Expanding Beyond Psychiatry and Antipsychiatry:

Mental Illness in 1960s Literature

by

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Abstract

This dissertation analyzes literature written about mental illness by mentally ill authors in the 1960s to demonstrate how they converge with and diverge from the antipsychiatry ideas of Erving Goffman, Thomas Szasz, R. D. Laing, and Michel Foucault. I highlight fiction's capacity to resist rigid definitions of mental illness, challenge binary perspectives, and ultimately provide a healing space for readers. Chapter One extends Goffman's notion of the "self-story" in *Asylums* (1961) to Sylvia Plath's *The Bell Jar* (1963) to establish the power of fiction as a medium for portraying personal experiences with mental illness. Chapter Two investigates how Szasz's concept of the "language of illness" in *The Myth of Mental Illness* (1961) operates in Joanne Greenberg's *I Never Promised You a Rose Garden* (1964) to reveal that mental illness cannot be translated into ordinary language and, as such, is more appropriately described in literature. Chapter Three applies Laing's theory of "metanoia" in *The Politics of Experience* (1967) to Kurt Vonnegut's *Slaughterhouse-Five* (1969) to argue that literature has healing potential through the narrative journey of mental illness. Chapter Four discusses the parallels between Foucault's arguments on madness and literature in *Madness and Civilization* (1964) and Janet Frame's *Faces in the Water* (1961) before using Foucault's theory of the author-function in "What is an Author?" (1969) to analyze how Frame's identity as a mentally ill author has perpetuated and, in turn, challenges binary understandings of mental illness. This dissertation ultimately argues that literature is a vital, underexplored realm for depicting mental illness, encouraging an expansive understanding of mental illness that transcends confining categories.

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Dedication

For *moja kochana Babcia*:

thank you for creating a family of teachers

and for being the *słoneczko* in my life.

☼

And for all those who bear not only the weight of mental illness

but the exhausting barrage of people's opinions on your mental illness.

May we experience freedom from it all in our lifetime.

Introduction

Psychiatry has rested upon one foundational belief for well over a century: mental illness is an illness. These days, that statement might sound like a tautology; in the 1960s, it was the central point of conflict debated by the antipsychiatry movement. From our position in the twenty-first century, in which a biomedical understanding of mental illness has prevailed, the antipsychiatry era is either misconstrued as a momentary lapse in judgement by hippies high on LSD and social justice, or else it is entirely forgotten.[1] This lack of understanding or, worse, erasure of the antipsychiatry movement is a grave error as much can be learned from it. That our society is increasingly rent apart into binary extremes is no secret, and understandings of mental illness are no exception to this cleaving of beliefs. The conventional understanding adheres to the American Psychological Association's definition of mental disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning." This definition privileges a biological view of mental illness by specifying that a "culturally approved response" to stressful circumstances is "not a mental disorder," nor is "[s]ocially deviant behavior." Mental illness is just that: an illness, a biological dysfunction. The opposing viewpoint to this is gaining popularity, with more people considering "the role of structures and systems—such as capitalism—in developing mental illness" (Luiggi-Hernández). In contrast to the *DSM*, this understanding explicitly implicates both normal responses to stressful circumstances and socially deviant behaviour (i.e., not adapting to capitalism) in the

[1] Michael E. Staub, in his book on mental illness diagnoses from 1948–80, succinctly explains that antipsychiatry is now, "in the early twenty-first century, frequently dismissed and denounced as sure signs of the counterculture's loopy excesses. . . . [People in the antipsychiatry movement] are summarily identified as products of the 1960s, with the popular success of their ideas typically attributed to the 'feverish atmosphere of that decade'" (3).

diagnosis of mental illness. Without knowledge of the antipsychiatry era, it may seem that the latter perspective is a radically new way of fighting against the institutions and social structures that oppress us. It is not. This dissertation is grounded in the urgent need to resituate our debates about mental illness in their historical context so that mentally ill people are not doomed to be spoken over—again.

The enigmatic etiology of mental illness has, in fact, swung between extremes of the binary for as long as people have had minds capable of suffering. As Susan Sontag argues in her formative text, *Illness as Metaphor*, when severe, agonizing disorders lack an identifiable cause or understanding, humans rush to give them meaning, whether that be moral, supernatural, or otherwise. There have been two general responses to solving the cause of mental suffering: to expound any inklings of a biological cause into a definitive statement that mental illness is undoubtedly a biological illness, or to cast out the body altogether and ascribe any number of social ills to mental suffering. In the socially turbulent 1960s, the latter response was prevalent. While understanding mental illness as a social construct was by no means novel, it was the first time that this understanding gained widespread acceptance while psychiatry was firmly established. In order to dissent against such a well-established institution, social theories about mental illness could not simply be presented: they had to first undermine psychiatry itself.

And so, the antipsychiatry movement was born. The designation of antipsychiatry[2] was staunchly rejected by all of the figures in the movement, with valid reason: their primary goal

[2] *Antipsychiatry* is also commonly written as *anti-psychiatry*. My choice to omit the hyphen was inspired by the common stylization of *antisemitism*. According to the International Holocaust Remembrance Alliance ("Spelling of Antisemitism"), hyphenating *anti-Semitism* places emphasis on the base word, which does two things: it suggests that Semitism exists, which validates the Nazi theory that Jews are a separate racial classification; and it "divides the term, stripping it from its meaning of opposition and hatred toward Jews." Because antipsychiatry was not necessarily anti psychiatry, removing the hyphen more accurately identifies it as an altogether separate ideology, just as antisemitism is wholly different to the racist concept of Semitism. However, to my knowledge, there is no scholarly conversation on *antipsychiatry's* hyphenation, and so when *anti-psychiatry* is quoted from other sources, it should be read as interchangeable with *antipsychiatry.*

was *not* to critique psychiatry, but rather to present alternative theories of what mental illness is. However, because these alternative theories by nature required disagreements with how psychiatry defined and treated mental illness and they were otherwise distinct from each other, being "antipsychiatry" was their sole common denominator. Thus, the term *antipsychiatry* is less a verdict on how those in the movement felt about psychiatry and more a locution to refer to the alternative notions about mental illness that emerged in the 1960s.

Movement is also somewhat of a misnomer (inaccurate definitions will become a theme in this dissertation). A social movement is generally understood as a collective enterprise to enact societal change (Smelser et al.). The antipsychiatry movement certainly was not collective nor was societal change necessarily a primary goal, if a goal at all. In contrast to the Civil Rights and Women's Rights movements, antipsychiatry was not led by the people. Instead, what is now remembered as a movement was in fact largely the disparate theories of a few white, male academics. Unlike the other 1960s social justice leaders, like Martin Luther King Jr., Betty Friedan, and Gloria Steinem, antipsychiatry leaders were not a part of the group they purported to speak for. These men are often referred to as *antipsychiatrists*, but this is somewhat misleading. Many of the antipsychiatry theorists were actually psychiatrists, which is often overlooked (perhaps in part because they have been referred to as antipsychiatrists). I instead refer to them as *antipsychiatry theorists* in order to retain the necessary locution of *antipsychiatry* while emphasizing their positions as theorists. The antipsychiatry theorists that this dissertation analyzes are Erving Goffman, Thomas Szasz, R. D. Laing, and Michel Foucault. These four men are widely acknowledged to be the most prominent antipsychiatry theorists,

though the total number of known antipsychiatry theorists from the ‘60s does not exceed a dozen.[3]

Even amongst these few theorists, they had almost no consensus between them. This is due partly to their geographical locations: Foucault was in France, Laing, though born in Scotland, worked in England in the ‘60s, and Hungarian-born Szasz and Canadian-born Goffman were on opposite coasts of the United States (New York and California, respectively). Their works, therefore, concerned different mental health policies and psychiatric practices, and they had little opportunity to collaborate or march upon the steps of government buildings, even if they had had the desire to do so. Tom Burns has generously characterized them as “entirely independent; the authors had no connection with each other before or after their publication” (312). They did, in fact, have connections with one another—if public enmity can be considered a connection. Szasz, a staunch right-wing libertarian, was the main instigator of the feuds. He implicitly disagreed with anyone who leaned towards the left, which includes every antipsychiatry theorist excluding himself, and so naturally reserved his fiercest vitriol for the antipsychiatry theorist farthest on the left: Laing. Szasz so strongly disagreed with Laing’s theories that he would become “enraged” if Laing was mentioned within earshot and refused to even speak to one of Laing’s former colleagues until “he publicly dissociated from Laing” (Balbuena 319). Laing was evidently divisive; while Foucault was more subtle, he also rebuffed Laing, reportedly acting “strained and ironic” upon eventually meeting in 1975 (Burston, “R. D. Laing” 19). While Foucault likely did not disagree with Laing’s theories as vehemently as Szasz

[3] Other notable names attached to antipsychiatry include Franco Basaglia, the pioneer of antipsychiatry in Italy, and his colleague, Giorgio Antonucci; Timothy Leary, best known for his experimentation (often self-experimentation) with psychedelic drugs in the treatment of mental illness; David Cooper, a colleague of Laing who so infamously ascribed the label *antipsychiatry* to the aforementioned men; the French authors Gilles Deleuze, and Félix Guattari; and American professor Theodore Lidz.

did, being more aligned in political values, he "seemed to regard Laing as an irrelevant has-been" (19). As for Foucault and Szasz, Foucault ultimately did not align with his views but politely discussed the "strong and important" aspects of Szasz's ideas in an interview (qtd. in Szasz, *Antipsychiatry* 131). In contrast, Szasz believed that Foucault did not criticize psychiatry or the concept of mental illness enough to even warrant considering him as part of the antipsychiatry movement. Szasz, with his usual biting wit, dismissed Foucault by saying, "Foucault was opposed to Capitalism, Democracy, Liberalism, Libertarianism, and the West. . . . Since he was anti everything, he may be said to have been an antipsychiatrist" (*Antipsychiatry* 131). The only antipsychiatry theorist that Szasz did not have disdain for was Goffman, likely due to Goffman's increasing unsympathetic approach to mentally ill people in the mid-1960s (this shift will be discussed in Chapter One). In the sole alliance between antipsychiatry theorists, Szasz worked with Goffman in 1970 to found the American Association for the Abolition of Involuntary Mental Hospitalization (Szasz, *Antipsychiatry* 28). Otherwise, there was no collaboration amongst them: only a substantial degree of dismissal, at best, and animosity, at worst.

All of this is to say that the "antipsychiatry movement" could be better described as a loose grouping of men who happened to all criticize psychiatry at the beginning of the 1960s. Szasz himself best characterized how antipsychiatry theorists related to one another: "as that of Churchill to Stalin, i.e., as having nothing in common except a common enemy" (Berlim et al. 65). Peter Sedgwick, in his brilliant dissection of the four theorists, corroborates this, explaining that they were by no means part of a cohesive "school of thought" (21) but rather held "a consistent and convergent *tendency of opposition* directed against *positivist method* in the study of abnormal human behaviour" (22, original emphasis). With respect to psychiatry, the positivist

method has aligned with a biological or biomedical view of mental illness, while the opposition to this view is broadly called a social view.[4] Despite all of the disagreements and public lambasting, the antipsychiatry theorists can safely be said to unanimously hold a social view of mental illness.

This was by no means the first time that social understandings of mental illness have been proposed in history. In fact, the first asylums were predicated on the notion that madness, as it was then called, was a social failing. Prior to psychiatry, mental illness was not regarded as a health issue, and family members largely decided whether to personally care for their relatives or cast them out of the home (Scull, *Civilization* 84–85). However, by the turn of the nineteenth century, houses of correction, poorhouses, and the like were increasingly popular for anyone unable or unwilling to work; because mentally ill people were often unable or unwilling to work, they became overrepresented in the populations of these institutions. Asylums designed specifically for the care of mentally ill people arose largely due to wealthy families who desired this same institutionalization but who would have been socially tarnished if their relatives were discovered to live amongst the poor and unfortunate (Scull, *Civilization* 133–34). Psychiatry as a scientific discipline emerged *after* these institutions were erected. This sequence of events—first the buildings and then the discipline—is in sharp contrast to almost all other institutions in our society: academia did not develop because there were buildings full of students and professors; medicine did not shift out of private practice after doctors suddenly discovered themselves on

[4] These terms originate in disability rights activism. In 1976, two early disability rights organizations, the Union of the Physically Impaired against Segregation and the Disability Alliance, published the booklet *Fundamental Principles of Disability* which outlined a revolutionary new way of viewing disability: "it is society which disables physically impaired people" (3). Rather than a spinal injury itself being the disability, for example, it is the lack of a ramp to accommodate wheelchairs that is the disability. Disability rights activist Mike Oliver coined this perspective the "social model" of disability in 1983. While there has been contention in the disability rights movement about whether or not mental illness can be considered a disability, the biomedical vs. social framework is applicable when discussing the diverging theories of mental illness.

wards. Those statements might sound absurd, and yet this pattern is true of psychiatry: doctors of the mind were in demand only after buildings had been filled with mentally ill people. However one feels about psychiatry now, it is understandable that psychiatry's unorthodox origin has been the basis of many attacks against its validity as a science.

It is perhaps in part because of these critiques that psychiatrists embraced a biomedical view of mental illness by the turn of the twentieth century. This dramatic shift was not, as has been suggested, entirely a ploy to be seen as a legitimate medical field. In 1905, the field had cause to believe that they had discovered a biological cause for what was then seen as a mental illness: syphilis. Because the symptoms of syphilis are similar to those of mental illness symptoms,[5] people with the infection were often housed in asylums and indistinguishable from other mentally ill people. When two scientists discovered the bacterium that caused syphilis in 1905, then, it seemingly proved that, at last, a biological cause of mental illness had been found. A host of biological treatments in the next few decades ensued: prolonged sleep therapy (drugging patients to remain unconscious for long periods), malaria fever therapy (giving patients malaria to induce fever thought to cure epileptic convulsions associated with mental illness), chemical convulsive therapy and electroconvulsive therapy (inducing seizures with camphor or electricity, respectively), lobotomies (severing the prefrontal cortex with a tool resembling an ice pick), wet packs (wrapping patients in cold, wet sheets), and continuous baths (confining patients to a bath with only their heads exposed) (Sadowsky 26–27). Many of these treatments seem to us now to be profoundly cruel, punitive torture, and, indeed, the result *was* torture: hundreds of thousands of patients had their brains and bodies often irreparably damaged.

[5] One 1901 article in *The Journal of the American Medical Association* identifies syphilis's symptoms in psychiatric terms: "acute mania, ordinary melancholia, terminal dementia or resembling so closely paretic dementia that experts may differ in their diagnosis" (McBride 297).

The goal, however, was not to punish—these treatments were intended to help people: if mental illness has a biological origin, it follows that its treatment should be biological. However, because of the severity of the treatments and their limited success rates, there was much criticism of psychiatry well before the antipsychiatry era. Daniel Burston explains that psychiatry was often viewed "as a pseudo-medical 'enforcer' that suppressed deviance and sidelined malcontents while propping up the status quo" ("Antipsychiatry" 159). These critiques were ongoing for decades, and perhaps would have remained relegated to discontent whispers for decades still, but other societal changes laid the foundations for antipsychiatry to shout its protests.

World War II brought change to almost every corner of society, and psychiatry was no exception. Prior to the 1930s, psychoanalysis, created by Austrian-born Jewish Sigmund Freud, had very little influence outside of Jewish communities in Europe. However, due to the increasing antisemitic violence in Europe, many Jews fled to America, including many Jewish psychoanalysts. These psychoanalysts steadily shifted psychiatry's balance away from the primarily Anglo-Protestant men who practised biomedical psychiatry, and "[b]y 1960, every major academic department of psychiatry in the United States would be chaired by a psychoanalyst or a psychoanalytic fellow traveller" (Scull, *Short* 86). As psychoanalysis inherently disputes a biological understanding of mental illness, and psychoanalysis was most often practised in non-institutional settings, this shift drastically changed the blueprint of psychiatry in the mid-twentieth century.

In addition to the unprecedented genocide of Jews, the Nazis targeted "anyone they believed threatened their ideal of a 'pure Aryan race,'" which included the Romani, Black people, Slavic people, gay people, transgender people, and disabled people, including those with

mental illness ("Nazi Persecution"). It is little known that mentally ill people were the first group that the Nazis experimented on and killed. From 1933 leading up to the outset of WWII, an estimated 360,000 mentally ill people were forcibly sterilized by Nazis. The first gas chamber was used on a group of mentally and physically disabled people after Nazis realized that murdering them via lethal injection or starvation was 'inefficient' for the number of people they planned to slaughter ("Disabled People"). By the end of the war, an estimated 250,000 disabled people had been murdered in concentration camps. After these crimes against humanity were revealed, other nations were forced to contemplate how they treated their own mentally ill citizens.

Investigations into various institutions ensued, spurred on by Bruno Bettelheim's famous 1943 article investigating how Nazi concentration camps operated, "Individual and Mass Behavior in Extreme Situations" (Grob 140). The most famous exposé of a mental hospital came in 1948 with journalist Albert Deutsch's *The Shame of the States.* Mental hospitals were never the height of luxury, but their conditions were truly dire after the war. Between 1903 and 1955, the number of patients in mental hospitals in the United States increased from 150,000 to 559,000 with no equivalent increases in either physical space or staff members (Scull, *Short* 104). Deutsch exposed the horrific physical reality of these numbers as well as the disturbing parallel to how Nazis treated mentally ill people. He writes that upon entering a ward, he was "reminded of the pictures of Nazi concentration camps . . . with naked humans herded like cattle and treated with less concern" (42). He ends the book by asserting that the only difference between concentration camps and mental hospitals is the intentionality of murder: "No, indeed, we are not like the Nazis. We do not kill off 'insane' people coldly as a matter of official state policy. We do not kill them deliberately. We do it by neglect" (96). To draw similarities to

Nazism in any regard in 1940s America was the harshest criticism, and so *The Shame of the States* became "a clarion call for reform" (Grob 74).

While the institutional care for mentally ill people was being interrogated, new questions about the nature of mental illness were being asked due to the abrupt appearance of a new mentally ill population: soldiers. When drafting for the war, those with a history of mental illness were rejected for service as it was believed that shell shock or combat fatigue only manifested if a soldier already had a mental illness (Decuers). Therefore, when swarms of soldiers began developing symptoms of mental illness despite being confirmed to have no preexisting mental illness, the nature of mental illness became suspect. That previously mentally sound people—in particular, white men—could develop symptoms of mental illness proved that mental illness was not entirely biological: extreme environmental stress could indeed deteriorate mental health. And, furthermore, that these people could be successfully treated in non-institutional settings by field doctors proved that inpatient psychiatric care was not necessary. And so, when the war was over, there was a new paradigm: mental illness can have environmental causes and mentally ill people need not be treated in institutions, particularly institutions that resemble the very concentration camps in which mentally ill people were killed.

It was not until the 1960s that the paradigm shift yielded tangible changes in psychiatry. Despite the increasing onslaught of critiques about mental hospitals, there were simply not the resources nor policies to either improve care or discharge patients who required care—that is, until the development of psychiatric medications. The creation of the first antipsychotics (chlorpromazine in 1952 and haloperidol in 1958) and antidepressants (imipramine in 1958 and amitriptyline in 1961) allowed for reliable, outpatient biological treatment of mental illness (Burns 312). Psychiatrists dedicated to the biomedical model could prescribe these medications

to patients for use at home, as opposed to the prior biological treatments that required inpatient stays and substantial hospital resources. In this regard, psychiatrists were finally able to concede to increasing pressure to treat mentally ill people non-institutionally.

For the 1960s, however, this was not enough; dreams of a utopia without war or social divides did not include merely medicating those who were suffering. In her study of 1960s literature, Patricia Waugh characterizes the decade as one of exceptional "optimism about the potential dawn of a new social order," especially with respect to "authority, sexuality, censorship, and civil liberties" (5). Her incisive description of the decade clarifies why drastic changes in psychiatry were finally achievable:

> Relative affluence; a new consumerism feeding off technological innovation; the rise of youth subcultures around varieties of popular music, philosophy, and fashion; the massive expansion of education; increased arts funding; television; and a marked development of the genre of political satire, all helped finally to bring to an end the more deferential and consensual culture which had been gradually eroded since the early fifties. (5)

Indeed, the changes came swiftly and strongly at the turn of the decade, beginning with the *Action for Mental Health* report in 1961. The report was created by the Joint Commission on Mental Illness and Health (JCMIH), which waited until the inauguration of John F. Kennedy to present it to Congress, believing that Republican Dwight D. Eisenhower would not be receptive to it (Grob 203). The report declared that mental illness has "biological, chemical, psychological, and social . . . complexities" (JCMIH v) and called for greater funding for research and care of mentally ill people. Based on this report, Kennedy, whose sister Rosemary was intellectually disabled and had a disastrous lobotomy, passed the Mental Retardation and Community Mental

Health Centres Construction Act in 1963. This act allocated 150 million dollars (equivalent to about 1.5 billion dollars today) to constructing a variety of community mental health centres (Grob 233). As a result, from 1955 to 1988 there was a shocking eighty percent decrease in institutionalized patients (Shorter 280). This trend is referred to as deinstitutionalization and is now heavily criticized, particularly because the community centres failed to support the multitude of mentally ill people who were suddenly discharged, resulting in a third of them becoming homeless (Shorter 280).

While many, like Edward Shorter, largely blame the catastrophe of deinstitutionalization on antipsychiatry, none of the antipsychiatry theorists were advocates of community mental health care. Instead, as I have mentioned, they focused primarily on redefining mental illness. Before discussing their definitions, I should clarify my own. As this dissertation will make clear, there is no one specific word for or definition of mental illness that can capture all of the experiences of those experiencing it. Like the word *antipsychiatry*, which is a helpful locution for the new ideas about mental illness in the 1960s rather than a declaration that the ideas are anti psychiatry, I consider the term *mental illness* to be a useful locution rather than a concession to the biomedical model. This notion that *mental illness* admits loyalty to psychiatry has been a common critique of antipsychiatry, with which I agree. Ronald W. Pies, for example, argues that antipsychiatry theorists like Szasz understand the term too literally, when really most people understand *mental illness* as connoting the ordinary—not medical—definition of *illness*: general "human suffering and incapacity," in this case "involving disordered emotion, cognition, reasoning, and behavior" (12.5). I use the term *mental illness* with this non-medical definition. The words *mad* and *madness* are now frequently used to avoid any association with the biomedical model, as evident in the emergent field of mad studies; however, with a more

expansive definition of illness that does not include biomedical views, I do not feel the need to reclaim stigmatized terms (but respect the choice of others to do so). I will, however, use *mad* and *madness* when discussing the antipsychiatry theories that employ them and when it is appropriate in a historical context.

To clarify some additional terms: I also use the terms *asylum*, *mental hospital*, and *psychiatric institution* according to the historical period or antipsychiatry theorist being discussed (Foucault, for example, favours *asylum* while Goffman utilizes *mental hospital*).[6] Similarly, I use identity-first (*mentally ill person*) and person-first (*person with mental illness*) language according to the preference expressed by an individual being referenced; if no preference is mentioned or I am speaking generally, I use them relatively interchangeably.[7] All of this is to say that the terminology I use to refer to the world of mental health is always context dependent. As I hope will become clear by the end of this dissertation, choosing the precise terminology and definitions to perfectly capture mental illness is akin to drawing constellations on fiery stars that in actuality are unfathomable distances apart: they make an impossibly complex concept into something simple and understandable. This is not bad, nor is it wrong—the constellations *are* how we see them from our confined location on Earth, just as these definitions of terms are how issues of mental suffering appear to us at any point in time. And, at the same time, it is futile to continually redraw the lines between stars light years apart, hoping to get the picture exactly right.

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[6] Goffman's preference for *mental hospital* is odd, given that his book is titled *Asylums*. It is possible that he chose this title to be more provocative as *asylum* is more associated with the abuse of patients than *mental hospital* was.

[7] See Dana S. Dunn and Erin E. Andrews's article, "*Person-First* and *Identity-First Language*: Developing Psychologists' Cultural Competence Using Disability Language," for a balanced and thorough discussion of this issue. They ultimately suggest that there is no correct answer due to the complexities of the issue, though personal preference should be respected.

With this history and context of antipsychiatry and mental illness now established, I turn to the enterprise of my dissertation: mental illness in literature. As Roy Porter argues in *A Social History of Madness: Stories of the Insane*, "Mad people's writing often stake counter-claims, to shore up that sense of personhood and identity which they feel is eroded by society and psychiatry" (25). That literature of the 1960s stakes a counterclaim against psychiatry and therefore reflects antipsychiatry ideas has been well established. Joanna Stevenson, in her dissertation *Psychiatry Under Fire: Novelistic Challenges to Biomedical Psychiatry in American Fiction 1961–1964*, argues that many novels "shared this moment [of antipsychiatry], and function as part of a wider pattern of cultural indictments against biomedical psychiatry" (332). Gerald N. Grob similarly argues that the "attack on psychiatric theory and practice was . . . mirrored" in films and novels such as *One Flew over the Cuckoo's Nest* (1962) (291), while Patricia Waugh argues that 1960s playwrights, such as Edward Bond and Harold Pinter, "reflect the influence of R. D. Laing" (86). My argument is certainly not in opposition to these, as it is undeniable that many literary texts in the 1960s criticize psychiatry in ways similar to the antipsychiatry theorists. I do, however, question the notion that literature merely acts as a mirror reflecting these ideas. Instead, I argue that this literature is a light source of its own, illuminating the flaws in how both psychiatry *and* antipsychiatry define mental illness.

The parameters for selecting which literary texts to analyze in this dissertation were few but significant: they had to be published in the 1960s, written by an author with mental illness, and centre on a protagonist's experiences of mental illness/institutionalization. While a large body of poetry and plays falls under these parameters,[8] I ultimately opted solely for novels,

[8] Some of the most prominent examples from mentally ill artists include poetry by Sylvia Plath, Anne Sexton, Robert Lowell, and Allan Ginsberg and plays by Harold Pinter, especially *The Birthday Party* (1960), and Tennessee Williams, especially *The Night of the Iguana* (1961) and *In the Bar of a Tokyo Hotel* (1969).

primarily because the novelists' experiences more easily map onto their protagonists' experiences, which is an important aspect of my inquiry. By focusing exclusively on a select few novels, I was also able to conduct richer close readings in conjunction with analyses of the authors' biographies and scholarship. These novels are *The Bell Jar* by Sylvia Plath (1963), *I Never Promised You a Rose Garden* by Joanne Greenberg (1964), *Slaughterhouse-Five* by Kurt Vonnegut (1969), and *Faces in the Water* by Janet Frame (1961).

I have limited the novels to those published in the 1960s as I am interested in how novels concurrent with antipsychiatry texts conceive of mental illness similarly or differently; literature, too, spoke about mental illness in this decade. I have also excluded novels written by those without mental illness in order to privilege those with lived experience of mental illness. This is because I wanted to avoid what often happens when scholars turn their attention to mental illness: with a Western, biomedical gaze. This privileging of medical knowledge over those who have lived with mental illness, and indeed any disability, results in a loss of knowledge about the subject. As disability studies scholar S. Kay Toombs explains in her formative article "The Lived Experience of Disability," to write about someone else's experiences is to render them inherently as objects, while to write from one's own embodied experience fosters empathy, dismantles stigmas, and encourages positive changes for disabled people.

While there are many novels that fall outside my parameters that are useful in analyzing how literature at large converged with antipsychiatry, like *One Flew over the Cuckoo's Nest*,[9] I am concerned instead with determining how mentally ill people conceive of mental illness in their fiction. In particular: in what ways do these novels reflect antipsychiatry arguments? In

[9] The author, Ken Kesey, was not mentally ill but rather took mescaline and LSD to relate to mentally ill people (by having an altered experience of reality) and began writing the novel while on mescaline to capture "the mood and particularly the voice" of the mentally ill protagonist (Parker 153–54).

what ways do the novels expand antipsychiatry arguments? And, most importantly, do the novels contain portrayals and discussions of mental illness that go beyond both psychiatry and antipsychiatry?

This dissertation ultimately aims to uncover a much richer relationship between these novels and antipsychiatry than has been previously revealed. Scholarship that suggests that these novels primarily echo antipsychiatry sentiments, such as the aforementioned quotes from Stevenson, Grob, and Waugh, inadvertently reduces them to telegrams simply forwarding the ideas of Goffman, Szasz, Laing, and Foucault to the public at large. This is misguided for two reasons. For one, there is very little evidence that Plath, Greenberg, Vonnegut, or Frame were aware of the antipsychiatry theorists. While a lack of awareness of these antipsychiatry theorists does not preclude the authors from mirroring their ideas, it is clear that they were at least not in direct conversation with them. There is evidence of Greenberg's and Vonnegut's familiarity with Laing, but only after the publication of their novels. In a lecture given in 1986, Greenberg referenced Laing in passing when stating her disagreement with "[p]eople like Laing" who believe in the notion that mental illness is a spectrum, meaning that everyone is mentally ill to one degree or another (qtd. in Hornstein 382). As Laing developed this belief in the latter half of the '60s, Greenberg would not have written her novel with knowledge of it. The evidence of Vonnegut's familiarity with Laing is even more tenuous: an interviewer in 1977 describes Vonnegut's desk as holding a copy of Clancy Sigal's *Zone of the Interior*, a fictionalized portrayal of Laing's experimental antipsychiatric institution (Vonnegut, *Palm Sunday* 74).[10] Again, however, there is no evidence that Vonnegut, or another of the other authors, knew of these specific men before writing. They almost certainly came across antipsychiatry ideas due to

[10] Vonnegut's son, Mark Vonnegut, was very familiar with Laing as evidenced by his vividly titled article, "Why I Want to Bite R. D. Laing." This article was also published after *Slaughterhouse-Five*.

the prevalence of antipsychiatry at the time and their involvement in psychiatric treatment (especially Plath and Frame, who were actively in therapy in the early '60s), but this is the most that can be said for their connections to it.

Even if the authors had been intimately aware of each antipsychiatry theorist and their works, it is still reductive to suggest that these novels are simple vehicles for antipsychiatry sentiments. This suggestion takes part in the long tradition of privileging non-mentally ill people's definitions of mental illness and has resulted in the novels' actual messages about mental illness going unheard. To view the novels as simply picking up on and transmitting the mental illness theories *du jour* is to ignore how they function as part of the larger conversation about mental illness, in which psychiatry and antipsychiatry are two of the multitude of voices. These novels, which depict mental illness in ways that neither ever conceived of, have resonated with millions of readers and are significant in their own right. *I Never Promised You a Rose Garden*, which is perhaps the least known of the four novels today, was by far the most popular in the '60s: an impressive four million copies sold in just a decade after its publication (Wolfe and Wolfe 896). *Slaughterhouse-Five* was similarly popular after its release, spending sixteen weeks on the *New York Times* bestseller list in 1969, and has retained its place in the literary canon today. While *The Bell Jar* was not a bestseller until its American publication in 1971,[11] it is perhaps the best known of the four novels in our current age. And lastly, despite *Faces in the Water* lacking international acclaim, its publication skyrocketed Frame to one of New Zealand's most revered authors to this day. Clearly, these novels have value in their own right, and in this dissertation, I hope to establish exactly what that value is.

[11] It was previously published only in England due to objections from Plath's family, which Chapter One discusses.

My analytical approach is the use of literary criticism to elaborate on and critique the antipsychiatry ideas of Goffman, Szasz, Laing, and Foucault. To analyze how the novels converge with and diverge from their ideas, each chapter pairs one novel with one antipsychiatry theorist. The chapters follow a general pattern: I briefly outline how the novel aligns with the particular antipsychiatry theory to criticize psychiatry's understanding and treatment of mental illness; I then explore how the novel diverges from those antipsychiatry theories to expand and challenge narrow antipsychiatry understandings of mental illness; finally, I use a non-antipsychiatry concept or theory from the antipsychiatry theorist—that is, a concept or theory that they created after they divested from antipsychiatry or in a work published outside the scope of antipsychiatry—to analyze how the novel, as a literary text, is an expansive site in which mental illness can be described more accurately and productively.

Chapter One begins the dissertation by delineating how fiction is a powerful site for describing one's own experiences with mental illness. To do so, I utilize and expand Erving Goffman's concept of a self-story. In *Asylums: Essays on the Condition of the Social Situation of Mental Patients and Other Inmates* (1961), Goffman argues that patients in mental hospitals devise self-stories, or stories about their own lives, to convince themselves and others that they are not truly sick and that they came to be in a mental hospital through no fault of their own. To demonstrate the limits of this concept and suggest its potential for expansion, I pair Goffman with Sylvia Plath and her self-story, *The Bell Jar*. I conduct an analysis of some of the scholarship on Plath and *The Bell Jar*, particularly feminist scholarship and scholarship dedicated to diagnosing Plath and her characters, to draw a comparison to psychiatry and antipsychiatry. Each type of scholarship, like psychiatry and antipsychiatry, crafts a particular perception of mental illness and, in doing so, erases any aspects of mental illness described in the

novel that do not fit their perception. In contrast, *The Bell Jar* resists confinement to any one particular perception or story of mental illness. I use Goffman's ideas about biography in his non-antipsychiatry work, *Stigma: Notes on the Management of Spoiled Identity* (1963), to analyze Plath's and Goffman's biographies, revealing that forcing complex individuals into a simplified story is limited and harmful. I ultimately suggest that *The Bell Jar*, as a self-story, allows for multiple definitions of mental illness and Plath's multiple selves to exist simultaneously, thus acting as a more expansive site in which to describe mental illness than psychiatry or antipsychiatry can offer.

Chapter Two builds on how novels resist antipsychiatry's need to define mental illness. I interrogate Thomas Szasz's assertion in *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (1961) that mental illness is a language that can be translated into English. Szasz argues that when people cannot—or will not—express their problems in English, they resort to the "language of illness," or bodily symptoms, to communicate their suffering. I compare this theory to Joanne Greenberg's *I Never Promised You a Rose Garden*, initially arguing that it is true in the novel—to an extent. I argue that the novel depicts mental illness as a language, but it is one that cannot be translated into English: only approximate translations are possible if they are done empathetically alongside the mentally ill person, and they are never exact. It is literature's capacity to communicate multiple "languages," multiple understandings of mental illness, that allows for recovery and healing. I argue that this perspective on literature's capacity is in line with one of Szasz's theories that is peripheral to his antipsychiatry theories: his theory that literary language can uniquely describe mental illness in ways that psychiatry cannot. I use this theory to argue for the power of literature in describing, but not defining, mental illness.

Chapter Three proposes that these literary descriptions, rather than explanations, of mental illness can be a site of healing. I analyze R. D. Laing's radical theory in *The Politics of Experience* (1967) that schizophrenia can offer people a break*through*, not a break*down*. I hone in on his concept of metanoia: a metaphysical journey through space and time that schizophrenic people embark on to discover truths about the universe and, consequently, heal themselves. I apply Laing's theory of metanoia to Kurt Vonnegut's *Slaughterhouse-Five* to argue that metanoia is possible, but only through writing. I analyze Billy Pilgrim's journey through space and time, analogous to metanoia, and the metanoia experienced by Mary Barnes, one of Laing's patients, as she describes it in her memoir *Two Accounts of a Journey Through Madness* (1971), co-authored with her therapist, Joseph Berke. In doing so, I reveal how it was the process of writing their narratives of metanoia, rather than undergoing it through schizophrenia, that was healing. It is healing not because the authors seek to define mental illness, as Laing does, but it is healing precisely *because* they do not define it. I reveal that this same phenomenon—that metanoia in literature is healing because it avoids definitions—is also true of Laing's poem appended to *The Politics of Experience*, *The Bird of Paradise* (1967). For all of these authors, Vonnegut, Barnes, and Laing (in his literary work), literature provides a space in which to describe the experience of mental illness without any claims to truth, liberating and healing them.

Chapter Four focuses on challenging binary views of mental illness. I focus on two of the primary arguments in Michel Foucault's *Madness and Civilization: A History of Insanity in the Age of Reason* (1964): that psychiatry controls and "silences" madness and that literature can allow for madness to "speak" again. I outline how these two arguments are depicted as true in Janet Frame's *Faces in the Water*: psychiatry in the novel does control madness through oppressive mechanisms and the novel's intent was to force readers to confront and "listen" to

madness. However, I then argue that readers did not "listen" to the madness in the novel precisely because of Frame's public identity as a mentally ill person. Readers, unable to reconcile Frame's mental illness and her literary talent, ultimately disregarded her identity as an author and dismissed her novel as a case history of a mentally ill person. I utilize Foucault's post-antipsychiatry argument in "What is an Author?" (1969) about the author-function, which refers to how readers perceive and construct authors, to explain why readers struggled to reconcile her two identities: madness is thought to be mutually exclusive to art. I return to a close reading of the novel to argue that reading it *without* binary constructions of mental illness is far more powerful, offering a more productive view of mental illness outside of Foucault's initial romanticized view or psychiatry's dehumanizing view.

I conclude my dissertation by suggesting that this exploration of mental illness in 1960s literature is important for two reasons: it demonstrates the limits of antipsychiatry ideas, so that present-day critiques of psychiatry do not replicate their flaws, and it proposes a method for future analyses of similar literature that go beyond existing discourses of mental illness. It is not an overstatement to say that, throughout history, mental illness has been ceaselessly debated, dissected, and demonized. It has ever been used as a scapegoat (think of all the school shooters whose whiteness and maleness affords them the title of *mentally ill* rather than *murderer*) or a scary story (when the words *insane asylum* are most often in the mouths of ghost hunters or horror novelists). These endless narratives often leave those with mental illness with nowhere to go, contorting and constricting their understanding of their own mental illness into pre-established configurations. The goal of my project is to reveal literature as an under-explored site for mental illness to be described, interrogated, lamented, and healed from outside of confining

categories. In our current world, where confining categories feel increasingly inescapable, I offer this expansive space as one that holds hope.

Chapter One

"I Am, I Am, I Am": Self-Story in Sylvia Plath's *The Bell Jar*

Mental illness is not, according to antipsychiatry, an illness. This was the universal, and only, idea that proponents of antipsychiatry agreed upon. Because it is not enough to state only what something is *not*, what it *is* instead must be defined, and that is where the contention began. Without being beholden to quantifiable lab reports or even a set of agreed-upon research standards, each antipsychiatry theorist was free to use their own academic disciplines and individually established research methods to base their theories on. Therefore, when sociologist Erving Goffman began researching mental illness, he arrived at the conclusion that mental illness is a term forced on 'deviant' individuals. This theory later was developed by subsequent scholars into labelling theory, which Goffman unequivocally rejected[1] despite labelling theory exactly describing his foundational argument. This rejection was not due to semantics. Although it seems so at first, Goffman did not view mental illness as a label—he viewed it as a story. This understanding of mental illness is not at the forefront of Goffman's works but is rather foundational to them, which is perhaps why this description of his arguments is, to my knowledge, unique. Central to Goffman's philosophy is the idea of an individual's self-story: the narrative that an individual creates from their past and present experiences to form an identity. The opposing side of this is the psychiatric story:[2] the rewritten story of a patient's life that narrates how their behaviours are symptoms of a mental illness. In Goffman's view, the problem is that the psychiatric story of mental illness is wrong, and he remedies this by creating his own story about what mental illness is.

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[1] In his 1969 essay, "The Insanity of Place," he writes that to "treat mental illness merely as a labeling process" is to have "dismally failed to examine" the "havoc" (destructive behaviour) of mental illness symptoms (369).

[2] *Psychiatric story* is my terminology to succinctly state Goffman's description of stories that are "constructed along psychiatric lines" (*Asylums* 142).

Those familiar with Goffman's work might recognize that Goffman does not use the term *story* in his work except to refer to self-stories. I, however, ascribe that term to his theory for two reasons: it is consistent with his ideas, as I will argue in the next section of this chapter, and it reveals the irony, or even hypocrisy, in his theory. By understanding both the psychiatric theory of mental illness as a story *and*, by extension, Goffman's theory of mental illness as a story, it is clear that the problem lay not in psychiatry creating the wrong story, but in creating a story about mental illness at all. In this chapter, I will use Goffman's theory of self-story to analyze Sylvia Plath's *The Bell Jar*, revealing that the complexities of mental illness can only be contained in a self-story and never in a story imposed on another individual.

The Bell Jar, published in 1963, is ideal to analyze alongside Goffman's work as self-story is a key theme both within the novel and in Plath scholarship. I have categorized the scholarship on Plath into two main types: feminist readings, which understand mental illness to be in response to and/or created by the patriarchy, and pathologized readings, which seek only to diagnose Plath and her characters according to psychiatric classifications. Through an analysis of both readings, I will demonstrate that any story about mental illness, whether it be a feminist understanding of mental illness or a pathologized one, is harmful when it erases the mentally ill individual's self-story. Esther's self-story of mental illness, and by extension Plath's self-story, cannot be confined to one simplistic narrative. This chapter will argue that Goffman's concept of the self-story can be expanded beyond what Goffman intended it to be: as an individual's alternative to both psychiatric and antipsychiatric definitions of their own mental illness. In *The Bell Jar* and Plath's life, self-story has the ability to contain the complexity of self and mental illness that definitions from outside institutions and movements cannot.

Goffman's Story

Part of the reason why the antipsychiatry movement contained such diverse theories about mental illness is the diverging disciplines of each antipsychiatry theorist. Erving Goffman is perhaps the most extreme example, having studied almost everything *except* for psychiatry or psychology. Goffman began with a chemistry degree at the University of Manitoba before shifting to sociology and anthropology at the University of Toronto and, finally, obtaining his MA and PhD in sociology at the University of Chicago. From there, he strayed from the more traditional path of academia and instead sought out a position at the National Institute of Mental Health (Shalin, "Interfacing" 11). With the help of a colleague, Goffman gained access to St. Elizabeth's Hospital in Washington, D.C. to conduct the research which eventually contributed to his most influential antipsychiatry text, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961). Rather than working to reform the institution of psychiatry, as the other antipsychiatry theorists were ostensibly aiming for, Goffman, as a sociologist, sought to demonstrate its inner workings and understand society through its problematic structure. He begins *Asylums* by mildly stating that he has "no great respect for the discipline of psychiatry nor for agencies content with its current practice" (8). This statement, it turns out, was made with restraint, as one of Goffman's contemporary sociologists, Melvin Kohn, clarifies that Goffman intended for the publication of *Asylums* to "show those bastards [psychiatrists] up. He was fighting them" (qtd. in Shalin, "Goffman" 129). While this may seem like inconsequential gossip, it will become clear later in this chapter why Goffman's vested interest in psychiatry is important.

Goffman did not begin his career writing about psychiatry. In the same year that he began his fieldwork at St. Elizabeth's, *The Presentation of Self in Everyday Life* (1956) was published.

