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Disease, Diagnosis and Drugs: A History of American Biological Psychiatry From the Patient Perspective

by

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For my family,

for never agreeing on one version of a story

and arguing over all of the unimportant details,

con muncho amor.

With many thanks

Professor Typhaine Leservot
pour votre temps, votre sagesse et votre patience

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Introduction

"My heels hurt, my head weighs a ton, and something like a giant invisible diving bell holds my whole body prisoner."[1]

In *The Diving Bell and the Butterfly* Jean-Dominique Bauby describes his life as a quadriplegic after he was severely injured in a car accident. His mental faculties were still fully intact yet he was completely unable to convey his mental functioning with his body. The only physical movement and means of communication Bauby was left with is blinking his left eye. Despite this extreme handicap, Bauby used his ability to blink to author and publish a work that has been widely read and recently adapted into film. He has enabled those of us who take for granted our ability to express ourselves and function independently to get a glimpse of what it is like to be trapped within a physical body that can barely convey the inner workings of the mind.

For individuals with mental illness the asymmetry Bauby experiences between his mind and body works in the opposite direction: their physical bodies are fully intact while their illness occurs in their minds. Rather than being trapped by their bodies, the mentally ill are trapped by their minds. In both cases the patient's experience is not readily comprehensible or visible to others. Just as for Bauby the act of communication is extremely difficult and taxing, for those battling mental illness, it is extremely difficult to convey their invisible illness to outsiders. The invisibility of mental illness in part explains the enormous stigma attributed to it well into the twentieth century. Such stigma has discredited the mentally ill as crazy or insane, labels that suggest "blemishes

[1] Bauby, *The Diving Bell and the Butterfly*, 3.

of individual character."[2] As a result, patient testimonials written before the 1990s, when psychiatric drug use increased and such stigma decreased, are hard to find. Because of the highly subjective nature of mental illness, individuals' own experiences shed light onto conditions that are otherwise left as invisible pathologies, and illuminate the profound impact social views have on the individual's experience of their illness. These personal accounts, whose presence and popularity has dramatically increased over the past fifteen years, are not merely representations but have the power to engage with and reshape society's understanding of mental illness. Therefore, when investigating the history of mental illness, one must be aware of the psychiatric, social and patient discourses present in a given time period. Furthermore, within social discourses, one should distinguish between public social views that have to do with widespread assumptions of the mentally ill and their portrayal in the media, and private social views that are contained within the family, those who perceive mental illness at a close proximity.

Given the nature of my project, which roughly spans a fifty-year period, I have tried to show the way in which the discourses present at one moment in time are linked to those that develop and gain provenance in the years that follow, or explain their disappearance. The history of psychiatry is not one of ruptures but of revision that was not immune to cultural changes that occurred in society at large. Raymond Williams' terms 'dominant,' 'residual' and 'emergent,' which he introduces in his brief chapter by the same name, provide a framework in which to talk about the shifting psychiatric and

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[2] Goffman, *Stigma*, 4.

social discourses.[3] Williams explains how using these three terms to designate different types of discourses at play in a given moment recognizes "not only 'stages' and 'variations' but the internal dynamic relations of any actual process."[4] Indeed the history of psychiatry in the latter half of the twentieth century fits such a model.

In the first half of the twentieth century there were only two options for patients facing mental illness: the asylum or psychoanalysis. In 1955 the future of psychiatric treatment drastically changed when scientists discovered that psychiatric drugs could change brain chemistry. The revolution in treatment that this discovery and the development of drugs and other advancements such as electroconvulsive therapy (ECT) sparked was only an emerging discourse in the late fifties and early 1960s. In the years between 1965 and 1970 psychiatry experienced a paradigm shift as psychoanalysis faded into a residual discourse, and biological psychiatry, with the help sedative drugs such as Valium, became the dominant discourse by 1970. From 1970 onward, biological psychiatry cemented itself as the dominant psychiatric discourse as neuroscience and genetic theories gave psychiatry a stronger scientific footing. The biological paradigm has been bolstered by the development of psychotropic and antipsychotic drugs to successfully treat different types of mental illness, such as lithium, which was approved for use by the FDA in 1970 and has been used to treat manic-depressive illness since.

Over the past fifty years the history of psychiatry, and specifically advances in treatment, have been impacted by the cultural trends in the United States, from the conservative views of the 1950s to social upheaval of the late 1960s and the emergence of corporate culture through the 1980s and 1990s. The social and cultural context each

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[3] Williams, *Marxism and Literature*, 121.
[4] ibid., 121.

work engages with provides an essential component of the patient's experience and allows the reader to have a fuller understanding of the many forces at play during their respective time periods. Sylvia Plath's *The Bell Jar*[5] (1971) relates Esther's coming-of-age and struggle with depression in the late 1950s and early 1960s, a time of social conservatism when treatments for depression were in their initial stages of development. Plath shows how the prevailing discourse, which saw mental illness as either so serious that it merited institutionalization or so trivial that it was the patient's fabrication, equated mental illness with identity. Patients were faulted for their illness and offered no support from their family or from psychiatrists. However, with the advent of ECT Plath illustrates that depression existed on a scale and was not as black and white as psychiatrists and society presumed.

From the conservative values of the fifties to the radical views of social change, Susanna Kaysen's memoir *Girl, Interrupted*[6] (1994) chronicles the cultural shift that occurred between 1965 and 1970. While Esther's depression made her abnormal in the eyes of those around her, Kaysen's dismissal of her parents' expectations for her caused them to assume she had a mental illness. In her account of her institutionalization at McLean Hospital from 1967 to 1969 Kaysen reveals how adolescent patients were subjectively diagnosed based on their social deviance, then controlled and pressured to adhere to social norms by sedative drugs that psychiatrists administered against their will. During a time of social change, psychiatrists became the authorities of normalcy, an authority they dubiously gained because of the presumed scientific nature of their field.

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[5] Sylvia Plath, *The Bell Jar* (New York: Harper Perennial, 1971).
[6] Susanna Kaysen, *Girl, Interrupted* (New York: Vintage Books, 1994).

The science behind psychiatry gained momentum in the 1970s and 1980s as Kay Jamison expresses in her memoir *An Unquiet Mind*[7] (1995) which focuses on the role of lithium, an anti-psychotic medication, in her lifelong battle with manic-depressive illness.[8] Jamison's emphasis on the importance of adhering to one's medication reflects the dominance of the biological model and the widespread use of psychiatric medication among Americans in recent decades. As a result of the development of psychiatric drugs in combination with the corporate culture of the 1980s and 1990s depression has faded from an illness into a mood, one that is readily ameliorated by simply taking a pill. As depression has become normalized, other psychiatric illnesses such as manic-depression and schizophrenia have become the primary object of society's attitudes towards mental illness.

Due to their widespread popularity these three works have helped condition our attitudes towards individuals dealing with mental illness and as a result, they lend themselves to cultural and social analysis. All three books have been widely read, each selling millions of copies. Kaysen and Jamison's memoirs each spent time on the New York Times best-seller list. Their popularity has been furthered by their adaptation into major motion pictures: the film adaptation of Kaysen's novel was produced in 1998 with a well-known Hollywood cast, and production has begun on a film adaptation of Plath's novel this year.

The recent adaptation of these memoirs into films accompanies a dramatic increase in memoirs written by mentally ill patients since the 1990s, particularly memoirs

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[7] Kay Jamison, *An Unquiet Mind* (New York: Vintage Books, 1995).
[8] When talking about Jamison's book, her illness will be discussed as manic-depressive illness, as she does. Further explanation for this choice is provided in chapter three.

of madness, which Susan Balée outlines.[9] Our culture simultaneously valorizes this sort of confessional writing and cultivates it. The increase in first-person memoirs Balée outlines is evident in the publication history of the three works I consider. Jamison and Kaysen published their works in the mid-1990s while Plath's was published in 1960. Plath's fictionalized work was originally written under a pseudonym, while Jamison and Kaysen openly published their works during the moment when such memoirs were gaining popularity. Susan Herbert argues that the writing of 'madness narratives' has increased in part because they have become part of the psychotherapy process. To overcome one's illness is to speak openly about it as "revelations that were once reserved only for the ears of the therapist, are now trumpeted to the world for all to hear and judge."[10] Kay Jamison directly addresses the choice to publish such a candid picture of her mental past, writing "I have no idea what the long-term effects of discussing such issues so openly will be on my personal and professional life, but, whatever the consequences, they are bound to be better than continuing to be silent…I am tired of acting as though I have something to hide."[11] Over the past fifty years the stigma of mental illness, whether chronic or lingering in the past, has diminished. This decrease is inversely related to a dramatic increase in the number of individuals seeking therapy either from medication, psychotherapy, or both. Yet even in this medicated culture in which individuals both young and old speak openly about their experiences with mental illness, the societal knowledge of mental illness remains minimal. Most Americans do not have a well-developed understanding of what it is like to deal with a serious mental illness, or the repercussion of being diagnosed with one. It is through autobiographical

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[9] Balée, *From the Outside In,* 51.
[10] Balée, 48.
[11] Jamison, *An Unquiet Mind* , 7.

works by current and former mentally ill patients that the general public can gain a sense of what it is like to be diagnosed with a mental illness.

Women and Mental Illness

All three of the works I address were written by women. While this choice was not intentional, neither was it haphazard. Women have always outnumbered men in psychiatric hospitals; they are more likely to seek help for psychiatric conditions, and they are more likely to be medicated with psychiatric drugs. In recent statistics published by the Center for Disease Control, women were almost twice as likely as men to experience a major depressive episode.[12] In 2004, the World Health Organization found that depression was "the leading cause of disease burden for women in both high-income and low- and middle-income countries."[13] During an interview Jamison stated that depression ending in suicide is the number two killer of women between the ages of 15-44 worldwide, while it ranks fourth for men.[14] One of the reasons psychiatrists have diagnosed and treated illness more often in women than in men—depending on the time period, up to three times more often in women—is the result of a long-standing gender bias in psychiatry. Mental illness has long served to keep women in second-class citizen status, with the psychiatric community employing terms such as *hysteria*, whose etymology derives from women's sex organs. Given the effect of mental illness, and particularly depression on women worldwide, the female voice on this topic is one that deserves to be heard.

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[12] Jonas and Brody, *Mood Disorder Prevalence Among Young Men and Women in the United States*.
[13] World Health Organization, *The Global Burden of Disease: 2004 Update*, 46.
[14] Charlie Rose LLC, *An interview with Kay Redfield Jamison*.

In her essay "Kinder, Kuche, Kirche as Scientific Law: Psychology Constructs the Female" published in 1968, Naomi Weisstein illuminates the way in which psychology had fallen prey to disparaging social views of women, turning these views into scientific terms that solidified their apparent truth. She writes that the outcomes of psychiatric studies were not objective, but in fact grounded in traditional expectations of women: "if women, according to Bettelheim, want first and foremost to be good wives and mothers, it is extremely likely that this is what Bruno Bettelheim, and the rest of society, want them to be."[15] Given the particularly limited roles afforded women, especially offspring of the upper class, Weisstein argues that the social views of normalcy that plagued psychiatry during the 1950s and 1960s were even narrower and more confining when it came to women. Psychologists, she contends, "are limiting discovery of human potential" and "until social expectations for men and women are equal, until we provide equal respect for both men and women, our answers to this question will simply reflect our prejudices."[16] Despite many advances in the past forty years, such inequality remains.

One of the most notable authors to have written on the topic of women and psychiatry is Phyllis Chesler, a well-known psychologist and co-founder of the Association for Women in Psychology, whose work *Women and Madness* (1972, updated 2005) provides a foundation for understanding women's relation to psychiatric illness. Chesler articulates that throughout history, and particularly in the early twentieth century, women have often been viewed as "somehow naturally mentally ill. Women were hysterics (*hysteros*, the womb), malingerers, child-like, manipulative, either cold or

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[15] Weisstein, "Kinder, Kuche, Kirche as Scientific Law."
[16] ibid.

smothering as mothers, and driven to excess by their hormones."[17] In Ancient Greece, Hippocrates was the first person to employ the term hysteria, which has become the most noticeable example of the longstanding gender bias in psychiatry because it suggested that psychotic behavior was a result of disturbances in the uterus (*hystera*) and therefore limited to women. As this view has faded, Chesler explains that the disproportionately large percentage of women in psychiatric institutions "is also predicted by the comparatively limited social tolerance for 'unacceptable' behavior among women—which leads to comparatively great social and psychiatric pressure to adjust—or be judged as neurotic or psychotic."[18] All three authors, if only briefly, touch upon the way in which their identities and aspirations were stifled because of the history of limited social roles available for women. Plath correlates Esther's recovery from depression with her female doctor, who helps Esther achieve sexual freedom and independence during a time of social conservatism. Kaysen confronts the way in which women's sexual identity was stigmatized in the years leading up to the sexual revolution and development of feminism. Lastly, Jamison's work addresses the contemporary issues women face in developing their professional lives in working worlds that are often dominated by men. This gender bias is not limited to one particular time period, but has adapted each generation.

Hand in hand with the notion that women are naturally mentally ill is the notion that they are responsible for their illness. In *The Bell Jar* and *Girl, Interrupted* and until the 1970s when the biological paradigm became the dominant psychiatric view, mental illness was largely seen as the patient's fault. Chesler, who completed her training as a

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[17] Chesler, *Women and Madness*, 1.
[18] ibid., 177.

clinical psychologist in the 1960s and early 1970s, reports that she was taught "to blame the victim for what had happened to her."[19] Chesler is quick to view this professional rationale as one that "merely repeated and falsely professionalized our previous cultural education."[20] As a genetic understanding of mental illness has been established in recent years, this notion has begun to dissolve.

One of the long-standing ways of dealing with mentally ill women has been to visibly remove them from society. The establishment of mental asylums, which became psychiatric hospitals, cemented this practice. However, Chesler argues, "there are very few genuinely (or purely) mad women in our culture. Society generally banishes such experiences from understanding, respect—and from plain view. Madness is shut away from sight, shamed, brutalized, denied, feared, and drugged."[21] In their works, Plath and Kaysen delve into their own institutionalizations with particularly interesting details. While Plath portrays her experience in a positive light, Kaysen does not. Chesler characterizes the two poles of asylum experience that these two writers experienced, detailing that

> At their best, mental asylums are special hotels or college-like dormitories for white and wealthy Americans, where the temporary descent into 'unreality' (or sobriety) is accorded the dignity of optimism, short internments, and a relatively earnest bedside manner. At their worst, mental asylums are families bureaucratized: the degradation and disenfranchisement of self, experienced by the biologically owned child (patient, woman), takes place in the anonymous and therefore guiltless embrace of strange fathers and others.[22]

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[19] ibid., 1.
[20] ibid., 2.
[21] ibid., 85.
[22] ibid., 95.

These two vastly different experiences of the asylum as therapeutic or curative are ones that Plath and Kaysen skillfully recreate for their readers. Despite their different outcomes, in both instances these women were physically ostracized from society.

The limited social roles allowed for women and the impetus to remove mentally ill individuals from society represent longstanding social and cultural views towards those battling psychiatric illness. These views, however, are not limited to public social perceptions or private family views, but have consistently affected psychiatric practices. In particular, psychiatric illness has a history of being viewed as a threat to the community. As early as 1958, Thomas Szasz synthesized this association, describing that "In-fringements of the rights of others, or threats against the social order, are viewed as criminal acts, and its perpetrators as 'criminals.'"[23] In a similar vein, Szasz differentiates between the social interpretations of physical and mental illness, stating "To have pneumonia is not considered to be 'bad'-but to have a 'psychopathic personality' is only a more elegant way of expressing moral condemnation."[24] Psychiatric diagnoses, then, are intrinsically attached to social judgments of moral behavior, social expectations and a communal social welfare that psychiatric institutions' presence supposedly upholds. The implications of such diagnoses lie at the core of Plath's, Kaysen's and Jamison's works.

Thesis Outline

In my thesis I explore the development of the biological psychiatric paradigm through Plath's *The Bell Jar*, Kaysen's *Girl, Interrupted* and Jamison's *An Unquiet Mind*. Moving chronologically through these three works I trace the psychiatric discourse, the

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[23] Szasz, "Politics and Mental Health," 186.
[24] ibid., 195.

social discourses, both public and private, and the patient discourse of psychiatric illness. In the first chapter, I will focus on Sylvia Plath's autobiographical novel *The Bell Jar* and the way in which Plath uses the metaphor of the bell jar to offer an alternative view of mental illness based on her experience with depression. Confronting the conservative social views of the late 1950s and early 1960s that saw psychiatric illness as either so severe it merited lifelong institutionalization or so trivial that it was the patient's invention, Plath suggests that mental illness is uncontrollable by the patient and exists in a much more varied way than society's two extreme understandings allow for. In part, the disintegration of such extreme views had also begun in the psychiatric setting with the development of electroshock therapy (ECT), which finally provided a way for psychiatrists to treat their patients and help them recover from their illness.

The second chapter will focus on Susanna Kaysen's memoir *Girl, Interrupted* and the way in which the years between 1965 and 1970 were ones of transition and change both in psychiatry and in American society. As a counter-culture developed that threatened the older conservative guard, a generation gap grew between adolescents and their parents. This lack of understanding among generations meant institutionalization for teenagers, whose adolescent characteristics were new and threatening. Psychiatrists, much like parents, made subjective diagnoses that hinged more on social views of normalcy than psychiatry pathology, and in place of conservative social norms, used recently developed sedative medication to control their teenage patients and force them to conform to the social standards of the older generations.

The third chapter explores Kay Jamison's memoir *An Unquiet Mind*, which details her lifelong experience dealing with manic-depressive illness. After 1970, when the

biological paradigm of psychiatry became the dominant view, many more drugs were developed to help treat mental illness. As a result, the American population has become increasingly more attached to medication to the extent of over-privileging the role medication plays in daily life. By viewing compliance with psychiatric drugs in black and white terms, individuals such as Jamison re-dichotomize mental illness as a matter of life (with medication) or death (without). This view is reinforced by the advent of direct-to-consumer advertising, which encourages medication for non-illness, such as stress. Additionally, the development of genetic information about mental illness turns illness into something the individual does or does not have the gene for, thus returning to the all-or-nothing view of mental illness, which Plath was fighting against in the '50s. Genetic information about the heredity of mental illness has helped mitigate its stigma, yet the danger of such information is that it will create a culture of determinism in which individuals no longer feel any sort of responsibility or preventability with respect to such illness. Although the history of psychiatry is often written as a history of progress, individual patients' experiences of mental illness have lagged behind advances in psychiatric treatment.

