

Building upon the need to heal one’s identity, the second typical goal for mental illness memoirists is regaining their voices. As previously explored in this project, one consequence of the stigma is the silencing patients endure; this silencing may be imposed by mental health professionals, by people in the community outside the hospital, or by the patient himself. Ex-mental patients quickly learn the consequences of discussing their previous experiences with mental disorders because such admissions often lead to ostracism. However, this silence only reinforces the stigma, and if this silence is not fought, future generations are doomed to repeat the same miseries. This social and rhetorical suppression stems from the stigma myth that claims

individuals with mental disorders are unreliable narrators, even, or perhaps especially, when retelling of their personal experiences. Pryal describes this loss of credibility: “Psychiatric disabilities—even mild ones, or ones that respond well to treatment—mark a person as unreasonable or incapable of rational thought, producing an unreliable ethos for the mentally ill” (480). The concept that mental disorder automatically makes a person unreliable comes from the stereotype that psychiatric patients are inherently illogical, incomprehensible, and, at worst, liars.

The archetype of mental patient as unreliable narrator is precisely why the second common purpose of these memoirists is imperative; if one desires to reconstruct her identity through narrative, the next crucial step in the process is regaining one’s narrative voice. Pryal concludes, “Using narrative to convey their experiential knowledge, mood memoirists overcome rhetorical exclusion by creating a narrative space in which their voices can be heard, generating a rhetorical capital grounded in narrative logic rather than scientific logic” (484). Moreover, although scientific logic appeals to an audience’s sense of reasoning (*logos*), narrative logic appeals most strongly to an audience’s emotions (*pathos*). For mental illness memoirists, if their narratives appeal to readers’ emotions in meaningful ways that encourages empathy, then readers may be more willing to consider the logical appeals these memoirists also include in their texts. The *pathos* of the narrative chips away at the unreliable narrator assumption, thereby allowing the audience to reassess the author’s ethos, or credibility. As Wood emphasizes, “Most of these writers...insist on their ability to contribute to their own healing and demand the right to be acknowledged as experts on their own illness” (109). To this end, two major narrative tropes illustrate these authors’ desire to be seen as legitimate experts on their own experiences. First, many memoirists include moments of awakening, directly connecting this type of life writing to the generic traditions of spiritual conversion narratives, which fosters the audience’s sense of

trust. Secondly, these memoirists typically give vivid descriptions of their mental disorders to redefine and humanize the experience and symptoms of these disorders; this works to counter the depersonalizing definitions and examples found in case studies and the *Diagnostic Statistical Manual of Mental Disorders*, which is the authoritative text used by all psychiatrists to diagnose patients. Wurtzel, Jamison, and West best illustrate moments of awakening and the trope of redefining their disorders.

First, to authenticate mental illness life narratives as a genre worthy of study, these authors often emulate other traditional life-writing genres in American literature, including the slave narrative, the captivity narrative, and the spiritual conversion narrative. Following the literary conventions of these early-American genres appeals to the audience's sense of ethos because the American reader has learned to trust, if not to expect, many of the pre-established narrative arcs and literary tropes that occur within these genres. For example, the moment of awakening is a common narrative trope within mental illness life narratives, but this trope finds its roots in early American literary traditions for autobiographical writing. Pryal magnifies this "coming-to-consciousness" as a characteristic device of mood memoirs, although this extends to mental illness life narratives in general, and she ties this trope to the expected narrative arcs of other traditional American life writing:

[One] convention of the mood memoir is the moment of awakening to the reality of the memoirist's illness. Mood memoirs often include an early denial of the illness and then an awakening, followed by the confession of the illness to others and the seeking of treatment, and treatment failures followed by a final success. These conventions share strong similarities to the conventions of older memoir genres, such as the spiritual autobiography (or conversion narrative), when the author comes to God; the

slave narrative, when the former slave comes to political consciousness; and the breast cancer narrative, when the “survivor” discovers a lump. The similarities are so striking that...the mood memoir can be thought of as a recent addition to a much older family. (490)

As Pryal emphasizes, many of these authors deny their symptoms of disorder at the beginning of the memoirs; this denial discourages them from seeking treatment, often for the first half of the narrative. During the rising plot actions, the author illustrates the horror, wonder, confusion, and pain of living with an untreated mental disorder. This mental turbulence mimics the spiritual turmoil authors of conversion narratives portray: the author experiences immense distress which he cannot overcome through self-reliance alone. Furthermore, the moment of awakening in a mental illness life narrative is often the climax of the plot, much like in a spiritual conversion narrative, because it represents the apex of the author’s distress and helplessness. The memoirist no longer can deny her disorder, usually because of a definitive outburst, which destroys the false rationalizations of denial. In addition, many authors include a brief introduction of this moment near the beginning of the narrative because it foreshadows the main topic of the memoir. For example, Cameron West begins the narrative time of his memoir just before he experiences his first symptoms of mental disorder. He describes how he believes his mental pains are physical and sinus-related, so he originally seeks treatment from medical doctors. Four sinus surgeries later, West still feels something is wrong. Next, he foreshadows his moment of awakening during a strange incident in his workplace restroom:

I opened my eyes and checked my reflection in the mirror, and as I did, something bizarre happened. A sudden jolt shot through me like an electric shock, and my whole body trembled for just a second. Then I began to mumble gibberish, like I was trying to say

something, but had lost control of my mouth. Terrified, I looked in the mirror again and saw a reflection—mine—disconnected, staring blankly, mumbling. I tried to decipher my words, but they were unintelligible. *What's happening to me?!* And then, with another jolt and shake, I was back and the mumbling stopped. I slumped to the floor, chest heaving, heart racing, the tile felt cold against my hands. After a couple of minutes I pulled myself to a standing position, relieved that no one had walked in on me. *You're a very sick person. Go home.* (C. West 20)

Although he cannot deny something is wrong, West does not begin to recover until he seeks psychiatric help, goes through a series of treatments, and eventually resolves his denial during the falling action of the plot. Nevertheless, this early coming-to-consciousness that “something is wrong” occurs in many of these memoirs. For instance, Wurtzel illustrates this foreshadowing of the moment of awakening in her “Prologue”:

I start to get the feeling that something is really wrong. Like all the drugs put together—the lithium, the Prozac, the desipramine, and Desyrel that I take to sleep at night—can no longer combat whatever it is that was wrong with me in the first place. I feel like a defective model, like I came off the assembly line flat-out fucked and my parents should have taken me back for repairs before the warranty ran out. But that was so long ago. I start to think there really is no cure for depression, that happiness is an ongoing battle, and I wonder if it isn't one I'll have to fight for as long as I live. I wonder if it's worth it. I start to feel like I can't maintain the façade any longer, that I may just start to show through. And I wish I knew what was wrong. (1)

Here, although Wurtzel acknowledges that “something is really wrong,” she denies medications will heal her mental disorder, thereby resisting the expected recovery resolution from the

beginning of her memoir—a theme she maintains throughout the text. The climatic awakening occurs later in Wurtzel’s plot, almost halfway through the memoir, when she is a student at Harvard: “And I knew, as Ruby chased me [with a knife for stealing her boyfriend]...that I had finally crossed some line. It all became so clear to me. I knew that *this was insanity*: Insanity is knowing that what you’re doing is completely idiotic, but still, somehow, you just can’t stop” (112-113). Wurtzel’s moment of awakening stems from her belief that she should be happy at Harvard because she worked so diligently to earn admittance there; nevertheless, she acts selfishly in her depression and provokes strong reactions from others. In the above example, she steals her close friend’s boyfriend, even though she does not like him, because she desperately wants to feel something other than depression. This moment marks Wurtzel’s decision to seek treatment of her own volition, as opposed to her mother’s insistence. As exemplified in *Prozac Nation*, the moment of awakening often marks the beginning of the falling action of the plot within mental illness life narratives.

After this coming-to-consciousness, typically, the author seeks professional treatment and a diagnosis. In a case study, the patient’s entrance into treatment serves as the beginning of the plot, though, of course, the patient’s personal history occurs like flashbacks. From a doctor’s narration, the patient’s positive response to treatment serves as the climax of the narrative, but for the patient, the moment of awakening and the end of denial marks the height of the plot. In Jamison’s memoir, her moment of awakening also occurs near the middle of the plot. Because her focus is to explain her illness and recovery and to emphasize the necessity of psychotherapy, medications, and a loving support system, Jamison divides her memoir into four parts: the first explains her childhood; the second part illustrates her mental disorder and the various treatments she tries; the third discusses her support system and the need for love; and the fourth part

demonstrates her recovery and advocacy. Her moment of awakening in the second part comes as a shock to Jamison:

My work and professional life flowed. But nowhere did this, or my upbringing, or my intellect, or my character, prepare me for insanity. Although I had been building up to it for weeks, and certainly knew something was seriously wrong, there was a definite point when I knew I was insane. My thoughts were so fast that I couldn't remember the beginning of a sentence halfway through. Fragments of ideas, images, sentences, raced around and around in my mind like the tigers in a children's story. Finally, like those tigers, they became meaningless melted pools. Nothing once familiar to me was familiar. (*Unquiet Mind* 82)

Jamison, as in the other examples, directly states the common theme of this moment: "something was seriously wrong." From this point of recognition, the falling action in a mental illness memoir portrays the author tumbling through ineffective treatments and bad doctors until he finally finds a capable doctor, who helps him recover through an effective treatment plan. The second part of Jamison's memoir demonstrates this typical struggle of finding and maintaining an effective treatment plan. Unlike in case studies, the patient rarely finds relief from the first doctor she visits. Thus, although the expected resolution of a mental illness memoir is recovery as with a case study, if recovery occurs, it is through the active collaboration between the patient and a competent doctor. Unlike when doctors narrate the resolution, the patient memoirist demands an active role in her treatment; the doctor alone cannot heal the patient.

Therefore, the moment of awakening serves as more than the climax of the narrative; the self-awareness involved in the realization invokes ethos, appealing to the audience's trust in the author as a credible source to his own experiences. Using an allusion that subverts the fairytale

of the boy who cried wolf, Wurtzel emphasizes her decision to take an active role in her recovery after a serious suicide attempt; in this moment of awakening, Wurtzel remembers:

While I'm lying in bed at Stillman [Infirmery]...I am so tired of the girl in the infirmary, I am so sick of the girl who cries wolf all the time—even though not one of those cries was ever a false alarm. Not one of my pleas for help was ever less than truly urgent because when it's all in your mind, there always *is* a wolf. That's what it feels like...This wolf has been stalking me for ten years, and now it's time he went away. Time for me to get better. (322-323)

Although the authors may express confusion during the moment of awakening, their consequential coming-to-consciousness establishes the authors as reliable narrators, which ultimately supports the goal of regaining one's voice through life writing. As Pryal confirms, the moment of awakening for mood memoirs is:

Unique among similar genres in that the narrator is recounting the awareness of a mental illness; an illness which, in a paradoxical fashion, does not impede the author's self-awareness. This apparent paradox renders the awakening moment as particularly rhetorically powerful: the precision of the descriptions of awakening establishes the author's reliability as narrator, despite the author's mood disorder. By describing the awakening with ostensible clarity, precision, honesty, and self awareness, the memoirist tacitly invites the audience to trust her narration of events. In short, although the mood memoir is a story of mental illness, the awakening implies that the illness does not impede the narrator's ability to tell the story. (490)

Therefore, the moment of awakening is a crucial trope to include in mental illness life narratives because it emphasizes the author as a credible narrator.