In this work, he set out the theory that would inform all of his later writings: that the self is created through the roles that individuals take on in social interactions. These roles are not natural but learned, idealized, and prescribed (34). When a customer and an employee are interacting, for example, society dictates that they carry out the performances that are expected of a customer and an employee. To deviate from these set expectations, on one hand, is to invite negative social consequences (242), while to adhere to them too rigidly at the cost of repressing other parts of the self, on the other hand, can lead to dissociation and self-estrangement (81). There is one role in particular that becomes the focus of Goffman's subsequent work: the role of the mentally ill patient.

It is worth delving into Goffman's argument in *Asylums* in some detail as it is this argument that will provide the foundation of my analysis of *The Bell Jar*. *Asylums* was wildly successful to the point that it became required reading for most undergraduate sociology students (Sedgwick 3) and has been used as a foundational theory for many subsequent sociological studies on subjects unrelated to mental illness, such as studies on body weight or AIDS (Pescosolido 273). *Asylums* is a questionable work by contemporary academic standards, with a lack of recorded interviews, primary documents, or any quantitative standards, and it is instead focused on Goffman's personal observations and generalizations (Gambino 53; Grob 283).[3] This writing style may be, however, why it was so successful with the public, as Grob argues that its "literary and intellectual qualities overshadowed methodological issues" (284). Goffman's literary style combined with his comparisons of mental hospitals to totalitarianism and

[3] While qualitative studies like Goffman's can be done effectively, Goffman's qualitative research has been shown to be biased and with severe omissions. Matthew Gambino in particular analyzes how the missing primary documents from patients at St Elizabeth's Hospital reveal that the patients were far more "critical, self-reflective, and semi-autonomous" (53) than Goffman portrayed them to be.

concentration camps greatly appealed to readers in the 1960s with lingering anxieties from World War II (Gambino; Shalin, "Goffman").

The central argument in *Asylums* is that mental hospitals are total institutions: places of authoritarian control which remove the barriers that normally separate the three spheres of life (sleep, play, and work). Total institutions can be as seemingly innocuous as boarding schools or as purposefully malicious as concentration camps. They all have one goal in common: to strip the individuals that inhabit them of their previous selves and replace them with new selves, whether that be the role of a student, prisoner, or mentally ill patient. This is done through a process called 'self-mortification,' or removing all aspects of the individual's previous self, including their schedules, relationships, possessions, appearances, and, usually, names. This argument culminates in Goffman's claim that mental hospital patients are 'sick' with mental illness in name alone; just as a woman in a convent is called a nun or a person in army barracks is known as a solider, a person confined to a mental hospital is 'ill.'

Since a mentally ill patient can only be made sick through a process of labelling, there is an involved process, called the moral career of a mental patient, that must be undergone to be transformed from a healthy individual into a mentally ill patient. To simply designate an individual as mentally ill would have no effect: a person's identity and social status need to be denigrated and reshaped to embody a mentally ill patient. Another way of viewing this is rewriting an individual's life story. Just before admittance to a mental hospital, the patient has a previously established story of their own lives what Goffman calls a 'self-story.' Unlike terms like 'self-esteem' or 'self-employed,' in which the prefix 'self-' is used solely to indicate possession to oneself, 'self-story' in Goffman's terms connotes that the story is used to actually *create* one's self. The first task in rewriting one's self-story is to erase what was previously there.

This is accomplished through the "abandonment, disloyalty, and embitterment" (125) of being committed to a mental hospital by their next of kin. The admission process instigates a "betrayal funnel" as the patient passes from their betraying next of kin through various medical authorities that continually mislead and abandon them until they end "up on a psychiatric ward stripped of almost everything" (130). After the erasure of their previous self-story and, therefore, identity, the mental hospital can then work to rewrite the patient's story. The primary purpose of this, Goffman argues, is to justify their forced hospitalization; rather than admit that they are in the business of warehousing social deviants, a story of illness is created wherein the patient needs medical intervention (135). This new story, the case-history construction, casts the patient's life pre-hospitalization into the narrative of mental illness: no matter their personal circumstances or life events, they are portrayed as someone who was always destined to become sick and hospitalized.

Both the hospital and the next of kin readily accept the case-history construction, but the patient may be reluctant to adopt that illness story. To maintain some connection to their previous sense of self, they construct a specific kind of self-story: what Goffman terms an apologia. An apologia is a self-story that is designed to bring someone "into appropriate alignment with the basic values of his society" (139–40). There are two basic kinds: the success story, which focuses on how a person's positive characteristics have brought them their success, and the sad tale, which focuses on how external circumstances have brought the person to their sorry fate. While most people in society have an apologia, apologias in mental hospitals present a distinctive profile. The patient, if they do not accept the case-history construction that is forced on them, creates a sad tale to prove that they are not sick and their problems can be attributed to some innocuous circumstance, such as a heavy workload, a "bad nervous system," a

misdiagnosis, a bad childhood, etc. (141). These self-stories serve to placate the patient by convincing themselves and others that they do not belong in a mental hospital, and they also serve to sustain the patient community. Interactions amongst patients are based on "these reciprocally sustained fictions" (142) as they corroborate and encourage each other's stories.

While the self-stories are sustained between patients, they are not between the patient and the mental hospital. Mental hospitals are exceptionally "destructive of self-stories" (142), both naturally due to the environment—it is difficult to maintain a belief that you are not sick in an environment that treats you as such—and purposefully by staff—patients with sad tales make for poor patients. To combat patients' apologias, the hospitals formalize their case-history constructions into a case record. This formal document is the antithesis of the sad tale, portraying every aspect of the patient's life, from their childhood behaviour to their current appearance, as evidence of their illness. The problem with this, Goffman argues, is that any person could be deemed mentally ill through the storytelling power of the case record, as "almost anyone's life course could yield up enough denigrating facts to provide grounds for the record's justification of commitment" (146). In other words, mental illness is created through the stories that case records tell. The patient's "cure," then, is to accept the new story of their life and change their sense of self to correspond. Through this process, patients realize "that a defensible picture of self can be seen as something outside oneself that can be constructed, lost, and rebuilt, all with great speed and some equanimity" (151). What Goffman never admits to is that he constructs, takes, and rebuilds mental illness just as much, if not more, than a mental hospital. While the patients may create a story where they are not at fault for their problems and the hospitals may create a story where the patients are sick, Goffman creates a story that mental illness is nothing more than a role enforced on a person who had made errors in their previous roles.

The Bell Jar's Asylum

Goffman's theory about mental illness as a story may seem, initially, like an innocuous concept. It is not. In this chapter, I will analyze its potential harms and suggest a more productive use of it by applying it to *The Bell Jar*. Before doing so, however, I should establish that *The Bell Jar*'s portrayal of psychiatry corroborates Goffman's descriptions of it, especially the mental hospital's use of physicality as a means of control. The first hospital that Esther visits, run by the inept Doctor Gordon, is a vivid example of Goffman's claim that most mental hospitals "function merely as storage dumps for inmates" (73). His office waiting room is "hushed and beige," stripped of anything that the patients might identify with, such as "mirrors or pictures," the walls instead a blank, beige canvas for Doctor Gordon to showcase his authority through many medical certificates (122). His private hospital is much worse, with Esther immediately commenting on its location "at the end of a long, secluded drive" and its "enormous silence" (135). As Goffman argues, the physical isolation and imposing structures of mental hospitals aim to control their patients. In doing so, they do not need to have the safety features of prisons. Esther notes this and is unsettled by its normalcy, knowing that it "must be chock-full of crazy people" and yet there are "no bars on the windows that I could see, and no wild or disquieting noises" (135). When she enters the hospital, she is taken aback by the apparent normalcy of the patients—until she sees "that none of the people were moving" (136). They have "stiff postures" and a "uniformity to their faces, as if they had lain for a long time on a shelf, out of the sunlight, under siftings of pale, fine dust" (136). When they do move, it is with "small, birdlike gestures," mindlessly repeating the same motions over and over like automatons (136). They are not people, Esther concludes, but "shop dummies, painted to resemble people and propped up in attitude counterfeiting life" (136). This description is what is so horrifying about Goffman's

description of mental hospitals. They are no longer places where mad people run amuck; instead, the patients are barely people, treated like, Goffman says, "material upon which to work" with "the same characteristics as inanimate objects" (73). This dehumanization is purposeful, allowing the staff to work swiftly and emotionlessly without the fear of feeling sympathy (79), a claim which the portrayal in *The Bell Jar* seems to corroborate.

Plath also echoes Goffman's depiction of the dehumanization process as one that is coercive and violent. According to Goffman, the staff threaten patients' physical integrity via confinement and violence in order to maintain discipline. The disciplining violence takes the forms of physical abuse, electroconvulsive therapy (ECT/shock therapy), and surgeries (hysterectomies, teeth extractions, and lobotomies) (332). Plath describes Esther's first ECT experience as distinctly violent—"I thought my bones would break and the sap fly out of me like a split plant" (138)—and punitive—"I wondered what terrible thing it was that I had done" (138). Even more attention is paid to describing the violence that other patients are subjected to. As Esther is walking to her first ECT session, she is interrupted by a patient repeating "I'm going to jump out of the window" as she is being "dragged" by a nurse (137). The nurse tells Esther, "with a large, conspiratorial grin," that the patient "*thinks* she's going to jump out the window" (emphasis added) but the barred windows will prevent her from doing so (137). Despite the barred windows ensuring the patient's safety, the nurse feels it necessary to "grip" and drag her regardless, in a presumably painful manner due to her "muscular" description and the patient "struggling" against her (137). Esther witnesses this violent act in tandem with the realization that "everything that opened and shut was fitted with a keyhole so it could be locked up" (137). Though she does not know if everything is actually locked or not, it is this knowledge of potential confinement, of displayed keyholes and the grips of nurses, that contributes to her being

"stiff, like parchment" (138). As Goffman argues, Plath demonstrates that discipline is valued above all, even if that discipline requires force, captivity, and outright cruelty.

Mental hospitals are, for Goffman, a hospital in name only as they seek to control the patients rather than heal the sick. Plath again portrays this: when Esther innocently asks a nurse, "Why can't I get up? I'm not sick" (169), the nurse replies as though it were obvious: "Ward rounds. . . . You can get up after ward rounds" (169–70). The patients need to behave as if sick for the convenience of the staff; thus, in effect, the 'sickness' is created by the daily administration of the hospital. Esther's 'treatment' is almost entirely based on her obedience. For example, she is moved from the psychiatric ward in a regular hospital to a state mental hospital not because of her worsening sickness, but because she misbehaves (her negligible 'misbehaviour' being when she lets a mirror fall to the ground and shatter (169) and not talking to doctors or participating in Occupational Therapy (173)). The ECT and insulin treatment do eventually have a positive physical effect on Esther, but only when she receives them in Caplan, the second hospital she visits. This treatment is perhaps effective not only because of different techniques used, but because at this hospital she is treated by Doctor Nolan, a female doctor who cares for Esther and therefore does not fit the mould of a total institution staff member.[4] However, even in this better second hospital, her 'cure' is contingent on her effective lack of options: "Either I got better, or I fell, down, down, like a burning, then burnt-out star, from Belsize, to Caplan, to Wymark [progressively worse wards] and finally, after Doctor Nolan and Mrs Guinea had given me up, to the state place next-door" (200). With this pressure to be cured or else languish forever in a state hospital, Esther begins to cooperate and approach her release. She agrees, in other words, to play the part of the sick patient.

[4] I am grateful to Dr. Elizabeth J. Donaldson for bringing this point to my attention.

Esther's release from the hospital is also for the benefit of the staff and not the patient. Goffman argues that the authoritarian organization of mental hospitals does not facilitate readjustment to the outside world and patients feel severe anxiety at the thought of being released. Esther feels this anxiety: "I had hoped, at my departure, I would feel sure and knowledgeable about everything that lay ahead—after all, I had been 'analyzed.' Instead, all I could see were question marks" (233). Rather than framing her release as cure, she feels ambiguously "patched, retreaded and approved for the road" (233). The novel ends not with her release, but with her entering the interview room, guided by the "eyes and faces" of the staff "as by a magical thread," where the doctors will decide upon her release (234). Goffman suggests that the purpose of this interview is "to discover whether or not he [the patient] harbours resentment against the institution and those who arrange his entrance into it, and he is warned against causing trouble to the latter" (71). Esther's 'treatment' in the hospital and her 'cure,' then, align with Goffman's arguments that mental hospitals are total institutions, treating 'sickness' with discipline, treacheries, and threats.

Stories of Plath

Evidently, Goffman's explanation of how mental hospitals function is a useful way to conceptualize their flaws. It would be appealing to then also accept his theory that mental illness is a psychiatric story. In the absence of any concrete knowledge on the causes and cures for mental illness, it is comforting to adopt Goffman's idea about its narrative structure (what occurs in the "prepatient" and "inpatient" phases), its characters (the roles of the staff vs. patients), and its motive (to separate social deviants from society). It is tempting to continue with my argument as I have thus far in this chapter, tying a red thread from aspects of *The Bell Jar* to Goffman's

argument to show how closely they align. Indeed, *The Bell Jar* lends itself to this kind of argument as Plath is evasive in explaining Esther's mental illness, not even allowing the reader to be privy to her feelings on the mental hospitals she stays in. The ambiguity begs an answer, a particular reading. In the literary criticism on the novel, I have identified two types of readings: the feminist reading and the pathologized reading.[5] These readings do have value within their own fields of inquiry, but by imposing their narrow and confining definitions of mental illness onto *The Bell Jar,* they misread Plath's refusal to define mental illness.

Feminist readings of *The Bell Jar* are by large the most popular category, as Plath has become, as Janet Badia explains, synonymous with women readers and feminists. There are some feminist readings of the novel that do not directly address Esther's mental illness—but most do, and those that do understand it to be socially created rather than a biological illness. This argument is explained succinctly by Joanna Stevenson: "Esther's purported sickness is not . . . rooted within an individual psychopathology, but in the sick society in which she exists, most specifically in the arbitrary nature of its gender roles" (190–91). The exact gendered issue that causes Esther's mental decline is debated; some argue that it is "Esther's unwillingness to marry" that is seen as mental illness (Farland 250), implying that mental illness is nothing more than a label assigned to the socially deviant. Other scholars see mental illness as more than a label, arguing that Esther develops a mental illness after being forced to choose between creativity and femininity (Showalter, *The Female Malady* 216; de Villiers 9). Scholars also differ on whether or not mental illness is empowering for Esther. For some authors, mental illness is an entirely

[5] My aim is not to suggest that these are the only two types of readings of *The Bell Jar*. There are, of course, many others. The two that I have identified, however, comprise a large subsection of the literary criticism. Much of the scholarship falls neatly into one of these two types, while other pieces of scholarship incorporate aspects of feminist analysis or pathologization but do not focus on them; and, of course, there are certainly those that do not touch on either. I discuss in this section a strong trend rather than a rule.

negative consequence of gendered ideals, a "painful, traumatic result of external circumstances" (de Villiers 3). For others, mental illness is actually a positive rejection of the patriarchy, a "liberation from social imperatives" (Farland 248). While these nuances are important, in all iterations of the feminist reading, the overall narrative is the same: Esther is mentally ill exclusively because of her experiences as a woman under patriarchy.

In this argument, rather than mental hospitals being a total institution unto themselves, mental hospitals in *The Bell Jar* are instead a tool of the patriarchal total institution. Stevenson identifies the first instance of this in Esther's initial meeting with Doctor Gordon: a photograph of him with his family shows "that the patriarchal family consisting of husband, wife and children represents the epitome of health and as a medically sanctioned lifestyle" (239). Indeed, after seeing this photograph, Esther wonders: "how could this Doctor Gordon help me anyway, with a beautiful wife and beautiful children and a beautiful dog haloing him like the angels on a Christmas card?" (Plath 124). When viewed through a feminist lens, Esther feels that she cannot be helped by a man who personifies the patriarchal ideal because that is precisely what drove her to his office. One of the only other male characters, Buddy, her boyfriend and a medical student, also enacts the patriarchy in a medical sense. When speaking with Esther about her desire to be both a mother and a career woman, which she is conditioned to view as mutually exclusive, Buddy diagnoses her as neurotic. Rather than seeing her split desires as a natural consequence of being a woman under the patriarchy, he pathologizes the female experience. And, importantly, the men in Esther's life are not medicalizing her in order to help her but rather to invalidate how the patriarchy, which includes them, has harmed her.

To return to Goffman's argument, feminist readings correspond to the apologia explanation of mental illness. They adopt the same sad tales that patients tell about themselves:

stories about their lives that demonstrate that their external circumstances, and not any fault of their own, have carried them to their tragic endings. Feminist readings attribute Esther's mental state to the patriarchy: either that the patriarchy has caused her illness or that her illness is a rebellion against the patriarchy. These readings take care not to paint Esther or Plath as an exceptional case but rather as typical of the female experience—there is nothing wrong with the woman and everything wrong with their external circumstances, the patriarchy. There is merit in this argument and evidence that Plath sees the patriarchy as a total institution. As an apologia, however, it claims to be the definitive explanation for mental illness. The apologia, like the case record, replaces or, at the very least changes, the individual's previous self-story; the feminist readings of *The Bell Jar* do the same.

One of the issues with having such a definitive explanation for mental illness is that it can lead to severe judgements on a mentally ill person's behaviour. For instance, there are a select few feminist critics who argue, based on their feminist readings of Plath's works, that Plath's suicide was instigated by her writing. Annette M. Krizanich, for example, argues that Esther has "internalized the dominant discourse of the patriarchy" (401) instead of truly healing at the end of the novel. For Krizanich, writing this ending spelled the end for Plath: "it did not help the author heal from her depression" (407), whereas an ending that rejected the patriarchy might have, and thus Plath died by suicide a month after the novel was published (Brown and Taylor). As Plath finished writing *The Bell Jar* a couple of years before its publication, it would be more logical to assume that its poor sales impacted her mental health; but even so, it is impossible to know the factors that led to her decision to take her life, especially since her husband, the poet Ted Hughes, burned her journals that documented the last two years of her life. And regardless of the real-life circumstances behind Plath's death, Krizanich's argument destroys Plath's self-

story in *The Bell Jar* by subsuming it into a greater sad tale of her life under the patriarchy. Any content or meaning in *The Bell Jar* is rendered null and void because, in Krizanich's apologia, it is a plot device: the novel failed to extract Plath from the patriarchy, leading to her suicide. Similarly, Sandra M. Gilbert and Susan Gubar argue that the use of the first person in women's poetry, including Plath's, results in the poet "enact[ing] her themes herself" (548). They argue that "the intensity of her [a female poet's] dangerous impersonation of this creature may cause her to take her own metaphors literally" so that, as a result, Emily Dickinson felt compelled to exclusively wear white and "Sylvia Plath and Anne Sexton really gassed themselves" (549). For Gilbert and Gubar, poetry, especially confessional poetry, forces writers to confront their own experiences and subjectivity—a confrontation that is, evidently, too horrible for female poets to bear (548). While this overarching argument is compelling, to suggest that the use of the first person led to Plath's suicide is, as with Krizanich, subsuming her writing and self-story into an apologia about her mental illness.

If feminist readings are analogous to apologia, then pathologized readings are their antithetical match: the case record detailing the individual's experiences and symptoms to decide which illness they have. Pathologized readings of *The Bell Jar* are often not written by literary scholars but rather academics in the mental-health field who tend to use the novel as evidence for the treatment of mental illness. They create a case record for Plath and/or Esther as a necessary prelude to their treatment-oriented goals. Using literary evidence to affect changes in mental health care has a strong precedence. In 1856, John Conolly, the founder of the first asylum to practise nonrestraint in England, advocated for treating madwomen in the asylum rather than the home, likely having been inspired by the tragedy of Bertha Mason in *Jane Eyre* (Showalter, *The Female Malady* 68). Evidently, it can have positive results. My goal in analyzing these

pathologized readings of the novel is not to critique their suggestions for mental-illness treatment but rather to demonstrate how this goal confines their literary analyses. Michael Bérubé articulates the issue with diagnostic readings of literature: they look "past the text to the 'content' within" (135). In other words, these readings ignore how Plath writes about mental illness by treating her protagonist as a patient and searching for diagnostic clues in her language and behaviour.

Diagnosing even with benign intent holds the power that a case record has in telling someone's story for them. As Maria Rovito has catalogued, critics have diagnosed Plath with everything from depression and bipolar disorder to split personality disorder and psychosis (320–21). These critics do not always take an explicitly medical approach to diagnosing. A subsection of the pathologized readings involves linguistic approaches, which report the types or amounts of certain words used in the novel and analyze any emergent trends. Initially, this linguistic approach seems to be more benign. Zsófia Demjén, for example, analyzes Plath's language to determine how her "affective states" are expressed (1). By comparing Plath's linguistic patterns to the linguistic patterns associated with different mental illnesses, she concludes that "Plath's writing is dominated by negative affect. Her literal and metaphorical language indicates a negative self-image, insecurity and self-doubt" (211). Similarly, Daniel Hunt and Ronald Carter analyze Plath's writing through a linguistic computer program that counts the frequency of words in the novel. Hunt and Carter then categorize those words into groupings, such as "vague nouns" and "negative verbs" (32), in order to see which categories are largest, presuming that the largest categories will reveal Plath's mental state. Through this process, they conclude that Plath's language reveals "a profound disconnection from others" and "persistent and sometimes

inexplicable feelings of incapacity or impotence" (37).[6] Both of these linguistic approaches are similar to how Goffman describes the process of creating a case record: "to show the ways in which is patient is 'sick' . . . by extracting from his whole life course a list of those incidents that have or might have had 'symptomatic' significance" (144). It makes little difference that the only access to Plath's life is her writing and that the "incidents" are not actual events in her life but Esther's. By asserting that Plath's language is always indicative of her negative affect or depressive symptoms, these readings ignore any *content* in her writing that might indicate the contrary. Of course, their readings of Plath do largely correspond with the content of Plath's novel, poetry, and sections of her *Journals*, but the implication is that their statistical analysis of her words is to be trusted over what readers can glean from reading Plath's words on the page.

Another similarity between pathologized readings of Plath and case records is their goal: cure. Many of these authors suggest therapies and strategies that Plath hypothetically could have used if she had, presumably, been born in another time, lived in another context, and altogether had a different life. Demjén, for example, suggests that, based on her linguistic analysis of her words, Plath might have benefitted from a therapist who "could have attempted to steer her towards a more outward looking perspective" (215). Other authors avoid taunting the deceased Plath with the treatment she can never seek and, instead, use Plath's case to suggest treatments for others. Anthony Ryle briefly analyzes Plath's behaviour, as well as her poetry and Ted Hughes's poetry, to argue that she has borderline personality disorder (BPD) and that her BPD presents differently to the diagnostic criteria included in the *DSM-IV*. His point in diagnosing

[6] Hunt and Carter do clarify that their aim was "not to perform a diagnosis of her character or Plath's but to consider how Esther's fictional state of mind is manifest in the verbal content of the novel itself" (28). They also acknowledge that an approach like theirs cannot "definitively contain the meaning of a literary work within decontextualised statistics" (30). While I agree with their assertion of "the importance of linguistic form for conveying meaning" (30), my subsequent analysis will argue that this reductionist approach does more harm than good in the context of *The Bell Jar*.

Plath, then, is not to make any particular claims about her work or her as an individual, but rather to use her case as evidence that the *DSM*'s diagnostic criteria and treatment for BPD should be changed (472). Ryle's diagnosis of Plath is the most explicit in its goal to directly change psychiatry and treat patients. Hunt and Carter suggest more generally that their analysis of Plath's language could be used to analyze "the language of real patients' narratives and clinical interactions" (38).

It seems odd that Plath, rather than an actual research subject, would be used as a case study, but Demjén articulates why Plath in particular is analyzed for this goal: "precisely because of her facility with language, she may have been able to express what others also feel but cannot articulate" (1). This "facility with language" is also pathologized. James C. Kaufman coins it as the "Sylvia Plath Effect": the phenomenon which makes female writers, particularly female poets, more likely to be mentally ill than any other subset of writer. In Kaufman's analysis, Plath's writing does not just make her more suitable for pathologization, but it is the *reason* that she, and other female poets, should be pathologized. In lieu of being able to diagnose these poets with an established mental illness, he creates a new one with Plath's name at the helm. He suggests multiple reasons why female poets are most frequently mentally ill, such as their penchant for "put[ting] a negative spin on traumatic life events" (46) or their attribution of their success to "divine inspiration" or a "muse" rather than their own abilities (47). The purpose of Kaufman's study is to, tellingly, have psychologists "[a]rmed with knowledge" so that, instead of "merely reading (and applauding)," they can help "young female poets at risk . . . so they can better cope with their muse instead of letting it swallow them" (48). In other words, the writing of "young female poets," particularly Plath as she is "one of the most gifted and troubled poets in the sample" (46), needs to be first pathologized and then cured.

And that is the key: it is particularly Plath's *writing,* the way that she constructs her story, that needs cure. This is the purpose of the case record: it arms hospital staff with their knowledge about the patient in order to "press him to reconstruct his stories" (Goffman, *Asylums* 149). A pathologized reading reconstructs Plath's story into not only a story of medically understood mental illness but one in which her story is actually symptomatic or even the *cause* of her mental illness. And publicly publishing these articles goes far beyond Goffman's criticism that the case record is available to every member of the hospital staff (146). Although Plath is no longer present to be "threatened by knowing that they [the facts] are neatly available," there is still "no control over who gets to learn them" (146). What is particularly problematic about these public reconstructions is that the implication is to trust the pathologized reconstructions of Plath's writing over Plath's writing itself, particularly because of the valorization of their professions as medical doctors and linguists over Plath's as a writer.

The irony of these pathologized readings is that, if one were to truly read *The Bell Jar*, it would become clear that Plath shows pathologization to be one of the causes of Esther's mental illness because it, like the pathologized readings, diminishes language. Esther's physics classes make her "sick" because of "this shrinking everything into letters and numbers" (33). It is not the scientific approach itself that she "couldn't stand," as she falls in love with her botany class because of its language (33). She finds biological terms like "carotene xanthophyll" to be beautiful, and she is enraptured by its ability to expand what is otherwise small, such as the "enlarged diagrams of the holes the leaves breathe through" (33). Science itself is not distressing; it is specifically the lack of enlarging language in physics that distresses her with its "hideous, cramped scorpion-lettered formulas" (33). Combined with her distaste for shorthand when typing, it is clear that reductive approaches to language are the problem. Non-reductive language

is the antidote for her as she requests an exception from the next semester's chemistry class and spends the class time writing "page after page of villanelles and sonnets" (34). Most significantly, it is not just that she dislikes physics: it makes her "sick" (33). She ends the passage by stating, "If I had to strain my brain with any more of that stuff I would go mad" (33), and she even considers asking for "a doctor's certificate" to prove that she is "unfit to study chemistry" because "the formulas made . . . [her] dizzy" (34). This declaration is particularly poignant when reflecting on the pathologized, reductive readings of Plath which literally diagnose her with mental illness through their readings.

And lest one imagine that diagnosis benefits Esther in the novel, there are several pieces of evidence that indicate otherwise. Esther actually does diagnose herself: "I had bought a few paperbacks on abnormal psychology at the drug store and compared my symptoms with the symptoms in the books, and sure enough, my symptoms tallied with the most hopeless cases" (153). Rather than feeling relieved with this diagnosis, however, her certainty that she is a "hopeless case" directly leads to her decision to overdose. Even when this diagnosis and analysis is conducted by a professional, it is no better, since, as I previously discussed, Esther's departure is marked by "question marks" (233) rather than answers. Just as a diagnostic analysis of Esther does not result in cure, a diagnostic analysis of a text, as Bérubé forewarns, does not solve a text. For Esther, mental illness is not so easily understood nor solved. Her body, or a biological understanding of mental illness, is not the problem, as she muses when deciding against cutting herself: "it was as if what I wanted to kill wasn't in that skin or the thin blue pulse that jumped under my thumb, but somewhere else, deeper, more secret, and a whole lot harder to get at" (142). A pathologized reading of that quotation would note the negative, abstract language and symptomatic hopelessness, or even disregard the words altogether to focus on her self-harm and

suicidal ideation. A non-reductive, non-pathologized reading of that quotation reveals that her experiences are beyond words, beyond analysis.

In comparing the pathologized readings and feminist readings to case records and apologia, I do not mean to disparage these readings wholly. There is a long and problematic tradition of vilifying Plath scholarship. Badia details how this vilification was started by Plath's husband, Ted Hughes, who had a "long-standing distrust of literary criticism" (131). In general, he held an aversion to all readers of Plath, but he reserved the most animosity for literary scholars, or members of the "crazy club," as he called them (Badia 128). Feminist literary criticism has been especially reviled, with Plath's daughter, Frieda Hughes, insinuating "that Plath's readers are failed mothers/creators who, in their desperation, live parasitically off Plath" (Badia 157). Early critic and acquaintance of Plath, Al Alvarez, more simply characterizes feminist readers as "dissatisfied, family-hating shrews" (qtd. in Badia 35) who are unable to acknowledge or even understand Plath's literary merit. I do not intend to replicate this criticism: both feminist readings and pathologized readings have value in their own disciplines. What I do see as problematic, however, is the attempt of each side to define mental illness in the process. Plath's understanding of mental illness was much more ambiguous than either reading is able to articulate.

A more nuanced reading that accepts Plath's ambiguous depiction of mental illness allows for both of these readings to exist at once. As my previous close readings show, Plath does portray psychiatry as patriarchal, an aspect that the pathologized readings outright ignore. Similarly, the feminist readings tend to ignore Esther's identification with mentally ill people irrespective of gender. This identification is powerful, as Esther is able to read about mental illness when she is otherwise unable to physically read. In addition to diagnosing herself via

"paperbacks on abnormal psychology" (153) as previously discussed, she is also able to read scandal sheets. In one, she finds an article about a man who was prevented from killing himself. Being able to read about another person with mental illness is essential for her as she has just learned that she is to receive ECT from Doctor Gordon, and she looks to the man in the article as she feels that "he had something important to tell me, and that whatever it was might just be written on his face" (131). Another presumably mentally ill man that she connects with is a literary figure: Oswald Alving from Henrik Ibsen's play *Ghosts*. In fact, this is the only piece of literature that she is able to connect with "because it had a mad person in it, and everything I had ever read about mad people stuck in my mind, while everything else flew out" (149). All of these depictions of mental illness that Esther seeks out and identifies with are not female and the focus is not on their diagnoses or symptoms. Rather, it is the identity of being mentally ill that provides her with significant comfort as she loses her other identities.

Rose Miyatsu makes a similar argument that Esther makes "legitimate attempts at community building" in order "to connect with others who share her mental distress" (53). Miyatsu argues that Esther's desire for this community is so strong that she wonders if she could join a nunnery or visit the local Deer Island Prison (58). Though Esther's desire for a community is often thwarted, Miyatsu points to a few instances where she makes connections with other mentally ill people. The first is Esther's strong connection with Joan. While Esther frequently resents their connection, after seeing Joan's self-harm scars, Esther reflects, "For the first time, it occurred to me Joan and I might have something in common" (Plath qtd. in Miyatsu 61). Esther also initially connects with another patient, Valerie, once she notices her lobotomy scars; however, Miyatsu notes that the sheen of "normality," or mental wellness, that the lobotomy gives Valerie causes a distance between the two (60). The most positive connection is with Miss

Norris, “a mute and seemingly unresponsive patient” (60) whom Esther spends time with in “sisterly silence” (Plath qtd. in Miyatsu 60). Of course, all of these patients are women since wards were segregated by gender, but the reason that Esther finds connection with them is because of the severity of their mental illness. Because the pathologized and feminist readings are primarily concerned with identifying the cause and/or symptomology of Esther’s mental illness, they ignore this important aspect of community. For Plath, the goal is to articulate a shared experience, not to define and categorize mental illness, which would further isolate those who do not fit into those definitions and categorizations. With a story, one may or may not connect with Esther’s experience of mental illness, but in either case it does not invalidate their own.

Unfortunately, as Miyatsu points to, all of these connections are eventually severed by the hierarchy of the total institution which forces patients “to see each other as competitors in the quest for wellness rather than as fellow sufferers” (63). This portrayal of institutions is consistent with Goffman’s. Miyatsu concludes by arguing that, metatextually, then, *The Bell Jar* is an offering for community. Esther, and by extension Plath, “offers her own story to others” and “provide[s] as many details as she can about the consequences, opportunities, and insights that can arise out of an experience of mental distress” (65). Although Plath did not live to see it, her story did create a community. Miyatsu points to a score of books that cite *The Bell Jar* as their inspiration, including *Girl, Interrupted* and *It’s Kind of a Funny Story* (65). Badia writes that Plath’s readership, who connect so deeply with Plath and Esther, are stereotyped as cult followers to the point that films show characters reading *The Bell Jar* as a shorthand to tell their audience that a character is a mentally ill young woman. In spite of these negative conceptions, Badia notes that Plath “inspires young women” to write their own stories (83). What is clear

throughout Miyatsu's argument and a broader analysis of Plath's readership is that mental illness can be described and connected with outside of the scope of the binary definitions that pathologized and feminist readings create.

A Biography of Multiplicities

Another one of Goffman's concepts can clarify why these binary simplifications of mental illness occur: biography. This is not a focus of Goffman's, but rather a smaller discussion within the larger context of his non-antipsychiatry work, *Stigma: Notes on the Management of Spoiled Identity* (1963). According to Goffman, biography is reductively understood as a record of facts about a person when, in reality, these 'facts' are "very subject to retrospective construction" (81). Like a case record, biographies create a story about a person. The problem with this, for Goffman, is that biographies ignore that every individual has a "multiplicity of selves" (81): a variety of different roles that entail different identities and different public perceptions to create each complex human being. Biographies cannot encapsulate this multiplicity and, thus, facts that do not fit with the biographical narrative are left out or warped, and the inevitable gaps are filled in with tenuous or fictional connections. Additionally, people assume that each individual can only have one truthful biography. This ends with the individual becoming "anchored as an object for biography" (81), their subjectivity and complexity erased.

This theory accounts for why feminist and pathologized readings of *The Bell Jar* are mutually exclusive: as 'biographies' of Esther, one narrative proves the other incorrect. To fully explain how insufficient biographies are in writing a complex, multifaceted story of a person's life, there is perhaps no better example than biographies of Plath herself. There have been scores of biographies written about Plath and none without at least a modicum of scandal. As Janet

Malcolm argues, writing a biography about Plath is inherently problematic because the different narratives about her life are mutually exclusive. In one narrative, started by Alvarez's memoir *The Savage God*,[7] Plath was cast "as an abandoned and mistreated woman and Hughes as a heartless betrayer" (Malcolm 23). This narrative is the one that most feminist critics adopt. In another narrative, endorsed by Ted Hughes and his sister, Olwyn Hughes, Plath was responsible for the tragedies in her life, both because of her mental illness and because she was not the innocent saint that others supposedly believe her to be. As Olwyn Hughes stated in an interview, Plath "wasn't the innocent victim, or half so helpless as she's been made out to be," but rather she "was vicious," "a bit crazy," "a very difficult woman with a very difficult personality," and "a monster actually" (Jordison).

Olwyn Hughes attempted to have this narrative formalized by working closely with Anne Stevenson to write *Bitter Fame*, a highly contentious biography of Plath. The disaster of *Bitter Fame* reveals the problematics of a biography. While critics wrote off *Bitter Fame* as slanderous to Plath, Olwyn Hughes resented that Stevenson did not make it slanderous enough. Her criticism of Stevenson closely matches Goffman's criticisms of biography. She laments, "I wanted the facts to be on record. I didn't know she [Stevenson] would write her little personal musings on Sylvia Plath. Biography isn't a poem, it isn't a novel, it's a document" (Malcolm 45). Her letter sent to Stevenson evokes Goffman's argument that biography requires a "private detective" to "fill in the missing facts and connect the discovered ones" (*Stigma* 81): "I thought you would . . . handle each new piece of the jigsaw with pleasure and interest as it fell into place, slowly forming the whole picture" (Malcolm 116). Despite Olwyn Hughes's dissatisfaction with *Bitter Fame*, the biography was widely panned simply because it was the Hugheses' "version of

[7] Though technically *The Savage God* is an examination of suicide at large, Plath's memoir makes up a significant portion of the book.

Ted Hughes' relations with Plath" (Malcolm 11), which was evidently not a version to be trusted. Malcolm argues that biographies tell the reader more about the person writing the biography than the person being written about. There is no biography that contains the one true narrative of Plath's life or, indeed, any individual's life. To claim the objective truth is, in Goffman's terms, part of a total institution. Interestingly, Malcolm describes Olwyn Hughes's eventual role as Plath's literary executor as "like the principal of a school or the warden" (44). This metaphor is literalized in that, during her time as literary executor after her brother's death, she did have control over Plath's writing and writing about Plath (the Hugheses have been notoriously tight-fisted in granting permission to use any writing related to them or Plath).[8]

Clearly, then, biographies about Plath are a contentious issue. What is even more interesting is that the main anxiety is not necessarily these various narratives of Plath themselves but that the narratives are formalized in a biography. Alvarez presumably had his own personal ideas about Plath as he was friendly with her and ran in the same literary circles in London. However, those personal ideas only became contentious once they were written down and, therefore, 'official.' In a letter to Alvarez, Ted Hughes criticized him for giving "details and interpretations in a form that is now being taken as the official text" (Malcolm 124). For Ted Hughes, Alvarez's account of Plath's death created "a public sacrifice. Her poems provided the vocal part of that sort of show. Your account, in apparently documentary style, of how she lived up to her outcry inevitably completes and concludes the performance. Now there actually is a body" (127). His use of the word *body* literalizes Goffman's argument in *Stigma*: that biography strips the individual of their "multiplicity of selves," confining them, instead, to one self (81).

[8] Badia relates just one example in her preface—she was close to receiving permission for the quoted material in her book until she "made the mistake of sending my request directly to Ms. Hughes," upon which she was denied (ix). In the face of this, she had to follow a fellow Plath scholar's path in familiarizing herself with fair-dealing laws in the UK.

Biography, with its one set story about Plath's life, is figured as resurrecting Plath's body, demonstrating the power of writing someone else's story for them.

The issue of biography is by no means confined to Plath. Goffman, in fact, has had biography impact the perception of his life and works as well. Goffman was wary about disseminating any personal information about his life, perhaps because he knew very well that biographies could control or even create public perception of him—and it turns out that this wariness was justified. Since his death, information about Goffman's life has been used to reasonably question and criticize his work. Dmitri N. Shalin, for example, draws parallels between Goffman's work and his wife Angelica Schuler Choate-Goffman's experiences with mental illness and psychiatry—indeed, arguing that Goffman's work is a "message in a bottle" about his personal struggles ("Goffman" 123). He suggests that, first, Goffman decided to focus on mental hospitals in his study of total institutions because of resentment towards how psychiatry was unable to help his wife (129). Goffman's sympathetic feelings towards institutionalized patients were also, Shalin argues, because Choate-Goffman's behaviour was manageable at the writing of *Asylums* (126). Choate-Goffman's mental state declined after the publication of *Asylums*, leading to her death by suicide in 1964. It is after her death that Goffman's argument shifts to hostility against mentally ill people and support of mental hospitals.[9] This is, of course, not coincidental. Shalin demonstrates how the seemingly random manic-depressive symptoms that Goffman focuses on in his work after 1964 are "nearly perfectly aligned" with the symptoms that Choate-Goffman had (129). The result of only

[9] The best example of this is in "The Insanity of Place." Shalin astutely characterizes the essay as "urgent, pained, and even indignant" (126). No longer does Goffman consider mental hospitals as the constructors of mental illness. Instead, "[i]t is the manic disorders and the active phases of a paranoid kind that produce the real trouble. It is these patterns that constitute the insanity of place" (373). More simply put: "mental symptoms are *willful* situational improprieties" (368, emphasis added).

addressing his wife's symptoms, Shalin argues, is that Goffman's argument about all mental illness is biased and narrow (137). Matthew Gambino makes the similar suggestion that Goffman did not believe in the severity and reality of mental illness before Choate-Goffman's death and, afterwards, was more sympathetic to the family of the mentally ill individual precisely *because* of how severe and real mental illness can be. In these arguments, a biography of Goffman is created: a dismissive husband first resentful of mental hospitals and then resentful of his wife's mental illness so that his work became merely a veneer for his autobiography.

What is fascinating about the biography of Goffman and Choate-Goffman is how eerily similar it is to Plath and Ted Hughes. Both wives died by suicide (and only months apart), and those deaths have cast doubt upon the work of both husbands. To some people, Choate-Goffman and Plath are suffering wives driven to madness and suicide by their patriarchal husbands. As with Plath, it was well-known that Choate-Goffman's intellectual aspirations came second to her husband's. She was unable to finish her PhD after having a child with Goffman and resented, in her words, that she was not "doing what [she] want[s]" (Shalin, "Goffman" 136). In addition to her sidelined career, one peer of Goffman's wrote that "everybody thought that Goffman has driven her to suicide because he was such a bastard. . . . It was like, 'Anyone who had to live with him would jump off the bridge'" (137). This claim echoes those made about Ted Hughes by some feminist critics, especially in the 1970s. In Robin Morgan's infamous poem "Arraignment," she writes that "the entire British and American / literary and critical establishment / has been at great lengths to deny" that Ted Hughes was responsible for "the murder of Sylvia Plath" (Morgan qtd. in Badia 90). However, to other people, Goffman and Ted Hughes are the victims of their mentally ill wives' mental illnesses. Another contemporary of Goffman calls the rumours "nonsense" and ignorant of "what he went through, how he cared for

her and her son" (137). Olwyn Hughes similarly calls the criticism of Ted Hughes "nonsense" that "didn't take account of the fact that Ted had nursed the bloody woman for seven years. The patience that he had with her!" (Jordison). This story that Goffman and Ted Hughes are wrongly accused and are, in fact, the more caring spouse overwrites the previous story that their patriarchal authority drove their wives to suicide. As Goffman theorizes, biographies erase previously existing stories by claiming to be the objective truth. Additionally, they reveal that stories are created based on cultural tropes. Rather than seeing these four individuals as complex with their own unique stories, they are cast into the narrative of victimized wife/abusive husband or crazy wife/forbearing husband. Stories are created to fit our societal framework.

The same is true of our stories about mental illness. If we extend our understanding of biography from a narrative about one particular person to a group of people, biography is a useful way to understand the theories about mentally ill people discussed in this chapter. Theories about mental illness, like biographies, imply that there can only be one objectively true explanation: according to a psychiatrist, it is a disease; according to a feminist, it is a result of the patriarchy; according to Goffman in *Asylums*, it is a social product. And, like biographies, as Goffman himself later argues, these theories are insufficient.

Plath's Self-Story

Although these theories may be insufficient in describing mental illness, mental illness can still be described through an alternative: the self-story. Goffman does not present the self-story as a radical resistance to case records or biographies. As previously discussed, he refers to self-stories only in the context of apologias, defensive strategies for the patient to make sense of their misfortune until the mental hospital erodes it and replaces it with their stories of mental

illness. Self-stories, however, can be much more powerful and resistant to the dominant narratives than Goffman's limited use of the term allows for. Plath's self-story, *The Bell Jar*, and her thoughts on the importance of self-stories in her *Journals* reveal that there is a way to describe mental illness without imposing a strict narrative onto mentally ill people.