Chapter One: Redefining Depression in *The Bell Jar*

In her novel *The Bell Jar* (1971) Sylvia Plath brings her reader into a world of anxiety, depression and suicidal episodes through her fictionalized rendering as the personage of Esther Greenwood. When the novel begins, Esther is about to spend the summer as an intern at a fashion magazine with other young women, but soon into her adventure she realizes that she is losing control over her life. Convinced that her years of winning literary prizes are over, her sense of self-worth plummets and she cascades into a series of anxiety attacks, depressive moods and suicide attempts. To cope with her altered state-of-being Esther sees a psychiatrist and is prescribed medicine. When this is not enough to help her, she is sent to a psychiatric hospital where she is treated with shock therapy. Her institutional experiences provide vivid accounts of the way the mentally depressed was defined and treated in 1950s America. As an author, Plath relies heavily on her own experience, which lends a fresh and realistic quality to her work. By honestly portraying the emotions and images of depression and the reactions Esther receives from others, Plath uses her work to empower the patient perspective of depression. Delving deep into her own mind and the mind of her protagonist, Plath offers a way of looking at depression that moves away from the contemporary discourse of depression as an all-or-nothing phenomenon to one that exists on a scale. Her novel gives the depressed patient exactly what society had stifled: a voice and the power to redefine her depression as an illness instead of an identity.

Most critics view *The Bell Jar* as an autobiographical piece that illuminates Plath's own depression. Given that Plath regarded her novel as an "autobiographical apprentice

work," literary critics have largely read the book as autobiographical as well.[25] Initial reviewers of Plath's first edition, published under a pseudonym, characterized *The Bell Jar* as a piece by a literary newcomer.[26] After her second publishing with her own name on the cover, an English critic wrote that the novel "suffers in comparison with Plath's poems," feeling as if her poetry condensed the same emotions her novel spelled-out.[27] As a result of an autobiographical reading of the text, Gordon Claridge, a British psychologist and author who studies individual proneness to schizophrenia, has included the novel in a tradition of works by psychotic authors.[28] In a similar capacity, many writers have compared Plath to Virginia Woolf in trying to understand the relationship between female writers and mental illness. However, these approaches are limited to understanding Plath's identity as an author in the context of her own illness.

Plath's work has also been widely read from a feminist perspective, which interprets Esther's depression as a case of disillusionment with the limited role permitted for women during the American society of the 1950s. Phyllis Chesler remarks that for Plath, "madness and confinement were both an expression of female powerlessness and an unsuccessful attempt to reject and overcome this state."[29] More specifically, Pat MacPherson, a scholar who has written on the socio-political conditions surrounding *The Bell Jar*, reads the novel as expressing Esther's fear of motherhood, commenting: "Esther's fear and hatred of her mother entrap her within a misogynist version of mother hood that is potentially lethal."[30] Similarly, Marjorie Perloff, a critic interested in

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[25] Alvarez, *The Savage God*, 21.
[26] Gill, ed., 127.
[27] ibid., 127.
[28] Claridge, ed., *Sounds from the Bell Jar: Ten Psychotic Authors*, 211.
[29] Chesler, 76.
[30] MacPherson, *Reflecting on The Bell Jar,* 59.

contemporary poetry's relation to the media, observes that Plath's focus "is not on mental illness per se, but on the relationship of Esther's private psychosis to her larger social situation. Indeed, her dilemma seems to have a great deal to do with being a woman in a society whose guidelines for women she can neither accept nor reject."[31] While these authors see a relationship between Esther's, and perhaps Plath's, psychosis and the social and cultural milieu, this perspective is confined to social roles.

A largely overlooked approach to reading *The Bell Jar* is in the context of a moment in American history when practices and views towards depression were changing, both in society at large and within the medical community, as new methods for treating depression came into existence. In her novel Plath engages with both the contemporary social and medical discourses about depression to suggest their limit and offer an alternative. She moves away from pejorative language of 'madness' and 'insanity', which implies that such states are permanent, to the metaphor of the bell jar, which externalizes depression as a force the patient cannot control. While Plath evokes the stereotypical image of the insane individual in Esther's negative experiences with Dr. Gordon, she replaces this negative understanding of depression with the metaphor of the bell jar in Esther's positive experience with Doctor Nolan. Unlike Doctor Gordon, Doctor Nolan helps Esther take control of her own illness and eventually recover. These two drastically different approaches to Esther's care illustrate the psychiatric community's shift from a psychosocial to a biological view of mental illness, which was in its earliest stages in the late 1950s. By viewing these two different treatment styles through Esther's eyes, Plath creates a setting in which the reader is forced to view mental

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[31] Perloff, "A Ritual for Being Born Twice," 511.

illness through a new perspective: the patient's. Although memoirs of mental illness are now frequently published, Plath's fictionalized narrative was one of the first widely read accounts of this kind. In her novel Plath effectively redefines the patient's status within a larger society by separating the individual's identity from their illness and showing that depression as she knows it does not fit into the extreme views society and the medical community offered at the time. Plath successfully achieved this shift in representation and understanding of depression by using her already established identity as an author and the genre of her writing as a novel to put forth a personalized account that was widely read.

1955-1965: Psychiatric and Social Views of the Mentally 'Insane'

During the 1950s and early 1960s when Plath struggled with depression and wrote *The Bell Jar*, the dominant psychiatric view of depressed individuals was that they were crazy, so thoroughly one with their disease that they were doomed to spend their lives in asylums. In the first half of the twentieth century there were only two options available to those dealing with mental illness: asylums or psychoanalysis.[32] However, psychoanalysis was understood as "a therapy suitable for the needs of wealthy people desiring self-insight, but not for really psychiatric illnesses."[33] Given the higher cost of psychoanalysis and the perception that individuals with mental illness were harmful to society, the only 'real' treatment for mental illness was institutionalized care, and many patients, especially those of lower socioeconomic status, ended up in state asylums. This trend led to crowded asylums whose care steadily declined. However, this result was not

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[32] Shorter, *A History of Psychiatry*, 238.
[33] ibid.,190.

the intention of American asylum reformers who advocated for 'moral therapy' back in the 18th century, envisioning asylum care as therapeutic, "with its orderly routines and communal spirit, and the doctor-patient relationship."[34] These moral doctors intended asylums to provide temporary care that emphasized patients' self-control as a therapeutic goal.[35] Over time as asylums filled, and psychiatrists replaced moral doctors, they abandoned these altruistic roots along with any pretenses of cure or discharge, focusing more on institutionalization than treatment.

By the middle of the 20th century asylum care symbolized the 'need' to physically remove the mentally ill from society, perpetuating their association within society at large as crazy individuals. In 1953 the *Los Angeles Times* published an article by Amy Selwyn titled, "Don't Let Mental Illness Scare You," suggesting precisely that Americans were afraid of 'the insane,' as the article labels those with mental illness.[36] The term 'insane' implies that the individual has lost his or her sanity and ability to think and act rationally, and therefore has lost precisely those faculties that defined him or her as human. The extent of the stigma surrounding mental illness is evident in newspaper articles of the time. A 1955 article stated, for instance, that "most of the mentally ill, so to speak, merely feel, think and act 'wrong,'"[37] By associating sanity with normalcy and insanity with unacceptable deviance, the media justified the psychiatric perspective that the only option for such individuals was to lock them up in asylums. The journalistic discourse entrenched the public image of those with depression and other mental illnesses with negative associations.

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[34] ibid.,18.
[35] ibid.,18.
[36] Selwyn, "Don't Let Mental Illness Scare You," 17.
[37] Engel, "Survey of the Present State of Psychiatry."

The recurrent use of the word 'insane' to refer to the depressed individual eventually turned the mental patient's illness into an identity, a permanent and indelible self. In the 1940s the public discourse of mental illness was that it was irreparable, carrying "enormous social stigma and the morbid dread of potential institutionalization," a view that continued well into the 1950s.[38] Selwyn's article perpetuates this sense of mental illness as irreversible, writing "the average citizen is apt to consider mental illness a one-way passage to doom."[39] Thus the insane individual would always remain this way, and it was in the absence of a successful and permanent treatment for mental illness that these attitudes and beliefs arose.

The view that mental illness was so serious it merited permanent institutionalization, occurred, however, alongside the opposite view that it was so insignificant that it could be ignored. This opposite but equally extreme understanding of depression was more prominent within family circles than in public discourse, as represented in newspaper articles. Given the American climate of conformity during the 1950s, families likely minimized the severity of the disease because they didn't want to have their children locked up or appearing 'crazy.' For families, asylum care cultivated a "desperate panic to avoid at all costs the confinement of a relative in an insane asylum."[40] The desire to hide the disease contributed to a reluctance to admit it existed altogether. Because mental illness is linked to behavior, families easily dismissed or resisted the notion of a member being 'crazy,' instead viewing their conduct in terms of a conscious choice to act out. The mental patient moping around the house in an unpleasant mood, by this logic, had complete control to 'snap out of it' or 'toughen up.' While this view of

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[38] Callahan and Berrios, *Reinventing Depression*, 85.
[39] Selwyn, 17.
[40] Shorter, *A History of Psychiatry*, 115.

mental illness seems antithetical to the public view of depression as deserving of institutionalization, it shows that the stigma surrounding mental illness was so great it could tarnish an entire family, hence the desire to keep up appearances while making the disease seem like an invention. In response to a physician's suggestion that their son be institutionalized, a family lamented "It's inconsiderate of him not just to pull himself together…nobody wants to marry into a family with mental illness."[41] Although this anecdote is from the 1890s, asylum care went largely unchanged from that time until the 1950s. Minimizing the disease by focusing on the individual's inherent rationality completely contradicted the notion that this person could be insane to begin with. Rather, it expressed the will to see the individual simply 'decide' to be normal and sane again.

The co-existence of extreme and polarizing views, instead of one dominant view, in both the public and private realms, is evidence of a large-scale societal misunderstanding of mental illness. There was no attempt in either realm to understand depression. Instead, society either removed the afflicted individual or ignored the possibility of illness. Both of these reactions indicate that mental illness was simply unacceptable in American society in the 1950s. Furthermore, these views expose society's extreme ignorance of the daily trials depressed individuals faced, and in both cases simplified an illness that warranted further attention and care. The medical world's understanding that physicians in asylums "could cure nothing" bolstered society's disregard of depression and its symptoms.[42] Seen within this context, both discourses:

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[41] ibid., 115.
[42] ibid., 192.

removing the individual from society or ignoring the illness, reflect the impetus to disregard the mentally ill rather than treat their illness.

Plath's Representation of Social and Psychiatric Discourses

The Bell Jar provides a rich source of contemporary psychiatric history that synthesizes many of the different social, medical and patient understandings of clinical depression. In her novel Plath takes the reader through Esther's struggle understanding, coping with and treating her depression, a struggle that is bound up in society's misunderstanding of her illness. At the heart of this ignorance was both society's and the medical community's understanding of the depressed patient as nothing more than their disease.

Plath conveys the public perception of mentally ill patients as 'insane' in Esther's stay at Dr. Gordon's hospital. Esther observes that Dr. Gordon's private hospital "seemed normal, although I knew it must be chock-full of crazy people," showing that she too had internalized the public discourse of aligning illness with identity.[43] However, she soon becomes a crazy individual in the eyes of those around her, which she notices when a doctor "gawped at us with big, rolling eyes."[44] In this moment Esther realizes "we were his first crazy people."[45] The 'crazy people' is no longer a group she observes but one she belongs to, as the doctor's look indicates. After this experience Esther is not a normal, functioning individual anymore, but rather another crazy patient who cannot be trusted. The implications are that she is her illness; she is insane.

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[43] Plath, 141.
[44] ibid.,180.
[45] ibid., 180.

The public fusion of identity and illness is illustrated in the newspaper clippings Joan, another patient, shows Esther at the private hospital. Joan has saved a pile of newspaper excerpts related to Esther with headlines that read "SCHOLARSHIP GIRL MISSING. MOTHER WORRIED…*Ms. Greenwood asked that this picture be printed in hopes that it will encourage her daughter to return home*."[46] This public portrayal of Esther's disappearance, and indirectly of her disease, paints the entire episode as a daughter who has brought undue suffering to her mother. The victim is not the 'girl missing' but the 'mother worried.' This headline references a societal discourse that, like Esther's mother, is not concerned about Esther's illness so much as it is concerned with the appearance of the perfect home and family. This emphasis on returning home alludes to the public notion that such individuals had to be removed from the public view, exiled either to the home or the asylum. By focusing on removal from society and public appearances, the newspaper synthesizes the public and private discourses of mental illness. Furthermore, the newspaper articles indicate that the mere mention of mental illness was socially unacceptable. Esther is never described as 'mad' only as 'missing.' By returning home, Esther will no longer be the focus of public attention nor will she pose a problem to her worried mother.

By dismissing her daughter's illness, Esther's mother presents a view that typifies the private social discourse that saw depression an invention. Throughout the novel Esther's mother assumes that her daughter would get better if she only tried, impatiently pleading "Oh, Esther, I wish you would cooperate. They say you don't cooperate. They

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[46] ibid., 198.

say you won't talk to any of the doctors."[47] Her comment expresses the notion that Esther's illness is an illusion of her own mind, and that if she really wanted to, Esther could simply 'cheer up' or change her attitude and her illness would no longer exist. In consoling words, she tells Esther "I knew you'd decide to be all right again," revealing her ignorance of the situation and perception that there should be a simple solution to Esther's problems.[48] This view, however, is limited to Esther who she separates from "those awful dead people," the other patients at Dr. Gordon's hospital.[49] Instead of helping Esther, this separation from the other patients, whose characterization as 'dead' further dehumanizes them, only perpetuates the notion that Esther has the ability to decide to get better, a decision these 'dead' patients cannot make.

Through Dr. Gordon Plath demonstrates that the private discourse of mental illness as an insignificant fabrication extended into the psychiatric realm as well. Doctor Gordon exhibits this view of depression as an invention when he asks Esther what is wrong in her life. Esther becomes enraged by Dr. Gordon's misperception, seething, "what did I *think* was wrong? That made it sound as if nothing was *really* wrong, I only *thought* it was wrong." His question devalues Esther's experience, treating her illness as trivial and unimportant. Doctor Gordon is portrayed as uninterested in restoring Esther's sense of self, instead leading her deeper into despair and self-doubt. Plath emphasizes that the medical community validated the private discourse of depression as the patient's fabrication. By blaming the patient, doctors and family members were able to exonerate themselves as actors in the patient's disease and absolve themselves of any responsibility.

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[47] ibid., 179.
[48] ibid., 146.
[49] ibid., 145.

Esther's dialogues in the asylum with Dr. Gordon and at home with her mother combine the social and psychiatric discourse that considered mental illness to be the patient's fault. When looking at her daughter, Esther's mother does not see an individual struggling with depression, but rather a rebellious, selfish child who refuses to cooperate. Similarly, Dr. Gordon rationalizes that by choosing to act the way she does, Esther 'deserves' to be hospitalized. These insensitive views expose the insurmountable stigma the depressed individual faced within society at large, the family, and the psychiatric community. Instead of helping the individual battle her illness, society cultivated a paternalistic discourse that patients like Esther could not make good decisions and deserved to be treated as children. The two alternative discourses that either viewed the patient as deliberately acting ill or as radically insane reinforced one another and produced the negative view of mental illness that reigned in 1950s America.

Redefining Mental Illness: Plath's Discourse and the Arrival of ECT

In *The Bell Jar* Plath skillfully moves beyond the contemporary social and psychiatric discourses to develop a new view of mental illness in which a mentally ill individual is not defined by her identity, illness exists on a scale, and the patient is not at fault for her illness. Plath conveys these three elements of this new discourse through Esther's relationship with her doctors and her environment. At the center of her institutional experience, however, is her treatment with ECT, which was one of the first examples of the emerging discourse of biological psychiatry. As Plath advocates for a nuanced view of depression, one comes to realize that the development of ECT was a crucial step in the medical community's ability to distance itself from a black-and-white understanding of depression.

Electroconvulsive therapy (ECT), also known as electroshock therapy or simply shock therapy, was developed by the Italian doctor Ugo Cerletti in 1938.[50] ECT was part of the 'physical therapies,' as distinct from psychotherapy and psychoanalysis, developed during the pre-war period as attempts to cure depression.[51] Although ECT has come to be synonymous with electroshock, patients do not actually go into shock; rather they "experience unconsciousness from a dose of electric current or chemical stimulus and then undergo a therapeutic convulsion of about a minute's duration, regaining consciousness shortly thereafter."[52] Cerletti's use of electric shock to achieve a convulsion was seen as innovative at the time and soon became the treatment of choice for manic-depressive illness and major depression.[53] ECT spread rapidly within the world of psychiatry, for the first time giving doctors the sense that they could *do* something about mental illness that might even make the disease disappear.[54] By 1954 ECT was seen as an incredible triumph, acclaimed as "the most widely recognized achievement in the field of organic treatments in psychiatry."[55] As its popularity grew, ECT became widely implemented and greatly impacted the way that depression was treated.

During the 1950s and early 1960s American psychiatrists saw ECT as a way of moving beyond the limiting options of asylum care or psychotherapy. The advent of ECT and anti-psychotic drugs led many physicians to conclude that it would soon be "unecessary to hospitalize many patients."[56] The main reason that ECT was originally lauded in the psychiatric community was that it "permitted individuals to function more

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[50] Shorter, *A History of Psychiatry*, 218.
[51] ibid., 218.
[52] Shorter, *Shock Therapy*, 6.
[53] Shorter, *A History of Psychiatry*, 223.
[54] ibid., 221.
[55] Hoch, ed., *Depression*, 190.
[56] Plumb, "Drug Use Hailed in Mental Cases."

or less normally."[57] ECT represented a short-term out-patient alternative to asylum care and hospitalization that, for the first time, allowed physicans to think of depression as a curable condition. The idea that mental illness was not permanent and could be remedied through treatment, was revolutionary, yet the "'all-or-none' view of madness remained inscribed in popular culture into the twentieth century."[58] Nonetheless, the development of ECT was a crucial step in breaking the social and medical dichotomization of depression.

ECT was a particuarly attractive option because it was both effective and inexpensive. The primary reason for the popularity of ECT was its success in treating depression in as much as 80 to 90% of cases.[59] Even though drugs were developing at the same time, ECT was known for producing "a therapeutic effect more quickly than the psychiatric drugs. Also, many more patients respond to it."[60] Indeed, ECT has been an extremely successful treatment in those patients on the brink of suicide and, at the time, was regularly more curative than drugs, which did little more than sedate patients. Not only have many different patients responded well to ECT, in 1949 it was "the most effective treatment that is economically available…the vast majority of people cannot afford any other type."[61] Thus, the low cost of ECT also lead to its popularity and widespread use. The quick treatment and therapeutic effects of ECT were important during a time when asylum care posed a heavy financial burden to state governments. Although its popularity as a treatment has waned because of negative portrayals in the media, ECT is still used today to treat severely depressed patients.

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[57] Shorter, *A History of Psychiatry,* 221.
[58] Callahan and Berrios, 85.
[59] Robie, "Electro-Shock Therapy."
[60] Shorter, *Shock Therapy,* 7.
[61] Freeman, "Shock Treatment Held Not Enough."

Although ECT may be viewed in the history of psychiatry as the lynchpin in helping patients with severe depression recover from their illness, Plath is careful to offer a different perspective. By representing Esther's first experience with ECT as disastrous, Plath cautions that ECT could be an incredibly negative and de-humanizing experience akin to torture. In Plath's novel, ECT only fulfills its promise as a treatment when it is combined with two key environmental factors: a trusting doctor-patient relationship and the understanding that depression exists on a scale. In other words, Plath reveals how the environment around ECT matters almost as much as ECT itself.