The second common trope authors use to establish ethos as well as pathos is re-defining their disorders through personal descriptions and metaphors; this trope humanizes the distanced scientific rhetoric of the *DSM* by illustrating mental disorders through emotionally engaging language. Although most of the memoirists I explore here do not deny their diagnoses from the vantage point of a now-recovered (or recovering) narrator, they re-define their psychiatric diagnoses by adding nuanced context, which the *DSM* and case studies lack. Pryal highlights how memoirists respond to and add to established psychiatric knowledge:

Memoirists seize the rhetorical authority provided by the DSM...and combine it with the authority provided by autobiography as a genre...They use narrative to describe their illnesses, often echoing the descriptions of illness that doctors provide in their patient files, seizing the authority inherent in the act of describing for themselves—implying that patients, not just doctors, are capable of describing symptoms and their attendant suffering. (482-483)

By insisting that patients can provide valuable wisdom, these authors re-write and revise dominant authoritative narratives produced by doctors. Moreover, by appealing both to ethos and pathos, these authors regain their voices that have been silenced through stigma myths and scientific jargon. Moreover, they demonstrate the necessity of patients' active participation in treatment and recovery. While illustrating their personal understanding of their mental disorders, these authors often combine psychiatric terms they have learned in treatment with metaphors that humanize their experiences and appeal to the literary conventions of memoirs as a genre. Wood explains, "Some of these writers take control of their life stories by refiguring the medical terms they have learned and often internalized in their histories as psychiatric patients," and by doing so, they "provide their own methods of analysis as they expose the constructiveness of

psychiatric knowledge” (87). Because psychiatric knowledge relies upon the use of narratives and anecdotal evidence, these authors demonstrate how their counter-narratives teach as much about mental disorders as the best authoritative texts.

Wurtzel demonstrates this trope multiple times. In the one example, Wurtzel uses her prior knowledge of psychiatric jargon to demonstrate scientific rhetoric cannot define depression with precision; she accentuates this concept by wishing she had a less deniable mental disorder, such as a drug addiction:

Here was this thing called depression that was not definable in any sort of concrete way...that had simply taken up residence in my mind—a mirage, a vision, a hallucination—and yet it was creeping into the lives of everyone who was close to me, ruining them, all as I was ruined myself...this was just madness...I found myself *wishing* for a real ailment, found myself longing to be a junkie or a cokehead or something—something real. (67-68)

Wurtzel uses psychiatric terms—mind, hallucination, madness—but she emphasizes the inadequacy of such language to explain her experience, not only to herself but to her audience. To resolve this conflict, Wurtzel relies upon metaphors to illustrate the feeling of depression; specifically, Wurtzel utilizes nature metaphors—ice, fog, avalanche, and wave—which underline both the commonality of mental disorder in human nature and the powerlessness one has over such natural forces. First, she compares the feeling of depression to becoming ice:

I feel a numbness come over me that is, I’m sure, worse than anything ever. It is more like a deep freeze, in which the ice threatens to crack at any moment, but underneath there won’t be water, there won’t be anything fluid at all, just more and more layers of

ice and ice and ice—ice cubes and icebergs and ice floes and ice statues, where a girl used to be. (Wurtzel 95)

The ice she describes is deadly—invoking the image of a girl buried deeply beneath numerous layers of it. Resisting the expected Recovery Narrative resolution, Wurtzel denies the living existence of the girl she used to be and opines she will never return to that pre-disordered self. Next, Wurtzel equates depression to an all-encompassing fog: “That’s the thing about depression: A human being can survive almost anything, as long as she sees the end in sight. But depression is so insidious, and it compounds daily, that it’s impossible to ever see the end. The fog is like a cage without a key” (191). This metaphor appeals to the audience’s sense of fear; mimicking the feeling of claustrophobia, Wurtzel describes depression as a fog that closes in like a cage without a key. This evokes images from gothic literature and horror films of walls closing in with no escape in sight. This redefinition of depression creates a tangible sense of fear with which the audience can sympathize; thus, Wurtzel exemplifies how literary devices humanize the experience of mental disorder. Wurtzel continues using metaphors to capture the overwhelming power of depression; for example, she states, “I feel like her mountain. Only I’m about to have an avalanche,” and “I feel the black wave drowning me” (308-309). Wurtzel’s metaphors offer alternative ways to understand depression; they do not refute the psychiatric definitions of depression, but they emphasize how psychiatric rhetoric, such as definitions in the *DSM*, often lacks the pathos which figurative language inspires. Importantly, the pathos inherent within mental illness life narratives is what encourages empathy in readers, which, in turn, fights the stigma one reader at a time.

Similarly, West combines psychiatric jargon with a nature metaphor. West describes his experience of dissociative identity disorder with the metaphor of snow: “Normal neurological

pathways felt piled high with heavy snow, while driverless microscopic plows forged random routes through my brain” (42). Here, West juxtaposes scientific language with literary metaphor, emphasizing the necessity of both types of knowledge to fully understand mental disorders from multiple perspectives. This suggests wisdom comes from a collaboration of meaning-making. Likewise, Jamison reminds readers of the importance of psychiatric knowledge and her personal career in the field, while simultaneously presenting manic-depression through nature metaphors. First, Jamison equates manic-depression to fire: “Manic-depression is a disease that both kills and gives life. Fire, by its nature, both creates and destroys...Mania is a strange and driving force, a destroyer, a fire in the blood” (*Unquiet Mind* 123). Notice, although she represents this disorder as a disease with a medical name, she describes the first-hand experience of it through the metaphor of fire—it is both creator and destroyer. She extends this metaphor from her 1993 cultural critique *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*, in which she lays claim to genius artists in history who created through, if not because of, manic depression. The fact that she connects her prior scholarly work to her memoir further emphasizes her purpose to regain her voice, part of which she submerged within her prior work; like Wurtzel’s palimpsest metaphor, Jamison’s personal story fights to surface in *Touched with Fire*, but she shines light upon it in *An Unquiet Mind*, further underscoring that her personal shadow narrative could remain hidden no longer. Jamison appeals to the audience’s sense of fear and wonder when she represents manic depression as a tide:

It was a tidal existence: When I was depressed, nothing came to me, and nothing came out of me. When manic, or mildly so, I would write a paper in a day, ideas would flow, I would design new studies, catch up on my patients charts and correspondence, and chip away at the mindless mounds of bureaucratic paperwork...Like everything else in my

life, the grim was usually set off by the grand; the grand, in turn, would yet again be canceled out by the grim. It was a loopy but intense life: marvelous, ghastly, dreadful, indescribably difficult, gloriously and unexpectedly easy, complicated, great fun, and a no-exit nightmare. (*Unquiet Mind* 131-132)

Describing manic depression as an ebb and flow in functioning allows the audience to understand how the disorder both disrupts and ignites productivity. Additionally, Jamison captures how this disorder can be an alluring dream or an unending nightmare. By including psychiatric terms but overwhelming them with metaphors, Jamison and West stress the importance of understanding mental disorders from the perspectives of doctors and patients. Furthermore, by using literary devices, these authors appeal to wider audiences, which improves social understanding and inspires empathy for mental patients.

Correspondingly, mental illness life narratives crash through the silencing, allowing the authors to regain their voices and deny the stereotypes of the dominant cultural narrative. Through narrative, the authors “offer their own interpretations and reevaluations of the power structures that seek to control and silence them,” White explains (6). Moreover, White declares this genre highlights “marginalized experiences” to shatter the silencing imposed by the stigma (8). By sharing personal experiences of mental disorders, these authors challenge the label of “marginalized” because their texts disrupt the idea that mental disorders are rare, especially when one attempts to count the increasing numbers of such publications. At this point in the 21st century, many individuals, including celebrities, have started sharing their experiences of mental illness through social media outlets, in documentaries and interviews, and in memoirs. As the proliferation of these experiences increases in printed texts and digital mediums, the concept of “otherness” begins to disappear, making the silencing easier to combat. Wurtzel reflects on this

purpose in a similar way; by breaking her silence, she aims to demonstrate the importance of understanding depression as a serious disorder, not one to be taken lightly nor dismissed:

In effect, if *Prozac Nation* has any particular purpose, it would be to come out and say that clinical depression is a real problem, that it ruins lives, that it ends lives, that it very nearly ended *my* life; that it afflicts many, many people, many very bright and worthy and thoughtful and caring people, people who could probably save the world or at the very least do it some real good, people who are too mired in despair to even begin to unleash the lifespring of potential that they likely have down deep inside. (356)

By composing mental illness life narratives, authors combat several stigma myths, including concepts of weakness, otherness, and malingering; moreover, through this genre, readers learn how common these experiences are within the human condition. Furthermore, by ending their silence, these authors also fight the isolation inflicted by it.

5.6.3 Goal 3: Ending Isolation

When I first began to suffer from mental disorder, I felt completely alone. I did not know many other people who had bipolar disorder, and the few I did never spoke about it. It felt like a shameful secret everyone worked to hide, and the subsequent isolation caused by this only made my diagnosis more devastating. How did other people react to this disorder? Did others have similar experiences to mine? Predictably, I turned to books for answers. The memoirs I read changed my life because I found kindred spirits in the authors; their tales confirmed I was not alone. When Wurtzel encountered the same feeling of isolation, creating her memoir became a stratagem to contend with her loneliness:

When I finally have to explain my motives for writing this book, it really does come down to wanting to feel less lonely in this lonely feeling, wanting to shed depression's

thick, tender, suffocating skin. I wanted to open up and say, *This may not matter to anyone else, but as far as I'm concerned, at times it has felt like I've had Vietnam going on in my own brain.* And I really hoped to reach other people and touch a little bit of their loneliness. (359)

Obviously, Wurtzel accomplished both objectives to end her own isolation and that of others based on the memoir's popular success. Though it received poor critical reviews after its initial publication in 1994, *Prozac Nation* became a mainstay on American bestseller lists, and its popularity led to a film adaptation in 2001, starring Christina Ricci. According to American journalist Anne Lee Beyer in the *Bustle* magazine article "25 Years Ago This Book Changed the Game for Mental Health Memoirs" (2019), at the time of *Prozac Nation*'s publication, "Prozac had been prescribed to more than six million people in the U.S." Apparently, Americans were interested in this memoir because many readers were struggling with the same disorder.

