AN UNFRIENDLY SPIRIT:
BIPOLAR DISORDER IN/AS PERFORMANCE

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ABSTRACT

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In 1921, German psychologist Emil Krapelin published the first formal account of bipolar disorder in his book *Manic-Depressive Insanity and Paranoia*. Since Krapelin’s initial publication, clinical understandings of bipolar disorder have shifted, moving from detailed descriptive accounts of patient behavior to codified diagnostic criteria based on patient affect. While helpful in determining the appropriate treatment for bipolar disorder, many contemporary manuals offer little information on the patient’s experience of self and disorder, thus cultivating a troubling lacuna in understandings of bipolarity. Given the pervasive stigma surrounding mental health issues, recovering the patient’s experience is of paramount importance to connecting people with care while simultaneously giving voice to a growing population of individuals deemed “mentally ill.”

In this thesis, I interrogate the performative nature of bipolar disorder through an examination of specific contexts that shape the patient’s understanding of self and disorder. Drawing on my own experiences as a woman diagnosed with bipolar disorder, I employ autoethnography and performative writing to better render my bipolar experience. In doing so, I position the clinic, the home, and the stage as sites of struggle, each drawing on specific aspects of performance to construct the patient’s identity. In exploring how these constructions interact with pervasive notions of stigma, I question the ways in which performance might contribute to stigmatizing understandings of mental health while simultaneously providing the patient with a means through which to understand and, at times, subvert that identity.
Drawing on theories of neurotypicality, I argue that in the clinic, bipolar patients are positioned as “other” through a process of clinical performance criticism—wherein a clinician makes a bipolar diagnosis based on the patient’s alterior performance—thus supporting hegemonic notions of normative neurology that contribute to stigma. While problematic, this process also gifts the patient with a vocabulary by which to communicate and understand bipolar disorder, providing a means to engage treatment options for optimal management. In the home, I focus more squarely on my own familial narrative of “touched” women. Drawing on Marianne Hirsch’s theory of postmemory, I dissect this narrative, highlighting the ways in which this act of transmission provides a means by which stigmatizing images of mental illness are subverted and reclaimed. I also note the ways in which the patriarchal structure of my own family relegates this transmission to “women’s spaces,” thus positioning the home as a place of contest between safety and stigma. Finally, I examine bipolar performance in the theatre, drawing on my experience as a bipolar actress playing a woman who experiences a mental episode in Rebecca Gillman’s The Sweetest Swing in Baseball. I place my experience in dialogue with Marvin Carlson’s theory of ghosting in order to interrogate the ways in which theatrical performance brings the performative elements of bipolar disorder to bear on the body, providing a means through which the performer might interact with the fear of stigma ghosted onto her/his performance. I also suggest that while challenging, the act of performing additionally provides the opportunity for the performer to exercise agency in her/his performance of character, and by extension, her/his performance of self and disorder.

In pointing to the contexts that contribute to constructions of self and disorder, I also point to the ways in which performance supports and subverts stigma. Ultimately, I position bipolarity as a fluid identity that is inextricably linked to performance and is, like performance, always in-flux and ever contested.
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I will tell you a secret: I’m not taking my medicine.

I know, I know. I should. I need to take care of my body. I need to take responsibility for myself. I need to keep myself safe. I need to do my part in ensuring my treatment is carried out as planned. I need to respect the work my doctors have done in determining an effective course of care. I need to do as mom says. I need to take advantage of the free on-campus medical services offered by the university while they are still available to me. I need to make use of my insurance coverage while I still have it.

I need to pick up my Lamictal.

I need to set up autofill on my Lexapro.

I need to schedule an appointment with my psychiatrist to fix the nausea from my Celexa.

I need to buy one of those pill cases for old people so I remember to take my Lamictal and my Lexapro and my Celexa.

I need to be in bed by midnight.

I need to be up by seven.

I need to cut out caffeine.

I need to find a new psychologist because “When you are having a panic attack, stop panicking” has not proven to be a useful coping strategy.

I need to sleep.

I need to get out of bed.

I need to get out of these yoga pants.
I need to do a lot of things.

But what I really need is to just

Not. Be. Bipolar.

This isn’t the first time I’ve been off my medicine. Whenever I stop taking my meds, I usually do so as a form of personal feminist protest. In an oppressive society that insists on regulating my body, why too must I submit to its regulation of my mind? I have been diagnosed as bipolar II for the past eleven years, and if I were to consider my feelings in terms of the five stages of grief, I would land squarely in anger. I am angered by the cold, impersonal nature of the diagnostic process I was put through when I was only 13. I am angered by the outrageous cost of my psychiatric care. I am angered by the never-ending medicinal experimentation that infects my person.

I have spent a great deal of time feeling very guilty for that anger. But as my best friend often reminds me, there are times in which it is reasonable to be angry. She was speaking of feminist issues at the time, but I have increasingly found the causes of feminism and mental health activism to be irrevocably intertwined. Both are plagued by a patriarchal drive to silence and control. When I was diagnosed, I could not talk about it. It was an unwelcome specter in our otherwise happy home. My period came two months later. Mom bought me a pack of razors and told me to shave my underarms. She was kind about it. I cried the whole time. I took my pills.

Those years are a hazy gray; only flashes remain. I do not remember my body changing from girl to woman any more than I remember what mom knows as the slow scary erosion of her daughter into a suicidal stupor. Both happened without my knowledge, without my consent. I could not cope with the changes and I was too scared to speak of my diagnosis lest I offer it
some legitimacy. I did not want to hurt my father. I did not want to worry mom. I wrote poetry.

Two weeks later, I was in the principal’s office. The teacher was concerned for my safety. My writing was “dark” and “alarming.” I stopped writing.

In the following months, I fell deeper into my silence. Had I lost my voice completely? Or did I simply not have the energy to move my mouth? Prayer became my secret speaking place. Each night before I fell asleep I would crawl under my daisy printed comforter and hold my teddy bear close, tracing constellations into the popcorn ceiling. As the cool plaster looked down on me, I wished that God would pull the sickness from my mind and make me normal again. I wished that God would cut off my breasts and give me my body back. I begged to be emptied of chemicals and unburied by body parts.

I was already tired of doctors fixated on my pathology.

I was already tired of men fixated on my biology.

Truth be told, it was a twice-prayed-prayer. I feared my bipolarity. I feared my body. But above all, I feared them together. Asylums, witches, yellow-wallpaper-hysteria; the disinterested eye rolls of men she’s-on-the-rag type write offs; unemployment, special schooling, living with my parents—these shades became the red hues from which I painted dreams in my night-mind. Perhaps I could have more successfully navigated by bipolar diagnosis had it occurred in isolation. But my bipolar diagnosis comingled with an ever-growing female form were simply too much to bear.

And so, I come to the present, where the doing meets the writing, the archiving of that particular repertoire of acts extracted from my memory.

It’s not something I’ve been looking forward to. In fact, I have been avoiding this.
Summer was good, and the sunshine seems to have kept me stable. I had some rough nights, but they were mild, negligible even, at least in hindsight. It was the kind of summer that makes me feel like a fraud, like my research is the product of an overactive imagination striving for originality. Any work I tried to do on this project seemed dishonest. My keystrokes fell short—a soft, frantic staccato searching for anywhere but there; a quiet, ticking clock too aware of the passing time. I was scared.

I am scared.

But my time is up—I know the season. I can feel the icy breath of a beast I dare not name barreling down my neck, signaling the impending fall. It took me three hours to read thirty pages last night. My class work is erratic and unfocused. I had to wake up early to do my homework; I was up till four crying over nothing. It cannot stop. It will not stop. It is here.

My days are filled with mourning, my nights are filled with tears.

My body is bruised. My insides are broken.

My eyes are tired. My mind is adrift.

I am here and gone.

I am nowhere at all.

I am myself without context.

[breathe]
Depression is pure reflection in the cruelest sense. The present is consumed by past and only misdeeds remain... Perhaps it is fitting that I write from this vantage. My cognitive impairment is less than ideal, but the landscape is flattened—Picasso’s view from all sides, all shades; all together, all apart. The pieces are not random. In their angles lie the stages that have played host to my mental drama: the clinic, the home, and the stage. Each has provided me with a different script—a different way of understanding my bipolar self and how I might learn to better be in the world. But being is not a static state; it is a mode of performance. At every turn in my journey, I find myself subjected to a particular brand of performance criticism:

In THE CLINIC, my behavior is analyzed, detached from my neurobiological mechanisms and wholly rooted in the incongruencies between my “hysterical” performance and a constructed neurotypical natural.

In THE HOME, I am positioned as the inheritor of a grand mystic tradition of women-seers whose performance of bipolarity signifies each woman as the bearer of a secret truth unavailable to and unwanted by the men in my family.

On THE STAGE, I have found a most welcome home—a chance to exercise agency and intent over my own performance—but the texts I encounter often explore experiences of psychic disjuncture without any awareness of its reality. As a performer, navigating these texts becomes akin to walking a tightrope, aware of the conflicts between text and experience, but evermore weary of their potential congruencies.
And so, in a search for myself, I pose the following research questions:

What understandings do the clinic, the home, and the theatre performatively invoke for the bipolar experience?

How might the performance-based understandings undergirding the clinic, the home, and the theatre simultaneously construct and deconstruct notions of self and illness within the bipolar patient?

Does a performative/performance analysis of the clinic, the home, and the theatre reveal context-centered contributions to stereotype, shame, and stigma that are detrimental to personal and private notions of self and mental illness?

Do the performances assumed by clinic, the home, and the theatre work in tandem to create a singular narrative of the bipolar experience, or do they collectively present a narrative in crisis?

How do I navigate an illness that consistently colors my performance of self?

In order to better guide my work, I take several foundational texts as fellow travelers:

Emil Krapelin, a German Psychologist whose 1921 book *Manic Depressive Insanity and Paranoia* first linked mania and depression under one diagnosis, forming the foundations of our contemporary understandings of bipolarity. His meticulous notes provide a
glimpse into the lives of his patients while providing clues as to how Krapelin and his contemporaries viewed the disorder:

*The patients . . . often try to starve themselves, to hang themselves, to cut their arteries; they beg that they may be burned, buried alive, driven out into the woods and there allowed to die . . . . One of my patients struck his neck so often on the edge of a chisel fixed on the ground that all the soft parts were cut through to the vertebrae.* (25)

Kay Redfield Jamison, whose book *Touched with Fire: Manic Depressive Illness and the Artistic Temperament* first set my feet on this journey. Her book *Manic Depressive Illness*, coauthored with Francis Goodwin, is an invaluable resource that provides a painstakingly detailed analysis of bipolar disorder from its conception. As a bipolar patient herself, Jamison brings a deep sensitivity to her work, having experienced firsthand the realities of a bipolar self:

*I have often asked myself whether, given the choice, I would choose to have manic-depressive illness. If lithium were not available to me, or didn't work for me, the answer would be a simple no... and it would be an answer laced with terror.*

*But lithium does work for me, and therefore I can afford to pose the question.*

*Strangely enough, I think I would choose to have it. It's complicated...* (217)
Marianne Hirsch, author of “Marked by Memory: Feminist Reflections on Trauma and Transmission,” investigates the role of second-generation daughters in the transmission of trauma. Her theory of postmemory serves as a tool for parsing through my own familial experience of bipolarity, distinguishing my unique role as a bipolar daughter of a bipolar mother:

*Postmemory is a powerful form of memory precisely because its connection to its object or source is mediated not through repetition or reenactment but through previous representations that themselves become the objects of projection and recreation.* (76)

Jill Dolan, whose book *The Feminist Spectator as Critic*, offers a feminist lens through which I as a bipolar woman might understand the particular position I hold in both performing and audiencing theatrical texts that deal with mental health issues. Her work not only provides theoretical insight into feminist performance criticism, it also challenges me to maintain a nuanced approach to difficult issues, allowing contradictions while avoiding facile binary logic:

*The terms good and bad have no purchase here. Feminist criticism still isn’t about facile judgments or consumer reporting; it doesn’t arbitrate taste. It strives to consider what theatre and performance might mean, what it might do, how it might be used in a world that requires ever more and better conversations about how we can imagine who we are and who we might be.* (xxxvii, emphasis in original)
Marvin Carlson, whose book *The Haunted Stage* interrogates meaning making in the theatre. While Carlson’s book focuses mostly on audience reception, I apply his concept of ghosting to myself as a bipolar performer, suggesting that like the audience, the performer’s experience of a role is often constituted, and at times affected by, multilayered rememberings:

*All theatrical cultures have recognized, in some form or another, this ghostly quality, this sense of coming back in the theatre, and so the relationships between theatre and cultural memory are deep and complex... The present experience is always ghosted by previous experiences and associations while these ghosts are simultaneously shifted and modified by the process of recycling and recollection.*

(2)

and

Dwight Conquergood, whose essay “Performing as a Moral Act: Ethical Dimensions of the Ethnography of Performance” posits a moral map of performance, noting tensions performers face in their representation of others. In modifying his map to reflect the various pulls I experience in my disorder, I interrogate the possibility of attaining a “dialogical center” between self and disorder:

*Dialogical performance is a way of finding the moral center as much as it is an indicator that one is ethically grounded. One does not have to delay entering the conversation until self and other have become old friends. Indeed, as the metaphor makes clear, one cannot build a friendship without beginning a conversation.* (152)
Beyond these texts, I offer myself—my distant memories and present realities—all in the hopes of tempering the purely theoretical while challenging stigma. Here I aim to own, explore, and voice my own position as a mental health patient (auto), speak back to clinical discourse as a female member of the emerging community of mental health patients hitherto denied vocal space as a competent interpretive community (ethno), while also connecting these claims to a larger Western patriarchal understanding of mental illness whose effect on patients warrants further interrogation and problematization (graphic), thus employing a postcritical autoethnographic approach. As D. Soyini Madison writes in *Critical Ethnography: Methods, Ethics, and Performance*:

> This “new” or postcritical ethnography is the move to contextualize our own positionality, thereby making it accessible, transparent, and vulnerable to judgment and evaluation. In this way, we take ethical responsibility for our own subjectivity and political perspective, resisting the trap of gratuitous self-centeredness or of presenting an interpretation as though it has no “self,” as though it is not accountable for its consequences and effects. (8)

This critical self-reflexivity and awareness of my own autoethnographic process is intended to bring my bipolar experience into stark relief, setting it against various backdrops while opening myself to critique from the very interpretive community whose voice I hope to make known. In doing so, I welcome critique from all readers. Allowing room for both self-critique and critique from the community of mental patients I claim to be a member of will hopefully position my work as a catalyst for future dialogue. Thus, I strive to proceed with an attitude of, to borrow David Román’s term, critical generosity—remembering that my experience is not universal while asserting that my experience is valuable to both the continued
and still nascent formation of solidarity within the community of mental health patients seeking support and self-identification that presents counternarratives to neurotypical assumptions (ethno) while dialoguing with notions of shame and stigma present in Western culture (graphic).

Additionally, I craft my study using performative writing as a means of better rendering my bipolar experience. Performative writing is a mode of scholarship that seeks to embrace subjective experience in the service of disciplinary knowledge. Acknowledging the diverse forms performative writing often takes, Performance Studies scholar Della Pollock describes performative writing as occupying a space:

...at the brink of meaning, poised between abjection and regression, writing as doing displaces writing as meaning; writing becomes meaningful in the material, dis/continuous act of writing. Effacing itself twice-over—once as meaning and reference, twice as deferral and erasure—writing becomes itself, becomes its own means and ends, recovering to itself the force of action. After-texts, after turning itself inside out, writing turns again only to discover the pleasure and power of turning, of making not sense or meaning per se but making writing perform:

Challenging the boundaries of reflexive textualities; relieving writing of its obligations under the name of “textuality”; shaping, shifting, testing language. Practicing language. Performing writing. Writing Performatively. (75)

Thus, performative writing recognizes both the power and limits of language, seeking to draw the reader’s attention to form and content. In his book *Performance: An Alphabet of Performative Writing*, Ronald J. Pelias gives six criteria for performative writing, noting that this mode of scholarship: expands the notion of what constitutes disciplinary scholarship, features lived experience, rests on the belief that the world is constructed and composed of multiple
realities, evokes identification and empathetic responses, turns the personal into the political and the political into the personal, and participates in relational and scholarly contexts (11-5). In including my own autoethnographic experiences, I additionally employ performative writing in an attempt to incorporate Pelias’ six claims, thus offering a view of my bipolarity while simultaneously pointing to the ways in which this view is constructed. In doing so, I position my work within a disciplinary history drawn from J. L. Austin’s assertion that words do not merely describe, they perform, that is to say, they act. In my own use of performative writing, I am to treat the page as stage, playing with words on the page as actors might perform on a stage. Ron Pelias takes up this notion of play when he describes performative writing:

> While playing, it wants its language to remember its limits and its possibilities, to know how each word carries with it an ideological kick and how each word is marked by its representational failure, to sense how the body languages meaning and meaning languages the body, to turn back on itself to consider its own investments and their material consequences, and to evoke through sense and sensibility everyday and aesthetic performance. (7)

While this ethos of play may initially seem odd to the reader, I hope the aesthetic use of text as actor and page as stage might serve to better communicate my bipolar experience while gently inviting the reader into what are often jarring, comic, or even uncomfortable moments. In using performative writing, I hope to offer not a single text, but multiple texts, each in dialogue with one another, each aware of their own aesthetic, ideological, and representational positions within a larger disciplinary and cultural narrative.

And so, here we are: the beginning. It could not come at a worse time. Between the percussive patterns of my keys, I hear the echo of a particular bipolar patter, that slow and
careful movement that churns the words of the world like molasses stretching slowly from a
spoon. Caught somewhere amid the swing of mania and depression, I read in slow motion,
dissecting each character with painful care. Both two letter and five syllable words become terms
of equal fixation. For example, the entire month of September past was dedicated to teasing out
“recognize.” My results are as follows:

Recognize.

Re-cognize.

Re(again)-cognize(cognition)/againthink./thinkagain./rethink.

Re(again)-cognize(cognate)/againrelate./relateagain./rerelate.

Re(again)-cognize(colonize)/againappropriate./appropriateagain./reappropriate.