At the most basic level, there is power in self-stories simply in the therapeutic act of writing. That writing is therapeutic is commonly, almost instinctively, known by most people, but there is also a vast body of literature that has researched this topic. While I take issue with the conclusion of Krizanich's argument, as discussed above, her article on the general benefits of therapeutic writing provides a succinct overview of some of this research done by Louise DeSalvo, Suzette Henke, and James Pennebaker. DeSalvo argues that writing can transform traumatic events as it acts as a testimony to what the traumatized individual experienced (qtd. in Krizanich 397). Similarly, Henke uses the term *scriptotherapy* to refer to writing's unique ability to restore agency to the writer (qtd. in Krizanich 397). From a psychologist's perspective, Pennebaker found that his patients' emotional, mental, *and* physical health improved through writing (qtd. in Krizanich 398). The act of writing is, almost undeniably, therapeutic.

For Plath specifically, I argue that the power of her self-story lies in its ability to hold the multitude of selves. The very structure of *The Bell Jar* confirms this: Esther alludes to having become a mother by mentioning "the baby" (3) in the first few pages. Despite the roles of mother and writer being presented as mutually exclusive throughout the novel, Esther has become both and is able to show this through the act of writing. These dual roles are presented as natural: Esther only implies and never explicitly states that she has become both a writer and a mother. Through not directly addressing what is repeatedly presented as a torturous choice between

motherhood and artistry, Plath is able to show the multiplicity of selves as the most natural outcome.

Another obvious example of the multiplicity of selves contained within writing is one of the most well-known passages in *The Bell Jar*: the fig tree metaphor wherein Esther sees each mutually exclusive, "wonderful future" possibility represented as one fig amongst dozens (73). She fears being unable to choose amongst these choices because she "wanted each and every one of them, but choosing one meant losing all the rest" (73). Though this story speaks to the inability of women to be simultaneously a mother, poet, professor, editor, traveler, lover, and champion, it also speaks to the ability of writing to hold all these possibilities aloft in the metaphor of a fig tree. Within these lines, she is able to experience all of these futures simultaneously for a moment, and this is only possible through writing. When Esther first hears the original fig tree story, she wishes that she could "crawl in between those black lines of print" and "sleep under that beautiful big green fig-tree" (52), signaling that she is aware of its power as writing to contain all selves.

The original fig tree story is often overlooked in favour of Esther's subsequent metaphorical twist on it. However, this story is also more literally about the multiplicity of selves. In the original story, a Jewish man and Catholic nun harmoniously collect figs together until they touch hands while witnessing a bird hatching and, suddenly, the nun is replaced by a maid the next day. The maid becomes controlling of the fig collection, ensuring that the man is not taking more figs than her. Though Esther does not initially explain why she "thought it was a lovely story" (52) beyond enjoying the descriptions, her later self-story inspired by it reveals why this may be the case. Initially, there is no one controlling the fig collection, and it is a point of beauty and connection between two different individuals—viewing the figs as metaphors for

different selves, they are free to choose as many as they would like. That is, of course, until they share a moment together, the nun presumably prohibiting herself or being prohibited from seeing the man again and freely choosing. Consequently, the maid, who replaces the previous self of the nun, controls the division of figs after this point, carefully counting out how many figs, or selves, each person is allotted. In combination with the self-story that Esther later writes, it is clear why she finds comfort in this story, as it explains how selves are controlled by others and that it is possible to live in a world in writing without that control.

This ability to have multiple selves is explicitly connected to healing. Esther discovers the original fig tree story in a book that was sent to her by *Ladies' Day* magazine after their event gave her food poisoning. Upon opening the book, a get well soon card falls out of it. This gift is notable since it clashes so starkly with the "piles and piles of free bonuses" they receive which are related exclusively to fashion, such as make up and fashion show passes (3). It is only when Esther is sick that she is given a book. Being able to contain her multitude of selves in writing is, for Esther, her health. When Esther is unable to write, she feels as if she does not and cannot exist. In fact, one of the main symptoms of Esther's mental illness is an inability to read and write. When Philomena Guinea asks Esther's mother about her suicide attempt, her mother tells her: "No, it is Esther's writing. She thinks she will never write again" (178). Her inability to read and write is consistently connected to her inability to do basic human functions: "I hadn't slept for fourteen nights. . . . I couldn't read or write or swallow very well" (129). Her existence is dependent on reading and writing. Some of Plath's most evocative metaphors are used to describe this problem: when writing, her "hand made big, jerky letters, like those of a child, and the lines sloped down the page from left to right almost diagonally, as if they were loops of string lying on the paper, and someone had come along and blown them askew" (125); when

reading, words "twisted all awry, like faces in a funhouse mirror, fled past, leaving no impression on the glassy surface of my brain. . . . The letters grew barbs and rams' horns . . . [and] they associated themselves in fantastic, untranslatable shapes, like Arabic or Chinese" (120). These incidents are not random mental illness symptoms or phenomena. Rather, they are always associated with her selfhood in some way: she writes letters like "loops of string" when writing to Doreen to ask for a place to stay and work, and she sees only "untranslatable shapes" in *Finnegans Wake*, which Esther had planned to write her thesis on. In both cases, Esther's future is connected to those pieces of writing: a future she no longer sees as plausible and, therefore, cannot write or read about. Her past is also blocked off to her, as she attempts to study German, her ancestry from her father's side, and her "mind shut like a clam" each time she attempted to read "those dense, black, barbed-wire letters" (30). Writing, as a connection to her self, becomes impossible when she can no longer connect to that self.

As a result of no longer being able to write her own story, Esther becomes deeply suspicious of stories about her. When Doctor Gordon asks her what is wrong, she "turned the words over suspiciously, like round, sea-polished pebbles that might suddenly put out a claw and change into something else" (124). In being prompted to tell her story to him, she is not only reluctant but feels that his own words pose a threat. Soon, she begins to see herself as a story that is entirely out of her control. When learning that she is going to have ECT, she "felt a sharp stab of curiosity, as if . . . [she] had just read a terrible newspaper headline about somebody else" (130). And, in fact, she is made into a terrible newspaper headline. When Esther looks through the newspaper clippings about her overdose, she is completely dissociated from her own story, referring to herself in the articles as "a girl," only recognizing herself once she comes across an old photo of herself with her mother and brother (191). Esther learns details about her near-death

experience via the newspaper articles and then refers to her unconscious body as "a long, limp blanket roll with a featureless cabbage head" (192), not only depersonalized but completely dehumanized. In reading about herself as written by other people, forced into the narrative of "SCHOLARSHIP GIRL MISSING" (191), she is completely unable to connect with it. Unable to write her own story, the stories written about her are unrecognizable and threatening.

Esther implicitly knows that to write is to exist. Upon returning to her mother's home and experiencing her first sleepless night, she decides to "spend the summer writing a novel. That would fix a lot of people" (115). Significantly, her idea for a novel is explicitly a self-story, deciding with a "feeling of tenderness" to name her protagonist Elaine, "myself, only in disguise" (116). She writes one line about Elaine sitting in the heat, as Esther is, and then spends an hour "trying to think about what would come next" (116); unable to decide this for her protagonist, she is unable to decide this for herself. While this attempt at writing failed, her next did not—the narrative that constitutes the novel *The Bell Jar* itself. While Plath does seemingly suggest that Esther never gained complete mental health, her ability to write her narrative does imply that she at least gained back her sense of self. The novel's most famous line, "I am I am I am," is often repeated out of context as a sign of healing or even empowerment. In fact, its first usage occurs when Esther swims out to sea with a man she had just met in an attempt to die by drowning. When he turns around, panicking about dying, she swims on, her heart beating: "I am I am I am" (152). The repetition of it almost taunts her as she fails, yet again, to die. The second instance is at Joan's funeral as she reflects on Joan's grave eventually being erased by the soil and the snow. She breathes deeply and again hears her heart's "old brag": "I am, I am, I am" (233). The phrase is, simply, a statement of her existence. What is often overlooked, however, is the addition of commas in the second instance. The first is grammatically incorrect, with subject

and verb bleeding into one another without distinction, while the second clearly separates them. The subject has its clear action to complete: to be. The repetition, as well, again indicates the need for multiple selves, multiple "I"s, to exist at once. And it is not merely that Esther's heart could beat out these words that allows her to exist: it is that she could write the words in her story. Though the written narrative is not necessarily proof that Esther has healed, it is proof that she continues to exist and she has recreated her sense of self.

And, of course, Esther only exists because Plath has literally written her into existence. As I have indicated above, much of Plath scholarship has been preoccupied with the degree to which *The Bell Jar* is autobiographical. In an article that is exemplary of this preoccupation, Susan J. Behrens connects the threads between people and events in Plath's life and Esther's, calling Esther Plath's "stand in" (239) and "alter ego" (240) and referring to the novel as Plath's "thinly veiled look back" at her past (239). Others, like Augustus M. Kolich, argue that insisting on it being autobiographical "weaken[s] the fictional fabric of *The Bell Jar* to the point that the entire disguise is tattered and worn," thereafter revealing it as either unimaginative and, therefore, poorly written or merely "an important autobiographical artifact" (171). In other words, it only has literary merit if viewed primarily as fictional. I suggest that perhaps an alternative viewpoint is that Esther is a new self created by Plath through story. Esther is not just Plath by another name, nor is she a wholly imagined character separate from Plath; she is one particular self through which Plath sought to understand herself and her health.

Plath's collected journals, republished in their near entirety in 2000 as *The Unabridged Journals of Sylvia Plath*, contain a wealth of information on how she views self-stories. The basic act of writing without story (as she does in her journals) is important to her: "Simply the fact that I write in here able to hold a pen, proves, I suppose, the ability to go on living" (334). It

is, however, specifically writing's ability to create self-stories that is so profound for her. She writes that "merely trying to record descriptions and sensations" is "pointless," and that writing can only have "purpose" when it is "synthesized into a story" with plot, motive, and dialogue (77). She calls this kind of writing a "religious act: a relearning and reloving of people and the world as they are and as they might be" (436). This "relearning and reloving" is necessary, as she continually writes of life without writing as a burden, the "colossal job of merely living" which must be rectified by "order[ing] life in sonnets and sestinas" (184). Writing allows her to "find a vehicle to express" her "disturbing thoughts" (75). By "mak[ing] stories out of . . . heartbreak, beauty out of sorrow" (23), she avoids "crawl[ing] back home, beaten, defeated" (23). This "crawl[ing] back home" is reminiscent of Esther's return home for the summer, when her inability to write is her defeat.

It is not a unique idea that writing is helpful; what is unique, however, is how Plath sees it as her *health*: "My health is making stories, poems, novels, of experience: that is why, or, rather, that is why it is good, that I have suffered & been to hell. . . . I cannot life for life itself: but for the words which stay the flux" (286). Plath portrays Esther losing her health when she cannot create stories because this is how Plath understands her losing her health. In her journals, she reflects that both she and her mother understand her attempt to kill herself "[a]s a result of my not writing, no doubt" (448). Plath implies, however, that her mother thinks this is because Plath was afraid of her writing being appropriated by her mother. Instead, Plath reflects, "Writing, then, was a substitute for myself: if you don't love me, love my writing & love me for my writing. It is also much more: a way of ordering and reordering the chaos of experience" (448). To not accept Plath's "ordering and reordering" of her life, her self-story, is to reject Plath herself. And, when Plath cannot create her own self-story, she feels that she can no longer live.

By analyzing the importance of self-story in Plath's work and life, I hope to make clear that Goffman underestimates the prevalence of self-story in understanding mental illness. In *Asylums*, self-stories are understood only as a way for the individual to bring themselves "self defensively . . . into appropriate alignment" with society (140). In mental hospitals, patients, according to Goffman, create self-stories in which they are not mentally ill to resist the hospital's case record story. This is their sole function: a self-deluding defence against mental illness. Goffman assumes that it is the particular story about mental illness that patients defend against. Instead, Plath's self-story reveals that it is simply any one confining, imposed story about mental illness that self-stories may resist.

Additionally, self-stories resist the need to define mental illness, as Plath never does. Clearly, Esther is negatively affected by events such as being rejected from summer classes, the patriarchy, and her father's death, but these are never identified as the exclusive causes of her mental illness. Plath describes the feeling of mental illness in vivid detail but does not delineate it as a biological illness, a sociological phenomenon, a spiritual occurrence, or any other kind of category. Just as writing allows Plath to capture a multitude of selves, it also allows her to capture a multitude of mutually exclusive explanations for mental illness. In Plath's mental illness self-story, mental illness does not have a story. That is to say that while Esther has a story, one that involves experiencing mental illness, the concept of mental illness is allowed to exist in the novel without explanation, justification, or meaning.

Chapter Two

"A Language with Which to Address Myself": The Language of Mental Illness in Joanne Greenberg's *I Never Promised You a Rose Garden*

"Mental illness is a myth" is a phrase that has burrowed into the minds of far too many people wishing to invalidate mentally ill people's suffering. I would venture that almost every person who has experienced long-term mental illness has had the phrase hurled at them at least once by a skeptical relative, a dismissive authority figure, or a jeering peer.[1] This phrase translates to: there is nothing wrong with you except willful laziness/rudeness/strangeness/other personal flaws. Needless to say, this is an exceptionally painful message to hear when already undergoing profound suffering. The man to thank for the popularization of this phrase is Thomas Szasz. In Chapter One, I focused intently on the problematics of Erving Goffman's antipsychiatry theories, so readers may be surprised to learn that Goffman is arguably the least controversial of the antipsychiatry theorists, and Szasz is undoubtedly the most.[2] While the theories of Erving Goffman, R. D. Laing, and Michel Foucault certainly are at odds with one another in their nuanced understandings of mental illness and its treatment, they are generally in alignment with their left-leaning political ideologies. As a result, their theories were initially written with an intention of, if not liberation, compassion towards marginalized mentally ill people. The right-wing libertarian Thomas Szasz did not have such an intention. In fact, his intention was quite the opposite: to prove that mentally ill people, not institutions and certainly

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[1] While it is difficult to substantiate this claim beyond my personal observations, that most mental health organizations address it as a common misconception on their websites gestures towards its prevalence. To list just a few examples: the Canadian Mental Health Association's website takes care to dispute the myth that "[m]ental illnesses aren't real illnesses," and the Substance Abuse and Mental Health Services Administration (a branch of the United States government) has an entire page on "Mental Illness Myths and Facts," debunking common notions like this one: "[m]ental health issues are a result of personality weaknesses or character flaws, and people can 'snap out of it' if they try hard enough."

[2] This chapter will focus on his controversial theories, and so a discussion of his deeply controversial activism is outside the scope of my argument. See Donald A. Westbrook for an in-depth discussion on Szasz's most controversial alleged affiliation (one that is so controversial that I have been advised not to discuss it here).

not an illness, are to blame for their own conditions.

Szasz first set out his theory that mental illness is a myth in his book of the same name, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (1961). In this book, Szasz posits that mental illness is not an illness but a language. When an individual is suffering from normal human problems and is unable to communicate them in ordinary language,[3] they resort to communicating their struggles via symptoms. Szasz terms symptoms as *body signs* (equivalent to word signs in ordinary language); these body signs form what he calls the *language of illness*. His argument is essentially this: psychiatrists have incorrectly translated the language of illness into the language of psychiatry and, as a result, mistakenly believe that the language of illness is indicative of a biological illness.

While Szasz's theory of the language of illness is just one facet of his argument, it is arguably the most important as it informs his treatment of mentally ill people. If mental illness is a language, then it follows that therapists can correctly translate the language of illness into ordinary language. Szasz advises that the therapist's responsibility is to translate, while the patient's responsibility is to accept this translation of their symptoms and make efforts to improve their personal troubles. In this chapter, I will argue that this approach is limited and harmful because the language of illness is adopted by people who cannot express their reality through ordinary language, and, thus, therapists cannot translate it into ordinary language.

There is no better novel to analyze the language of mental illness in than *I Never Promised You a Rose Garden* (hereafter *Rose Garden*) by Joanne Greenberg. Greenberg was diagnosed with schizophrenia as a young teen and consequently spent her teenaged years

[3] This is Szasz's term that he uses throughout his work. The closest he gets to defining this term is when he clarifies in *The Myth of Mental Illness*, "for example, speech or writing" (118), or in a later article when he parenthetically adds, "ordinary languages (such as English or German)" ("Crazy Talk" 66). He presumably uses the term *ordinary language* so as to distinguish it from the other unordinary languages that he also discusses.

institutionalized. In 1964, several years after her recovery and release from the psychiatric institution, she published *Rose Garden*. The novel follows Deborah Blau, a teenager with schizophrenia whose experiences correspond with Greenberg's, as she exists simultaneously in a mental hospital and in the kingdom of *Yr*. Yr is a place of fantastical and often frightening landscapes with gods who speak to Deborah in a language called *Yri*.[4] Her therapist, Dr. Fried (referred to in Yri as *Furii*), who corresponds to Greenberg's famous psychotherapist, Dr. Frieda Fromm-Reichmann, understands Deborah's symptoms to be meaningful communications and works to translate her language and symptoms into ordinary language.

By applying Szasz's theory to *Rose Garden*, I will argue that mental illness is outside of the realm of discursive language and therefore cannot be reliably translated into ordinary language by anyone, including mentally ill people themselves. However, I will also suggest that while Szasz's theory is limited, it is not wholly unusable. In Greenberg's novel, understanding mental illness to be a language has the power to create connection between mentally ill people and others on two conditions: if the translation is done with empathetically with the patient's contribution; and if a multilingual approach is taken so that direct translation is not always necessary. Creating connections in this way not only allows Deborah to recover in the novel, but it also metatextually expands to connect with and help readers of the novel. By exploring Szasz's own theory of literary language as being one of the sole languages able to describe mental illness, this chapter will ultimately argue that a literary depiction of mental illness acts as a powerful contribution to other mentally ill people and the mental health world at large by giving

[4] The pronunciation of these terms is an interesting aside. Since *y* can be either vowel or consonant, the lack of clarity on their pronunciation certainly adds to my subsequent argument about purposeful ambiguity in language. That said, a hint towards their correct pronunciation can be found in Greenberg's similarly named land and language, *Yria* and *Yrian*, sometimes spelled as *Iria* and *Irian*. This would make *Yr* a homonym of *ear*, which alludes to the importance of listening to Deborah, and *Yri* a homonym of *eerie*, referring to how people often find her language strange and unsettling.

a language to an often unspeakable experience.

Szasz and Language

Despite producing over seven hundred publications in his lifetime (www.szasz.com),[5] Szasz was known primarily for *The Myth of Mental Illness.* He was, perhaps surprisingly given his desire to abolish psychiatry, a psychiatrist himself. In 1938, Szasz's family, who were Jewish, emigrated from Hungary to the United States. Szasz first studied physics and then medicine at the University of Cincinnati, after which he completed his residency at the University of Chicago (Haldipur et al.). It was at the Chicago Institute for Psychoanalysis that he began to form the basis for his ideas by researching psychosomatic illness (Pols 2.1). Szasz's medical education influences his theories on mental illness as they rest almost entirely on his narrow definition of illness. In the introduction to the 1974 edition[6] of *The Myth of Mental Illness*, Szasz clarifies that he uses the early nineteenth-century definition of illness: a "detectable alteration of *bodily structure*" (12). The mistake, Szasz argues, was in expanding this definition to encompass the "alteration of *bodily function*" (12)—that is, that physicians can identify an illness based on a patient's behaviour. In Szasz's definition of illness as "a visible deformity, disease, or lesion, such as a misshapen extremity, ulcerated skin, or a fracture or wound" (11), mental illness cannot be an illness. He dismisses psychiatry as being "in the company of alchemy and astrology" in that all three speak "of mysterious substances" and conceal "their methods from public scrutiny" (1). Jan Pols, Stephen Wilson, and Ronald W. Pies all argue that Szasz's

[5] (Reproduced with the permission of Jeffrey A. Schaler. All rights reserved.) I should note here that this chapter will include several of these texts published far beyond the scope of the 1960s in order to elaborate on Szasz's antipsychiatry theories. This is a choice that I have opted for since, unlike the other antipsychiatry theorists, Szasz's argument did not significantly change over the decades (this is especially remarkable given that he died in 2012, decades after the deaths of Goffman, Laing, and Foucault). In fact, his later texts only make more obvious what was subtly implied in *The Myth of Mental Illness*.

[6] All citations from *The Myth of Mental Illness* after this paragraph are from the 1961 edition.

theory is only made possible by refusing to acknowledge any broader, more nuanced definitions of the term *illness*. Most definitions of *illness*, Pies explains, are broad enough to include "suffering, incapacity, or impairment in various spheres of human endeavor" (12.2.1), and very few would ever define it as narrowly and archaically as Szasz. Additionally, many people use the term *mental illness* as a locution, an "imperfect, shorthand term to describe a particular kind of suffering and incapacity" (12.3). In other words, the use of the word *illness* need not be a claim that mental illness is a type of physical illness. What becomes clear in this discussion is just how critical the use of language is in forming arguments about mental illness: with one changed definition, theories can form and crumble.

Language is commonly understood to be a verbal, written, or visual (in the case of sign languages) form of communication (Crystal and Robins). Szasz, in contrast to his narrow definition of illness, defines language broadly as any form of communication. He labels the language of illness, in which personal troubles are communicated through body signs as a nondiscursive, presentational protolanguage. To break down these terms: *nondiscursive* refers to communication that is not intelligibly verbal or written (e.g. sign language, dance, facial expressions); *presentational* refers to expression that presents itself as it literally is (e.g. a photograph shows the photographed object directly rather than describing it); and *protolanguage* indicates that it is primitive, as the prefix proto- means "earlier or lower than something" (*Myth* 119). Putting it all together, a nondiscursive, presentational protolanguage is a primitive form of language that is not verbal or written and expresses itself literally. Nondiscursive, presentational protolanguages are used when trying to express something that "is not (explicitly) known" (121). The only example of a nondiscursive, presentational protolanguage that Szasz discusses is the language of illness. In Szasz's opinion, catatonia, or the inability to move/speak, would not be a

symptom of schizophrenia or depression that indicates a chemical imbalance or other bodily defect. Instead, the lack of movement/speech is a primitive way for someone to express with their body that they feel powerless and immobilized by their life. Szasz explains that the language of illness is used by people to "secure help" (183). The three sole aims of language, Szasz argues, are to inform ('I am suffering'), to arouse emotions ('feel for me'), and to promote action ('help me'). In other words, some individuals are unable to get help for their problems by communicating them in ordinary language and thus turn to the language of illness (183).

Initially, Szasz's theory of body signs may seem akin to current trauma theory and its understanding that inner turmoil can manifest physically in the body. For example, two of the most prominent scholars in trauma studies today, Bessel van der Kolk and Gabor Maté, have each argued that trauma can cause chronic diseases and pain.[7] Szasz, though he does not use the term *trauma*, similarly argues that the physical symptoms of mental illness are rooted in negative experiences and thoughts. The small but pivotal difference is that scholars like van der Kolk and Maté use this theory to *affirm* the legitimacy of mental illness, arguing that the physical symptoms are proof that an individual's suffering is profound enough to develop into an illness, while Szasz uses this theory to *invalidate* mental illness, arguing that since the root cause is emotional and not physiological, it is not an illness.

This argument from Szasz is where the troubling implications begin, for it is only "relatively less sophisticated human beings" who "do not readily speak a higher level of language" that need to resort to using the language of illness to express themselves (121). These people are "the lonely, the downcast, the poor, and the uneducated" who "hope to 'get something' which they had failed to obtain in other ways" (301). While that statement may be

[7] See their respective works, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (2014) and *When the Body Says No: The Cost of Hidden Stress* (2004).

true of some mentally ill people, Szasz reductively categorizes all mentally ill people into two groups: the "unsatisfied and 'regressed'" (301), whom he later terms "the unwilling," including "the protesters, the revolutionaries, those on strike against their relatives or society" and "the unfit," including "the inadequate, unskilled, lazy, or stupid" (*The Second Sin* 89). There is no third alternative. And whether unwilling or unfit, a mentally ill person deceives others with their language in order to hide their true meaning.

The language of psychiatry is, in Szasz's view, equally deceiving. Psychiatry, as it is widely practised, "has the power to abuse language" and as such mistranslates the "defiant" behaviour of patients into medical terminology to excuse their actions (*Meaning of Mind* 129). The only correct language is ordinary language, and thus the therapist's[8] "necessary" task is to translate the language of mental illness into ordinary language, not the language of psychiatry (*Myth* 120). Rather than seeking a "cure," psychiatrists should seek a "translation" (129). He articulates this best in one of his early articles: "the psychiatrist's role is like that of a translator and interpreter of a foreign language. He must translate the patient's body-language (for example, 'I have pains in my chest') into the language of everyday speech ('I am unhappy with my wife, husband, job, children, religion, etc.')" ("Language and Pain" 993). In keeping with his libertarianism, once the patient's problems have been explained to them in ordinary language, it is their responsibility as autonomous humans to have "a successful mastery of the problem in the new idiom" (995). If they do not successfully abandon the language of illness and speak in ordinary language, Szasz argues throughout his body of work that they have the right to mentally

[8] Throughout this chapter, the terms "therapist," "psychiatrist," and "psychotherapist" will be used somewhat interchangeably as these terms did not have the distinctions in the mid-twentieth century that they hold today. Szasz, for example, refers to himself as all three.

deteriorate, do drugs, kill themselves, or commit a crime and be penalized for that crime.[9]

Szasz reserved his most vitriolic arguments for people diagnosed with schizophrenia. While *The Myth of Mental Illness* has hysteria as its primary focus, most of his subsequent work uses schizophrenia as the paradigmatic mental illness to attack.[10] Schizophrenia was first coined and described by the German psychiatrist Eugen Bleuler in 1911. Szasz takes issue with how the original German description has been translated into English and re-translates it more 'accurately' in order to prove that, by its original definition, schizophrenia is a language of illness and not a brain disease. (Ironically, this shows that Szasz understands the dangers of mistranslation, an issue that will arise later in my analysis.) Bleuler defines schizophrenia as having two primary symptoms: *Gedankenlautwerden*, often translated as "hearing voices," and *Sprachfehler*, usually translated as "disordered speech" and more popularly referred to as *word salad* or *schizophrenese*. Szasz argues, making no allowances for the possibility that he has also mistranslated, that a more accurate translation of these words would be "thinking out loud" (meaning that the voices schizophrenic people hear are actually their own disturbing thoughts) and "faulty speech" (meaning that schizophrenic people simply speak inappropriately because they only intend to understand themselves rather than be understood by others) ("'Audible Thoughts'" 533). By simply retranslating two words, Szasz revises the meaning of

[9] These arguments can be found throughout his body of work but particularly in *Ceremonial Chemistry: The Ritual Persecution of Drugs, Addicts, and Pushers* (1974), *Psychiatric Justice* (1978), *Cruel Compassion: Psychiatric Control of Society's Unwanted* (1998), and *Suicide Prohibition: The Shame of Medicine* (2011). Szasz was especially passionate about the right to suicide, particularly for such unfit and unwilling mentally ill people. To his credit, this was a genuine conviction and not merely cruel goading, as Szasz died by suicide after a fall that would have required medication and a surgery (Schaler).

[10] His arguments about schizophrenia have almost no salient difference to those about hysteria. In *The Female Malady*, Elaine Showalter argues that in the post-war period, the schizophrenic woman replaced the hysterical woman as the symbol of society's ailments. While Szasz's arguments are not overtly gendered, and he wrote *The Myth of Mental Illness* in the post-war period, his shift from hysteria to schizophrenia is indicative of this increasing emphasis on schizophrenia as the symbol for all that is wrong with 'people these days' (analogous to our current preoccupation with anxiety and depression over other mental illnesses).

schizophrenia. In his new meaning, schizophrenic people speak in a way that is intelligible, beneficial, and natural to themselves, the speaker, but unintelligible, upsetting, and unnatural to the listener. According to his theory, if a schizophrenic person hallucinates a voice commanding them to harm others, that is actually the schizophrenic person's true desire and they are simply too cowardly to admit it. In his words, schizophrenic people "are not so much disturbed as they are disturbing" (qtd. in Fuller Torrey 8.2). They are morally responsible for their thoughts and speech and by denying "that the voice he hears are his own thoughts and that his delusions are metaphors he interprets literally," the schizophrenic person is "profoundly dishonest with himself" and "a liar" to others (*Meaning of Mind* 129–30). In a theory that understands mental illness to be an expression of the individual's true thoughts and feelings, Szasz is able to unironically refer to a symptom of a schizophrenic person as being "the poorly suppressed amusement of the con man, secretly laughing at his mark" (*The Second Sin* 105). Although I hope that the problems with this kind of thinking are obvious, my analysis of Deborah's schizophrenia in *Rose Garden* will show exactly how limited, inaccurate, and cruel this statement is.

Deborah's Growing Vocabulary in the Language of Illness

In seeming accordance with Szasz's theory, Deborah uses Yri instead of English because "no verbal language may be available with which legitimately to address their fellow man" (*Myth* 301). Throughout the novel, Deborah's family is unable to speak directly about her mental illness, leaving Deborah with no language to explain her experiences. Her father, Jacob, refers to Deborah's diagnosis as "something nameless" (*Rose Garden* 22) and becomes enraged when Deborah's mother, Esther, calls Deborah "[s]ick," shouting back: "Unhappy! . . . Just unhappy!"

(23). While Jacob refuses to use anything other than euphemistic language, Esther allows for some medicalized language but balks at anything to do with madness. When she nearly calls Deborah insane during a meeting with Dr. Fried, she gasps and covers her mouth with her hand, to which Dr. Fried replies: "it's the *word* that is making you frightened" (181). How Deborah's parents speak, or rather, do not speak, about mental illness causes more suffering and concern than Deborah's illness itself: "When he [Jacob] and Esther quarreled, the crucial thing remained unspoken," which, rather than alleviating the situation, creates "an atmosphere of wordless rancor and accusation" (21). In this speechless environment, Deborah, not having the language to articulate her mental illness, creates one. She begins to speak in Yri to herself when "thoughts … came, and happenings also, for which there seemed no sharer on the hard earth, and so the plains, pits, and peaks of Yr began to echo a growing vocabulary to frame its strange agonies and grandeurs" (45). Eventually, this language becomes the only one that she can use to truthfully articulate her experiences. English, by contrast, becomes "for the world—for getting disappointed by and getting hated in. Yri is for saying what is to be said" (53). As Szasz argues, "the need for this mode of communication arises typically in the family," leading to "the inhibition ('repression') of direct forms of communication" and "the stimulus for the development of relatively more devious, or indirect" language (*Myth* 300).

Szasz's theory about how the language is created, then, seems to be supported by *Rose Garden*. The language of Yri is not portrayed, however, as the illness in and of itself. In Szasz's formula, mental illness is nothing more than a language masquerading as an illness. In *Rose Garden*, Deborah's language is only one aspect of mental illness. Deborah explains this to Dr. Fried: "The illness is not seeing or hearing things—the illness is underneath those" (83). Dr. Fried later adds to this, saying: "It is not the language, and not the gods themselves . . . but their

force of keeping you from the world, which is the sickness" (246). As the creator and sole speaker of the language, Yri perfectly articulates Deborah's inner world, but this comes at the cost of her ability to connect with others. As Dr. Fried explains it to Deborah: "you use your language to communicate with yourself and not with us of the world" (53). When Deborah hears this comment, she perceives it as "the threat of the doctor, and the claim she was putting on the communication" (53), in that Dr. Fried is defining communication as inherently done with others and not oneself. In order to recover, Deborah must learn how to form connections with others through communication so that her language no longer keeps her from the world. With this understanding of mental illness, translation is not intended for Deborah to 'correctly' communicate in ordinary language but so that she might connect with others.

Therapists as Translators

In the afterword to her novel, Greenberg explains that she supports the medicalization of mental illness in as far as it absolves mentally ill people from personal responsibility for their suffering. She laments, however, that medicalization "comes at the cost of a loss of vital spiritual and psychological involvement, the exercise of free will, and the necessity of essential long-term contact between one human being and another: therapist and patient" (290). For Greenberg, therapy is essential in recovery precisely because of this connection that is formed. Dr. Fried's real-life counterpart, Dr. Frieda Fromm-Reichmann, understood the necessity of this connection and, like Szasz, viewed translation as a fundamental part of therapy. Fromm-Reichmann was a renowned polyglot, fluent in several languages. She lived in Germany until the Nazi occupation forced her to immigrate to the United States in 1934 (she was Jewish), and her fluency in multiple languages served her well as she began practicing there. She would use these languages

to connect with her patients; when one patient was in crisis, "crying out alternatively in English, French, German, and Hebrew, claiming his enemies were out to get him, Dr. Fromm-Reichmann began clambering over the furniture with him, answering him in . . . whichever language he was using at the moment" (Hahn 133). She also utilized nonverbal language in her practice, studying it extensively before her death. At a memorial lecture soon after her death, Gregory Bateson explains that in her last project she had

> hoped to synthesize into her psychoanalytic background whatever skills and insights she might be able to glean from semantics, linguistics, and the theories of communication. . . . [I]f it were possible to transcribe and point to the nonverbal transactions, this would provide an enormously valuable tool for the teaching of psychiatry. (96–97)

Fromm-Reichmann knew that translating language of all kinds forms a point of connection rather than a barrier, so when Greenberg began speaking in *Yrian* (the equivalent of Yri in the novel), Fromm-Reichmann did not assume she was incoherent and would ask her: "Would you feel like translating?" (Hornstein 224).

Although working with a patient's created language was a new challenge, Fromm-Reichmann was always inherently translating in her therapy sessions. On a surface level, she had to translate her thoughts in order to speak in her non-native languages and, on a deeper level, she, like Szasz, understood symptoms as metaphors that could be translated into ordinary language. In a lecture that Greenberg gave in 1986 titled "Metaphor and the Treatment of Schizophrenia," she explains that both she and Fromm-Reichmann understood her symptoms as "metaphors … dust-throwing devices, ropes from which I fondly hoped my damned therapist would hang herself" (qtd. in Hornstein 380–81). She used metaphors because she "was so terrified of saying the thing" that she meant to say, and that repressed truth expressed itself in hallucinations (380).

Rather than "fall for that, to go with all those big symptoms," Fromm-Reichmann "was able, by means of those metaphors, to grab that rope and pull in until she got me at the other end. A me, who by that time, some years later, was willing to be more literal, more direct" (381). Fromm-Reichmann never deprived Greenberg of "the use of . . . [her] metaphors" (381) but over time was able to translate them into direct and literal problems. Fromm-Reichmann's approach allowed her to understand what the symptom might mean without having "to descend to the literalism, to say this equals that" (381).

It would appear, at first glance, that Szasz would approve of Fromm-Reichmann's methods as an analyst. However, in addition to her choice of working with involuntary patients, which Szasz equates to commanding "psychiatric slaves" (*Antipsychiatry* 21), [11] Fromm-Reichmann's therapeutic approach is also distinct from Szasz's in that she prioritizes empathy. Rather than having "an attitude of 'live and let live' toward your patients" (Szasz qtd. in Dewan and Kaplan 11.3), Fromm-Reichmann "worked hard to establish a close relationship with withdrawn and depressive patients" (Halliwell 249). Hornstein connects this quality to Fromm-Reichmann's adherence to the Jewish concept of *tikkun*: the idea that people have the responsibility to heal the connection between God and humans, and, by redeeming one person, you are doing your part to redeem the world (28). Fromm-Reichmann was known to "embrace her patients," literally and figuratively, even those who "smeared feces or pelted her with food during sessions" (24). This is a far cry from Szasz's advice to therapists: "You need not show that you are humane, that you care for him, or that you are reliable by worrying about his physical health, his marriage, or his financial affairs. Your sole responsibility to the patient is to

[11] Szasz was actually aware of Fromm-Reichmann, citing her as the rare example of a psychoanalyst working with involuntarily patients (whom normally only psychiatrists worked with). He disapproved of this and mentions her only to clarify that anyone, including psychoanalysts, who work with involuntary patients are working within an unjust power imbalance (*Antipsychiatry* 26).

analyze him" (qtd. in Dewan and Kaplan 11.3).

One psychiatrist who worked with Fromm-Reichmann describes her approach as a "strategic rosetta stone [sic]," implying not only her ability to translate effectively, but that she was able to do so because of her "capacity to shift gears, be flexible, and change roles with patients based on changing circumstances" (Halliwell 249). For Fromm-Reichmann, translating requires empathy: "the psychiatrist has to listen to the communications of the mentally disturbed and try to understand them, irrespective of whether or not he can always grasp their meaning" (*Psychoanalysis and Psychotherapy* (*P&P*) 21). And, even if their meaning cannot be grasped, the psychiatrist "still owes the respect to the mentally disordered person to know that his communications are practically always self-meaningful" (21). In contrast to Szasz, who views self-meaningful communication as petulant obstinance, Fromm-Reichmann sees value in it. She substantiates this perceptive with the reasoning that "'healthy' people [do not] 'understand' all that is said to one another" and yet respect is still expected (23), implying that understanding is not a requirement for basic human decency. Jacob Arlow argues that without this respectful approach, Fromm-Reichmann's method of translation would not have worked: "Hers was a special ability to understand a patient's metaphoric language, but, more than that, she had the ability to communicate the understanding in a way that helped to create for her patients a bridge that led from metaphor to simile to objective communication," all while herself using language that made the patient feel understood (181–82). Fromm-Reichmann's therapeutic approach demonstrates that translating a patient's meaning is less important than treating them with the respect deserving of any person.

While the therapeutic process is, naturally, explained more explicitly in Fromm-Reichmann's case notes, the novel more clearly shows the necessity and healing potential of

empathetic communication. Fromm-Reichmann's name in the novel itself signifies the connection between therapist and patient as one that is positive and liberating. *Fried* is a homonym of *freed*, as pointed out by Jeffrey Berman (161), and it is also very close to the German word for peace, *Frieden*, as well as the English word *friend*. Moreover, it is a shortened version of Frieda, Fromm-Reichmann's first name, indicating a closeness and familiarity with her. Lilian R. Furst argues that this close relationship is produced specifically through Dr. Fried's communication style. In analyzing her verbal patterns, Furst finds that Dr. Fried often uses modifiers, such as "try" and "just," leaves statements open ended, and apologizes for potentially misunderstanding Deborah, all of which foster reciprocal respect (220). It is through this careful use of language that Dr. Fried is able to cross the language barrier with Deborah and connect with her. Gail Berkeley Sherman makes a similar argument to Furst that Dr. Fried's use of language is integral to her ability to connect with Deborah ("My Difference"). Berkeley Sherman draws attention to the first instance of Dr. Fried's appearance in the novel when she speaks to herself, first in German and then in English: "*Aber wenn wir*. . . If we succeed. . ." (Greenberg, *Rose Garden* 12, original ellipses). Dr. Fried's response is hopeful and, because of the use of first-person plural, as Berkeley Sherman notes, indicates that she and Deborah will work together. This language especially stands out in stark contrast to the case report on the previous page that explains Deborah through "various statistical measurements of personality factors and test scores" and judges her behaviour to be inappropriate and illogical (11). Berkeley Sherman also argues that the inclusion of Dr. Fried's German throughout the novel, often with an English translation accompanying it, helps to normalize the presence of the foreign language of Yri, showing that "foreign language, even the private language of madness, need not be a threat" (169). By frequently speaking to herself in German, Dr. Fried is replicating what Szasz calls

schizophrenic "self-conversation" ("'Audible Thoughts' 543) and, in opposition to Szasz's claim, normalizing it as potentially healthy behaviour.

Greenberg greatly esteemed Fromm-Reichmann for her therapeutic approach, stating in an interview that "it was helpful that Dr Fromm-Reichmann always insisted that the treatment was a collaboration," and, after therapy, she was able to see relationships with authority figures as collaborative for the first time (McGlashan and Keats qtd. in Stevenson 298). When Fromm-Reichmann describes their collaboration in one of her papers, the mutual respect between therapist and patient is clear:

> One exuberant young patient . . . was warned against expecting life to become a garden of roses after her recovery. . . . When we reviewed her treatment history after her recovery, she volunteered that this statement helped her a great deal, "not because I believed for a moment that you were right, Doctor, but because it was such a great sign of your confidence in me and your respect for me, that you thought you could say such a serious thing to me and that I would be able to take it." (*P&P* 204)

That Fromm-Reichmann describes Greenberg as an "exuberant young patient" alone demonstrates her gentleness (compare this description to Szasz's adjectives of choice: liar, stupid, regressed, etc.). But, more importantly, Greenberg is quoted as stating that it was Fromm-Reichmann's "confidence in" and "respect for" her that aided her recovery, not the statement's message itself.

So important was this that Greenberg included it in the titular scene of *I Never Promised You a Rose Garden*. In contrast to the scene as Fromm-Reichmann describes it, Deborah does not necessarily identify the confidence and respect as particularly healing. However, the conversation's context adds another dimension to its significance. The conversation occurs after

Deborah has witnessed one of the most severe instances of institutional abuse in the novel: a nurse physically beating a patient strapped to the bed. Witnessing this shakes Deborah to her core, the event becoming "forever after the symbol of the impotence of all mental patients: the blow again, calm and accurate and merciless, and the [patient] spitting back again and again" (105). When Deborah reports this abuse to one of the doctors on staff, he gives her "a variety of the old 'fine-fine,' which went, 'Yes, yes, of course,' and was meant to placate without changing, silence without comprehending, and end friction by doing nothing" (106). Again, when Deborah reports it to Dr. Fried, Dr. Fried informs her that she is unable to do anything as she does not have the authority over the ward policies or personnel. Deborah is justifiably upset, telling Dr. Fried, "What good is your reality, when justice fails and dishonesty is glossed over and the ones who keep faith suffer" (107). Rather than simply dismissing Deborah's experience as an unfortunate result of the injustices of psychiatry, Dr. Fried uses this as an opportunity to teach Deborah how to withstand suffering in reality: "I never promised you a rose garden. I never promised you perfect justice. . . . I never promised you peace or happiness. . . . The only reality I offer is challenge, and being well is being free to accept it or not at whatever level you are capable" (107–08). The scene in the novel reveals that it is not just confidence and respect that makes this statement so powerful: it is that Dr. Fried listens to Deborah and is honest with Deborah, unlike the dismissive ward doctor. What Dr. Fried does promise is to be listened to with respect and empathy. *Rose Garden* clearly demonstrates that translating the language of illness requires much more than Szasz's recommendation to "induce the patient to relinquish his indirect . . . communications and to substitute for them direct messages framed in the straightforward idiom of ordinary English . . . by placing him in a situation in which hinting is not rewarded" (*Myth* 301). Only through empathetic mutual translation can the therapist

accomplish this goal.