Ultimately, memoirs like *Prozac Nation* illuminate the commonality of mental disorder to fight social isolation. In another example, Cameron West struggled to understand his experiences with dissociative identity disorder (DID). First, due to psychic repression (one of the mind's defensive responses to trauma), West denied his disorder until the end of his treatment because he could not remember the childhood sexual abuse he endured by his mother and grandmother. Moreover, because his diagnosis is rare and extremely misunderstood due to media representations like *Sybil*, West's sense of isolation was overwhelming. In his memoir, *First Person Plural: My Life as a Multiple* (1999), he explains why he shares his story in his memoir and in public speaking engagements: "I desperately want to feel like I'm part of this world and somehow connected to the people in it...I'm through being disconnected...I am who we [his multiples] are, and it's got

to be okay, or I've got no chance for a better life" (C. West 311-312). By sharing his experiences with DID, West ends his isolation by finding others with DID.

The authors further highlight their purpose to end isolation with the narrative strategy of laying claim. Pryal outlines "laying claim" as a key feature of mood memoirs, but other mental illness life writers include this technique as well. Pryal defines "laying claim":

Every mood memoirist I have studied lays claim to other sufferers of mental illness as a means to create rhetorical authority. By "laying claim" I mean, on one level, simple name or statistics-dropping. Memoirists seek to normalize their illnesses; until quite recently—and many would argue, still—patients were advised to hide their diagnoses. Memoirists can break this taboo by pointing out the large number of people who are also diagnosed with mental illness (statistics-dropping) or by invoking famous persons with mental illness (name-dropping). (495)

Statistics and name-dropping exhibit the commonality of mental disorders and demonstrate intellectual productivity is possible in spite of mental disorder. Wurtzel and Jamison present statistics to illustrate the prevalence of mental disorder in late-20th-century America. First, Wurtzel confronts the financial expense of mental disorders in America during the 1990s: "I recently read that treatment for depression costs the United States something like \$43 billion annually in lost productivity and employee absence" (280). Notice this statistic looks at the cost to the American economy and corporate profit margins; Wurtzel introduces these effects on the American workforce to intrigue her readers. However, instead of blaming sufferers for missing work, Wurtzel underscores the problems of American capitalism—such as the demands for unending productivity, which affect American stress levels—and the psychopharmaceutical industry's insatiable desire for higher profits. In the "Epilogue" to *Prozac Nation*, Wurtzel lists

compelling statistics that focus on the positive correlation between increasing diagnoses for depression and pharmaceutical profits: “\$1.3 billion spent of prescriptions for Prozac last year (up about thirty percent since 1992)”; “The *New York Times*, reporting on the eleven million people who have taken Prozac—six million in the United State alone—would declare on its front page that this constituted a ‘legal drug culture’”; and “Since I first began taking Prozac, the pill has become the second most commonly prescribed drug in this country (behind Zantac, the ulcer remedy), with one million orders filled by pharmacists each month” (Wurtzel 334-335). These statistics emphasize the prevalence of depression in America and suggest the miracle of Prozac is not a cure at all but merely a temporary remedy, much like Zantac. Like treating an ulcer, a pill only relieves the symptoms, but it cannot solve the underlying cause, such as immense stress. Thus, Wurtzel implies Prozac does not resolve the medical issue, nor does it combat the social issues that contribute to depression, such as expectations for hyper-productivity to increase profit margins. Contrastingly, Jamison takes a different critical approach when presenting statistics about lithium and patients’ typical resistance to taking the drug: “Unfortunately, this resistance to taking lithium is played out in the lives of tens of thousands of patients every year. Almost always it leads to a recurrence of the illness; not uncommonly it results in tragedy” (*Unquiet Mind* 105). The difference between Wurtzel’s statistics and Jamison’s illustrates the deviation in their perspectives on taking medication. Wurtzel believes medication helps, but the drug industry is corrupt. Jamison, as a psychiatrist, does not address the problems of the psychopharmaceutical industry because her focus is encouraging patients to take medications as prescribed. Nevertheless, both authors use statistics to emphasize the prevalence and impact of mental disorders in Americans’ lives. Statistics help to destigmatize mental illness because they offer a

glimpse at the sheer volume of people who experience mental disorders; therefore, laying claim through statistics fights the social isolation of this marginalized group.

The second part of laying claim involves recognizing famous, accomplished, historical figures who suffered from mental disorders. This tradition of laying claim through name-dropping stretches back to Aristotle's theories on rhetoric; according to Pryal, "Aristotle calls this practice of comparison 'amplification,' or *auxesis* in Greek. Since mental illness is often taboo, it is not surprising that laying claim—comparing oneself to a famous person who has a similar illness—would take central importance in establishing authority" (495). Thus, the practice of *auxesis* increases the author's credibility and challenges stereotypes that claim mental illness makes one inferior, weak, and unintelligent. On the contrary, by employing *auxesis*, these authors show what extraordinary accomplishments people with mental disorders can achieve. As Pryal explains, laying claim through name-dropping serves two purposes:

It can either normalize the author—a great step in establishing authority—or, through retroactive diagnosis of creative geniuses, push the author's ethos into the realm of genius, which seems like an even stronger rhetorical position, particularly in the context of creative nonfiction. (496)

In fact, this type of laying claim is exactly what Jamison focuses on in her sociohistorical critique *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*. In her memoir, Jamison briefly mentions a few of the authors she analyzes in *Touched with Fire*, including Lord Byron, Virginia Woolf, and Robert Lowell, but she does not examine these figures in great detail within *An Unquiet Mind*. However, as Pryal points out, Jamison's argument in *Touched with Fire* sets a potentially dangerous stereotype: "This research, combined with the fine creative work produced by many mood memoirists, has created a popular

misconception that all mood disorders carry creative potential” (498). However, Jamison is not the first to posit this correlation; as she illustrates in *Touched with Fire*, Socrates, Plato, and later Aristotle believed madness could be a creative gift from the gods (51). Thus, this tradition of naming geniuses who suffered from mental disorders stretches from ancient civilization to today. In *Girl, Interrupted*, Susanna Kaysen lays claim through name-dropping when listing all the famous patients of McLean Hospital:

Our hospital was famous and had housed many great poets and singers. Did the hospital specialize in poets and singers, or was it that poets and singers specialized in madness? Ray Charles was the most famous ex-patient...We had the Taylor family...James...Kate and Livingston...Robert Lowell...Sylvia Plath...What is it about meter and cadence and rhythm that makes their makers mad? (48)

Kaysen implies creative genius and madness are related to each other. Readers are familiar with these names, if not also their works, so this appeals to the readers and increases the author’s credibility by showing some mental patients are brilliant. Wurtzel drops more names than the other authors combined, so consider her longest auxesis as an example of this rhetorical strategy:

Madness is too glamorous a term to convey what happens to most people who are losing their minds. That word is too exciting, too literary, too interesting in its connotations, to convey the boredom, the slowness, the dreariness, the dampness of depression. You associate madness with Zelda Fitzgerald in all her rich, gorgeous, cerebral disturbedness, or maybe you think of it as something that members of Aureliano Buendia’s family sank into at the incestuous end of *One Hundred Years of Solitude*. Madness is something of the fiery hot tempers of Latin American or the Deep South, of Borges and Cortazar or William Faulkner and Tennessee Williams...Madness is Jim Morrison swinging

suggestively out of the seventh-floor window...it's Elizabeth Taylor and Richard Burton duking it out through the cramped camera angles of *Who's Afraid of Virginia Woolf?*; it's Edie Sedgwick in all her anemic, anorexic beauty, trying to do herself in with amphetamines and pearls...it's Kurt Cobain, in every one of those Nirvana videos, looking like a man who is sick, deeply sick, who needs help badly and wears his desperation like a badge of cool; it's Robert Mitchum, with his tattooed knuckles, preaching and ranting in *The Night of the Hunter*; it's Pete Townshend smashing his perfectly good guitar to bits and pieces; it's every great moment in rock and roll, and it's probably every great moment in popular culture...The word *madness* allows its users to celebrate the pain of its sufferers, to forget that underneath all the acting-out and quests for fabulousness and fine poetry, there is a person in huge amounts of dull, ugly agony. Why must every literary examination of Robert Lowell, of John Berryman, of Anne Sexton, of Jean Stafford, of so many writers and artists, keep perpetuating the notion that their individual pieces of genius were the result of madness? While it may be true that a great deal of art finds its inspirational wellspring in sorrow, let's not kid ourselves about how much time each of those people wasted and lost being mired in misery. (294-295)

Unlike Jamison and Kaysen, Wurtzel does not glamorize madness with creativity; on the contrary, Wurtzel emphasizes depression never helped anyone create art. If anything, it may serve as an inspiration, but most of the artists she lists committed suicide. Thus, in her estimation, depression kills both creativity and artists. Nevertheless, by employing *auxesis*, these authors fight their sense of isolation by connecting to the famous sufferers who came before them. Ending the isolation caused by stigma is a shared goal of many authors in this genre, and

although this objective begins with a personal desire to end loneliness, its reach extends to fighting many readers' isolation as well.

5.6.4 Goal 4: Protest

The fourth common goal of mental illness life narratives is protesting the stigma and the individuals who cruelly perpetuate it. This protest is certainly one reason I discuss my experiences of mental illness. As illustrated in the Foreword of this project, my rebellion against the stigma burgeoned when my diagnosing psychiatrist told me I would never earn a Ph.D. because I have bipolar disorder. This personal example illustrates why mental illness life narratives should be mandatory curriculum for those seeking careers in mental healthcare. Perhaps if Dr. E. had read the memoirs of Kay Redfield Jamison or Cameron West (both of whom earned doctorates despite serious psychiatric disorders), maybe he would have higher hopes for his patients. Part of me is certainly writing in protest of Dr. E.'s lack of vision. How many of his patients have believed his pessimism? How many people have given up on their dreams because of psychiatrists who did not believe them capable? If there is one spark that ignited my passion for this subject, it was then, in that expensive doctor's office, when I vowed to prove him wrong. As I explored mental illness life narratives, I continuously encountered this rebellion staring back at me through the texts. These authors always protest bad doctors, and they often protest the expected generic conventions for a Recovery Narrative. This specific genre applies to case studies and patient-written narratives solicited by doctors. By resisting Recovery Narrative conventions, authors protest psychiatric standards of representation for patient experiences. Oftentimes, authors include facsimiles or quotes from their patient files to further support their protests and develop ethos as narrators. Ultimately, mental illness memoirs submerge doctors' narratives beneath the patients'; when compared to case studies, this role

reversal makes the doctors' experience into the shadow narrative, buried but not quite silent beneath the new narrative authority of the patient. Wood explains that in case studies:

[Doctors] seek an understanding of schizophrenia [and other mental disorders] through scientific methods. And yet, as they describe their research or their clinical experience, submerged narrators provide glimpses of themselves and buried narratives often emerge that reach beyond the procedures of science. These implied stories take shape in the metaphors the writers use, in their (at time) shifting narrative voices, and in the telling moments—often moments of puzzlement or doubt—when their inquiry seems to burst the constraints of scientific study. (27)

By including evidence from their patient files and recollections of their doctors, mental illness memoirists unbury themselves from the shadows of doctors' accounts. In their life narratives, the patients take back their power by backgrounding the doctors' interpretations; the authors select which of their doctors' ideas to foreground and which ones they background, ignore, or ridicule—just as doctors do of patients' words in case studies. Pryal analyzes the criticism of doctors as a narrative trope:

Nearly all mood memoirists write about interactions with doctors who ignore patient stories in favor of other forms of knowledge, such as observations and diagnostic criteria. When they criticize doctors, mood memoirists pass judgment on the failures of the medical system, relying upon their experiential knowledge to talk back to traditional medical knowledge. This “talking back” gives rhetorical power to the memoirists; they deliberately oppose their experiential, narrative-based knowledge as patients to the empirical, scientific knowledge of the medical profession. Doctors, like lawyers and other

experts, can be blinded to the different types of knowledge possessed by the lay. (492-493)

Once again, who tells the story matters. For the mental illness life writer, her protest demands for her voice to be heard and for her personal insights to be held as valuable knowledge, though it is different from scientific knowledge. Susanna Kaysen's memoir best exemplifies the protest of bad doctors, and Elizabeth Wurtzel's memoir effectively illustrates the protest against the traditional Recovery Narrative promoted by medical professionals.