Re(again)-co(with)gnize(nice)/againwithnice./againnicely./renicely.

Re(again)-cog(wheel)-n(in)-ize(make)/

againwheelinmake./makeinwheelagain./remakeinwheel.

R(are)eco(earth)gnize(nice)/areearthnice./eartharenice./niceearth.

And so on.

Soon, it is three o’clock in the morning. I have read three paragraphs in three hours, and have
three more chapters of dense writing to read. With little control over the peaks and valleys of an
illness that claims my mind and my person, I often spend my nights wading in an ocean of
floating signifiers, struggling to anchor them to a clear meaning. Why am I shaking? Why am I
crying? Why can’t I sleep?

It is nights like these that leave me groveling at the altar of psychiatric care. But I must
say, for all the libations I have poured out (mostly in the form of staggering amounts of U.S.
currency), I am disappointed with the prophesied return. Had I initially been presented with
terms and conditions, I might have developed a much healthier attitude towards my disorder and myself. But alas, I was diagnosed at age 13. The gods of the clinic saw fit to bequeath to me the title “bipolar” the same year the god of the heavens saw fit to slap me with breasts. What a cruel joke. I was a minor at the time, and in many ways, my feelings about my diagnosis were of minor concern. Even in my angriest moments, I cannot fault my mother, who brought me to the doctor, or the psychiatrist who diagnosed me. I was, after all, suicidal; they were simply trying to keep me alive.

Eleven years later, I find myself engaged in an act of autobiographical historiography, seeking to understand what it means to be a young American woman celebrating her eleventh bipolar-versary in 2015. I am ever-fixated on the name “bipolar,” a trope echoed by psychiatric literature whose obsession with naming has appropriated my identity. While my efforts in past years have most often been directed at disaggregating “Alexis” and “bipolar” in order to avoid the stigma of being hailed as “mentally ill,” my more recent strategy has been to focus on the context in which “bipolar Alexis” came into being. And so, it seems, I must return to the beginning, to 2004, that cruelest of years; to a dark grey cloud whose foggy presence threatens even the sunniest of hours. I return to a small office now closed, present only in my memory, whose grinding has turned those days like sharp class captured by the sea—dulling its hard edges. I cannot promise these events to be true (if you believe in such a thing); only that they are as I remember them today.

Tarry with me a while?
When I was thirteen, my mother brought me to the doctor. I remember sitting in the cool yellow waiting room, surrounded by printed landscapes and People magazines. I nervously clicked my heels together while the grownups talked about me in the next room, the rhythmic tap-tap-tap of my shoes marking my anxiety as the clock filled the down beat. The doctor glanced at my responses, turned his gaze to me, and told my mother, “Well, Mrs. Riley. I’ll call you when I have the results. But these seem to indicate what we’re looking for.”

We got into the car, the tap-tap-tap of the wiper blades hurling water from the windshield. As we drove home, my mother told me that I was bipolar. Red hot trepidation crept into my cheeks, the same feeling I got when I first discovered a box of tampons under my mother’s bathroom sink, not knowing what they were but not daring to ask. A few months later, I would incur a box of my own.

For the next twenty minutes, she did her best to explain bipolar disorder to me, but my mind remained stuck on the name. I didn’t know what bipolar meant, but I knew the meaning of disorder. Disorder is wrong. Disorder is embarrassing. Disorder is bad. My mother turned off the car and said in a deep, quiet voice, “You must never tell anyone. You will never get a job. You will never get married. You will lose your friends. You must Never. Tell. Anyone. Do you understand?” And so, a secret was born. I climbed out of the car and stepped into the freezing winter air, the tap-tap-tap of my shoes leading me into a familiar home that felt very foreign indeed.
That is a story I swore I would never tell, and certainly never write. I must confess my initial reluctance is a selfish one. Shame and stigma are recurring themes in the drama of mental health, and their power to silence only serves to support condemning constructs of normative neurology. As I continue to explore the intricate nuances of my own diagnosis, I am increasingly unable to separate the peaks and valleys of bipolarity with the constant undertow of shame it induces. Thus, it seems I must brave the whole ocean: in order to confront my experiences with bipolarity, I must also confront my experiences with shame. Given Western culture’s reluctance to speak of shame (lest the speaking itself be shameful) finding a space in which to conduct this exploration is tempestuous at best, and the places most readily reserved for these discussions are often the most shaming themselves.

But there is a penetrating dimension to this stigma; an inner sense of self built upon the foundations of diagnostic claims claiming my person. In my own ever-changing book of days, a sharp chapter break exists between the twelve-year-old “normal” and the thirteen-year-old “bipolar” whose apparition continues to haunt my identity. From thirteen onward, I have performed my bipolar role as this spectral script demands—to my unbounded joy, to my hell-bound peril. True, hallucinations, night terrors, and suicidal ideation have haunted my mind since as long as I remember I. But it was in the clinic that I first discovered the name of this terrible ghost; it was here that I first acquired, in Goffman’s terms, my spoiled identity: a stigmatized trait that disqualifies the bearer from full social acceptance (2). And so, if I am to banish this specter, or at least make nice with it, I must return to its place of dwelling—the clinic—seeking to discern how its hallowed halls have shaped my performance as a woman diagnosed with bipolar disorder. Here, I use performance as metaphor to uncover the ways in which the clinic
might draw on performance, and how these potential performative elements might contribute to
the patient’s experience of self and disorder.

UNTITLED 1

THE SCENE: Spring. A small meeting room at a conference. The four walls are painted a
generic-hotel-tan. The drapes are colored a generic-hotel-gold. The floor is patterned a generic-
hotel-green. The light is soft; the room is full.

I am positioned between two friends, facing the crowd, an audience of eager but tired listeners:
anxious. I sit in the middle of the table, on the awkward seam where the middle supporting legs
extend: awkward. I fiddle with my hose, riding up, falling down, but never in the right place:
annoying. But these things cannot hold my attention. I am, in all respects, on.

Having just given my paper, I give myself permission to relax a bit. I feel my heart rate slowing,
my stomach a little less-nauseous. Will it always be like this? The caffeinated all-nighters race to
the finish anxious rehearsals last-minute edits reading reading reading and the fear fear fear. All
for this moment—the single, easy, unencumbered breath. But the highs and lows that
characterize my academic experience are hardly surprising. I am—after all—bipolar.

Such was the subject of my paper, my journey through college as a bipolar woman, finally
finding solace from stigma and shame through theatrical improvisation. And yet, even after
giving a presentation on overcoming stigma and shame, I sit in fear of stigma and shame. But
being bipolar is not a static state. It is not one remaking, but a series of remakings, and with it a
series of new contexts, new worries, new reflections. 1 I rarely stand on solid ground, but instead
have learned to soften my knees.

Back to the room: I was relieved to find gracious, generative dialogue. I leaned back in my chair.
I uncrossed my legs. I smiled. And then, a lone hand peaked over the crowd, and a woman
spoke. She said, “Thank you for your paper. I have two sons who are also ( )...” and I write ( ) because honestly, I can’t remember the exact word she said, or the rest of her comments
for that matter. I know that the word was a noun. It was a noun naming a group of people
somewhere on the mental health spectrum. It was a noun naming a group of people somewhere
on the mental health spectrum that was not me. Where my memory of the specifics fails, my
body remembers

the familiar prickle of shame creeping through my skin

the once-more pounding of my heart struggling to escape my chest

1 Here, I am reminded of Dwight Conquergood’s notion of kinesis, a concept that positions
performance as a process of “breaking and remaking” (see “Of Caravans and Carnivals:
Performance Studies in Motion,” 138).
the frantic gasping of still lungs unable to breathe

as I heard myself publicly named (accused?) as a member of a group with whom I do not identify.

I felt like a failure. Here, I had just spent 20 minutes explaining to the room the intricate nuances of the bipolar experience, the horrible gut-wrenching shame that stigma imposes, the ardent need for sensitivity in language when discussing bipolar disorder. My head was swimming. Didn’t she understand? I am not also. I am an intelligent, articulate, driven woman.

She didn’t understand my paper.

FROM SINGULARITY TO EXPANSION: ORIGINS

Bipolar disorder has gone by many names: madness, insanity, manic-depressive paranoia, and manic depression. (There is, of course, the more common colloquialisms: nuts, crazy, bat-shit, off-her-rocker, touched, disturbed, and, perhaps worst of all, menstrual. Needless to say, I prefer the more technical terms…) In its current incarnation, bipolar disorder is classified as a mood disorder—a pathological disturbance in prolonged emotion that is not caused by any organic abnormality. These disturbances range from manic, or elevated states, to depression, or depleted states. However, there is a large spectrum of mood states that comprise the range of bipolar disorder, from full-blown mania with its psychotic, hallucinatory features, to major depressive episodes that often induce suicidal ideation.²

As it is currently understood, bipolar disorder is a relatively new phenomenon. Had I been born prior to its development, I might have simply been called “mad,” sent away to the deplorable prison of the sanitarium, or shamefully abandoned by my family and left to wander the streets. Mania and melancholy were treated separately prior to 1896, often lumped together with schizophrenia and other forms of “insanity.” It was not until German professor Emil

² For a more in-depth definition of bipolar disorder, see Appendix A.
Kraepelin observed a link between the two mood states that the concept of bipolar disorder first started to form. Kraepelin’s 1921 study, *Manic-Depressive Insanity and Paranoia*, continues to be a foundational text in the field, exerting incalculable influence on contemporary understandings of the disorder. As Francis Goodwin and Kay Redfield Jamison note in *Manic-Depressive Illness*, Krapelin remains “without peer,” having contributed a vast amount of literature on the subject of bipolar disorder that continues to inform contemporary notions of bipolarity (15).

In addition to linking mania and depression, Kraepelin’s text provided clear descriptions of the two mood states, providing specific observations from his clinical work. Of mania, he writes:

The patient asserts that he is descended from a noble family. That he is a gentleman; he calls himself a genius, the Emperor William, the Emperor of Russia, Christ, he can drive out the devil. A patient suddenly cried out on the street that he was the Lord God, the devil had left him. Female patients possess eighty genuine diamonds, are leading singers, leading violinists, Queen of Bavaria, Maid of Orleans, a fairy; they are pregnant, are going to be engaged to St. Francis, are to give birth to the redeemer… the Messiah. (62)

In addition to the problematic gendered nature of his observations, it is important to note that while accurate, Kraepelin is describing mania in its most psychotic form, citing delusions and possibly hallucinations. These observations are certainly valid from the standpoint of the clinician, and as the clinician, Krapelin also assumes they are truthful for the patient as well. However, they are also sensational in tone, representing the highest peaks of mania that are often
the most entertaining to readers, adding to the cultural currency of his work by virtue of its entertainment value.

Additionally, Krapelin’s descriptions of his patients introduce a performance as a central concern in working with patients. In this description alone, Krapelin’s observations are focused not on a static affect, but rather on the things patients do—the way patients perform—be it through messianic claims or running through the streets. Similarly, Robert Lowell, a novelist who most likely suffered from bipolar disorder, writes of mania:

The night before I was locked up I ran about the streets of Bloomington Indiana crying out against devils and homosexuals. I believed I could stop cars and paralyze their forces by merely standing in the middle of the highway with my arms outspread… Bloomington stood for Joyce’s hero and Christian regeneration. Indiana stood for the evil, unexorcized, aboriginal Indians. I suspected I was a reincarnation of the Holy Ghost, and had become homicidally hallucinated. To have known the glory, violence and banality of such an experience is corrupting.

(qtd. Hamilton, 157)

Lowell’s experience, and his description, is extreme in its form and content. Mania itself is, by definition, extreme, and the echoes between Kraepelin’s and Lowell’s descriptions seem to resonate with that fact. Furthermore, both descriptions also employ similar language to evoke the experience—language that is tied to a clear cultural referent. Krapelin and Lowell’s accounts both draw heavily on Christian imagery to render mania known, be it the firm belief that one is “Christ” or that one “can drive out the devil,” or, in Lowell’s account, that Bloomington, Indiana stood as a symbol for “Christian regeneration,” and Lowell himself a “reincarnation of the Holy Ghost.” Furthermore, the sexism, racism, and Eurocentrism present in these two descriptions
alone nods to the cultural assumptions at work in articulations of bipolar disorder. These
descriptions cannot be taken as detached or unbiased, but are, rather, colored by the subjective
worldview of both the clinician and patient. Thus, articulating a clear understanding of bipolar
disorder is an exercise in interrogating performance in context, and which articulations are
privileged (at the expense of others) in dominant discourse.

HOW TO BIPOLAR

How to Depressed: A Beginner’s Guide to the Riley Repertoire of Bipolarity

1. Do nothing.
2. Think nothing.
3. Feel nothing.
4. Eat everything.
5. Regret everything.
7. Repeat

***In the rehearsal of depression, remember, it is not an emotion. Depressed is NOT sad. Perhaps begin by reviewing your life in slow-motion tallying each and every mistake you’ve ever made, replaying it twenty times, and deciding how it best illustrates the inadequacy of your character. Be sure to only eat food that will remind you how fat and slovenly you are. DO NOT UNDER ANY CIRCUMSTANCES LEAVE THE BED. Do maintain that “just about to cry” feeling in your throat. Also consider funeral plans should things go south.**

How to Manic: A Beginner’s Guide to the Riley Repertoire of Bipolarity

1. Acquire four Monster Energy Drinks, orange only. Drink one. (Do this only if attempting to induce mania. If already manic, skip to step two.)
   This tastes like melted jolly ranchers. I can feel my heart in my throat.
2. Turn on Pandora 70s/80s rock station. Dance if you want to. Leave friends behind. My body has no borders. Time is a construct. I am boundless energy.
3. Text everyone you love. Or enjoy. Or know. Tell them you love them and why. Immediately. Use many emojis and exxtraaa letterrrssss forrrrr emppphhassssissss.
   Do you ever just feel like jumping up and down and words are just music with less pitch and lots of rests!
4. Grab journal. Lots of plans. Consider ontological deconstruction of post-modern phantasmagoric representations of others → contributions/confluence with indigenous fetishization → disarticulation as mode of montage → Catholic Church → I am I am.
   Self-explanatory. But my brain burns when I write; I can hear the motor.
5. Reflect on brilliance. Consider starting cult.
I can feel the blood of Christ in my veins. I can feel the energy. Pulse. Pulse. Pulse.

6. Decide cult is unethical. I am a cult of one. I might throw up. Nope, just excited. Legs shaking.


8. Write for 12 hours. Type

9. PANIC ATTACK 10. PANIC ATTACK 11. PANIC ATTACK
Face cry Nose cry Chest cry

12. Sleep for one.

13. Wake up, review behavior, bask in guilt.

BRAVING THE ALTERIOR: NEUROTYPICAL LONGINGS

Like Krapelin, I as a patient certainly understand why running around proclaiming to have heard the voice of god might be considered a problem. There is the issue of potential false claims, development of apocryphal texts, unnecessary holy wars, and perhaps most egregious of all, the discomfort caused to one’s neighbors. However, as a woman raised in the American Christian tradition, I can’t help but note that such behaviors enacted during a worship service are often lauded and celebrated. It would seem that within the walls of the church, I am prophetic. (Praise the Lord.) It would also seem that within the walls of the grocery store, I am pathological. (Lord have mercy.) Determining which performances are acceptable and which performances are psychotic relies on an examination of the contexts in which these performances occur.

When a patient’s performance does not match the culturally coded expectation for the given context, the patient is repeatedly rendered as “other” in the context of normative neurological systems—a move that disempowers those deemed pathological as “broken” or “deficient” while implicitly defining the undiagnosed as possessing a superior neurology natural to the human species. This homogenizing logic bears striking similarities to Aristotle’s view of
women as “deformed,” having not fully developed into a male body and offers little incentive for those who might benefit from treatment to “cross over” into the realm of the diagnosed (Generation of Animals, 737a. 28). It is this positioning of the patient as “other” that enables stigma. Helene Cixous explores the position of the other in The Newly Born Woman, writing:

…everything throughout the centuries depends on the distinction between the Selfsame, the ownself (-what is mine, hence what is good) and that which limits it: so now what menaces my-own-good (good never being anything other than what is good-for-me) is the “other.” What is the “Other”? If it is truly the “other,” there is nothing to say; it cannot be theorized. The “other” escapes me. It is elsewhere, outside: absolutely other. It doesn’t settle down. But in History, of course, what is called “other” is an alterity that does settle down, that falls into the dialectical circle. It is the other in a hierarchically organized relationship in which the same is what rules, names, defines, and assigns “its” other. (69-70)

Here, Cixous notes that the selfsame (or dominant identity) and other (or alterior identity) function relationally. While the selfsame occupies a privileged position in dominant culture, the presence of the other is needed in order to define and protect the power of the normative identity group. In marking the other as alterior, the selfsame naturalizes their own identity by positioning the other as unnatural, thus establishing an oppositional system of binaries that works to marginalize and disempower the other.

The binary of selfsame and other is relevant to unpacking the context of bipolar disorder because the same binary structure informs notions of “mental illness” in contemporary culture. Criteria for diagnosing a person as mentally ill has been painstakingly laid out by the American Psychological Association in an ongoing project to cure mental illness. Comparatively little
attention has been given to defining the normal range of mental wellness. In an effort to draw attention to this binary construction, autism advocates in the late 1990s began using the term “neurotypical” to describe persons whose neurology meets the expectations for normal functioning in society and is often favored by that society. At times abbreviated as NT, this term has been modified to indicate people who are not marked as autistic, attention hyper deficit disorder, bipolar disorder, dyslexia, Tourette’s syndrome, and other mental, emotional, or intellectual differences (see Kathryn Boundy, 2008). The impetus behind this neologism is advocacy. By naming the naturalized/dominant identity as “neurotypical,” mental health advocates seek to draw attention to the privileges this identity incurs. Taking Peggy McIntosh’s essay, “White Privilege: Unpacking the Invisible Knapsack” as its inspiration, a collaborative online effort by members of the mental health advocacy community have created a “Checklist of Neurotypical Privilege,” including:

3. When attempting to purchase health insurance, I know that I will not be rejected because I am NT.

5. I can assume that police officers will not become alarmed at my natural body language and find it necessary to subdue me in advance of any wrongdoing.