Mistranslation and the Multiplicity of Meaning

Translating with empathy, rather than imposing a translation onto someone, is essential because of the multiplicity of meaning in symptoms. Szasz himself briefly writes about this in *The Myth of Mental Illness,* after which he rarely, if ever, addresses it again in his works. He writes that when translating the language of illness, "the possibilities for error are vast" (148), because in nondiscursive language there is a "*multiplicity of meanings* that may be attached to a communication" (148). What Szasz means by this is that a body sign often has layers of meaning: one of his patient's symptoms of abdominal pain, for example, may be a metaphor for grief and resentment, as well as a symbol of the patient's mother who died of a hysterectomy. For Szasz, the possibility of multiple meanings existing does not mean that the therapist should work with the patient to ensure as many as discovered as possible. Instead, he argues that the therapist should work harder to be "attuned to" their patients to determine all possible meanings alone (139). He then outlines how he would communicate these meanings to his patient: there is a standard order in which to do so, with the caveat that "[n]ot all levels of" the meanings need be communicated to the patients (163). The "end-goal" of discovering the multiple meanings of the patient's body signs is to have "a multidimensional perspective of the patient's human situation" until an "adequate 'development' of this 'picture'" is created (163). This picture is, of course, Szasz's.

Fromm-Reichmann, like Szasz, recognizes the multiplicity of meaning in mental illness, explaining in a similar manner that the patient's symptoms and communication have "multiple meanings," and therefore therapists "should be resigned to the multiplicity of meanings" as it is

"incorrect" to abide by the old psychoanalytical rule that there is one correct and certain interpretation (*P&P* 212). However, while Szasz understands the multiplicity of meaning to mean a countable set of translatable meanings that the therapist can and should expose, Fromm-Reichmann warns that a therapist would be "lucky" if able to translate "*one* aspect of a cryptic schizophrenic verbalization" (212). Rather than trying to correctly uncover a set number of meanings and then serving the patient "answers ready-made on a silver platter," she explains that the therapist should "give the patient the opportunity to find . . . [their] own answers" (*P&P* 213), an aspect that is absent in Szasz's instruction. Greenberg quite directly states that Fromm-Reichmann made "a lot of mistakes" in her interpretations but "would just admit her errors and move on" (Hornstein 381). In order to mitigate mistakes, Fromm-Reichmann consistently recommends working empathetically with the patient to discover the patient's interpretations of their own symptoms. She states that the therapist's role is to be "listening alertly, expecting . . . [the patient] to make sense" (183) rather than to search for and impose meanings of their own.

One of Fromm-Reichmann's case studies, with a patient we can assume from context is Greenberg herself, shows the importance of listening to the patient's own interpretations. She describes one of Greenberg's symptoms: self-harm in the form of pulling the skin from her heels. Fromm-Reichmann presents three potential meanings of this act, emphasizing in the first-person plural that "we," meaning herself and Greenberg, "discovered the meaning of this symptom" (213). The first potential meaning, that Greenberg was maintaining her sick identity by hurting herself, was discovered collaboratively. The second meaning, that Greenberg was resentful of Fromm-Reichmann having misinterpreted her previous acts of self-burning, was identified solely by Greenberg. And the third meaning, that it was representative of an issue with her mother, was again discovered by Greenberg. Fromm-Reichmann relates this story not only to explain the

multiplicity of meaning and that all "three interpretations appeared to be correct" (213) but also to show how important the patient's own insights are in translating an initially unintelligible symptom. While all three meanings were significant discoveries, the latter two were the most productive for Greenberg in understanding her symptoms and how to reduce the self-harm behaviour. Without Greenberg's input, Fromm-Reichmann may have struggled to even determine the first potential meaning herself.

And yet, despite the importance of Greenberg's investigation of the meaning of her own symptoms, the patient's interpretation is often dismissed in favour of the therapist's. In an earlier paper, Fromm-Reichmann explains that she believed Greenberg's self-inflicted burns were "a serious expression of tension," of resentfully displaying on the outside how Greenberg felt on the inside, whereas Greenberg "thought of it as a means of relieving tension," in that burning herself reduced internal discomfort (206). This contest of interpretations is depicted in *Rose Garden*. Deborah conceptualizes her feelings of rage as a volcano burning within her and the self-inflicted burns as "backfires" that ease "the pressure of the stifled volcano inside her" (174). When Dr. Fried presents her interpretation of the symptom (the same as Fromm-Reichmann's in the case study), Deborah knows "[a]lmost at once" that Dr. Fried's interpretation is incorrect and asserts this directly, "'You are wrong,' Deborah said simply, hoping that the doctor really believed what she had so often said about the patient trusting her own deep beliefs. . . . 'I don't know why, but you are wrong'" (184). As opposed to Fromm-Reichmann's description in the case, which poses the two contrasting interpretations as both having the potential to be correct, Greenberg's description of the event positions the reader to agree with Deborah's interpretation. Additionally, Deborah was only able to disclose this more accurate interpretation because she knows that Dr. Fried values the patient's opinions—had this not been the case, Deborah's interpretation might

not have come to light. And, when Fromm-Reichmann's biographer, Gail Hornstein, describes this same symptom, she omits Greenberg's interpretation: "Burning her arms with lighted cigarettes and engaging in other acts of mutilation were expressions of self-loathing and guilt" (235). The therapist's meaning, even when the therapist herself has admitted that it might be wrong, is valued over the patient's and viewed as fact.

The patient's interpretation of their own symptoms and experiences is so heavily dismissed that it has manifested in fierce contention over the novel. In the same vein as the pathologized readings of *The Bell Jar*, scholars criticize *Rose Garden*'s 'inaccurate' description and interpretation of schizophrenia because Greenberg's portrayal of it is often in opposition to the psychiatric understanding of schizophrenia. Although several of these reviews are from scholars in various disciplines, two of the most egregious ones are written by psychiatrists. One psychiatrist, Lawrence S. Kubie, wrote a review of *Rose Garden* in *The Journal of Nervous and Mental Diseases* in 1966, two years after the novel's publication. By analyzing Deborah's symptoms, he determines that her hallucinations are, in fact, "'pseudo'-hallucinations" (191), and so she likely does not have schizophrenia but instead hysteria, potentially triggered by "an early toxic delirium" from the operations she underwent as a child (193). He laments that the work of fiction does not contain "temperature charts, x-rays, clinical studies or EEG, and no nursing notes describing her behaviour"[12] and wonders whether "anticonvulsant drugs would have lessened the frequency, duration or intensity of these outbursts" (194).[13] He uses this interpretation of Deborah's symptoms to argue for a change in how patients similar to her are

[12] Greenberg does actually include statements from nurses describing her behaviour, overheard by Deborah: "Lord! In the bathroom yelling all kinds of nonsense. Filled the wall with some kind of crazy writing and come out fighting like a tiger. All the time we was packing her she was swearing in that kind of babble-talk – not anything you could understand, but you looked at her face and there was hate. Brrr" (198). This dialogue, meant to show the casual cruelty of hospital staff towards patients, is likely not the objective, scientific information that Kubie desires.
[13] Deborah frequently takes chloral hydrate, a sedative that is also used as an anticonvulsant.

diagnosed. And, because he believes Deborah's mental illness is described incorrectly, he cautions against families of people with schizophrenia reading the novel without "psychiatric guidance in digesting and understanding its implications" (191). This recommendation implies that both Greenberg's interpretation and the reader's potential interpretation are inferior to and under the authority of his own. Hornstein explains that Kubie took this distrust to the extreme by going as far as to personally harass Greenberg:

> Kubie did not stop at a book review. He wrote a series of letters to Greenberg in care of her publisher and became increasingly arrogant and hostile when . . . [the publisher] refused his requests for her telephone number. After Greenberg wrote him a gracious reply, he started calling her. 'He was arguing with me and arguing with me and arguing with me,' Joanne recalled. When she politely disagreed with his interpretations in a subsequent written exchange, he kept insisting that only he could accurately characterize the meaning of her illness. (370)

This extreme reaction is an example of what "guidance in digesting and understanding its implications" can look like when certain psychiatrists believe that they are the objective authority on the inner experiences of others.

Nearly two decades after Kubie's review, Carol North and Remi Cadoret, also psychiatrists, make a similar argument. Reviewing several novels depicting schizophrenia, including *Rose Garden*, they decide that most representations of schizophrenia in literature are nothing more than "misinformation" that is "widely disseminated to the public" (133). After examining the novel "page by page" and making note of "every symptom of any kind" (133), North and Cadoret create a chart of Deborah's symptoms. They make a point to note that a "limitation" of their analysis is that the patient, and not the psychiatrist, has reported their

symptoms (133). Furthermore, the patient describes their symptoms in a "vague" way (136), leading to a "lack of scientific quality" (137). The conclusion they reach is that such limited and vague descriptions of symptoms in a fictional novel result in a "grossly misinformed and confused" public and "the word 'schizophrenia' [striking] fear in the hearts of the uninformed" (137). They decide, like Kubie, that Deborah actually has hysteria (called somatization disorder at the time of publication). Because they believe that Deborah is not really schizophrenic, they argue that Deborah's recovery raises "false hopes . . . in people who have schizophrenia or who have loved ones with it" (137). They go as far as to suggest that psychiatrists should review novels depicting schizophrenia before they are published in order "to point out gross clinical incongruencies and inaccuracies" (137). Kubie and North and Caboret not only dismiss the interpretations of Deborah's symptoms in the novel and supply their own interpretations as replacements, but they also argue that the interpretations in the novel are dangerous for others to read and must be erased lest they be trusted over the interpretation of the 'expert.'

In an interesting twist of fate, North published her own book on her rare schizophrenia treatment a few years after publishing this article that criticized Greenberg for that very same thing. In *Welcome Silence: My Triumph over Schizophrenia*, North writes that Cadoret was her therapist and that Cadoret cured her of schizophrenia through kidney dialysis. Hornstein portrays this as hypocrisy to the highest degree, stating that after publishing her personal account of her treatment, "North became a psychiatrist and has presumably spent her time persuading other patients not to write personal accounts of their treatments" (371). It is possible, of course, that North and Cadoret simply changed their minds after experiencing for themselves an unorthodox treatment that worked. However, regardless of if they were hypocritical or had a change of heart, something more significant is revealed through this turn of events: people tend not to believe

mentally ill people unless they too experience it.

Greenberg was aware of these critics (Kubie, North and Cadoret were but a few among many) and "understood their hostility," since her novel proves that, contrary to psychiatric belief, "plain old psychotherapy" was able to effectively treat her schizophrenia (Hornstein 370). Nonetheless, "it was still painful and bizarre to have to deal with these attacks" (370). Ironically, what these critics miss in their hunt for Deborah's symptoms is that the novel portrays this exact dynamic of the imposing, callous psychiatrist and the harassed, misunderstood patient. When Dr. Fried is away from the hospital for a period of a few weeks, Deborah has a replacement psychiatrist, Dr. Royson, who takes an opposite approach to Dr. Fried. He begins the therapy session by telling Deborah, "Your doctor has told me a lot about you" (166), immediately valuing the therapist's perception of Deborah over Deborah's autonomy to introduce herself. She has no response to this since it is not a dialogue: "Deborah turned her mind for something to reply, thinking only: How stiffly he sits" (166). Throughout their conversation, there is no back-and-forth like there is with Dr. Fried. Dr. Royson asks questions "like a demand" and treats her answers "as if it were some prize" when she responds in a way that is elusive (166). He focuses the therapy session on forcing his interpretation of Yri onto Deborah, lecturing her about the Latin, French, and German roots of Yri words and the English syntax of Yri sentences in order to "convince her" that Yri is a self-fabricated delusion (168). He demands translations of words from Deborah and, after Deborah simplifies an expansive Yri word into a flat English translation, asks her why she does not just say the English word. The rest of the session is "a long silence between them," talking but not actually communicating, because his "responses brought down the muteness like a night" (168). She attempts to communicate this to him in a Yri phrase, eventually translating it to him as: "It suffered and died in translation" (168). He ignores the

significance of what she is trying to communicate to him, instead delving into tearing apart her words to analyze the roots and syntax, the irony of that action completely missed. The critics do the same thing that psychiatrists like Dr. Royson do when they ignore the content of the patient's words for the form.

The issue is not necessarily that Dr. Royson's interpretation and translation of Yri is wrong; Deborah admits that what he says is "clever and detailed and sometimes almost brilliant, and she had many times to agree with him" (168). The issue is, then, that he is forcing his translation onto her words without creating that empathetic dialogue. As she later explains to Dr. Fried, "I tried with Dr. Royson . . . and he wanted only to prove how right he was and how smart" (178). She compares his words to "scalpels" intruding "into her mind just as long-ago doctors had intruded into her body" (168), putting this approach to therapy into a specifically medicalized context. The more he translates for her and digs around in her mind for the "icy logic" of her mental illness, "the more profound was the silence which enveloped her … there could be nothing else but muteness" (168). The issue is not that Yri words get lost in translation—it is that they are forcibly and insensitively translated by the psychiatrist. She ceases to react or be connected to the outside world after this moment.

To take away Deborah's language of mental illness by forcing it into an English translation is not the cure that Szasz makes it out to be; it renders her mute, unable to express the true complexity of her mental illness. Simply put, the novel contends that mental illness cannot be translated. To argue that it can be translated implies that, semiotically speaking, there is a known referent being signified. In Szasz's formula, the referent is personal troubles that are simply being signified by the wrong signs (bodily symptoms instead of ordinary language). *Rose Garden* suggests that the referent is unknown and, therefore, exact translation of the signs into

ordinary language is impossible. In the Afterword, Greenberg explicitly states, “The hard truth is that we don’t know enough about the brain’s capacities to do any more than speculate on cause or cure. I don’t know what caused my illness” (291). This sentiment is mirrored in the novel when Dr. Fried explains to Deborah, “The symptoms and the sickness and the secrets have many reasons for being. . . . If it were not so, we could give you a nice shot of this or that drug or a quick hypnosis and say, ‘Craziness, begone!’” (209). Deborah’s recovery from mental illness cannot be only an uncovering of its one true meaning because, simply put, there is none.

Mirroring her symptoms, Yri words often have several simultaneous meanings that have no accurate counterpart in English. As she explains, fruitlessly, to Dr. Royson, *Quaru* means “wavelike, and it can imply something more of the sea, sometimes the coolness, or that soft, swishing sound, too. … You can use it for the way the wind is blowing sometimes, or … leaving” (167). *Leaving* itself can also be translated into a different Yri word “depend[ing] on whether one has the intention of coming back” (167). Yri is dependent on these metaphors, articulating Deborah’s complex feelings and perspective with multiple layers of comparisons in a contrapuntal blend of meaning. Some ideas do not even exist in Yri, such as ‘thank you,’ and when Deborah finally has cause to thank Dr. Fried, her gratitude “remained a mute weight inside her” (191). When there is no referent, or there is an overly complex combination of referents that cannot be untangled, translation of Deborah’s language of mental illness silences the only means she has to articulate her inner experience.

Multilingualism as a Healing Alternative to Translation

This silence is something that Szasz would have predicted: either the patient accepts the psychiatrist’s translation and learns to communicate in ordinary language, or they remain

confined to their language of illness forever. Deborah's silence, however, does not last forever, and *Rose Garden* demonstrates that the answer is not to return only to ordinary language but to traverse among the different meanings, the different languages. After her silencing sessions with Dr. Royson, Deborah begins to feel overwhelmed with "voices and counter voices, hates, hungers, and long terrors" (169). She conceptualizes these voices as a volcano inside her, the volcano she tried to quell at first with self-inflicted burns. When her attempts to silence the volcano do not work, it erupts in a cacophony of different languages. She scrawls Yri words all over a bathroom in pencil and blood and begins speaking in "English, Yri, and gibberish," as even Yri loses the capacity to provide "logic and frame" for her thoughts (188–89). After months of Dr. Royson stripping away Deborah's language, Deborah has no medium to articulate her experiences and, eventually, can only throw "her head in a soundless scream, wide-mouthed" (189), not even having access to sound.

Although the volcano eruption seems like Deborah has severely regressed, it in fact precipitates her recovery. In order to overcome the silence that befalls her when translation of her mental illness is not possible, Deborah becomes multilingual, so to speak. For months, her meaning bursts forth in a confused "mangled Anglo-Yri-gibberish and there was only enough [words] to try to answer a question or to hint at a need. The ambiguity of what she said surprised her as much as anyone" (197). This is her process of becoming multilingual and being able to access more than just Yri. At first, "she struggled to translate" and "the confusion of tongues only alienated her further. She would become frightened, whatever she said next could not be translated at all, and the formless sounds would make her even more frightened" (197). However, it is only because of this eruption of languages that she slowly learns how to "span the light-years of distance between herself and them [others]" (197). In a therapy session, Dr. Fried

remarks, “when this volcano of yours broke, something else broke, too: your stoniness of expression. One sees you now reacting and living by looking at your face” (203). As Deborah is being escorted from the session back to her wards, a conversation with the nurse shows the positive result of this breakthrough. When the nurse remarks that it is cold, Deborah attempts to reply with “truth” (204). Because Deborah feels three types of cold (“real cold,” “Yr-cold,” and “intraregional cold,” the cold of having to live between the two worlds), she tells the nurse, “You’ve only got one kind of cold, the kind coats can fix” (204). For Deborah, who understands the three levels of cold, this statement is comforting, akin to telling someone with a sprained ankle that at least it did not fracture. This nurse, who lacks any knowledge of Yr, is offended, and Deborah is able to recognize her offence instantly for the first time. She apologizes, after which the nurse confides in her about the difficulties of her job and personal life. This is the first ordinary small talk that Deborah has with someone—a moment of connection where “Deborah felt that she was giving a confidence also” (204). Although she initially speaks in a way that only she herself can understand, because of her new multilingualism she is suddenly seemingly able “to hear into the attendant’s mind” (204) and cross the boundary to converse in ordinary language to connect with another person.

After this moment of connection, Deborah experiences a turning point in her healing. Once she is able to converse multilingually, switching more easily between Yri and English, she experiences her first moment of peaceful silence and realizes that “she would not die . . . she was going to be alive” (205). Previously, Deborah only ever had silence imposed on her, and the voices within her never stilled even when she was silenced. This time, however, it is her surroundings that still: “It was quiet. Yr was quiet and the Collect [a crowd of people in Yr that continuously taunt her] was silent also. All the voices in the world seemed stilled” (205). For the

first time, after seeing only in two-dimensional greyscale for years, she "began to see the colors in the world" and could see the "Third Dimension, the meaning, . . . in the bare lines of walls and doors and the planes of people's faces and bodies" (205). Importantly, she can now see "over the hedge" (205)—hedge is the term that Greenberg and Fromm-Reichmann use to refer to metaphorical symptoms. As Deborah learns multilingualism and, thus, is able to truly connect with others without a forced translation of her language into ordinary language, she no longer needs her hedging metaphors and can now be in reality.

Deborah's final act of healing, proving that she can live in the world despite it not being a rose garden, is a demonstration of her mastery of this multilingualism. In the closing pages of the novel, after being discharged for a brief period, Deborah has returned to the hospital in order to regain her strength and study for an exam that would allow her to apply to college. The last pages are a cacophony of different voices reflected in different fonts: snatches of conversation and complaints from the patients in standard font, the academic prose of her schoolbooks shouting various facts in ALL CAPS, and taunts from the Yri gods and Deborah's replies to the taunts in *italics*. The result is chaotic and overwhelming, reflective of her liminal position as patient, student, and recovering mentally ill person. However, the communications are intelligible, proof that Deborah can communicate in varying contexts. Amidst these dissonant voices, an Yri god entices Deborah to continue using Yr as a shield against the world. Deborah replies, her dialogue written in the same italics as the god: "*I am going to hang with the world*. *Full weight*" (278). The novel closes with Deborah reiterating her statement, though not in italics for the first time in the novel: "'Full weight,' Deborah said" (279). Greenberg uses an enticing, evocative metaphor here—to hang with the world, full weight—and lets it hang without explanation. Although the reader might be tempted to look to other sources to discover the

meaning behind "full weight," as Jeffrey Berman does when he argues that its meaning is "lost to the reader of *Rose Garden* unless" they read Fromm-Reichmann's case notes (176n15),[14] the meaning can be found in the fact that there is no obvious meaning. In other words, Deborah is finally able to speak without translating her meaning into ordinary language. What exactly is "full weight" a metaphor for? The novel cannot be mined for this information; Deborah knows the meaning herself, and this is why it is powerful. Additionally, the shift away from italics in her response indicates that rather than speaking to Yr, she is addressing the world and herself. Berkeley Sherman articulates this idea, explaining that the novel ends on "a significant declarative clause: 'Deborah said.' Rather than simply conveying the content of a character's articulation, these words emphasize the act and the ownership of speech" ("My Difference" 179). The end of the novel proves that Deborah has learned that not every metaphor, every language, can be translated or explained entirely, contrary to Szasz's argument. The exact meaning of what Deborah said is less important than the simple fact that "Deborah *said*."

The Contribution of Art

Thus far, I have maintained that Szasz's argument about the necessity of translating the language of mental illness into ordinary language via therapy is limited, as seen in *Rose Garden*'s emphasis on the importance of empathetic therapy and moving past translation to multilingualism. At this chapter's close, I return to Szasz to suggest one final limitation in his argument: the potential of art in contributing an authentic and healing portrayal of mental illness.

Szasz is interested in the connection between art and mental illness, arguing in a select

[14] In the case notes, Fromm-Reichmann states that Greenberg negatively associates the word *weight* with her overeating behaviour and an incident in which she wet herself in a towel as a child, making the towel heavy. Berman suggests that Deborah is then freeing herself from this childhood trauma by embracing a *full weight*.

few of his texts that art, particularly literature,[15] is the ideal medium in which to describe mental illness. This argument can be traced back to his foundational claim that "neither the language of the mental patient nor that of the psychiatrist is serviceable for the proper description of either madness or reactions to it" as both languages consist of "fraudulence" (*The Second Sin* xix). Szasz proposes that an appropriate alternative to these languages is literature, advising that "if you want to learn about psychology or psychiatry, do not read psychology or psychiatry, but great literature, and especially biography" (24). Szasz hit on this realization early on in his career before *The Myth of Mental Illness*. In one of his first articles he remarks, but does not fully explore, that while an individual's personal problems often manifest as the language of illness, they can also "find expression in . . . literary creations" ("Language and Pain" 993). He fully articulates this idea a few decades later in 1982, explaining that the mistake that psychiatrists make in attempting to write about mental illness is twofold: they use medical jargon, and they attempt to look too deeply into the meaning of mental illness ("Literature and Medicine" 37). Writers, in contrast, do not attempt "the whole enterprise of 'explaining' behavior—by attributing or reducing acts to progressively more abstract and mysterious entities" (37). Instead, they limit their writing to "the surface of human behavior (that is, to what we do and say)" and use "ordinary language appropriate to human affairs" (37). Crucially, literary works do not claim to cure illness by writing about them. With their sole task of describing a "true account of human tragedies," they more accurately capture mental illness than psychiatric texts are able to (37).

In a subsequent article, Szasz further clarifies that this ability to describe rather than explain mental illness is because literature and mental illness are in the same category of language, that of a "presentational form of self-expression and communication" ("Intentionality

[15] He often writes about art in general, but nearly all of his examples in his articles subsequently cited in this section pertain to literature.

and Insanity" 2). However, he believes that literature is preferable to the language of illness because it does not pretend to be that which it is not (as the language of illness does when normal human suffering masquerades as illness): "art is not, and cannot be, true or false; instead it is expressive or inexpressive, and it succeeds or fails" (3). This is the extent of his argument. He does not argue that mental illness in literature is productive or healing or powerful, only that it, like the therapist-translator, can more accurately describe mental illness than psychiatry can.

This understanding of art and mental illness holds true, to an extent, in *Rose Garden*. Like Szasz, Dr. Fried sees an important connection between art and mental illness and ends her last therapy session with Deborah by advising that she combine the two. The conversation starts as she optimistically asks Deborah, "How does it feel to go on without all that old, stinking garbage?" (270), referring to her mental illness symptoms. Deborah, however, immediately defends Yr as it also holds "shining things" (270). She disappointedly asks if she is "never to think of" those things again "or of the words in Yr that are better than English for certain things" (270). Dr. Fried does not answer her question either way. Instead, she asks why Deborah, a prolific and talented artist, has never drawn the Yri gods before. Deborah reminds her of the secrecy of Yr, to which Dr. Fried responds, "Perhaps the time has come to share the good parts, the lovely and wise parts of Yr, with the world. Contributing is building the commitment" (271). This commitment that Dr. Fried refers to is the commitment to exist fully in the world. The answer, then, to Deborah's question is that she need not wholly cast Yr away. Instead, Deborah can create art about Yr to convert the connection that she has with Yr into a connection with the world. Here, Greenberg suggests that the final stage of recovery is art, which once again emphasizes the limitations of the therapist as translator: an empathetic therapist can suggest a medium through which the patient can communicate, but she cannot communicate for her. In

order to recover, Deborah must contribute her own art to the world.

As I am beginning to suggest, Greenberg has a much more nuanced argument about the connection between art and mental illness than Szasz does. Like Szasz, she sees art as a language. Deborah explains that she draws in both English and Yri (53), implying that her art can both portray ordinary language and the language of illness. However, portraying her mental illness in art is not a simple translation. Art acts as a vehicle for her mental illness, sometimes negatively, in the same way that creating the Yri language allowed Deborah to articulate her mental illness. At the end of the novel, Deborah suddenly remembers that the main Yri god looks identical to pictures of Satan that she once saw in an illustrated edition of *Paradise Lost*. This frightening image of an otherworldly being came to manifest Deborah's negative inner thoughts and experiences, with art serving to help her make sense of her seemingly nonsensical world.

Conversely, just as art facilitates her mental illness, her mental illness is also exacerbated by her creativity. This is the age-old question: does creativity precipitate mental illness, or does mental illness result in creativity? *Rose Garden* answers: both. For Deborah's family, particularly her mother, Esther, Deborah's creativity "was a bright and easy answer to Esther's gray, vague suspicions, and she tried to pull it up over her eyes. To the whole family it suddenly seemed to explain all the sickness and sensitivity. . . . [S]he was special, a rare and gifted spirit. Allowances were made for her complaints of illness, for her vagueness" (34–35). In excusing her mental illness as merely creativity, Deborah is delayed from getting much needed help, thus worsening her delusions and self-harm. Greenberg consistently speaks against this view of creativity and mental illness. Rather than visual art, Greenberg's artistic talent naturally lay in writing. She explains in one interview that because she "learned to write" and "learned to be sick" at the same time, she erroneously "thought for a time that the two were inextricable"

(Gibble 1064). In another interview, she clarifies that this overlap is coincidental, but she was unable to realize this at the time, since people think that "[i]f you're mentally ill and creative, you associate those two things together, . . . so you think that if I get rid of my mental illness, this is the only thing I've got [in order to be creative]. . . . it's very damaging both to creative people and to mentally ill people" (Berkeley Sherman, "A Conversation" 87). Greenberg reiterates this in the afterword, stating directly, "The promulgation of this myth [that creativity and insanity are inextricable] makes creative people reluctant to seek needed therapy because they fear their gifts will vanish. It also makes mentally ill people fear invoking what creative forces they have for fear of deepening their already substantial anguish" (290).

Instead, Greenberg makes a unique delineation between "what defenses creativity is serving and where that creativity can be harnessed in the service of health" (Afterword 290). Deborah explains this same distinction in the novel, asking Dr. Fried that if she drew a picture of one of her Yri gods, "would . . . [she] look at it as my old nuttiness, or as a 'contribution'?" (271). Dr. Fried replies that she "would have to see it first" (271). Depending on how one approaches art, it can either further separate one from the world or connect one closer to it. Soon after Deborah sees colour again for the first time, she encourages this new colourful connection with the world through art:

> Deborah, still in the first urgency of hunger and love for the world's forms and colors, had radiated her artistic gift into a dozen mediums and styles. . . . She yearned to play with all the toys of the earth, while Yr and the world's darker parts fought it out inside her. To Earth's usages and people she felt she could never come, but to the material things there was new access and freedom and great reward. (231)

In this phase of Deborah's healing, art acts almost as a substitution for the parts of life that her

mental illness still prevents her from accessing; it is not yet a contribution but is slowly contributing to her recovery. The last thing that Deborah tells the Yri gods is a vow to create a contribution because she can finally fully live in the world: "I am of them. Furii says that you will be a contribution, but I don't yet know how. . . . I will have to learn how. Then, maybe . . ." (278, second ellipsis in original). While the reader is left to imagine what Deborah's contribution will be, they have been reading Greenberg's contribution all along: this novel.

Greenberg's contribution took many years to come to fruition. Initially, as Hornstein details in Fromm-Reichmann's biography, Fromm-Reichmann approached Greenberg after realizing that the only appropriate way to write about Greenberg's remarkable case was to write it collaboratively. This "unprecedented" collaborative case history[16] would have included perspectives from Fromm-Reichmann, Greenberg, Greenberg's mother, and Greenberg's childhood psychiatrist (Hornstein 314). Greenberg wrote a fifty-page report in anticipation of this project, taking a nonfiction approach (315). Unfortunately, Fromm-Reichmann died in 1957 before the project could be realized and Greenberg, "never want[ing], to think about . . . [her experiences] again" (315), believed that this report would be the last time she ever wrote about it.

This mindset changed for Greenberg after a conversation with a neighbour about why people misrepresent horrific past events. He told her, "There are two things a person can do with experiences that are overwhelming. He can forget them, or change them" (Afterword 286). She explains that this harsh realization was the impetus for writing *Rose Garden*: "A voice in my

[16] It was not quite unprecedented. There is one other case study published before *Rose Garden* that I have been able to find that was also intended to be a collaborative case history: *Autobiography of a Schizophrenic Girl*, first published in 1951. The first part is a memoir by a patient, Renee (a pseudonym), and the second part is an interpretation of Renee's memoir done by her psychiatrist, Marguerite Sechehaye. While this structure is technically collaborative, Sechehaye frequently disregards Renee's interpretations of her own symptoms and implies that hers are the objective truth. On the cover of the 1979 edition of the book, it claims that it is "A BOOK EQUAL TO *I NEVER PROMISED YOU A ROSE GARDEN*." One is left to wonder if this unbalanced narrative is what psychiatrists, including possibly Fromm-Reichmann, mean by a "collaborative" case history.

mind said that I hadn't forgotten being mentally ill, so I'd better write about it before I changed it too much" (286). Turning her experiences into art was, then, a conscious and purposeful decision, not only for her own memory but for humanity in general: "Writing is a reactive art, I believe, a conversation with the world. I didn't want to write a case history; I wanted to show what being mentally ill felt like, how it felt to be so deeply estranged from the world" (286). In order to authentically depict mental illness, Greenberg had to turn to fiction.

As Szasz does argue, the art of fictional writing more accurately depicts mental illness than nonfiction writing does, despite its departure from objective facts. This is because nonfiction requires definitive statements and accuracy in the minute details, while a literary depiction is better able to approximate the inexpressible aspects of mental illness. Greenberg explains that fiction gave her the freedom of being able to change "certain facts, dates, times, and place" as her goal was to "make the work a coherent whole rather than to be medically or personally precise" (Fromm-Reichmann, "Discusses the 'Rose Garden' Case" 131n1). She reiterates this in her afterword, explaining that "cutting away great swaths of time, eliminating people and events" allowed her to get at the significant questions like, "What was therapy like? How did life feel?" (286). This lack of accuracy in the details importantly allowed her to avoid the "toughest question—how did I recover" which "can't be answered because I don't know" (286). As Szasz argues, literature allows for a more accurate description of mental illness without claiming a reason or cure.

However, Szasz's argument begins to fail when he extends this argument to claim that there can be no deeper meaning in art because presentational languages inherently cannot have a deeper meaning—they literally mean what they present, no more and no less. Any interpretation of art, Szasz argues, is a grave error, as it claims a deeper meaning where there is none. He

lambasts Freud especially for his influence on art and literary criticism as Freud wrongly claims to know the artist's "real intention" of their art (8) which "must be revealed by translating its 'content' into the jargon of psychoanalysis" (9). By not seeing art as the presentational language it is, literally showing the viewer or reader what it presents, Freud is effectively "deforming art into non-art and hence destroying it" (8). Furthermore, "he not only robs art precisely of that quality that makes it art (namely, its specially executed presentational form of self-expression and communication), but also actively demeans art by treating it as if it were like madness or a symptom of madness" (9). To declare an interpretation of art and madness is, then, inaccurate, harmful, and is done to exert "legal and rhetorical control" over the artist or mad person (11). This deduction seems strange as Szasz seems to do just this when he claims he can accurately translate both mental illness and art into ordinary language. However, because Szasz believes that they are presentational languages, he does not view this translation as an interpretation but rather converting them into their correct idiom. My analysis of *Rose Garden* demonstrates that *any* direct translation of mental illness into ordinary language holds this same harmful control and should be relinquished.

What Szasz does not anticipate is that this release of interpretation and control allows for *connection*, and connection is the key to healing. Just as Deborah is able to connect with others and the world once she surrenders her need to speak only in Yri or in ordinary language, Greenberg is able to connect with readers through her ambiguous, undefined portrayal of mental illness. As Lilian Furst argues, in her clinical case studies "Fromm-Reichmann consciously fights off the 'temptation to dramatize' (*P&P* 200) in the interests of scholarly seriousness," while Greenberg's fiction dramatizes to appeal "to readers' imagination in depicting Deborah's state of mind and inviting empathy with her" (225). This empathy, as with Fromm-Reichmann's

empathy in her translations, is deeply important to understanding and healing from mental illness.

Testimonies from readers of *Rose Garden* prove the power of empathetic connection in fiction. Even prior to the novel's widespread success, Greenberg began receiving letters from parents expressing gratitude "for giving them an insight into the mental illness of their children" (Afterword 288). Hornstein includes several excerpts of letters from mentally ill people thanking Greenberg for writing the novel, even decades after it was published. One mentally ill reader expressed doubt that "anyone [could] write a novel about mental illness the way it ought to be written," but that Greenberg achieved it by capturing "the ephemeral moods and nuances of mental illness . . . the mute and urgent beauty of the sickness itself" (Hornstein 361). Just like Deborah, this reader's experience of mental illness is marked by otherworldliness and muteness that could only be articulated by a novel. Other readers expressed that the novel gave them hope that they, too, could recover or that they did actually recover after reading the novel. The common thread through these letters is articulated best by one reader: "*Rose Garden* gave me back . . . a language with which to address *myself*" (373). It is not merely that Greenberg writes about a topic that readers are intimately connected with but that that writing gives them a *language*. Szasz defines presentational language, like mental illness and art, as "greatly inferior" to ordinary language because its sole goal is "for purposes of affective and promotive communication" (*Myth* 299); in other words, emotion and connection. In writing about mental illness in a novel, Greenberg is able to demonstrate the sheer power of affective and promotive communication: it gives the listener or the reader the language to understand, address, and heal themselves without needing to interpret or translate their experiences. The novel's contribution to the world is showing that there is a way to speak about the inexpressible experience of mental

illness, confirming it as real even without identifying its cause or meaning.

In his analysis of the antipsychiatry theorists, Peter Sedgwick precisely describes the main issue underpinning all of Szasz's work:

> [Szasz's argument] deals only in what the patient does to other people, never in the personal anguish, alienation or stupor which predates the sufferer's communication with others. Mental illness is a language: but it is also the sick one's miserable inability to use a language. It is, to be sure, a social state: but, before that, it is a private hell. Szasz attains his role as *proxy spokesperson* for the rights of the mental patient by ignoring, simply, what it is to be a mental patient. (175, emphasis added)

In claiming to know the truth behind the myth of mental illness, Szasz's translations amount to speaking over and for mentally ill people without ever really listening to them. While understanding mental illness as a language does hold potential in viewing it as an attempt to communicate one's suffering or unique inner experiences, mental illness simply cannot be translated into ordinary language. An apt quotation that speaks to this is one that Szasz himself quotes in the epigraph to "'Audible Thoughts:'" "*Traduttori traditori*," or "Translators are traitors" (533n1). In *Rose Garden*, Deborah never finds a way to faithfully translate her language and symptoms into ordinary English, neither for Dr. Fried nor the reader. Her mental illness is simply described as she experiences it, that is, as mostly beyond the bounds of language. While letting go of the need to translate and accepting that mental illness is inexpressible in any language is what allows her to begin recovery, mental illness can still be expressed to others through literature. People like Szasz, Dr. Royson, and the critics who criticized and harassed Greenberg are threatened by a literary depiction of mental illness like this. Despite that, what holds the most meaning is that, since its publication, readers have benefitted from reading the

untranslated, empathetic, and *full weight* portrayal of mental illness in *I Never Promised You a Rose Garden*, which gives them a language with which to address themselves.

Chapter Three

When Nothing Can Be Said: Literary Metanoia in Kurt Vonnegut's *Slaughterhouse-Five*

Though Erving Goffman and Thomas Szasz were key figures in the antipsychiatry movement, the face of the movement was not the dispassionate, nonpartisan Goffman nor the harsh, libertarian Szasz. A third figure, R. D. Laing, is responsible for the popular understanding of antipsychiatry as antiauthoritarian, psychedelic, and radical. Laing's brand of antipsychiatry was born out of the countercultural movement whilst simultaneously contributing to it. Amongst the "make love, not war" and "don't let the man keep you down" bumper stickers on a quintessential hippie Volkswagen bus, one could find Laing's very own bumper sticker: "I'm Mad About R. D. Laing" (Sedgwick 70). Angela Carter has attributed the countercultural glamourization of madness to Laing, stating that he "set the pace for the crazy hinge of the decade" (qtd. in Tonkin 367). The most radical of the antipsychiatry theorists discussed in this dissertation, Laing presented himself as a Marxist and part of the New Left. His radical views on the positive power of mental illness as a reaction against normative society made him what Peter Sedgwick has aptly termed one of the primary "psychiatric prophets" (69). With his radically empathetic approach to a marginalized population and his lyrical writing style, Laing became, and is still, the poster child for antipsychiatry. M. Guy Thompson proclaims him "the most widely read psychiatrist in the world" at the time and a "social icon" who "inspired a generation of psychology students, intellectuals, and artists" ("Introduction" 1). While his ideas have since fallen out of favour, and Laing himself denounced them in the 1970s,[1] Laing is considered to

[1] This chapter focuses on Laing's theories in the mid-to-late '60s, which Peter Sedgwick has described as his momentary "flirtation" with mysticism and radicalism (109). Sedgwick characterizes Laing as an aspiring cult leader who was always more of a "collector and populariser of ideas from intellectually diverse quarters" (125). Thus, when the radical 1960s came to a close and conservatism became popular again, Laing embarked on a "campaign of normalization" (116), publicly denouncing drugs (which he previously did liberally), writing forewords and afterwords to his works that reframed their messaging to be less radical, and making claims that he had never been a Marxist and that his spiritual retreats to India had merely been fun getaways from England.

have made lasting contributions to society's distrust of psychiatry and respect for psychotic people (Kirsner 150).

While all the antipsychiatry theorists discussed in this dissertation, including Laing, criticize or denounce psychiatry, Laing uniquely venerates mental illness. He began his antipsychiatry career with the publication of *The Divided Self: An Existential Study in Sanity and Madness* in 1960 and posited this one radical question: what if schizophrenia was intelligible, a logical reaction to one's circumstances? His early works, while progressive for the time by diverging from biological psychiatry, remained conventionally focused on how the family can create an environment in which schizophrenia naturally manifests. His most radical work came later with the publication of *The Politics of Experience and The Bird of Paradise* (hereafter *Politics*) in 1967. In *Politics*, Laing posits that society, and not just the familial home, is an environment ripe for schizophrenia—and that this is not a bad thing. *Politics* makes the radical claim that schizophrenia is an attempt to heal from societal alienation.[2] What psychiatrists perceive as frightening schizophrenic symptoms are, in fact, a metaphysical journey called *metanoia*.

Laing's concept of metanoia was revolutionary, even within the most radical countercultural circles. Its insistence that schizophrenia is actually a treatment for the 'disease' of alienation, rather than being a disease in and of itself, is entirely antithetical to both biological psychiatry *and* other antipsychiatry theories, since both assume that mental illness, whether a

[2] Laing does not define *alienation*, instead adding in a footnote: "It is too late in the day now to go over the ground again covered by the thinkers of the last 150 years who have spelled out the nature of alienation, especially in relation to capitalism" (12). He points readers toward discussions of alienation in Joseph Gabel's *La fousse conscience* and Ernst Fischer's *The Necessity of Art*. Gabel discusses how institutions, such as prisons and asylums, prevent individuals from connecting to their true selves, which is alienation: separation from themselves and from the world. Fischer argues that capitalism forces people's labour to be separate from their true selves and their creativity, which leads to alienation, defined as a lack of fulfillment and purpose. Laing's vague use of *alienation* can be understood to mean the various ways that individuals are separated from themselves, others, creativity, etc.

biological disease or social condition, requires treatment and cure. The logical conclusion of Laing's theory is not only the abolition of psychiatry but indeed the *encouragement* of schizophrenic symptoms. *Politics* presents a how-to guide for this journey so that schizophrenic people might reach the pinnacle: the truth of all being. By discovering truth through metanoia, Laing argues that the schizophrenic individual can heal from alienation. In this chapter, I will apply Laing's concept of metanoia to Kurt Vonnegut's *Slaughterhouse-Five* to argue that this healing schizophrenic journey is possible—but only through writing.

In *Slaughterhouse-Five*, Kurt Vonnegut writes about Billy Pilgrim's journey through space and time during and after World War II. Through understanding Billy's journey as schizophrenic metanoia, I will explore the value and limitations of Laing's theory. First, I will argue that Vonnegut portrays Billy's metanoia as potentially both healing and non-healing, as demonstrated by the notoriously opposing scholarship on the meaning of *Slaughterhouse-Five*. Vonnegut's ambiguous portrayal of metanoia is mirrored by the experiences of Laing's own patient, Mary Barnes. In analyzing these three narratives of metanoia—Billy Pilgrim's, Laing's, and Barnes's—I will reveal that they are exactly that: narratives. And whilst I will argue that the theory of metanoia through schizophrenia has severe limitations, writing a narrative about metanoia, what I have termed literary metanoia, is possible and healing.[3] Literary metanoia in *Slaughterhouse-Five* and, significantly, Laing's literary text, *The Bird of Paradise*, evade the truth that Laing argued was necessary for healing. Paradoxical to Laing's claim in *Politics*, it is literary metanoia's evasion of truth that heals the writer.

[3] In this chapter and elsewhere in this dissertation, I follow after the disability studies scholars who do not view *healing* as a synonym for *cure*. S. Kay Toombs explains, "[a] person can be cured and not healed (for example, a cancer patient whose disease is cured but . . . [has] a deep sense of loss of integrity and continued suffering); and a person can be healed and not cured, as in the case of someone with debilitating disease who retains a sense of personal integrity that enables them to live well in the face of illness" (2). As I use the term, therefore, healing does not necessarily mean no longer being afflicted with mental illness but rather to live with it or in spite of it.