Susanna Kaysen's protest of psychiatric knowledge and inept doctors presents the fiercest roar from among these four texts. In her memoir *Girl, Interrupted* (1993), she remonstrates her diagnosis, the treatment of women in mental hospitals, and the sexism of the 1960s that labelled nonconforming women as insane. Kaysen includes facsimiles of her patient files and an excerpt from the *DSM* defining her diagnosis in order to refute her diagnosis and protest the authority of medical narratives. Moreover, Kaysen protests the hypocrisy of doctors' presumption that they know more about mental disorder than their patients: "For nearly a century the psychoanalysts have been writing op-ed pieces about the workings of a country they've never traveled to" (142-143). Her criticism is "sane" doctors misunderstand mental disorders because they reject the value of patients' perspectives. Pryal argues this is a typical criticism in mood memoirs because it "points to weaknesses in the presumption of expertise and strengthens the position of the non-expert" (493). Therefore, again, even in protest, these authors consistently work to build their credibility as narrators, and one way of doing this is debating medical authorities, who deny the trustworthiness of patients' narratives. In one chapter entitled "Do You Believe Him or Me?" Kaysen compares her version of events with the medical file created by the doctor who recommended her confinement. The chapter begins immediately with the official account she

will protest: “That doctor says he interviewed me for three hours. I say it was twenty minutes.

Twenty minutes between my walking in the door and his deciding to send me to McLean”

(Kaysen 71). Kaysen devotes the remainder of the chapter to disproving the doctor’s narrative.

She includes a facsimile of the time-stamped hospital document (one of many she adds from her patient files) as evidence to support her claim. Wood describes the impact of these facsimiles on the reader:

Read next to Kaysen’s own version of her emotional and mental state, the words on the hospital’s form, a page whose stretch of blank whiteness following the printed words emphasizes the failure of communicative language, appear critical and contemptuous.

The form presents its language as merely descriptive—“patient withdrew to her room, ate very little, did not work or study”—yet behind that bare description is a narrative of what this adolescent girl should have been like, should have been doing, should have been thinking. (59)

By using the timestamps on the document, Kaysen proves her consultation interview lasted only 30 minutes: “There we are, between nine and nine-thirty. I won’t quibble over ten minutes. Now you believe me” (72). Here, she shows that although she was not perfectly correct in her estimation, she was far more accurate than the doctor’s records. Using her patient files against them, Kaysen disproves many of her doctors’ assertions and decries her diagnosis by sustaining her moody, rebellious attitude was typical teenage angst, not illness. She protests her diagnosis in the chapter “My Diagnosis”; she includes an excerpt from the *DSM* which defines borderline personality disorder, but she augments it with her “annotated diagnosis” to satirize the inaccuracy of a diagnosis that symptomizes adolescent rebellion as a mental disorder. Kaysen uses verbal irony to emphasize her defiance against the psychiatric labelling, which forced her to

be hospitalized for almost two years: “I’m tempted to try refuting [my diagnosis], but then I would be open to the further charges of ‘defensiveness’ and ‘resistance’” (150). Of course, this is ironic because she clearly does the opposite through the rhetorical techniques she uses to compose her memoir and the adversarial tone she uses when describing her doctors. Moreover, using irony again, Kaysen ridicules the diagnosis of borderline personality disorder by quoting one of her psychiatrists:

What does *borderline personality* mean, anyhow? It appears to be a way station between neurosis and psychosis: a fractured but not disassembled psyche. Though to quote my post-Melvin psychiatrist: “It’s what they call people whose lifestyles bother them.” He can say it because he’s a doctor. If I said it, nobody would believe me. (151)

Here, Kaysen illuminates the hypocrisy of expert psychiatric knowledge; despite demonstrating the same opinion, a psychiatrist’s words are more socially credible than a patient’s. Through her use of irony, facsimiles, and comparisons, Kaysen protests through narrative discourse. Leah White argues mental illness life narratives work as a form of protest because they “function as a form of discursive resistance against a world that does not want to hear the story of mental illness, and a medical community that depersonalizes the female subject” (4). For Kaysen, exposing the sexism involved in the mistreatment and overdiagnosis of female patients is a key provocation for her fight against these injustices. By rewriting the hospital’s official version of her patient history, Kaysen empowers herself by refusing to accept the psychiatrists’ interpretation of her experiences. In a way, Kaysen is much like Dora in her refusal to accept the psychoanalysis of her character and past; however, unlike Dora, Kaysen fights back by re-writing the inaccuracies out of her narrative. In the literary analysis “Depathologising the Traumatized Self in Susanna Kaysen’s *Girl, Interrupted*” (2019), American psychology

professor and researcher Hyun-Joo Yoo describes the personal benefits Kaysen achieves through her narrative protest:

Through [her] “act of healthy defiance”—that is, her trauma writing—Kaysen, refusing to be re-traumatised, is empowered to speak and write about trauma in her own ways and exercises agency over her traumatic experiences by giving her own interpretations of the events, something that she was not allowed to do when she was young. (204)

By reclaiming her experiences through life writing, the memoirist can resolve incongruities in her own narrative and refute the inaccuracies within psychiatric knowledge. Kaysen exemplifies one approach to protesting psychiatry is directly exposing mistreatments and hypocrisy within the field through patient file facsimiles, which include doctors’ written notes and evaluations of her recovery progress. By verifying her versions of events through official hospital records, Kaysen proves her credibility with hard evidence.

Another type of protest sometimes exists within mental illness life narratives; for example, in *Prozac Nation*, Elizabeth Wurtzel not only protests doctors and psychiatry but also consistently rejects the generic conventions of the Recovery Narrative. Originally, the Recovery Narrative as a genre began when psychiatrists and psychotherapists sought to help patients understand their experiences and believe in the possibility of recovery through the act of narrative therapy. These narratives also became a way for doctors to better comprehend patient experiences, so many begin presenting these accounts at medical conferences, sometimes inviting patients to share their narratives publicly. In the *Culture, Medicine, and Psychiatry* journal article “The Recovery Narrative: Politics and Possibilities of a Genre” (2022), British researchers Angela Woods, Akiko Hart, and Hellen Spandler accentuate, as a genre, Recovery Narratives are medical “technologies of recovery”: these texts “are actively solicited, circulated

and mobilised in ways intended to benefit service-users, professionals and services...it would be difficult to underestimate the centrality of narrative to the way recovery is enacted, recorded, evidenced and legitimated” (226). Thus, Recovery Narratives begin not with patients, as the authorship suggests, but at the behest of doctors, who seek to legitimize the field of psychiatry through anecdotal evidence of successful recoveries. Highlighting the far-reaching impact of this genre, the narrative arcs and common tropes of the Recovery Narrative seep into other mental illness life narratives. The dominant conventions of the Recovery Narrative *require* the following narrative arc: 1) a detailed description of the patient’s mental disorder and an analysis of its origin; 2) a discussion of the different types of treatments the patient tries; 3) an illustration of the patient’s transformation and recovery. Woods et al. elaborate on these generic expectations and give examples of how patient-writers may develop them:

The Recovery Narrative can document many different ways of understanding and framing the nature and origin of mental distress (including in relation to trauma, biological illness and/or personal crisis), suggest multiple pathways to recovery (including therapy, medication, familial or peer support, religious counselling, and mental health activism), and give varying accounts of the depth of transformation (ranging from being “symptom-free” and “back to normal,” to “living well with illness and disability,” to accepting and celebrating experiences framed as unusual). As a genre, it confers power to the reader/audience by soliciting a two-fold confirmation: first, that the narrator does indeed possess insight into her own mental distress, and second, that this insight has been hard-won through the shedding of false (erroneous, delusional, ideological or otherwise unhelpful) beliefs. The Recovery Narrative therefore functions as evidence, testifying to an individual’s experience of recovery as something which has already been achieved, at

least in part. But at the same time it functions as enactment, a way of materialising recovery in the shared moment of the present. (230-231)

Notice, this genre's goal—to demonstrate the possibility of recovery—is well-intended and often helpful to struggling patients. Nevertheless, even demonstrated in this quote, the genre “confers power to the reader/audience,” but not the narrator. The patient constantly must fight to be recognized as a credible source, and within the Recovery Narrative genre, ultimately, the target audience (doctors) are still the arbiters of which patient is a reliable narrator or not. If a patient-author exercises too much literary creativity or questions the conventions of the Recovery Narrative, then her narrative may be excluded from this genre and deemed less legitimate. Moreover, only narratives which are solicited by healthcare professionals and follow strict adherence to the generic conventions officially count as Recovery Narratives; Woods et al. explain, “While the stories told by individuals about their experiences of madness, mental illness and distress are immensely diverse, only a narrow subset of such stories are socially, professionally and politically recognised as being Recovery Narratives” (228). Once again, the status of “official recognition,” or not, questions the reliability of a patient-narrator who writes without the strict guidance and supervision of a doctor; therefore, despite seeming to be an opportunity for self-autonomy and free expression, the official Recovery Narrative forces the patient-author to follow strict generic conventions and expectations. In this context, the Recovery Narrative is controversial, so for many creative memoirists, their personal narrative structures become battlegrounds to protest the Recovery Narrative as the only “legitimate” type of patient-written text. On the other hand, some activists see the Recovery Narrative as a site for empowerment. Woods et al. draw attention to diverse activists' ambivalence toward the genre:

The Recovery Narrative has become a deeply divisive issue amongst survivor activists. While it has been a primary vehicle for trauma-focused, narrative-driven activism (especially within contexts like the international Hearing Voices Movement...), it has also been strenuously disavowed by other activists who, for example, see the imperative to narrate traumatic experiences as another form of oppression. (227)

Woods et al. illustrate some activists and patient-authors support the Recovery Narrative, claiming its structure helps patients understand their experiences, develop hope for recovery, and fight the stigma by following a plotline that emphasizes recovery through psychiatric treatment. In contrast, other activists and patient-authors view the Recovery Narrative as another display of the scientific authority of doctors, who encourage, if not insist, upon patients reliving their trauma through narrative. Seemingly, the level of choice involved in the decision to write and to whom divides these groups of activists on this issue.