8. People of my neurology are not generally considered burdensome to our families or to tax-payers.

17. I can reveal my neurology to my boss and coworkers without fear of losing my job.

23. No one sees my neurology as being in need of elimination or cure.

29. I am never told that I should not have children lest I pass on the genes that cause them to share my neurological type.
39. The definitions of rude and irritating conduct were developed by and for people with my neurology.³

In sum, the list contains 50 items on topics such as safety, inclusion, relationships, and respect. These privileges are key contributors to the stigma surrounding mental health, barring those who are deemed subaltern from participating in their public and private lives with equal agency as their neurotypical counterparts.

This is certainly true of my experience with bipolar disorder.⁴ I am terrified of turning twenty-six, that awful year when I am no longer on my father’s health insurance and I have to find my own. I am scared of what might happen should I be pulled over and discovered to be “mentally ill,” and where I might end up. I have spent many nights wondering at the amount of gray strands I have added to my mother’s hair (and dollars I have sucked from my father’s bank account) between three a.m. manic bursts and four a.m. panic attacks. I am sickened by the thought of what will happen once the “gentle” arms of graduate school thrust me forth into the job market, and how upon first meeting potential employers I might navigate the reasonable inquiry into my research interests. I am haunted by the repeated feelings of dissociation and loss of my sense of self that seems to accompany so many switches to new medicines meant to cure me. I spend an inordinate amount of time engulfed in my own desire to be a parent coupled by

³ The full “Checklist of Neurotypical Privilege” can be found in Appendix C.
⁴ In reflecting on the “Checklist of Neurotypical Privilege” there are items that I identify with, despite my non-neurotypicality, which are given as follows: “1. I have never been told, because of my neurology, that I am incapable of feeling pain. 6. I do not have to carry a special card or bracelet with me to explain my natural body movements or the sounds I naturally make. 16. People who have power over my education will probably not decide that, instead of receiving the academic education most of my peers receive, it would be best for me if my time in school were spent learning non-academic skills.” My ability to identify with these privileges is in part due to the fact that there is a great amount of diversity amongst people who are not neurotypical. I feel it is important to point out this identification to avoid eliding difference, while also noting the position of bipolar disorder within the larger mental health spectrum.
the fear that subjecting a child to my own neurology, be it biologically or environmentally, is selfish and wrong. And I spend a lot of time alone, combating the fear of unintended offense by barricading myself in my own room as a preventative measure.

But perhaps my largest fear is the fear of being publicly discovered, of being named. Here, I experience the stigma of the hail, as described by Louis Althusser:

…ideology “acts” or “functions” in such a way that it “recruits” subjects among the individuals (it recruits them all), or “transforms” the individuals into subjects (it transforms them all) by that very precise operation which I have called *interpellation* or hailing, and which can be imagined along the lines of the most commonplace everyday police (or other) hailing: “Hey, you there!” (105)

In this case, the ideology at work is one that privileges the neurotypical while subjugating the other, allying mental concerns with moral connotations that turn diagnoses into adjectives, and negative ones at that. Given the various privileges that neurotypicality incurs, why would anyone seek out a diagnosis at all?

**AN ODE TO DIAGNOSIS**

A small, slim, thirteen year old girl sits in a hard grey chair, her knee-length socks pooling around her ankles. She holds a pen, a clipboard, and an enormous stack of forms reaching well above her navel. The scene might be considered comical, if only it were not true. Pushing her frizzy locks behind her ears, she feebly answers as the pages demand:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you felt irritable and easily annoyed?</td>
<td>Yes</td>
<td><em>Don’t we all?</em></td>
</tr>
<tr>
<td>Do you feel that you are a particularly important person or that you have special talents or abilities?</td>
<td>Yes</td>
<td><em>Mr. Rodgers said so.</em></td>
</tr>
<tr>
<td>Have your thoughts been racing through your mind?</td>
<td>Yes</td>
<td><em>My brain moves faster than I can write.</em></td>
</tr>
</tbody>
</table>
Have you been sleeping more than usual? No. But my mom thinks so.

Have you felt anxious, tense, or irritable? No. But my mom thinks so.

Have you lost or gained much more weight than is usual for you? No. But my mom thinks so.

Have you been thinking about death or taking your own life? Yes.

**THE NAMING**

Medical professionals typically make a bipolar diagnosis based on questionnaires, personal interviews, and an overview of the patient’s medical history. This data is then compared to the criteria for bipolar disorder given in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. For over 60 years, *DSM* has served as the defining manual for the field. Published by the American Psychological Association, *DSM* is now in its fifth edition, having been painstakingly revised in 2013. The introduction states:

*DSM* is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders. It is a tool for clinicians, an essential educational resource for students and practitioners, and a reference for researchers in the field. (xiii)

As a diagnostic aid, *DSM* stands as an archive of pathology with an aim toward care. In her book, *The Archive and the Repertoire*, Diana Taylor defines the archive as,

…documents, maps, literary texts, letters, archaeological remains, bones, videos, films, CDs, all those items supposedly resistant to change… Insofar as it constitutes materials that seem to endure, the archive exceeds the live. (19)

Thus, *DSM* serves as an archival record of live patient behaviors, enduring long after the patients have been observed. The concise, pragmatic language of *DSM* is ideal for diagnostic efficiency.
Within the covers of this 900-page-plus tome are clear categories and criteria for diverse mental disorders. These disorders are broken into several smaller categories such as neurodevelopmental disorders, schizophrenia spectrum and other psychotic disorders, and bipolar and related disorders, among others. The bipolar category is further broken down into subsets: bipolar I, bipolar II, cyclothymic disorder, substance/medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, unspecified bipolar and related disorder. These subsets are further broken down into their components. In the case of bipolar II, my own diagnosis, these components are broken into hypomanic episode, and major depressive episode. These components are also described in detail, providing clear criteria for making a diagnosis. The descriptions are meticulous, and their specificity is worth quoting at length. For example, the criteria for a hypomaniac episode is as follows:

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, and abnormally and persistently increased goal-directed activity or energy, lasting at least one week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree and represent a noticeable change from normal behavior:

1. Inflated self-esteem or grandiosity

2. Decreased need for sleep (e.g. feels rested after only three hours of sleep)

3. More talkative than usual or pressure to keep talking

4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or other, or there are psychotic features.

D. The episode is not due to the physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or another medical condition.

Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

Note: Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder. (124)

Despite its claim to scientific grounding, the creation of this archive is wholly rooted in the realm of performance. Unlike most medical conditions, there is no testing available, or even possible to indicate a bipolar diagnosis. In the absence of any biological artifact, mental health professionals must rely on their observations of patient affect in order to make a diagnosis. Consider the

5 For a complete summary of diagnostic criteria, see Appendix B.
performative criteria for diagnosing a manic episode: more talkative than usual, pressure to keep talking, psychomotor agitation, decreased need for sleep, distractibility; or in the case of depression: insomnia or hypersomnia, psychomotor agitation or retardation, tearful disposition, or agitation. It is important to note that isolated occurrences of either mania or depression are not sufficient to warrant a diagnosis. The criteria stated in DSM notes that, “Bipolar II disorder is characterized by a clinical course of recurring mood episodes” (135). Thus, it is only when the symptoms recur—when they, like Richard Schechner’s definition of performance, are twice-behaved—that a diagnosis is made (Schechner, 29). I received a bipolar diagnosis because I repeatedly performed both manically and depressively. To return to Diana Taylor, my repertoire fit the bipolar script as archived in DSM, therefore, I may be named as bipolar.

However, Taylor notes that the archive is often mediated, implying that the material presented has been selectively included, to the exclusion of others. She writes, “What makes an object archival is the process whereby it is selected, classified, and presented for analysis” (19). In the case of DSM, the selectors, classifiers, and presenters are members of the American Psychological Association—hundreds of clinicians and researchers working together to mediate, edit, and protect, the respected archive. These are the namers and the classifiers; the authors obsessed with taxonomy, ranking people from “normal” to “pathological.” It is a privilege to mediate the archive, a privilege I often envy. And yet, how could any archive capture the breadth of the bipolar experience?

Although DSM has garnered much respect over the years, this archival script has a clear, if not problematic, performance tradition; one that is based on an assumption of a patient’s defective agency. Francis Mondimore of Johns Hopkins University, whose articulation of bipolar disorder resonates with my own experience, describes the disorder as follows:
The symptoms of bipolar disorder, which seem to be caused by a deficit in the brain’s regulation of mood, also spill over to the areas of functioning… Imagine a person who suddenly starts shivering on a warm, sunny day and breaks out into a sweat in a room in which everyone else is chilly. This person’s reaction to warm and cold are abnormal: her body “thinks” it is cold when it isn’t and she feels hot when the temperature is cool. (9)

Mondimore’s definition hones in on a key aspect of bipolar disorder—a lack of discernable causation and absence of performative agency. Patients are not only unable to control their own affect; additionally, the all-consuming nature of the mood also renders them unable to effectively communicate and understand their experience in a way that is conducive for devising treatment. This places an excessive burden on the clinician, casting them as the arbiter in an act that I call clinical performance criticism: the process wherein a patient’s performance is critiqued by a clinician in order to determine the appropriate diagnosis. It was perhaps this removal of performative agency that I found most traumatic in my own journey with bipolarity. Not only was I unable to control my symptoms, it seemed as though I was also unable to actively participate in my own care. Furthermore, this lack of agency barred me from challenging the larger clinical archive into which I had been hailed. I was a spectator to myself. And yet, the simple fact remained: I was not well. I needed help. I still need….

And so, aided by my ever-concerned mother, I began a management routine as prescribed by my physician to cultivate and manage my bipolar identity: 300 mg Lamictal, 1 mg Klonopin, psychiatric check ups twice a month (which I continue to go to), counseling every one to two weeks (which I don’t). I too have added to the routine, mainly focusing on manipulating my bipolar moments, a dangerous game. I hide in the closet when I have panic attacks. I try to stay
away from caffeine because it triggers my mania. I write when I’m manic. I drink caffeine to trigger my mania to write. I hide in the closet when the caffeine wears off and I have a panic attack. These performative acts—they are how I know I am bipolar. No “sane” person would go through all the trouble. When enacted correctly, these acts are also how I know I have not been exposed. Most people I know aren’t aware that I have the disorder, and more than a few have been shocked to find out. If bipolarity is, as Goffman asserts mental disorders are—a stigmatized identity without a stigma symbol, and in my view known only through their performance—then I suppose I have chosen to, insomuch as I can, conceal that identity through the stylization of acts the archive deems most normal, seeking to pass as neurotypical. But I am ever haunted by the potential slip-up. Perhaps I will talk too fast, or make too many logical jumps. Perhaps I will be too loud or too excited. Or perhaps I won’t be friendly enough. Perhaps I won’t get out of bed. Perhaps my body will break and the specters pour out—the mania, the depression, the shame—Frankenstein’s monster laid out in full view. Suddenly, I am thirteen again, haunted by a hydra whose ghostly form whispers like teenage girls in a middle school locker room.

I AM CRYING

I am crying. I am crying because I am depressed.
   An unearned chemical cocktail overtaking a mind that is no longer my own.

I am crying. I am crying because I am sad.
   A normal human emotion without cause for alarm.
      But I am not sad. Am I? No. I am blue.

I am crying. I am crying because I am blue.
   Becalmed beneath a vaulted sky whose grey clouds forbid the passage of light.

I am crying. I am crying because I am broken.
   Sixty more years of doctor’s visits. Sixty more years of doctor’s bills.
But I am not broken. Am I? No. I am dramatic.

I am crying. I am crying because I am dramatic.
A histrionic penchant for exaggeration inflating experience in search of importance.

I am crying. I am crying because I am lazy.
Don’t want to get out of bed. A stubborn two-year-old.

I am crying. I am crying because I am afraid.

How depressing.

A PASSING FANCY: NAMING FEARS

Within the walls of the clinic, it is the clinician that is responsible for critiquing my performance, working with me to devise the best treatment. The continuous nature of care serves to repeatedly remind me of the various ways in which my performance might be critiqued. Thus, I have developed an acute awareness of my performance, comingled with a fear that the naming I have experienced in the clinic might translate to unwanted hailing outside the clinic. Simply being hailed as “bipolar” has the power to alter others’ perceptions of both myself as a patient and my performance, thereby affecting my agency and the privileges to which I have access.

Thus, in keeping with JL Austin’s notion of performatives, the word itself does not simply report, it acts (6). The term “bipolar” is a change-inducing agent in the diagnostic process, and in the life of the patient. In his discussion of performatives, Austin differentiates between felicitous and infelicitous performatives. A felicitous performative acts because the context in which it is uttered supports this action, while an infelicitous performative occurs in an unsupportive context (6). When a priest says, “I now pronounce you spouses,” her/his words enact the marriage in part because she/he is ordained. It is understood that she/he has the status
necessary to marry couples. Thus, the utterance is felicitous. Should an unordained person say the same words, the act would be infelicitous and the couple unmarried, as an unordained person does not have the status needed to perform marriages. When a medical professional diagnoses a patient with bipolar disorder, the utterance is felicitous. The doctor has obtained the necessary training and credentials to make a diagnosis and prescribe treatment. When she/he diagnoses the patient, this felicitous performative effectively enacts the personal and social change attributed to the term bipolar. However, this felicitous performative extends well beyond the walls of the clinic. Echoing Mondimore’s observations on lack of causal behavior in bipolar patients, Emily Martin notes in *Bipolar Expeditions*,

> Being known as a manic-depressive person throws one’s rationality into question. There are high stakes involved in losing one’s status as a rational person because everything from one’s ability to do one’s job, teach, one’s students, obey the law of the land, or live with one’s family can be thrown into doubt. (5)

The questionable rationality of a person diagnosed with bipolar disorder introduces a status dynamic that implies felicity in the speaker’s utterance. In assuming that the person with bipolar disorder is irrational, the speaker assumes a higher status by invoking her/his own rationality. Note that I am not just talking about clinicians or researchers. Here, I am extending the diagnosis made by the clinician into the social sphere—the clinical archive influences the social archive, and vice versa.⁶ This creates a clear divide between those who are clearly able to critically asses

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⁶ Like the sensational descriptions of bipolarity provide by Krapelin, popular media continues to present extreme and often inaccurate renderings of mental illness, profiting from the scopophilic—or perhaps even schadenfreude—experienced by viewers. For a more in-depth study of depictions of mental illness in popular media, see Otto F. Wahl’s *Media Madness: Public Images of Mental Health*, M. Anderson’s “‘One flew over the psychiatric unit’: Mental Illness and the Media,” and Meryl Williams and Judy Taylor’s “Mental Illness: Media Perpetuation of Stigma.”
a bipolar performance—the speaker—and those who are unable to rationally assess a bipolar performance—the patient. True, a doctor is afforded an accredited level of status that makes her/his naming clinically valid. But by simply naming another as bipolar, whether it is medically true or not, invokes a status dynamic that casts the speaker as rational and the named as irrational. Furthermore, by making this divide, the speaker removes any potential to dispute the claim, as the defendant is irrational by nature and assumed unable to make a cogent counter-claim. A young woman may not think she has bipolar disorder, but if her mother deems her performance abnormal, that woman has little agency in refuting the claim. And even if it is true, the palimpsest of irrationality remains ever imprinted on the word, and on the person to whom the label is applied.

The implied lack of rationality associated with the term bipolar also casts the performance as suspect. Reflecting on Mortimer’s definition of bipolar disorder—that emotional affect is not regulated in connection with any organic condition—those audiencing a person with bipolar disorder may find a disconnect between behavior and context. While the performance may be clear, the cause of that performance may be absent or non-existent. There is a perceived irrational behavior. Thus, since these behaviors cannot consistently be attributed to any rational cause with certainty, the performance itself becomes subject to scrutiny. Does a given performance of an individual with bipolar disorder reflect her/his intentions? Or is the performance misleading? Whereas before the performance may have previously been taken at its word, once the person is named as bipolar the performance becomes untrustworthy; the performance is suspect. Furthermore, since a person diagnosed as bipolar is assumed to have no rational control over her/his performance, she/he is effectively robbed of her/his performative
agency, subsumed in the larger social narrative. It would seem that as long as the name persists, the stigma pervades.

Having undergone the clinical performance criticism that constitutes diagnosis and treatment, and well aware of the archive to which I would play host, I quickly sought to distance myself from the experience. Perhaps the messy business of diagnosis was but a small stain on my record, an isolated event from which I could be absolved through the linear progression of time and a willingness to ignore. I took my medicine as prescribed by my psychiatrist and laid out each night by my mother. I did not see a counselor—too expensive—and so I was not reminded of my disorder as much as I might have been. Unlike other non-neurotypical diagnoses, I am at times able to construct my performance of self in a way that passes as neurotypical, as the absence of a physical marker of bipolarity privileges performance (and the subsequent criticism it incurs) as the sole indicator of the disorder. Such an act might be considered akin to a drag performance, which Judith Butler describes in *Gender Trouble: Feminism and the Subversion of Identity*:

…acts, gestures, and desire produce the effect of an internal core or substance, but produce this *on the surface* of the body, through the play of signifying absences that suggest, but never reveal, the organizing principle of identity as a cause. Such acts, gestures, enactments, generally constructive, are *performative* in the sense that the essence or identity that they otherwise purport to express are *fabrications* manufactured and sustained through corporal signs and other discursive means.

(73)

Having been diagnosed as bipolar through an analysis of my performance of bipolar acts, I am well aware of the impact performance has on marking identity. But, as Butler notes, performance
can also be stylized in order to project an alternate identity, and it is through this heavy policing of self that I have attempted to control my bipolar performance in order to express a neurotypical affect. If I am able to recognize that I am manic or depressed, I may be able to hide out in my apartment and weather the storm privately, free from other’s critical gaze. Furthermore, I do experience times between episodes where my behavior is neurotypical, despite the knowledge that the neutral state is temporary. And yet, even in these more normative moments, I cannot escape the shadow of stigma. What if I am not passing as well as I think I am? If I am not already marked through my performance, I fear that I soon will be marked. I may be “normal” now, but I will be “bipolar” again soon, torn from the selfsame into the land of the other. It is the name I fear, and the stigma it brings everywhere I go.