Laing's Journey

R. D. Laing began his career as a psychiatrist in the 1950s, first for the British Army and then, returning to his native Scotland, at the Glasgow Royal Mental Hospital. In his autobiography, *Wisdom, Madness, and Folly: The Making of a Psychiatrist*, Laing recalls that he entered the medical field not to learn about diseases and their treatment, as one might expect, but to uncover larger meanings about existence. He sought to "ferret out some sort of truth about what was going on in the human world" (66–67). Mental illness, with its mysterious lack of clear etiology and dearth of effective treatments, was an ideal place to ferret out truth. From the start, Laing had a romantic approach to mental illness[4] that was at odds with conventional psychiatry. He recalls feeling perturbed when psychiatrists would make remarks, allegedly, that "Hamlet was just a badly conditioned rat" or that King Lear should have received ECT as there was "no need for all that nonsense" (13–14). With a keen understanding of literature, he naturally understood that Hamlet's and King Lear's madness revealed truths about their circumstances and societies that would have been lost had they undergone modern treatment. Increasingly, Laing became disillusioned with the psychiatry that treated mental illness as an aberrant condition that needed to be fixed, and so he set out writing about the truth that mental illness could reveal.

Laing's focus from the beginning was schizophrenia. It is important to note at the outset that Laing is not referring to schizophrenia as it is understood today. Schizophrenia was defined more broadly in the 1960s. The *DSM-II*, published in 1967, refers to schizophrenia as a "large category" of "disorders manifested by characteristic disturbances of thinking, mood and behavior" (American Psychological Association 33). These disturbances include the

[4] Laing consistently denied the popular criticism that he romanticized mental illness, claiming in *Wisdom, Madness, and Folly* that he "never idealized mental suffering, or romanticized despair, dissolution, torture or terror" (8). Perhaps romanticization was not his intention but, as the rest of this chapter will demonstrated, it was the result.

"misinterpretation of reality," such as "delusions" and "hallucinations," a lack of empathy and emotion, and "withdrawn, regressive and bizarre" behaviour (33).[5] Laing, however, rejects even this broad definition for a vaguer and broader one. He first establishes in *Politics*: "In using the term schizophrenia, I am not referring to any condition that I suppose to be mental rather than physical, or to an illness, like pneumonia, but to a label that some people pin on other people under certain social circumstances" (103). He believes that "[t]here is no such 'condition' as 'schizophrenia,' but the label is a social fact and the social fact is a *political event*. This political event . . . imposes definitions and consequences on the labelled person" (121). Laing offers this alternative mystifying definition:

> Some people labelled schizophrenic (not all, and not necessarily) manifest behavior in words, gestures, actions (linguistically, paralinguistically and kinetically) that is unusual. Sometimes (not always and not necessarily) this unusual behavior (manifested to us, the others, as I have said, by sight and sound) expresses, wittingly or unwittingly, unusual experiences that the person is undergoing. Sometimes (not always and not necessarily) these unusual experiences expressed by unusual behavior appear to be part of a potentially orderly, natural sequence of experiences. (123)

In essence, Laing understands schizophrenia in the same way as the *DSM-II*—it involves unusual experiences and behaviours—but does not agree that it is a disorder. It may be helpful to understand Laing as using the term *schizophrenia* as shorthand for a particular set of unusual experiences diagnosed incorrectly as a disorder.

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[5] In contrast, the latest iteration of the *DSM*, the *DSM-5*, is far more specific in its diagnostic criteria of schizophrenia (which is typical of the *DSM-5* in general). To be diagnosed with schizophrenia, one must have two of five types of symptoms for a set period of time to a set degree of severity and have ruled out all other possible disorders. And the latter possibility is very likely: it lists seven alternative disorders that are considered to be on the "schizophrenia spectrum" but not schizophrenia itself (American Psychological Association).

His most revolutionary idea informing all of his works is simply: schizophrenia is intelligible. While psychiatrists at the time rarely held any consensus about the etiology of schizophrenia, the one aspect they agreed on was its unintelligibility. While mental illnesses like depression or hysteria could be connected to negative life experiences or genetics, the etiology of schizophrenia was unknown; the symptoms appeared to be entirely random, and schizophrenic speech was nonsense. Beginning with *The Divided Self*, Laing contends that schizophrenia is a logical reaction to untenable living conditions. Laing's goal, then, is "to make madness, and the process of going mad, comprehensible" (9). With the right Rosetta Stone, "psychotic 'hieroglyphic' speech and actions" (31) can be understood. Laing's argument here is that schizophrenia is the result of ontological insecurity, or an insecurity in being. Essentially, the schizophrenic, because of parental neglect in their infancy and childhood, becomes split between a true inner self and a false outer self. According to Laing, some children are born with an "inner deadness" that is often confused for a child being quiet, good-natured, and compliant (183). If the "inner deadness" of the child is ignored or encouraged, symptoms of paranoia/anxiety (he conflates these), catatonia, and depersonalization are all defences that the schizophrenic's outer self employs to protect their inner self. When this process goes too far, the true inner self is irretrievable, and what is seen as chronic schizophrenia is really "*a death-in-life existence in a state approaching chaotic nonentity*" (195). Since schizophrenia is therefore a logical result of an inability to exist in the world, Laing argues that empathy is paramount.

In his subsequent books, *The Self and Others* (1961) and *Sanity, Madness, and the Family* (1964, co-authored with his colleague Aaron Esterson), Laing does develop his theory on schizophrenia, exploring more aspects of its social origins. However, in these works he still maintains his belief that schizophrenia, while understandable, should still be treated. Thus, while

Laing's early works diverge from the medical model, they still operate under the psychiatric assumption that schizophrenia is aberrant.

As Laing was writing these early works, he was putting his empathetic approach into practice by working in psychiatric hospitals with patients. One particular anecdote illustrates his approach best. A schizophrenic patient was considered beyond all help, having been mute for months. When Laing saw her sitting on the floor naked and rocking back and forth, he mirrored her actions, also stripping naked and rocking beside her. This approach worked as the patient broke her mutism to speak with Laing (Kotowicz qtd. in Pickering 59). [6] While this approach seems helpful, this kind of equalizing interaction with patients was all but unheard of. It is significant, then, that in the mid-1950s, Laing formalized this therapeutic approach by opening a "Rumpus Room" in a psychiatric unit. In the Rumpus Room, the goal was for nurses to interact with patients without any power dynamics. According to Laing, this experiment was a success: the conduct, appearances, and self-esteem of the patients improved and the nurses "spoke warmly" of the patients (Laing qtd. in Gans 104). Eventually, Laing took this experiment a degree further with the founding of the Philadelphia Association in 1965. The Philadelphia Association, a cohort of like-minded colleagues with Laing at the helm, established and ran several buildings modelled on the Rumpus Room. The initial goal was similar: to create therapeutic environments where individuals who would otherwise be 'patients' and individuals who would otherwise be 'nurses' or 'doctors' could coexist without any formal power dynamics. In addition to the psychiatrists forgoing their positions of authority, their role was to allow schizophrenic people to wholly embrace and act out their symptoms rather than repress and manage them.

[6] What they spoke about was not recorded, only that they had a conversation.

The first and most famous of these buildings was Kingsley Hall. It is Laing's experiences in Kingsley Hall that inform and transform his theories in the late 1960s. Published seven years after *The Divided Self*, *The Politics of Experience* and its mystical theory of schizophrenia fully abandons any psychiatric vestiges that his previous work contained. While *Politics* seems drastically different from his earlier texts, Peter Sedgwick, in his criticism of Laing, astutely notes that *Politics* is the logical conclusion of his claim that schizophrenia is intelligible. Sedgwick rationalizes that Laing's seemingly sudden veneration of schizophrenia in *Politics* is "an inevitable move" that "sprang from his insistence that all human experience is potentially valid and potentially intelligible" (107). *The Divided Self* presents schizophrenia as intelligible to "a limited degree"; while schizophrenic symptoms are logical reactions, they are still negative reactions, so "we are left with the position that the schizophrenic is a disabled victim" (107). In *Politics*, therefore, the only way that Laing can succeed in "his campaign to upgrade the status of the apparently abnormal and insane," he must incorporate mysticism to argue that schizophrenic symptoms are logical *and* positive (107). This is a significant task given the disorienting and disruptive symptoms of schizophrenia. To account for this, Laing localizes insanity not in the schizophrenic but in their environment. And, importantly, it is not that their environment negatively causes schizophrenia but instead that schizophrenia is the only positive, sane response to an insane world.

It is not difficult to see why Laing viewed the world as insane, with white people desperately withholding even basic human rights from their Black neighbours, and men being drafted into the senseless Vietnam War, men who often had been previously drafted into World War II with its heinous crimes against humanity, and the dark shadow of the Cold War's threat of nuclear annihilation hovering over it all. In this world, it makes sense that Laing proposed that

it is now "normal" people, not schizophrenic people, who have adapted to an alienating, insane society by developing false outer selves; people without schizophrenia are "a product of repression, denial, splitting, projection, introjection and other forms of destructive action on experience" (*Politics* 27). By identifying society itself as insane, Laing's concept of sanity then becomes a "collusive madness" (73), a "pseudo-sanity" (144). Schizophrenic people, by not adapting to society, have actually maintained their sanity by not tolerating these insane conditions.

Laing does not deny that schizophrenia is a disturbing and alienating experience despite his glorification of it. Rather, he presents it as a tumultuous healing journey called *metanoia*. The term *metanoia* originates from the Greek New Testament, translating to, according to Laing, "a change of mind" ("Metanoia" 12).[7] If conducted correctly, a successful metanoia can transform a schizophrenic "breakdown" into a "breakthrough" (*Politics* 133). This breakthrough occurs if a schizophrenic person fully immerses themselves in their inner world. Once immersed, they will begin their journey, "experienced as going further 'in,' as going back through one's personal life, in and back through and beyond into the experience of all mankind, of the primal man, of Adam and perhaps even further into the beings of animals, vegetables, and minerals" (126). This journey is described rather abstractly as follows:

> What is entailed then is:
>
> (i) a voyage from outer to inner,
>
> (ii) from life to a kind of death,
>
> (iii) from going forward to going back,

[7] Laing first calls the schizophrenic journey *metanoia* in "Metanoia: Some Experiences at Kingsley Hall, London," a paper that was originally published a year after *Politics*. Although Laing only uses the generic terms "journey" and "voyage" in *Politics*, I will use Laing's retroactive term *metanoia* even when discussing his ideas in *Politics* to maintain consistency.

(iv) from temporal movement to temporal standstill,

(v) from mundane time to eonic time,

(vi) from the ego to the self,

(vii) from outside (post-birth) back into the womb of all things (pre-birth). (128)

He then reverses this list in his explanation of the return journey, emphasizing that metanoia ends with "an existential rebirth" (129). This journey, which appears to outside witnesses as having delusions, hallucinating, regressing, and otherwise acting "crazy," is in fact a method to dissolve the ego and recover essential truths about one's self and existence as a whole. Similar to razing a forest to allow for new growth, metanoia is "*a natural way of healing our own appalling state of alienation called normality*" (167). Laing primarily bases this theory on the experiences of one of his friends, Jesse Watkins, who underwent a schizophrenic breakdown that felt to him like a "fantastic journey" (154) and that helped him feel "that everything was so much more real than . . . it had been before" (166). His metanoia is detailed by Laing in the chapter, "A Ten-Day Voyage."

With this theory, Laing can account for the disturbing presentation of schizophrenia while still revering it—and revere it he does. Laing consistently uses grandiose language, describing schizophrenic people as the "lost explorers of the Renaissance" for whom "the light began to break through the cracks in our all-too-closed minds" (129). In his condemnation of how society Others schizophrenia with negative stereotypes and treatment, he ironically Others schizophrenia by portraying it as divine, mystical, and otherworldly. Rather than seeing those with schizophrenia as subhuman, as biological psychiatry might, he sees them as superhuman, the first people to "reach a higher stage of evolution" (158). By casting schizophrenic symptoms as a transcendental journey, schizophrenic people become de facto religious prophets. Laing

explicitly states that transcendental experiences, like metanoia, are "the original wellspring of all religions" (137), and so the schizophrenic is "the hierophant of sacred," "an alien," "a stranger signaling to us from the void," a "mad ghost," or one of the "demons and spirits" among us (133). In this new religion of schizophrenia, Laing, stating this in an interview, sees himself "as a priest of Asclepius" (Itten 129), the Ancient Greek god of medicine. Kingsley Hall was his temple and the residents there, Adrian Chapman explains, saw themselves as "early Christians finding asylum from the world's hostility," forming a new religion in "a site of spiritual renewal and discovery" ("Dwelling in Strangeness" 480). Understandably, this movement remained relegated to the Philadelphia Association's buildings, but this new religion of prophetic schizophrenia became a fertile site for authors to explore—including Kurt Vonnegut.

"Take a Trip with Billy Pilgrim"[8]

Before analyzing how metanoia functions in *Slaughterhouse-Five*, it is necessary to establish the similarities in Laing's and Vonnegut's foundations. As I discussed in the Introduction of this dissertation, I have not found any evidence that Vonnegut was aware of Laing before or while writing *Slaughterhouse-Five*. In spite of this, they both see mental illness and war as inextricably linked in remarkably similar ways.

Laing's argument in *Politics* cannot be separated from his antiwar beliefs; the alienation that causes insanity (both the insanity of "normality" and the perceived insanity of schizophrenic people) is in part because of the need to "rationalize our industrial military complex," a task so horrific that it requires a mental split (*Politics* 57). He even subtly links Jesse Watkins' schizophrenia and subsequent metanoia to his tumultuous experiences in the Royal Navy (146).

[8] Title prefacing the reviews of the novel in the 1971 edition of *Slaughterhouse-Five*.

This link of mental illness to war is unsurprising given the political climate of the time as well as Laing's early experiences as a psychiatrist for the Royal Army; it is obvious to associate mental suffering with witnessing and perpetrating inconceivable violence. For Laing, however, the real harm of war is that its "outrageous violence" creates alienation in society (13). Alienation, being "strangers to our true selves, to one another, and to the spiritual and material world" (13), is the real consequence of a violent, destructive society responsible for the unfathomably horrific wars of the twentieth century.

Vonnegut, too, portrays Billy's mental illness[9] as inseparable from his experiences in World War II. At the most basic level, Billy's experiences in the war are implied to be the cause of his becoming unstuck from time. But, more than this, the war becomes a part of the mental illness itself by virtue of Billy continually being transported back to it; the war is both cause and symptom. And, importantly, it is specifically the alienation caused by violence that contributes to Billy's mental deterioration. Vonnegut, like Laing, believes that alienation is the greatest ill in society, although he refers to it with the more colloquial *loneliness*. In a speech given after the publication of *Slaughterhouse-Five*, Vonnegut reports telling a politician that "the number one American killer wasn't cardiovascular disease, but loneliness" (*Palm Sunday* 186). He explains that people attempt to "fight loneliness" by joining a religion or, notably, the army (196). In Vonnegut's understanding, then, loneliness is both the impetus to join the army and, tragically, the consequence.

[9] I will refer to Billy's experiences as mental illness throughout this chapter. However, this is not making a claim to any particular diagnosis nor a statement that Billy's experiences are nothing more than symptomatic delusions. Mental illness here is used in a Laingian sense to refer to Billy's experiences of being unstuck in time. Vonnegut himself is remarkably ambivalent about labelling Billy's experiences as mental illness, which this chapter will later discuss. Under Laing's extremely broad definition of schizophrenia as unusual experiences expressed as unusual behaviour, Billy can also be considered to be schizophrenic in a Laingian sense.

The fight against loneliness is frequently recognized as the underlying concern in *Slaughterhouse-Five*. Kathryn Hume identifies the "absence of community" as one of the main reasons why "[v]irtually none of Vonnegut's characters enjoys life" (235). She specifically points to the characters' lack of indulgence in the "distractions" of the "middle-class world" as the cause of their "anesthetic, depressive condition" (235). This argument fits neatly with Laing's concept of pseudo-sanity; when someone like Billy Pilgrim is unable to adapt to pseudo-reality, their "madness . . . is an artifact of the destruction wreaked on them by us [society]" (*Politics* 144). Similarly, Kevin Brown explains why Billy's loneliness results in an inability to sanely adapt to the world. He argues that Billy's loneliness falls under what the sociologist Émile Durkheim, in his influential book, *Suicide: A Study in Sociology* (1897), calls *anomie*, or a "breakdown of dependence" that follows a "breakdown in society" where one can no longer depend on others (Brown 102). Brown believes that "Vonnegut wants to do more than simply show the horrors of war. . . . He also wants to remind the reader of the anomic alienation that existed in the society that came after that war" (107). This kind of existence is untenable, and so Billy attempts to adapt to *anomie* by, Brown states, creating "imaginary worlds," like Tralfamadore, "where he is loved and accepted" (105). Key to this argument is the point that Billy's imaginary worlds are created in order to solve his alienation rather than to simply escape the violence of war. For Vonnegut, like Laing, alienation creates conditions under which sane adaptation is impossible.

Thus far, it is clear that Billy exists in a society that Laing would deem necessary for a metanoiac transformation to take place in. Billy is also the ideal voyager, fitting the Laingian mould of the schizophrenic-as-prophet, a "hierophant of the sacred" (*Politics* 133). Lawrence Broer calls Vonnegut's protagonists "devious prophets" whose "mad escapist visions warn

against fatalism" (17), phrases which would not seem out of place in *Politics*. An overlooked aspect of *Slaughterhouse-Five* is that Billy, while initially mocked and reviled, does become a sensational prophet. Vonnegut alludes to this by making Billy's last name "Pilgrim," invoking a religious voyager on a journey to discover divine truths. In a select few passages, Billy preaches about his journey through space and time first on the radio (25), then in a newspaper article (26), eventually garnering large enough crowds with his "crushing popularity" to warrant police protection (141). Unlike the false prophets that would perpetuate pseudo-reality, Billy shares the "wonderful things" that Tralfamadorians want "to teach Earthlings, especially about time" (26). Billy is, as Laing would say, "a stranger signaling to us from the void in which he is foundering" (*Politics* 133). Billy's death as a martyr also enacts Laing's theory that "we feel impelled to rid him [the schizophrenic prophet], cleanse him, cure him" (133), either through psychiatric treatment or, in extreme cases, murder. Initially, Billy's death seems to be a mere result of Paul Lazzaro's vow to murder him. However, it is framed in the novel as martyrdom. Lazzaro blames Billy for Roland's death, when in reality it was the cruelty of the German soldiers who forced him to wear uncomfortable shoes that resulted in fatal gangrene. Lazzaro, unable to see war's "outrageous violence perpetrated by human beings on human beings" (*Politics* 13), instead blames Billy for what society has done. As Laing would argue in this case, Billy declares that Lazzaro is therefore "insane" (141). And, as the insane are wont to do, according to Laing, they rid the world of the sane—in this case, Billy, who understands that it is the world that is to blame for Roland's death. Billy, then, could be considered the ultimate exemplar of the Laingian schizophrenic prophet: martyred for truth-telling and disposed of by the insane.

With Billy Pilgrim aligning so closely with Laing's ideal schizophrenic and his environment matching the alienation that Laing writes of, a logical assumption is that Billy's trip

is a perfect example of metanoia. And, at first glance, it seems that Billy's metanoia is successful in healing him. In debating whether or not Billy heals, critics focus on the famous refrain, "so it goes." The phrase encapsulates the Tralfamadorian philosophy that death is meaningless. This philosophy hinges the Tralfamadorians' ability to travel through space and time. Since Tralfamadorians are not confined to linear time, a "dead person is in a bad condition in that particular moment, but . . . is just fine in plenty of other moments" (27). Given the significance of this phrase, written after the death of anything, from poisoned fleas on prisoners' coats (84) to the annihilation of the universe (117), the entire philosophy of the book seems to hinge on one's interpretation of it as either consoling or nihilistic. For critics who argue it is consoling, Billy's journey is then ultimately healing, a way to positively cope with the horrors he undergoes. Willis McNelly argues that because "[t]he sin of Dresden is so great that it will require an eternity to expiate," Vonnegut has created a journey of the "eternal present" to "accept the unacceptable" (126). By discovering the philosophy of "so it goes" on his journey, Billy is able to heal. Gail Landsman agrees with McNelly's argument, adding that "Billy's conception of time becomes the only perspective which will allow Vonnegut, and with him Western man, to face Dresden, and yet to still go on and find meaning and love in life" (991). For Landsman, this new approach to time is the creation of a new mythology. Laing's metanoia can also be seen as a new mythology: in a society where one is doomed to be alienated, metanoia is a new path to healing.

While McNelly and Landsman view the Tralfamadorian philosophy as solely a creation of science fiction, in that they do not view his journey as indicative of mental illness, Charley Baker et al. specifically point to Billy's madness as the key to the philosophy of "so it goes." For these authors, his "ethereal psychotic reality and journey inward" allows him to go "one step further than daydreaming or entering into his imagination for escape by stepping directly into the

alternative, existing within the utopian" (52). They continue, stating that while this might be considered psychosis by outsiders, Billy's journey "is a preferable reality to the horror within which Billy exists and has existed" (52). They believe that Billy's journey is an example of "pleasurable psychotic phenomena" that is directly resistant to "the atrocities" of war (52), a line of thought that is remarkably similar to Laing's. Similarly, Barbara Tepa Lupack states that it is "precisely his craziness—his getting unstuck in time—which allows Billy to come to terms with the far greater lunacy of the war and of his own postwar society" (177). She revealingly refers to his journey as a "pilgrimage" (177), again evoking a divine quest for truth. All of these critics articulate Billy's journey as something spiritual and, thus, Laingian: his journey is access to the eternal, a new mythology, a pilgrimage to hope.

This reading, however, is far from the only one. As Vonnegut himself said, the phrase "so it goes" "exasperated many critics, and it seemed fancy and tiresome to me, too" (*Palm Sunday* 269). In direct contrast to the theory that "so it goes" is indicative of healing, many critics argue that Vonnegut warns *against* adopting a nihilistic Tralfamadorian philosophy, and Billy's journey is an example of how *not* to heal. This non-healing theory hinges on the paradoxical fact that the healing theory is actually quite pessimistic: the only way that Billy is able to adapt to his violent society is by viewing death as entirely meaningless. Martin Coleman explains that, contrary to what has been said about the author, "Vonnegut is not a fatalist, cynic, quietist, or nihilist" (682) and in fact condemns those philosophies in *Slaughterhouse-Five*. Coleman builds on Peter Reed's argument that Vonnegut actually presents the reader with the horrors of Billy's philosophy: "'so it goes,' initially almost a shrugging acceptance of the inevitable, becomes a grim reminder meaning almost the opposite of what it says, and finally another more poignant kind of expression of the inevitable" (Reed qtd. in Coleman 694). Though Billy lacks any

connection to linear time, the "accumulated meaning" of 'so it goes' creates linear time for the reader; it has an "inescapably temporal aspect. . . . [I]ts meaning does not remain static and in fact grows as it recurs in the novel" (Coleman 694). This reading highlights how Vonnegut shows that Billy's journey is not an effective way to heal while providing the reader with the more favourable alternative: being grounded in linear time and confronting what Billy attempts to escape from.

To further the point that Vonnegut presents Billy's journey as a warning sign, Lawrence Broer points out that Tralfamadore is an anagram for "OR FATAL DREAM" (68). He argues that Tralfamadorian philosophy is "the very antithesis of Vonnegut's position. . . . Billy Pilgrim becomes the very embodiment of what Vonnegut has warned against for years. Insulated from pain, Billy has simply abdicated his humanity, trading his dignity and integrity for an illusion of comfort and security, and becoming himself a machine" (16). In a very Laingian turn of phrase, Broer attributes Billy's downfall to "the irreconcilable contrast in his life between an ideal world of beauty, justice, mercy, and peace, and that of the psychologically devastating accumulation of horrors that turn him into a dazed and disembodied scarecrow. This principle of ironic contrast . . . separates Billy from his sanity" (72). Interestingly, Broer actually analyzes Billy's mental state through the lens of *The Divided Self*: "Vonnegut tells us that the protagonists's [sic] withdrawal from the real world is 'a screen,' or what in psychiatry is called a 'mask,' a deliberately cultivated strategy of maintaining personal freedom by withdrawing behind some sort of protective shield, and putting another, false self forward" (15). The notion of a "false self" is what Laing based his idea of pseudo-sanity on. In other words, Broer not only argues that Billy's journey is antithetical to healing but that Billy is an example of pseudo-sanity, of an adjustment to an insane society.

If it is unclear whether or not Billy successfully undergoes a healing metanoia, then this is the point. There is just as much evidence for Vonnegut supporting the Tralfamadorian philosophy and journey as a means to heal as there is against it. However, when specifically looking at Billy's journey as an example of successful or unsuccessful metanoia, the point could be made that it was unsuccessful because Billy simply did not do it according to Vonnegut's instructions: namely, in a setting like Kingsley Hall with people, such as Laing, to support them. I am not concerned with whether or not Billy successfully follows a Laingian metanoia. What I am suggesting is that Vonnegut portrays something akin to metanoia that is more expansive and ambiguous than Laing's conception of it. To further complicate the notion of metanoia before suggesting its capabilities in literature, I turn now to a third narrative of metanoia.

Accounts of a Journey Through Madness

While Laing bases his explanation of metanoia in *Politics* on Jesse Watkins, who relates his experiences nearly three decades prior, the only account of successful metanoia is Mary Barnes.[10] Barnes was the first resident of Kingsley Hall, moving there in 1965. While Laing does not mention her in *Politics*, she is extensively discussed (though not named) in his subsequent article, "Metanoia." Here, he presents her story as one fulfilling nearly every aspect of metanoia that he outlines in *Politics*. During her prior career as a nurse (a detail which happens to indict the medical field as a cause of mental illness), Laing writes that she "lost herself" and "felt that she had to go back to where she had lost herself in order to find herself again, and that *only* by

[10] Advocates of Laing's therapeutic methods often suggest that many more people were cured by metanoia. After all, the rehospitalization rate of Kingsley Hall patients was only 29%, implying that 71% of them were never hospitalized again; however, Peter Sedgwick explains that this number may be so low because there were no follow-ups conducted, meaning that many may have been hospitalized again years later or potentially were still struggling and simply received no further treatment (137). Additionally, Sedgwick notes that psychiatric institutions at this time did not have rehospitalization statistics, so Kingsley Hall's numbers may have been comparable to them (137). In any case, there are no other accounts of patients, Laing's or otherwise, successfully undergoing metanoia.

going back might she possibly find herself and be able to live in a way that was not false" (17). Once at Kingsley Hall, she "quickly went completely into a very full regression," which meant needing to be bottle-fed, covering herself with feces, and nearly starving to death (17–18). According to Laing, this regression meant that she returned "not only to prebirth, but to pre-incarnation" (18). After a voyage of five or six weeks, she slowly "came back" by seeming to mentally age until she was healed (18). As Laing writes it, Barnes seems to be exemplary of metanoia's process toward a positive outcome. Thus, it could be argued that Billy Pilgrim may not have successfully healed from metanoia because he, unlike the star pupil Mary Barnes, did not regress fully under the care of the Philadelphia Association.

However, a closer look into Barnes's case reveals that Laing's telling of her metanoia is a carefully crafted narrative designed to fit his own theory. We have access to alternative narratives from Barnes's psychiatrist, Joseph Berke, and Barnes herself in their coauthored memoir, titled *Mary Barnes: Two Accounts of a Journey Through Madness* (hereafter *Two Accounts*) (1971). The memoir is a fascinating text, alternating between more traditional memoir-like sections by Barnes and clinical explanatory sections by Berke, with Barnes's sections taking up a larger portion of the text. Though the basic details are the same in both, the interpretations are starkly different from one another and Laing's. Berke, a more traditional psychoanalyst focusing on sexuality, understands mental illness to be "emotional suffering brought about by a disturbance in a whole field of social relationships. . . . '[M]ental illness' reflects what is happening in a disturbed and disturbing group of people" (78). In particular, Berke narrows in on Barnes's repressed sexual feelings as the cause of her breakdowns. He explicitly acknowledges that this interpretation is not one that Barnes shares: "Mary sees her 'going down' and 'return' as a spiritual journey rather than as a sexual struggle" (349). However,

he does not see these different interpretations as "incompatible" since they both argue that her schizophrenia "*is not unintelligible*" (349), which is, of course, also compatible with Laing. As Berke explains, Barnes's interpretation is deeply religious, based on her Catholic background. She believes that "madness is a purification," quoting her as saying that, for her, metanoia from madness "brings [her] nearer to God, to [herself], helps [her] to a more conscious awareness of God, to a fuller participation in the sight of God" (351). Her interpretation is therefore more aligned with Laing's than Berke's, albeit through a Catholic lens rather than Laing's pantheistic approach.

Barnes's description of what her metanoia entailed is, however, much more similar to Berke's than Laing's. This difference between Barnes's description and Laing's is more than just narrative choices: Laing changes basic and essential details. The first main difference is in the timeline of metanoia. Adrian Chapman notes that Laing implies in the chapter titled "A Ten-Day Voyage" that "madness might be a brief, recuperative, self-healing voyage" ("Dwelling in Strangeness" 473), a trip that could be taken on one's time off, perhaps. Laing amends this timeline in "Metanoia," explaining that Barnes's metanoia actually took "five to six weeks" (18). This is still, at best, a stark omission of truth as both Barnes and Berke reveal that she underwent several metanoias over the course of five *years*, not five weeks.[11] The second difference between Laing's and Barnes's narratives is in, put crudely, the degrees of how gross they are. In *Politics*, metanoia is portrayed as frightening, certainly, but not disgusting. "Metanoia" shifts from this very slightly, adding two lines about Barnes covering herself with feces and needing to have her feces "digitally removed" at one point (17). Even so, this line does not communicate the

[11] It should be clarified that Laing originally published this article in 1968, so he could not have known that Barnes would continue to undergo metanoia for an additional two years. However, he would have been aware that Barnes had been in and out of metanoia for three years at the time of publication and neglected to mention that she went in and out of metanoia dozens of times. He describes only one journey.

magnitude of Barnes's obsession with feces and other socially taboo topics. In nearly every chapter, Barnes unabashedly describes "playing with her shits" (26) in almost loving detail as a part of her regression and discusses how her journey forced her to confront incestuous feelings toward her brother and father. All of this is completely omitted from Laing's narrative, portraying metanoia as cleaner, neater, and nobler than the reality that Barnes depicts.

Elaine Showalter's analysis of metanoia reveals one possible reason why Laing may have been incentivized to portray metanoia as "archetypically epic, heroic, and masculine, a psychic pilgrimage more exotic and perilous than the voyages of Ulysses or Kurtz" (*The Female Malady* 230). For Showalter, it was Laing's dedication to casting metanoia as a patriarchal narrative that resulted in him rewriting the real story. Indeed, he compares metanoia to the voyage of Columbus and the climbing of Mount Everest, which Showalter argues is based "upon his own heroic fantasies" and experiences climbing mountains in Scotland (237). Showalter even suggests that Laing was disappointed by Barnes's metanoia since the reality of spending "three years changing diapers, giving bottles, and generally wiping up after a noisy, jealous, smelly, middle-aged woman" did not quite match the "male adventure of exploration and conquest" that he envisioned (236). Showalter connects this to Laing's desire to erase how Barnes's experiences as a woman contributed to her mental illness and recovery but also notes that Laing imposes his narrative onto Jesse Watkins, a man (230). While "A Ten-Day Voyage" is largely comprised of an interview with Watkins, he interjects throughout Watkins's narrative with his own interpretation of the events, construing it as far more spiritual than Watkins does and notably adding the need for a "physician priest" to assist, despite Watkins not having had one (230). By attempting to fit metanoia into a patriarchal framework with himself as the head patriarch, Laing crafts his narrative carefully to omit any details that sully or weaken it.

Adrian Chapman makes a similar argument to Showalter about the difference between Barnes's "prosaic" journey and "Laing's quasi-Conradian voyage" ("'May All Be Shattered'" 208). Chapman highlights how *Two Accounts* shows a much more "fractious" and confining Kingsley Hall with traditional doctor/patient roles than Laing ever admits to (208). As Barnes and Berke show, Kingsley Hall was "beset by quite ordinary problems," such as rent and how to coexist as roommates, which was "far from Laing's poetic fantasy" (219). The process of recovery was also decidedly less divine than Laing makes it out to be. M. Guy Thompson, a psychoanalyst who worked in a Philadelphia Association building,[12] reveals that one resident refused to leave his room for six months. He filled the house with the "stench of his incontinence," shrunk down to ninety pounds after consistently vomiting up the little food he was forced to eat, and was eventually moved from his room after developing bed sores (Thompson, "Post-Kingsley Hall Households"). Again, this filth and commonplace peril are neatly left out of any of Laing's descriptions. Correspondingly, Barnes reveals that she was physically assaulted by Berke himself, calling him "rather a brute" (131). Of course, Laing had self-serving cause to hide the often disastrous reality of Kingsley Hall. Barnes had no such reason to protect Kingsley Hall, especially as it had been shut down by the time of the book's publication. In any case, stories about metanoia that were not published by Laing show that the reality of undergoing metanoia was far more like Billy Pilgrim's journey than the heroic adventure narrated by Laing.

Chapman notes one other crucial difference between Laing and Barnes: for Laing and his colleagues, Kingsley Hall was an experiment; for Barnes, it was her "last chance" ("'May All Be Shattered'" 219). Barnes's last chance to heal, fortunately, was successful. *Two Accounts*

[12] After Kingsley Hall's lease ended, Laing and the other members of the Philadelphia Association set up several buildings modelled on Kingsley Hall.

concludes with a triumphant art show put on by Barnes, her creativity serving as proof of her healed mind. Laing, Berke, and Barnes herself attribute this healing to her metanoia. Adrian Chapman, however, astutely observes that Barnes's healing concluded not with the art show but with the writing of *Two Accounts*. Chapman demonstrates how creativity had always been essential to Barnes's healing as she was able to "symbolize her rage and guilt through religious painting and brief therapeutic narratives" ("'May All Be Shattered'" 208). In fact, Laing includes one of her creative short stories at the end of "Metanoia" as an example of how metanoia was healing for her. Her stories read like fairy tales, portraying the process of breaking down and healing through folkloric imagery. Chapman notes that these stories are "a foreshadowing of the therapeutic significance of Barnes's writing of her *Two Accounts* narrative" (216). For Chapman, the reason why writing *Two Accounts* was healing is because the act of writing restored her subjectivity, a subjectivity that was previously stolen by passively being written about as the miraculous proof of metanoia. By writing her own story and strongly stating her own interpretation of her journey, Barnes is no longer relegated to anonymous third-person case studies. Her account is rawer and messier than Laing's, but, more importantly, it is hers. An understanding of her metanoia, then, is not complete without recognizing the crucial component of *writing* metanoia.

Writing Metanoia

It might be tempting to end the argument here: Billy Pilgrim's metanoia aligns more with Barnes's realistic narrative rather than Laing's heroic narrative, demonstrating that Laing overlooks the gritty reality of mental illness journeys. However, even if Laing got the formula wrong, he got the answer right: both Vonnegut and Barnes found healing through the act of

writing metanoia. Vonnegut himself understands writing, especially the writing of *Slaughterhouse-Five*, as a necessary and healing experience. When asked in an interview if his books "have been therapy" for him, Vonnegut replied, "Sure. That's well known. Writers get a nice break in one way, at least: They can treat their mental illnesses every day" (Standish qtd. in Allen 109). Vonnegut only ever spoke of his need to heal mental illness through writing, and indeed his mental illness in general, in these indirect ways. In a letter to Broer, who studies schizophrenia in Vonnegut's works, Vonnegut clarified that he is mentally ill but not schizophrenic: "I haven't ever hallucinated, or been hospitalized or incapacitated for mental illness of any sort. I have been profoundly depressed, but have always been able to keep working somehow. [In] a study of established writers, . . . myself included, . . . [we learned] we were all depressives—from families of depressives. There was scarcely an hallucinator in the lot" (19). Vonnegut wrote elsewhere that he was prescribed Ritalin and began attending therapy for depression not long after the publication of *Slaughterhouse-Five* (*Wampeters, Foma & Granfalloons* 253). Some scholars have suggested that Vonnegut would now qualify for a posttraumatic stress disorder (PTSD) diagnosis, and the only reason he alludes to schizophrenia in the novel and depression for himself is that PTSD was not included in the *DSM* until 1980 (Wicks; Czajkowska).[13] Vonnegut's exact diagnosis is not necessarily important here: diagnostic categories are everchanging. Vonnegut may have been perceived as schizophrenic by Laing in the 1960s, as he certainly had unusual experiences that he expressed in an unusual way (that is, writing this novel); once the *DSM-III* was published in 1980, he may have been diagnosed with

[13] Amanda Wicks states that Vonnegut had "symptoms consistent with having undergone a traumatic experience," symptoms that would now be classified as PTSD (330). Aleksandra Czajkowska extends this notion of Vonnegut's "misdiagnosis" to Billy: "Referencing schizophrenia is an obvious attempt to find the right words to describe Billy's condition, and Vonnegut's confusion must have been amplified by the fact that no medical discourse on PTSD existed yet" (63).

PTSD. What is important here is that Vonnegut experienced mental illness, however it might be categorized, and, as I will discuss, wrote in order to heal from it.

As this dissertation has shown thus far, the therapeutic benefits of writing are so widely known[14] that the mechanism behind why it is therapeutic is often not interrogated. Vonnegut himself never expands on how or why writing was healing for him—it simply was. Amongst scholars, however, there are two popular theories on why writing Billy's journey was healing for Vonnegut: the ability to split oneself and the power of trauma writing. In both of these theories, it is specifically Vonnegut's choice to put Billy, and not himself, on a time-bending and space-jumping journey that creates healing.

The first theory posits that Vonnegut is able to heal through writing *Slaughterhouse-Five* because, put simply, it is a novel and not an autobiography. Though Billy Pilgrim lives through the same events as Vonnegut, Vonnegut takes care to make Billy the protagonist. Since Vonnegut establishes himself as a narrator and character in the very first lines of the novel, readers are discouraged from seeing Billy as a stand-in for Vonnegut (as readers so often do with Esther Greenwood/Sylvia Plath and Deborah Blau/Joanne Greenberg). Taking a metafictional approach allows Vonnegut to separate himself from Billy's experiences. Kathryn Hume notes that Vonnegut's own reactions to the events are never directly stated; they are only ever peripherally shown through "talking of his drinking jags and his return to Germany for a visit" (226). She theorizes that this separation was the only way that Vonnegut was able to write about Dresden. Vonnegut works around being unable to articulate his own reactions "by splitting narrative focus" and casting Billy as the one "whose emotional fuses are blown by the experience" (226). Vonnegut's presence in the text is carefully controlled and Billy, as Broer

[14] See Annette Krizanich's summary of this research, as discussed in Chapter One.

articulates, "becomes Vonnegut's scapegoat, carrying the author's heaviest burden of trauma and despair" (68). For Broer, this "symbolic amputation" of Billy from himself "saved his [Vonnegut's] own sanity through the therapeutic processes of art" (74), resulting in a "rebirth" (68). The theory that Vonnegut heals through writing by splitting himself is eerily akin to Laing's theory of the divided self, in which schizophrenic people protectively split between an outer mask and inner world. And, of course, Laing later developed his theory in *Politics* to suggest that retreating to the inner world is the starting point of metanoia. This reading of *Slaughterhouse-Five* suggests that Vonnegut is able to accomplish this split through writing rather than through schizophrenia by splitting himself between an outside narrator and Billy Pilgrim as the inner voyager.

However, the question may be asked: would it not have sufficed to write a linear narrative through Billy's eyes? Why did Vonnegut need to write about a journey through space and time? At first, a linear narrative is what Vonnegut attempted—for more than two decades. In a 1974 interview, Vonnegut explains his struggles with this:

> I came home in 1945, started writing about it, and wrote about it, and *wrote about it*, and WROTE ABOUT IT. This thin book [*Slaughterhouse-Five*] is about what it's like to write a book about a thing like that. I couldn't get much closer. I would head myself into my memory of it, the circuit breakers would kick out; I'd head in again, I'd back off. The book is a process of twenty years of this sort of living with Dresden and the aftermath. (Bellamy and Casey qtd. in Allen 163)

In another interview, Vonnegut clarifies that Billy's otherworldly journey was necessary to overcome this mental block. When an interviewer asked him if he had first attempted to "deal with the subject on a purely realistic level," Vonnegut replied that he "couldn't, because the book

was largely a found object . . . [and] one of the characteristics about this object was that there was a complete blank where the bombing of Dresden took place. . . . There was a complete forgetting of what it was like" (*Wampeters* 263). Because of the traumatic nature of the subject, Vonnegut was psychologically unable to write a linear, realistic narrative; Billy's journey had to bend time and space because Vonnegut's memories did.

The framework of trauma theory, then, informs the second theory of why writing was healing for Vonnegut. Trauma theory posits that traumatic memories are inaccessible through language; after a traumatic event, people are often unable to articulate their experiences, even to themselves. Trauma theory scholars trace this inability to speak about traumatic events to how the brain processes or, more accurately, does not process trauma. In her analysis of trauma in *Slaughterhouse-Five*, Amanda Wicks explains that "traumatic events circumvent the cerebral cortex, which assists in defining and interpreting," so that it is nearly impossible to discuss trauma "by means of language" (329). For therapists, whose therapies are often language-based, this poses a unique problem. To bypass the issue, most trauma therapy is somatic-based, avoiding language altogether.[15] However, there is an exception. Literary scholars have gained considerable traction in trauma-theory scholarship with their unlikely therapeutic underdog: literature.

In her history of trauma theory, Nicole A. Sütterlin identifies three pioneers who brought trauma theory to literary studies in the 1990s: Cathy Caruth, Shoshana Felman, and Dori Laub. She cites Geoffrey Hartman's famous articulation of their work: "A theory emerges focusing on

[15] In *The Body Keeps The Score: Brain, Mind and Body in the Healing of Trauma*, arguably the most popular self-help book on healing trauma, Bessel van der Kolk primarily recommends *Eye Movement Desensitization and Reprocessing* therapy, yoga, and mindfulness, none of which involve language. Just one chapter discusses writing, and it is focused on how to somatically rewire the connection between brain and body so that writing can eventually be made possible. This book is indicative of the current modality of trauma therapy: to first heal the body with the hope that the mind will follow.

the relationship of words and trauma and helping us to 'read the wound' with the aid of literature" (Hartman qtd. in Sütterlin 18). Sütterlin notes that these scholars were focused on the interrelationship of "wounds" and "words" as they began to investigate how literature might provide a unique opportunity to express otherwise inexpressible trauma. The central focus of trauma theorists in literature is the study of figurative language as a means to evoke traumatic memories rather than access them directly. Joshua Pederson explains that "if non-literary language tries to pinpoint trauma and fails, literature gestures toward or evokes trauma and sometimes succeeds" (98). Pederson has devised a now widely adopted framework for the three main literary devices that are used when writing about trauma: 1) absence, which involves gaps in the narrative, often eliding or excising the traumatic event; 2) indirection, such as metaphors or general comparisons to the traumatic event without actually stating it; and 3) repetition, when a text returns to the traumatic event ad nauseum, usually with absence and indirection involved. All of these techniques point to the same phenomenon: literature can express trauma by, paradoxically, not expressing it. By leaving glaring gaps in the narrative, which ironically draw the reader's attention to that which is left out, making comparisons to the traumatic event, and constantly circling the traumatic event, the trauma is evoked without ever directly stating it.