The reader first experiences the shift towards a more nuanced and less polarizing view of mental illness that ECT eventually provided society through Esther's realization that she does not fit into the limited and extreme views of depression society purported at the time. She is neither 'crazy' nor is her depression an invention. Over time she recognizes that she is not like the other mental patients in the hospital and furthermore, that her disease does not define her identity. When she arrives at Dr. Gordon's hospital, Esther notices a man who repeatedly counts the number of cards in a deck and a woman playing with a string of beads; however, this mindless behavior is not what Esther experiences.[62] Instead she is hyper-aware of her surroundings—the barred windows, the furniture in the room fitted with a keyhole to be locked up, her mothers knuckles—and ultimately decides that she will not go back to this hospital for more electroshock treatments. Her decision, although explicitly rooted in her negative experience with shock therapy seems equally based in her negative perception of the patients in the hospital, patients whose illness does not resemble Esther's own. On the other hand,

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[62] Plath, 141.

Esther cannot will her depression away. Her understanding of her illness does not fit into the polarizing dichotomy that society puts forth. Her disease is neither all consuming nor trivial, falling somewhere in the middle. This realization combined with her move to a private hospital pushes Esther to understand her illness in new terms.

Plath's metaphor of the bell jar encompasses a new understanding of depression as external to the individual, and as an experience that one neither chooses nor controls. Contemplating her inability to feel emotions, Esther comments "wherever I sat—on the deck of ship or at a street café in Paris or Bangkok—I would be sitting under the same glass bell jar, stewing in my own sour air."[63] The image of the individual trapped by the bell jar becomes a symbol for Esther's depression. The bell jar's unpredictable rise and fall mimics the equally unpredictable depressive episodes Esther experiences over the course of the novel. Plath externalizes the depressive forces that control Esther, using the image of the bell jar to show that Esther is not her disease, but rather that her disease traps her. When Esther's mother tries to trivialize her experience in the hospital as 'a bad dream,' Esther replies, "to the person in the bell jar… the world itself is 'a bad dream.'" Her response shifts the emphasis from the individual's experience as the bad dream to the environment as the bad dream, moving the blame from herself to her situation.[64] Additionally, equating mental illness with the individual implies that the condition is permanent. Plath moves away from this fusion of disease and identity with the bell jar, which depicts Esther's disease as episodic rather than permanent. The image of the bell jar conveys what clinical diagnoses until this point in time had not: that an individual *has* a mental disease, just as one *has* a physical ailment, a broken leg, or the flu. Plath's

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[63] ibid., 185.
[64] ibid., 237.

metaphor allows for a nuanced look at depression ignored by previous discourses about the disease.

Plath develops her nuanced discourse on mental illness in Esther's experiences with her doctors: Dr. Gordon and Dr. Nolan. Each doctor embodies a different approach to her disease and its treatment. Dr. Gordon treats Esther as if she were invisible, making decisions without consulting her and avoiding communication, causing her to believe that her illness is her fault. While Dr. Gordon is unable to truly help Esther, Dr. Nolan allows Esther to make her own choices and helps her recover. These two drastically different approaches represent a shift in the patient-doctor relationship from ignoring the patient perspective to placing it at the core of a treatment plan.

Instead of reaching out and connecting with his patient, Doctor Gordon avoids communication as much as possible, epitomizing a time when patients had no voice whatsoever with regards to their treatment. When Esther first goes to see him, he is all but unresponsive, only remarking that he remembered her college had a WAC station. The lack of communication between Esther and Dr. Gordon continues when on the next visit he asks only to speak to her mother, whom he uses as a conduit to tell Esther she is going to have shock treatment. By avoiding Esther entirely, Doctor Gordon treats Esther as a child, unable to make decisions for herself. When Esther arrives at his hospital for the shock treatments she tries to ask him what the treatment will be like but "when I opened my mouth no words came out."[65] Doctor Gordon's own lack of communication had effectively stifled Esther's own. This situation was unfortunately common, since at the time women were "not permitted to define *for themselves* the nature

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[65] ibid., 143.

of their problems."[66] Before Esther's first encounter with ECT the only words she hears are not from Dr. Gordon, but from a nurse who unconvincingly says, "don't worry…their first time everybody's scared to death."[67] Afterwards Esther wonders "what terrible thing it was that I had done."[68] Doctor Gordon's impersonal approach with Esther causes her to believe her disease is her own fault. Furthermore, his lack of compassion, impersonal demeanor and lack of communication leave Esther's illness unchanged, if not worse. However, Esther's lack of improvement is not attributed to Dr. Gordon's poor doctoring skills, but to Esther's inability to simply choose to get better. Esther's sense of guilt with Dr. Gordon shows how his approach is linked to a public perception of depression as the patient's fault, a perception of illness that doesn't make the physician eager to help the patient get any better.

In this environment, Esther's experience with ECT is exceedingly negative and only makes her feel worse instead of treating her illness. She describes her first course of ECT with Dr. Gordon as an experience full of fear and violence:

> Then something leapt out of the lamp in a blue flash and shook me till my teeth rattled, and I tried to pull my hands off, but they were stuck, and I screamed, or a scream was torn from my throat, for I didn't recognize it, but heard it soar and quaver in the air like a violently disembodied spirit.[69]

Plath depicts Esther as 'stuck' both with Dr. Gordon and with a therapy that does nothing but submerge her into a greater pit of fear. Reflecting on her shock therapy experience with Dr. Gordon, Esther worries being subject to it ad infinitum "once I was locked up they could use [ECT] on me all the time," revealing her understanding of ECT

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[66] Thompson, "Women in Inpatient Facilities: Impressions and Reflections," 51.
[67] Plath, 143.
[68] ibid., 143.
[69] ibid., 144.

as a punishment and violent act instead of a treatment.[70] Additionally, Esther has internalized the perception that as a depressed patient, she has no say in her treatment. Although he uses a new psychiatric treatment, Dr. Gordon's way of using it, without talking to the patient, perpetuates an old understanding of depression. Not once during her time with Dr. Gordon does Esther indicate any hope of recovery, which was characteristic of post-1900 asylums, "warehouses in which any hope of therapy was illusory."[71] In associating this negative experience of ECT with Dr. Gordon, however, Plath emphasizes that ECT does not exist in a vacuum, but occurs at the hand of a physician who determines how much to shock the patient and for how long. By underlining the doctor's involvement in ECT, Plath shows that it is Dr. Gordon's approach, not the therapy, is at fault.

In contrast, Esther's second doctor, Dr. Nolan, communicates with her and encourages her to make her own decisions about her illness and life, cultivating a doctor-patient relationship that is built on trust. Appalled by her previous experience with shock therapy, Dr. Nolan promises that she will talk to Esther about any potential shock therapy she will administer. Rather than avoid communication and distance herself from her patient, Dr. Nolan is described as Esther's confidant: "she hooked her arm in my arm, like an old friend, and helped me up, and we started down the hall."[72] Dr. Nolan understands that what is at stake in Esther's illness is her self-confidence, and she helps Esther restore it by including her in decision-making and taking the time to listen to her. When Esther pauses outside of the door with 'Electrotherapy' written on it, Dr. Nolan doesn't force her to enter but waits patiently until Esther decides, "let's get it over with,"

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[70] ibid., 159.
[71] Shorter, *A History of Psychiatry,* 65.
[72] Plath, 212.

and enters the room.[73] By allowing Esther to choose, Dr. Nolan validates Esther's ability to make her own decisions and to be a part of her own treatment. Instead of presenting Esther with a fixed treatment plan, Dr. Nolan is careful to remind Esther that the decision ultimately "depends…on you and me."[74] Where Dr. Gordon acted as a supreme authority, Doctor Nolan treats herself and Esther as equals in managing Esther's care. Afterwards Esther feels "surprisingly at peace," a reaction that validates her trust in Doctor Nolan.[75] Dr. Nolan's approach empowers the patient and her perspective, showing that the patient deserves a voice and often knows what's best for her.

Additionally, Doctor Nolan shows she cares about Esther as a total person, not just in her capacity as a patient when she arranges a visit for Esther to the gynecologist. During this visit Esther is fitted for a diaphragm, which becomes a symbol of her sexual freedom and her freedom to make decisions for herself. Although Esther expresses that she was "buying my freedom," without Doctor Nolan she wouldn't have achieved this moment. The doctor is no longer a stranger uninterested in the patient, but one who can greatly affect the patient's success as an individual and their ability to recover. Plath portrays Dr. Nolan as Esther's ally, having Esther profess: "I liked Doctor Nolan, I loved her, I had given her my trust."[76] Instead of feeling alone and scared as she had with Dr. Gordon, Esther is assured that Dr. Nolan is there to help her and treat her illness instead of faulting Esther for her depression.

Esther and Dr. Nolan's doctor-patient relationship represents a shift in understanding and treating depression. For one, Dr. Nolan inverts the societal notion

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[73] ibid., 213.
[74] ibid., 216.
[75] ibid., 215.
[76] Plath, 211.

that the depressed patient is at fault. Instead, she implicates society as a barrier to the patient's recovery and potential cause for depression. This shift is illustrated when Dr. Nolan bans Esther's mother from the hospital. To her mother as with Dr. Gordon, Esther is not capable of making her own decisions and is not an independent person. However, what her mother doesn't see is that her very assumption inhibits Esther's ability to be an independent person. Dr. Nolan's ban on visitors shows Esther, the patient, that her illness is related to her environment and that her mother is a barrier to Esther's improvement. Dr. Nolan helps Esther recover by convincing Esther that she is not responsible for her illness and by providing her with a supportive community at the private hospital.

Dr. Nolan's new understanding of depression and the depressed patient is mirrored by the hospital in which she works. The very structure of the hospital with its three-tiered organization negates the all-or-nothing discourse of depression. As patients get better they move from Wymark, which houses patients with the most severe cases, to Caplan, which corresponds to a middle level of depression and where Esther is first housed, to Belsize, from which patients eventually return home. The three building structure of the hospital emphasizes not only the ability for patients' conditions to improve, but also their ability to recover and return to their previous lives. Patients are given privileges according to each building and to the severity their illness. Valerie, a patient who conveys this system to Esther, explains that at Caplan one can "go to town […] or to a movie, along with a nurse."[77] By emphasizing patient autonomy within each level, the private hospital conveys a new approach to treating mental illness. This

[77] ibid., 192.

approach was so new that when Esther first arrives at the private hospital, she remarks: "I couldn't understand what these people were doing, playing badminton and golf. They mustn't really be sick at all, to do that," demonstrating that she had come to believe the discourse around her, that she was incapable of doing anything 'normal' people do.[78]

Many scholars view this private hospital as a representation of McLean Hospital in Belmont, Massachusetts where Plath was a patient. Although the three building structure was not universal and was perhaps confined to McLean, at the time it remained an example of a hospital designed with therapeutic intentions that over more than a hundred years hardly strayed from those roots despite the rise in popularity of a psychosocial perspective. To physicians at McLean, like other therapeutically minded institutions, it was evident that patients responded to positive treatment, "the comfort of the spoken word and to the expression of concern on the doctor's part," essential ingredients of Dr. Nolan's therapy.[79] Thus the kind of care that Esther (and Plath) received was in many ways unique, but also provides evidence of emerging biological psychiatry on an institutional level.

A new doctor and a new environment enable Esther to accept the ECT treatment and to view it as curative rather than punitive. While her first experience with ECT pervades Esther's memory, Dr. Nolan convinces Esther to give electroshock therapy another chance, assuring her that it will not be like her experience with Dr. Gordon. In stark contrast to her previous negative experience, Esther describes her second experience with shock therapy in peaceful words:

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[78] ibid., 188.
[79] Shorter, *A History of Psychiatry,* 22.

> Miss Huey began to talk in a low, soothing voice, smoothing the salve on my temples on either side of my head…and she set something on my tongue and in a panic I bit down, and the darkness wiped me out like chalk on a blackboard…I woke out of a deep, drenched sleep…All the heat and fear had purged itself. I felt surprisingly at peace.[80]

The calm and soothing aspect of this experience contrasts markedly with the rattling teeth, fear and entrapment Esther felt after her shock treatment with Dr. Gordon. Esther's 'panic' evaporates and by the time she wakes up 'the heat and fear had purged itself.' Her previous negative experience with ECT as a punitive measure is replaced by the understanding that ECT can be curative and restorative, giving her a sense of peace. The success is such that Esther's depression disappears: "The bell jar hung, suspended, a few feet above my head. I was open to the circulating air," offering Esther a sense of hope that she can combat the illness that has been suffocating her.[81] This moment validates Esther's feeling that her depression was not something she could control and that her mother and Dr. Gordon's assumptions were wrong. It also underlines the viewpoint that the environment matters as much as the treatment. Esther's sense of hope results largely from Dr. Nolan's approach. Dr. Nolan, in contrast to Dr. Gordon, talks about Esther's depression as something that can be cured, not by having Esther simply 'decide to get better' but through a combination of treatments and a supportive environment. Although there are other changes in the shock treatment, such as the level of electric current, that realistically could have affected this change, those changes would have been at the hands of the respective doctors. The reader is left with the feeling that the lifting of the bell jar would never have been possible with Dr. Gordon, but is a direct result of Dr. Nolan's new understanding and approach to Esther's illness. While Dr.

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[80] Plath, 214-215.
[81] ibid., 215.

Gordon is stuck in the past, Dr. Nolan's reflects a new way of looking at depression and the role that ECT, if properly administered, can play in the patient's recovery process.

Dr. Gordon and Dr. Nolan's differing views of Esther's depression are representative of two trends in the history of psychiatry that saw the causes of psychiatric illness either in terms of internal factors such as biology and neuroscience while the other school of thought saw psychiatric illness as a result of external causes such as stress and environmental. Throughout the history of psychiatry each view has dominated for various periods of time; however, it was the psycho-social view supported in the US predominately by Adolf Meyer that dominated the American psychiatric discourse until the 1960s, precisely the time when Plath wrote her biographical novel, when the emerging biological psychiatric discourse was in its earliest stage. It is within the context of these two psychiatric paradigms that Dr. Gordon and Dr. Nolan's perspectives on Esther's depression take shape. Dr. Gordon becomes symbolic of the residual psychosocial discourse that viewed Esther's depression as the result of social and personal stress she had not adjusted to. By showing the severely damaging effects of Esther's time with Dr. Gordon, Plath reveals the detrimental effects the patient suffers at the hand of a medical view that ignores a patient. Although Dr. Nolan includes psychosocial elements, her approach is based on a biological view, which explains her understanding of depression as an illness the patient cannot control. Within this context Dr. Nolan implicates Esther's mother and other social factors instead of blaming Esther for her illness. She removes Esther's mother because she is a barrier to her daughter's recovery, Dr. Nolan's goal. The discrepancy among Dr. Gordon and Dr. Nolan's treatment styles can be explained by their different understandings of the causes of psychiatric illness, which "when it comes to treating individual patients…really are polar

opposites."[82] A physician's broader understanding of psychological illness as rooted in either social or biological causes determined the extent to which they saw potential for recovery and therefore greatly affected their treatment plan.

Furthermore, Dr. Nolan's identity as a woman is an integral part of her relationship with Esther, in comparison to Dr. Gordon, who treats Esther in a paternalistic way that characterized many male-female interactions during this time period. Phyllis Chesler explains that feminist therapists approach their female patients differently and try to "listen to women respectfully, rather than in a superior or contemptuous way. A feminist therapist does not minimize the extent to which a woman has been wounded. Nevertheless, a feminist therapist remains resolutely optimistic. No woman, no matter how wounded she may be, is beyond the reach of human community and compassion."[83] Although Plath never characterizes Dr. Nolan as a feminist, her interactions with Esther, particularly when she arranges for Esther to be fitted for a diaphragm fits Chesler's description and represents the sort of female compassion male doctors lacked. In the decade between 1947 and 1957 female patients constituted up to 68% percent of all psychiatric inpatients.[84] Despite the overwhelming gender bias in the patient population, this was not reflected in the psychiatric professions, which remained overwhelmingly male. The positive nature of Dr. Nolan's therapy in contrast with Dr. Gordon's condescension seems to be a matter of their respective genders in addition to their psychiatric leanings.

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[82] Shorter, *A History of Psychiatry*, 26.
[83] Chesler, 30.
[84] Mannucci and Kaufman, "The Psychiatric Inpatient Unit in a General Hospital: A Functional Analysis."

Within the novel a crucial part of the movement towards a biological perspective is Esther's environment at the private hospital where Doctor Nolan treats her. The emphasis on a biological understanding of mental illness is rooted in the way that the doctors approach their patient's illness but also in the way the hospital is physically structured. The hospital is made up of three buildings that correspond to the severity of illness, Wymark for the most severe cases, Caplan in the middle, where Esther enters, and Belsize for the least severe cases. By introducing a third level the hospital shows a shift in the medical discourse of depression on an institutional level by negating the all-or-nothing dichotomy of the past. Additionally, because the three levels are described as tiers, the hospital's structure emphasizes that recovery is possible, a structure that allows the patient to envision herself without her illness.

Conclusion: Sylvia Plath and Esther Greenwood

In reading Sylvia Plath's novel through a cultural, historical lens one cannot neglect its publication history or that her established reputation as an author allowed her to write such a candid novel. While the posthumous American publication of the novel was widely read, her initial printing in London under a pseudonym was not.[85] Once it was published in London under Plath's name the novel found new readers; however, what the novel's publication history shows is that Esther Greenwood (and largely Plath's own) story of coming-of-age and learning to cope with chronic depression was read because Plath had already established herself as a poet. Had this novel been written by a newcomer, it's cultural effect probably would have been much more limited. Plath was able to capitalize on her celebrity to respond to a world that had treated her and her

[85] Gill, ed., 127.

illness in less than serious terms and also to provide a first-person account of what her depression was like. In so doing Plath opened up a space for the patient voice and a patient relationship and discourse with the outside world.

By writing a novel instead of poetry, Plath is able to more accurately portray one individual's experience with depression in a way that any reader can sympathize with. Not every individual has dealt with depression as Esther has, but fiction encourages the link between reader and protagonist, providing Plath with a wide audience that another genre might not have achieved. Moving through Esther's depression with her, the reader is given a much more personal and realistic account of depression, which allows them to sympathize with Esther and understand her dilemma in way that few other genres offer. By delving into Esther's life and experiencing the world through her eyes, the reader does not encounter a 'crazy' individual, but instead one that seems very aware of the crazy world around her. Fiction further allows for the development of the metaphor of the bell jar, which allows the reader to visualize a disease that otherwise seems difficult to explain.