UNTITLED 2

2012. I’m working on a show, rushing from my dorm room, to rehearsal, per usual. Winded, I arrive at the dressing room to find my friend and fellow performer putting on her makeup.

Words. I have so many words:


“Yes. We can tell.”
INTERROGATING PERFORMATIVES: REVISIONS

Interrogating the multivalent forces that influence my performance of bipolar disorder within the clinic is a humbling act. Safe in the walls of my apartment, I find a depth of reflection unencumbered by fear. It is easy to critique, easy to blame. At times, I long for a neat ending, pinning the whole of my bipolar experience on a cruel construction I might write off as invented, thus banishing bipolarity from my life all together. But it is not that simple. The day-to-day realities of a bipolar life ground the theoretical in the practical, creating a critical balance as delicate as the maintenance of my biochemistry.

My junior year of undergrad, I experienced strong change in my bipolar symptoms, as is often the case in bipolar patients in their early twenties. My treatment remained unaltered. Week after week, I sat sandwiched between the cool yellow walls of my therapist’s office, recounting the unthinkable highs and unbearable lows of the previous week—the results of a poorly medicated chemical concoction whose ubiquitous and fickle nature left my therapist disoriented, while I remained lost at sea.

As the semester rolled along, I sat in silence as my school desk morphed into a dysphoric sculpture of therapy bills, prescription bottles, monster energy drinks, sleep aids, and coffee pods, all piled atop a base of homework and textbooks. I soon found myself wading through endless bottles of Lexapro, Pristique, and for one terrible three-month period in early spring, Adderall, prescribed in part as an accidental ADD diagnosis, and also in part because one doctor suggested we try it and “see what happens.” What happened was an endless parade of emotional breakdowns, panic attacks, manic tirades, depressive paralysis, a unnatural familiarity with the hour of four a.m., twenty pounds added expressly to my stomach, a firm belief that I could fly—
if only I believed in myself hard enough—tempered by a crippling conviction that I could no longer move my own body.

And yet the demands of academia and my own self-imposed perfectionism insisted that I keep my struggle behind the scenes. As therapist after therapist filled the role of passive audience and prescriptions became script, I found myself cast in an endless one-woman tragedy, a non-consensual narrative whose Beckett-like absurdity was never lost on its heroine. The floorboards of my mind began to buckle under the pressure of its contents. And finally—break. A phone call.

“Mom. I’m…not okay…”

followed by the sudden realization that my diagnosis is not a joke. It is not a dream. It is not a trick. I am bipolar.

The term “bipolar” has a stigmatizing edge, but in these moments, I am well aware that the name that condemns me is the name by which I am saved. At the very least, it provides some relief from the self-imposed shame brought on by the sobering remembering of manic nights past. Diagnosis gifts the patient with a vocabulary through which to describe and understand experience. At times, this can help to explain odd or abnormal behavior that might have seemed foreign or frightening. So that time that I randomly kissed a girl at a party? Or spent a ridiculous amount of money at a mall? Or decided it was no longer necessary to look before crossing streets? I was manic! Finally, a clear explanation for behavior that even seemed bizarre to me as the patient. And while I often struggle with my medication, it is the prescription pad that has kept me from padded hospital rooms.

Fear is embedded within the vocabulary of mental health practice. Disaggregating the stigma attached to the words we use is of paramount importance to connecting people to optimal care. It can be tempting to over-invest in these words, to allow their performance to elide the
difference between self and disorder. I have had clinicians that were a terrible fit for my needs. I
have had clinicians that were a great fit for my needs. But I have never had a clinician that
wasn’t honestly seeking to dedicate her/his energies towards helping others and myself. Fear can
overshadow this fact, distorting friends into enemies while privileging the performance of words
over the earnest efforts of speakers. I am far from immune to this fear. And so, I must revisit:

THE SCENE: Spring. A small meeting room at a conference. The four walls are painted a
generic-hotel-tan. The drapes are colored a generic-hotel-gold. The floor is patterned a generic-
hotel-green. The light is soft; the room is full.

Back to the room: I was relieved to find gracious, generative dialogue. I leaned back in my chair.
I uncrossed my legs. I smiled. And then, a lone hand peaked over the crowd, and a woman
spoke. She said, “Thank you for your paper. I have two sons who are also (          )...” and I write
(          ) because honestly, I can’t remember the exact word she said, or the rest of her comments
for that matter. I know that the word was a noun. It was a noun naming a group of people
somewhere on the mental health spectrum. It was a noun naming a group of people somewhere
on the mental health spectrum that was not me. Where my memory of the specifics fails, my
body remembers

the familiar prickle of shame creeping through my skin

“You will never get a job.”

[I am sickened by the thought of what will happen once the “gentle” arms
of graduate school thrust me forth into the job market, and how upon first
meeting potential employers I might navigate the reasonable inquiry into
my research interests.]

the once-more pounding of my heart struggling to escape my chest

“You will never get married.”

[I spend an inordinate amount of time engulfed in my own desire to be a
parent coupled by the fear that subjecting a child to my own neurology, be
it biologically or environmentally, is selfish and wrong.]

the frantic gasping of still lungs unable to breathe

“You will lose your friends.”

[And I spend a lot of time alone, combating the fear of unintended offense
by barricading myself in my own room as a preventative measure.]

as I heard myself publicly named (accused?) as a member of a group with whom I do not
identify.
And while I was, in the moment, so quick to conclude that the woman speaking didn’t understand my paper, upon reflection, I find a shameful and convicting realization.

I didn’t understand my paper.

I heard the words, and I allowed these words to perform without my consent, conjuring fears and associations that are wholly characteristic of the fears I have as a woman living with bipolar disorder. I fear the subjugation that so often comes with the term bipolar. The speaker’s assumption that she/he knows; the speaker’s assumption that I do not, cannot, know. But in my reaction to the woman’s comments fully embodies everything I am trying to combat in larger discussions of mental health. I heard the words, and I heard the hail. I allowed these words to perform, conjuring up a host of deep-seated fears wholly particular to my person.

But I also invoked the binaries that inform condemning constructs of neurotypicallity. I cast myself as the knower, and her as one who does not, cannot know. I know what it is like to be bipolar. I assumed that she did not, could not know. I may have bipolar disorder, but I did not want to be thought of as unwell. It would seem that I simply wanted, and at times still want, to be subsumed into the normative, unencumbered by the bipolar script.

The fear attached to this now forgotten word performed so strongly, I could not hear beyond the performative associations of the term. Perhaps she meant that she felt connected to my paper because she has experienced firsthand the constant struggle of managing a mental illness. Perhaps she meant that she too has felt pain in addressing stigma and shame. Or perhaps, like me, she simply wished to offer her voice to a conversation that so often relies on stereotyped categories to inform its content. I cannot say. I was mired in my own associations, and I mourn the loss of support and understanding I was not able to contribute to and actively receive that night. Herein lies my true shame.
It is very hard for me to share this story as I have, first allowing it to stand without direct comment, and then to augment the story with the exposure of my own hypocrisy. But understanding bipolarity and the various dimensions of its performance is an ongoing process. The trajectory is far from linear; the performatives pervasive. What could this woman have said to me that would have seemed more empathetic, while still honoring her own experience? Upon honest reflection, I can offer none. While the terms surrounding mental health discourse are problematic in their performances, they remain the language of the field. Thus, it is of paramount importance that we not be taken in by these performances, but rather understand their infelicitous and precarious nature. There will be missteps. There will be hurt feelings. But the power present in contesting a diagnosis—in speaking back to language that so often subjugates and objectifies—necessitates this journey. The question then is not how to arrive, but rather how to proceed. Tackling these issues requires that we push through tough moments with an openness to potential miscasting, the courage to refuse our roles, and the willingness to listen deeply beyond words and into the heart of human expression.

APologies

I managed to stay mad at mom for years. I felt so deeply betrayed through it all. Everything hurts when you’re thirteen. I did not think there was anything wrong with me. It seemed like a personal attack, evil-queen-level malice. Week after week, she drove me to appointments, made sure I took my medicine, and monitored my mood. I saw it as control. Now I know—she was keeping me alive. As in all things, she has taken my most painful struggles and hoisted them upon herself. We were alone, the two of us. My father never said a word about the
diagnosis, the visits, the pills. But I was never upset with him. It never bothered me. I could only be mad at her. Like most teenage girls, I learned blame.

My experiences in the clinic, and the diagnosis that followed, was not only a source of shame for me. It was, and still is, a deeply shameful experience for my family. The familial silence that surrounds my bipolarity served to reinforce my own conviction that I was broken. Shortly after diagnosis, my mother took me aside before a family trip and explicitly told me I was never to let my grandparents—my father’s parents—know that I was bipolar. In many ways, I felt as though the more shameful aspects of the clinical script had infected and accused me within my own home. But while in my teenage years, my resentment for my mother grew, it was through her care, and the care of my grandmother, that I survived.
NO. 3: THE HOME

PSA NUMBER ONE

I regret to inform you that I must begin this chapter with a contradiction.

Having just completed the last chapter, you may be under the impression that I find the institution of American psychiatry to be incredibly misguided and wholly damaging to my mental, that is to say, human well being. And you would be right. Hell-bent on self-definition, I refuse my medicine like a sick toddler unfooled by the promise of cherry-flavored cough syrup. Consider it my personal feminist revolution—a radical act of love and acceptance. Oprah would be proud.

I water the weeds of my mental garden into golden dandelions bursting forth in all directions. Its seeds are carried on brainwaves whirling in rhythmic syncopation; a neural dance reaching through time; unaware of space: electric light.

I am here and there
I am now and then
A particle and a wave
A particle and a wave

-BUT-

IF THE WORLD IS TO BE UNDERSTOOD, IF WE ARE TO AVOID SUCH LOGICAL PARADOXES WHEN TRAVELING AT HIGH SPEEDS, THERE ARE SOME RULES, COMMANDMENTS OF NATURE THAT MUST BE OBEYED... THOU SHALT NOT ADD THY SPEED TO THE SPEED OF LIGHT. ALSO, NO MATERIAL OBJECT MAY MOVE FASTER THAN LIGHT: THOU SHALT NOT TRAVEL AT OR BEYOND THE SPEED OF LIGHT... FOR THE WORLD TO BE LOGICALLY CONSISTENT THERE MUST BE A COSMIC SPEED LIMIT. (CARL SAGAN, COSMOS 214)

I have gone too far. I am a liar—a fraud. I have attempted to exceed the limit, and The Wave has overtaken me; it’s salty splash pouring down my face: hour after hour after hour after hour...

I have just finished writing. The mania is waning... According to the literature I’ve read, the tip from mania to depression is a swing, but I’ve never experienced it that way. It is a swift straight drop. But perhaps depression is the wrong word. It is total anguish, the weeping and gnashing of teeth. I have never looked so ugly in my life, my face contorted and drowning in its own fluid. A scream builds and swells inside of me but it cannot escape: I cry in the bathroom. I cry on the bed. I cry on the floor beside my bed. I don’t know why I’m crying; it is all I am; it is me. My body and action are one and the same. I am sucked into the black whole of my own reprehensible name; the wax of my wings melting as I tumble from the heat of the sun.

Thou shalt not add thy speed to the speed of light.
Thou shalt not travel at or beyond the speed of light.
In my writing, I hide behind alliterative syllogisms, clever metaphors. But there is nothing artful about this place. Perhaps it is my struggle to articulate. Perhaps it is my fear of confronting the real. Here, I have no poetry, just signs void of meaning. I close my eyes and imagine the sinking; the warm water flooding every opening and pushing me down down down further into a soft, sinking sleep.

I want the medicine.
I need the medicine.
Please please please give me the medicine.
It’s not fun anymore.
I don’t like the MANIA anymore.
It’s not a game anymore.
I don’t feel special.
I don’t feel safe.
I believe it now.
I believe it now.
I believe it now.

I am a madwoman.

INTRODUCTIONS

I am my father’s daughter. Despite having been born of my mother, I have grown up knowing well that I have little evidence of my maternal family written on my form. My great-grandmother always said, it’s a good thing for children to look like their fathers (especially at birth) and having been born with jet black hair and my father’s nose, I suppose I did my best in utero to cultivate my features in such a way as to proclaim my mother’s honor, thus erasing her from my body. My pale skin knows nothing of her olive hues; her full lips far exceed the thin pink line that rests so solemnly above my chin. Growing up, my more prized faculties—calm articulation, level headed rationality, and an overwhelming desire to succeed—were always followed by the phrase “just like your daddy.” I was rather happy in this arrangement. But in my father’s house, there are many rules....
One of my first memories—or rather, collage of memories—spans from approximately age four to the present. Early on, my mother and I developed a performative ritual, first beginning with the collection of relics (an ice bag and coke to soften her migraines), followed by a dimming of the lights and reverent viewing of *Dr. Phil* at three o’clock, *The Oprah Winfrey Show* immediately following at four.¹ Even before I could tell time, I knew that dad would be home by the end of *Oprah*, and nothing upset him more than to find my mom watching television on the couch upon his arrival, especially if there were dirty dishes in the sink. Some days, overcome with anxiety, I would pop up between commercials and frantically rinse the dishes, haphazardly piling them into the dishwasher in an attempt to beat the clock. Some days, I would forget. Some days, I just didn’t want to. And some days, he came home early—the worst possible outcome, allowing for no mental preparation. Far preferring my father’s dress shirt and tie to her nightgown and socks, I looked at my mother on the couch and, to my shame, thought, “I will not be *that.***”

I am my father’s daughter.

Still, while I bear my father’s name, I have always grown up with the understanding that I am not a part of his family, rather, I receive my history from my mother’s side. Between car rides to and from school, time spent preparing holiday meals, or that oh-so-predictable parting of the genders that characterizes any family gathering, I have come to know who I am from the stories and stylings of my mother and her mother. Here, we women are positioned as the inheritors of a grand tradition of “touched” women; women with supernatural gifts; women with

¹ Whereas excessive caffeine makes me feel manic, my mother’s love of Coke-a-Cola has resulted in a kind of dependency. When she omits her daily can, a migraine ensues, inducing withdrawal-like symptoms. Whether or not her initial love of the soda had anything to do with her bipolarity, I cannot say. My father hides two liters in the garage so he doesn’t have to go to the store to get her a bottle when she wants one, thereby saving him the trip.
the ability to see what others cannot. Perhaps it was my knowledge of this tradition that first lead me to believe that the migraines weren’t just migraines; that there was a deeper mechanism occupying my mother’s headspace that required attention and care. Perhaps my father could not recognize the reality of her experience because he was not one of us; he could not be a woman-seer—after all, he is not of our blood, or a woman. But perhaps he didn’t want to see, preferring the aesthetic value of newly cleaned flatware to the messy nuances of psychiatric care.

We were all diagnosed as bipolar within the same year; each of us placed on our respective medications and sent for the appropriate counseling. While the experience of bipolarity itself remained a rather individual exercise (we rarely discuss our clinical experiences), preserving the lineage of madwomen in our genealogy soon morphed into a counter-archive, asserting that our “pathology” was but a misunderstood gift worthy of protection. As Phillip Martin writes in *Mad Women in Romantic Writing*:

> Woman and madness share the same territory…they may be said to enter a concentric relationship around a central point occupied by a fundamental male normality. Like some insidious virus, insanity therefore invades the mythology of woman, finding there a semiotic fund that it may use for the purpose of self-definition. (42)

While in the clinic we each found ourselves hailed as “mentally ill,” we were also asked to proffer our own histories as evidence in order to validate the diagnosis. Bipolar disorder does seem to have a genetic etiology, and considerations of family history are taken into account when making the diagnosis. Despite the felt presence of a genetic predisposition to bipolarity in my own maternal line, there is something insidious about the naming of other family members as “mentally ill,” something that tastes of a McCarthy-esque flavor, unsettling my stomach. Must I
name others in order to be so named myself? And at what cost? My memories are the currency by which I relinquish my self-definition within the walls of the clinic.

My grandmother, mother, and I may have named each other as bipolar on psychiatric surveys, but within the context of the home, performing our history of great-mothers has served to develop an alternative counter-archive, a powerful semiotic fund in its own right that reclaims our agency, our story, and our identity. True, we rarely speak about our personal experiences as bipolar women—such explicit clinical dialogue does not permeate the home. But I suppose this is par for the course, as I have yet to receive any acknowledgement of my disorder from any male member of the family. Echoing Martin, insanity has invaded the mythology of woman, and the women of my line have, it would seem, always been charged with the mental maintenance of their daughters. At age 13, my mother handed me a box of sanitary pads and a bottle of antidepressants…

In an attempt to better understand how my performance of bipolarity has been shaped within the home, I am interested in not only how women are positioned within the clinic, but also how the oral history transmitted to me by my mother and grandmother might function as a resistant reading of this subjugation, seeking to embrace and reframe notions of “madness” as prized qualities within our own family line. Thus, while in this chapter I focus on the home, I will first interrogate how we as women feel we are read, and often devalued, in the clinic. Then, I will parse through our shared familial narrative in an effort to understand how we attempt to upend clinical subjugation and position ourselves as agents within the home. In addition to examining the narrative itself, I am particularly in considering the transmission of this history from mother to daughter, and how this act of sharing affects individual and shared notions of self
and disorder. Within the walls of our home, I have learned not only what it means to be a woman, but also a madwoman.

MY MOTHER AND I

We do not wear bras when dad is at work.
    We do not bind ourselves in the presence of each other. Our forms are not offensive or discomforting. We do not lift. We do not press.

We do not cook when dad is at work.
    We do not spend our time over Stouffer’s and stoves. We pass boxes of Girl Scout cookies and pizzas. We do not baste. We do not braise.

We do not pray when dad is at work.
    We do not make declarations of faithfulness to the silent stonework of our floors. We have no sins to atone for. We do not thank. We do not apologize.

We watch The Real Housewives—all of them. We say “shit” and “damn”. We do not put on makeup. We hand each other unconcealed tampons. We wear our pajamas all day. We lay on couches. We watch Oprah and Dr. Phil. We leave dishes in the sink. We talk about the medicines we are on and how they are working. We talk about the dreams we’ve had. We talk about the eye. We laugh. We laugh a lot.