Prozac Nation is a perfect example of a rhetorical protest of the Recovery Narrative because Elizabeth Wurtzel purposefully subverts its generic expectations. In this memoir, Wurtzel cannot locate an origin for her depression; her pleas for medical help rarely lead to effective treatments; she reverses the expected transformation and refuses to resolve the memoir with recovery. By doing so, Wurtzel opines mental illness life narratives cannot always fit into the strict, sterile parameters designed by “saner” minds. In her literary analysis “Reading *Prozac Nation* as a Post-Humanist Resistance to the Recovery Narrative” (2021), Scottish researcher Maria Elena Carpintero Torres-Quevedo magnifies Wurtzel’s preoccupation with the narrative structure of her memoir:

Rather than landing her at a culturally intelligible and coherent narrative of the development of her depression, attempting to account for it makes her aware of the role

of language in creating meaning within a fixed set of parameters. Her experience with mental illness does not make her incapable of “making meaning”...or irrational in an Enlightenment Humanist sense, but illuminates the societal pressure to construct and impose a logical order and a narrative onto complex phenomena and the ways that doing so omits and reduces as much as it describes. (214)

By destabilizing the conventions of the Recovery Narrative, Wurtzel protests the generic expectations and questions the practicality of forcing logical understanding (logos) onto a phenomenon that relies upon emotional knowledge (pathos); this is not to say there is no logic in madness, for there certainly is, but the “logic” of disordered minds does not play on the same field as the reasoning of neurotypical minds. Wurtzel emphasizes this barrier between a patient’s first-hand understanding of mental disorder and the measuring observations of the distanced medical audience. In addition, through her subversive narrative structure, Wurtzel implies mental illness life narratives should march to their own logic, not to the conventions of the official Recovery Narrative.

Firstly, although she repeatedly searches for it, Wurtzel never locates a definitive origin, or underlying cause, for her depression; this lack of origin represents the first Recovery Narrative expectation she rejects. Early in the narrative, Wurtzel warns the audience that she knows she is depressed, but she does not know why: “I have this palpable, absolute sense that I’m cracking up, that there’s really no good reason why, and that—even worse—there’s nothing I can do about it” (7). Here, she denies both a known origin and a recovery resolution. Throughout the memoir, Wurtzel wonders if her depression has a definitive origin because the experience of its onset is ambiguous:

The scariest part is that if you ask anyone in the throes of depression how he got there, to pin down the turning point, he'll never know. There is a classic moment in *The Sun Also Rises* when someone asks Mike Campbell how he went bankrupt, and all he can say in response is, 'Gradually and then suddenly.' When someone asks how I lost my mind, that is all I can say too. (22)

In addition to emphasizing her inability to pinpoint an origin for her depression, Wurtzel likens it to the bankruptcy in the classic American novel *The Sun Also Rises*, which encourages the audience to understand depression as emotional and spiritual bankruptcy. In addition, as Torres-Quevedo emphasizes, "At numerous points, [Wurtzel] attempts to locate or construct a point of origin for her depression, but these are undermined by their shifting nature and the number of them that are in conflict with each other" (213). Wurtzel contemplates childhood family conflicts or adolescence as possible instigators, but she cannot validate these as just causes for her depression. Tracing her depression back through her memories, she cannot blame it on adolescence, as Kaysen does, because her symptoms began in childhood. Attempting to remember her first experience of depression, Wurtzel recalls: "It seems to me that I was about eleven when it happened. Maybe I was ten or maybe I was twelve, but somewhere in my preadolescence. In other words, since puberty hadn't kicked in yet, no one was expecting it" (23). Noting she cannot blame puberty, Wurtzel looks for conflicts within her childhood as possible sources; she considers her parents' contentious divorce and heated child-support disputes: "Problem was, they had a child, and for many years after they spilt up, I became the battlefield on which all their ideological differences were fought" (27). Wurtzel analyzes this instability as a possible source of depression, but she quickly rejects this as a sufficient cause because divorce is too common. As she rationalizes, most people in her generation are children

of divorce, yet they do not all have depression, so her parents' divorce cannot be the provoking cause of her disorder:

The more children of divorce I have met over the years, the more common and trivial my own family history starts to seem. And I always feel so stupid sitting in therapy talking about my problems because, Jesus Christ, so what? I can't equate the amount of pain and misery and despair I have suffered and endured as a depressive with the events of my life, which just seem so common. My reaction has been uncommonly strong, but really, it seems wrong to blame a statistical fact of life for any of it. (Wurtzel 34)

Ultimately, Wurtzel simply decides something is innately "wrong" with her and her response to life's typical hardships. Because she cannot locate the cause of her depression, Wurtzel integrates this "brokenness" to her ego identity: "I feel like a defective model, like I came off the assembly line flat-out fucked and my parents should have taken me back for repairs before the warranty ran out" (1). Like others diagnosed with mental disorder, Wurtzel embeds this "defect" into her self-concept. Nevertheless, she remains unsettled by her depression's lack of clear origin. Torres-Quevedo notes:

The "wrongness" or the corruption or loss of the self that she describes is at times attributed to her upbringing, some fault within her essential self, her depression, or medication. It is never coherently accounted for or consistently described, and it is intermittently either the cause or consequence of her depression. (212)

Wurtzel's refusal to account for a definitive origin emphasizes the confusing experience of the mental disorder; furthermore, its absence within the emplotment of her memoir challenges the generic expectations of the Recovery Narrative. Torres-Quevedo purports that Wurtzel's "failed attempts to construct a coherent narrative with an origin and a cause highlight the 'making' of

making sense and denaturalise the received teleology of the recovery narrative” (214). Therefore, by refusing a reasonable cause for her depression, Wurtzel challenges the Recovery Narrative’s story arc.

Secondly, Wurtzel protests the Recovery Narrative by resisting the traditional pathway-to-recovery trope: she rejects American ideals of recovery through self-reliance; she criticizes mental health doctors for their ineptitude to view her depression as legitimate; and she showcases the psychiatric treatments she received as nearly useless. First, Wurtzel alludes to the traditional theme of American autobiography: one achieves success through self-reliance and hard work. However, she demonstrates this cultural value supports the stigma of mental illness as a personal weakness or character flaw. Torres-Quevedo connects this generic convention of American autobiography to narrative expectations within the Recovery Narrative’s trope of describing the effective methods one took to recover:

Recovery in the context of the recovery narrative is not a process that the body undertakes; rather, it is the product of volitional steps, self-reflection, and the right attitude. Whatever else its politics, the recovery narrative tends to champion individual agency and the bootstrap-pulling rhetoric so central to the genre of American autobiography from the publication of that of Benjamin Franklin to the present day. In this way, it can be read as the corporeal and psychological companion to the rags-to-riches narrative. (208)

Wurtzel calls attention to the cultural imperatives which encourage the belief that “bootstrap-pulling” is enough to recover from mental disorder. Wurtzel recalls her friend Julian’s advice on how to recover from depression:

Julian says stuff like, Happiness is a choice, you've got to work toward it. He says it like it's an insight or something. He says, You've got to believe. He says, Come on! Cheer up! Pull yourself together! I can't believe how trite all this is. For a moment I want to step outside of myself so I can teach him some better interpersonal skills, so I can help him learn to sound a little more sensitive, more empathic than all this. But I can't stop crying. (10)

Here, Julian promotes common stigmatizing ideas: mental health is a choice, and one only needs to pull herself up by the emotional bootstraps to feel better. At the beginning of her memoir, Wurtzel cringes at these suggestions and Julian's lack of sympathy. However, by the end of the memoir, she has internalized this faulty logic: "I keep telling myself that recovery is an act of will, that if I decide one day that I simply must get up and out of this bed, that I must be happy, I will be able to force it to happen. Why do I believe this is possible?" (Wurtzel 233). She questions why she still believes this myth when her experiences demonstrate self-reliance is not enough to stop her depression; this dilemma encourages readers to contemplate which cultural myths they believe.

Continuing to subvert the pathway-to-recovery trope of the Recovery Narrative, Wurtzel criticizes doctors, talk therapy, and psychotropic medications to argue traditional methods of recovery are flawed. Wurtzel presents a slew of inept doctors she visited before finding an effective physician. For instance, she describes three doctors, using negative slant to emphasize their uselessness. The first doctor, Dr. Isaac, employed psychotherapy (talk therapy) to treat Wurtzel when she was 11 years old; during one of their meetings, Wurtzel recalls thinking, "I can't imagine that we're actually accomplishing anything in these sessions. I mean, I really do believe we might have gotten to the bottom of the root of the mess if such a place existed, but my

misery is just too random” (43). Here, she both denies the origin of her depression and rejects Dr. Isaac’s psychotherapy as an effective treatment. Another doctor Wurtzel criticizes is a Harvard clinician named Dr. King, who suggested a rest cure for her depression: Dr. King “thought that this break from activity would give me perspective. But sadly, I knew better: This break is nothing but time-out, take five, recess. Lying in bed for a few days wouldn’t help enact the kind of personality overhaul it would take to pull me away from [depression]” (Wurtzel 115). The rest cure is historically significant: it began in the 19th century with Dr. Weir Mitchell, a physician who worked to cure cases of female neurasthenia through rest then reintegration into domestic life. According to American professor Suzanne Poirier in her medical history “The Weir Mitchell Rest Cure: Doctors and Patients,” Mitchell believed nervous women must be reoriented into a domestic life slowly; thus, the Weir Mitchell cure began with rest, seclusion, and a fattening diet (20). Mitchell’s patients were not allowed to have any physical or intellectual stimuli; Poirier explains, during a rest cure, patients were required to leave their own homes and retire to a location free of distractions (20). They no longer had any responsibilities beyond resting and eating. In the 1990s, these remain the basic tenets of Dr. King’s rest cure; he assumes the stress of Harvard coursework is causing Wurtzel’s depression, so he recommends she stay in the clinic for a few nights. Wurtzel emphasizes the idiocy of this prescription because, obviously, a few days of rest will not end a depression that has lasted half of her life. Dr. King’s rest cure represents the older ineffective treatments that physicians still prescribe to patients. Wurtzel, thus, alludes to the history of inept psychiatrists and harmful treatments in this example. A third doctor Wurtzel criticizes is Dr. Ira, her psychopharmacologist; Wurtzel condemns Dr. Ira as nothing more than a drug-dealer: “I like to call his office the Fifth Avenue Crack House, because all he really does is write prescriptions and hand out pills...I don’t trust him. He’s a pusherman,

and it's in his interest to see that I stay loaded" (4-5). Wurtzel's imagery of the Fifth Avenue Crack House alludes to the failed War on Drugs and showcases the irony of the government's approval of and medical science's promotion of psychopharmaceuticals, pointing to the hypocrisy of America's drug culture, which divides drugs into legal and illegal categories—a division which seemingly depends upon whom receives the profits. If doctors, pharmaceutical companies, and the government (through lobbyists) receive profits or trade-offs for legalizing and promoting certain drugs, then these are more likely to be FDA-approved, regulated, and prescribed. Consider the differences between heroin and legal opiates; there are not many meaningful disparities other than government regulation and Big Pharma profits. Both versions of the drug relieve severe pain, and both cause addiction and ruin lives. Of course, doctors and politicians often do not admit such discrepancies, so Wurtzel highlights this by employing negative slant when representing Dr. Ira. Wurtzel expresses her concerns over the amount of medication he prescribes her, and although Dr. Ira attempts to quiet her worries, Wurtzel distrusts his promises because psychopharmacology has a flawed history littered with harmful treatments once guaranteed by the best doctors:

[Dr. Ira] says a bunch of reassuring things, explains over and over again how carefully he is monitoring me—all the while admitting that psychopharmacology is more art than science, that he and his colleagues are all basically shooting in the dark. And he acts as if a million doctors didn't say the same things to women about DES, about the IUD, about silicone breast implants, as if they didn't once claim that Valium was a non-addictive tranquilizer and that Halcion was a miracle sleeping pill. As if class-action suits against pharmaceutical companies were not fairly routine by now. (18)

As readers today do, readers in the late-20th century observed the continuous class-action lawsuits that occurred against pharmaceutical companies every year. Moreover, readers know the FDA approves these medications for use long before class-action suits arise. Wurtzel further highlights this cultural problem with a common suspicion experienced by many patients who take psychotropic medications:

I can't pull myself away from a nagging suspicion that it just can't be this simple. What I mean is this: Prozac has rather minimal side effects, the lithium has a few more, but basically the pair keep me functioning as a sane human being, at least most of the time. And I can't help feeling that anything that works so effectively, that's so transformative, has got to be hurting me at another end, maybe some time further down the road. I can just hear the words *inoperable brain cancer* being whispered to me by some physician twenty years from now. (17-18)

Although she cannot deny the medications help her, Wurtzel worries there will be negative physical consequences of consistently taking psychopharmaceuticals for the rest of her life. Here, she complicates the most effective treatment method she encounters and subverts the positive transformation of the Recovery Narrative by insinuating the best psychiatric treatments may be harmful in the long run. Significantly, even with the prescriptions from Dr. Ira, Wurtzel does not fully recover:

I don't mean to sound like a spoiled brat. I know that into every sunny life a little rain must fall and all that, but in my case the crisis-level hysteria is an all-too-recurring theme. The voices in my head, which I used to think were just passing through, seem to have taken up residence. And I've been on these goddamn pills for years. At first, the idea was to get me going so I could respond to talk therapy, but now it seems clear that my

condition is chronic, that I'm going to be on drugs forever if I just want to be barely functional. (8)

From the start of her memoir, Wurtzel subverts the Recovery Narrative expectation for the pathway-to-recovery trope. She posits, no matter how many pills she takes or how much talk therapy she endures, these treatment methods cannot return her to a prelapsarian self before mental disorder; she never will fully recover from atypical depression because it is chronic, so even if psychotropic medication helps, she can never stop taking it if she wants “to be barely functional” (Wurtzel 8). This directly protests the standard treatments for depression and the Recovery Narrative requirement for a clear path to successful recovery. Even after finding a competent doctor, Dr. Diana Sterling, whom Wurtzel describes as “the only psychiatrist about whom I can truly say, she saved my life,” Wurtzel resists the expectation of recovery (236). Dr. Sterling inspires Wurtzel to believe she can survive depression, although Wurtzel does not believe in a full recovery: “After several fruitful conversations with her, I had even settled it in my mind that somehow, some way, with Dr. Sterling’s guidance, I would eventually be *okay*...I would survive depression. I didn’t completely believe this” (252). By admitting that at least one doctor helped her survive, Wurtzel acknowledges counter-opinions about the benefits of seeking medical treatment. Moreover, although most of the doctors she meets are incompetent, she concedes capable doctors do exist. Many mental illness life writers include this comparison between bad doctors and good doctors, and much like Wurtzel’s presentation, typically, most doctors represented in these narratives are “bad,” incompetent, ignorant, or cruel. Nevertheless, usually one compassionate, savior-like doctor enters the narrative, and this is when the process of healing becomes the most efficacious. By acknowledging some doctors truly save patients’ lives, Wurtzel gains more credibility as the narrator because she is not simply on a warpath to

denounce all psychiatrists. Nevertheless, she complicates the path-to-recovery trope by filling it with more ineffective treatments and inept doctors than not. This also anticipates Wurtzel's denouncement of the expected resolution for a Recovery Narrative.

Thirdly, the last Recovery Narrative trope Wurtzel protests is the required resolution of this genre—the patient's transformation from illness to recovery. The conventions of the Recovery Narrative expect an explanation of the patient's transformation (including insight gained along the way) to a recovered self like the patient before her illness. This expectation emphasizes what recovery should look like: a return to the prelapsarian self. This convention implies mental illness is curable when given the best treatments and with the patient's active participation toward recovery. Unfortunately, such a presentation is artificial when focusing on mental illness because many mental disorders are chronic, not only requiring constant medical care but also destroying the possibility of a prelapsarian return to a pre-patient self. Wurtzel protests this specific aspect of the Recovery Narrative resolution by presenting atypical depression as a transformative force with irreversible consequences; she thereby denies any possibility of returning to a pre-depressed version of herself:

Every so often...I would fantasize about going back to the person I had always been. The reverse transformation couldn't be that much of a leap...The trouble was, I thought this alternative persona that I had adopted was just that: a put-on, a way of getting attention, a way of being different. And maybe when I first started walking around talking about plastic and death, maybe then it was an experiment. But after a while, the alternative me really just was me. Those days that I tried to be the little girl I was supposed to be drained me...I remember being in a panic one day at school when I realized that I could not even fake being the old Lizzy anymore. I had, indeed, metamorphosed into this nihilistic,

unhappy girl...This was what I'd come to. This was what I'd be for the rest of my life.

(45-46)

Wurtzel admits to fantasizing about a return to her former self, but she knows this is impossible, and she argues that depression will be part of her identity for the rest of her life. The expected transformation of the Recovery Narrative works in reverse in *Prozac Nation*. Instead of presenting a narrator transformed through effective psychiatric treatments and compassionate doctors, Wurtzel's depression is the transformative force. The depression "metamorphosed [Wurtzel] into this nihilistic, unhappy girl," and no treatments or doctors can reverse this fundamental change. Moreover, the narrative resolution of the memoir—her supposed recovery—is not static but in a continuous state of transformation. Torres-Quevedo highlights Wurtzel's presentation of her recovery as in-progress but incomplete:

She conceptualises the end of her depression as a process of becoming, not a return to a prelapsarian self. This process is not completed entirely through medication nor is it finished by the end of the text...While depression has fundamentally changed her, she stops thinking of herself as broken and fantasising about returning to an originary uncorrupted state and begins to think of herself as being in continuous development.

(219)

Thus, at the end of the memoir, Wurtzel resists saying she is recovered. Recovery is never as clear-cut as what is promoted in official Recovery Narratives. Additionally, because Wurtzel's "recovery" is neither straight-forward nor obvious, she denies another aspect of the Recovery Narrative's transformation trope—she does not gain new insights or an enlightened self-understanding through therapy. Instead, Wurtzel once again highlights the myths of psychiatric treatment and recovery:

I think that some insight is supposed to be hitting me right now. Something about the meaning of life, about dancing in the face of adversity, about struggling and persevering and succeeding...Clarity. The truth will set me free, and all that. Of course, it never happens. Years of therapy, and it never happens. Psychotropic drugs, and it never happens...that's the problem with reality, that's the fallacy of therapy: It assumes that you will have a series of revelations, or even just one little one, and that these various truths will come to you and will change your life completely. It assumes that insight alone is a transformative force. But the truth is, it doesn't work that way. In real life, every day you might come to some new conclusion about yourself and about the reasoning behind your behavior, and you can tell yourself that this knowledge will make all the difference. But in all likelihood, you're going to keep on doing the same old things. You'll still be the same person. You'll still cling to your destructive, debilitating habits because your emotional tie to them is so strong—so much stronger than a dime-store insight you might come up with—that the stupid things you do are really the only things you've got that keep you centered and connected. They are the only things that make you *you*. (313-314)

Wurtzel criticizes the ideology of psychotherapy because she denies the “transformative force” of insights gained through therapy; to Wurtzel, even if she could understand the root causes of her depression, this knowledge cannot “cure” her depression or take away her symptoms. By denying the power of psychoanalytical insight, Wurtzel directly protests the field of psychiatry, which would never be allowed within an official Recovery Narrative. In total, *Prozac Nation* challenges three major generic conventions of the Recovery Narrative emplotment, and by doing

so, Wurtzel protests the concept that only one way of narrative meaning-making can be official and legitimate.

To conclude, the rhetorical protests that shout through mental illness life narratives may help future generations fight the stigma. Whether protesting ineffective treatments, useless doctors, or psychiatric theories, many mental illness life writers aim to change prejudice attitudes and misunderstandings about mental patients. Leah White describes this characteristic when analyzing the memoirs of Kate Millett, Susanna Kaysen, and Kay Redfield Jamison: the “final component of the autobiographical manifesto involves looking toward the future in order to find a vision for successful revolution and change. The manifesto is at its core political, with clear goals of securing a better future for those whom the author speaks” (11). This hope for a better future marches from the objective of protest to the fifth goal—helping others within this marginalized community through activism and advocacy.

5.6.5 *Goal 5: Advocacy and Activism*

Even stronger than my burning rebellion against the myths of stigma was my desire to help others with similar experiences. To them, I wanted more than anything to shout across this black and white page: “Don’t give up hope! You are not alone. Many people struggle with mental disorder, and there are ways to survive and function again. And, most importantly, we came overcome the obstacles of stigma together if we have the courage to speak about our lived experiences of mental illness.” My desire in this pursuit is not unprecedented. Young also notices many authors of this genre aspire “to offer hope to other people with mental illness” (65). One way to offer this is by claiming one’s membership in this stigmatized social group; by sharing his mental illness life narrative, an author becomes a public member of this marginalized community. No longer can the author hide his discrediting information, as Erving Goffman

describes it; by writing a life narrative, his stigma becomes publicized, changing his social identity from “discreditable” to “discredited” (41-42). This choice is frightening, but the author makes it the moment he sends his manuscript to editors and readers. Typically, the possible good the text may do for others encourages the author’s decision to publish. White discusses how this admission of in-group affiliation is a crucial step in advocacy:

By conceptualizing herself as part of a larger community, the autobiographer is able to see connections between her own experiences and those experiences of others.