Lastly, one cannot forget that while Esther triumphs within the space of the novel, her author and real-life model, Sylvia Plath, did not. Plath committed suicide months after finishing her novel. Alone in London with her two children, Plath was far away from the oasis she had found at McLean hospital, and the support of Dr. Ruth Beuscher, her physician there who the character of Dr. Nolan is based on. Although Plath took her own life, her novel shed remarkable light on the everyday reality of those facing depression, a reality that was largely absent in popular culture until *The Bell Jar*'s publication.

Chapter Two: Challenging Diagnosis in *Girl, Interrupted*

In her memoir *Girl Interrupted* (1994) Susanna Kaysen reflects on the two years she spent at McLean hospital from 1967 to 1969. In short, succinct chapters Kaysen encapsulates McLean as both a haven and jail for those living on the Belknap ward. Kaysen alternates from vivid accounts of moments on the ward—the endless frustration of being followed around, episodes with nurses and doctors—to retrospective contemplation of the significance and reasoning behind the years that interrupted her life. Through the split temporality of her work, Kaysen illuminates that she was a victim of a larger psychiatric misstep that diagnosed patients ad hoc in order to fit the fading social climate. While understood herself as an adolescent who disagreed with society's values, it was impossible for her to exist outside the social norms her parents and doctors ascribed to. This gap between her parents' view and her own was in part due to a lack of understanding of adolescence in American culture at large, and particularly in the upper class culture Kaysen was brought up in. The conservative social world that Kaysen rebels from is in many ways similar to the world Plath describes in her novel. However, while in *The Bell Jar*, Esther's illness is what causes others to view her as abnormal, in Kaysen's case her nonconformity is what causes others to view her as mentally ill. As Kaysen probes into her past she reveals that in mid-1960s America, deviance from social norms was both a diagnosable illness, Borderline Personality Disorder, and grounds for institutionalization at McLean.

Most critics have read *Girl, Interrupted* either as a new voice in coming-of-age literature or as a narrative of mental illness. In a review of the book in *The Boston Globe*, Alison Bass goes so far as to claim that Kaysen's memoir has replaced Plath's *The Bell Jar*

as a "a must-read for young women in high school and college."[86] As one high school student explains, "a lot of problems she faced are problems that teenagers face today," illuminating the current relevance of Kaysen's memoir.[87] In *The Women's Review of Books* Carole Maso writes that the book's popularity stems from the way the characters invert their typical associations, "the 'lunatics' come off as lovable and zany and irreverent."[88] In academic circles, many authors draw on Kaysen's memoir as a means to understand different kinds of suffering that mentally ill patients experience. Susan Herbert thus comments: "Instead of providing sensational accounts of bizarre behavior and miraculous cures [narratives like Kaysen's] question modern psychiatric practice."[89] Similarly, English professor Marta Caminero Santangelo reads Kaysen's work as an example of autobiographical writing that is essential in developing theoretical claims about madness.[90] In another sphere Kaysen's novel has allowed scholars to look at the gendered methodologies behind psychiatry. Elizabeth Marshall contends that Kaysen's narrative "throws into relief how everyday cultural texts participate in the production of gendered pedagogies that define adolescent girlhood as a period of psychic trouble."[91] While many authors have posited Kaysen within a tradition of autobiographical coming-of-age literature or within a tradition of literature on madness, few have tried to reconcile these two readings, often looking at them as separate narratives.

An analysis of the patient discourse Kaysen develops, her diagnosis and the environment at McLean, reveals that the psychiatric climate of the 1960s was bound up

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[86] Bass, "New 'Girl' in Class."
[87] ibid.
[88] Maso, "The Inside Story."
[89] Herbert, *Questions of Power: The Politics of Women's Madness Narratives*, 96-97.
[90] Caminero-Santangelo, *The Madwoman Can't Speak*, 19.
[91] Marshall, "Borderline Girlhoods," 125.

with contemporary concerns about normalcy that pervaded the private social discourse of the time. During the mid-1960s psychiatry was closely connected with science, especially given the recent development of psychiatric drugs. While the psychiatric field was focused on science, the public grew increasingly wary of authority, and particularly of authority as it played out in the realm of mental health. As rebellion became popular in society at large, families in Kaysen's upper class milieu often looked unfavorably on rebellious counter-cultural teenagers. Unable to understand or control their adolescent children, such parents' financial situation allowed them to look to psychiatry for an answer. In return, psychiatrists placed their allegiances with rich parents instead of patients who, like Kaysen, were struggling to maintain their identity in a milieu that reacted against society's change. Kaysen's diagnosis of Borderline Personality Disorder implies that it is her identity, not her brain, that is the problem. The tipping point that pushes Kaysen from the realm of sanity into the halls of McLean is not a diagnosis made about her mental state, but one that is predicated on social norms. The environment at McLean was not a respite for Kaysen as it was for Plath. Instead, patients were consistently sedated and their insecurities cultivated. For Susanna Kaysen there was no escaping her difference; the social view of normalcy that she rebelled against was imbedded in and inseparable from psychiatric practices. Susanna Kaysen's memoir reveals psychiatry's own reactionary attitude towards rebellious culture and how it diagnosed and institutionalized patients on the basis of social deviance rather than for true psychiatric disorders.

1965-1970: The Emergence of Biological Psychiatry and Adolescence

From 1965 to 1970 the dominant discourse in psychiatry shifted from psychoanalysis to biological psychiatry. During this time, psychoanalysis, the residual discourse, faded as biological psychiatry, the emerging discourse, developed with investigations into the genetic roots of psychiatric illness and progress in drug therapy. The development of outpatient treatment led to a decrease in inpatient stays on hospital wards: "before 1965 many patients spent years, if not decades, in asylums. After 1970 length-of-stays began to be measured in days or weeks."[92] The biological paradigm encapsulated the view that major psychiatric illness "rested on a substrate of disordered brain chemistry and development."[93] Scientists determined that mental illness was caused by malfunctioning neurotransmitters, which were identified beginning with serotonin in 1952.[94] As a result, individuals working in conjunction with Arvid Carlsson, a pharmacologist at the National Heart Institute, developed the serotonin hypothesis of depression: that by modifying the action of neurotransmitters one could treat psychiatric illness.[95] As more neurotransmitters were discovered, physicians concluded that one neurotransmitter was responsible for one illness, a theory that was prominent until the 1980s.[96] This view was supported by the development of Chlorpromazine (Thorazine), a sedative that was used to effectively treat many psychological conditions such as schizophrenia.

However, as the science behind mental illness expanded so too did the number of conditions that merited chronic treatment, either by talk therapy, medication, or both. The medical discourse that evolved was overzealous in its diagnosis and treatment of

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[92] Grob, *The Mad Among Us*, 287.
[93] Shorter, *A History of Psychiatry,* 239.
[94] ibid., 266.
[95] ibid., 267.
[96] ibid., 267.

cases that were likely not as serious or biologically rooted as psychiatrists wanted to believe. As psychiatry strengthened its ties with science, it became so confident that it often over (and wrongly) diagnosed patients, setting itself up for a wave of backlash.

While the biological paradigm of psychiatry gained prominence, a parallel emerging social discourse with a distrust of psychiatry and of physicians' power, anti-psychiatry, grew in response. The fear of custodialism that plagued society during the first half of the twentieth century, was soon replaced with the fear of 'science.'[97] In the wake of World War II, the Nazi regime's disastrous application of science to human biology was still present in the public consciousness. Additionally, the social climate of the '60s and '70s cultivated a distrust of authority of all kinds. In the medical realm this distrust was directed at physicians, particularly psychiatrists, who were seen as overly controlling of their patients.[98] The anti-psychiatry movement's basic argument was that psychiatric illness was not in fact biological but "social, political, and legal: society defines what schizophrenia or depression is, and not nature… there really was no such thing as psychiatric illness. It was a myth."[99] This tenet was combined with an association between psychiatry's shift to science with an "imputed loss of caring."[100] Physicians were seen as power-hungry individuals who simply prescribed medication but were otherwise uninvolved in caring for individuals.

In the public realm the anti-psychiatry movement gained momentum from the media and well-known intellectuals. In particular, Ken Kesey's *One Flew Over the Cuckoo's Nest*, which was published in 1962 and then adapted into film in 1975, had a profound

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[97] ibid., 273.
[98] ibid., 273.
[99] ibid., 274.
[100] ibid., 273.

effect on the public. While Kesey himself did not experience mental illness, he volunteered for a government experiment on LSD on a psychiatric ward, using this experience as the basis for his novel.[101] Kesey's message that "psychiatric patients are not ill, they're merely deviant," grew a popular following in the years surrounding the civil rights movement.[102] The novel's protagonist encapsulates the powerful and stifling force of social control, lamenting that he would just "play poker and stay single and live where and how he wants to, if people would let him…'but you know how society persecutes a dedicated man.'"[103] The anti-psychiatry movement included the support of some psychiatrists, such as Thomas Szasz, who accused institutions like McLean of "authoritarianism, ignorance, sadism, exploiting patients and creating hospitalism – in sum, dehumanizing patients."[104] This movement was furthered in large part by intellectuals, such as Michel Foucault who in *Madness and Civilization* (1961) highlights how madness is in part a social construct, writing, "madness belonged to social failure, which appeared without distinction as its cause, model, and limit."[105] Sociologist Erving Goffman's work on asylums and stigma also supported the view of the anti-psychiatry movement, even though Goffman did not consider himself part of the movement. While this may have been an intellectual debate known by the public, private spheres of the upper class, such as Kaysen's milieu, did not have the same perspective on psychiatric care.

Parents of teenagers in the '60s and early '70s faced something they had not experienced themselves: adolescence. Instead of fighting in wars, their kids were

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[101] ibid., 275.
[102] ibid., 275.
[103] Kesey, *One Flew Over the Cuckoo's Nest*, 20.
[104] Strauss, *Review of Psychiatric Ideologies and Institutions.*
[105] Foucault, *Madness and Civilizaiton*, 259.

protesting them, going to rock concerts, and rejecting many of the conservative values of the Greatest generation. For parents of such teenagers, the rebellious antics that are now viewed as a hallmark of adolescence were new and practically impossible to understand, collectively described as "expressions of discontent."[106] As columnist for *The Los Angeles Times* Kitte Turmell described, psychiatric illnesses were the new scapegoat: "In Dad's youth he had an economic depression on which to blame all sorts of problems. Now, we have a so-called psychological depression which teenagers are going through."[107] Teenager's independence and unwillingness to subscribe to their parent's views led to a profound lack of communication and understanding between generations. From the parent perspective, these teenagers were unmanageable and out of control. What both parents and offspring alike experienced was a generation gap of extreme proportions. In some cases, as in Kaysen's, this lack of understanding led to her institutionalization. In such situations, families would accept their children "back into the fold only after they had been 'cured.'"[108] But as Kaysen describes, McLean simply became a harsher microcosm of the family unit where the patients rebelled against their new superiors.

Patients like Kaysen found themselves stuck in between these three discourses—biological psychiatry, anti-psychiatry, and a conservative family view—none of which helped them deal with their adolescent issues. If institutionalized for their rebellious attitude, these teenagers encountered a system that was focused on illness based on biology, not social maladjustment. The generation gap between parents and adolescents was mirrored in the medical community between doctors and their teenage patients. The records at McLean are "full of the kind of well-intentioned floundering that has always

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[106] Levy, "Inpatient Treatment for Troubled Adolescents," 18.
[107] Turmell, "Teenagers."
[108] Beam, *Gracefully Insane*, 206.

characterized the older generation's attempts to understand their children."[109] While well intentioned, they nonetheless represented society's inability to adjust to the new social phenomenon of adolescence. As a result, teenage patients found themselves medicated and institutionalized for conditions that were simply created to fit the symptoms they displayed. Mental illness became a catchall for deviant or reckless behavior of any kind. In the end, patients finally 'recovered' and left institutional care when they realized that their task was actually quite simple: "Figure out what society deems to be sane behavior and copy it. You act like you are getting better, and you will get better."[110] As this former McLean patient relates, getting 'better' entailed acting 'normal'. By making it seem as though counter-culture teenagers actually had an illness, this idea, which began in the family realm, was furthered by the medical community that turned social deviance into a diagnosable illness.

Kaysen's representation of the psychiatric and social discourses

By delving into Kaysen's institutionalization, *Girl, Interrupted* brings to life the differing psychiatric, public and private social discourses that existed from 1965 to 1970, a time of changing social views. In her memoir Kaysen gives her readers an intimate look at the psychiatric community that was more interested in sedating and controlling adolescents than understanding them. While the private and psychiatric realms rejected Kaysen's values, the public discourse was becoming much more open and radical, embracing Kaysen's choices. However, this emerging discourse fell on deaf ears within

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[109] ibid., 202.
[110] ibid., 206.

the private realm that Kaysen was stuck in, one in which social deviance constituted mental illness.

During her years at McLean, Kaysen experienced first-hand the shift from the waning psychoanalytic discourse to the strengthening biological psychiatric discourse. For a time Kaysen underwent psychoanalysis, which she describes as talk therapy in which her therapist continually asked the same two questions, "'Yes?' and 'Could you say more about that?'"[111] During these years of transition between 1965 and 1970, doctors could switch between the two psychiatric paradigms in a single day,

> Earlier in the day, the doctor had a map divided into superego, ego, and id, with all kinds of squiggly, perhaps broken, lines running among those three areas. The doctor was treating something he or she calls a psyche or mind. All of a sudden the doctor is preparing to treat a brain. This brain doesn't have a psyche-like arrangement, or if it does, that's not where its problem is. This brain has problems that are chemical and electrical.[112]

Eventually, however, Kaysen stops psychoanalysis and the biological paradigm, particularly its emphasis on drugs, dominates in her anecdotes of McLean.

In her use of scientific language and her descriptions of drug therapy at McLean, Kaysen exposes the hospital's heavy reliance on science to justify psychiatric practices. The overuse of scientific discourse is such that Kaysen's own rhetoric becomes imbued with it. While dissecting a single group outing, she describes the group of patients that goes to the ice cream parlor as "an atomic structure: a nucleus of nuts surrounded by darting, nervous nurse-electrons charged with our protection."[113] The use of chemistry rhetoric underscores the hospital's predilection for scientific ways of thinking. Kaysen's

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[111] Kaysen, 119.
[112] ibid., 141-142.
[113] ibid., 49.

appropriation of this language, to narrate a moment at the ice cream parlor, mocks the way psychiatry used biochemical pretenses to achieve a false sense of authority

The authority of biology within psychiatry in the years surrounding Kaysen's institutionalization is much more explicit in her references to the different sedative drugs given to patients. These drugs, a recent innovation in psychiatric treatment, were extremely popular among physicians: "Thorazine, Stelazine, Mellaril, Librium, Valium: the therapists' friends…once we were on it, it was hard to get off."[114] The benefit of such medication was not necessarily for patients, but for the nurses since it was much easier for them to control sedated patients. In one of her flashbacks, Kaysen recalls the first time she experienced the effects of Thorazine: "it was like a wall of water, strong but soft…I couldn't hear my own voice very well. I decided to stand up, but when I did, I found myself on the floor."[115] Kaysen portrays the psychiatrists' treatment program as so drug-dependent that they avoided getting to know their patients and sedated them to prevent them from causing any trouble.

The barrier between patients and doctors was reinforced by the generation gap between adolescent patients and their parents. While Kaysen looks back on her adolescence as a moment when she knew that she didn't subscribe to the social and cultural values surrounding her, her parents saw a different reality. For them, she writes, "their image of me was unstable, since it was out of kilter with reality and…their needs and wishes. They did not put much value on my capacities, which were admittedly few, but genuine."[116] Kaysen was not the only patient in this situation. In the novel this clash

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[114] ibid., 87.
[115] ibid., 104.
[116] ibid., 155.

between parents and adolescents is also represented in the case of Torrey, whose parents blame her for their own personal problems such as alcoholism, flying from Mexico to Boston every so often to harangue their daughter. This rejection of parents' expectations caused adolescents to end up in hospitals such as McLean, where "the prevailing wisdom [among both nurses and patients] was that [our families] were the reason we were in there."[117] In both instances, the latter much more extreme, Kaysen depicts the private family discourse that saw the refusal of conservative social norms as a problem, especially when it came from young women. Unable to solve the problem, they sent their children away for treatment.

By sending their rebellious children away, parents were able to maintain that the rest of the family was sane. Kaysen remarks "often an entire family is crazy, but since an entire family can't go into the hospital, one person is designated as crazy and goes inside…most families were proving the same proposition: *We* aren't crazy; *she* is the crazy one."[118] By refusing to step outside of their upper-class values, parents like Kaysen's silenced the voice of their children and radically isolated them at psychiatric hospitals where they could not cause any public embarrassment. This phenomenon seems to have been relatively common given that adolescents comprised between 25 and 30 % of the patient population in psychiatric hospitals between 1965 and 1970.[119] However, the ability to send counter-culture teenagers away to such places as McLean was limited to upper-class families that could pay $60 a day in 1967 simply for the room, not including therapy, drugs and consultations, which were extra.[120] Susan Cheever, who

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[117] ibid., 95.
[118] ibid., 95.
[119] Levy, 18.
[120] ibid., 95.

reviewed Kaysen's memoir in *The New York Times Book Review,* categorizes McLean "in another sort of Ivy League, places that also had tree-lined campuses with tennis courts and high tuitions."[121] Within the upper echelon of society, McLean became a status symbol of its own that was not universally available.

This conservative fifties social view was being challenged throughout society by the emerging independent spirit of the sixties. Although this counter-cultural movement does not figure prominently within the sphere of McLean that Kaysen describes, a key component of it—the rejection of authority—pervades Kaysen's anecdotes. In 1966 when Kaysen graduated from a prestigious high school, her decision not to attend a 'fancy college' was rebellious by her parents' standards; however, she reports that just a few years later when the political and cultural climate had shifted, "at least a third of my classmates never finished college. By 1968, people were dropping out daily."[122] In the chapter of her memoir named for that very year Kaysen recalls watching people on TV "doing the kinds of things we had fantasies of doing: taking over universities and abolishing classes; making houses out of cardboard boxes and putting them in people's way; sticking their tongues out at policemen."[123] Suddenly, deviance had found a place in American culture that adolescents could associate with, yet Kaysen and her ward-mates were stuck at McLean. The months when scenes of riots filled TV screens, Kaysen writes, "were easy times for the staff. We didn't 'act out'; it was all acted out for us."[124] By the time the cultural movement occurred, it was too late for patients like Kaysen who

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[121] Cheever, "A Designated Crazy."
[122] Kaysen, 156.
[123] ibid., 92.
[124] ibid., 93.

had already been institutionalized. The times may have been changing for many, but not for those in McLean.

Whereas in Plath's time the dominant discourse was that mental illness indicated an abnormality which caused her social deviance, Kaysen's work reveals how ten years later this discourse was inverted to the point that her social deviance was diagnosed as a mental illness: Borderline Personality Disorder. This reversal highlights the slight difference in how each author implicates society. In Plath's time, society cultivated a misperception of mental illness that viewed it as the patient's fault or the patient's fabrication. While in Plath's time mental illness was seen as the patient's invention, Kaysen shows that a decade later it became the invention of the psychiatrist. This shift illuminates the way in which the mental hospital and psychiatry became enmeshed in a social view of normality and became another source of social control, one that, because of its ability to sedate patients, was extremely powerful. In Plath's case, McLean treats her illness and helps her recover; however, the McLean that Kaysen experiences is an exaggerated microcosm of society where chemical sedatives replace social norms as a controlling force. The collusion between psychiatrists and those in the upper classes left no means of escape for patients such as Kaysen, who were forced to conform if not voluntarily then forcibly.