    I am not SICK.          I am not WRONG.          I am not CRAZY.

I am one of two, we two, two of three.

We are all that has come before, that particular brand of female knowing.
We do not speak in phallic words, logos at the cost of meaning.
We sing the same sound song of mothers past.

My grandmother completes the circle:

    We, the Graeae,          We, the Moirai,          We the Weird Sisters
Three grey sisters,  Three timeless fates,  Three wayward souls
One eye to see,      Spinning strings of fate  Arm in arm
One tooth to bite.  All terrible, all good.  Fair and Foul.

But it is six o’clock, and the singing stops.

I am sick once more.
“WE’VE FOUND A WITCH—MAY WE BURN HER?”

The history of psychiatry has not been kind to women. Even before its formalization as a discipline, it would seem that “women” and “madness” have been inextricably linked since at least the time of Hippocrates, who attributed women’s hysteria to a floating womb, curable only through vigorous (heterosexual) intercourse (Garland 110). When reflecting on my own family, I cannot help but note its Hellenistic underpinnings—proof of concept for this pervasive narrative. I wonder at my male family member’s unwillingness to even acknowledge the presence of mental illness within our own home. Perhaps it is that same fear I fear—the fear of being hailed—that motivates my family, irrespective of gender, to keep quiet about this whole bipolar business.

With the formalization of psychiatry came a formal articulation of women’s particular predisposition to madness. While much has been written about the problematic gender politics of Freud, such suppositions were not limited to his practice. Thomas Coutts Morison writes in 1848,

It is generally understood that mental alienation is of more frequent occurrence among females than amongst men…because there exists in the female a variety of causes, as disorders of the menstrual function, pregnancy, parturition, and suckling; which are, of course, peculiar to sex. (17)

Echoing his contemporaries (Taylor, Beard, Charcot) Morison notes that the biological sex of the individual is to account for the higher rates of female to male patients. With its clear roots in the
“wandering womb” hypothesis of Hippocrates, this justification explicitly names and attempts to naturalize a hormonal basis for madness, positioning sex-based discrimination in the clinic as scientifically valid. This logic does so without any consideration of the cultural factors at play in psychiatry. In her article in *Feminist Psychology*, Rachel Liebert observes,

> The hormonal discourse constructs women as biologically and innately inferior, if not dangerous…naturalizes patriarchal authority, and the institutions (such as heterosexual marriage, heteronormativity, house-wifery, and protectionist sex “education”) that brings this into practice. (279)

Liebert’s comments are prescient, pointing to the political consequences of this naturalizing narrative. Even more troubling, this narrative is not relegated to the past, but is written into the current edition of *DSM*. Clinical criteria notes the hormonal differences women experience, particularly taking care to note concerns for women who are pregnant or hoping to become pregnant. A clinician’s attention to hormonal changes does not constitute a subjugating dialogue, as there are distinct biological concerns when treating a disorder with a biological component. However, the comingling of psychiatry’s own gender trouble with cultural stereotypes of women often inform the clinical performance criticism offered by the clinician, relying not only on notions of performance deemed neurotypical, but also on notions of gender performance deemed normative. Reviewing several clinical studies in her book *Women and Madness*, Phyllis Chestler summarizes her findings as follows:

> Clinicians had different standards of health for men and women. Their concepts of healthy mature men did not differ significantly from their concepts of healthy mature adults, but their concepts of healthy mature women did differ significantly from those for men and for adults. Clinicians were likely to suggest that women
differ from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more easily hurt, more emotional, more conceited about their appearances, less objective, and less interested in math and science. (128-9)

Not only do these concepts separate male and female patients in the clinic, they become the standard and infect the archive with a constructed bias that enables clinicians to pathologize the patient’s performance of gender alongside any possible neurological condition. This bias is, in part, a product of the gendered expectations tied to the patient’s performance of self in everyday life, expectations that are unconsciously invoked in the act of clinical performance criticism. Furthermore, a woman’s understanding of her own disorder is colored by her understanding and performance of her own gender through the specific hormonal concerns she and her clinician address throughout treatment. As a psychiatric patient, I am doubly marked within the clinic, first as a patient, second as a woman.

Speaking back to the clinical archive can be incredibly challenging. As a female patient, I am not afforded the same level of rationality granted others—my performance is always already suspect. Furthermore, the archive itself is highly guarded by a host of clinicians, backed by the American Psychological Association. As Michel Foucault notes,

The constitution of madness as a mental illness, at the end of the eighteenth century, affords the evidence of a broken dialogue, posits the separation as already effected, and thrusts into oblivion all those stammered, imperfect words without fixed syntax in which the exchange between madness and reason was made. The language of psychiatry, which is a monologue of reason about madness, has been established only on the basis of such a silence. (xi)
Morphing this monologue into a dialogue seems almost impossible, particularly given the gendered assumptions often at work in the clinician’s performance criticism, and the archive guiding the critical gaze. If healthy women are, as Chestler notes, expected to be more submissive, less independent, more easily influenced, less aggressive, and more emotional (which is to say, less rational) than women who seek to expose this monologue put themselves at greater risk for being labeled as “hysterical,” thus validating the underlying tautology of psychiatric care. This catch twenty-two is particularly evident in the archetypes of the witch and the madwoman, whose vociferous, meddling ways are cast as a stain on society. Often ostracized, or in certain periods, publicly executed, her presence served as a reminder of the power (or lack thereof) of the speaking woman, and her consequential stigmatization cast her as subaltern, thereby defining the hegemonic norm. Jane Ussher writes in her book, *Women’s Madness: Misogyny or Mental Illness?:*

> The witch has come to symbolize female oppression and female powerlessness, and her treatment to exemplify men’s cruelty. In many feminist analyses both the witch and the mad woman have been portrayed as women who dared to question, who attempted to rebel, and who thus speak for us all. Witchcraft and madness are seen as analogous means of controlling women. But in the Law of the Father witches are seen as sick, or as evil. (39)

The clinic may be ruled by the Law of the Father, but in certain areas of my home, the ground is more contested. I can’t count how many times we have sat at the kitchen table, my father scrubbing at the porcelain, my mother turning to me and saying emphatically, “If anyone in this house needs to be on medication, it’s that one….” We laugh like a pair of witches. He does not hear over the water running from the faucet. And while my grandmother and mother would
rather be burned at the stake than labeled as “feminists,” I cannot help but notice the underpinnings of Radical Feminism in the family narrative they have given to me, much akin to Mary Daly’s *Gyn/Ecology*. Daly writes,

> I am using the term *Gyn/Ecology* very loosely, that is, freely, to describe the science, that is the process of know-ing, of “loose” women who choose to be subjects and not mere objects of enquiry. *Gyn/Ecology* is by and about women amazing all the male-authored “sciences of womankind,” and weaving world tapestries of our own kind… It is dis-possessing our Selves, enspiriting our Selves, hearing the call of the wild, naming our wisdom, spinning and weaving world tapestries out of genesis and demise. (11)

In this narrative, we perform our own *Gyn/Ecology* to reclaim our subject position, and our own self-knowing. Whereas in clinical and cultural discourse, the witch and madwoman are, as Ussher notes, positioned as menacing, in our family our story is built upon them. Rather than accepting the negative value placed upon those diagnosed with the “female malady,” the women in my family have directly embraced the image of the witch as a subaltern mascot, thus refusing the clinic’s ability to stigmatize our identity—at least within our own space.

Have you heard of my Aunt Alice?

**ALICE**

Growing up, I remember my mom telling me about my Aunt Alice. Aunt is more a term of convenience, as she lived in the early fifteenth century, and no one seems to know exactly how we are related. Still, we are related, and her story goes like this:
Alice Nutter (Yes, Nutter. That is our family name. We are literally Nutters. My mom, grandma, and I still get into fits of laughter over it…) was born a long, long, long, time ago in England and she was a witch. She had the evil eye, and one day she gave it to the man next door (for some unrecorded but certainly justifiable offense) and the next day, his cattle and son died. So, she was declared a witch and hung, or burned at the stake, or whatever the witch disposal method of choice was at the time.

That’s how I remember the story from when I was a kid. Mom says she has a rubbing from her tombstone somewhere in the attic, but as I got older, I wrote the whole thing off as family lore—probably just an exaggeration of a misremembering, quoth my rational mind. Imagine my surprise, then, but a few months ago as I typed “Alice Nutter witch” into Google, only to be greeted by a host of images, pictures, and books documenting the trial of the Pendle Witches in Lancashire, England. The whole affair was documented by the clerk to the court, Thomas Potts, in *The Wonderfull Discoverie of Witches in the Countie of Lancaster*, published in 1613. *The Lancashire Witches*, written in 1849, presents the trials in novel form, while the Caroline-era playwrights Thomas Heywood and Richard Brome produced *The Late Lancashire Witches* for the stage. And in 2012, to commemorate the 400th anniversary of the trials, the city of Roughlee unveiled a life size statue of my Aunt Alice, sculpted by artist David Palmer. The plaque beside her statue reads:

The early 1600s in England were a time of religious persecution and superstition. To commemorate the 400th anniversary of the infamous Pendle witch trials, one of the best known—Alice Nutter—has been immortalised here as ‘alice’ [sic] in the village from where she came. She was unusual amongst the accused in that she was comparatively wealthy, the widow of a yeoman farmer. There was no
evidence that she was a ‘witch’ [sic] and she pleaded not guilty to the charge of murder, but was hanged, along with nine others, at Lancaster in August 1612.

(Roughlee)

The account of Aunt Alice given here is quite different than the one I received as a child. Far from being a “witch,” most accounts posit that she was named thus in part because she was a Catholic, in part because she was a landed widow (BBC).

Still, I like the story I grew up with better, not for its more fantastical elements (though those are good too), but rather because my mother’s telling was more about me than it was about Aunt Alice. See, my grandmother has the evil eye, the same one Aunt Alice had. It’s a certain look she can give someone, and that’s it. They’re cursed. But it’s also the ability to sense and see, to just, know things. My grandma dreams in numbers, always numbers. Sometimes they turn out to be lotto numbers; sometimes an important date; sometimes nothing. She says it’s the eye. My mother gets feelings. Feelings that we need to go somewhere, or we need to leave, or we need to do something, or we need to stop doing something. They don’t always make sense. But even my dad knows, when mom gets a feeling, do what she says. Because she is always right.

Personally, I have a connection to dates and seasons. When I close my eyes, the calendar spreads itself out for me in an inverted “U” shape, its opening facing backwards. Like Majong tiles, they “show” themselves to me by standing up, marking themselves as important. If a “tile” stands up, I know that a big change is coming. We can all talk to dead people. At least, that is what my mom says. But we choose not to do so.²

² She frequently wins. Not too much, but she makes her money back several times over. I’ve tried a few times too. It appears that while I may have gotten the Eye, I didn’t inherit my grandmother’s gift for numbers.

³ Well, I choose not to do so. While some might find excitement in the prospect, I was, and still am, terrified by my mother’s frequent reminders of our ability to converse with the dead. Both
I am, of course, hesitant to write this all down, as it seems exactly the kind of thing an insane person would talk about—magic numbers, strange feelings, secret calendars. I’m not claiming that any of our eye-given superpowers are real; there is certainly a lot to be said for confirmation bias. It is, however, how I understand myself. My grandma has the eye. As her daughter, my mother also has the eye, and as her daughter, I have it too. It’s part of what makes us…different… I have, of course, never used it for evil purposes. I’m too afraid. But I do have it, and Aunt Alice had it, and if I have a daughter, she will have it also.

GOOD CHRISTIAN WOMEN

[I must pause here for a moment. My grandmother and my mother would both be very upset if I did not assure you before continuing that we are good Christian women. Well, they are. The family is. But we are also from West Virginia, the north of the south and the south of the north. The in-between-ness of homeland situated among peaks and valleys necessitates some contradictions. I grew up in a house where it was normal for us to have strict family prayer and Bible time together morning and evening, augmented by church at least three times a week, only to hear my mother five minutes later threaten to get her West Virginia can of whoop-ass out if the neighbors don’t turn down their music. It can be confusing if you’re a kid, but you modulate. We come from a land between peaks and valleys—the north of the south, the south of the north. Nothing is mutually exclusive. We are a good Christian family.]

my grandma and my mother have told me about encounters with relatives long past. My grandmother regularly sees angels. It does not seem to bother either of them, but me—I’m completely freaked out by it. I used to pray at night: “Dear God, thank you for this day, and this family, and please make it so the dead people leave me alone and I never have to talk to any of them. Amen.” And while my current relationship with the Almighty is somewhat ambiguous, I do hope the prayer still stands.
IDA

In my great-grandmother’s house, there hung an old black and white portrait of a woman dressed in ragged farm clothes, her long dark hair plaited in a braid that fell well below her waist. To my child’s eye, the canvas print was about four feet by three feet, though I haven’t seen the original in at least ten years. While the cousins played, I would often sneak into the back room, hopping over the giant heating grate in the floor, being careful not to draw attention to myself. There, forgotten above an old sewing machine, I looked into the eyes of the photographed woman. Deep and dark, they stared back at me with a hollow stillness. She seemed sad.

One year, after many trips to the back room, my mother told me her name—Idabelle (Ida) Nutter. She was my great-great-great grandmother, though much of her story has been forever lost. My mom has done a lot to try to find out who she was before she became “Ida.” That name was given to her. Before she married my great-great-grandfather, she was a Native American. We aren’t sure which tribe; my mom thinks Shawnee, maybe Cherokee. I say “was a Native American” with great care, because when she got married, that identity was lost. She became Ida Nutter. Between the awkward pauses and occasional glances to the floor present in my mother’s telling, I have gathered that no one is quite sure how consensual these events were, from the donning of Western clothing to the marriage itself. She died a few years later giving birth to my great-great-grandpa, Ralph.

4 Here you may note that both Alice and Ida are Nutters in name. Thus, while these women come to me through my grandmother, they also come to me through my great grandfather. I feel it is worth noting that his involvement in this transmission is wholly omitted, as his silence was but one of many that nearly lead to their erasure. It was through my grandmother and mother that the stories were revived. Oddly enough, my grandmother’s knowledge of these stories came from her mother, Avery’s wife, I suspect in an attempt to blame my grandmother’s “wild ways” on those “Nutters.”
Shortly after her death, my great-great grandpa got remarried. The farm was big, and he needed a mother for his child. By all accounts, she was a mean woman, having sensed that she was brought on as a matter of necessity rather than mutual desire. She was incredibly strict, particularly with Ralph. After the marriage, Ralph’s father sat him down and told him—he was never to speak of his mother again. He was to call his new wife his mother and never again think of the woman who passed. Should he even utter her name, they would be punished severely.

Two “I” words were banned from the house: “Ida” and “Indian.”

Only now are we starting to talk about her, the stain of that silence having made its mark. In kitchen conversations, we have wondered who she was, where she came from, and if she might have brought a bit of the eye with her too. I like to think she would have fit in with our club of “mad” rebels. Was she a witch like us? I don’t remember, but my mom says that if you look closely at the picture of her, you can see on her left wrist a small stack of beaded bracelets—a reminder of a home and self now lost, but also, a small act of transgression; of speaking out.

ALEXIS

By all accounts, I was a strange child.

Incredibly talkative, I was, perhaps, the most devout five-year-old one might hope to encounter. I remember standing in the Giant Eagle with my mother as the carts of Bud Light went by, passing judgment on the irresponsible adults who so easily gave themselves over to vice and sin. Unaware of my parents’ selective non-participation in the teetotal-ing aspect of our church, I felt secure in my valorization of the Riley family values.
I started having night terrors around age two. My mom tells me I would wake up screaming at night, eyes wide open but still asleep. They could not wake me. It was the first stirrings of the eye. I refused to use anything but a black crayon to draw with, and often stayed up past my bedtime until what felt like three in the morning, flashlight in tow, absolutely absorbed in the latest art project or new invention that would change the world. I also talked about a woman named Pacha, dressed in purple robes with soft yellow hair. No one knows who I was talking about—or talking to.

And then there were the lights—hundreds of them floating in the air. They had a golden glow about them and would whisper things to me. I would find patches of sunlight and twirl in them, the polyphony of their voices joining in unmetered time. They were something akin to fairies, but if I concentrated too hard or drew my attention to their presence, they would grow quiet and disappear.

When I got older, things began to get darker. I was convinced that I was being followed around by an old Ukrainian woman with a hooked nose poking through her babushka, jagged dagger poised in the air, ready to strike. She was accompanied by two henchmen, one tall and skinny, one fat and round, both comically incompetent. I could feel her at my back whenever I was on stairs, in hallways. But she was clever. Whenever I would turn around, she would turn too. I could never catch her; only hold my image of her in my mind while I panicked, contemplating my impending impalement. I didn’t tell my parents—I was too scared.

NOT IN MY CAVE

It is that time again. The same fog. The same grey. The same words:
I want to go home. I want to go home. I want to go home.

Not my house. My home. Not as it is. As it was before—my high school bedroom.
The safe shelter nestled above the garage:
The lamps that lit my manic nights. The pillows that soaked my tears like sponges.
The door that cut off all outside, never breached without a knock.

My mother, making her careful watch outside. Calling school. Can’t come. Sick.

The best three weeks of my life were spent in that room—December 2013.
I did not medicate my sleep. I slept when I did. I woke when I did.
I did not medicate my moods. I wrote when I did. I cried when I did.
I did not medicate my performance. I mania-ed when I did. I depression-ed when I did.

My mother, making her careful watch outside. Calling me. Don’t worry. Rest.

My dad laughed. He called it “the cave”.

I AM NOT CRAZY—I AM OF MY KIND.
do you know the things our bodies have held?
more than babies
more than blood
I CANNOT PERFORM THE SPECTACLE YOU SEEK.

*I want to go home. I want to go home. I want to go home.*

IN POST-MEMORIUM

While I find the very existence of this family history to be incredibly powerful in shaping how I perform my bipolar identity in the home, I am also interested in the act of transmitting this narrative. The profound removal of agency necessitated by clinical performance criticism removes a patient’s ability to act. Thus, I consider any opportunity to intentionally act and have that action be received in good faith as a form of psychiatric protest, reclaiming the validity of my own performance on my own terms. The transmission of our family story is particularly prescient in that in addition to giving voice to the mother-patient, the transmission itself directly speaks back to the clinical and cultural discourses through a clearly defined act. As Phyllis Chestler notes, “The institutions of middle-class psychotherapy and marriage both encourage women to talk—often endlessly—rather than to act” (168). Here in the home, this transmission
seems to provide what the clinic cannot: an opportunity to reclaim one’s performative agency through action.