Positioning herself as part of a group allows her to serve more accurately as an advocate for that community...by articulating empathy for fellow sufferers of mental illness. (10)

Once an author shares her mental illness life narrative, she demonstrates a successful functioning life is possible for someone living with mental disorder, and she illustrates her own empathy for fellow sufferers. For example, in *Willow Weep for Me: A Black Woman’s Journey Through Depression*, Danquah explains her desire to help others suffering from depression by demonstrating the reality of the disorder and disproving the stereotypes of stigma:

I want [readers] to recognize themselves in one of the characters in my book, to look beyond the fear of depression and see the humanity of the person who is struggling against the illness. I want readers to understand that clinical depression is an illness, not a weakness or a character flaw. Learning how to separate the person that I am from the illness that was affecting me was ultimately the key that unlocked the door to my well-being. (275)

Danquah illustrates her struggles with depression and stigmatization to inspire empathy within her readers and to disprove common stereotypes; her emphasis on the person as separate from the disorder encourages this. Two common tropes accentuate the rhetorical goal of advocacy and

activism in mental illness life narratives: the first is the inclusion of an apologia, and the second is the comparison of mental illness to physical illness. Both literary devices appeal to the audience through ethos, pathos, and logos. The apologia allows the writer to build her credibility by establishing her selfless aim to help others and to encourage the readers' compassion toward those living with mental disorders. Wood explains, life narratives by patients with schizophrenia often "move beyond the narrative task at hand to address the needs of others with schizophrenia, turning the individual memoir into political testimony" (111). The typical apologia emphasizes this altruistic goal, appealing to both ethos and pathos. Kay Redfield Jamison presents an effective apologia in the "Prologue" of her memoir to outline her philanthropic purpose for sharing her personal experiences. Secondly, by using comparisons to physical illness, many authors employ logical reasoning and ethical appeals to argue mental disorders should be treated as seriously as physical illnesses. Elizabeth Wurtzel and Cameron West engagingly utilize comparisons to fight the cultural narrative which claims mental illnesses are less life-threatening than physical illnesses. By including these tropes, the authors underline their fifth common purpose of activism, which specifically aims to raise public awareness, advocate for equitable treatment in healthcare, and inspire empathy within the audience.

The apologia as a literary device has historical roots leading back to early American literature as a common trope in American slave narratives. In both slave narratives and mental illness life narratives, the apologia emphasizes the writer's aims are philanthropic; this encourages readers, who believe the stereotypical myths about slaves or the mentally ill, to suspend prior prejudices when engaging with the text. Pryal explains why writers of such controversial narratives include the apologia:

The apologies of these slave narratives defend the authorship of former slave and justify their autobiographical projects by casting the authors' purposes as selfless. Similarly, many mood memoirists draw on the apology to depict their work as selfless, driven by a desire to break down taboos, which will help other sufferers of mental illness. (486)

The apology within a mental illness life narrative works to emphasize the author's desire to help others with mental disorders. After years of living with manic depression, Jamison exclaims, "I became more and more determined to pull out some good from all of the pain, to try and put my illness to some use" (*Unquiet Mind* 125). Therefore, Jamison decides to share the wisdom she learned from her personal experiences. In the "Prologue" of *An Unquiet Mind*, Jamison presents her apology immediately to establish her purpose to help others survive by educating patients and physicians through the combination of her personal experiences and her scientific education:

It took me far too long to realize that lost years and relationships cannot be recovered, that damage done to oneself and others cannot always be put right again, and that freedom from the control imposed by medication loses its meaning when the only alternatives are death and insanity.

The war that I waged against myself is not an uncommon one. The major clinical problem in treating manic-depressive illness is not that there are not effective medications—there are—but that patients so often refuse to take them. Worse yet, because of a lack of information, poor medical advice, stigma, or fear of personal and professional reprisals, they do not seek treatment at all....

I am fortunate that I have not died from my illness, fortunate in having received the best medical care available, and fortunate in having the friends, colleagues, and family that I do. Because of this, I have in turn tried, as best I could, to use my own

experiences of the disease to inform my research, teaching, clinical practice, and advocacy work. Through writing and teaching I have hoped to persuade my colleagues of the paradoxical core of this quicksilver illness that can both kill and create; and, along with many others, have tried to change public attitudes about psychiatric illnesses in general and manic-depressive illness in particular. It has been difficult at times to weave together the scientific discipline of my intellectual field with the more compelling realities of my own emotional experiences. And yet it has been from this binding of raw emotion to the more distanced eye of clinical science that I feel I have obtained the freedom to live the kind of life I want, and the human experiences necessary to try and make a difference in public awareness and clinical practice. (6-7)

In this apologia, Jamison targets two specific audiences—patients and medical practitioners—because she aims to encourage patients to seek and maintain effective treatments, and she aspires to change the prejudicial thinking of clinicians to better the practices within the fields of psychology and psychiatry. To accomplish these lofty goals, Jamison reaches out to both clinician-readers and patient-readers.

Firstly, to change common misconceptions held by other physicians and to prevent medical students from developing these attitudes, Jamison delineates, “I was absolutely and single-mindedly determined to make a difference in how the illness was seen and treated” (*Unquiet Mind* 126). Specifically, Jamison strives to change clinical pessimism about bipolar disorder as well as prejudiced public opinions. While her scholarly publications before her memoir address this concern, her life narrative cements this purpose. In the classroom, Jamison includes mental illness life narratives within her curriculum to encourage compassion and to show mental disorders from different perspectives: “In order to give the residents and interns

some notion of the experiences that patients went through when manic and depressed, we encouraged them to read firsthand accounts from patients and writers who had suffered from mood disorders” (*Unquiet Mind* 128). By adding patients’ perspectives to curricula, Jamison encourages her medical students to advocate for compassionate care within their future careers.

To her other target audience—patient-readers—Jamison includes her personal struggles, her compliance and refusal cycle when taking medication, and the different ways she encounters stigma. From her personal experience, Jamison illustrates, “At this point in my existence, I cannot imagine leading a normal life without both taking lithium and having had the benefits of psychotherapy” (*Unquiet Mind* 88). She encourages patients to find effective treatments and to actively participate in their recovery, as she has. Moreover, Jamison’s entreaty to patient-readers is to seek treatment and believe in the possibility of recovery. One of the most compelling examples of this plea occurs when Jamison recalls the heartbreak of losing one of the patients she treated for years. Jamison presents this example as a cautionary tale to inspire readers with manic depression to take their psychiatric medications as prescribed and to warn them against discontinuing treatments against medical advice:

I knew that I was the one constant throughout all of his hospitalizations, court appearances, family meetings, and black depressions. As his psychotherapist for years, I had been privy to his dreams and fears, hopeful and then ruined relationships, grandiose and then shattered plans for the future. I had seen his remarkable resilience, personal courage, and wit; I liked and respected him enormously. But I also had been increasingly frustrated by his repeated refusals to take medication. I could, from my own experience, understand his concerns about taking lithium, but only up to a point; past that point, I was

finding it very difficult to watch him go through such predictable, painful, and unnecessary recurrences of his illness.

No amount of psychotherapy, education, persuasion, or coercion worked; no contracts worked out by the medical and nursing staff worked; family therapy didn't help; no tallying up of the hospitalizations, broken relationships, financial disasters, lost jobs, imprisonments, squanderings of a good, creative, and educated mind worked. Nothing I or anyone else could think of worked...His attacks of mania and depression became more frequent and severe. No breakthrough ever came; no happy ending ever materialized. There was simply nothing that medicine or psychology could bring to bear that would make him take his medication long enough to stay well. Lithium worked, but he would not take it; our relationship worked, but not well enough. He had a terrible disease and it eventually cost him his life—as it does tens of thousands of people every year. There were limits on what any of us could do for him, and it tore me apart inside.

We all move uneasily within our restraints. (*Unquiet Mind* 108-109)

By including this tragic example, Jamison emphasizes not all patients survive manic depression. She often reiterates she is lucky to have survived; thus, despite the hope often inspired by her memoir, Jamison reminds her readers about the serious life-or-death stakes inherent in the experience of manic depression.

Like Jamison's announced philanthropic purpose, in *First Person Plural*, Cameron West hopes to help other people with dissociative identity disorder and to provide mental health professionals with a patient's perspective. After years of therapy and psychiatric treatment, West learned how to function with this difficult disorder, and through his memoir, he strives to help others by sharing his break-through moments from his time in therapy, where he uncovered

repressed memories of childhood trauma, and the techniques he learned to cope with his psychic disturbances. During his recollections, he vividly illustrates his multiple personalities in their unique complexities, showing his ambivalence toward them through moments of love, fear, and frustration. Eventually, West recovered and pursued a Ph.D. in psychology. Soon after the completion of his doctorate, West wrote his memoir to inspire hope in readers suffering from DID. In the last pages, he presents an apologia which explains his decision to publish his life narrative:

I finished my doctoral work at last and am now officially a doctor of psychology, a title in which I take a good deal of pride. It has instilled in me a sense of responsibility to help other dissociative people in ways that I am able. Having DID is, for many people, a very lonely thing. If this book reaches some people whose experiences resonate with mine and gives them a sense that they aren't alone, that there is hope, then I will have achieved one of my goals. (C. West 318)

Here, West sincerely emphasizes his wish to help others like him, but he does not stop there. He follows this goal with his other desire to further clinical knowledge: "If this book provides practicing and future clinicians certain insight into DID, then I will have accomplished another goal" (C. West 318). As explained within his apologia, West transforms his private struggles into a public text to advocate for others and encourage a fuller clinical understanding.

To achieve their activist goals, Cameron West and Elizabeth Wurtzel challenge stigma myths by including comparisons to physical illness. Pryal notes this type of comparison commonly occurs in mood memoirs:

Memoirists often compare their illnesses to more socially acceptable diseases in order to convince readers of the seriousness of mood disorders, usually diabetes and cancer. By

proving that their disease is serious and deadly, the authors further justify writing memoirs about their experiences with the disease. (489)

West and Wurtzel utilize this trope to develop ethos and logos, change public views, and advocate for better mental healthcare. In a vivid example, West illustrates the difficulty of obtaining proper care. Because his insurance company did not view DID as a serious life-threatening disorder or medical emergency, they refused to pay for the lengthy in-patient treatment West required:

The insurance company wanted me out of Del Amo [Hospital's Dissociative Disorders Unit] fast. They didn't understand why a person with DID would need special psychiatric care. Of course, they'd spring for a few more unnecessary sinus surgeries, or a heart transplant. But DID? Forget it. They did agree to hospitalize me in the local psych unit, though, if I tried to kill myself. Ed Mandel [Del Amo psychiatrist] went to bat for me, arguing that psychologists and psychiatrists at most psychiatric hospitals weren't that familiar with DID and would likely be unable to deliver the kind of treatment I needed. But the insurance company people wouldn't listen and pulled the plug after only six days. (187)

This example highlights multiple problems within the Community Mental Healthcare Movement, which encourages out-patient psychiatric treatments as opposed to extended hospitalizations. The Anti-psychiatry Movement of the mid-20th century fought against involuntary commitment to hospitals and inhumane psychiatric treatments; this movement morphed into the Community Mental Healthcare Movement of the late-20th century. Unfortunately, although involuntary confinement is now harder to legally enact, the negative consequence is insurance companies in the late-20th century often refused to pay for in-patient

care longer than one week. Thus, for patients like West, even when they require longer hospital stays, without the support of insurance, most patients cannot afford the treatments they need. Further, West highlights the hypocrisy of health insurance: his insurance will pay for more pointless sinus surgeries but not the life-saving psychiatric treatment he needs. This emphasizes the stigma myth that propagandizes that physical illnesses are more serious and deadly than mental disorders. West portrays another catch-22 within mental healthcare: typically, mental patients only receive insurance support for extended in-patient care if they attempt suicide. This appeals to the audience's logical reasoning by highlighting the hypocrisy present in this situation. Further, West develops his credibility as an expert on this topic through his credentials as a doctor and his personal experiences as a patient.