Maintaining Authority: From Parents to Psychiatrists

Although it may seem relatively difficult for an average 'sane' person to end up in a mental institution, Kaysen candidly tells her reader it was "easy."[125] It was particularly

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[125] ibid., 5.

easy for an adolescent who did not subscribe to the social values of her conservative parents. When looking back on her adolescent years, Kaysen reflects "Was I crazy? I can't say. I was desperately unhappy, but I'm not sure that's the same thing."[126] As a teenager, Kaysen had bouts of insecurity and depression, once attempting suicide by swallowing 50 aspirin. Kaysen realized, however, that the only part of herself she wanted to kill was "the part that wanted to kill herself."[127] The attempt, which ended with Kaysen having her stomach pumped, seems like a cry for help from an adolescent who understood her life as a series of failures, a feeling her family cultivated. Kaysen writes, "my family had a lot of characteristics—achievements, ambitions, talents, expectations—that all seemed to be recessive in me," expressing a sense of genetic difference from her family that she can neither change nor escape.[128] Her constant sense of failure and difference cultivated Kaysen's contrariety, alienating herself from her peers, parents and surrounding social climate. She writes, "my ambition was to negate…The world, whether dense or hollow, provoked only my negations," including her decision not to attend college.[129] Kaysen writes that at the time she knew she "wasn't mad," she simply did not view herself and her life in her family's terms. Despite mounting family and social pressure to conform, Kaysen refused to do so, and the price she paid was her sanity. As Thomas Szasz, a psychiatrist who has spent his career critiquing his field, writes "mental health is the ability to play whatever the game of social living might consist of and to

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[126] Cheever.
[127] Kaysen, 37.
[128] ibid., 165.
[129] ibid., 42.

play it well. Conversely, to refuse to play, or to play badly, means that the person is mentally ill."[130] This was a lesson that Susanna Kaysen found out the hard way.

Vexed by their teenagers' reluctance to follow in their footsteps, parents, explains Shervert Frazier, who became McLean's psychiatrist-in-chief in 1972, turned to psychiatrists for another opinion on the matter. He writes that families "knew there had been a noticeable change in personality, and they wanted to know what caused the change in personality and what could we do about it."[131] Doctors, summoned by individual families, were expected to provide an answer to concerned parents. Thus their allegiances lay with parents, not patients. Kaysen writes, "It was 1967. Even in lives like his [her psychiatrist's], professional lives lived out in suburbs behind shrubbery, there was a strange undertow, a tug from the other world—the drifting, drugged-out, no-last-name youth universe—that knocked people off balance."[132] Her doctor, eager to wash his hands of a rebellious teenager, had to give Kaysen's parents an answer. Not surprisingly, these answers often supported the existing views of such upper-crust parents, who were willing to pay a good deal of money for these second opinions. A study done on women inpatients validated such this link between family and psychiatric staff, who "on the whole… seemed to concur with the family's definitions initially, and to persist in this way of viewing the clients."[133] By siding with parents, psychiatrists gained a sense of power and authority over teenagers, whose present incarnation as social rebels was both foreign and threatening.

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[130] Szasz, "Politics and Mental Health," 509.
[131] Beam, 201.
[132] Kaysen, 39-40.
[133] Thompson, "Women in Inpatient Facilities: Impressions and Reflections," 51.

Instead of parents telling them what to do, teenage patients had a plethora of psychiatric staff to do the same. Kaysen represents the paternalistic nature of psychiatric institutions when Lisa mimics the ward nurses: "Valerie, time for lunch, Valerie, you don't have to yell, Valerie, time for your sleeping meds, Valerie, stop acting out."[134] Despite the fact that most of the women on the ward are in their late teens or older, this quote reflects the paternalism of the psychiatric hospital that treated them as little children. While at first this authority seems insignificant to Kaysen, it grows on her to the point that she sees herself as "a plate or shirt that had been manufactured incorrectly and was therefore useless," perpetuating her self-doubt and insecurities.[135] This sense of incorrectness is cultivated by Kaysen's family and doctors, who effectively tell her that it is not okay for her to be who she is. Her identity is more than an alarming difference to her parents and psychiatrist, it becomes her illness. If Kaysen was dealing with some kind of depression, as she presumes she was, this depression is never treated and instead is cultivated with the hope that her increased feelings of isolation and difference would make her want to conform to social norms. The first way in which psychiatrists cultivated patients' abnormality was by diagnosing them with an illness, regardless of whether one actually existed.

Subjective Diagnosis

In her chapter titled "Do you believe him or me?" Kaysen skillfully reveals the subjective nature of her diagnosis. Although her referring doctor claims he interviewed Kaysen over a three-hour time span, she uses her admission note from McLean to

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[134] Kaysen, 80.
[135] ibid., 59.

investigate the reality of this claim. While at first it seems as though the doctor was right and Kaysen had misperceived reality, by working back from her time of admission to the hospital Kaysen deduces that, in fact, she was right. Kaysen warns the reader "don't be so quick" to assume that her version is wrong or to assume that the doctor is always right.[136] Her interview only lasted twenty minutes, a limited amount of time to accurately diagnose an individual with a psychiatric illness, and certainly not the same as spending three hours with them. Her doctor read into the situation what he wanted to get out of it, arbitrarily pinpointing characteristics and traits that suggested a lack of normalcy, such as picking at her pimples in public, that would allow him to make some sort of claim about her insanity. These two anecdotes, lying about how much time he spent with the patient and labeling Kaysen abnormal because she picks her pimples, reveals the recklessness of such diagnoses at the time. Diagnosis, as Erving Goffman relates, easily degenerated into subjective judgment: "inappropriate behavior is typically behavior that someone does not like and finds extremely troublesome, decisions concerning it tend to be political…expressing the special interests of some particular faction or person."[137] Kaysen's psychiatrist convinced her that she needed "a rest."[138] While a 'rest' sounds pretty good to Kaysen, the doctor uses this term as a euphemism for institutionalization, a reference Kaysen doesn't catch until it's too late, and a 'rest' becomes her cab's destination: McLean.

Psychiatrists, eager to diagnose, applied the social understanding of normalcy to the medical realm in order to diagnose patients like Kaysen who lacked symptoms of severe psychiatric illness. Particularly at this moment in psychiatry, diagnostic standards

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[136] ibid., 72.
[137] Goffman, *Asylums*, 363.
[138] Kaysen, 8.

were not universal. Dr. Alan Stone, a former resident at McLean hospital, writes that to McLean staff patients like Kaysen,

> Looked and acted crazy by conventional standards but they did not fit into any of our diagnostic categories. We eventually had to create a new diagnosis for patients like Kaysen: Borderline Personality Disorder. It was by no means easy for us to decide when someone had crossed the border from hippie to hippiephrenia.[139]

Dr. Stone's insensitive comment exposes that doctors were judging patient's 'craziness' simply by how they looked and acted based on social norms, 'conventional standards.' Thomas Szasz theorizes this point, writing that the difference "between social non-conformity (or deviation) and mental illness… does not necessarily lie in any observable *facts* to which they point, but may consist only of a difference in our *attitudes* toward our subject."[140] In 1973, D.L. Rosenhan, professor of psychology at Stanford decided to test the validity of such claims by attempting to have eight individuals gain secret admission to twelve different hospitals.[141] In all but one case, the pseudopatients were admitted with an average institutionalization of 19 days.[142] None of the pseudopatients were detected and each were discharged with a diagnosis of "schizophrenia 'in remission.'"[143] Instead of questioning whether or not the patient was actually ill, the question was always, 'what illness do they have?'

In Kaysen's case the answer was Borderline Personality Disorder (BPD). Kaysen cites the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III) description of her illness, which is characterized by a pattern of "instability of self-image,

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[139] Beam, 201-202.
[140] Szasz, "Politics and Mental Health," 509.
[141] Rosenhan, "On Being Sane in Insane Places."
[142] ibid., 251.
[143] ibid., 252.

interpersonal relationships, and mood…uncertainty about several life issues."[144] Generally, BPD is marked by extreme moods that can border on either psychosis or mania.[145] This illness was integrated into the DSM-II in 1980 for the first time and remains a diagnosable illness by DSM standards and according to the National Institute of Mental Health.

Kaysen's entrance and exit from McLean also reveal the extreme gender bias that was attached to such diagnoses at the time. In 1969 women constituted 65% of the psychiatric inpatient population.[146] Chesler writes that the subjective diagnosis Kaysen experiences was more likely to occur with women since "psychiatric hospitalization or labeling relates to what society considers unacceptable behavior… women are allowed fewer total behaviors and are more strictly confined to their role-sphere [therefore] women, more than men, will commit more behaviors that are seen as ill or unacceptable."[147] This explanation for the diagnosis of deviance along gender lines seems particularly plausible given that Kaysen's psychiatrist's admission note cites "promiscuous, might kill self or get pregnant," under 'reasons for referral.'[148] These fears stemmed from a perception of adolescent patients as "people unable to control their sexual and aggressive impulses," according to a study done in 1966.[149] During a time when social deviance was treated as an illness, Kaysen is only able to leave McLean when a marriage proposal is made to her. By choosing to marry and follow the path of a 'normal' twenty-year-old woman, Kaysen provided proof of sanity in the eyes of her parents and doctors alike, and cures herself of her supposed promiscuity. As Kaysen

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[144] Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, 346-47.
[145] National Institute of Mental Health, "Borderline Personality Disorder."
[146] Gervais, "Changing Patterns of Psychiatric Inpatient Care in a University General Hospital," 1273.
[147] Chesler, 99.
[148] Kaysen, 13.
[149] Caplan, "Identification, A Complicating Factor in the Inpatient Treatment of Adolescent Girls," 724.

reflects earlier, "how could a person who was locked up have a boyfriend?"[150] Both Kaysen and the reader are forced to wonder how much longer she would have stayed at McLean had this option not presented itself.

DSM and Unease: Diagnosis in Perspective

In order to counteract the sort of reckless diagnosis that Kaysen experienced, the Diagnostic and Statistical Manual of Mental Disorders (DSM) was initiated to synthesize and standardize psychiatric practice. In 1952 the first edition of the DSM was published by the APA as its "first independent system of naming."[151] After a 1969 study that showed that the US and UK were badly disjoint in how they diagnosed patients, the APA decided to begin revisions for the third edition of the DSM, with a focus more on biological roots and diagnostic criteria instead of the psychoanalytical perspective that predominated in the first two editions.[152]

Although the DSM had specific criteria by which doctors could categorize individuals, unlike medical diagnosis, the DSM diagnosis did not lead to a specific treatment plan. Instead, doctors decided on a case-by-case basis how to treat patients who they had identified as suffering from the same illness. While the aura of science and the establishment of the DSM gave the perception of an objective eye, in reality diagnosis was highly subjective. In the DSM-III "the chronic depressions were made to sound more like personality disorders…this corresponded to the analytic view of depression as a kind of character disorder treatable only through lifelong

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[150] Kaysen, 25.
[151] Shorter, *A History of Psychiatry*, 298.
[152] ibid., 301.

psychotherapy."[153]By turning chronic depression into a character disorder, doctors were diagnosing deviance, rather than a mental illness. Kaysen's diagnosis, Borderline Personality Disorder, her current psychiatrist tells her, is "what they call people whose lifestyles bother them."[154] As Kaysen illuminates through her memoir, doctors were imposing their own views of normalcy onto their patients and making opinionated judgments rather than careful diagnoses.

In the years between Kaysen's institutionalization at McLean and the publication of *Girl, Interrupted* homosexuality, once seen as deviant sexual practice, was removed from the DSM. As the addition and removal of homosexuality and the subjective nature of Kaysen's diagnosis suggest, the momentum of the biological psychiatric movement in the sixties overstepped its boundaries. Doctors came up with diagnoses that were social exclusions masked with a psychiatric rhetoric. While homosexuality was removed from the DSM, with every revision of the manual there has been an increase in the number of diagnosable illnesses, a pattern that has caused individuals both inside and outside the psychiatric community to question the possibility that so many new illnesses were possible or even real.[155]

This feeling of unease resonates with individuals who worked at McLean during the late 1960s. Barbara Schwartz, a social worker who started at McLean in 1962 reflects on the medical and social climate, expressing,

> The parents were in great distress. They had lost control. The kids were running away, doing all kinds of things. Now I shudder when I think of who was hospitalized …If I only knew then what I know now, some of those kids

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[153] Shorter, *Before Prozac*, 160.
[154] Kaysen, 151.
[155] Shorter, *A History of Psychiatry*, 302.

> would never have been admitted to that hospital, they would never have had to go through that kind of experience. It saddens me. It was a shame.[156]

Regrets such as these from individuals who worked at McLean during the late sixties show the extent to which biological psychiatry was wrapped up in the social climate of the time. As Dr. Michael Sperber, who worked on South Belknap and Bowditch wards at McLean during the 1960s acknowledges, patients like Kaysen "probably wouldn't be considered severe enough to be hospitalized now."[157] By admitting that by today's standards these patients wouldn't be diagnosed as mentally ill, Dr. Sperber recognizes that their diagnosis was based more on social rather than medical factors. It is not that adolescent behavior has changed, but rather that collective social attitudes towards it have: adolescents like Kaysen are no longer seen as deviant. In fact, the description of Borderline Personality Disorder—unstable self-image, changing interpersonal relationships, uncertainty about long-term goals or career choice, feelings of inadequacy, boredom—sounds like a very good description of an adolescent today. Similar statements about these diagnoses have also been proffered from Dr. Robert Spitzer, the psychiatrist who was chair of the task force for the 3rd edition of the DSM. With regard to categories such as "'borderline and narcissistic' [personality disorders]" Dr. Spitzer stated that "we have little confidence concerning their reality."[158] Nonetheless, these categories remained in the DSM-III.[159] Decisions of diagnosis were left up to opinion rather than evidence on a level much larger than one single institution. For those like Kaysen who ended up in psychiatric institutions, life was a harsher version of the real world where the recklessness of psychiatry had much more immediate implications.

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[156] Beam, 199.
[157] ibid., 198.
[158] Shorter, *Before Prozac*, 166.
[159] ibid., 166.

McLean: Medicating Conformity

For teenage patients, McLean provided neither rest nor time out from the outside world. As Phyllis Chesler notes, "mental asylums rarely offer asylum. Both their calculated and their haphazard brutality mirrors the brutality of 'outside' society."[160] Parents gave psychiatrists the power to diagnose, but even worse, they gave psychiatrists the power to 'treat.' Given that Kaysen's 'illness' was phrased in terms of rebellion against social norms, the 'treatment' she receives at McLean does not actually treat any of her depressive symptoms, but comprises a medical version of social control where privacy is curtailed with surveillance and conformity was induced with sedative drugs.

McLean exerted a controlling force on its patients through constant surveillance, with nurses flying into the patients' rooms every fifteen minutes for 'checks.' Through this perpetual infringement on patients' freedom, the nurses "murdered time in same way—slowly—chopping of pieces of it and lobbing them into the dustbin with a little click to let you know time was gone."[161] To patients this surveillance conveyed that neither their time, nor their lives, belonged to them anymore. For a brief moment Lisa exposes the harsh reality of ward life and its limits on personal agency of any kind, screaming,

> I'd just like to see how you'd manage this place, never going outside, never even *breathing* fresh air, never being able to open your own fucking window, with a bunch of sissy cunts telling you what to do…You know? I mean, how the fuck would you manage, hunh?…I mean, you wouldn't last ten minutes in this place.[162]

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[160] Chessler, 95.
[161] Kaysen, 54.
[162] ibid., 80.

Similarly, the physical barriers at McLean, "double-locked doors, our steel-mesh window screens…our bathroom doors that didn't lock," reinforced the notion that such individuals, as a result of their uncontrollability, didn't deserve any privacy at all.[163] Kaysen initially describes her mental state as one that was incrementally "slipping into a parallel universe [which] exists alongside this world and resemble[s] it, but is not in it."[164] Here, however, Kaysen is not describing her thoughts; she is describing McLean. McLean is the parallel universe that existed alongside the real world but was not in it, as her description of watching the 1969 riots on TV exemplifies. McLean was in many ways a stricter microcosm of society, with explicit rules and physical barriers in place of the social constraints teenagers like Kaysen had already confronted in their private lives.

The most drastic way McLean controlled its patients, both physically and mentally, was through sedative drugs such as Thorazine. Stuart Auerbach, a columnist for *The Washington Post*, wrote in 1974 that here were no diagnostic chemical tests for psychiatric illness; as a result drug treatment was offered on a trial-and-error basis.[165] Although sedative medication was developed at the time to help patients deal with their anxiety, mania or depression on a day-to-day basis, Kaysen experiences medication at McLean as a way to control patients, so powerful that the nurses "who got addicted to our taking it."[166] To ensure that Torrey went directly to the airport and didn't try to escape along the way, Valerie gives her Thorazine. Instantly Torrey's eyes glistened as the medication set in, "she took a step away from us and lost her balance slightly," her physical incapacitation mimicking her induced state of mental sedation.[167] The

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[163] ibid., 47.
[164] ibid., 5.
[165] Auerbach, "Mental Illness: The Chemical Causes," H2.
[166] Kaysen, 87.
[167] ibid., 100.

therapeutic gains are not for the patients on the ward, but rather a controlling force they cannot overcome.

By treating Kaysen as if she was insane, McLean made Kaysen act and believe that she was crazy. Kaysen's memoir includes brief descriptions that delve into her thought processes while she was at McLean. Her perception of her illness, however, is hard to trust given that it is contingent on her environment, one that, as I have already discussed, treated her based on a diagnosis that was based on social norms rather than pathology. Her view of her mental state, then, cannot be separated from her environment or diagnosis, since they hinged on these very factors. Furthermore, they are not entirely trustworthy given that she was often medicated on Thorazine. Her descriptions, however remain interesting in so far as they reveal the power of her environment at McLean to control her thoughts and views of herself, views that contradict her understanding of herself both before and after she entered McLean.

Before she enters McLean, Kaysen writes that she was "at all times perfectly conscious of my misperceptions of reality."[168] This objective perspective is one that she loses as soon as she enters McLean, where the extreme effects of Thorazine and the controlling nature of the hospital alter her thoughts and self-perception. The sedative effect of Thorazine is so powerful that it manipulates Kaysen's thought process. Kaysen explains that her thought process came in two forms: slow and fast. The slow form Kaysen dubs 'viscosity,' a state in which experiences move slowly and the body is half-asleep. This viscosity exactly mirrors her description of being treated with Thorazine, "Then the Thorazine hit me. It was like a wall of water, strong but soft… Valerie and

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[168] ibid., 41.