In her article “Marked by Memory: Feminist Reflections on Trauma and Transmission,” Marianne Hirsh explores the ways in which daughters understand and represent historical traumas experienced by their mothers. Hirsch specifically focuses on the work of two writers and visual artists in exploring their mother’s identities as Holocaust survivors. Hirsch writes, “For survivors of trauma, the gap between generations is the breach between a traumatic memory located in the body and the mediated knowledge of those who were born after” (71-2). Seeking to bridge this gap not only allows second-generation daughters to bear witness to their mother’s trauma, it also allows them to place themselves within this history.

While the memories of holocaust survivors and women defined by a history of madness stand as two separate and distinctly defined experiences that should not be confused or compared, Hirsch’s theory of Postmemory serves as an apt lens through which to examine the transmission of my own family narrative. Her emphasis on the daughter as the recipient of the transmission is of particular import, as it is the position in which I find myself. Hirsch writes,

> When the mother’s experiences are communicated through stories and images that can be narrativized, integrated—however uneasily—into a historically different present, they open up the possibility of a form of second-generation remembrance that is based on a more consciously and necessarily mediated form of identification. (76)

Here, Hirsh identifies two elements of Postmemory present in the narrative I have received as a second-generation daughter: stories and images that can be narrativized, and the narrative’s integration into a historically different present. The images of Aunt Alice that form the
cornerstone of this history, as well as Ida and to a lesser extent, my grandmother and mother, have been shared in the form of oral narratives that have been cultivated and revised through multiple tellings. Furthermore, the stories take place, in the case of Aunt Alice and Ida, in a distinctly inaccessible and unarchived past. Joseph Roach observes in *The Cities of the Dead* that memory is as much a forgetting as it is a remembering (xi). Hirsch notes that in some cases “the mark of memory gets erased to make space so that—generations later—it may again be found and re-adopted across lines of difference” (89). It is through this erasure that the present Nutter women are able to gain a critical distance from the initial acts of trauma committed against our early great-mothers so that we may better understand our own identities through our understanding of theirs. Furthermore, erased from the telling is an implicit “and every Nutter woman before her; every Nutter woman after,” that connects the generations through a common experience of the silenced other.

As the recipient of this Postmemorial narrative, I am presented with a representative history that has been shaped by the women in my family entrusted with its transmission. Hirsh writes, “Postmemory is a powerful form of memory precisely because its connection to its object or source is mediated not through repetition or reenactment but through previous representations that themselves become the objects of projection and recreation” (76). While my mother may not have known my Aunt Alice or grandmother Ida, she is responsible for representing them to me, her daughter, just as her mother was responsible for representing them to her. In addition to giving a faithful rendition of their lives (or as faithful a rendition as possible, given the absence of a clear archive), my mother is also tasked with shaping the narrative in order to best communicate it to me as her daughter, a right only mothers can claim in the transmission process. It is in this act of representing the narrative in context that allows for the narrative itself
to gain traction and influence my understanding of self in the present day. It is not enough for me
to know that Aunt Alice had the eye. I as my mother’s daughter must know that I too hold the
same eye within me. Thus, with each retelling, these women are recreated and reperformed,
always to remind us of who we are as Nutter women, but always represented in a slightly
different context, for a slightly different need.

The value of this Postmemorial narrative cannot be underestimated, as it provides an
invaluable inoculation against the subjugating dialogue of the clinic and neurotypical culture writ
large. While I have grown up well aware of the clinical and cultural constructions of the witch
and madwoman, I have also known a space apart in which these women might be embraced as
heroes and visionaries, owing to their ostracization. I came to value separateness in certain
circumstances, bolstered by the recognition that not all popular opinions were
desirable, and not all madwomen mad. This realization became particularly important in the years following my
diagnosis, when I felt most severed from the social fabric. Furthermore, the narrative’s
Postmemorial function also provides a critical distance which guards against overidentification.
Hirsh writes,

Postmemory is defined through an identification with the victim or witness of
trauma, modulated by an admission of an unbridgeable distance separating the
participant from the one born after… Postmemory thus would be retrospective
witnessing by adoption… This form of identification means the ability to say, “It
could have been me; it was me, also,” and, at the same time, categorically, “but it
was not me.” (76)

Because the events recounted to me happened so far in the past, I was able to identify with the
struggles of my predecessors without taking on their full weight. The radical difference in our
circumstances meant that the stories could not easily be superimposed onto my own. I am neither a fifteenth century landed Englishwoman or a turn-of-the-century Native American woman. But their stories did allow me to contextualize my present. I was not afraid of the dancing lights when I was a child in part because I knew there was nothing to fear. I was simply participating in an event countless unnamed others before me had experienced. Even in the face of night terrors and a murderous old woman, I took some comfort in the fact that the very survival of our family line bore witness to the tenacity of the women in my family, and I allied myself with their strength. As I grew older, I also reflected on the injustices of their subjugation. If I felt mistreated as a patient or shunned by my peers, I wondered, “Is this how Aunt Alice felt?” Or I might think to myself, “Ida must have felt fundamentally different too.” While such thoughts never muted the pain of these moments, it did mean that I did not have to experience them alone. I simply had to remember who I was. I had to remember our name.

UNTITLED 3

My great-grandmother passed away last week, my mother’s mother’s mother. I suppose the condensed nature of my family has been a blessing, as I, at the advanced age of twenty-four have made it the farthest in years without having a child, while the short span between parent-child/parent-child/parent-child has routinely rendered five generations of Nutters living together. Now there are four generations of our family living, three generations living in my direct line. I feel strangely peaceful about her passing, despite the fact that she is the first family member I have lost in my lifetime. Even here, I am afforded some critical distance, be it through the distance of miles that separated us, the distance of time since I had last seen her, the distance of generations that often resulted in quiet visits, or perhaps most cruelly, the distance echoed in a
gaze plagued by a plaque of forgetting: Alzheimer’s. But perhaps I take the most comfort in my own knowing.

*My mother called me Sunday morning to say my great-grandmother had passed away. My mother was not upset. My mother said she knew the night before—Sunday was the day, the day my great-grandmother would pass.*

*My mother called me Sunday morning to say my great-grandmother had passed away. My mother assured me that my grandmother was not upset. My mother said my grandmother knew the night before—Sunday was the day, the day my great-grandmother would pass.*

*Saturday night I laid my head on my pillow, ready to go to sleep. Closing my eyes, I thought, tomorrow is the day....*

I know very little of my great-grandmother, and her place in our family story. I do know that she frequently told my mom, who frequently inquired about the family, “You’d better be careful what you go looking for. You just might find it”. Was she speaking of the Eye? I cannot say.

Both my mother and grandmother (via my mother) asked me to not come to the funeral. From what I gathered, they feared the emotional outbursts that might occur amongst the family, though I harbor suspicions they don’t want me to see their grieving. Even as bipolar women, I have rarely seen my mother cry. We each retreat to our caves. We each stand guard for one another. But we do not penetrate that sacred space. It is not for others to know.

**LONGING FOR REMEMORY: withholdings**

There is a significant distinction between the stories my mother and grandmother have told me about Aunt Alice and Ida, and the larger narrative of madwomen that emerges. Both my mother and grandmother have offered their own stories as proof of the unbroken line, however, their stories fall into two categories: stories that implicitly invoke the matrilineal line in order to
verify the presence of the eye, and stories of their experiences of mania, depression, anxiety, and other states that might better be understood as bipolar.

The first, stories that implicitly invoke the matrilineal line in order to verify the presence of the eye, attempts to function as Postmemory by positioning these present day narratives as operating outside of time, free from its governance. Stories of my grandma’s number dreams or my mother’s “feelings” do occur in particular time-bound contexts. However, they are presented as repeated performances. Thus, the presence of one dream evokes not only that single dream, but also a lifetime of dreams, and by extension, a centuries-old history of special dreams and dreamers, touched with the same gift as the Biblical Joseph, albeit lacking a colorful coat. Through a refusal to understand and transmit this aspect of the narrative in linear time, the present experiences of my grandmother and mother are granted a similar critical distance as stories of my Aunt Alice and Ida, inserting a similar unbridgeable distance of time. This method of transmission also incorporates Hirsch’s “It could have been me; it was me, also, but it was not me,” by positioning the performance as one that is experienced both in the present as an individual, but also creates reverberations that move through the past and future, connecting all Nutter women in a transcendent act of communion.

While all three of us are more than willing to share the more sensational aspects of our heritage, discussions of our identities as bipolar women are few and far between. Our shared silence is in part due to the lack of critical distance available in such discussions, as each of us is arguably always somewhere on the mania/depression spectrum, and thus moods are not so much memories as present realities or potential threats. The ongoing present reality of bipolarity limits the possibility for Postmemorial transmission. In the absence of a documented archive to transmit, our shared identity as bipolar women functions solely through our in-home
performance of the clinical script: the scheduling of doctors visits, the daily taking of medication, the paying of one’s bills. We do these in full view of each other, driving each other to appointments, sharing medication when prescriptions are forgotten in now-closed pharmacies, and placing our doctor’s bills on the respective patriarch’s desk. It is this repetition and reenactment that typifies the transmission of our bipolar identities. However, there is also a degree of intentional silence. Hirsch writes,

> The implication, on the one hand, that interest and empathy are heightened within the matrilineal family in particular, and the articulation, on the other, of the “historical withholding” that intervenes even between mothers and daughters, make…for the contradictions that define the intergenerational transmission of trauma. (73)

It is this same silence that marks the absence of any shared articulations of our individual experiences of bipolarity—the dual terrifying realities of mania and depression. At a later point in her essay, Hirsch asks how the traumatic mark can be transmitted and received without the violent self-wounding of transposition (76). Her response is achieved, in part, through the critical distance achieved through Postmemory. However, since a Postmemorial representation is not possible in this particular instance, the space is marked by a “historical withholding” that functions as a safeguard against this wounding. Here, I use the term “historical withholding” not to mean a withholding of facts comprising a larger social history, but rather my grandmother and mother’s own withholding of their histories with bipolar disorder. I have a family history of “touched” women. But I know nothing about the way the disorder affects their day-to-day lives. Well aware of the felicitous performative that is the term “bipolar,” I suspect that this withholding is largely driven by a desire to do no harm to the daughter as recipient.
And yet, on my more selfish days, I cannot help but mourn this silence. While the transmission of our family narrative has given me a separate “semiotic fund” through which to understand myself in the context of the home, this narrative functions on a more abstract plane and is of little help in navigating the more tumultuous elements of a bipolar diagnosis. I know that I am not alone in my feeling “other,” however, when mired in a manic episode or doubled over in a panic attack, I have little with which to identify. I long to know the nuances of my mother’s pain. Does she feel like she can’t breathe too? Does she feel like her bones are fracturing too? Does she feel like she could cry for days too? In these darker matters, I remain respectfully silent. While I look in the mirror and see only my father, I desperately search her body for signs of my own somatic experiences of mania, depression, and anxiety. My whole life I have born witness to her moods—the never-ending migraines on the couch. But even so, I know little of her subjective experience. My disorder and I are born of my mother’s body. How can I fully know my disorder and myself if I do not know her disorder? If her bipolar body is withheld, in whose body do I moor my own bipolarity. It is too much for my singular body to hold. And so, I fantasize about what Hirsh refers to as rememory, the process of remembering another’s trauma as though it were one’s own. She writes, “Rememory is the same for the one who was there and the one who was never there” (74). In Hirsch’s view, rememory happens through the retelling. The stories of my forebears focus on the gifts of their alterity. But they tell me nothing of the particular experience that is bipolarity. Not even my grandmother or mother speak of such things. And so, I cannot experience any rememory of their bipolarity. Despite the conceited remarks of my elementary school self declaring that I will never be that, it is clear I have that within me, and if I can uncover the truth of how that works in her, perhaps I wouldn’t
have to carry the whole of *that* alone. Maybe even if I (re)remembered *that* enough, I could learn how to fix myself, to be bipolar no more, and only the eye of our great-mothers would remain.

But perhaps I have learned more through my mother’s withholding than had she given me the rememory I so desire. What little I do know is precious, and it has taught me to receive their sharing with a deep sense of reverence. It has taught me that while it is not spoken of often, one’s own experiences with bipolar disorder are worth speaking about with great care. And it has taught me to respect their stories without appropriating them. As Hirsch writes:

…the second-generation daughter can *hold* the memory with which she has been entrusted, because she can respect and perpetuate her parents act of historical *withholding*. And, at the same time, she can acknowledge the inevitability of her own act of violation that emerges from the lack of *recognition* that marks the relationship of survivors to their children. (83)

My grandmother and mother—they are survivors. They made it through most of their life without any medication; they were left to weather the storm of bipolarity alone. As I was diagnosed at thirteen in 2005, theirs is an experience I cannot recognize. I respect their withholding because it reminds me that it is through their acts in the home that I am able to speak. And I too participate in that withholding. There are aspects of my bipolarity that I will not share outside the home. There are aspects of my bipolarity that I will not share. It is in this ability to decide for myself not only to speak, but also to withhold, that I find healing in the act of transmission. Transmission is, in some small sense, the ability to shape and name one’s own story. My daughter will grow up hearing about Aunt Alice and her great-great-great-grandma Ida. She will hear stories about her great-grandma’s number dreams, her grandmother’s feelings, her mother’s dates. I will take it as my sacred duty to tease her about the evil eye until
she’s embarrassed. I will tell her the stories. I will tell her about my bipolarity. I will tell her some things. I will withhold others. I will hold her when she cries and feels hopelessly “other.” I will cheer her on in the midnight hours as she celebrates and feels wonderfully “other.” I will talk. I will listen. I will remember. I will perform.

I am my mother’s daughter.
NO. 4: THE STAGE

PSA NUMBER TWO

I regret to inform you that I must begin this chapter with a contradiction.

Having just completed the last chapter, you may be under the impression that I am perfectly at home at home—the one safe harbor from my maelstrom of moods and the critical gaze they incur. And you would be right. I miss my mother. I miss my grandmother. I miss women I have never met, but whose presence in my self-story ground me like the soles of my feet.

I miss my cave.

-BUT-

It is a cave still, and like the great philosopher, I know only shadow.

How many generations of women will my family see kept?

How long to wonder alone in the shelter of this wandering womb, laboring in fear of that which must be borne in pain?

How long to be pushed farther and farther into the background, behind patterns of delicate florals and yellow damask designed to distract from the papered-over truths of the women hidden beneath?

How long to celebrate together, only to dance alone cry alone die alone preferring radical musings untempered by material realities, each new girl child, an offering to the Father?

DAUGHTERS OF ALICE: WHERE IS YOUR POWER?

It is offered up in gold-leafed collection plates

“WOMEN SHOULD REMAIN SILENT IN THE CHURCHES. THEY ARE NOT ALLOWED TO SPEAK, BUT MUST BE IN SUBMISSION, AS THE LAW SAYS. IF THEY WANT TO INQUIRE ABOUT SOMETHING, THEY SHOULD ASK THEIR OWN HUSBANDS AT HOME; FOR IT IS DISGRACEFUL FOR A WOMAN TO SPEAK IN THE CHURCH. OR DID THE WORD OF GOD ORIGINATE WITH YOU? OR ARE YOU THE ONLY PEOPLE IT HAS REACHED? IF ANYONE THINKS THEY ARE A PROPHET OR OTHERWISE GIFTED BY THE SPIRIT, LET THEM ACKNOWLEDGE THAT WHAT I AM WRITING TO YOU IS THE LORD’S COMMAND.” (1 CORINTHIANS 14:34-7)

The high priest of the home holds court
"But I would have you know, that the head of every man is Christ; and the head of the woman is the man; and the head of Christ is God." (1 Corinthians 11:3)

And we, the broken women, punishment for an ancient unnamed sin.

I, the Lord your God, am a jealous God, punishing the children for the sin of the fathers to the third and fourth generation of those who hate me, but showing love to a thousand generations of those who love me and keep my commandments. (Exodus 20:5-6)

And so, the fear of separation:

wheat from chaff, wheat from chaff, wheat from chaff
Always watched. Always on guard.
(Do you think God is bipolar?)

Be bipolar, that’s fine. But keep it to yourself.

“Love the sinner, hate the sin”
Perform as we do, that’s fine, in worshipful lock-step.

wheat from chaff, wheat from chaff, wheat from chaff
My feet don’t move as yours do!
My arms don’t move as yours do!
My moods don’t move as yours do!
pulled pulled
pulled along
thrown
thrown
thrown about

wheat from chaff, wheat from chaff, wheat from chaff
chaff chaff chaff

I am not like my forbears. I cannot be at home in this place—a place that so ardently declares me chaff and imprisons me in my cave. And so I emerge, searching for a stage on which to tell my story:

“...it takes an unshakeable desire to be an actor together with a need to express what one has sense and felt in the concrete terms of the characters with whom one will identify on stage” (Hagen, XIII, emphasis in original).

I am bipolar—an identity bound up in performance itself.
I will not be silent.

I will perform.
AUGUST 2011: THE SWEETEST SWING

It was a terrible summer. I took a job as an intern at a small regional theatre, hoping to bolster my resume while sharpening my skills. I wasn’t taking my medicine, and although I didn’t realize it at the time, I was the most manic I had ever been. I drank (whiskey). I smoked (cigarettes). I [redacted]. I was in a bad place. The thought that my terrible summer might have been spurred on by near-psychotic mania never crossed my mind. I chalked the whole thing up to a hostile work environment and an embarrassing want to be a “grownup.” In the moment, I was unable to reflect, and without the critical gaze of a clinician, I was dangerously unaided. It is only in hindsight, separated from the experience by several years, that I am able to realize: I was manic. Why else would I fantasize about lying on the spinning table saw each day at three?