In *Slaughterhouse-Five*, then, it is precisely Billy's complex, event-dodging, memory-avoiding journey that makes it possible for Vonnegut to write *around* the traumatic experiences. Wicks conceptualizes Billy's time travel as a clever literary structure to show the reader how traumatic memory functions as flashbacks. With time travel, Vonnegut can "create a more accessible tale to explain why . . . [Billy] randomly and unwillingly travels from past to present to future, often revisiting painful moments in his life" (335). By "mov[ing] into the realm of unreality," Vonnegut avoids needing to "transform an inconceivable experience into language"

(339). Of course, the most inconceivable experience is the night that Dresden was bombed. Alberto Cacicedo, in his trauma-theory analysis of the novel, identifies this as the "central traumatic moment" that "Billy constantly circles around . . . almost recollecting it but, as is typical of traumatic memories, not quite managing to seize on the moment" (363). The most direct description of the bombing of Dresden has layers of opaque distance: Billy watches a barbershop quartet whose facial expressions remind him "shimmeringly" (*Slaughterhouse-Five* 177) of when he watched the faces of guards witnessing the bombing. Nil Santiáñez describes Vonnegut's non-descriptions of Dresden as a "narrative voiding of the event" (414). Using "the language of silence," which involves leaving "gaps" in the narrative for the readers "to mentally add words in order to make up for those purposefully left unsaid by the author," Vonnegut is able to conjure up the traumatic event without ever directly describing it (418). Because "the language of silence" is only possible in literature, then, writing provides the unique opportunity for Vonnegut to articulate his experiences.

Santiáñez further argues that this writing process parallels, and in turn drives, the healing process: "the articulation of a void within a narrative first, and the readers' filling in the gaps later, mirror the healing process, through the reconstruction of the story of the traumatic event, in traumatized people" (418). Vonnegut expresses the healing power of this process in a 1973 interview:

> I felt after I finished *Slaughterhouse-Five* that I didn't have to write at all anymore if I didn't want to. It was the end of some sort of career. I don't know why, exactly. I suppose that flowers, when they're through blooming, have some sort of awareness of some purpose having been served. . . . At the end of *Slaughterhouse-Five,* I had the feeling that I had produced this blossom. So I had a shutting-off feeling, you know, that I had done

> what I was supposed to do and everything was OK. And that was the end of it. I could figure out my missions for myself after that. (Standish qtd. in Allen 107)

Although Vonnegut never interrogates why *Slaughterhouse-Five* specifically gave him this profound release, trauma theory reveals one possible answer: writing a journey that can twist and turn back and forth through time and in and around memory gaps is the closest that Vonnegut could get to expressing his traumatic experiences.

In both of these theories about why writing was healing for Vonnegut, the common denominator is that it is the writing about Billy's journey, rather than going on the journey itself, that is healing. Vonnegut did not need to undergo metanoia—only write about it. Both of these theories centre on Vonnegut's literary distancing techniques which allowed him to avoid directly confronting the events; writing allows for evasion. Building on these theories, I posit a third theory: that writing is healing because it specifically allows for the evasion of *truth*, that is, the definitive knowledge that Laing proposed is discoverable through metanoia. Vonnegut is very explicit about the lack of truth in the novel, beginning in the very first line: "All this happened, more or less" (1). It is the "less" that is significant. In *Slaughterhouse-Five*, the lack of linearity surrenders any claim to coherent meaning, which is imperative given that Vonnegut does not have a coherent meaning. As the narrator states, "[This book] is so short and jumbled and jangled . . . because there is nothing intelligent to say about a massacre. Everybody is supposed to be dead, to never say anything or want anything ever again" (19). This statement is not dramatic hyperbole for the sake of the novel. Vonnegut was once asked to speak at a showing of a documentary about war crimes, including the Dresden bombing, and "contribute . . . [his] notions as to the meaning of it all" (*Palm Sunday* 274). Reflecting on this, Vonnegut tersely writes: "Atrocities celebrate meaninglessness, surely. I was mute. I did not mount the stage. I went

home" (274). Within and beyond the novel, Vonnegut explicitly states that there is no meaning to be found in it; all that can be said is "so it goes."

Despite this, scholars have attempted to mine the novel for a singular meaning, asking questions about even the basic plot structure: does Billy "really" travel to Tralfamadore and through time or is he merely experiencing delusions? Does Vonnegut encourage the "so it goes" philosophy or disparage it? Each conclusion is presented with a wealth of convincing evidence and yet, somehow, each conclusion is irreconcilable with the others. It seems to be that all readings of the novel are equally true, and therefore also equally untrue. Martin Coleman articulates this best when he explains that Vonnegut "declares no doctrine; he invites the reader to glean what insight he or she can from the immediate experience of the work" (693). For Coleman, this reading experience, where the meaning is not provided to the reader, mirrors the experience of war: "the conflict, the absurdity, the isolation, the violence done to reason and understanding" are all parts of "the author's experience," in turn experienced by readers (693). The novel, then, cannot provide truth to the reader because its truth is, paradoxically, that there is no truth.

For Vonnegut, then, literary metanoia is healing because Billy's journey evades truth and meaning. This is directly oppositional to Laing's claim that the function of metanoia is to take the schizophrenic person from incoherent non-meaning through to a discovery of truth and, therefore, coherent meaning. Interestingly, Alison Torn argues that Barnes herself also healed because literary metanoia allowed her to evade truth. Torn explains that the aim of therapy has long been to find "coherence in both narrative and identity," and thus narratives that lack linearity and meaning (called incoherent narratives, in that they are difficult for readers to follow) are seen as a barrier to healing (131). Laing, for one, is clearly operating under this

assumption. However, Barnes's narrative is healing in spite of, and indeed because of, its incoherence. Torn points out that Barnes experiences crisis moments that disrupt her linear progression and drastically shift her narrative. These are the moments that Laing omits from his narrative because, presumably, he assumes they are nonsensical or failures. However, Torn argues that Barnes's "returns to former states" are actually "progression" since suffering is not a step backwards but "part of the transformation" (144). The only reason why a non-linear narrative, such as Barnes's narrative in *Two Accounts* or Billy's in *Slaughterhouse-Five,* is perceived as non-healing is because they are "inaccessible to others" (147). I would add to this that they are inaccessible largely because they surrender a claim to truth. When a journey that is as horrifying as Billy's or as uncomfortable as Barnes's does not reach its pinnacle, with no Mount Doom to throw a ring into nor ninth circle of Hell to leave the Devil imprisoned in, the reader is left with the frightening realization that they are without a guiding map should they embark on a similar journey. However, it is precisely the abandonment of providing a map that allows Vonnegut and Barnes to write about their journeys and heal. Torn's argument demonstrates that, though potentially inaccessible, the incoherency of a narrative does not preclude healing, and a narrative should not be forcibly twisted into a more accessible, linear framework for healing to begin. Indeed, to do so is to ignore the healing potential of allowing a narrative to be seemingly incoherent.

Thus far, mental illness has been peripheral to my discussion by virtue of the texts I have discussed: both Vonnegut and Laing are much more concerned with the experiences that happen to be labelled mental illness than a direct discussion of what the label *mental illness* means. Returning to it now, I suggest that Vonnegut's evasion of truth is also necessary as he refuses to subscribe to a single interpretation of mental illness. Evading any one interpretation is done

rather subtly in *Slaughterhouse-Five*. Characters label Billy as "crazy" several times, but the only instance in which a cause is identified is when Billy is admitted to a mental hospital. The psychiatric interpretation is then shrewdly mocked. In a book where it is clear that Billy's mental state cannot be extricated from the war, the psychiatrist's suggestion that Billy's craziness did not have "anything to do with the war," and is instead because of being thrown in the deep end of a pool and taken to the Grand Canyon (100), is absurd. The book does not, however, ever explicitly state an alternative cause to the psychiatric one. While it is clearly related to the war, the exact mechanism of how war causes mental illness is never stated. Just as Vonnegut evades explaining the meaning of Billy's experiences, he also evades defining the cause or meaning of his mental illness.

Looking beyond the novel, it is clear that Vonnegut ambivalently holds both biological and sociological understandings of mental illness in tandem. In a lecture to the Mental Health Association, Vonnegut explains that after his son was hospitalized with schizophrenia, he learned "never to romanticize mental illness" since it "is an internal chemical catastrophe. It is a case of monstrously bad genetic luck, bad luck of a sort encountered in absolutely every sort of society" (*Palm Sunday* 222–23). Eventually, Vonnegut also sought biological treatment for his depression, as I have mentioned, writing that Ritalin "really impressed" him, and by speaking with a doctor and "trying to understand . . . [depression's] nature," he discovered that "an awful lot of it is physiological" (*Wampeters* 253). However, in that same lecture, he qualifies this by saying, "I believe that a culture, a combination of ideas and artifacts, can sometimes make a healthy person behave against his or her best interests, and against the best interests of the society and the planet, too" (*Palm Sunday* 223). For Vonnegut, then, biology accounts for "an awful lot" of mental illness while it is also "sometimes" caused by culture. These paradoxes, as

with the paradoxical potential meanings of the novel, are allowed to exist simultaneously in *Slaughterhouse-Five* because the journey structure of the novel allows for it. Vonnegut's point is that there is no one definition or understanding; he seeks not an answer, but a question: why must mental illness be defined? A lack of truth is not just an expression of trauma but a statement on its nature: it cannot be captured. And, in literature, it need not be captured.

Laing and Literature

In the novel, Billy's fellow patient, Eliot Rosewater, shows Billy a copy of Kilgore Trout's *Maniacs in the Fourth Dimension*. Trout's book "was about people whose mental diseases couldn't be treated because the causes of the diseases were all in the fourth dimension, and three-dimensional Earthling doctors couldn't see those causes at all, or even imagine them" (104). Billy, of course, experiences the fourth dimension through his space and time travel. Why, then, does Billy never discover the causes of mental diseases or treat them? Using Vonnegut's notion of the fourth dimension as a helpful framework, I suggest that the reason for this lack of discovery is that literature is the fourth dimension. Metanoia can only be literary, a point that Laing never consciously acknowledges. To close this chapter, I will highlight the importance of literature in Laing's theories and closely read Laing's own literary text to argue that he inadvertently suggests that metanoia is only possible through literature, as it allows for the evasion of truth.

From Laing's earliest writings, literature is inseparable from his theories. It is not often remarked upon that he first identified metanoia not through witnessing it in a patient but by reading a written account of it. Showalter explains that the most significant source of his theory was an analysis of an autobiography by John Perceval, a schizophrenic man from the mid-

nineteenth century. This autobiography was republished as *Perceval's Narrative* by Gregory Bateson, though he could have called it *Bateson's Narrative*; as Laing did with Watkins and Barnes, Bateson inserts his interpretation of Perceval's schizophrenia as a voyage from reality and back again (*The Female Malady* 229). The original metanoia was a narrative about a schizophrenic experience. Laing frequently bases his theories on literary texts and analyses. His definitions of ontological security and insecurity, the foundation for his argument in *The Divided Self* and beyond, are based on a literary critic's analysis of the works of William Shakespeare and Franz Kafka (39–40).[16] He frequently "proves" his theories with the sole evidence that literary characters are exemplary of them, such as Estragon and Vladimir from Samuel Beckett's *Waiting for Godot* demonstrating ontological insecurity (40–41). Literature is used as the foundation and proof of his theories, and, moreover, his works read like literary texts themselves.

As Anthony David writes in the introduction to the 2010 edition of *The Divided Self*, "Laing proved that a sensibility to poetry, art and philosophy was not only not incompatible with psychiatric practice but also a positive boon" (xi). Many readers read Laing solely for his literary skill. In an article reflecting on her literary career, renowned fiction author Hilary Mantel attributes her inspiration to become a writer to Laing's works, particularly *Sanity, Madness, and the Family*, co-authored with Aaron Esterson ("Author Author"). One case study from the book begins with a description of the patient's home in a way that is difficult to distinguish from a novel: "Inside the Blair house time has stood still since before the turn of the century. The front garden is overgrown with a profusion of trees, plants, weeds. The inside is stuffy and dark. The living-room and front parlour are cluttered with Victorian and Edwardian bric-à-bac" (36).

[16] Lionel Trilling argues that Shakespeare's characters suffer but feel "alive and complete" (what Laing calls ontologically security), making their suffering less horrific, while Kafka's characters suffer and are also "stripped of all that is becoming to a man" (what Laing calls ontologically insecurity), which is a far worse state (Trilling qtd. in Laing, *The Divided Self* 40).

Mantel perceptively describes these case studies as "vivid, direct, gripping. . . . Each interview is a novel or play in miniature" ("Author, Author"). This style is not inconsequential or an odd quirk; Laing's use of literature in his arguments as well as his literary style of writing was the key to his appeal and success. *Politics* was actually only accepted by its second reviewer solely for its literary qualities after having been rejected by a medical reviewer (Chapman, "Dwelling in Strangeness" 488). The book's style, and not necessarily its content, allowed for its publication and spurred its success. Showalter argues that this quality is Laing's legacy: "If Laing's work lasts it will not be in the realm of psychiatric practice or social style, but in art and literature, where it may provide instructive images and tropes for other imaginations. Laing created himself out of images and books, and to images and books he has returned" ("R. D. Laing" 127).

While it is true that Laing never articulated metanoia as a literary endeavour, he does address the power of writing in his work. In *Politics* in particular, he extols the power of poetry to uniquely create meaning in an alienated society. He explains that our default state is a "point of nonbeing" which is "at the outer reaches of what language can state" (40). Therefore, because we naturally exist in this void, using language to create meaning is to create "something *out* of nothing" (40). Laing's emphasis on the word *out* indicates that language is a kind of escape from the void, a journey outward, so to speak. While this argument about language alone is not uncommon, Laing specifically identifies *literary* language as necessary to escape from this point of nonbeing. He argues that while "one cannot put a sound to soundlessness, or name the unnameable," language in poetry "can be used to convey what it cannot say—by its interstices, by its emptiness and lapses, by the latticework of words, syntax, sound and meanings" (41). This, of course, is what trauma theory posits: literary language, through its ability to talk around something, can express the inexpressible. The reason why I believe this is connected to metanoia

is because Laing uses the metaphor of the journey to speak about this ability. In discussing literary language in poetry, he explains that words have the goal of "recaptur[ing] personal meaning in personal time and space from out of the sights and sounds of a depersonalized, dehumanized world" (43–44), which is the same goal as one embarking on metanoia. Like an individual undergoing metanoia, he portrays the words as revolutionary explorers: "They are bridgeheads into alien territory. They are acts of insurrection" (44). And, as with metanoia, the words can only find meaning by journeying to the centre of being, or more accurately, nonbeing: "Their source is from the Silence at the center of each of us" (44). To further his point, emphasizing the journey metaphor further, he quotes *The Journals of Jean Cocteau*: "The creative breath 'comes from a zone of man where man cannot descend, even if Virgil were to lead him, for Virgil would not go down there'" (44). If the journey metaphor were not already clear, he explains that artists such as "Hölderlin, John Clare, Rimbaud, Van Gogh, Nietzsche, Antonin Artaud" have "become shipwrecked" after they failed to make the return journey home (141). However, if the return journey is made successfully, the words, just like someone who has successfully undergone metanoia, have a "power that . . . generates new lines of force whose effects are felt for centuries" (44). Though Laing never labels this literary journey as metanoia, their shared identical route from alienation and non-being through to meaning and being is unmistakable.

What can then be called literary metanoia is actually attempted by Laing. As the full name of some editions, *The Politics of Experience and the Bird of Paradise*, suggests, attached to the end of *Politics* is a literary text,[17] *The Bird of Paradise* (hereafter *Bird*). When reading

[17] *The Bird of Paradise* shifts between prose and verse and is exceptionally difficult to categorize. Adrian Chapman suggests that it "def[ies] the notion of genre" and that its lack of identifiable genre has perhaps contributed to its neglect from scholars ("Dismemberment" 394). For simplicity, and because of its creative interweaving of prose and verse, I will refer to it as a literary text.

Politics, it is tempting to skip over what seems like a superfluous creative addition, and therefore it is rarely discussed by scholars. However, *Bird* adds essential nuance and doubt to Laing's arguments in *Politics. Politics* only theorizes metanoia; *Bird* acts it out. One scholar who does address this text is Adrian Chapman in his article titled "Dismemberment and the Attempt at Re-membering in R. D. Laing's *The Bird of Paradise*." Though Chapman does not connect *Bird* to metanoia, he does argue that because the text can act out Laing's theories, as Laing himself suggested language could do, *Bird* reveals what the nonfiction prose in *Politics* cannot. In particular, Chapman highlights how *Bird* seeks to solve the problem of "the denuded nature of experience" that *Politics* "rails against"; at the close of his book, Laing "adopts literary means in order to expand and reclaim experience" (412). Thus, although Laing suggests in *Politics* that metanoia is the sole method to escape alienation and access true meaning, *Bird* reveals that this can also be attempted through literary metanoia.

The speaker in *Bird* undergoes a journey that parallels the treacherous journey of metanoia: as they travel "farther in," they are terrified "of being blinded, frizzled up, destroyed" and "[f]all away from light to darkness," and experience a litany of horrors:

> Carnage. Butchery of spirit in final horror of incarnation. Blood. Agony. Exhaustion of spirit. Struggle between death and rebirth, enervation and regeneration.
>
> Cosmic vomit, sperm, smegma, diarrhoea, sweat . . . (182)

These horrors are more akin to Barnes's written descriptions of metanoia than Laing's, ironically. Laing's descriptions in *Politics* are much more refined: "In this journey there are many occasions to lose one's way, for confusion, partial failure, even final shipwreck; many terrors, spirits, demons to be encountered, that may or may not be overcome" (126). The same trials and tribulations are suggested but without the bodily fluids and gory violence. While

embarking on this journey literarily, the speaker interestingly finds that these obstacles align more with the carnal filth that Barnes describes in her literary metanoia.

Then, as with the metanoia described in *Politics*, the speaker begins to find their way after traversing through turmoil. Slowly, meaning is made as "notes . . . [find] themselves in chords, chords in sequence, cacophony turning to polyphonous contrapuntal chorus, a diapason of celebration" (189). The language now shifts from prose to verse, implying that literary language assists the voyager and reflects the newfound meaning as the speaker now feels "lovely lightful life diffusing an ever newer fiercer freshness" (189). They have reached the apparent pinnacle of their voyage, signified by them having seen the titular "Bird of Paradise," after which the speaker declares, "I shall never be the same again" because "[t]here is nothing to be afraid of. Nothing" (190). Their metanoia is successful.

However, despite having successfully completed their journey, there is no particular truth that the speaker gains at this moment, or at least no truth that can be articulated in words, just as in *Slaughterhouse-Five*. The final stanzas declare that, despite having successfully gone through metanoia, the speaker cannot articulate this experience:

> There is really nothing more to say when we come back to that beginning of all beginnings that is nothing at all. Only when you begin to lose that Alpha and Omega do you want to start to talk and to write, and then there is no end to it, words, words, words. At best and most they are perhaps *in memoriam*, evocations, conjurations, incantations, emanations, shimmering, iridescent flares in the sky of darkness, a just still feasible tact, indiscretions, perhaps forgivable. . . .
>
> If I could turn you on, if I could drive you out of your wretched mind, if I could tell you I would let you know. (190, ellipses in original)

As these final lines reveal, the speaker finds that they cannot tell the reader what they discovered nor how to embark on this journey of metanoia themselves—it is beyond words, and any words are only "evocations" of the truth but not the truth itself. The literary metanoia is successful as the speaker has healed after journeying to the "beginning of all beginnings." And yet, after Laing has undertaken this literary journey, he finds that he cannot express what he has found in words. As with *Slaughterhouse-Five,* metanoia is accomplished through literature and inherently evades truth.

The ending of *Bird*, of course, directly contrasts with Laing's earlier instructions for metanoia in *Politics,* as the speaker now proposes that it is in fact impossible to instruct someone on how to embark on it. As Chapman explains, *Bird* indeed "raises doubts" about the ability of madness to regain wholeness in direct contrast to what Laing argues is possible in *Politics* (409). It seems that this process can only be done through literature. In *Politics*, Laing writes that "we need a place where people . . . can find their way *further* into inner space and time, and back again" (128). Naturally, Laing is referring to a physical place, such as Kingsley Hall, but what Laing overlooks in *Politics* and reveals in *Bird* is that this place is literature. Metanoia is potentially a way to heal, but, as I have demonstrated in my analysis of *Slaughterhouse-Five*, *Two Accounts*, and *Bird*, metanoia can only be accomplished through the act of writing. Writing allows for "the creation of something *out* of nothing" (*Politics* 40). Writing allows for an entire novel to be written about a massacre when "[a]ll there is to say about a massacre" is "things like 'Poo-tee-tweet'" (*Slaughterhouse-Five* 19). Writing, in other words, allows for an evasion of truth, of precise definition. Neither the journey of metanoia, nor a claim to the truth about mental illness, can be precisely articulated in literature, and this is what allows it to be spoken.

Chapter Four

Listening to Her: Reconciling Madness and Literature in Janet Frame's *Faces in the Water*

Michel Foucault, among all the antipsychiatry theorists thus far discussed in this dissertation, appears on the surface as the most likely to accurately and compassionately speak for mentally ill people. He was never a psychiatrist nor did he study psychiatry at any point, unlike Szasz and Laing who remained tied to their discipline. And yet, despite his lack of loyalty to psychiatry, he was also the most on the fringes of antipsychiatry, having been adopted into the movement without even having knowledge of its existence; and once he did learn of antipsychiatry, he immediately rejected the label. He also experienced mental illness in the form of depressive episodes as a young adult. All of these aspects position Foucault at the periphery of psychiatry and antipsychiatry and closer to the experiences of mental illness that are portrayed in the novels discussed in this dissertation. Due to his own personal experiences with it, it would be reasonable to assume that his 1961 work, *Madness and Civilization: A History of Insanity in the Age of Reason*[1] (hereafter *M&C)*, would explain mental illness with more care and sensitivity than Goffman, Szasz, or Laing managed.

This assumption is true in many respects. Foucault's argument incorporates some of the most promising aspects of each antipsychiatry theory: Goffman's critique of the power of institutions, Szasz's understanding of mental illness and psychiatry as languages, and Laing's insistence that madness holds unique wisdom otherwise inaccessible. Foucault, however,

[1] *Madness and Civilization* is the title of the abridged English edition published in 1964. Throughout this chapter, this is the title and version that I will be referring to for the simple fact that this was the version read in the antipsychiatry era. Of course, the French edition was read, but the English edition was far more accessible for reasons beyond its language: namely, it is approximately 400 pages shorter. When I use the title *Histoire de la folie à l'âge classique* (hereafter *Histoire de la folie*), I am referring explicitly to the original French 1961 publication. To further complicate matters, there is a third title; in 2009, the unabridged text was translated into English and titled, more accurately, *History of Madness*. Despite this translation being more faithful to the original, in that it keeps its near 800-page length, I will not be referring to it by virtue of antipsychiatry-era readers not having had access to it.

approached the subject historically, defining *M&C* as "a history of the *imaginary and moral social* context within which . . . [madness] developed" (qtd. in Macey 80). While his enterprise was admirable, it is largely this historical approach where Foucault's faults begin. It is now understood that Foucault largely cherry-picked historical evidence[2] to support his case that the medicalization and institutionalization of mental illness is a result of the steady social exclusion of madness from society. The foundation of his argument is the contention that madness was largely given free rein in society in the Renaissance era. Madness was a simple "aesthetic or day-to-day fact" and was often revered as the voice of wisdom; it had "the function of manifestation, of revelation . . . (Lady Macbeth, for instance, begins to speak the truth when she goes mad)" (qtd. in Macey 115).[3] It is important to understand that Foucault sets up his discussion in terms of binaries: there is madness, or unreason,[4] and sanity, which is reason. During the Renaissance, because there were no restraints on mad people, madness/unreason and sanity/reason were constantly in dialogue. This dialogue uniquely revealed important truths about existence. (Like Laing, Foucault is unspecific about what these truths might be—he is only certain that they allow humans to understand themselves.)

In Foucault's history, this age of freedom and truth-telling for the mad ended with the Great Confinement of the seventeenth century. The Great Confinement was a project to imprison anyone abnormal—the poor, criminal, and mad alike—in squalid institutions. Through this act,

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[2] This argument has been made by a host of scholars, but José Guilherme Merquior in particular, in his book *Foucault* analyzing Foucault's methodologies, insightfully outlines all of the historical evidence that Foucault ignores because it proves his thesis incorrect. This chapter will not outline this evidence, as my goal is to analyze the implications of antipsychiatry theories, but suffice it to say that each antipsychiatry theory, including Foucault's, has questionable methodologies.

[3] Macey's quotations of Foucault in the remainder of this section are from an interview in which Foucault summarized his argument in *M&C*.

[4] While an unorthodox term in English, *unreason* is a literal translation of the common French word *déraison*, meaning a lack of reason. Foucault uses it interchangeably with madness (*folie* in French) but tends to prefer *unreason* as it signifies how he views madness (as the absence of reason).

"madness goes through a period of silence, of exclusion" (qtd. in Macey 115). The advent of psychiatry in the nineteenth century replaced this silence with the creation of a new language: the "language of psychiatry" (*M&C* x). For Foucault, this new medicalized, positivist language is a deep tragedy because there is no longer any dialogue with unreason, only "a monologue of reason *about* madness" (xi) that silences madness's truths. As the years have progressed, this monologue has only strengthened as psychiatry has become increasingly positivist. Foucault, however, does not see this as the grim, final fate of madness. His argument in *M&C* culminates in the claim that madness can, even now in this age of silence, speak.[5] However, madness can only speak via one medium: literature.[6] The goal of speaking madness in literature is to force readers to confront how psychiatry has debased madness so that they might realize that our society has lost access to the truths madness once held.

Upon first glance, Foucault's argument seems to coincide with my own: literature can express mental illness beyond the confines of the rigid definitions of others to more accurately explain what it is. In each chapter thus far, I have sought to establish that this expression is valuable not because it provides a better definition of mental illness than psychiatry or antipsychiatry does, but because it does not define mental illness at all. Although Foucault does not endeavour to explain mental illness as Goffman, Szasz, and Laing do, he too confines it by

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[5] Foucault uses the word "speak" both figuratively and literally throughout *M&C*. Psychiatry literally silences madness in that it prevents mad people from vocalizing or even writing down their mad thoughts (e.g. demanding that they be quiet in the hospital, discouraging them from expressing what they think through cultivating shame). It also figuratively silences madness by redefining madness as an illness and, therefore, segregating mad people from the rest of society and preventing their wisdom from being shared. To "speak" madness, then, is both to literally be able to vocalize/write down mad thoughts and to be reintegrated into respectable society.

[6] Like Szasz when he makes his similar claim, Foucault often writes about art generally but primarily identifies literature as the ideal artform. He mentions Vincent van Gogh as one example of a visual artist whose work "speaks" madness, but the rest of his examples are literary. The argument itself is also tailored to literature as Foucault writes of how language and the writer can accomplish expressing madness. He does not explain, at least in any specifics, how this might be done in non-literary art. As such, art and literature can be considered here to be approximate synonyms.

identifying its value as one of truth-telling. For Foucault, madness should be expressed in literature with the eventual goal of once again being able to extract wisdom from madness. In this chapter, I will argue that this need not be the goal for madness in literature to be powerful; literature can simply accept madness regardless of understanding and to help mentally ill people regardless of what they can or cannot offer the world.

The novel that best exemplifies the goal of accepting madness and helping mentally ill people is Janet Frame's *Faces in the Water* (1961). This story about a young woman, Istina Mavet, and her decade-long institutionalization has been swamped and mired by the public's fascination with Frame's biography. Frame, one of New Zealand's most celebrated authors, was diagnosed with schizophrenia at around 20 years old and subsequently institutionalized until she was almost 30, narrowly escaping a scheduled lobotomy. The plot twist? Frame maintained that she was not, and had never been, schizophrenic. That someone who had been fated to have her frontal lobe severed became an acclaimed author proved to be a more fascinating story than the novel that was crafted as a result of those experiences. Readers were unable to reconcile Frame's two identities of mentally ill person and writer and, much to Frame's chagrin, perceived her primarily as a mentally ill person. *Faces in the Water* (hereafter *Faces*) does enact Foucault's theory about madness: that psychiatry controls it through oppressive mechanisms *and* that it can be expressed in literature with the goal of forcing readers to confront madness. I will establish both of those aspects first before arguing that, ultimately, the public's perception of Frame limited this goal. Foucault's post-antipsychiatry argument in his paper "What is an Author?" reveals why readers were unable to reconcile Frame's madness and her literary skill: her *author-function*, how an author is perceived and constructed, signifies her madness more than her writerly identity. I will delve into this argument, demonstrating how it manifests in Frame's

autobiographies and *Faces*, to argue ultimately that literature should be used to express madness because it resists the confining binaries that psychiatrists and antipsychiatrists alike impose on it.

A Part of Foucault's Biography

Frame was not alone in her animosity toward public perceptions of herself. Despite Foucault's fame, almost no biographies of him exist.[7] One of his few biographers, David Macey, explains the straightforward reason for this: Foucault detested the concept of biography. As Macey articulates it: "Alive, he would have rejected the advances of any biographer; in death, he still struggles to escape them" (xi). Foucault famously proclaimed he did not need a biography because "[e]ach of my works is a part of my biography" (qtd. in Macey xi). Of course, such a statement, which is seemingly philosophical, conveniently allowed him to safeguard personal information. Naturally, this aversion to biography is, as Macey says, a "major problem for a biographer" (xxiii). Thus, while I have begun each chapter with a comprehensive biography that draws from many sources for each antipsychiatry theorist, this chapter will solely use Macey's endeavour to capture Foucault in the grips of biography. Later in this chapter, the problematics and complexities of using an author's biography alongside their written works will be explored; for now, however, I will use it primarily to locate Foucault in the antipsychiatry movement and to elucidate his antipsychiatry theories.

Because Foucault eventually became "France's most prominent philosopher" by the end of his life (Macey xi), contemporary readers might be surprised to discover that he primarily

[7] Stuart Elden, who has published several books on Foucault's work, notes that, as of 2018, there have been only three biographies of Foucault written: *Michel Foucault* by Didier Eribon (1989; translated into English 1991), *The Passion of Michel Foucault* by James Miller (1993), and *The Lives of Michel Foucault* by David Macey (1993). Macey's biography often considered the best, likely because it is the least biased; Eribon was a personal friend of Foucault's, and Miller controversially focuses on how Foucault's sexuality and involvement in the sadomasochist community influenced his works.

studied psychology, not philosophy. At the time of his studies, however, psychology was considered "a philosophical discipline" (35) rather than the social science it is known as today, so it was not strange that Foucault followed his philosophy degree in 1948 with a psychology degree in 1949 and a psychopathology diploma in 1952 (Macey 47). Foucault did not have a favourable opinion of psychology[8] but accepted a position teaching it at the Université de Lille. This is how his initial research into mental illness came to be. Despite not thinking it a very serious discipline, he was explicitly interested in studying madness: "After having studied philosophy, I wanted to see what madness was: I had been mad enough to study reason; I was reasonable enough to study madness" (qtd. in Macey 57). Foucault is clearly being clever with his wording here, but this statement does reveal what would become an important factor in his later theories: he experienced mental illness.

During his university years, Foucault "suffered serious bouts of depression" (27) and is rumoured to have attempted suicide (28). He underwent psychoanalysis during this time but stopped attending because, simply, "he was bored" (29). Already underwhelmed with the field of psychiatry, his opinion only worsened after spending time conducting research in psychiatric institutions, a time marked with ambivalence and ambiguity. He researched in not one but two institutions: a more standard psychiatric hospital, Sainte-Anne, and an unorthodox one, Fresnes Prison. At the time called the Centre National d'Orientation at Fresnes, it specialized in monitoring the mental health of its inmates. This was quite a change from its role in World War II, wherein German forces used the site as an interrogation and torture centre (Miller). It is undoubtedly during this research that psychiatric institutions became intertwined with other

[8] To the offence of psychology graduates everywhere (who must remind themselves that it was a very different discipline at this time), Foucault commented that "a psychology graduate knew nothing and could do nothing because the revision required for all his certificates could easily be done sitting in the garden on a summer's afternoon" (Macey 47).

penal institutions in Foucault's mind. To further add to the ambiguity of his research, psychologists had no official role in psychiatric institutions, and so he was not held to rules or regulations, occupying a strange "position between the staff and the patients" (Foucault qtd. in Macey 56). And yet, these institutions were known at the time for being relatively pleasant towards patients, and so rather than firmly forming an opinion for or against psychiatry, Foucault developed a deep "ambivalence" (60). Feeling uncertain about his future career, Foucault recalls that he began "looking for something different from the traditional grids of the medical gaze, a counterweight" (qtd. in Macey 60).

Foucault found this counterweight in Ludwig Binswanger, a psychiatrist who focused on existential psychotherapy. In 1954, an inspired Foucault wrote a lengthy introduction to one of Binswanger's essays. While this book (Foucault's 128-page introduction transformed Binswanger's modest essay into a substantial manuscript) was unsuccessful, the introduction to existential psychology laid the groundwork for Foucault's dissertation. This dissertation was destined to become *Histoire de la folie*—eventually. For the better part of a decade, Foucault struggled to finish his dissertation, in the meantime publishing five other commissioned works. The most relevant of these works is his first book, *Maladie mentale et personnalité*, published in 1954. While this text demonstrates the early workings of the theory that would inform *M&C*, Foucault ultimately despised it and attempted to erase its existence.[9] He then refocused his attention on uncovering the previously undocumented history of madness.

[9] Readers of this book will find that its arguments correspond closely with those in *M&C*. This is because Foucault rewrote its second section in 1962, changing its argument quite significantly, and changed its title to *Maladie mental et psychologie* (*Mental Illness and Psychology*). Because he was still displeased with it, he prevented a reprint in 1966. He was unable, however, to prevent reprintings of the English translation (the most recent version of which is titled *Madness: The Invention of an Idea*).

Foucault finished writing his dissertation in 1957 but, upon submitting it to Uppsala University in Sweden, was outright rejected due to its "speculative generalisations" that went against the tradition of historical positivism at the university (Macey 79). Foucault spent the next three years revising it based on these criticisms despite not agreeing with them. In a letter defending his project to his supervisor, Foucault clarified that "there was no objective knowledge of madness" until the 1800s and, so, the project required a "very unobjective, unscientific and ahistorical" approach (Macey 80). Foucault later explained to his examination committee that in order to maintain this approach while appeasing his supervisors, he tried to construct a history by researching in "archives comprising of decrees, rules, hospital and prison registers, and acts of jurisprudence" (Macey 94). By constructing a history of madness out of this somewhat haphazard collection of documents, Foucault was able to lend some objective credence to his argument. And so, in 1961, Foucault successfully defended his thesis, and *Histoire de la folie* was published. It initially did not sell very well, selling only 3000 copies in three years, but it was widely reviewed, both negatively and positively. Foucault was disappointed with this but, as Macey notes, it was exceedingly rare for a dissertation to be reviewed, and that it had any reviews at all reflects its popularity within scholarly circles (117). It was not, however, until the publication of *M&C* in 1964 that it received attention beyond academia.

The moment that the far more accessible abridged and English-translated *M&C* was published, it "became an icon of the 'counterculture' of the late 1960s" (Macey 211). David Cooper, who created the term *antipsychiatry*, wrote its preface, and it soon received a glowing review from none other than R. D. Laing. Foucault was "bemused" that Laing and his colleagues considered him to be part of the antipsychiatry movement, having been completely ignorant to the fact that antipsychiatry even existed (Macey 212). Once he learned of its existence, he was

unimpressed. He was even invited to lead an antipsychiatry group, which he outright rejected, believing the group and its movement to be too "shambolic" to achieve anything (Macey 290). By the 1970s, Foucault was stating that it was "quite hilarious" that *M&C* was considered an antipsychiatry work (qtd. in Raffnsøe et al. 103) and that he had really intended it to be "a denunciation of all totalitarianisms and of Soviet totalitarianism in particular" (Macey 385). While this claim is unconvincing, Macey argues that it was likely due to *M&C*'s applicability in criticizing institutions at large that the book became popular in the 1960s: "The theme of the great confinement now seemed to provide the archetype for the confinement of workers in factories, students in universities and of desires in repressive structures" (210). In other words, its popularity was not out of concern for mentally ill people, per se, but because it provided a framework for understanding institutional oppression.

The general anti-institutionalist spirit of Foucault's argument can certainly extend to areas beyond psychiatry, but many of his specific arguments only make sense in the context of psychiatry. For one, the basis of his argument is that psychiatry sought to oppress madness specifically because unreason threatens reason. While other institutions may persecute groups because of their perceived deviance or exploitability, the reason why psychiatry *silences* madness is because to speak madness, or unreason, is to risk losing the reason that the Enlightenment treasured so greatly. In order to specifically suppress unreason, Foucault argues that asylums devised four organizing principles: silence, recognition by mirror, perpetual judgment, and medical personage. To elucidate Foucault's theory of madness and how it is demonstrated in *Faces*, a description of these four principles in the novel will follow.

Istina's Great Confinement in *Faces in the Water*

Throughout *M&C*, Foucault argues that psychiatry metaphorically silences madness, in that it prevents madness from providing others with truth, but he also argues that silencing is a literal tactic enforced by psychiatrists. This tactic was established by Phillipe Pinel, the psychiatrist who physically unchained imprisoned mentally ill people at the Hospice de la Salpêtrière at the turn of the nineteenth century and birthed the modern asylum. Foucault relays an anecdote from one of these asylums that Pinel ran. One prisoner believed that he was Jesus, and this delusion was fuelled by his previous confinement; as spectators gawked at him, he assumed that he was undergoing the Passion of Christ. However, once in the new asylum, Pinel forbade others to speak to him, a fate which elicited far more torment to the man than his previous imprisonment. Eventually, the man was so humiliated and isolated that he abandoned his delusion and returned to society. Thus, Foucault makes the conclusion that "the dialogue of delirium and insult gave way to a monologue in a language which exhausted itself in the silence of others. . . . Delivered from his chains, he is now chained, by silence, to transgression and to shame" (261). In Foucault's formulation, silence did not cure the man but rather forced him to hide his madness.

Silence as a tactic to force madness to retreat into hiding is prominent in *Faces*. Shock treatment is figured as "the new and fashionable means of quieting people" (9). Many of the patients had "given up attempts at speech, and now made noises more appropriate to their habitat: animal noises, whimpers; sometimes they bayed, and howled like lonely dogs attending the moon. Others were dumb, retreating, entirely, curled up all day, and moving, under the long tables that were used for meals and afterwards pushed back along the wall" (78–79). Istina does not figure this silence as a biological symptom of mental illness but rather a result of not being

spoken to: “Although I was capable of what I think was ‘sensible’ conversation there were few people to talk to” (92). Speech with others is limited, as outsiders assume that they are

> deaf or dumb or mentally defective or all three, so that when they spoke they raised their voices or moved their lips with exaggerated care, and their vocabulary was the simplest, in case we did not understand. Sometimes they gesticulated as if we were foreigners and they were the visitors to our land who needed to try and talk our language. (142)

Istina implies that, given the opportunity, most of the patients would reply articulately. It is merely impossible to respond with intelligence to vague gesticulations and words, and so a self-fulfilling prophecy is enacted: when spoken to as though mad, mad speech will be created. Istina explains how the patients inevitably have to create an alternative silent language: “the mad language which created with words, without using reason, has a new shape of reason; as the blind fashion from touch an effective shape of the sight denied them” (91). When they are forced to become “like rests in the music” (91), inevitability “a new kind of music” (77) will be created. Using the same term as Foucault, Istina describes the new “violent orchestration of unreason . . . with the undertone of silence flowing from the quiet ones, the curled-up, immovable and nameless” (77). Like Foucault, Frame does not figure silence as a healing treatment. Rather, it forces the patients to craft a new language out of silence that to them, and them alone, resembles reason.

The second aspect of psychiatric institutions that Foucault proposes is recognition by mirror. Foucault believes that prior to the age of asylums, “madness had no immediate grasp of its own character” (262), meaning that mad people had no self-awareness or knowledge of how they appeared to others. Asylums, by virtue of being filled solely with mad people, forced them to confront one another and recognized their absurdity by witnessing it in others. For example,

Foucault relays an anecdote of a man whose delusion that he was a king crumbled after a worker at the asylum asked him "why if he were a sovereign . . . he remained mingled with madmen of all kinds" (263). By being exposed to others like them, mad people endure humiliation and come to doubt and hate themselves—Pinel considered this to be helpful treatment, while Foucault considers it a means of controlling madness.

Throughout her nearly decade-long stay in psychiatric institutions, Istina frequently moves between wards for mild mental illness cases and severe ones. Early in her stay in one of the less severe wards, she does not recognize herself in the severely mentally ill people. They approach Istina and her fellow patients "as if we were indeed what we felt ourselves to be, a race apart from them. Were we not the 'sensibly' ill who did not yet substitute animal noises for speech or fling our limbs in uncontrolled motion or dissolve into secret silent hilarity?" (12). Later, when she is moved to the ward for severe cases, she begins to recognize herself in them and so spends the majority of her narration describing the patients around her with equal tenderness and disgust. Their most abject behaviour is described in detail: there is Carol, who believes she is engaged to any man who shows interest in her, constantly showing off her a fake "gagement ring" (140); Louise, who is so obsessed with the thought of her own "miles and miles of intestines" (93) that she never sleeps and is consequently lobotomized; and Brenda, who after her lobotomy frequently reaches into her pants to pull out "a lump of feces" (129) and subsequently falls into a seizure whilst screaming about the brother she is hallucinating. These are just three examples: dozens of patients are mentioned by name, their abnormal behaviour described with compassion and yet without euphemism. This balance results in sympathy *and* shame: without sympathy, the shame might turn to derision, but the patients see themselves in

their peers' behaviours and, therefore, turn the derision in on themselves. The patients' ability to connect with the humanity in each other is corrupted into a communal shame.