Georgina picked me up under the arms and steered me down the hall to our room. My legs and feet felt like mattresses, they were so huge and dense."[169] In contrast to the "cellular coma" of viscosity is velocity in which the individual experiences what Kaysen describes as an overdose of perception, hyperawareness.[170] This velocity of thought and hyperconsciousness would be a natural response to the constant surveillance at McLean. Having been drugged to the point of sedation, it seems logical that in response Kaysen would be extremely attune to her environment and surroundings given that they drug her so that she will be unable to exercise any sort of agency or control.

The atmosphere at McLean was so powerful that it controlled and altered the way that Kaysen understood herself and her mental state. Kaysen describes her thought process as a competition between two interpreters. In this model the two interpreters function like good and bad consciences; however, instead of debating ethical questions the interpreters argue over whose perception of reality is the real one. The 'social' interpreter says "you're a little depressed because of all the stress at work," while the 'scientific' interpreter says "you're a little depressed because your serotonin level has dropped."[171] While at first these two views seem only to serve as references of the paradigm shift in psychiatry from psychoanalysis to biological psychiatry, they reveal that the psychiatric community's views of Kaysen have insidiously become her own. The power of her environment is so strong that it causes her to view her thoughts in terms of psychiatric paradigms. A crucial detail in this passage is Kaysen's use of the word 'depressed.' While her doctors do not diagnose her with depression, her haphazard use of this word is the only indication she gives that she views herself differently than her

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[169] ibid., 103.
[170] ibid., 75.
[171] ibid., 138.

doctors do. This 'depressed' characterization is one that much more closely fits her views of herself before she enters McLean and after she leaves it, while her self-perception at McLean is contingent on her environment and the Thorazine she's given.

The only way for teenagers like Kaysen to counteract the severe constraints of McLean was to rebel; however, rebellion only perpetuated the notion of uncontrollability that was used to classify them as mentally ill. In one episode, the patients hid all of the light bulbs, sending the staff into frantic search only to find them smashed in the phone booth.[172] These actions are the only instances in which, if even for a moment, patients on the ward were able to invert the power hierarchy and assert themselves. The type of rebellion and audience didn't matter as much as the rebellious actions, such as when Lisa demands to have the nurse open the window and then only minutes later asks for it to be shut to "pass the time."[173] The complete surveillance Kaysen and the other adolescent women around her faced didn't make them eager to comply with their superiors. If anything, it only made them more eager to be their rebellious selves. From acting out at the ice cream parlor, to covering all of the furniture in toilet paper, these pranks, while often comical, reveal that these teenagers were relentlessly rebellious, to parents and nurses alike. Despite their efforts to regain a sense of independence, patients like Kaysen were already doomed, and instead of improving their condition they only made themselves appear even more abnormal.

While in Plath's novel Esther has the support of Dr. Nolan who separates Esther's identity from her illness, no such distinction is made in Kaysen's case. The only respite from the judgmental social and psychiatric discourse in the memoir is Valerie, a

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[172] ibid., 61.
[173] ibid., 82.

nurse, and the only staff person Kaysen and her ward-mates trust.[174] Kaysen describes Valerie as a relief from the doctors because instead of using medical jargon, she said what she meant, and most of all because "she didn't have much to say about anything."[175] Valerie is also the only person in the hospital who validates Kaysen's judgments. After observing her decision to postpone her wisdom teeth surgery, Valerie tells Kaysen, "That was sensible of you."[176] This compliment blindsides Kaysen who has never considered herself so composed as to be 'sensible.' While at the time Valerie was an antidote to the rest of the hospital, within the sphere of the memoir she provides an example of the kind of attitude that benefitted the patients: one that was honest and non-judgmental, but sadly one that was largely absent during Kaysen's teenage years.

Conclusion: Shifting Cultural Views of Normalcy

Kaysen succinctly encapsulates the impact of social view on psychiatry and sardonically pokes fun at psychiatric history in her brief chapter, 'Etiology.' In the chapter (Appendix) Kaysen asks the reader to pick an option to describe a hypothetical individual, filling in the blank with one of ten theories about the mentally ill. Her options, ranging from "on a perilous journey from which we can learn much when he or she returns," to "bad, and must be isolated and punished," to "a victim of society's low tolerance for deviant behavior," illustrate an important point: over history each of these theories has been popular, yet they are almost entirely based on prevailing views towards normalcy on the one hand and the mentally ill on the other.[177] In 1967 Willard Clopton

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[174] ibid., 83.
[175] ibid., 83.
[176] ibid., 107.
[177] ibid., 15.

Jr. cites this problem in *The Washington Post*, writing, "the error of medical psychiatry… is in seeing abnormal behavior as the opposite of normal, in the same sense that 'healthy' is regarded as the opposite of 'diseased.'"[178] The inherent problem with associating disease with normalcy is that social views of normalcy shift over time. The error of biopsychiatrists and successive editors of DSM editions was their "underlying failure to let science point the way."[179]

The history of psychiatry has not existed in a vacuum. Through her memoir, Kaysen opens up the debate about what it means to be normal, and how much mania, depression, rebelliousness or insecurity is a normal amount. By challenging the culture surrounding her own diagnosis, she forces us to take another look at a system that has silenced patients like her by labeling them as crazy, effectively taking away their credibility. The combination of anecdotal narration, retrospective analysis, hospital reports, and excerpts from DSM-III provides convincing evidence of the normalcy of a misunderstood teenager. Kaysen highlights how McLean was a teen's punishment for failing to adhere to her parent's expectations, a punishment that ended only when she decided to marry or adhere to those expectations she had previously rejected.

Although American culture and social opinions about teenagers have changed to the point that few individuals such as Kaysen would likely be institutionalized today, the controversy surrounding the DSM continues. Now in the process of developing the fifth edition of the DSM to be published in 2012, the APA is already facing criticism and debate. Today this debate involves the many OCD diagnoses. As Benedict Carey notes in his recent article in *The New York Times* "labels like obsessive-compulsive disorder

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[178] Clopton, "Is Mental Illness Really Only 'Ineffectiveness'?" B3.
[179] Shorter, *A History of Psychiatry*, 305.

have connotations in the wider culture and for an individual's self-perception," as Kaysen's diagnosis had for her.[180] Kaysen explains that "in the world's terms, though, all of [the mentally ill] were tainted," as is any individual who figures in the DSM.[181] Because psychiatric illness can be caused by so many different factors, biological and social, one would hope that the implications of these diagnoses would be taken more seriously now than they were in the late 1960s.

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[180] Carey, "Psychiatrists Revise the Book of Human Troubles."
[181] Kaysen, 124.

Chapter Three: Lithium as Life in *An Unquiet Mind*

In her memoir *An Unquiet Mind* (1995) Kay Jamison reflects on a life of dealing with mania and depression. In her sympathetic self portrayal Jamison moves through time chronologically, meditating on pivotal moments of both success and heartbreak, her identity as both a patient and a clinician and her persistent struggle with an illness that at times could have cost her her life. She describes her exhilarating manic highs and debilitating depressive lows that led to her diagnosis with manic-depressive illness. However, even after her diagnosis, Jamison struggles with her illness and the medicine she uses to combat it: lithium, her highs and lows becoming so extreme that she attempts suicide. Her experiences with her manic-depressive illness and particularly with her medication provide vivid accounts of the way patients have dealt with mental illness in the era of psychopharmacology since the 1970s. As an author, Jamison relies equally on her personal experiences as a patient and her vast professional knowledge of mental illness, affording her readers a dual-perspective on a double-edged illness. Having written the diagnostic manual on manic depression and a book on manic-depression and creativity, Jamison was already a leading expert on manic-depressive illness before the publication of her memoir in 1995. In her memoir, Jamison focuses on the role lithium has played in her life, using her work to advocate for total compliance with psychiatric medicine, as she sees it, a choice of life over death. By looking at lithium in such an extreme way, Jamison supports a re-dichotomization of mental illness as an all-or-nothing phenomenon predicated on adherence to psychotropic drugs.

While Plath pushes for a nuanced view of depression and Kaysen highlights the inherent injustices in her diagnosis, Jamison's memoir focuses on drugs. In the two

previous chapters, mental illness and abnormality were linked, and in both cases society viewed mental illness as the patient's fault. While Plath and Kaysen were able to overturn the polarity of views that wrongly afflicted them through their personal accounts and inquiries into their pasts, Jamison's work reinforces a new dichotomization that stems not from inflexible social views, but from science. Individuals are no longer seen at fault for their illness, and milder forms of depression afflict such a large proportion of society that taking psychiatric drugs has become the norm rather than the exception. To be sane and to consistently medicate oneself are no longer antithetical, while to be insane is to fail to adhere to one's medication. Lithium and other medications are in many cases effective in helping treat mental illnesses, yet the discourse Jamison's book extols is one that seems exaggerated and potentially dangerous given the way in which it easily aligns with pharmaceutical corporation's statements about their own drugs as something patients cannot afford to live without.

Jamison's dual identity as both patient and clinician, combined with her wide-ranging publications on manic-depressive illness have vaulted her to the position as the most knowledgeable and most well-known authority on the illness. Jamison has published over one hundred articles and excerpts from *An Unquiet Mind* have figured prominently in many anthologies on madness literature. In addition to her scientific publications and her memoir, Jamison has written about the link between manic-depressive illness and creativity in famous artists, writers and musicians in her work *Touched with Fire*. She has written two more books addressed to a popular audience, a book on suicide, *Night Falls Fast*, and *Exuberance*, a book on moods. A second memoir, *Nothing Was the Same*, on death, grief and loss is slated to come out in September of this year. Her work has appeared in ethnographic research, such as Emily Martin's *Bipolar*

Expeditions (2007), in which Martin cites Jamison's ubiquity, writing, "it would be hard to exaggerate the impact of Jamison's work, which has been featured in newspapers, magazines, and documentary films."[182] Almost without exception, Jamison's work has been received with acclaim. As Martin writes, Jamison's "revelation in 1995 that she had the diagnosis of manic-depressive illness added further to her popularity."[183] In *Intimate Reading: The Contemporary Women's Memoir* (2001) Janet Ellerby prides Jamison for allowing "intimate readers to live through the specific insidiousness of her mental illness…her willingness to reveal the devastation of her illness leaves me full of respect for her endurance and honesty."[184] Ellerby reads Jamison's memoir as "a warning to those people who might also be tempted to suspend medication," a warning that has garnered widespread attention.[185] On the other hand David Healy, a prominent psychiatric historian, focuses on the way in which Jamison's perspective is one that could be easily manipulated or misconstrued "and used to sell treatments to people who should not have them—and whose lives may be put at risk by them."[186] Although Healy has reservations about the effect of Jamison's work, and slight ones at that, he was the only author I encountered with reservations at all.

As Healy cites, the power of pharmaceutical companies has reached an unprecedented level in recent years. Their success with marketing depression as a catch-all term for stress and general discontent that can be easily overcome with anti-depressant medication, is both remarkable because of drug companies' ability to overturn years of stigma surrounding depression, but also because being depressed now

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[182] Martin, *Bipolar Expeditions*, 23.
[183] ibid., 24.
[184] Ellerby, *Intimate Reading*, 166.
[185] ibid., 165.
[186] Healy, *Let Them Eat Prozac*, 1.

pervades a sense of normalcy. While depression became the norm, pejorative views toward mental illness have not entirely disappeared, but have shifted towards what are now viewed as major psychiatric illnesses, such as manic-depression and schizophrenia. As science gains new knowledge about the genetic component of mental illness, stigma surrounding such illnesses may in fact increase as 'bad genes'—those carrying the marker for serious mental illness—are seen as the objective and lasting way of labeling those who are both insane and abnormal. Thus, for individuals with these illnesses, to maintain a sense of normalcy is to medicate, to continually counteract the effect of one's genes. While for individuals with manic-depressive illness, medication curtails the manic times of intense production and creativity, this cost is countered with the ability to exist as a normal individual in society, a benefit that is hard to ignore. In Jamison's memoir, these views become extreme to the point that adhering to her lithium is likened to a choice of life or death. Her view of lithium, its curative abilities and life-or-death effect originate from her clinical education and patient experience, perspectives that mutually reinforce each other and are confirmed with the counter-example of Jamison's father, who suffered from the disease without medication, and the advent of genetic information.

1970 onward: Biological Psychiatry and the Rise of Psychiatric Treatment

Biological psychiatry, which was already in the process of eclipsing psychoanalysis in the late 1960s, became the dominant psychiatric discourse during the 1970s and has remained the dominant paradigm since. As biological psychiatry gained momentum, new classes of drugs developed that were able to affect mood in powerful ways. Two of the most important drugs that were developed to treat depression were lithium, which was introduced in 1970, for manic-depressive illness and Prozac, an anti-

depressant, which was introduced in 1988. The development of drugs to treat psychiatric illness boosted the biological psychiatry movement by providing patients with a way to counterbalance the negative effects of their illnesses instead of simply sedating them, the essential effect of earlier drug classes such as Thorazine (Chlorpromazine) and Valium. With the development of medicine that could temper the symptoms of a variety of conditions, patients battling mental illness were rarely removed from society to asylums; the majority of patients were treated in outpatient clinics.

The invention of new drugs to treat different mental illnesses as a means of moving patients back into the community was paralleled by a national and government-sponsored creation of community mental health centers (CMHCs) beginning in 1965 and continuing throughout the 1970s. These health centers were initially meant to provide alternative means of support especially for patients who simply could not afford to pay the high price of staying at an institution.[187] Despite their failure to achieve this goal, CMHCs became part of psychiatry's growing patient base that included individuals seeking help with stress-related issues and domestic problems in addition to serious mental illnesses. In part, this was due to another effect of deinstitutionalization: psychiatrists had lost one of their main sources of income and employment. To recover financially from this change psychiatry pushed the boundary of pathology "steadily to the right, away form the unwell and toward the commonplace. The message was that these ubiquitous features of the human condition represented billable psychiatric illnesses."[188]

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[187] Grob, 280.
[188] Shorter, *A History of Psychiatry*, 292.

As the criteria for psychiatric patients expanded, biological psychiatry was also trying to unlock the genetic component of mental illness. By searching for the genetic roots of mental illness, psychiatrists hoped to re-establish their profession within the medical community, emphasizing "the importance of exploiting new technologies that might illuminate the pathology of mental disorders and reintegrate themselves with other medical specialties."[189] The power of genetic underpinnings of mental illness has grown so strong that when doing research for her recent book, published in 2007, Emily Martin writes that most of the individuals she interviewed already assumed that "the brain and its genetic determinants lie behind mental disorders like manic depression."[190] She relates, "I often heard from my psychiatrist that my problems were related to my neurotransmitters, and I always found this comforting. I took this to mean that my problems were not entirely within my control."[191] In this way the blame that has so often been attributed to patients was removed and passed on to genes and neurotransmitters, at least within the psychiatric and medical communities. On the other hand, genetics allowed clinicians to retain authority over the validity of an individual's illness. By genetically testing the individual, the psychiatrist can verify if the illness is truly present, retaining his or her position as the ultimate arbiter. The authority of science that was so falsely applied in Kaysen's case was able to regain a validity that the patient could not surmount in the development of genetic explanations for mental illness.

Manic-depressive Illness and Lithium

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[189] Grob, 277
[190] Martin, 11.
[191] ibid., 13.

Kay Jamison was diagnosed with manic-depressive illness, commonly referred to as bipolar disorder. Manic-depressive illness was first identified by Emil Kraeplin in 1850s as 'circular insanity' which he renamed 'manic-depressive illness' in 1899.[192] The term bipolar first came into use in 1957 and was adapted within psychiatry in 1975 when depression was categorized into four kinds: major, minor, unipolar, bipolar by Robert Spitzer in DSM-III.[193] Emily Martin notes that in more pubic sources, such as newspapers, from 1980 to the late 1990s the two terms were often used interchangeably, but since 1999 'bipolar disorder' as been used three times as often.[194] In DSM-IV bipolar disorder is characterized by "the occurrence of one or more manic episodes or mixed episodes. Often individuals have also had one or more major depressive episodes."[195] Although the term bipolar, used by the APA, is more common, Jamison prefers the term manic-depressive illness. Jamison defends her preference, explaining that as a patient "I find the word 'bipolar' strangely and powerfully offensive: it seems to me to obscure and minimize the illness it is supposed to represent…'manic-depressive,' on the other hand, seems to capture both the nature and the seriousness of the disease I have."[196] Using her scientific background, Jamison writes "splitting mood disorders into bipolar and unipolar categories presupposes a distinction between depression and manic-depressive illness—both clinically and etiologically—that is not always clear, nor supported by science."[197] Science does support, however, that medication is extremely effective in controlling manic-depressive illness and in preventing suicide.

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[192] Shorter, *A History of Psychiatry*, 105.
[193] Shorter, *Before Prozac*, 158.
[194] Martin, 27.
[195] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, 350.
[196] Jamison, *An Unquiet Mind*, 181-182.
[197] ibid., 182.

Lithium is the drug most commonly used to treat manic-depressive illness. The effectiveness of lithium was first discovered in 1949 but the drug was not licensed for use in the US until 1970.[198] In the treatment of mood disorders, the effectiveness of Lithium remains unsurpassed: "over the years, no drug has made as much of a difference in the lives of patients with manic-depressive illness, now known as bipolar disorder, as lithium; it not only effectively treats the acute manic phase of the illness, but it also prevents relapse from both mania and depression."[199] Among manic-depressives lithium is widely used because of its curative powers and the ability to allow those with such a severe illness to simply continue living. However, individuals who go on lithium often have a hard time adjusting to their 'new' lives without the bursts of creativity and productivity mania provides. Lithium, from the clinicians' standpoint is in many ways a miracle drug, yet for patients, its miracle comes at a cost. The nearly toxic effects of lithium necessitate periodic blood tests. As a result, Emily Martin characterizes lithium, as a "stern schoolmaster" that "cannot be escaped without detection…if you aren't taking your lithium as prescribed, your physician will know that, without a doubt."[200] Because constant testing is a fact of life for those on lithium, perhaps it comes as no surprise then, that lithium has a high degree of non-compliance. While lithium is not widely used beyond those with manic-depressive illness, the drug class it belonged to began a movement towards psychopharmacology that has drastically changed the public's view of mental illness over the past thirty years.

Social Views of the Mentally Ill since 1970

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[198] Shorter, *Before Prozac*, 65.
[199] ibid., 67-68.
[200] Martin, 163.