When I got back to school, I was eager to distance myself from that awful summer, and to regain control of my identity, and myself. I was still manic, but my anxiety softened, and I was able to channel that energy into more productive tasks. Happy to be back at a school that felt more home than my real home, I absorbed myself in work, preparing for pending auditions. Among the upcoming season was Rebecca Gillman’s The Sweetest Swing in Baseball. Imagine my surprise when I read the play’s description on the publisher’s website:

…an artist named Dana Fielding is suffering from a slump in both her career and her personal life. After a disastrous gallery showing, her paranoia and depression send her boyfriend packing. When Fielding attempts suicide, she lands in a mental ward and finds she enjoys the structure of the days. But when she learns her health insurance will pay for only a 10-day stay, she cooks up a scheme with two fellow patients to fool the doctors into believing she’s psychotic. (Dramatist Play Service)
Having attributed none of my summer woes to my bipolarity, I looked up from the notice overjoyed. “Finally,” I thought, “they have written a play about me.” I wanted that part. I wanted that part until my desire burned in my body. My desire burned in that way where if someone had asked me “Would you kill a person to get this part?” I probably would have paused just a little too long before saying, “No.” So when I did get the role, I was certain that the director had seen something special—a deeper understanding of Dana’s psychological turmoil, brought on by my intimate relationship with mental illness radiating from within. Funny how in all these years, I have only just now considered the fact that I might have gotten the role because I gave a good audition. But that’s how my bipolarity works. It tends to show up to cosign everything I do.

Even before I auditioned for the part, I had already developed an interest in identification through theatre, perhaps encouraged in part by a growing recognition of the disjuncture between the psychiatric and familial archives into which I had been hailed. The production also came at a busy time in my mental calendar. Most people who are diagnosed with bipolar disorder are diagnosed between ages 20-25, and while I had been diagnosed much earlier, the normal changes routinely occurring in brain functioning at that age meant that my brain chemistry was once again in flux. While still engaged in my usual routine of taking Pristiq on and off (mostly due to my inability to maintain a regular routine), I was additionally prescribed Adderall, as my physician suspected that I might have ADD as well. The rapid pace of my speech and untraceable leaps of logic my mind often takes in conversations seemed convincing enough, so he suggested we “try it and see what happens,” as though medication were a series of paint swatches one sticks on a wall for a week before redecorating.
The result was pure, unadulterated, euphoric mania. God I miss it. It still happens frequently, but not like that—all day, every day; full force. There was, of course, the terrible period at 5 p.m. every night where I became instantly mute and angry, as though someone flipped a switch. At that time, and I am not making this up, I would excuse myself to the cool wood floor of my dorm room, place four speakers in a circular fashion two inches from my ears, and blast Verdi’s Messa da Requiem: Sequenza Dies irae at full volume, on repeat for one hour. No, I did not have any roommates. (Side note: if you are ever interested in knowing what mania feels like, listen to Verdi.) After that, long hours until four in the morning, painting; writing; composing, all in the name of creativity. For a brief moment, it seemed as though I had recreated the cave of my home in my on-campus dorm room.

I cannot fault myself for this practice. The term “bipolar” is so bound up in shame and stigma; it is a rather unappealing identity to embrace, after all, one might never get a job, never get married, never have friends. The highs and lows of a bipolar performance are simply too uncouth to excuse. However, the term “artist” carries with it a certain appeal, particularly for a twenty-year-old woman who had been told for the last seven years her identity hinged on being “mentally ill.” The thought of being an artist seemed to justify the more awful aspects of my bipolarity, putting them in service to some higher good. And if I was truly an artist, perhaps my bipolar idiosyncrasies might be forgiven as fun markers of a creative mind. As I have noted, determining which performances are acceptable and which performances are psychotic relies on an examination of the contexts in which these performances occur. While the performances bear some resemblance, the contextual criteria for “mentally ill” and “artist” have somewhat different standards. They are, of course, not mutually exclusive. But they are met with very different
consequences. Even now, four years later, the absolution offered by an artistic identity carries with it some appeal.

The role carried with it several challenges. As the back of the playscript reads, “Holed up in a psychiatric hospital, she’s [Dana’s] looking for help. It comes, not from her insurance company, but from some unlikely friends and the inspirational swing of baseball legend Darryl Strawberry” (Faber and Faber). The “inspiration” Dana receives does not come in the form of introspective revelation, but rather through her impersonation of Strawberry himself. Her decision to take on the identity of the famed baseball player comes when Dr. Gilbert, a psychiatrist at the hospital, informs her that her insurance will only pay for a ten-day stay:

DANA You’re going to kick me out, aren’t you?
GILBERT What?
DANA I heard my insurance will only pay for ten days.
GILBERT It depends on your progress…
DANA I’m self-employed. My insurance is the cheapest one. Golden Rule. I think it only covers if I get hit by a bus.
GILBERT (small beat) Then we’ll continue therapy on an outpatient basis, if we have to. We’re here to help you for as long as you need help.
DANA But it’d go a lot faster if I went on the drugs.
GILBERT I’m not implying that.
DANA You know, the thing about those stupid drugs is if I take them, that makes me the problem. But I’m not the problem.
GILBERT It was only a suggestion—
DANA I’m not trying to kill anybody or hurt anybody. I’m just trying to paint. (Gillman, 33).

Dana’s conundrum is painful, pervasive, and one that I can, in my own way, relate to. Feeling safe in the care of the clinic, Dana is aware that her insurance will soon stop paying, and she will be thrust into the conditions that led to her stay. Her decision to imitate the famed baseball player Daryll Strawberry comes at the suggestion of a fellow patient, Gary, who is in the ward after attempting to kill Kevin Bridges, a man he believes is “the seat of all evil” (25). Gary advises:

GARY If you want to stay you have to have a major diagnosis. Depression won’t cut it.

DANA Like what?

GARY Paranoid schizophrenia. Multiple personality disorder. Manic depression. […] Trying to kill yourself. You just buy another ten days maybe. And unfortunately it’s a catch-22 situation. The fact that you want to stay means you like the safety of the place, which means you have a healthy sense of self-preservation, which means you’re not really suicidal, which means you’re ready to go home. (40-41)

Of her options, Dana chooses to perform multiple personality disorder in hopes of earning a longer stay. Her choice of Darryl Strawberry seems to come out of left field. As a male African-American athlete, Darryl is in many ways, the opposite of Dana. Even during rehearsals, playing Darryl scared me. I was afraid of offending or rendering a problematic performance. In her notes, Gillman offers some advice in tackling this challenge: “When Dana is being Darryl, she doesn’t
imitate him or try to talk like an African-American. Her language may be a little bit looser but she is essentially herself.”

While my anxiety in playing Darryl is certainly justifiable, I gave little consideration to playing Dana. Based on her identity as an artist and her suicide attempt, it seemed to me a given that Dana must be bipolar. When working on the piece, I gave little consideration to exploring and performing Dana’s mental health. Lee Strasberg, whose performance methods I had (unfortunately) encountered in the classroom, writes of a performer rehearsing *Hamlet*, “The actor does not act this monologue with the meaning that it may have in the immediate context of the play; rather he permits it to be affected by whatever sensations he is working on” (142-143).\(^1\) Similarly to Strasberg’s actor, I assumed that my own bipolarity was enough research, and my innate understanding of bipolarity would flow freely from me and subtly color the character without any effort on my part. Ultimately, I was naïve and unprepared to navigate the demands of performing mental health on stage.

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\(^1\) I write “unfortunately” due to the fact that I, like many, have found Strasberg’s methods to be abusive at best. For further critiques of Strasberg’s work, see Susan Burgoyne, Karen Poulin, and Ashley Rearden’s “The Impact of Acting on Student Actors,” and Rosemary Malague’s *An Actress Prepares: Women and ‘the Method.’* Here, I also note that accusations that Strasberg’s methods are psychologically damaging and akin to unlicensed therapy, while potentially harmful to any student, are particularly dangerous when working with students who are not neurotypical and, given the pervasive nature of shame, are unlikely to self-identify. Victoria Ann Lewis’ “Disability and Access: A Manifesto for Actor Training” and Carrie Sandahl’s “The Tyranny of Neutral: Disability and Actor Training” address physical disability in the acting classroom, however a diverse study of non-neurotypical acting students has yet to be conducted and is a hoped-for area of exploration in my continuing research.
DANA AND GARY

DANA

You know, the thing about those stupid drugs is if I take them, that makes me the problem. But I’m not the problem. (33)

I am not taking my medicine. I am not drugging myself because you are INCONVENIENCED by the way I am.

FORGIVE me for IMPOSING my FEELINGS on you. Why don’t you just take me to an orphanage and drop me off, if you want another kid. Or perhaps take me on Dr. Phill and SOMEONE ELSE CAN DO THE DISHES.

GARY

The fact that you want to stay means you like the safety of the place, which means you have a healthy sense of self-preservation, which means you’re not really suicidal, which means you’re ready to go home. (40-41)

I love home. Home is my happy place. Home is where the cave is. At home, I have no obligations, save church. At home, I can stay up all night and sleep all day. At home, I can be bipolar, and the world won’t know. I like the safety of the place. I like my cave.

A AND A’: PERFORMING BIPOLARITY

Oftentimes, throughout the course of rehearsal and performance, I identified with Dana’s words as if they were my own. Most of the time, these points of contact occurred in scenes where Dana was with one of her therapists, Dr. Gilbert and Dr. Stanton. Dr. Gilbert, who initially treats Dana and somewhat dismisses her depression and suicide attempt. Her approach is often pragmatic, which Dana finds frustrating, and perhaps even hurtful:
GILBERT    I think for the rest of this session, we should focus on what’s going
to happen when you leave tomorrow. These are simply strategies
for getting through your days, at first.

DANA      Okay.

GILBERT    Now, how long to you think it will take you to find a new place?

DANA      I don’t know. But Erica said I could stay with her if I didn’t want
to go home.

GILBERT    Well it would be better if you didn’t stay with Erica for too long,
simply because we want to get you into a normal routine.

DANA      Can I use the routine I have here? Because before I just slept. And
ate toast. And went crazy.

GILBERT    It’s not a given that you’ll go back to that.

DANA      You’re right. I probably won’t sleep. Or eat. (46)

Dana and Dr. Gilbert’s relationship is positioned as combative. Conversely, Dr. Stanton, head of
the unit, is patient with Dana, indulging her performance of multiple personality disorder. Here,
Dana is attempting to impersonate Darryl Strawberry:

STANTON   Are you afraid you’ll hurt yourself if you leave?

DANA      I might…do some drugs. And hurt myself. Like that.

STANTON   What do you think the chances are? That you might hurt yourself?

DANA      (thinks) Four and a half?

STANTON   Well, that’s better than five. […] This is a radical question, I know,
but have you ever considered another line of work?
DANA    Every day.

STANTON  And?

DANA    See, the thing is this: I love what I do. Or I did love what I do. But
it got ruined for me. And now I hate it. (53)

I have had good experiences in with doctors. I have had bad experiences in with doctors.
I have, after all, seen a lot of doctors. And while I drew on that experience throughout the course
of rehearsals and performance, I did have one condition: no one knew that I was bipolar, and I
intended to keep it that way. While I myself might draw on that experience in creating the part, I
felt safe in the mimetic mask of character. Here, I rely on Eric Bentley’s description of theatrical
performance, which he formulates as the following: A impersonates B while C looks on: A being
the performer, B being the character, and C being the audience (159). In the case of my work on
The Sweetest Swing in Baseball, the line between A and B becomes a bit murky. Marvin
Carlson’s observation that A, B, and C are more often groups than individuals makes this clearer
(59). If I as A am a psychiatric patient, play B who is also a psychiatric patient, the border
between the two starts to collapse. Noting the elements of self every actor brings to a role,
Carlson revises Bentley’s statement to read A impersonates A’ while C looks on. In essence, the
actor is playing an element of her or himself when creating a character. It is the assumption of
A’—that I am not what I play—that allowed me to take on the role. Yes, I was interested in the
piece because I felt a personal connection to the role through shared pathology, but I worked safe
in the knowledge that the persona I created, however close to “me” I managed to make it, would
decidedly be read as “not me.” As the audience was not privy to my diagnosis, I assumed any
aspect of the part that benefited from my experience as a patient might simply be thought of as
good acting.
Perhaps this intense concern with passing—avoiding a hail into my spoiled identity—should have been of greater concern, if only for my own safety as a performer. But it also indicated that I was not embarking on this task alone. I was accompanied by my disorder and even if no one else knew, my own awareness of the tensions between A and A’ were enough to affect my performance.

GILBERT AND STANTON

GILBERT     I think for the rest of this session, we should focus on what’s going to happen when you leave tomorrow. These are simply strategies for getting through your days, at first.

DR. X       In addition to your medication, we need to develop coping strategies for handling your anxiety. So, next time we might say that your bipolar is a person. And this person is sitting in this chair. And you can talk to your bipolar, and tell it how you feel.

DANA        Okay.

ALEXIS      Whatever. This is a waste of my time.

GILBERT     Now, how long to you think it will take you to find a new place?

DR. X       Now, when do you think you can come in again?

DANA        I don’t know. But Erica said I could stay with her if I didn’t want to go home.

ALEXIS      I don’t know. I’m seeing a psychiatrist, so that’s probably okay.

GILBERT     Well it would be better if you didn’t stay with Erica for too long, simply because we want to get you into a normal routine.

DR. X       Well, we don’t just want you to see a psychiatrist. You need to develop a habit of coming to counseling too.

DANA        Can I use the routine I have here? Because before I just slept. And ate toast. And went crazy.

ALEXIS      Can I just see a psychiatrist? Every time I see a counselor, I feel stupid. And broken. And crazy.

GILBERT     It’s not a given that you’ll go back to that.

DR. X       That’s not what we do here.

DANA        You’re right. I probably won’t sleep. Or eat. (46)

ALEXIS      …
ALEXISDANA sits onstage on beanbag, far right. DRGILBERTX sits on the couch, adjacent. ALEXISDANA rolls her eyes, employing a level of snark ALEXIS is often too polite to exhibit. ALEXISDANA sits with her legs open and arms crossed, a defensive “come at me” stance that ALEXIS has been conditioned to avoid. ALEXISDANA frequently cuts DRGILBERTX off, inserting heavy sighs to claim vocal space, an act ALEXIS would never dream of doing. And yet, encapsulated in this moment is every performative gesture ALEXIS has wanted to hurl at DR. X, despite the fact that these acts are being performed by ALEXISDANA in the ANNIERUSSELLTHEATREPSYCHWARD.

STANTON Are you afraid you’ll hurt yourself if you leave?  
DR. C Are you okay? Do you want me to stay with you?  
DANA I might…do some drugs. And hurt myself. Like that.  
ALEXIS I’m scared.  
STANTON What do you think the chances are? That you might hurt yourself?  
DR. C How soon do you think it will be until your mom gets there?  
DANA (thinks) Four and a half?  
ALEXIS In about ten minutes.  
STANTON Well, that’s better than five. […] This is a radical question, I know, but have you ever considered another line of work?  
DR. C Okay, that’s good. Are you in a safe space?  
DANA Every day.  
ALEXIS Yes.  
STANTON And?  
DR. C Good.  
DANA See, the thing is this: I love what I do. Or I did love what I do. But it got ruined for me. And now I hate it.  
ALEXIS I’m bipolar. And I’m having an episode. And I can’t come to class. And I can’t come to rehearsal.  

DANAALEXIS is seated down right in a hard wooden chair, assuming her Darryl Strawberry Stance. She is “manspreading” appropriately, occasionally leaning in and out while freely taking up space. Despite the fear DANAALEXIS feels throughout the exchange, DANAALEXIS feels a sense of warmth and comfort from DRCSTANTON, a perceived understanding that reminds ALEXIS of her mother. DANAALEXIS is relaxed and at ease. One might even say ALEXIS feels safe.
As rehearsals continued, I began to feel more secure in my performance of Dana, and my performance of self. Fears of being discovered and hailed as bipolar subsided as I felt the growing support of my director and peers. However, as many theatre practitioners know well, one cannot anticipate audience response, and how the very presence of an audience might impact the performance writ large. And there is, of course, the sudden addition of material elements to the performance—the costumes, props, lights, set, and sound that create the world of the play.

It was during one performance that I first felt a crack in my character. Yes, I had certainly been aware of how my own experiences influenced my performance of Dana, but I paid little attention to them. Relying on Stanislavsky’s oft-debated notion of “experiencing,” I understood my practice as Strasberg describes it: “The actor is at once the piano and the pianist” (59). While the moments in which my own experience as a bipolar woman bubbled up during performance, I took little notice and attempted to allow those moments to permeate my character. This time was different. Wherein the past I was in control of these emotions, here, I seemed to be a spectator to them.

Gillman’s notes in the script advise, “Set and costumes should be very minimal. Dana can wear the same costume for the entire play (black slacks and a white T-shirt) and it can be dressed up or down with accessories. She can make her changes on stage at scenery changes.” Our production maximized the potential, using the scene changes to not only perform my costume changes, but also stage specific moments of interaction between Dana and other characters. Oftentimes, these transitions were more abstract and silent. At other points, characters might repeat a line of dialogue said earlier. But in each transition, the lights would shift to an eerie
purple-green as characters played out Dana’s fears and desires. Each transition provided a material representation of Dana’s mind—and everything in it.

In the first of these transitions, the location shifts from the art gallery showing to the Psych Ward. At the beginning of the transition, the lights shifted and a sound similar to a sharp wind filled the stage as I (Dana) turned to face upstage. Two actors, men, walked up to me and began moving my body and taking my jacket off as one actress placed new shoes at my feet, taking the jacket offstage. The two actors sharply lifted my arms in tandem, straight up. I always braced for this part as one of the actors, much taller than I, always seemed to overestimate the length of my arm, thus threatening to pull it from its socket. On each wrist, they slipped a white pre-made bandage, quickly returned my arms to their original position, and walked off. From here, I walked squarely up to a table upstage. And yet, in this moment, I felt woozy, as if I might pass out. I lumbered to the table, certain that I appeared drunk in my movements. I looked at the bandages on my wrist and realized: suicide. This show talks about suicide. I often think about suicide. I am often suicidal. I began to feel a gaping fissure as Alexis threatened to pour out of Dana. As I looked down at the bandages, they appeared to me as handcuffs, chaining me to a lifelong prognosis of pre-mortem struggle. Soon, other characters began to walk onstage. I quickly snapped out of it and grabbed the play dough in front of me, rolling it in my unbloodied hands. The show went on.