The final two aspects of psychiatric institutions, perpetual judgment and medical personage, are closely intertwined. Perpetual judgment is a straightforward descriptor of the constant penal judgment enforced on patients and carried out by medical personage. For Foucault, these two aspects are distinct from previous forms of judgment and supervision in the Great Confinement, where mad people would be physically punished with the same methods as other prisoners. With the birth of asylums, inventively cruel forms of punishment emerged and were called "treatments": cold showers, straitjackets, and constant threats of punishment, the dread of which constituted the punishment itself. All of these "treatments" were sanctioned by medical certificates. Rather than benevolently opening up psychiatry to the helpful world of science, as is popularly believed, the creation of asylums merely "borrowed from science only [its] disguise, or at most [its] justification" (271). A cold shower, then, is not merely inflicting physical pain; quoting Pinel, it is a medical treatment to disconcert "the madman or . . . [drive] out a predominant idea by a strong and unexpected impression" (267). Foucault sees this as torture merely given credence as valid medical treatment by virtue of a physician prescribing it.

Both perpetual judgment and medical personage are emphasized in *Faces*. ECT holds no therapeutic value for Istina; she sees it only as a way to make patients "realise that orders are to obeyed and floors are to be polished without anyone protesting and faces are made to be fixed into smiles and weeping is crime" (9). Istina, recounting the "screams protests moanings [sic][10] . . . sounds of scuffles as a patient was forcibly persuaded to obey orders," sarcastically remarks: "For the people were patients. And it was a hospital. Wasn't it? I thought yes certainly it is a

[10] Frame frequently omits punctuation, especially commas, in *Faces*. I will refrain from using [sic] in subsequent quotations that are missing punctuation.

hospital; I had heard them say Treecroft Mental Hospital where the murderers go" (56). The hospital is a hospital in name only and certainly does not function as one. What hospital would be specifically created for murderers? One nurse tells Istina that she longed to work in "a general hospital where the patients were not shamed and abused because of their illness. . . . But here at Cliffhaven or any mental hospital . . . you had to forget that the patients were people, for there were so many of them and there was so much to do. The remedy was to shout and hit and herd" (121). None of these behaviours, quite obviously, would be even remotely accepted in a hospital for physical health. The nurses are consequently transfigured from medical personnel to "overworked, degraded, in many cases sadistic, custodians" (84). The doctors are better only because they rarely interact with the patients, except to prescribe lobotomies. Istina, in fact, is never "cured," or even moderately helped, by the treatments in all the years she spends at two different institutions. She is released by a doctor one day and the reasoning behind this is never provided in the novel. This ultimately creates the impression that for an institution that ostensibly believes mental illness is an illness, they, oddly, do not provide any medical care that an illness would require.

Although *M&C* has many issues, such as the ahistorical and unscientific methods that Foucault admitted to in his dissertation defence, his description of how psychiatry operates bears out in fiction. Frame portrays all of the four organizing principles that Foucault outlines, with Istina's madness cowered into submission through silencing, shame, and cruel faux-medical punishments.

Confronting Madness in Literature

An oft-forgotten argument in *M&C* is the power of literature in conveying madness. The last dozen pages of *M&C* are a treatise on the power of literature. Foucault begins this argument by clarifying how literature and madness functioned prior to the Great Confinement: literature was the prime location, even more so than everyday life, where madness spoke truth. Since madness had not yet been silenced, mad characters and their mad speech abounded, and so madness and literature were perfectly "interlaced" (285). Witnessing madness in art was a way to see "the truth" (286). It was only after the Great Confinement that madness and literature came to be at odds since, of course, madness was no longer allowed dialogue or language. Thus, the result is that "[m]adness is the absolute break with the work of art" (287).[11] In describing the work of Antonin Artaud, who spent much of his life institutionalized for mental illness, Foucault characterizes madness as a void that engulfs language:

> all those words hurled against a fundamental absence of language, all that space of physical suffering and terror which surrounds or rather coincides with the void—that is the work of art itself: the sheer cliff over the abyss of the work's absence. Madness is no longer the space of indecision through which it was possible to glimpse the original truth of the work of art, but . . . [where] this truth ceases irrevocably. (287)

Foucault's statement here, that literature no longer has the ability to convey madness and its wisdom, is a bleak verdict. However, he also sees this as an opportunity: when readers encounter

[11] Foucault also articulates this sentiment just a few sentences above as: "madness is precisely the absence of the work of art" (287). This statement is more frequently quoted than the one I have chosen, and Foucault scholars may find it odd that I avoid referring to his concept of the "absence" of art. However, even the well-known philosopher Henri Gouhier admitted during Foucault's dissertation defence that "he quite failed to understand what Foucault meant" by this (Macey 112). Understanding his ideas here as madness "breaking" with art is clearer.

a work such as Artaud's, they will be forced to confront how madness has been silenced. His explanation is worth quoting at length:

> 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 (for the first time in the Western world) 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. The madness in which the work of art is engulfed is the space of our enterprise, it is the endless path to fulfillment. (288)

In essence, madness in literature is a transformative space. Because madness is now fundamentally at odds with language, and therefore literature, it serves as disruption, challenge, and accusation. The world's goal, Foucault argues, should then be to reconcile madness and reason in order to once again gain access to the wisdom madness in literature holds.

Many aspects of Frame's works and life are debated, but it is almost universally agreed upon that *Faces* forces its readers to confront madness and how it is treated. Tonya Blowers, in her analysis comparing how Frame and Foucault portray madness and psychiatric institutions, argues that *Faces* "extend[s] Foucault's historical analysis into the present day" by offering "a sophisticated and disturbing commentary on and analysis of the social and structural conditions that led to the diagnosis and condition of madness" ("Madness, Philosophy and Literature" 79). Blowers emphasizes that the novel's ability to break "the silence of the mad" is rooted in its

fictional nature; had it been written as Frame's autobiography, it would "profess the ability to speak madness" (78), which Foucault argues is now impossible. Blowers does not connect this to Foucault's statements about literature at the end of *M&C*, but the connection is obvious: it shows readers psychiatry's cruel control of mental illness. As Mary Elene Wood articulates it, Frame's work "leads the reader to question what 'schizophrenia' would look like outside of the environments and discourses that help shape and define it" (202). Frame does not suggest alternatives, just as Foucault does not, but it is the path to the questions that is important for both of them.

Frame manages to lead readers to these questions through the previously outlined portrayal of psychiatric institutions and through generating sympathy for Istina's fellow patients. Alexis Brown proves this by comparing scenes in the novel to the adaptations of those scenes that featured in the film later made about Frame's life. In the film, the nameless and "faceless patients" are shown to "stare blankly, run wildly, or sway despite the lack of music," demonstrating that Frame, who does not act in the same manner, does not belong amongst them (116).[12] In contrast, Istina takes care to name and describe each patient and their "distinct personalities" in detail (116), so that when they are mistreated, there can be no mistake that their humanity is being debased. The very title of the novel speaks to this "humanitarian agenda" (36), as Jan Cronin refers to it. In the titular scene, Istina describes watching Brenda, the lobotomy patient who has frequent seizures and hallucinates her brother, playing the piano. Once a talented

[12] This is a common trope in films set in psychiatric institutions. In the adaptation of *One Flew Over the Cuckoo's Nest*, the producers initially considered hiring real patients to act in the film for authenticity but then, ironically, chose not to as they "did not look distinct enough to depict mental patients on the screen" (Wahl 37). Casting agents reportedly had a difficult time "finding a sufficient number of competent actors who looked unusual enough to portray mental patients" (37). Wahl argues that Hollywood's dedication to sensationalized portrayals of mentally ill people on-screen perpetuates the stereotype that mentally ill people are fundamentally different and, therefore, less deserving of the treatment awarded only to those considered fully human. *Faces* contradicts this stereotype.

piano player, she plays beautifully from memory until inevitably stopping to "rage and scream and thump violently and abusively upon the keys" (131). Istina reflects:

> Listening to her, one experienced a deep uneasiness as of having avoided an urgent responsibility, like someone who, walking at night along the banks of a stream, catches a glimpse in the water of a white face or a moving limb and turns quickly away, refusing to help or to search for help. We all see faces in the water. We smother our memory of them, even our belief in their reality, and become calm people of the world; or we can neither forget nor help them. Sometimes by a trick of circumstances or dream or a hostile neighbourhood of light we see our own face. (131)

This passage incisively articulates how the world responds, or does not respond, to mentally ill people. All of us have witnessed these reactions in others, and perhaps even ourselves: the constant remarks that mentally ill people are "just lazy," the laughter about "crazies" on the street, the hushed whispers about a family member's psychiatric treatments—these are all ways to turn away from the faces in the water. This turning away is institutional, too: the long waitlists for care, the withholding of medications or the overmedicating, the lack of accommodations in workplaces, and more. The alternative to this is not much more promising: to "neither forget nor help them." In either option, mentally ill people are "listened to," either for a moment or lifetime, but they are not responded to. It is only through empathy, through seeing reflections of our own faces in the water and recognizing the parts of ourselves that correspond to madness, that a third option emerges: to acknowledge their humanity.

Faces is remarkable for its ability to portray Istina and her fellow patients as distinctly human, with their flaws, their kindness, their meanness, their mundanity, and everything in between. Frame writing about Istina's madness and her fellow patients' madness is not, as

Foucault would have it, a means to an end. Foucault hopes that readers, in confronting madness in literature, will be compelled to restore a voice to madness so that it can communicate wisdom once more. Frame obliges the reader of no such thing. She does indeed force readers to confront the faces in the water; each reader must literally stare at *Faces in the Water* as they read each page. However, rather than hoping that one day madness will again be restored to speak wisdom, she urges readers to acknowledge the humanity of mentally ill people. This humanity is inherently erased by seeing mentally ill people as one extreme (diseased, useless) or the other (victims, truth-tellers). While Foucault does not demonize mentally ill people as harshly as Szasz or valorize them as greatly as Laing, his argument in *M&C* does entail an extreme romantic view of them. The foundation of his argument implies that without psychiatry mentally ill people's natural state is that of the fifteenth century: living "an easy wandering existence" (8); reminding "each man of his truth" (14); and having "something to do with the strange paths of knowledge" (25). Frame explicitly rejects this kind of thinking in *Faces*, as Istina's reflection shows:

> There is an aspect of madness which is seldom mentioned in fiction because it would damage the romantic popular idea of the insane as a person whose speech appeals as immediately poetic; but it is seldom the easy Opheliana recited like the pages of a seed catalogue or the outpourings of Crazy Janes who provide, in fiction, an outlet for poetic abandon. Few of the people who roamed the dayroom would have qualified as acceptable heroines, in popular taste; few were charmingly uninhibited eccentrics. The mass provoked mostly irritation hostility and impatience. Their behaviour affronted, caused uneasiness; they wept and moaned; they quarrelled and complained. They were a nuisance and were treated as such. It was forgotten that they too possessed a prized

> humanity which needed care and love, that a tiny poetic essence could be distilled from their overflowing squalid truth. (96)

In *Faces*, madness is neither the abject squalor that biomedical psychiatry reduces it to nor the romantic poetry that Foucault implies. To view it as either removes the true goal of representing madness in literature: to display it as a human experience deserving of care and to value its "poetic essence," even if it is so tiny as to be indiscernible. The goal is not to force the faces in the water to speak the truths or explanations that we demand—it is to listen to what they are already saying.

Signifiers of Janet Frame

Foucault and Frame may have had differences in their intended outcomes from readers encountering madness in literature, but neither was accomplished. With Foucault's goal, the world was not arraigned by reading madness in literature; in fact, the world even came to extend arguments about psychiatry to other institutions. As for Frame, readers were unable to take her plea to acknowledge the humanity of mentally ill people to heart because, with painful irony, they predefined her as mentally ill and therefore were less inclined to believe her. As Hilary Mantel writes in the introduction to the novel, "Frame is the prisoner of her biography" because it placed her firmly "into the mad category" (xii). Because Frame used many of her own experiences as inspiration for the novel, readers refused to read *Faces* as anything other than a thinly veiled autobiography. In an article tellingly titled "*Faces in the Water*: Case-history or Work of Fiction?," Donald W. Hannah states simply, "Istina Mavet, the main person in *Faces in the Water* is, of course, Janet Frame herself under another name. Thus, of all the faces in the book, the one most clearly seen is the author's own" (45). Hannah is so confident in his answer

that *Faces* is a case history that his primary question in the article is whether such a case history can even hold any literary merit. One of the main justifications for his argument is that *Faces* began as a therapy exercise. Frame explains that her therapist, whom she saw through outpatient therapy a few years after her release from the mental hospital, encouraged her to write about her "story of that time" in order to have a "clearer view of . . . [her] future" since she was still "suffering from the effects" of her institutionalization (qtd. in St. Pierre 14). This leads Hannah to conclude that *Faces* "demonstrates that therapy can also, on occasions, result in a remarkably successful work of art" (52). However, Hannah overlooks that Frame's therapist was disappointed in the result as a therapy exercise. Frame records that her therapist's comment was: "It's not brilliant but it will do. . . . You know, I'm not a literary chap" (qtd. in St. Pierre 19). As St. Pierre concludes, even Frame's therapist "viewed *Faces in the Water* as a work of literature, not an exercise in outpatient therapy" (19). Hannah characterizes *Faces* as "a desperately precarious means of survival and a defence against insanity for an author condemned to live perpetually in a state of siege" (46). However, arguments like Hannah's ironically create that state of siege for Frame, trapping her in an identity that she did not want, so that defences against insanity become necessary.

One of Foucault's post-antipsychiatry theories that explains how and why Frame came to be trapped by her biography is his concept of the *author-function*. Foucault coined this term in his paper "What is an Author?," originally presented to the Society at the Collège de France in 1969. By this point, Foucault had largely moved away from discussing madness as his primary focus. And yet, his ideas in this paper elucidate how madness stigmatizes authors as much as it does, making it surprisingly relevant to understanding different constructions of Frame. "What is an Author?" is commonly understood as a response to Roland Barthes's 1967 essay, "The Death

of the Author," in which Barthes famously argued that authorial intent should not be privileged in literary analyses. While the proximity in publication dates and titles of the works indicate that Foucault was certainly in conversation with Barthes, Foucault asserts that his argument is primarily a response to criticisms of his own previous work, *The Order of Things: An Archaeology of the Human Sciences* (1966). According to Foucault, that work was criticized for Foucault's use of authors' names "in a naïve and often crude fashion" (13), meaning that he did not describe the authors and their arguments in enough detail and he grouped disparate authors together to create "monstrous families" (13). However, rather than conceding that he should have provided more descriptions or been more thoughtful in his groupings of authors, Foucault uses "What is an Author?" to altogether redefine how he views authors in order to justify his controversial use of author names. More precisely, Foucault asks, "What is the name of an author? How does it function?"

Foucault sets up his discussion in terms of the death of the author. In particular, he argues that the concept of authorship has evolved because writing has undergone two distinct changes. First, writing is now focused on form over content. In ages past, the author pouring their emotions on the page would highlight the role of the author in creating the text. Now, with authors privileging the form of their writing rather than the emotions they are conveying, "an opening [is created] where the writing subject endlessly disappears" (15). Second, the relationship between writing and death has changed. Foucault argues that writing used to be a way to escape death. He cites ancient folklore: Greek epics in which "[t]he hero accepted an early death" in exchange for their story to be told, thus granting a kind of immortality; or the Middle Eastern *One Thousand and One Nights* in which the storyteller literally delays her death by telling her would-be murderer a story each night (15). In stark contrast, writing is now a way

to kill the author: “we find the link between writing and death manifested in the total effacement of the individual characteristics of the writer; the quibbling and confrontations that a writer generates between himself and his text cancel out the signs of his particular individuality” (15). Foucault’s task in the rest of the paper is to explore the “consequences” of the author’s disappearance (16).

Earlier, I argued that Foucault, while perhaps more nuanced than other antipsychiatry theorists, still adopts a binary approach to mental illness by romanticizing it. Foucault abandons extreme answers in “What is an Author?” by suggesting that there are two general approaches to addressing the author’s disappearance—and both of these are flawed. The first approach (the Barthesian approach, though Foucault does not acknowledge it as such) is to analyze a work entirely independently of the author who created it: the author is dead, and we should not even acknowledge their ghost. For Foucault, this approach is naïve and irrational, as there is often undeniable proof that an author’s life impacts aspects of their work. Moreover, to state that authorial intent is inconsequential is to suggest that the work has “hidden meanings,” that is, “implicit significations, silent purposes, and obscure contents” (17). Foucault, who referred to himself as “a total atheist” (Foucault qtd. in Macey 415), disagrees with the principle of “hidden meanings” in literature as it is rooted the “religious belief” that there is a “sacred origin” (17). The opposite approach, however, is not necessarily correct. Foucault questions where the line is drawn when addressing how an author impacts their work. If one admits to an author’s life impacting their writing, then logically any aspect of their life could potentially have an impact: “a notebook filled with aphorisms, . . . a reminder of an appointment, an address, or a laundry bill” (16). Additionally, Foucault critiques both of these approaches for not questioning what is

meant by a "work": how does one define a work if not created by an author? And what is a work if anything the author wrote can be said to be important?

Foucault does not offer answers. Rather, he suggests that this debate is entirely the wrong focus. Instead, the very concept of an author should be interrogated. To do so, he establishes that an author's name functions differently to the average person's name. To use Foucault's example: if it is discovered that a random man named Pierre Dupont has brown eyes instead of blue, his name will not function differently, whereas if it is discovered that Shakespeare was not the true author of the sonnets, it would drastically change how his name functions. As such, "an author's name is not simply an element of speech. . . . Its presence is functional in that it serves as a means of classification" (19). Because it is a means of classification, "its status and its manner of reception are regulated by the culture in which it circulates" (19). The culture regulates the author's name, which Foucault calls the author-function, in four distinct ways: 1) the author-function acts as a copyright claim to legally own a text; 2) the author-function is always changing over time, as evident in how scientific texts used to be legitimated mostly by the author's name (e.g. Hippocrates), whereas now evidence of adhering to the scientific methods matters more than who wrote the text; 3) the author-function is a complex construction informed by our psychology and projections rather than a simple designation of who wrote the text; and 4) the author-function inherently involves a "plurality of egos" in that there are always multiple "I"s present: when an author writes "I will argue," there is the "I" who is writing the sentence down and the "I" who is presented in the text, a "second self" (23). In essence, the author-function is not a simple statement of who wrote the text: it is a legal claim, it can change over time, it is a projection, and it represents multiple subjects.

The goal of Foucault's argument about the author-function is to retire the dead-end, "tiresome repetitions: 'Who is the real author?' 'Have we proof of his authenticity and originality?' 'What has he revealed of his most profound self in his language?'" (29). Instead, Foucault argues that we should focus on "an historical analysis of discourse" and "its mode of existence: the modifications and variations, within any culture, of modes of circulation, valorization, attribution, and appropriation" (28). And so, the question is: how has Janet Frame been circulated, valorized, attributed, and appropriated in culture?

After the publication of *Faces*, *Janet Frame* as an author-function became a signifier of madness. As Foucault argues, the author-function is strongly informed by projection "in the comparisons we make, the traits we extract as pertinent, the continuities we assign, or the exclusions we practise" (21). The projection operating here is the societal belief that madness and literary art are mutually exclusive. In *M&C*, Foucault operates under this societal belief in his argument that madness "is the absolute break with the work of art" (287). He imagines, as I have detailed, that this will positively encourage the world to change. What happened in reality in the case of Frame is that readers unable to reconcile madness and literature simply choose between the two: Janet Frame's author-function can signify madness, or it can signify sanity. Most readers chose the former. This decision is likely due to the strong stigma of mental illness, which often eclipses any other perceptions of an individual, but it is also because of the belief that mentally ill people do not have access to language.[13] One early reviewer of *Faces* assumed that Frame had wholly fabricated her history because of her literary talent, stating, "A woman

[13] In a fascinating discussion of the cultural politics of New Zealand, Ruth Brown argues that Frame's position as an author from New Zealand contributed to this dichotomy. In mid-twentieth century, New Zealand was thought to be uncultured in comparison to the 'superior' Britain. This perception was in large part due to its delayed colonization as the Māori were able to fight against British invasion until the late nineteenth century. Because of these racist associations, attempts were made by non-New Zealanders to paint Frame as an exoticized Other who could not possibly possess her degree of literary skill and was, therefore, merely mad.

who has been what this woman has been would never be able to remember and write about it in this way" (Frame qtd. in Blowers, *Locating the Self* 71). The implication that a person with schizophrenia would not be capable of writing such a novel speaks to the common belief that madness and artistry are mutually exclusive.

As more people questioned Frame's talent and continually described her solely in terms of her history of mental illness,[14] she became more irate. She wrote in a private correspondence "after reading a review of *Faces* that mentioned her past institutionalisation, . . . that it 'was almost as if I had read that I had been convicted of a crime & had served my sentence'" (106). Naturally, it must have been excruciatingly frustrating and insulting for Frame to have her profound literary talent so consistently diminished because of her author-function. And, to add insult to injury, Frame's author-function had previously signified the exact opposite. In *Faces*, it is never revealed why Istina's lobotomy is cancelled and she is released from the hospital; the doctor mysteriously begins to treat her as a person after the library van arrives and she is eventually told that she can leave. In her autobiography, Frame explains why her lobotomy was cancelled: she had written a book. As her surgery date approached, a doctor at the hospital happened to come across a newspaper article announcing that a book of short stories, *The Lagoon*, that she had previously published had won a literary prize for best prose. It is this, and this alone, that changes her course of fate. As Frame tells it, her doctor informed her about the award and immediately afterward said, "we're moving you out of this ward. And no leucotomy [lobotomy]" (*Angel* 297). She was suddenly "treated as a person of some worth, a human being" (298) and given the care required to be released from the hospital. In contrast, her fellow patient

[14] Even now, there is a significant subsection of Frame scholarship dedicated to diagnosing her rather than focusing on her literary merits. The recent trend, for example, is to scour her works for evidence of autism, which was first suggested, to much criticism from other Frame scholars and Frame's family, by medical doctor Sarah Abrahamson.

and friend, Nola, "who unfortunately had not won a prize, whose name did not appear in the newspaper," was lobotomized (298). It was solely because of her apparent ability to write an award-winning work of literature that the doctors, previously so sure that her mental illness was severe enough to warrant a lobotomy, decided she was not mentally ill at all.[15] In essence, her author-function signified sanity in this moment, and this saved her. As Frame articulates it: "It was my writing that at last came to my rescue. It is little wonder that I value writing as a way of life when it actually saved my life" (296). Writing literature *literally* removed Frame's mental illness diagnosis.

Because her author-function had signified sanity and saved her before, it is not surprising that Frame once again turned to writing to change readers' minds. Frame refuted the public's perception of her as mentally ill for years, but she did so relatively quietly—that is, until 1977 when her unauthorized biography was published. The biography was, for all intents and purposes, very complimentary of Frame. It can be assumed, then, that it was not necessarily a poor public image that enraged Frame: it was that her author-function was being created without her input. She wrote to the author of this unwanted biography, Patrick Evans, vehemently asking: "Who do you think you are? One of the Porlock people perhaps?" (Blowers, *Locating the Self* 78). As Blowers explains, "the Porlock people" refers to the unwanted visitor from the village of Porlock who interrupted one of Samuel Taylor Coleridge's writing sessions. In this writing session, Coleridge was feverishly writing *Kubla Khan: or A Vision in a Dream*, a poem inspired by, as its title would suggest, a vivid dream he had awoken from—only to be interrupted by a knock on the door. After this interruption, Coleridge was only able to retain, in his words, a

[15] While the improved treatment undoubtedly helped Frame recover her mental health, and therefore repel any potential doubts that she was still mentally ill, she positions her writing as more important than this change in treatment. Being treated as a capable human being "enabled [her] to be prepared for discharge from the hospital" (297–98), but it was writing that allowed for the discharge to be possible.

"fragment" of the dream poem (qtd. in Blowers 78). Blowers insightfully argues that Frame's use of this allusion suggests that Evans, in publishing Frame's biography, interrupted her while "she was dreaming, composing, or dare I say it, framing her own life. . . . This man not only takes away her material but also imposes a shape on her life that she will have to repeat or undo in her own writing: she is not free to start with a blank literary slate" (78–79). In the interruption, her sense of self becomes, like Coleridge's poem, a fragment.

In response, Frame began writing her own autobiography. Three separate publications followed, *To the Is-land* (1982), *An Angel at My Table* (1984), and *Envoy from the Mirror City* (1984), later collected into a single volume, *An Angel at My Table: A Complete Autobiography* (1989) (hereafter *Angel*).[16] Frame's autobiographies have often been analyzed as an attempt to reframe (Frame scholars rejoice in this pun) her identity. Using Foucault's idea, the autobiographies can also be understood as an attempt to have her author-function once again signify sanity instead of madness. The goal of the autobiographies, essentially, is to remove all suspicions of mental illness and portray herself solely as a gifted artist.

She does this quite straightforwardly by plainly stating that she faked having schizophrenia. The common story of Frame's diagnosis was that her professor, John Money (called John Forrest in *Angel*), realized that Frame was schizophrenic and informed the local mental hospital that whisked her away. Frame explains that this only occurred because Money was of the mind that the world's greatest artists were schizophrenic and she wanted to garner his interest. She made the conscious decision to malinger by "endow[ing] . . . [her] work—and when necessary—. . . [her] life with the mark of . . . schizophrenia" (79). She purposefully put "pure

[16] The title of the collected volume was originally *An Autobiography*. That it was changed to the title of the second volume, which covers the period of her institutionalization, reveals what readers were most interested in. All citations of *Angel* are from this collected volume.

schizophrenia" in her poetry, reasoning that it was "a disease interesting enough to be . . . [her] ally in . . . [her] artistic efforts and to ensure, provided . . . [she] maintained the correct symptoms, that . . . [she] had the continued audience of John Forrest. . . . [She] was playing a game" (79). She does, however, note that it was not entirely self-serving, as she did feel "a likeness between some of . . . [her] true feelings and those thought of as belonging to sufferers from schizophrenia," such as being extremely shy and withdrawn, "preferr[ing] to write, to explore the world of imagination, rather than to mix with others" (80). However, even with this explanation, Frame not only manages to dispute schizophrenia but also strengthen the perception of her as an artist first and foremost.

In addition to these overt methods of denying mental illness, Frame uses more subtle methods. In "What is an Author?," Foucault argues that a plurality of egos, splitting the self into the self who is writing and the self who is being written, is inherent in writing. Frame uses this inherent quality of writing to her advantage. Susan Ash argues that the autobiographies feature "the Frame who writes" who is "the subject of enunciation" and "the Frame who is written" who is "the object of utterance" (23). Simone Oettili-van Delden suggests that the Frame who writes is further split into the Explicit Author (in Foucault's terms, the "I" who writes, "I will argue") and the Implicit Author (the "I" who is actually sitting down to write). This careful splitting of self is done to, paradoxically, present a unified self to the reader. Ash argues that the Frame who writes "represents Janet as completed, the event considered, its significance measured, reported and closed" (30). This completion is in stark contrast to Istina, who is ever "evolving and reacting" (30) to the degree that she exists in the past, present, and future with shifting verb tenses: lines in the present tense ("I protest," "[t]he nurse answers" (*Faces* 29)) are followed immediately by the past tense ("I wept and wondered and dreamed" (*Faces* 30)). For Istina,

"[u]sing tenses to divide time is like making chalk marks on water. . . . [She] do[es] not know if . . . [her] experiences happened years ago, are happening now, or lie in wait for . . . [her] in what is called the future" (29). This lack of linear time erodes her sense of self: "I dithered in Time, not knowing what to call forth from the future, fearing to face the present . . . and not daring to turn to the past. So I was silent, attacking my time-bordered self, blighting, like black frost, the edges of my life until they crumpled and dropped" (165). And so, just as Istina cannot be viewed as a unified self without being anchored in linear time, Frame crafts a unified image of herself by firmly placing the Frame who is written in the concluded past. Foucault argues in "What is an Author?" that to equate the author (Frame as the Explicit Author) with "the actual writer" (Frame as the Implicit Author) "would be as false" as equating the author with "the fictional narrator" (Istina) (23). In the face of these false equations, Frame attempts in *Angel* to create the illusion that there is no division between the Explicit Author, the Implicit Author, and the Frame who she writes about in order to, as Ash writes, "be the last word" (39) on her self.

However, what Frame overlooks in this attempt to revise her author-function to her liking is that, as Foucault says, the author-function is constructed culturally, based on the historical context of any given time and the psychological projections of the readers. Frame's endeavour to have her author-function signify sanity rather than madness was far too much of a contradiction with how readers viewed her previous works. Foucault writes that, when encountering "the contradictions that are found in a series of texts," readers will create an author-function that resolves the contradiction and creates coherences out of incompatible elements (22). For Frame's author-function, this meant readers essentially disregarding how Frame portrays herself in the autobiographies. One critic, Gina Mercer, expresses dissatisfaction that the autobiographies evict the "madwoman in the attic" as they lack the "troublesome, troubling and trouble-making

capacities" of her fiction (43–44). This view was apparently shared by the filmmakers of the 1990 adaptation of the autobiographies. That the film is titled *An Angel at my Table*, the one book that covers her institutionalization, reveals what audiences were interested in watching: her institutionalization. In *Angel*, Frame largely elides the time period of her institutionalization in *Angel*, mostly pointing readers instead toward *Faces* instead in the following manner: "In my book *Faces in the Water* I have described in detail the surroundings and events in the several mental hospitals I experienced during the eight following years" (70). In spite of this, the filmmakers expressly ignored Frame's wishes and incorporated scenes from *Faces* that Frame had purposefully and carefully excised from *Angel*. Alexis Brown notes that this was Frame's "only point of contention" with the filmmakers (118). Frame's desire to tell her own story in order to fix her author-function was, ultimately, thwarted.

Stories for Brave People

Foucault establishes his argument in "What is an Author?" on the notion that writing is no longer the path to immortality. No longer can storytellers like the one in *One Thousand and One Nights* continue "their narratives late into the night to forestall death and to delay the inevitable moment when everyone must fall silent" (15). Frame is a vivid exception to this: rather than a thousand and one stories, the twenty-four stories that comprise *The Lagoon* saved her from figurative and perhaps even literal death by preventing her lobotomy.[17] It was

[17] A lobotomy is perhaps the only routine surgery that can literally remove a person's personality and selfhood as it severs the prefrontal cortex, which is responsible for "the executive functions of the brain: planning, insight, foresight, and many of the most basic aspects of personality" (Vanderah and Gould). Lobotomies also had a substantial mortality rate, meaning that Frame may have literally escaped death. One study that analyzed 771 patients who received lobotomies from 1947–58, when Frame would have received hers, found that a total of 7.4% of patients, or 57 patients, died as a result of the surgery (Ögren and Sandlund 356). The authors note that while this was more or less on par with other surgical procedures at the time, lobotomies were, unlike other surgeries, not necessary to save a person's life.

specifically literature, rather than her ability to create art, that saved her. In *Faces*, Brenda is a "talented girl, a pianist who was shortly to have taken a scholarship overseas" (128); creating musical art evidently did not prove her sanity. And yet, writing was unable to save Frame once the signifier of madness had been attached to her and her work because, once defined as mad, people stop listening. Istina experiences this with her own *One Thousand and One Nights*. Immediately before Istina receives news of her impending lobotomy, Dr. Trace, the new 'progressive' doctor—progressive for the mere fact that he "talked and listened with respect" to the patients—asks Istina: "What if I bring you some pictures to look at? Will you tell me stories about them?" (189). Istina imagines that "the pictures and . . . telling stories about them would save . . . [her] from all brain operations" (195), and so she spends her days "thinking about the pictures and imagining *the thousand and one stories* I would tell to save my conscience and my dreams from being chopped off" (196, emphasis added). However, when he finally brings up the stories again, it is only to tell her, "There's no time. There won't be any pictures. It would take too long. And there's no time" (208). Dr. Trace, like many a reader, does not have a thousand and one nights to waste listening to a mentally ill person try to prove she is not mad.

To close this chapter, I want to emphasize one final point: *Faces* calls to our attention the power of literature. It is a recurring theme in the novel, thus making dismissals of Frame's message and adherence to the binaries she fights against deeply ironic. In the text itself, Frame tells readers that literature holds great power, if only one is brave enough to listen. Indeed, were it not for the dismal psychiatric context, Istina might be mistaken for a typical English undergrad as she wanders around with a well-worn copy of *King Lear*. Despite rarely reading it, she notices it further deteriorating "as if an unknown person were devoting time to studying it" (97). Literature is so powerful that it does not even need to be read to have an impact; she suggests

that the book "had decided to read itself" (98). And, without re-reading the passages, she recites Lear's monologue on the moor and remembers the patients who resemble the "poor naked wretches" that Lear bemoans (98). Frame's selection of *King Lear*, Shakespeare's best-known depiction of madness, indicates this power of literature to speak madness autonomously. Frame constantly figures books as demanding to be read: when Istina returns home, she notices that her books have been eaten by worms "as if the books had told them to devour devour [sic] at all costs since whoever had experienced a spiritual hunger for them had long since departed or died" (112). Despite Istina being unable to read them, the books are figuratively read regardless. Literature is never figured as comforting or kind; its power is raw and its demands are taxing.

The most significant passage about literature is toward the end of the novel as Istina prepares for her lobotomy. A library van arrives at the hospital with a dismal selection of books for the patients, causing Istina to remember her childhood library. It was guarded by a "sharp-tongued librarian" and a "wicked-looking stuffed moa" (211), a flightless bird that could reach heights of twelve feet that was driven to extinction in New Zealand several centuries ago. Passing these two guardians feels to young Istina like a "forbidding journey" (211). Significantly, she notes all the signs that read *SILENCE*, which adds peril to the journey as she sees a man "petrified" by these signs. By "demanding Silence when one would never have dreamed of speaking," Istina is given the impression that "the room contained secret presences which had to be controlled and which related in a strange way the death and painstaking reconstruction of the moa and the micelike letters that were wired with meaning and resurrection to make words, and placed in imposing attitudes on the pages of the books" (211). The books are figured as powerful beings as Istina concludes that the librarian "hid behind a grille" for safety and is attempting to "subdue" the books with the notices (211). But, because this is a perilous

journey, she also concludes that "books must be wonderful treasures . . . only for brave people" (211). Viewing this passage through Foucault's argument, the library is analogous to psychiatric institutions, demanding *SILENCE* from madness in order to sever any dialogue that could reveal important, but threatening, truths. These efforts, however, can be overcome by a brave adventurer who is willing to read the books demanding to be read.

To read *Faces in the Water* is to undergo this brave adventure. The bravery that *Faces* entails, however, is not to brazenly diagnose Frame, nor demand that the madness within it speak wisdom or embolden others to restore madness's wisdom. The bravery of reading *Faces* is to truly listen. This can only be done by readers who are willing to live with the contradictions between madness and literature or the contradictions in Frame's author-function, rather than trying to reconcile them; readers who can accept a description of what madness feels like without an explanation of what causes it; readers who care for the "tiny poetic essence" of mentally ill people; readers who do not demand the faces in the water to speak before saving them from drowning. Foucault states that madness is silent, but the truth is that no one is listening. For these brave readers of *Faces* willing to listen, the treasure is having a space in the pages where mental illness need not be defined, explained, or exploited.

Conclusion

Throughout this dissertation, I have sought to draw scholarly attention to the expansive space that literature offers in which mental illness is able to be depicted in alternative and important ways. My goal in doing so is two-fold: to steer recent trends in mental health activism toward a more historically informed and productive future and to encourage future literary scholarship on mental illness to adopt a broader scholarly approach. I will now draw my project to a close in this conclusion by discussing each of these goals in turn.

As I alluded to in the introduction of this dissertation, antipsychiatry ideas have once again begun to gather popularity amongst the general public and in scholarly circles in recent years. This trend is nothing surprising: popular understandings of mental illness have ever oscillated between biomedical and social, and after years of a decidedly biomedical dominance, a swing to social perspectives was bound to arrive. Our era, however, is uniquely disposed for what could be another antipsychiatry era akin to the 1960s. For one, more people than ever are mentally ill. After the COVID-19 pandemic, rates of mental illness are nearly universally reported to have significantly increased (Ettman et al.; Cuomo et al.; Sibbald).[1] That there are people are aware of mental illness, supporting someone with mental illness, and diagnosed with mental illness inevitably results in more discussion about mental illness, specifically about its treatment, cause, and definition.

Increasingly, I have noticed that within discussions of mental illness are statements bearing a concerning resemblance to the antipsychiatry theories discussed in this dissertation.

[1] This is a small sample of the many studies recently published on this subject. Ettman et al. report a 3-fold increase in depression symptoms after COVID-19. Cuomo et al. surveyed 1281 physicians in Italy and found that 81% of them reported an increase in patients with mental illness, with a third of those physicians reporting a 51–75% increase. Kaitlin Sibbald asserts that "mental health is the next pandemic" (13) has become a widespread saying, often accompanied with problematic metaphors of needing to go to "war" on it.

One online article, for example, adopts a Laingian perspective by encouraging a more positive framing of mental illness as a superpower. It suggests the following mental illness superpowers, amongst others: "not feeling pain" (dissociative identity disorder), having a "super memory" (obsessive-compulsive disorder), being "a creative genius" (attention-deficit/hyperactivity disorder), and even "a super sense of smell" (bipolar disorder) (Veritas).[2] One TikTok video that accrued over 111,000 views and 30,000 likes reads, "mental illnesses are a result of human beings being forced into a society they aren't naturally designed to be a part of. . . . we [sic] were made to be one with nature, not to destroy it. going [sic] against that instinct is the main cause of all our mental issues" (Rain). The bold claim that society's imposition on us is "the main cause" of mental illnesses is strongly in line with antipsychiatry sentiment. There is also, of course, more recent scholarly antipsychiatry texts, such as Irving Kirsch's *The Emperor's New Drugs: Exploding the Antidepressant Myth* (2009) and Robert Whitaker's *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* (2010), both of which suggest the dangers of psychiatric medications and advocate for alternative treatments instead, such as psychotherapy or lifestyle changes that are not dissimilar to those advocated by Szasz or Laing.

These discussions have also advanced to the political sphere, as they did in the '60s. In 2020, the United Nations Human Rights Council published "Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health." This report recommends that, in order to end the "human rights violations in mental health-care systems," the psychiatric profession must "move far beyond a biomedical

[2] This article was selected because it is exemplary of the scores of typical online articles on mental illness that so heavily populate the Internet. A simple Google search of "mental illness superpowers" yields thousands of similar articles.

understanding of mental health" (1). In it, they make several statements reminiscent of those made in the '60s, such as: "Mental health systems worldwide are dominated by a reductionist biomedical model that uses medicalization to justify coercion as a systemic practice and qualifies the diverse human responses to harmful underlying and social determinants (such as inequalities, discrimination and violence) as 'disorders' that need treatment" (4). They call for "community-led recalibration" (4) and "a renewed emphasis on the importance of relational care and the interdependence of mental and social health" (8). There is certainly nothing wrong with these statements. It is, however, eerily similar to and even more extreme than the Joint Commission on Mental Illness and Health's 1961 report, *Action for Mental Health*, that instigated deinstitutionalization. This report also called for an emphasis on how "mental *differs* from physical illness," particularly as "a disorder with psychological as well as physiological, emotional as well as organic, social as well as individual causes and effects" (xviii), and advises that community mental health clinics be "a main line of defence in reducing the need of many persons with major mental illness for prolonged or repeated hospitalization" (xiv). While there is also nothing wrong with these statements, it is important to remember what antipsychiatry in the 1960s resulted in: a large mentally ill homeless population and audacious theories on what mental illness is.

I want to be clear that I am not against criticisms of psychiatry—far from it, in fact. As I hope my analysis of each novel has established, there are many valid critiques of psychiatry that still bear truth today. It is true that the institution of psychiatry is often authoritarian, with more focus on control over care, as seen in *The Bell Jar*, *I Never Promised You a Rose Garden*, and *Faces in the Water*. And it is true that other ways of understanding mental illness—especially as a story (*The Bell Jar*/Goffman), a language (*I Never Promised You a Rose Garden*/Szasz), or a

journey (*Slaughterhouse-Five*/Laing)—offer potential in dealing with and recovering from mental illness that the biomedical perspective lacks. Psychiatry offers useful support for mentally ill people—the efficacy of psychiatric medications is shown to be on par with non-psychiatric medications (Leucht et al.), for example—but it is necessary to call attention to its failings: high rates of abuse[3] and a lack of adequate services.[4] However, without also knowing what the 1960s antipsychiatry movement got *wrong*, it is possible that once again dissidents of psychiatry will not succeed in addressing its flaws. I hope that my analysis of the novels in this dissertation has demonstrated some of the limitations of the antipsychiatry ideas in the 1960s so that we may not merely reiterate them again and productive changes can be made to improve the lives of those with mental illness.

My basic thesis in each chapter has been that the novels corroborate some antipsychiatry criticisms of psychiatry and theories on what mental illness is, but ultimately each novel expands far beyond those criticisms and theories to depict mental illness productively without ever defining it. In making this argument, I do not wish to suggest that mental illness should cease to be defined altogether. This suggestion would be just as foolhardy as arguing that psychiatric institutions should simply no longer exist: to merely abolish the current treatments for and theories of mental illness would only leave mentally ill people without any support. On the contrary, I believe that interrogating past theories of mental illness is so important precisely

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[3] *Mad in America*, a website that publishes articles critical of psychiatry, surveyed 500 people in 2018 who had been institutionalized. Michael Simonson reports that a total of 37% of surveyed patients reported experiencing some form of abuse, with many respondents citing more than one form: 25% reported being forcibly drugged, 18% reported being placed in solitary confinement, 14% reported being physically restrained by staff, 18% reported physical abuse, and 7% reported sexual abuse. 56% of respondents reported feeling unsafe and not secure while institutionalized, and only 17% reported being satisfied with the quality of psychiatric treatment they received.

[4] The Centre for Addiction and Mental Health, the largest mental health teaching hospital in Canada, reports that it is underfunded by $1.5 billion, resulting in 33% of people who require mental health care not receiving services. They note that this discrepancy is even worse for Indigenous youth who "are about fix to six times more likely to die by suicide" as compared to other youth groups.

because it can improve how people currently theorize about mental illness, as I discussed above. So, while I believe that these discussions should and will continue, what I am suggesting is that literature about mental illness provides a space outside of the endless research and debates wherein people, especially those who have mental illness, can simply exist. In Chapter One, I argued that *The Bell Jar* is Sylvia Plath's self-story that allows her multiplicity of selves and the multiplicity of meanings of mental illness to exist simultaneously, even when they may be contradictory. In psychiatry or antipsychiatry texts, definitive statements about mental illness are made one way or the other; this need not be the case in literature. In Chapter Two, I outlined how multilingualism, rather than translation, is healing in Joanne Greenberg's *I Never Promised You a Rose Garden*. Instead of translating mental illness into easily understood terms, the novel simultaneously holds all these ways of thinking about mental illness without ascribing to any one particular psychiatric or antipsychiatric notion. In Chapter Three, I demonstrated that Kurt Vonnegut's ability to heal through writing *Slaughterhouse-Five* was because it allowed him to avoid any claims to truth. Claims to truth are all that psychiatry and antipsychiatry offer. And in Chapter Four, I submitted that a binary understanding of mental illness was harmful to Janet Frame and is actively resisted through the power of literature in *Faces in the Water*. Literature is a space in which these binaries of mental illness, these claims to truth and demands to swear loyalty to one mutually exclusive definition, do not exist. Mental illness can be described without being defined, healed from without claiming cure, and given space to breathe and exist outside of categorizations and theories.