While psychiatry underwent this paradigm shift in terms of ideology, society experienced a similar paradigm shift in its views towards psychiatric drugs. This shift was a result of psychiatry's broadened definition of psychiatric illness and the prevalent use of Valium. In the years leading up to 1970, as chapter two illustrates, psychiatry lowered the threshold of what constituted psychiatric illness by pathologizing essentially normal if somewhat troubling behavior, a move that dramatically increased psychiatry's patient base.[201] During this same time period Valium became so widely used that it garnered the nickname "Executive Excedrin."[202] Expanding the patient population from those with serious illness to the 'worried well,' individuals with general anxiety and depression preceded but was also the result of drugs like Prozac that were marketed as "a panacea for coping with life's problems even in the absence of psychiatric illness."[203] Such messages implied that taking these medications did not indicate serious mental illness. In his book *Comfortably Numb: How Psychiatry is Medicating a Nation* (2008) Charles Barber writes "For the first time in history, it was *okay* to take psychiatric drugs. Simply put, you didn't have to be crazy—*that is, you didn't have to be mentally ill*—to take the pills."[204] This view gained popularity as 'pill popping' to remedy any psychiatric or emotional malady became widespread among the American people. According to Maeline Amile, an expert in drug abuse and professor of clinical psychology at Mount Sinai Hospital, this culture has been reinforced by advertisements that persuade viewers "that drugs are a way to escape, and there is nothing wrong with doing it because the people in the ads are very

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[201] Shorter, *A History of Psychiatry*, 291.
[202] Barber, *Comfortably Numb*, 25.
[203] Shorter, *History of Psychiatry*, 323.
[204] Barber, 27.

ordinary people, and if they are doing it, why shouldn't I?"[205] As anxiety and depression have become chemically treatable, depression is no longer viewed as a severe illness.

Instead, depression has become the norm. Depression has become the most common reason individuals seek psychiatric help, accounting for 28 percent of patient visits.[206] By changing the public perception of depression and psychiatric medications, psychiatry and the pharmaceutical industry changed social views of normalcy to the point that "in contemporary America, it has been broadly accepted for some time that everybody, at some level, is depressed at least some of the time."[207] As Charles Barber notes, modern psychiatry has confused depression (the blues) with Depression (major depression).[208] At the same time the prevalence of those taking some kind of psychotropic drug has also increased to unprecedented levels. Of those individuals diagnosed with depression, only 37 percent received antidepressants in 1987 yet only ten years later almost 75 percent of patients were treated with antidepressants.[209] That such a large portion of the population sought some form of psychiatric therapy largely explains how the 'insane' "who had transfixed the public view with horror for centuries" were replaced by "people suffering from 'stress' for whom help was easily available."[210] The concept of stress is ubiquitous in today's world of overtime hours and job creep, to the point that stressed and depressed individuals are the rule rather than the exception. However, some forms of depression are still viewed both within psychiatry—and more

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[205] Hughes and Brewin, *The Tranquilizing of America: Pill Popping and the American Way of Life*, 267.
[206] Shorter, *A History of Psychiatry*, 291.
[207] Healy, *Mania*, 190.
[208] Barber, 112.
[209] Shorter, *Before Prozac*, 199.
[210] Shorter, *A History of Psychiatry*, 324.

importantly for this project, within society at large—as serious mental illnesses. Near the top of this list is manic-depressive illness.

Because so many people are now classified as 'depressed' and not as mentally ill, society's previously alienating views have devolved on other, more specific kinds of mental illness such as schizophrenia and manic-depression, which have become severe and even frightening illnesses in the public consciousness. In a general sense, this reconception springs from a tendency to believe that it is uncommon for a large quantity of people to have a serious illness, whether physical or mental. A study in 2006 shows that while Americans believe that mental illness has genetic causes, society is no more tolerant of those with mental illness that it was in 1996.[211] Given that public views of mental illness are also related to prevailing treatment, the use of anti-psychotics to treat manic-depression and schizophrenia reinforces the negative association with 'psychotic' behavior, whereas depression is treated with anti-depressants, which are associated with stress, not severe illness.[212] Family doctors now prescribe most anti-depressants, a trend which reinforces the view that they are common in comparison to other psychiatric drugs which are typically prescribed by a specialist.[213] Recently, public views have changed with increased awareness of the genetic component of mental illness. While genetic arguments associated with depression have positive associations with social acceptance, when applied to serious mental illness such as schizophrenia, genetic arguments are correlated with fears of violence.[214]

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[211] Schnittker, "An Uncertain Revolution," 1370.
[212] Sajatovic and Jenkins, "Is antipsychotic medication stigmatizing for people with mental illness?"
[213] Barber, 102.
[214] Schnittker, "An Uncertain Revolution," 1370.

This correlation between mental illness and violence is often exploited in the media. Throughout the 1980s reports of violent crimes committed by manic-depressive individuals pervaded the media, such as the *New York Times* headline "In Killer's Disorder, Cycles Of Elation and Depression"[215] In an article in *The Boston Globe* Alison Bass writes that this stigma and fear of the severely mentally ill persists as a cultural phenomenon because "Americans are also more likely than other societies to believe that severe mental illness is chronic and incurable. Such beliefs are a vestige of the time when little could be done for people with schizophrenia or manic-depression, mental health professionals believe."[216] While the notion of the 'severely mentally ill' has changed, pejorative views towards such ostracized groups have persisted.

However, Emily Martin argues, manic-depressive individuals are fast becoming a group that is valued for their creative mania, particularly in the fast-pace business world. Martin writes, "If there is an increasing demand for restless change and continuous development of the person at all times, in many realms, then manic-depression might readily come to be regarded as normal—even ideal—for the human condition under these historically specific circumstances."[217] In American profit-driven society, capitalist rhetoric has invaded the psychiatric realm. On the cover of a report from the Harvard Medical School readers are encouraged by a special bonus section on "strategies for success: tips for leaping common hurdles and getting good treatment," and are told that getting ahead is now part of managing their illness.[218] Most recently this logic has extended to medical practitioners such as Alice Flaherty who is described as using "the

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[215] New York Times, "In Killer's Disorder, Cycles of Elation and Depression" 1.10.
[216] Bass, "Illness coupled with stigma; Researchers see a cultural bias against mental disease."
[217] Martin, 216-217.
[218] Harvard Medical School, *Understanding Depression*.

racing mind of her manic phases to drive her ideas into forceful, highly personal treatments."[219] Mania, Martin writes, has market value because of its correlation with performance. According to Dr. Kessler, professor of Health Care Policy at Harvard, quoted in the *New York Times*, "The goal in life is constant hypomania: you never sleep too much; you're on; you keep going."[220] In a culture of corporate dominance and overachievement, hyperactivity is an asset.

While for some, mania is desirable, the stigma of mental illness has been both mitigated and increased as the public has been confronted with genetic explanations for mental illness to the effect that it is either uncontrollable or that mentally ill individuals are essentially damaged. Since the successful mapping of the human genome, Americans are "increasingly likely to accept genetic arguments for a variety of behaviors and traits."[221] The notion that mental illness was inescapable and "in your genes" came to dominate the social perception of illness that no longer faulted individuals for their mental differences. Many scholars have characterized the media's slant as genetic optimism, or the view that genes have the potential to explain mental illness, that scientists are on the brink of finding genes responsible for mental illness, and that this finding will quickly engender a cure.[222] Due to the media's positive portrayal of genetics, the public support for genetic arguments has increased, despite limited understanding of what this information actually means.[223]

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[219] Ely, "From Bipolar Darkness, the Empathy to Be a Doctor."
[220] Carey, "Hypomanic? Absolutely. But Oh So Productive!"
[221] Schnittker, "The Double Helix and Double-Edged Sword: How the Public Thinks About Genes."
[222] Schnittker, "An Uncertain Revolution," 1371.
[223] Schnittker, "The Double Helix."

Society's interpretation of genetic arguments also has negative implications. In their book *The DNA Mystique: The Gene as a Cultural Icon* (1995) authors Nelkin and Lindee coin the term 'genetic essentialism' to convey the notion that genes are destiny.[224] This argument has been associated with the belief that "interventions, no matter how effective, can never truly 'cure' behavioral problems."[225] Instead of being exonerated for one's actions, such information, when pushed to the extreme, makes seriously mentally ill individuals "almost a different species," magnifying the us-them distinction.[226] While the label of mental illness led to stigma in earlier generations, likewise, "once a person has been 'marked' [genetically] the label is difficult to leave behind."[227]

Similarly, in the private sphere the biological and genetic explanations for illness have been two-sided. Although the individual is no longer to blame for their illness, mental illness became a phenomenon that was much larger than one person. In a 1987 Newsweek article titled "When Manic Depression Is Part of the Family Legacy" Miriam Rogers expresses that while she used to blame her mother "for being so remote, for not baking cookies or doing the things mothers were supposed to do; now Miriam blames the family illness."[228] Because whole families are affected, particularly in the case of manic-depressive illness, they have been less likely to ostracize an individual, and instead have tried to help them manage their illness. The same Newsweek article notes that Miriam and her husband have made a concerted effort to help their son, who also has manic-depression, from taking him to therapy at an early age to buying him a bicycle so

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[224] Nelkin and Lindee, *The DNA Mystique: The Gene as a cultural icon.*
[225] Schnittker, "The Double Helix."
[226] Phelan, "Genetic Bases of Mental Illness- A Cure for Stigma?" 430.
[227] ibid., 431.
[228] Monmaney, "When Manic Depression Is Part of the Family Legacy."

that he can use up his extra energy.[229] At Beth Israel Hospital in New York the Family Center for Bipolar Disorder was developed in 2006 with the goal of enlisting relatives to help manage patients' illness.[230] However, families run the risk of becoming more stigmatized as genetic advances may create new labels like "'carrier' or 'at risk'" for particular family members.[231] Such labels may lead to stigma that pre-dates psychiatric symptoms in individuals, creating a new set of judgments for the non-, or not-yet afflicted.[232] Nonetheless, biological psychiatry has significantly improved patient's ability to treat their illness, not only through drugs but also because families are now encouraged to provide support instead of criticism.

Jamison's Representation of the Psychiatric and Social Discourses

As both a patient and a clinician, Jamison wholeheartedly endorses the biological psychiatric discourse in her memoir. Although Jamison writes that she has "never been able to fathom the often unnecessarily arbitrary distinctions between 'biological' psychiatry, which emphasizes medical causes and treatments of mental illness, and the 'dynamic' psychologies,' which focus more on early developmental issues, personality structure, conflict and motivation, and unconscious thought," many of the examples she gives both as a professional and a patient indicate that she is a firm believer of the former discourse.[233] Jamison wholeheartedly acknowledges, "I owe my life to pills."[234] She tempers this statement on many occasions by reinforcing that psychotherapy has

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[229] ibid.
[230] Hartocollis, "Clinic Treats Mental Illness by Enlisting the Family."
[231] Phelan, 431.
[232] ibid., 431.
[233] Jamison, 59-60.
[234] ibid., 89.

helped her heal, yet her experiences with psychotherapy are all described in relation to lithium.

By describing her psychiatrist in terms of lithium, Jamison shows that her primary understanding of her illness is pharmacological. Jamison likens the effect of her psychiatrist to lithium, writing that he "began to take effect, much in the same way that medications gradually begin to take hold and calm the turmoil of mania."[235] She views all aspects of her illness through the patina of lithium. The greatest success of psychotherapy is her therapist's ability to convince her of the necessity of taking lithium consistently.[236] She unequivocally denounces clinicians who oppose using medicine to treat psychiatric illness, going so far as to write "I believe, without doubt, that manic-depressive illness is a medical illness; I also believe that, with rare exception, it is malpractice to treat it without medication."[237] Even when delving into genes, Jamison views advances in genetics in terms of drugs, writing, "once the genes are located far more accurate diagnosis is likely to follow; so, too, is more specific, less problematic, and more effective treatment."[238] While she reiterates the importance of both kinds of therapy, it is clear that were she not on lithium, not only would she not be alive, but her psychiatrist would not be of much help.

Jamison's predilection towards looking at psychiatry in terms of pharmacology has become the fundamental perspective of society at large. Jamison conveys that others equate lithium with normalcy, expressing "people say, when I complain of being less lively, less energetic, less high-spirited, 'Well, now you're just like the rest of us,'

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[235] ibid., 87.
[236] ibid., 102.
[237] ibid., 102.
[238] ibid., 188-189.

meaning, among other things, to be reassuring."[239] The notion that medication can easily solve psychiatric problems was, by the time Jamison started taking lithium regularly in the early 1980s, a widespread assumption. The other psychiatric phenomenon that was gaining popularity in the lives of professionals was psychotherapy. In an offhand remark, Jamison writes, "almost everyone I knew was seeing a psychiatrist."[240] Without noticing it she confirms that psychiatric therapy, medication and psychotherapy, were ubiquitous in professional classes like her own. In society's eyes, mental illness and emotional stress were treated in the same way and were seen as problems that could be easily managed and solved.

The private discourse of mental illness figures in Jamison's experiences with her family. When recounting her childhood, Jamison describes her father as the person from whom she inherited manic-depressive illness, whereas her mother was the calm from the stormy illness that plagued many members of the family. Jamison also describes her and her sister's different attitudes towards their collective illness: "my sister saw the darkness as being within and part of herself, the family, and the world. I, instead, saw it as a stranger…it almost always seemed an outside force that was at war with my natural self."[241] These different perspectives of their illness, however, show a shift from a former, social view of psychiatric illness that was dominant before 1970, and Jamison's view, which became the dominant discourse after 1970. Jamison's true double within the narrative, however, is her father. Jamison depicts her father as a persistently curious man who was able to turn any mundane event into an adventure. These thrilling moments contrast sharply with "grimmer moods, and the blackness of his depression filled the air

[239] ibid., 92.
[240] ibid., 55.
[241] ibid., 15.

as pervasively as music did in his better periods…after a while, I scarcely recognized him."[242] As she discloses later in her memoir, the price Jamison's father paid for his illness was a failed marriage and the loss of his job. The anecdotes of her sister and father confirm that Jamison's illness was a fundamental part of her family's existence that is rooted in their genes instead of being the fault of any one individual. The other members of her family, those without the illness, prove bastions of love and care. Her brother becomes one of her most reliable allies, sending her plane tickets to meet him at a new destination, and, after her first severe manic episode, "made no judgments about my completely irrational purchases," helping her secure a loan to cover the massive debt she had incurred.[243] Similarly, Jamison credits her mother with helping to "keep me alive through all for the years of pain and nightmare that were to come."[244] Manic-depressive illness is not limited to the individual, but is a family matter to be experienced and managed as a group.

While Jamison's family provides her with emotional support, her personal life was not as forgiving. When Jamison tells a psychoanalyst colleague that she has manic-depressive illness, he responds that he is "'deeply disappointed.' He had thought I was so wonderful, so strong: How *could* I have attempted suicide? What had I been thinking? It was such an act of cowardice, so selfish."[245] Jamison internalizes his comment to mean that he is normal and she is not, words and judgment that sting even more coming from someone who is dedicated to treating those with mental illness as he was. As Jamison notes, "understanding at an abstract level does not necessarily mean understanding at an

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[242] ibid., 34.
[243] ibid., 78.
[244] ibid., 19.
[245] ibid., 200.

immediate level."[246] While the public had developed a general awareness of mental illness that was much more forgiving than in previous decades, when presented with an individual such as Jamison, some individuals left their compassion and understanding behind and instead insensitive knee-jerk reactions prevailed.

Jamison's Patient Discourse: Dual Existence

The patient discourse that Jamison presents in her memoir is one of dual existence as both a successful clinician and an out of control woman, waging a war with herself and her medication. Jamison reiterates that her mania fueled her professional life, describing, "when manic, or mildly so, I would write a paper in a day, ideas would flow, I would design new studies, catch up on my patient charts and correspondence."[247] However, the "grim was usually set off by the grand," and while her mania led to an intensely productive professional life, it was ruining her private life.[248] She writes that during the same time period "of increasingly feverish behavior at work, my marriage was falling apart. I separated from my husband…I was increasingly restless, irritable, and I craved excitement."[249] Jamison demonstrates a remarkable ability to maintain a flourishing professional life while her private life was falling to pieces, an imbalance as extreme as the two aspects of her still undiagnosed illness. Finally the moment came when she was aware that something had gone seriously awry, "a definite point when I knew I was insane."[250] Part of coming to terms with her illness and its symptoms, particularly violence, entailed the difficult task of reconciling two images of herself, a

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[246] ibid., 174.
[247] ibid., 131.
[248] ibid., 132.
[249] ibid., 73.
[250] ibid., 82.

"reasonably quiet-spoken and highly disciplined person, one at least generally sensitive to the moods and feelings of others, with an enraged, utterly insane, and abusive woman who lost access to all control or reason."[251]

Jamison's identities begin to converge with her diagnosis, and eventually she develops a new, unified self as a result of her consistent adherence to lithium. Jamison recalls the moment when her psychiatrist diagnosed her with manic-depressive illness, expressing, "the thought was very frightening to me—much less was known then than is known now about the illness and its prognosis—but all the same I was relieved: relieved to hear a diagnosis that I knew in my mind of minds to be true."[252] Jamison's feelings of relief and resentment mirror the extreme and opposite elements of her illness. Nonetheless, she begins to unify her previously bifurcated life. The discourse she purports is one in which to know and control one's illness is to become one's true, unified self. Instead of her manias propelling her work and her depressive moments driving her to a 'grinding halt' in almost all aspects of her life, as a result of her diagnosis and medication she is able to achieve a newfound balance in her moods.

Initially this process was prevented by Jamison's reluctance to take medication for both private and professional reasons. Jamison relates her initial hesitation to taking medication, writing "I simply did not want to believe that I needed to take medication…I genuinely believed…that I ought to be able to handle whatever difficulties came my way without having to rely upon the crutches such as medication."[253] Her unwillingness to comply with her psychiatrist and her self-described

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[251] ibid., 121.
[252] ibid., 87.
[253] ibid., 98-99.

'war with lithium' were motivated by fear. In her professional life she feared losing her clinical work and privileges. This fear was exacerbated by the fact that she was the only female in her department, and by a colleague who viewed women "in terms of breasts, not minds," and would have readily removed Jamison from her post.[254] In her private life, Jamison was racked with the fear that her condition was not treatable. Jamison confesses, "I was actually secretly terrified that lithium might *not* work…my psychiatrist very early on saw this terror in my soul…*Patient sees medication as a promise of a cure, and a means of suicide if it doesn't work. She fears that by taking it she will risk her last resort.*"[255] In her early days of taking lithium, Jamison's professional and personal live collided. She was working on a locked ward at the time, yet she continually rejected her own institutionalization, explaining, "I didn't relish the idea of not having the key."[256] Jamison's fear represents an internal struggle with the notion that being medicated meant losing her independence.

Jamison was also reluctant to take lithium because it curtailed the manic version of herself she had come to rely on. As Joseph and Jessica Hogan write, for those dealing with mental illness the question of "When are we 'ourselves' and when not ourselves?" does not have a straightforward answer.[257] Individuals dealing with manic-depressive illness are particularly reluctant to give up their manic highs in exchange for a stable equilibrium. For patients, it is hard to see an authentic identity in the new sense of self their medication gave them: "what had previously been thought of as the 'natural self' is now seen to be rooted in disease, in the non-natural, the not-normal (the biochemical

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[254] ibid., 133.
[255] ibid., 103.
[256] ibid., 112.
[257] Hogan and Hogan, "When the Subject Is Not the Self; Multiple Personality and Manic-Depression," 39.

and/or genetic disorder)."[258] Jamison confirms this tendency, expressing, "I tend to compare my current self with the best I have been, which is when I have been mildly manic. When I am my present 'normal' self, I am far removed from when I have been my liveliest, most productive, most intense, most outgoing and effervescent."[259] While Jamison longs for a return to her natural self, it becomes clear that her view of her normal self, is not normal to others.