Wurtzel also includes comparisons between physical illnesses and depression. She specifically calls attention to the social misconceptions about depression by comparing her friends' reactions to her depression versus her miscarriage. Wurtzel attempts to portray the seriousness of her depression to others, but in most instances, her friends do not display sympathy or understanding. To invoke ethos and logos, Wurtzel uses comparisons to physical illnesses and accidents to encourage a compassionate understanding of depression as a real illness:

Some catastrophic situations invite clarity, explode in split moments: You smash your hand through a windowpane and then there is blood and shattered glass stained with red all over the place; you fall out a window and break some bones and scrape some skin. Stitches and casts and bandages and antiseptic solve and salve the wounds. But depression is not a sudden disaster. It is more like a cancer: At first, its tumorous mass is not even noticeable to the careful eye, and then one day—wham!—there is a huge, deadly

seven-pound lump lodged in your brain or your stomach or your shoulder blade, and this thing that your own body has produced is actually trying to kill you. Depression is a lot like that: Slowly, over the years, the data will accumulate in your heart and mind, a computer program for total negativity will build into your system, making life feel more and more unbearable, But you won't even notice it coming on, thinking that it is somehow normal, something about getting older, about turning eight or turning twelve or turning fifteen, and then one day you realize that your entire life is just awful, not worth living, a horror and a black blot on the white terrain of human existence. One morning you wake up afraid you are going to live. (21-22)

By aligning depression most closely with cancer, Wurtzel illustrates the slow-then-sudden onset of depression and emphasizes the deadly consequences of it. To Wurtzel, cancer is a fatal disease produced by the body, and depression is a deadly disease created by the mind and brain.

Additionally, Wurtzel illustrates the difference in public opinion concerning mental disorders versus physical illnesses; although most of her friends avoid her during her darkest depressions, when Wurtzel has a miscarriage (even though she did not know she was pregnant), her friends flock to her with sympathy and support:

Suddenly my problems seemed to have a physical cause, and I was more satisfied with somatic explanations than the usual psychic ones. When I told close friends that I'd just had a miscarriage, that I hadn't even known I was pregnant until my body had ejected the fetus, they all seemed to have much more sympathy—even much more retroactive sympathy—for me than when it was all just depression and all so ineffable. (191)

Wurtzel recreates this situation to expose the consequences of stigma and persuade readers to reassess the ways they treat friends and family members with mental disorders. Perhaps if others

had taken Wurtzel's depression seriously from the beginning, she would not have resorted to a suicide attempt to receive effective help. By including comparisons between mental illness and physical illness, West and Wurtzel expose the hypocrisy within the healthcare system and public attitudes; furthermore, by appealing to logos and ethos, these authors work to fight the stigma by persuading the readers to view mental disorders as serious medical conditions.

In one way or another, most mental illness life writers illustrate one or more of these five rhetorical goals—narrative therapy, regaining one's voice and identity, ending isolation, protest, and advocacy. The authors illustrate these objectives through various narrative tropes, literary devices, and emplotment. Ultimately, these common goals empower stigmatized individuals, raise awareness, inspire empathy, and challenge the stigma of mental illness.

6 CONCLUSION: A CALL TO ACTION!

Now is the time to carpe diem! Now is the time to banish our fears and slay the monstrous stigma once and for all, and we must all play a role in this battle if the war is to be won. Maybe you will not write about your experiences with mental illness, but do you have the courage to speak about them? Maybe you do not have any experiences with mental illness, but will you listen to someone else's with patience and compassion? If we, as a society, come to this conversation with open-minds and open-hearts, perhaps we will be brave enough to recognize how many of us suffer to survive mental disorders and how much added weight the stigma imposes. The importance of combating the silence surrounding mental illness cannot be overstated because it is how we end the stigma. Many authors of this genre agree with this claim. For example, Danquah directly pleads for readers' understanding and action:

The most important message that I want my readers to take away with them is that any of us can fall prey at any time in our lives to clinical depression, if we break the silence and erase the stigma that surrounds the illness, we will be better equipped to help those who are in need of our care and understanding. We can make a difference, sometimes the difference between life and death, in each other's lives. (276)

The true mission here is to save lives and to better our understanding of the human condition. However, another glaring problem in this crusade is the terrible underrepresentation in authorship diversity. Overwhelmingly, most American authors who write about their personal experiences of mental illness are White and from the middle class. As a society, we need mental illness life narratives from culturally diverse authors if we are to fully understand how the stigma affects all Americans. In *Nightmare Factories: The Asylum in the American Imagination* (2019),

Troy Rondinone highlights this disparity and claims historical racism is the founding reason for it:

The socially abandoned are silent. Asylum narratives have long relegated certain groups invisible, including the poor, the immigrant, the racial minority, and the illiterate. These people are not the protagonists of asylum stories. If they enter the picture, it is as monstrous Others. Visible victims are almost invariably white and middle class. African Americans have long been asylum residents, yet my survey of one hundred thirty-odd years of popular narratives and representations finds them typically absent, comedic, or villainous. Their historically segregated facilities simply do not enter the public radar. This is despite the fact that, as Jonathan M. Metzl argues, African Americans since the 1960s have been more likely to be labeled schizophrenic than their white counterparts. Rare is the film like *Pressure Point* (1962) that features a helpful African American psychiatrist. The same historical amnesia goes for institutionalized, non-English-speaking immigrants and Native Americans. (278)

Logically, this lack of representation in the popular imagination, American literature, and mass media encourages the myth that mental illness is “a White person problem.” Obviously, this endangers individuals who refuse to seek treatment because of this stereotype. For many Americans, this near absence in representation further silences conversations about mental illness in their personal communities. For example, Danquah explains how the very language used to describe depression alienates the Black American community, emphasizing one reason for the silencing she encounters. Danquah describes the lack of suitable language and its effect on her conversations about depression:

When there aren't dismissive questions, patronizing statements, or ludicrous suggestions, there is silence. As if there are no acceptable ways, no appropriate words to begin a dialogue about this illness. And, given the oppressive nature of the existing language surrounding depression, perhaps for black people there really aren't any. You've heard descriptions of depression before: A black hole; an enveloping darkness; a dismal existence through which no light shines; the black dog; darkness, and more darkness. But what does darkness mean to me, a woman who has spent her life surrounded by it? The darkness of my skin; the darkness of my friends and family. I have never been afraid of the dark. It poses no harm to me. What is the color of my depression?...Darkness, it is not. (21-22)

Danquah shares her experiences with depression as an African American woman, and she certainly finds language to accurately describe her understanding of both depression and the stigma. Although other false myths in our culture try to racially divide Americans, what Danquah's memoir demonstrates is that mental disorders do not discriminate—not by race or age or social class or region, not by education or gender or employment or privilege. Anyone can be affected by a mental disorder. After publishing her memoir, Danquah found readers from various backgrounds related to her story, and this realization further illuminates how we can understand each other and relate to each other through life narratives:

Many readers who are not African American women have come up to me to tell me how closely they identified with my story, how much it mirrored their own. I am always so pleased when I hear that people have been able to see beyond race when they read my book because it means we can finally meet in a place where we see each other as individuals. And that is the point of my standing up in defiance of those things which had

kept me silent and suffering to say that I, an African American woman, have made this journey through depression. We must know that we are not alone and that we are not unlike anyone else who has gone through or is going through that same journey. (279)

American audiences need stories from a diverse authorship. We need to encounter mental illness life narratives from diverse American authors, so audience members can find experiences with which they relate because this encourages readers, suffering in silence and isolation, to seek help. Moreover, by increasing the diversity in authorship, readers can relate to authors who are from different backgrounds, and through these narratives, American audiences may begin to see we are not as divided as the hegemonic myths would have us believe. In *12 Million Black Voices* (1941), Richard Wright captures a vivid history in photographs and poetic prose of the struggles and victories of the Black American community. One of his aspirations for the text was to dismantle the myths that divide Americans by race; he opines:

The differences between black folk and white folk are not blood or color, and the ties that bind us are deeper than those that separate us. The common road of hope which we all have travelled has brought us into a stronger kinship than any words, laws, or legal claims. Look at us and you will know yourselves, for *we are you*. (240-241)

Like Wright's argument, by seeing the common challenges and shared hopes from diverse authors, American audiences can develop empathy for those with mental disorders because they may recognize parts of themselves in the authors' feelings, struggles, and hopes. Two basic themes emerge from these texts: firstly, mental disorders cause everyone pain—including those afflicted and their loved ones—and secondly, the consequences of stigma inspire a fervent hope for its end. These common themes appeal to the readers' emotions precisely because they are universal in the experience of mental illness. So, to fight the stigma, we must gather the courage

to speak about these stories and to actively listen to others' experiences; this practice nourishes a better understanding of not only mental disorders but also of each other.

Even today in the age of political correctness and amidst cancel culture censures, people with mental disorders are one of the few social groups still to be consistently misrepresented, ostracized, and demeaned. By comprehending how and why stigma myths are perpetuated, they can be dismantled. We, as a society, must challenge these social beliefs collectively to support each other with compassion instead of tearing each other down in fear. The social consequences of stigmatization should be studied through mental illness life narratives to reveal what it means to live with mental illness and to encourage empathy. The mission of this project is to inspire a conversation, to raise awareness about the lived experiences of mental disorder, and to fight the stigma. The best way to combat these prejudiced stereotypes in our society is to tell stories which focus on the person over the disorder. We must remember that those with mental disorders are not less human; in fact, their struggles encourage the blossoming of empathy within them, and hopefully, also within those who hear their stories.

Madness is not imprisoned in the mind; it leaks into the body and sets the soul ablaze, destroying and recreating everything at once, until the pieces of one's very being are scattered like ashes across the ground. But love gathers those strewn ashes, and with enduring patience and empathy, love raises up that lost soul like a phoenix. Love has the power to save, so to inspire empathy from which this love may grow, mental illness life narratives must be created, shared, and taught. So, let us find the courage of the Beat writers to howl our truths and rebel against the dehumanizing lies of stigma. Let us follow the verities of our souls and bare them to the world without shame, guilt, or fear. Let us encourage those of battered mind still hiding behind their "socially appropriate" masks to come out, true to who they are, naked in rigorous

honesty. Let those who will be shocked gain a new understanding. May we all develop empathy toward each other's suffering and destroy this stigma, once and for all, through language and love, courage and hope.

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