This space that literature provides is *essential* for readers who are mentally ill. To elaborate on this, I will offer a personal anecdote: this dissertation topic was born out of my experiences with mental illness. Before beginning my PhD, I knew that I wanted to research

some aspect of disability in literature, likely mental illness, due to my long history with it. During a particularly severe depressive episode, I came across *I Never Promised You a Rose Garden* and instantly knew that this was the topic I would dedicate myself to. Like the other readers that I cited in Chapter Two, I had never felt so seen or so heard as I did when I read that novel. Its ability to describe exactly what mental illness feels like without ever claiming to know what it is was life-changing. I sought out other similar novels—those discussed in the other chapters—and they have unfailingly been spaces that I return to in order to see myself and feel hope. Psychiatry has been a support to me in many respects, and I have found some helpful perspectives in antipsychiatry, but *nothing* has ever matched the freedom and comfort I feel in the expanses of these novels. As I have discussed throughout my dissertation, I am certainly not alone in this feeling. Unfathomable numbers of readers like me have found themselves able to rest inside the spaces of these books, breathing a sigh of relief that they did not even know was held.

This is ultimately my recommendation for how we as literary scholars can move forth: to inform on the expansive possibilities that literature about mental illness can hold. Literary scholarship on mental illness in literature has recently coalesced into an emerging field; it is optimistic and malleable, as emerging fields are. In the recently published *Madness and Literature: What Fiction Can Do for the Understanding of Mental Illness* (2022), the editor Lasse Raaby Gammelgaard characterizes the "knowledge of the field" as "limited but constantly expanding" (24). Elizabeth J. Donaldson similarly describes her anthology, *Literatures of Madness: Disability Studies and Mental Health* (2018), as "a provisional hub or way station: a point at which to meet together collectively, to commune, build on synergies, and honor differences, before continuing on the longer journeys forward" (3). As I approach the last words

of this dissertation, my hope is to add to the limited knowledge of the field with a spirit of synergy and collective work for the future.

Raaby Gammelgaard outlines the five approaches that almost all literary scholarship on mental illness and literature falls within: 1) politically-oriented studies (making political statements by way of literary analysis, such as interpreting a text as expressing antipsychiatry notions); 2) psychoanalytic approaches (which Freud himself does in psychoanalyzing the motivations and behaviours of literary characters, such as Oedipus); 3) narrative theory (studying how narratives are constructed, which converges with mental illness in the analysis of unreliable narrators and illness narratives); 4) the history of medicine (a historical investigation of mental illness/psychiatry that uses literature as evidence); and 5) studies on creativity and madness (investigating the symbiotic relationship between the two). I have used many of these approaches in this dissertation, and they all have the potential for productive and illuminating literary analyses. However, they are sometimes used in a way that replicates the binaries that are imposed on mental illness by psychiatry and antipsychiatry.[5] The ways in which literary representations of mental illness depict antipsychiatry ideas have been quite well established, and the ways in which literary representations of mental illness depict psychiatry's understanding of mental illness have been even more established with the long history of diagnosing literary characters and authors. My suggestion for moving forward is to challenge these replications in literary analyses. What has been virtually unexplored is the ways that literature depicts mental illness uniquely, outside of existing discourses. There are endless avenues for potential future research: How is mental illness portrayed within varying intersections of race, gender, sexuality,

[5] Binaries such as: biological disease/social construction, negative/positive, healthy/sick, etc. In general, the notion that these binaries are mutually exclusive and can never be true simultaneously, which I hope that I have demonstrated is not true.

and other identities? How does literature suggest that mental illness feels outside of symptomatic categorizations or antipsychiatry imaginings? How can mental illness be experienced or healed from in ways that do not correspond to traditional wisdom or current recommendations? Once we allow ourselves to break outside of existing dominant approaches to mental illness in our analyses of mental illness in literature, we allow ourselves far more productive, expansive, and powerful understandings of what mental illness is and can be.

Works Cited

Abrahamson, Sarah. "Did Janet Frame Have High-Functioning Autism?" *The New Zealand Medical Journal*, vol. 120, no. 1263, 2007, p. 2747. *ProQuest*, www.proquest.com/scholarly-journals/did-janet-frame-have-high-functioning-autism/docview/1034236726/se-2.

Allen, William Rodney, editor. *Conversations with Kurt Vonnegut*. 1988. UP of Mississippi, 1999.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 2nd ed., American Psychiatric Publishing, 1968.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed., Text Revision, American Psychiatric Publishing, 2022. *Psychiatry Online*, https://doi.org/10.1176/appi.books.9780890425787.

An Angel at my Table. Directed by Jane Campion, HanWay Films, 1990.

Arlow, Jacob. "Delusion and Metaphor." *Psychoanalysis and Psychosis,* edited by Ann-Louise S. Silver, International UP, 1989, pp. 173–82.

Ash, Susan. "'The Absolute, Distanced Image': Janet Frame's Autobiography." *Journal of New Zealand Literature,* no. 11, 1993, pp. 21–40. *JSTOR*, www.jstor.org/stable/20112221.

Badia, Janet. *Sylvia Plath and the Mythology of Women Readers*. U of Massachusetts P, 2011. *EBSCOhost*, uml.idm.oclc.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=e000xna&AN=1246217&site=ehost-live.

Baker, Charley, et al. "Mental States." *Madness in Post-1945 British and American Fiction*, Palgrave Macmillan, 2010, pp. 18–60. *SpringerLink,*

https://doi.org/10.1057/9780230290440.

Balbuena, Francisco. "Laing Versus Szasz: Antagonists, Kindred Spirits, or a Misconstrued Rivalry?" *Journal of Humanistic Psychology*, vol. 63, no. 3, 2023, pp. 306–25. *Sage Journals*, https://doi.org/10.1177/00221678211048115.

Barnes, Mary, and Joseph Berke. *Mary Barnes: Two Accounts of a Journey Through Madness.* 1971. Harcourt Brace Jovanovich, 1972.

Bateson, Gregory. "Language and Psychotherapy—Frieda Fromm-Reichmann's Last Project." *Psychiatry*, vol. 21, no. 1, 1958, pp. 96–100. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/doi:10.1080/00332747.1958.11023118.

Behrens, Susan J. "A Note on *The Bell Jar* (1963)." *Names*, vol. 61, no. 4, 2013, pp. 239–43, https://doi.org/10.1179/0027773813Z.00000000064.

Berkeley Sherman, Gail. "A Conversation with Joanne Greenberg." *Studies in American Jewish Literature*, vol. 28, 2009, pp. 86–101. *Project MUSE*, muse.jhu.edu/article/367001.

---. "'My Difference Is Not My [Mental] Sickness': Ethnicity and Erasure in Joanne Greenberg's Jewish American Life Writing." *Literatures of Madness: Disability Studies and Mental Health*, edited by Elizabeth J. Donaldson, Palgrave Macmillan, 2018, pp. 165–82. *SpringerLink*, https://doi.org/10.1007/978-3-319-92666-7.

Berlim, Marcelo T., et al. "Notes on Antipsychiatry." *European Archives of Psychiatry and Clinical Neuroscience,* vol. 253, 2003, pp. 61–67. *SpringerLink*, https://doi.org/10.1007/s00406-003-0407-8.

Berman, Jeffrey. "*I Never Promised You a Rose Garden:* The Limits of the Fictional Psychiatric Case Study." *The Talking Cure: Literary Representations of Psychoanalysis*. New York UP, 1985, pp. 154–76.

Bérubé, Michael. *The Secret Life of Stories: From Don Quixote to Harry Potter, How Understanding Intellectual Disability Transforms the Way We Read*. New York UP, 2016.

Blowers, Tonya. *Locating the Self: Re-Reading Autobiography as Theory and Practice, with Particular Reference to the Writings of Janet Frame.* 1998. University of Warwick, PhD dissertation. webcat.warwick.ac.uk/record=b1361586~S1.

---. "Madness, Philosophy and Literature: Janet Frame's *Faces in the Water*." *Journal of New Zealand Literature*, no. 14, 1996, pp. 74–89. *JSTOR*, www.jstor.org/stable/20079665.

Broer, Lawrence R. *Sanity Plea: Schizophrenia in the Novels of Kurt Vonnegut*. U of Alabama P, 1994. *EBSCOhost*, uml.idm.oclc.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=e000xna&AN=21091&site=ehost-live.

Brown, Alexis. "*An Angel at My Table* (1990): Janet Frame, Jane Campion, and Authorial Control in the Auto/Biopic." *Journal of New Zealand Literature*, vol. 34, no. 1, 2016, pp. 103–22. *ProQuest*, www.proquest.com/scholarly-journals/angel-at-my-table-1990-janet-frame-jane-campion/docview/1853264199/se-2.

Brown, Kevin. "The Psychiatrists Were Right: Anomic Alienation in Kurt Vonnegut's 'Slaughterhouse-Five.'" *South Central Review*, vol. 28, no. 2, 2011, pp. 101–09. *Project MUSE*, https://doi-org.uml.idm.oclc.org/10.1353/scr.2011.0022.

Brown, Ruth. "Beyond the Myth: Janet Frame Unframed." *Journal of New Zealand Literature*, no. 21, 2003, pp. 122–39. *JSTOR*, www.jstor.org/stable/20112359.

Brown, Sally, and Clare L. Taylor. "Plath [Married Name Hughes], Sylvia." *Oxford Dictionary of National Biography*, 1 Sept. 2017, https://doi.org/10.1093/ref:odnb/37855.

Burns, Tom. "A History of Antipsychiatry in Four Books." *The Lancet Psychiatry*, vol. 7, no. 4, 2020, pp. 312–14, https://doi.org/10.1016/S2215-0366(20)30106-1.

Burston, Daniel. "Anti-Psychiatry: The End of the Road?" *Psychoanalysis, Politics and the Postmodern University*, 2020, pp. 157–75. *SpringerLink*, https://doi.org/10.1007/978-3-030-34921-9_8.

---. "R. D. Laing and the Politics of Diagnosis." *Janus Head,* vol. 4, no. 1, 2001, pp. 12–28. *Philosophy Documentation Center*, https://doi.org/10.5840/jh2001412.

Cacicedo, Alberto. "'You Must Remember This': Trauma and Memory in *Catch-22* and *Slaughterhouse-Five*." *Critique: Studies in Contemporary Fiction*, vol. 46, no. 4, 2005, pp. 357–68. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/10.3200/CRIT.46.4.357-368.

Canadian Mental Health Association. "Myths about Mental Illness." *CMHA*, 28 Feb. 2016, cmha.ca/brochure/myths-about-mental-illness/.

The Centre for Addiction and Mental Health. "The Crisis is Real." *CAMH*, www.camh.ca/en/driving-change/the-crisis-is-real. Accessed 1 Aug. 2023.

Chapman, Adrian. "Dismemberment and the Attempt at Re-membering in R.D. Laing's *The Bird of Paradise*." *Literature and Medicine*, vol. 33, no. 2, 2015, pp. 393–418. *Project MUSE*, https://doi-org.uml.idm.oclc.org/10.1353/lm.2015.0017.

---. "Dwelling in Strangeness: Accounts of the Kingsley Hall Community, London (1965–1970), Established by R. D. Laing." *Journal of Medical Humanities*, 2021, vol. 42, pp. 471–94. *SpringerLink*, https://doi-org.uml.idm.oclc.org/10.1007/s10912-020-09656-0.

---. "'May all Be Shattered into God': Mary Barnes and Her Journey through Madness in Kingsley Hall." *The Journal of Medical Humanities*, 2020, vol. 41, pp. 207–28.

SpringerLink, https://doi-org.uml.idm.oclc.org/10.1007/s10912-018-9517-1.

Coleman, Martin. "The Meaninglessness of Coming Unstuck in Time." *Transactions of the Charles S. Peirce Society*, vol. 44, no. 4, 2008, pp. 681–98. *Project MUSE,* muse.jhu.edu/article/260158.

Cronin, Jan S. *The Frame Function: An Inside-out Guide to the Novels of Janet Frame*. Auckland UP, 2011.

Crystal, David and Robert Henry Robins. "Language." *Encyclopedia Britannica*, 21 Jul. 2023, www.britannica.com/topic/language.

Cuomo, Alessandro, et al. "Mental Health in Italy after Two Years Of COVID-19 from the Perspective Of 1281 Italian Physicians: Looking Back to Plan Forward." *Annals of General Psychiatry,* vol. 21, no. 30, 2022, https://doi.org/10.1186/s12991-022-00410-5.

Czajkowska, Aleksandra. "'To Give Form to What Cannot Be Comprehended': Trauma in Kurt Vonnegut's *Slaughterhouse-Five* and Martin Amis's *Time's Arrow*." *Crossroads*, vol. 34, 2021, pp. 59–72. *Repozytorium Uniwersytetu W Białymstoku*, https://doi.org/10.15290/CR.2021.34.3.05.

David, Anthony. Introduction. *The Divided Self: An Existential Study in Sanity and Madness*, by R. D. Laing, 1960, Penguin, 2010, pp. v-xii.

Decuers, Larry. "WWII Post Traumatic Stress." *The National WWII Museum*, 27 June 2020, www.nationalww2museum.org/war/articles/wwii-post-traumatic-stress.

Demjén, Zsófia. *Sylvia Plath and the Language of Affective States: Written Discourse and the Experience of Depression*. Bloomsbury, 2015. *EBSCOhost*, uml.idm.oclc.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=e000xna&AN=1019904&site=ehost-live.

Deutsch, Albert. *The Shame of the States*. Harcourt, Brace and Company, 1948.

de Villiers, Stephanie. "Metaphors of Madness: Sylvia Plath's Rejection of Patriarchal Language in *The Bell Jar*." *English Studies in Africa*, vol. 62, no. 2, Taylor & Francis, 2019, pp. 1–11. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/10.1080/00138398.2019.1685200.

Dewan, Mantosh J., and Eugene A. Kaplan. "The Clinical Wisdom of Thomas Szasz." *Thomas Szasz: An Appraisal of His Legacy*, edited by C. V. Haldipur et al., Oxford UP, 2019. *Oxford Academic*, https://doi-org.uml.idm.oclc.org/10.1093/med/9780198813491.003.0012.

"Disabled People." *Holocaust Memorial Day Trust*, www.hmd.org.uk/learn-about-the-holocaust-and-genocides/nazi-persecution/disabled-people/. Accessed 3 Aug. 2023.

Donaldson, Elizabeth J. "Introduction: Breathing in Airless Spaces." *Literatures of Madness: Disability Studies and Mental Health*, edited by Elizabeth J. Donaldson, Palgrave Macmillan, 2018. *SpringerLink*, https://doi.org/10.1007/978-3-319-92666-7.

Dunn, Dana S., and Erin E. Andrews. "*Person-First* and *Identity-First* Language: Developing Psychologists' Cultural Competence Using Disability Language." *American Psychologist*, vol. 70, no. 3, Apr. 2015, pp. 255–64. *APA PsycNet*, https://doi.org/10.1037/a0038636.

Elden, Stuart. "Do We Need a New Biography of Michel Foucault?" *American Book Review*, vol. 39, no. 2/3, 2018, pp. 12–23. *Project MUSE*, https://doi.org/10.1353/abr.2018.0008.

Ettman, Catherine, K., et al. "Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic." *JAMA Network Open,* vol. 3, no. 9, 2020, p. e2019686. http://doi.org/10.1001/jamanetworkopen.2020.19686.

Farland, Maria. "Sylvia Plath's Anti-Psychiatry." *The Minnesota Review*, vol. 55–57, 2002, pp. 245–56.

Fischer, Ernst. *The Necessity of Art*, translated by Anna Bostock, Verso, 2010.

Foucault, Michel. *Madness and Civilization: A History of Insanity in the Age of Reason.* 1965. Translated by Richard Howard, Random House, 1988.

---. *Madness: The Invention of an Idea.* Translated by Alan Sheridan, Harper Perennial, 1976.

---. "What is an Author?" *Screen*, vol. 20, no. 1, 1979, pp. 13–34. *Oxford Academic*, https://doi-org.uml.idm.oclc.org/10.1093/screen/20.1.13.

Frame, Janet. *An Angel at my Table: The Complete Autobiography.* 1982. Counterpoint, 2017.

---. *Faces in the Water*. 1961. Virago, 2009.

Fromm-Reichmann, Frieda. "Frieda Fromm-Reichmann Discusses the 'Rose Garden' Case." *Psychiatry*, vol. 45, no. 2, 1982, pp. 128–36. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/doi:10.1080/00332747.1982.11024143.

---. *Psychoanalysis and Psychotherapy: Selected Papers of Frieda Fromm-Reichmann*, edited by Dexter M. Bullard, The U of Chicago P, 1959.

Fuller Torrey, E. "Schizophrenia: Sacred Symbol or Achilles Heel?" *Thomas Szasz: An Appraisal of His Legacy*, edited by C. V. Haldipur et al., Oxford UP, 2019. *Oxford Academic*, https://doi-org.uml.idm.oclc.org/doi:10.1093/med/9780198813491.003.0009.

Furst, Lilian R. "Collecting and Disposing of Garbage: Frieda Fromm-Reichmann's *Psychoanalysis and Psychotherapy* and Joanne Greenberg's *I Never Promised You a Rose Garden*." *Just Talk: Narratives of Psychotherapy*, The UP of Kentucky, 1999, pp. 210–26. *EBSCOhost*, uml.idm.oclc.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=e00

0xna&AN=50521&site=ehost-live.

Gabel, Joseph. *La fausse conscience: Et autres textes sur l'idéologie*. 1962. L'Echappée, 2023.

Gambino, Matthew. "Erving Goffman's *Asylums* and Institutional Culture in the Mid-Twentieth-Century United States." *Harvard Review of Psychiatry*, vol. 21, no. 1, 2013, pp. 52–57, https://doi-org.uml.idm.oclc.org/10.1097/HRP.0b013e31827d7df4.

Gans, Steven. "Awakening to Love: R.D. Laing's Phenomenological Therapy." *The Legacy of R.D. Laing: An Appraisal of his Contemporary Relevance,* edited by M. Guy Thompson, Routledge, 2015, pp. 99–114. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/10.4324/9781315724942.

Gibble, Kenneth L. "Go Where You're Sent: An Interview with Joanne Greenberg." *The Christian Century*, vol. 102, 1985, pp. 1063–66. uml.idm.oclc.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=rfh&AN=ATLA0000951883&site=ehost-live.

Gilbert, Sandra M., and Susan Gubar. *The Madwoman in the Attic: The Woman Writer and the Nineteenth-Century Literary Imagination*. 2nd ed., Yale UP, 2000.

Goffman, Erving. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. 1961. Penguin, 1991.

---. "The Insanity of Place." *Psychiatry*, vol. 32, no. 4, 1969, pp. 357–88.

---. *The Presentation of Self in Everyday Life*. Anchor Books, 1959.

---. *Stigma: Notes on the Management of Spoiled Identity*. 1963. Penguin, 1974.

Greenberg, Joanne. Afterword. *I Never Promised You a Rose Garden*. 1964. Holt Paperbacks, 2009.

---. *I Never Promised You a Rose Garden*. 1964. Holt Paperbacks, 2009.

Grob, Gerald N. *From Asylum to Community: Mental Health Policy in Modern America*. Princeton UP, 1991.

Hahn, Patrick D. "Frieda Fromm-Reichmann and Chestnut Lodge." *Madness and Genetic Determinism*, Palgrave Macmillan, 2019, pp. 131–39. *SpringerLink*, https://doi-org.uml.idm.oclc.org/doi:10.1007/978-3-030-21866-9.

Haldipur, C. V., et al. "Introduction." *Thomas Szasz: An Appraisal of His Legacy*, edited by C. V. Haldipur et al., Oxford UP, 2019. *Oxford Academic*, https://doi-org.uml.idm.oclc.org/doi:10.1093/med/9780198813491.003.0001.

Halliwell, Martin. "The Human Face of Therapy: Humanistic and Existential Trends." *Therapeutic Revolutions: Medicine, Psychiatry, and American Culture, 1945–1970*, Rutgers UP, 2013, pp. 231–59, https://doi-org.uml.idm.oclc.org/doi:10.5840/enviroethics199214138.

Hannah, Donald W. "*Faces in the Water*: Case-history or Work of Fiction?" *Bird, Hawk, Bogie: Essays on Janet Frame*, edited by Jeanne Delbaere, Dangaroo Press, 1978, pp. 45–52.

Hornstein, Gail A. *To Redeem One Person is to Redeem the World: The Life of Frieda Fromm-Reichmann*. The Freepress, 2000.

Hume, Kathryn. "Vonnegut's Melancholy." *Philological Quarterly*, vol. 77, no. 2, 1998, pp. 221–38. *ProQuest*, www.proquest.com.uml.idm.oclc.org/scholarly-journals/vonneguts-melancholy/docview/1290981753/se-2.

Hunt, Daniel, and Ronald Carter. "Seeing through *The Bell Jar*: Investigating Linguistic Patterns of Psychological Disorder." *Journal of Medical Humanities*, vol. 33, no. 1, 2012, pp. 27–39. *SpringerLink*, https://doi-org.uml.idm.oclc.org/10.1007/s10912-011-9163-3.

Itten, Theodor. "Psychotherapeutic Compassion in the Tradition of R.D. Laing." *The Legacy of*

R.D. Laing: An Appraisal of his Contemporary Relevance, edited by M. Guy Thompson, Routledge, 2015, pp. 122–32. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/10.4324/9781315724942.

Joint Commission on Mental Illness and Health. *Action for Mental Health: Final Report, 1961.* Basic Books, 1961.

Jordison, Sam. "Interview: Olwyn Hughes, Sylvia Plath's literary executor." *The Guardian,* 18 Jan. 2013, www.theguardian.com/books/2013/jan/18/olwyn-hughes-sylvia-plath-literary-executor.

Kaufman, James C. "The Sylvia Plath Effect: Mental Illness in Eminent Creative Writers." *Journal of Creative Behavior*, vol. 35, no. 1, 2001, pp. 37–50. *Wiley Online Library*, https://doi-org.uml.idm.oclc.org/10.1002/j.2162-6057.2001.tb01220.x.

Kirsch, Irving. *The Emperor's New Drugs: Exploding the Antidepressant Myth*. 2009. Basic Books, 2011.

Kirsner, Douglas. "'Human, All Too Human': The Life and Work of R.D. Laing Interview." *The Legacy of R.D. Laing: An Appraisal of his Contemporary Relevance,* edited by M. Guy Thompson, Routledge, 2015, pp. 142–60. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/10.4324/9781315724942.

Kolich, Augustus M. "Does Fiction Have To Be Made Better Than Life?" *Modern Fiction Studies*, vol. 29, no. 2, 1983, pp. 159–74. *JSTOR*, http://www.jstor.org/stable/26281161.

Krizanich, Annette M. "The Pen Is Mightier than the Dominant Discourse: Writing as Agency and Healing in Plath, Gordon, Frame, Marmon Silko, and Hogan." *Interdisciplinary Literary Studies*, vol. 17, no. 3, 2015, pp. 396–425. *Project MUSE*, muse.jhu.edu/article/592727.

Kubie, Lawrence S. "Review of *I Never Promised You a Rose Garden*." *The Journal of Nervous and Mental Disease*, vol. 142, no. 2, 1966, pp. 190–95. *Ovid*, ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=yrovfta&NEWS=N&AN=00005053-196602000-00013.

Laing, R. D. *The Divided Self: An Existential Study in Sanity and Madness*. 1960. Penguin, 2010.

---. "Metanoia: Some Experiences at Kingsley Hall, London." *Going Crazy: The Radical Therapy of R. D. Laing and Others*, edited by Hendrick M. Ruitenbeek, Bantam Books, 1972, pp. 11–21.

---. *The Politics of Experience and The Bird of Paradise*. Pantheon Books, 1967.

---. *Self and Others*. 1961. Pelican Books, 1972.

---. *Wisdom, Madness, and Folly: The Making of a Psychiatrist*. McGraw-Hill, 1985.

Laing, R.D., and Aaron Esterson. *Sanity, Madness and the Family*. 1964. Penguin, 1971.

Landsman, Gail. "Science Fiction: The Rebirth of Mythology." *The Journal of Popular Culture*, vol. V, no. 4, 1972, pp. 989–97. *Wiley Online Library*, https://doi-org.uml.idm.oclc.org/10.1111/j.0022-3840.1972.0504_989.x.

Leucht, Stefan, et al. "Putting the Efficacy of Psychiatric and General Medicine Medication into Perspective: Review of Meta-Analyses." *The British Journal of Psychiatry*, vol. 200, no. 2, 2012, pp. 97–106. *Cambridge Core*, http://doi.org/10.1192/bjp.bp.111.096594.

Luiggi-Hernández, José Giovanni. "Capitalism is Destroying Our Collective Mental Health." *Mad in America*, 4 Nov. 2022, www.madinamerica.com/2022/11/capitalism-whats-destroying-collective-mental-health/.

Lupack, Barbara Tepa. "Inmates Running the Asylum: The Institution in Contemporary American Fiction." *Dionysus in Literature: Essays on Literary Madness*, edited by

Branimir M. Rieger, Bowling Green State U Popular P, 1994, pp. 169–82. *EBSCOhost*, uml.idm.oclc.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=e000xna&AN=490268&site=ehost-live&ebv=EB&ppid=pp_169.

Macey, David. *The Lives of Michel Foucault: A Biography*. Pantheon Books, 1993.

Malcolm, Janet. *The Silent Woman: Sylvia Plath and Ted Hughes*. Vintage, 1993.

Mantel, Hilary. "Author, Author: Every Writer Has a 'How I Became a Writer' Story." *The Guardian*, 6 Sept. 2008, www.theguardian.com/books/2008/sep/06/1.

---. Introduction. *Faces in the Water*, by Janet Frame. 1961. Virago, 2009.

Maté, Gabor. *When the Body Says No: The Cost of Hidden Stress*. Knopf Canada, 2004.

McBride, James H. "Mental Symptoms of Cerebral Syphilis." *JAMA: The Journal of the American Medical Association*, vol. XXXVI, no. 5, 1901, pp. 297–302. *JAMA Network*, https://doi.org/10.1001/jama.1901.52470050001001.

McNelly, Willis. "Science Fiction—The Modern Mythology." *America*, vol. 123, no. 5, 1970, p. 126.

Mercer, Gina. *Janet Frame: Subversive Fictions*. U of Otago P, 1994.

Merquior, José Guilherme. *Foucault*. U of California P, 1987.

Miller, Roderick. "Fresnes Prison." *Frank Falla Archive*, www.frankfallaarchive.org/prisons/fresnes-prison/. Accessed 17 June 2023.

Miyatsu, Rose. "'Hundreds of People Like Me': A Search for a Mad Community in *The Bell Jar*." *Literatures of Madness: Disability Studies and Mental Health*, edited by Elizabeth J. Donaldson, Palgrave Macmillan, 2018, pp. 51–69. *SpringerLink*, https://doi.org/10.1007/978-3-319-92666-7.

"Nazi Persecution of Other Groups: 1933–1945." *Holocaust Memorial Day Trust*,

www.hmd.org.uk/learn-about-the-holocaust-and-genocides/nazi-persecution/. Accessed 3 Aug. 2023.

North, Carol. *Welcome, Silence: My Triumph over Schizophrenia*. Avvon Books, 1987.

North, Carol, and Remi Cadoret. "Diagnostic Discrepancy in Personal Accounts of Patients with 'Schizophrenia.'" *Archives of General Psychiatry*, vol. 38, no. 2, 1981, pp. 133–37. *JAMA Network*, https://doi-org.uml.idm.oclc.org/doi:10.1001/archpsyc.1981.01780270019001.

Oettili-van Delden, Simone. *Surfaces of Strangeness: Janet Frame and the Rhetoric of Madness*. Victoria UP, 2003.

Ögren, Kenneth, and Mikael Sandlund. "Lobotomy at a State Mental Hospital in Sweden: a Survey of Patients Operated on During the Period 1947–1958." *Nordic Journal of Psychiatry*, vol. 61, no. 5, 2007. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/10.1080/08039480701643498.

Oliver, Mike. *Social Work with Disabled People*. Macmillan, 1983.

Parker, Scott F. *Conversations with Ken Kesey*. UP of Mississippi, 2014.

Pederson, Joshua. "Trauma and Narrative." *Trauma and Literature*, edited by J. Roger Kurtz, Cambridge UP, 2018, pp. 97–109.

Pescosolido, Bernice A. "Erving Goffman: The Moral Career of Stigma and Mental Illness." *The Palgrave Handbook of Social Theory in Health, Illness and Medicine*, edited by Fran Collyer, Palgrave Macmillan, 2015, pp. 273–86. *ProQuest*, ebookcentral.proquest.com/lib/umanitoba/detail.action?docID=4828222.

Pickering, Andrew. "Laing Beyond Words: Antipsychiatry as Performance." *The Legacy of R.D. Laing: An Appraisal of his Contemporary Relevance,* edited by M. Guy Thompson,

Routledge, 2015, pp. 59–68. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/10.4324/9781315724942.

Pies, Ronald W. "Thomas Szasz and the Language of Mental Illness." *Thomas Szasz: An Appraisal of His Legacy*, edited by C. V. Haldipur et al., Oxford UP, 2019. *Oxford Academic*, https://doi-org.uml.idm.oclc.org/doi:10.1093/med/9780198813491.003.0013.

Plath, Sylvia. *The Bell Jar*. 1963. Faber and Faber, 2005.

---. *The Unabridged Journals of Sylvia Plath*, edited by Karen V. Kukil, Knopf, 2000.

Pols, Jan. "Leading up to The Myth of Mental Illness." *Thomas Szasz: An Appraisal of His Legacy*, edited by C. V. Haldipur et al., Oxford UP, 2019. *Oxford Academic*, https://doi-org.uml.idm.oclc.org/doi:10.1093/med/9780198813491.003.0003.

Porter, Roy. *A Social History of Madness: Stories of the Insane*. Weidenfeld & Nicolson, 1987.

Raaby Gammelgaard, Lasse. "Introduction: Madness and Literature and the Health Humanities." *Madness and Literature: What Fiction Can Do for the Understanding of Mental Illness*, edited by Lasse Raady Gammelgaard, U of Exeter P, 2022.

Raffnsøe, Sverre, et al. "On the Borders of Madness." *Michel Foucault: A Research Companion*, Palgrave Macmillan, 2016, pp. 98–146. *SpringerLink*, https://doi-org.uml.idm.oclc.org/10.1057/9781137351029_4.

Rain, Grey [@shortstockotrauma]. Video with text about mental illness. *TikTok*, 2023, www.tiktok.com/@shortstackotrauma/video/7217485524540362030?_r=1&_t=8eLbGQFek9l.

Rovito, Maria. "Toward a New Madwoman Theory: Reckoning the Pathologization of Sylvia Plath." *Journal of Literary & Cultural Disability Studies*, vol. 14, no. 3, 2020, pp. 317–85. *Project MUSE*, muse.jhu.edu/article/762120.

Ryle, Anthony. "Sylvia Plath and the Depression Continuum." *Journal of the Royal Society of Medicine*, vol. 96, no. 9, 2003, pp. 471–72. *Sage Journals*, https://doi-org.uml.idm.oclc.org/10.1177/01410768030960.

Sadowsky, Jonathan. *Electroconvulsive Therapy in America: The Anatomy of a Medical Controversy*. Routledge, 2016. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/10.4324/9781315522852.

Santiáñez, Nil. "Representations of the Void, or, The Language of Silence in the Fiction on the Strategic Bombing of Germany." *Neophilologus*, vol. 102, no. 3, 2018, pp. 403–20. *SpringerLink*, https://doi-org.uml.idm.oclc.org/10.1007/s11061-018-9558-8.

Schaler, Jeff. "Kaddish for Thomas Szasz." *www.szasz.com*, 20 Sept. 2012, www.szasz.com/szaszdeath.htm

Scull, Andrew. *Madness: A Very Short Introduction*. Oxford UP, 2011.

---. *Madness in Civilization: A Cultural History of Insanity from the Bible to Freud, from the Madness to Modern Medicine*. Princeton UP, 2015.

Sechehaye, Marguerite. *Autobiography of a Schizophrenic Girl*. 1951. New American Library, 1979.

Sedgwick, Peter. *Psycho Politics: Laing, Foucault, Goffman, Szasz and the Future of Mass Psychiatry*. 1982. Unkant Publishers, 2015.

Shalin, Dmitri N. "Goffman on Mental Illness: *Asylums* and 'The Insanity of Place' Revisited." *Symbolic Interaction*, vol. 37, no. 1, 2014, pp. 122–44. *Wiley Online Library*, https://doi-org.uml.idm.oclc.org/10.1002/symb.84.

---. "Interfacing Biography, Theory and History: The Case of Erving Goffman." *Symbolic Interaction*, vol. 37, no. 1, 2014, pp. 2–40. *Wiley Online Library*, https://doi-

org.uml.idm.oclc.org/10.1002/symb.82.

Shorter, Edward. *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. John Wiley & Sons, 1997.

Showalter, Elaine. *The Female Malady: Women, Madness, and English Culture, 1830–1980*. Penguin, 1985.

---. "R. D. Laing and the Sixties." *Raritan: A Quarterly Review*, edited by Richard Poirier et al., Rutgers UP, 1981.

Sibbald, Kaitlin. "Migrating Metaphors: Why We Should Be Concerned About a 'War on Mental Illness' in the Aftermath of COVID-19." *Canadian Journal of Bioethics*, vol. 6, no. 1, 2023, p. 13–23. *Erudit*, https://doi-org.uml.idm.oclc.org/10.7202/1098554ar.

Simonson, Michael. "MIA Survey: Ex-patients Tell of Force, Trauma and Sexual Abuse in America's Mental Hospitals." *Mad in America*, 9 Dec. 2018, www.madinamerica.com/2018/12/mia-survey-force-trauma-sexual-abuse-mental-hospitals/.

Smelser, Neil J., et al. "Social Movement." *Encyclopedia Britannica*, 14 Aug. 2023, www.britannica.com/topic/social-movement.

Sontag, Susan. *Illness as Metaphor and Aids and its Metaphors*. 1977. Penguin, 2002.

"Spelling of Antisemitism." *International Holocaust Remembrance Alliance*, www.holocaustremembrance.com/antisemitism/spelling-antisemitism. Accessed 3 Aug. 2023.

Staub, Michael E. *Madness is Civilization: When the Diagnosis Was Social, 1948–1980*. U of Chicago P, 2011. *EBSCOhost*, https://doi-org.uml.idm.oclc.org/10.7208/chicago/9780226771496.001.0001.

Stevenson, Joanna. *Psychiatry Under Fire: Novelistic Challenges to Biomedical Psychiatry in American Fiction 1961–1964*. 2018. University of Edinburgh, PhD dissertation. era.ed.ac.uk/handle/1842/35590.

St. Pierre, Matthew Paul. *Janet Frame: Semiotics and Biosemiotics in Her Early Fiction*. E-book, Fairleigh Dickinson UP, 2011.

Substance Abuse and Mental Health Services Administration. "Mental Health Myths and Facts." *SAMHSA*, 24 Apr. 2023, www.samhsa.gov/mental-health/myths-and-facts.

Sütterlin, Nicole A. "History of Trauma Theory." *The Routledge Companion to Literature and Trauma*, edited by Colin Davis and Hanna Meretoja, Routledge, 2020. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/10.4324/9781351025225.

Szasz, Thomas. *Antipsychiatry: Quackery Squared*. Syracuse UP, 2009.

---. "'Audible Thoughts' and 'Speech Defect' in Schizophrenia: A Note on Reading and Translating Bleuler." *British Journal of Psychiatry*, vol. 168, 1996, pp. 533–35. *Cambridge Core*, https://doi-org.uml.idm.oclc.org/doi:10.1192/bjp.168.5.533.

---. *Ceremonial Chemistry*: *The Ritual Persecution of Drugs, Addicts, and Pushers*. Syracuse UP, 1974.

---. "Crazy Talk: Thought Disorder or Psychiatric Arrogance?" *British Journal of Medical Psychology*, vol. 66, 1993, pp. 61–67. *PubMed*, https://doi-org.uml.idm.oclc.org/0.1111/j.2044-8341.1993.tb01726.x.

---. *Cruel Compassion: Psychiatric Control of Society's Unwanted*. Syracuse UP, 1998.

---. "Intentionality and Insanity: Some Lessons from Reflections on Art." *Literature and Medicine*, vol. 4, 1985, p. 1–12. *Project MUSE*, https://doi.org/10.1353/lm.2011.0001.

---. "Language and Pain." *American Handbook of Psychiatry*, edited by Silvano Arieti, vol. 1, Basic Books, 1959.

---. "Literature and Medicine." *Literature and Medicine*, vol. 1, 1982, p. 37. *Project MUSE*, https://doi.org/10.1353/lm.2011.0203.

---. *The Meaning of Mind: Language, Morality, and Neuroscience*. 1996. Syracuse UP, 2002.

---. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct.* Dell, 1961.

---. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct.* Revised ed., Harper & Row, 1974.

---. *Psychiatric Justice*. Syracuse UP, 1978.

---. *The Second Sin*. Anchor Press, 1973.

---. *Suicide Prohibition: The Shame of Medicine*. Syracuse UP, 2011.

Thompson, M. Guy. "Introduction." *The Legacy of R.D. Laing: An Appraisal of his Contemporary Relevance,* edited by M. Guy Thompson, Routledge, 2015, pp. 1–10. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/10.4324/9781315724942.

---. "Living in One of R. D. Laing's Post-Kingsley Hall Households." *Mad in America*, 9 Nov. 2013, www.madinamerica.com/2013/11/living-one-r-d-laings-post-kingsley-hall-households/.

Tonkin, Maggie. "'The Time of the Loony': Psychosis, Alienation, and R.D. Laing in the Fictions of Muriel Spark and Angela Carter." *Contemporary Women's Writing*, vol. 9, no. 3, 2015, pp. 366–84. *Oxford Academic*, https://doi-org.uml.idm.oclc.org/10.1093/cww/vpv014.

Toombs, S. Kay. "The Lived Experience of Disability." *Human Studies*, vol. 18, no. 1, 1995, pp. 9–23. *JSTOR*, http://www.jstor.org/stable/20011069.

---. "Living at the Boundary: Healing and Incurable Illness." 2008 Medical Humanities Lecture, Baylor University 15 Oct. 2008, Waco. https://www.baylor.edu/content/services/document.php/74627.pdf

Torn, Alison. "Chronotopes of Madness and Recovery." *Narrative Inquiry*, vol. 21, no. 1, 2011, pp. 130–50. *John Benjamins*, https://doi-org.uml.idm.oclc.org/10.1075/ni.21.1.07tor.

The Union of the Physically Impaired Against Segregation and the Disability Alliance. *Fundamental Principles of Disability*. 1975, disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/UPIAS-fundamental-principles.pdf.

United Nations Human Rights Council. *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health.* A/HRC/44/48, 2020. digitallibrary.un.org/record/3862194?ln=en

Vanderah, Todd W., and Douglas J. Gould. "Cerebral Cortex." *Nolte's The Human Brain: An Introduction to its Functional Anatomy*, 8th ed., Elsevier, 2021, pp. 513–45. www-clinicalkey-com.uml.idm.oclc.org/#!/content/book/3-s2.0-B9780323653985000229?scrollTo=%23hl0001209.

van der Kolk, Bessel. *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. Penguin, 2014.

Veritas, Vicki. "Mental Illnesses that Can Give You Superhuman Brain Powers." *Grunge*, 1 Apr. 2021, www.grunge.com/35052/mental-illnesses-can-give-superhuman-brain-powers/.

Vonnegut, Kurt. *Palm Sunday: An Autobiographical Collage*. 1981. Random House, 1999.

---. *Slaughterhouse-Five*. 1969. Dell Publishing, 1984.

---. *Wampeters, Foma & Granfalloons (Opinions).* 1974. Dial Press, 2006.

Vonnegut, Mark. "Why I Want to Bite R.D. Laing." *Harper's Magazine*, Apr. 1974. harpers.org/archive/1974/04/why-i-want-to-bite-r-d-laing/.

Wahl, Otto F. *Media Madness: Public Images of Mental Illness*. Rutgers UP, 1997.

Waugh, Patricia. *The Harvest of the Sixties: English Literature and its Background 1960 to 1990*. Oxford UP, 1995.

Westbrook, Donald A. "'The Enemy of My Enemy Is My Friend': Thomas Szasz, the Citizens Commission on Human Rights, and Scientology's Anti-Psychiatric Theology." *Nova Religio: The Journal of Alternative and Emergent Religions*, vol. 20, no. 4, 2017, pp. 37–61. *JSTOR*, https://www.jstor.org/stable/26417720.

Whitaker, Robert. *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. Crown, 2010.

Wicks, Amanda. "'All This Happened, More or Less': The Science Fiction of Trauma in *Slaughterhouse-Five*." *Critique: Studies in Contemporary Fiction*, vol. 55, no. 3, 2014, pp. 329–40. *Taylor & Francis Online*, https://doi-org.uml.idm.oclc.org/10.1080/00111619.2013.783786.

Wilson, Stephen. "Study on the Szaszophone: Theme and Variations." *Thomas Szasz: An Appraisal of His Legacy*, edited by C. V. Haldipur et al., Oxford UP, 2019. *Oxford Academic*, https://doi-org.uml.idm.oclc.org/doi:10.1093/med/9780198813491.001.0001.

Wolfe, Kary K., and Gary K. Wolfe. "Metaphors of Madness: Popular Psychological Narratives." *Journal of Popular Culture*, vol. 9, no. 4, 1976, pp. 895–907. *Wiley Online Library*, https://doi-org.uml.idm.oclc.org/10.1111/j.0022-3840.1976.00895.x.

Wood, Mary Elene. "'The Speech Which Arranges the Dance': The Undoing of Schizophrenia in Janet Frame's Autobiography and Fiction." *Life Writing and Schizophrenia: Encounters at the Edge of Meaning*. Brill, 2013, pp. 173–216, https://doi-org.uml.idm.oclc.org/10.1163/9789401209434_006.

www.szasz.com. "The Writings of Thomas S. Szasz, M.D." *The Thomas S. Szasz, M.D. Cybercenter for Liberty and Responsibility*, 9 Jan. 2009, szasz.com/publist.html.