In choosing between independence without medication or dependence on lithium, Jamison chooses to be normal by society's standards rather than her own. While losing her mania means a partial loss of her identity, lithium allows Jamison to operate within a realm of social normalcy that her previously unmedicated self violated. In particular, Jamison's violent episodes, "frightening to others and unspeakably terrifying to oneself," transgressed society's view of normalcy.[260] In these moments, Jamison affirmed society's association between violence and mental illness and also jeopardized many of her personal relationships. In a study done in 1999 researchers found that "symptoms of mental illness remain strongly connected with public fears about potential violence and with a desire for limited social interaction."[261] As Jamison writes, these outbursts were particularly problematic given that she is a woman. She writes, "violence, especially if you are a woman, is not something spoken about with ease."[262] Her gender exacerbated the social ramifications of her illness, which had already cost her many embarrassing moments.

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[258] ibid., 41.
[259] Jamison, 92.
[260] ibid., 120.
[261] Link, et al., "Public Conceptions of Mental Illness," 1328.
[262] Jamison, 120.

For Jamison, her destructive manic nature became too risky professionally. In retrospect, she conveys that the social normalcy lithium affords far outweighs the manic highs she relished, writing

> Any temptation that I now may have to recapture such moods by altering my medication is quickly hosed down by the cold knowledge that a gentle intensity soon becomes first a frenetic one and then, finally, an uncontrolled insanity. I am too frightened that I will again become morbidly depressed or virulently manic—either of which would, in turn, rip apart every aspect of my life, relationships, and work that I find most meaningful—to seriously consider any change in my medical treatment.[263]

Fear changes from an anxiety, losing one's productive mania, to a motivation, sticking with her medication. Jamison's fear is no longer connected to her own view of her 'normal' self, but to other's perceptions of her normalcy, a normalcy that her medication maintains. In the choice between mania and violence or stability and normalcy, the latter is more compelling.

Medicated Normalcy

Jamison's adherence to a broader conception of normalcy rather than her own internal view is linked to her consistent adherence to lithium. Jamison writes that her family and friends "expected that I would welcome being 'normal,' be appreciative of lithium," suggesting that Jamison becomes 'normal' to them after she starts taking lithium.[264] Her previous handicapped existence is replaced by the normalcy of a medicated lifestyle. In a poignant passage Jamison illustrates that by taking the correct dosage of her medication she sees reality as others do. She writes "it was though I had

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[263] ibid., 212.
[264] ibid., 91.

taken bandages off my eyes after many years of partial blindness."[265] In this reflection, Jamison makes it clear that a drastic change occurred, one that allowed her to achieve a sense of normalcy that was previously unattainable. Jamison describes her newfound existence and sense of balance, expressing "there was a new solidness to both my thinking and emotions. Gradually, as I began to look around me, I realized that this was the kind of evenness and predictability most people had."[266] In this description Jamison privileges the sense of normalcy her medication affords her. Her medication is portrayed as the catalyst of the professional and personal successes these years bring when she establishes herself as an expert on manic-depressive illness, coauthoring a textbook on the subject, and finds personal fulfillment in her marriage.

By taking lithium consistently Jamison achieves a unified identity as a clinician whose very success comes from her personal understanding and control over her illness. One way in which she achieves a more unified self is in her professional interest in manic-depressive illness. She writes, "I was absolutely and single-mindedly determined to make a difference in how the illness was seen and treated."[267] By aligning her personal illness with her professional pursuits, Jamison focuses on her illness both as an individual and as part of a larger discipline. Her rhetoric in this passage is also noteworthy when she uses the word "single-mindedly" to describe her effort. While at first this usage seems coincidental, at second glance it reflects a change that is important and that moves away from her previous bipolar existence. The symbolic pinnacle of Jamison's unified sense of self is when she is awarded tenure, a moment of success she defines as an alignment of her personal and professional lives, "a celebration over years of struggling

[265] ibid., 161.
[266] ibid., 167.
[267] ibid., 126.

against severe mental illness, as well as a celebration of the major rite of academic passage" which are no longer separated.[268] As a result of her single-mindedness Jamison's fears dissipate, particularly her professional fears, to the point that her memoir exposes her illness not only to her colleagues, but also her students and her patients. The memoir as a single account of both her professional and personal life embodies the unified view of herself that lithium affords her.

While for Plath and Kaysen, treatment, including their very institutionalization, was seen as an affirmation of disease, for Jamison lithium indicates that she is treating her mental illness in a 'sane' way. In the context of Jamison's time, for her *not* to treat her illness with medication would be seen as insanity. This shift in the way that medication and sanity are linked represents medication's association with a degree of livability and preventative care. Jamison writes, "freedom from control imposed by medication loses its meaning when the only alternatives are death and insanity."[269] As long as Jamison is taking medication, society and Jamison reason, she will continue to avoid the violent version of herself that is threatening and 'insane.'

Lithium: A Matter of Life or Death

For Jamison taking lithium is more than an adherence to social standards, it is a choice of life over death. Jamison shows through personal examples that for those with manic-depressive illness life is not livable, in both absolute and relative terms, without medication. By portraying lithium in such drastic terms, Jamison returns to a view of illness as an all-or-nothing phenomenon, a perspective she supports through the

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[268] ibid., 135.
[269] ibid., 6.

counter-example of her father and with genetic portrayals of manic-depressive illness in black and white diagrams. Jamison never steps outside of this perspective and categorically rejects her sister's opposition to her dependence on lithium as an 'insane' and illogical reaction to the only successful therapy Jamison knows. For Jamison, there is only one way of treating manic-depressive illness: lithium.

Jamison presents lithium as the substance that maintains life, but, when taken improperly, can cause death. Jamison's initial inconsistency with her medication ultimately leads to her suicide attempt, which occurred when she took a massive overdose of lithium.[270] After this experience it became clear to Jamison that if she wanted to stay alive she had to be fully compliant with her medication. The discourse that Jamison creates is one in which anything less than continual use of lithium is suicide or death. In paraphrasing her psychiatrist, Jamison writes "the choice, as he saw it—and as is now painfully clear to me—was between madness and sanity, and between life and death."[271] Jamison owes her continued existence, and her ability to continue her professional life, to lithium.

Lithium is not only a matter of life and death in an absolute sense, but also affects the quality of Jamison's life in relative terms. Jamison writes with the clarity of hindsight, "my lack of judgment about the necessity to take lithium proved to be an exceedingly costly one."[272] This effect is also presented in a black and white manner. When she takes lithium consistently, Jamison is able to go about her day in a way that allows for stability and controlled productivity; when she takes it inconsistently, that

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[270] ibid., 114.
[271] ibid., 102-103.
[272] ibid., 89.

sense of stability was replaced by unending "grief and sorrow."[273] In retrospect Jamison regrets "it took me far too long to realize that lost years and relationships cannot be recovered, that damage done to oneself and others cannot always be put right again."[274] Without it she could have ended up "on the back wards of a state hospital" instead of continuing her professional life.[275] Again, the message is that to take lithium is to preserve one's life, not only in the abstract of life and death, but also in the immediate.

Jamison's view of taking medication as an all-or-nothing situation is put into relief with examples of her father, who is never mentioned as taking medication for his manic-depressive illness. Jamison writes of her father, "he sailed over the cusp of reason at times, and his grandiose ideas started to push the limits of what Rand could tolerate."[276] He was eventually fired from Rand, his employer, and his marriage to Jamison's mother ends in divorce. Jamison's father, who does not take lithium, is presented as a failure, a stark contrast to the success that his daughter achieves in her own life. Jamison conveys that it is the individual's responsibility to manage their illness, and if they don't they will pay the ultimate price: failure or death. Although Jamison and her father have the same genes, which she likens to "an impossibly wild, dark, and unbroken horse," Jamison breaks this horse with medication, which affords her success in place of her father's failure.[277]

As Jamison learns more about the genetics of manic-depressive illness, they confirm her re-dichotomization of mental illness in black and white terms. She recounts

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[273] ibid., 115.
[274] ibid., 6.
[275] ibid., 190.
[276] ibid., 34.
[277] ibid., 119.

a meeting she attended with Jim Watson, one of the initial scientists to discover DNA, and describes the types of genetic diagrams that were used at this meeting,

> Pedigree after pedigree was being projected onto the screen, some with relatively few ill family members, others containing large numbers of squares and circles that had been completely blackened in, indicating men or women who suffered from manic-depressive illness. Half-blackened circles and squares depicted depressive illness, and an *s*, cross, or slash flagged those individuals who had committed suicide.[278]

This diagram validates Jamison's view that mental illness, particularly manic-depressive illness, does not exist on a scale but is something one does or does not have. Within the genetic diagram an individual, represented by a circle, is either left blank or filled in. This diagram effectively dichotomizes illness in a visual form. Jamison directly relates this image to her own family, noting "I was amazed at how many of my squares and circles were darkened… manic-depressive illness occurred repeatedly, throughout three generations I had knowledge of, on my father's side of the family; asterisks, representing suicide attempts, showed up like a starfield."[279] While her fascination with the diagrams is logical, she overlooks the way in which they deceptively oversimplify an illness that may not be so black and white to others.

While Jamison's sister is mentioned only twice briefly in the span of her memoir, she provides the only opposition to Jamison's unrelenting support of medication. It is hinted that her sister also has some form of manic-depressive illness; however, unlike Jamison, she does not support using drugs to treat her illness. Jamison recounts, "the combination of her worsening moods with mine, along with the dangerous seductiveness of her views about medication, made it very difficult for me to maintain a relationship

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[278] ibid., 187.
[279] ibid., 189.

with her."[280] This difference is a severe point of contention between the two sisters, directly challenging Jamison's personal and professional views. Jamison presents her sister essentially as a threat to her life, "I could not afford to be too near someone representing, as she did, the temptations residing in my unmedicated mind…I was beginning, but *just* beginning, to understand that not only my mind but also my life was at stake."[281] Despite her unmedicated mind, Jamison's sister is never depicted as a social or professional failure as Jamison's father, whose illness also went unmedicated. Jamison's sister provides another perspective on the matter, one that is perhaps more complex, that Jamison conveniently ignores. Similarly, Jamison ignores recent changes in drug therapy that treat manic-depressive patients with a variety of drugs and less frequently with lithium. In a study done at the Mood Disorder Unit at the National Institute for Mental Health, 80% of patients in the early 1970s were treated with one medication, yet by the 1990s that percentage dropped to 25%, with the majority of patients on two to three drugs.[282] While she writes that she hopes genetics will lead to more effective treatment, she doesn't include the changes that have already occurred.

Conclusion: Pharmacology in Perspective

Since Jamison published her memoir in 1995 the psychopharmacological landscape has changed. One large component of this shift has been the advent of direct-to consumer (DTC) advertising, which first became legal for medicine in the United States in 1997.[283] DTC advertising, which has become a "mainstay of popular media,"

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[280] ibid., 99.
[281] ibid., 100.
[282] Healy, *Mania*, 176.
[283] ibid., 190.

allows pharmaceutical companies to market drugs and illness to particular patients and essentially try to convince them that they should seek consultation and treatment for illnesses they might not even have.[284] Healy cites a TV ad that tells the viewer, 'depression is only half the story,' switching from shots of a depressive woman to ones of her vigorously painting her apartment.[285] As Healy notes, drugs are never mentioned, but viewers are told to go to bipolarawareness.com, a site sponsored by Lilly Pharmaceuticals, to fill out a mood disorder questionnaire.[286] While the ad and corresponding website have the air of information, support and concern, they encourage individuals to self-diagnose so that when they go see their doctors they can tell the doctor what illness they have, and then receive the corresponding medication. In this reversal of traditional diagnosis, the drug is the invisible catalyst. Drug companies are capitalizing on the phenomenon that everybody is depressed, a phenomenon they helped create, and one which raises "grave questions about whether the pharmaceutical and other health care companies are more wedded to making profits from health that contributing to it."'[287] These are reasonable questions to raise, considering the enormous profits of such companies which have consistently ranked at the top of *Fortune's* profitability measures over the past fifteen years.[288] In 2002 alone, the combined profits of the top ten drug companies were "greater than the profits *of all the other 490 Fortune 500 companies put together*."[289] This enormous financial power will continue to control the way in which patients and doctors relate to their medications.

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[284] Schnittker, "An Uncertain Revolution."
[285] Healy, *Mania*, 190.
[286] ibid., 190.
[287] Barber, 112.
[288] ibid., 22.
[289] ibid., 22.

In fact, *An Unquiet Mind* can be read as a genre of direct-to-consumer advertisement. Given Jamison's unwavering support of lithium one wonders if perhaps she received any financial support from these drug companies when writing her memoir. At the very least, her memoir certainly scares readers who are also battling mental illness, into compliance with their own medications, a goal of many clinicians. Jamison recounts her experience with a particular patient, expressing that she became "increasingly frustrated by his repeated refusals to take medication."[290] Her memoir serves as a way of telling her own patients that drugs are a non-negotiable form of treatment through her own personal experiences. In taking this stand, Jamison's memoir of a personal struggle with manic-depressive illness, seems to be masking a clinician's agenda. One wonders not only if Jamison received any financial incentive from drug companies, but also if this type of writing is a way for clinicians to insidiously gain control over their patients. The fact that she is the author only adds to the troubling nature of her claims, given that she is the leading expert on mental illness. While her varied publications and personal and professional sources of knowledge about manic-depressive illness are impressive, they makes it extremely difficult for anybody to question her authority. Her message for patients with manic-depressive illness who don't take lithium is that they will either be total failures or end up dead. While this has been true in her own life, her clinical authority makes her message much more pointed than Plath's or Kaysen's. Furthermore, Jamison's message is one that critiques the patient above all else. She critiques her own supposed 'stupidity' in refusing to take lithium; however, it seems logical that she would apply this same attitude towards her patients. Kaysen's line, "take two Lithium and don't call me in the morning because there's nothing to say, it's innate," sums up Jamison's

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[290] Jamison, 108.

viewpoint and the pervasive effect of the pharmacological industry.[291]

[291] Kaysen, 42.

Conclusion

The landscape of memoirs about psychiatric experiences is changing from confessional accounts to what has been referred to as immersion journalism, which aims to expose the current psychiatric practices. In her book *Voluntary Madness* (2008) Norah Vincent, after dealing with depression and checking herself into a psychiatric hospital decided, upon her recovery, to do some investigative reporting by checking herself into three more psychiatric wards, ranging from a large public institutions to a small, alternative one. In interview on National Public Radio with Neil Conan, Vincent explained that she wanted to write about mental illness and therapy in real time. While this choice represents a shift away from the surge of retrospective memoirs that have proliferated since the mid-1990s, Vincent's memoir also confronts the changing landscape of mental illness as a result of genetic information in which individuals have become passive patients. As pharmaceutical companies offer up drugs as miracle pills and scientists tell us that mental illness is in our genes, patients, Vincent relates, "don't want to partake in their own health care."[292] As a result of her immersion in various psychiatric institutions, Vincent says she became convinced of the important role the individual plays in their treatment, "specifically the will of the individual to partake in treatment and therapy and change his or her life…you can't just get a quick fix…wellness is a process and a practice."[293] Perhaps the genetic representation of illness has been falsely interpreted as implying that individuals have no role in treating their illness. The perils of an overly deterministic view is one that science has cultivated, but

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[292] Vincent, interview by Neil Conan, "'Voluntary Madness' Details Life In 'Loony Bin'."
[293] ibid.

society and patients need to realize that, taken too far, this view is detrimental to their own health.

Most recently, investigations into the genetic roots of mental illness and epigenetics, which looks at the way in which genetic markers are turned on or off by environmental factors, have shown support for a model that would move away from the determinism that has resulted from genetics. Meta-analyses show that people's view of the locus of control of their actions has changed substantially from the 1960s to the 1990s.[294] Over the decades studied, people's belief that they do not control their own outcomes, belief in an external rather than internal locus of control, increased, largely due to the deterministic model of genes as destiny. However, recent research suggests that "although the DNA sequence provides the basic blueprint for life, this code is subject to a number of 'epigenetic' modifications that provide another complex layer of information."[295] Epigenetic modifications exist both on a molecular and environmental level. While psychiatrists and geneticists have claimed for years that most mental illness results from both genetic and environmental factors, it is only now that recent developments indicate that, indeed, "gene variants…do not automatically result in a disease, but that life events in combination with certain gene variants give a far higher likelihood of developing a disorder."[296] This finding means that individuals who are genetically predisposed to certain illnesses can be prevented from developing mental illness, such as depression with environmental intervention in the form of social support.[297] Environmental factors, then, are moderating forces that can either raise or

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[294] Vohs and Schooler, "The Value of Believing in Free Will," 53.
[295] Isles and Wilkinson, "Epigenetics: what is it and why is it important to mental disease?"
[296] ibid.
[297] ibid.

lower an individual's likelihood of crossing a threshold that will lead to gene expression and illness. Such theories show that despite similar rhetoric, epigenetics indicates an important break from the determinism of genetics and mental illness. While this revolution still seems to be limited to those working in the lab, it is only a matter of time before the implications of epigenetics on mental illness become part of the wider social consciousness.

The notion of progress has always been seductive in medicine. As science and medicine develop, the media and the general public need to be increasingly aware of how they infer new information about existing conditions and illnesses. The pattern that the three works I have discussed illuminate is that it is very easy to fall prey to extreme or overly simplistic views of mental illness, both in the psychiatric community and in society at large. Mental illnesses are complex, subjective and hard to describe and thus often go beyond their characterizations in the media, popular discourse, and even medical discourse. While Plath and Kaysen expose the injustices in psychiatry, Jamison supports two important pillars of biological psychiatry: drugs and genetics. With the evolution of an epigenetic understanding, perhaps opinions like Jamison's will become more nuanced as the importance of other kinds of treatment, prevention and management of mental illness are proven effective. Above all, as the epigenetic model enters social and patient discourses, one would hope that the patient perspective is placed at the forefront of public and psychiatric understandings of mental illness.

Appendix

Fig. 1

Etiology

This person is (pick one):

1. on a perilous journey from which we can learn much when he or she returns;
2. possessed by (pick one):
   a) the gods,
   b) God (that is, a prophet),
   c) some bad spirits, demons, or devils,
   d) the Devil;
3. a witch;
4. bewitched (variant of 2);
5. bad, and must be isolated and punished;
6. ill, and must be isolated and treated by (pick one):
   a) purging and leeches,
   b) removing the uterus if the person has one,
   c) electric shock to the brain,
   d) cold sheets wrapped tight around the body,
   e) Thorazine or Stelazine;
7. ill, and must spend the next seven years talking about it;
8. a victim of society's low tolerance for deviant behavior;
9. sane in an insane world;
10. on a perilous journey from which he or she may never return.

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[298]

[298] Kaysen, 15.

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