Several nights later, I felt the breech again, but this time it was much worse. Whereas before I encountered an external image, here, I was wholly consumed by my own inner-life. Standing alone on the extreme downstage corner of the apron, I as Dana looked out into the darkness and said,

DANA With those tiles, those little octagonal tiles. They’re so hard not to
stare at. I kind of got obsessed with them. But not in a good way. 

(Laughs.) There’s that crack along the floor where the tiles to the left are slightly higher than the walls on the right? From there, I tried to count all the tiles, but the rows are hard to keep straight and after a while, they kind of blurred together and I stopped seeing the grout. Just these octagons, fitting up against all these other octagons. I had this feeling, like, if one of the octagons could get free… If it could just get away from the other octagons everything would be okay, but… (Laughs again.) And then I thought, I’m lying on the bathroom floor. I don’t know how I got there. (Beat.) When you step out of the shower? It’s very cold. (39)

I hated that monologue. In truth, I hate any monologue that tends to tilt introspective, but this one was much worse. I didn’t want to talk about suicide, not explicitly. At least with the bandages it was implied, marked on my body, but not performed through my body. Still, I always managed to get through the monologue without any emotional investment. I performed emotional investment—as the audience expected. But that night, as I stood staring into the black nothingness that was myself, I heard myself speak: “It’s a very cold floor. When you step out of the shower? It’s very cold.” And I was there, head on the floor, the cool tile of my bathroom, not Dana’s bathroom, Alexis’ bathroom, bubbling in a river that covered red my red hair. Not a true memory, but a statistical possibility; a fantasy; a fear. I was spooked. I pulled back.

I remember this night very clearly, but I remember it in my body, not my mind. There was something about the word “cool,” that tingled up my face, the burning frustration I could feel in talking about the misaligned tiles on the floor, and that familiar, inarticulable experience
of feeling trapped, crushed, small, unable to leave but unable to stay… of drifting further and further down. It was a somatic experience, and for a woman who has intentionally stylized her performance in everyday life in such a way that banishes any and all awareness of bodily feeling, I was completely caught off guard.

Suddenly, I was aware of the audience. While my position on stage was designed to communicate Dana’s isolation, I as the performer quickly felt the hundred or so eyes that were witnessing this experience. I was certain that I would throw up right then and there. I felt as though my deepest fears had become reality, that my body had been bifurcated and my insides strewn about for all the world to see. In this moment, my awful secret was revealed, that I am a body, and a bipolar body at that. I felt as though I was an exotic exhibit of some sort, a human zoo, and to make matters worse, I was my own curator.

Surely the audience knew of my secret. They had witnessed it all—the monologue, my immersion, and the shocking effect brought to bear through my performance. Certainly the audience had noticed the stark shift from Dana to Alexis. I feared the whispers that would follow: “Did you see that? It was too accurate. She must be crazy too.” “What happened during that monologue? She looked as if she’d seen a ghost.” But no whispers came. In hindsight, the entire moment probably lasted no more than a few seconds, hardly noticeable to anyone viewing the piece. Even so, I was shaken up, having come face to face with my disorder in a moment where I lacked complete control. Despite the many rehearsals I had invested in, my mask was crumbling. I worried that I could not maintain the passing I had worked so hard to construct. Moreover, I feared I might lose control and accidentally hail myself.
I finished the run without incident, however, I remember very little of that particular performance following the monologue. But I do remember the awful sinking feeling as I walked out the stage door after the show, ashamed that I had lost control and dishonored my craft.

UNTITLED 4

“It’s a very cold floor. When you step out of the shower? It’s very cold.”

I want to go home I want to go home I want to go home

Everything is yellow. I can’t breathe yellow. Hours hours hours minutes minutes minutes seconds seconds seconds milliseconds milliseconds milliseconds and everything getting smaller. But the universe is expanding at an accelerating rate. I am expanding at an accelerating rate. Where are my walls?

1, 2.

1, 1.5, 2.

1, 1.25, 1.5, 1.75, 2.

1, 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 2.

1, 1.05, 1.1, 1.15, 1.2, 1.25, 1.3, 1.35, 1.4, 1.45, 1.5, 1.55, 1.6, 1.65, 1.7, 1.75, 1.8, 1.85, 1.9, 1.95, 2

1, 1.025, 1.05, 1.075, 1.1, 1.125, 1.15, 1.175, 1.2, 1.225, 1.25, 1.275, 1.3, 1.325, 1.35, 1.375, 1.4, 1.425, 1.45, 1.475, 1.5, 1.525, 1.55, 1.575, 1.6, 1.625, 1.65, 1.675, 1.7, 1.725, 1.75, 1.775, 1.8, 1.825, 1.85, 1.875, 1.9, 1.925, 1.95, 1.975, 2

1, 1.01, 1.02, 1.03, 1.04, 1.05, 1.06, 1.07, 1.08, 1.09, 1.1, 1.11, 1.12, 1.13, 1.14, 1.15, 1.16, 1.17, 1.18, 1.19, 1.2, 1.21, 1.23, 1.24, 1.25, 1.26, 1.27, 1.28, 1.29, 1.3, 1.31, 1.32, 1.33, 1.34, 1.35, 1.36, 1.37, 1.38, 1.39, 1.4, 1.41, 1.42, 1.43, 1.44, 1.45, 1.46, 1.47, 1.48, 1.49, 1.5, 1.51, 1.52, 1.53, 1.54, 1.55, 1.56, 1.57, 1.58, 1.59, 1.6, 1.61, 1.62, 1.63, 1.64, 1.65, 1.66, 1.67, 1.68, 1.69, 1.7, 1.71, 1.72, 1.73, 1.74, 1.75, 1.76, 1.77, 1.78, 1.79, 1.8, 1.81, 1.82, 1.83, 1.84, 1.85, 1.86, 1.87, 1.88, 1.89, 1.9, 1.91, 1.92, 1.93, 1.94, 1.95, 1.96, 1.97, 1.98, 1.99, 2

I can’t. I can’t count from 1 to 2. The distance is too great for me to cross.

I don’t know the difference anymore. I don’t know the difference anymore. I don’t know the difference between 1 and 2.

Water

Water

Water

Water
I have puzzled over Dana’s monologue for years, wondering how such a strong somatic image managed to overtake my performance. Here, I return to Carlson’s formulation of performance: A performs A’ while C looks on. As I have noted, in this case, A and A’—myself and the role—had a great deal in common. As Alison Hodge notes in her introduction to *Actor Training*, debates between work on the self and work on the role have been ongoing in discussions of acting theory since before the time of Stanislavsky. Some practitioners, such as Stanislavsky, Adler, and to a lesser degree, Hagen, have emphasized using the self in order to better understand the character. In this paradigm, the distance between A and A’ is greater, with teachers like Adler encouraging students to focus not just on the similarities, but also the differences between self and role. Other practitioners, believing that one’s human experiences are enough to fill any role, emphasize work on the self over work on the role, oftentimes unifying A and A’. However, in this particular scene, it seems like I had little control in mediating this identification. Here I experienced a clear instance where I sought to distance myself from the character, and yet, the similarities seemed to override my intent.

*I want to go home I want to go home I want to go home*
This confluence between A and A’ is particularly concerning when considering performer’s mental health, as the potential that this protective barrier between performer and character may cause harm to the actor. Any performance depicting patients living with mental health concerns must, either intentionally or by consequence, interact with the expected clinical script. The engagement of extratheatrical narratives is not unique to performances depicting psychosis, but is rather an interpretive device in performance writ large. In *The Haunted Stage*, Marvin Carlson explains this process through his theory of ghosting—the multilayered process of meaning making through memory. He writes:

> The primary tools for audiences confronted with new paintings, pieces of music, books, or pieces of theatre are previous examples of these various arts they have experienced. An audience member, bombarded with a variety of stimuli, processes them by selectively applying reception strategies remembered from previous situations that seem congruent...If a work requires reception techniques outside those provided by an audience’s memory, then it falls outside the horizon of expectations, but more commonly it will operate, or can be made to operate, within that horizon, thus adding a new experiential memory for future use. (6)

Thus, each theatrical performance is ghosted by a host of experiential memories, culminating in a unique blend of individual and collective reception.

The performer is not immune to this ghosting, and I as a performer do not have the luxury of severing my patient-self from my psyche in theatrical performance. When the border between A and A’ is strong, the performer may experience personal memories evoked in performance. However, I believe that the larger this gap is, the performer is afforded more control over the kinds of memories that are evoked, and the volume with which they occur. Stella Adler
advocates for this strategy, writing, “Acting is largely based on the differences between characters” (66). When the border between A and A’ deteriorates, overidentification occurs, and the performer becomes more susceptible to a flooding of memories that may threaten to overtake the performance. A performer experiencing overidentification may choose to clam up and pull back, as I did when performing Dana. Alternatively, the force of these memories may be so great that the actor is unable to control the impact she/he has on the performance, and, conversely, the impact the performance has on the actor.

ALL ACTORS ARE LIARS

Curtain rises. ALEXIS stands center stage, facing up, a single spotlight on her. She is dressed in a black pantsuit with black slip-on shoes. Her hair is up. She stands holding a glass of champagne. A large office chair is placed down-right. There is a table upstage with art supplies and a lunch tray. She turns.

ALEXIS: This is not a real glass champagne. It is apple juice.
This is not a real palate of paint. It is all dried up.
This is not a real apple. It is Styrofoam.
This is not a real office. It is a set.
This is not a real sketchbook. It is a prop.
This is not a real story. It is made up.

I am not Dana. I am an actor.
I am not an artist. I am an actor.
I am not sick. I am an actor.

I am remade.

[Blackout.]
LES DEMOISELLES DE L'ÉTAGE

February 2012. I am sitting in a familiar seat in a familiar theatre, watching my college’s production of *Picasso at the Lapin Agile* by Steve Martin only a few months after my performance in *The Sweetest Swing in Baseball*. Having not been involved in the production process in any form—a rare occurrence—I wasn’t sure what to expect. I certainly wasn’t prepared to witness a performance that would hit so close to home. One scene in particular remains forever burnt into the folds of my mind, a quiet moment whose reverberations continue to fill me with awe. In the script, Martin writes,

*Picasso stands, thinks, then steps back. The Visitor gestures toward the painting. The painting changes into the full-sized, eight-foot-square painting of Picasso’s Les Demoiselles d’Avignon. Picasso and the Visitor stare at the painting in wonder. No one else, of course, sees it. Picasso turns away from the painting, entranced.*

Picasso (to himself): I could dream it forever and still not do it, but when the time comes for it to be done, God, I want to be ready for it, to be ready for the moment of convergence between the thing done and the doing of it, between the thing to be made and its maker. At that moment, I am speaking for everyone; I am dreaming for the billions yet to come; I am taking the part of us that cannot be understood by God, and letting it bleed from the wrist onto the canvas. And it can only be made, because I have felt these things: my lust, my greed, my hatred, my happiness. (He turns to the bar.) So this is what it’s like… To be there at the moment… The moment I leave blue behind. (71)
Despite the subject matter—an artist and his work—the moment resonated with my creative bipolar experience. For the past few months I had been struggling to articulate and more often, simply acknowledge my bipolar identity. Sitting in that audience, I experienced the depths of my own feelings spoken not by myself, but by another. While the character of Picasso was never named as “mentally ill” throughout the course of the play, his rendering in this production, and the script, seemed to fit the “mad artist” stereotype. As Charlotte Waddell wrote in her comprehensive review of creative mental health literature, *Creativity and Mental Illness: Is There a Link?*:

> There is a long history of associating creativity and mental illness in western European cultures, starting with Aristotle, who equated insanity with genius, and culminating in the “mad genius” controversy of the last 2 centuries. Many authors have described famous, creative individuals who reportedly had mental illnesses. Recent accounts in popular media have touted a link between creativity and various forms of mental illness… In summary, much recent psychiatric and popular literature has enthusiastically promoted an association between creativity and mental illness. (166)

Throughout the course of the performance, I saw clear bipolar markers: the verbose dexterity and grandiosity characteristic with mania, tempered by the quiet introspection and stillness characteristic of depression. I saw the character—a true artist—as a man who wrangled the woes of mental illness and channeled them into his art. Not only did I identify with his want to create; I also identified with what I perceived to be our shared symptoms.

But I did not hear my symptoms listed in clinical terms, I heard them expressed as wholly human: lust, greed, hatred, happiness, freely bleeding forth. Furthermore, I heard these things
expressed in their most noble form, not as a shameful marker, but as the harbingers of that most noble pursuit—art. In short, I saw not only myself, I also saw what I as a bipolar woman wanted to be. I identified. As Helene Cixous writes in *The Newly Born Woman*,

> One never reads except by identification. But what kind? When I say identification, I do not say loss of self. I become, I inhabit. I enter. Inhabiting someone at that moment I can feel myself traversed by that person’s initiatives and actions. (148)

And so, I was traversed. Here, however briefly, the theatre had become a sacred meeting place for me, my disorder, and the artist who I felt understood the dark underbelly of my bipolar self. I had searched in clinics, in classrooms, in family meetings, but it was here, on the stage, that I first glimpsed myself. I became. I inhabited. I entered.

Well, insomuch as I could. I must confess I was, as a female performer, deeply envious of my fellow classmate, the actor who had so gracefully portrayed Picasso. While I reveled in the performance, I did so with an implicit understanding that I would never get to utter those words—Picasso’s words—on any conventional stage. In keeping with this understanding, I never attempted to audition for the role. No director, teacher, or coach ever told me I could not play Picasso. But after years in the theatre, a woman learns. After all, casting calls are always divided into “male roles” and “female roles,” and Picasso was a male role. Despite the presence of Picasso’s women painted in nude on the back wall of the set, as far as the script was concerned, my female form could not voice the (invented) words of the master artist. My womanly curves could not make the semiotic leap from object to subject. Ellen Donkin writes:

> Theatre history is full of accounts of women in conflicts of various kinds…

> Gathered up and taken as a whole, they tell a larger story. One such story is this:
That in all areas of theatre, but particularly in performance, women have made repeated efforts to establish a point of view that is distinct from that of men. In performance these efforts usually took the form of subverting dramatic texts that failed to reflect the reality of women’s lives. Some of these attempts to subvert were conscious; many were not. In theoretical terms we can formulate as follows: *that the history of women’s performance is the history of a struggle for a subject, rather than an object position in representation.* (317, my emphasis)

Donkin’s observations cut straight to the politics of women’s representation in theatre. While I did not particularly find Picasso’s text to be gendered, the script demanded that it be received as such. For many years, the gendered nature of the text did not color my experience of the performance. As Jill Dolan notes in *The Feminist Spectator as Critic:*

> Finding her position compromised if she allows herself to identify with these women, the feminist spectator contemplates the option of participating in the narrative from the hero’s point of view. She empathizes with his romantic exploits, or his activities in a more public sphere, but has a nagging suspicion that she has become complicit in the objectification or erasure of her own gender class. (2)

I certainly lived my life identifying with male heroes, much preferring the cool leadership of Captain Jean-Luc Piccard to vapid singing of cartoon princesses the other girls my age preferred. I did so willingly, fully aware of my own identity choices, consciously crafting a self that was *not* prescribed by dominant culture. If there was a nagging suspicion of my own complicity in my mind, it was deeply repressed and far from my conscious experience. Why was I, for so long, unable to make that critical leap?
I suspect that I did not want to challenge the fleeting sense of *communitas* I had experienced in that performance.\(^2\) To recognize the power structures informing the gendered aspects of the piece might mean that the recognition I found there might also be constructed; might also be fraudulent. As Elin Diamond writes in her breathtaking essay, “The Violence of ‘We’: Politicizing Identification”,

Dramatic realism produces precisely those conditions that allow for the creation of a smugly self-identifying spectator/critic and the creation in the late nineteenth century of an aggressively bourgeois we… Not only does the spectator see and reproduce a real relation between sign and referent, she achieves through her identification a satisfying group identity…. (393)

I was not, and perhaps still am not, ready to abandon such a precious moment, not because I wish to identify with a male performer, but rather because I wish to identify with a character whose experience of mental health, and at times, creativity resonates with how I view my own.\(^3\) Here, in this performance, I had come to know a facet of myself for which I had long been searching for. And in that moment, I knew I was not alone. I sat entranced as “Picasso” spoke, taking part in a concentrated reverence that pervaded the audience. Few times in my life have I experienced such an active form of respect, the audience seemingly “throwing” support to the performer as he summated a most delicate peak.

And so, I sat in the audience and wondered: Picasso’s lust, greed, hatred, happiness; these

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\(^2\) Victor Turner defines “*communitas*” as “a moment when compatible people…experience a flash of lucid mutual understanding on the existential level, when they felt that all problems, not just their problems, could be resolved, whether emotional or cognitive, if only the group which is felt (in the first person) as ‘essentially us’ could sustain its intersubjective illumination?” (Turner 45).

\(^3\) Mental health and creativity are difficult for me to separate, as in my personal experience they always work (or don’t work) in tandem.
things created some of the greatest works of art in our century. As a bipolar woman and aspiring artist, what would come from my lust, my greed, my hatred, my happiness? What story would my stage tell?

In viewing that performance of *Picasso*, I couldn’t help but compare the radically different ways Picasso and Dana are positioned within their respective scripts. To this day, *Picasso* seems far more desirable a role. Regardless of his mental state, he is presented as a potent creative *tour de force*, painting the great masterpieces of his century while bedding women left and right. Dana, on the other hand, is on a downward spiral, having just given a terrible gallery showing after getting dumped by her boyfriend. Despite the fact that she is an artist, she is creatively impotent. I cannot help but note the phallocentric logic that surfaces when these texts are held in contrast. Throughout the script, Dana’s emotions range far and wide, to say nothing of her identity. From the deep void of the bathroom tiles, to impersonations of Darryl Strawberry, to jumping up and down on a couch imitating a chicken, her performance is a spectacle. One might even call it hysterical.

And yet, *The Sweetest Swing* continues to hold a special place in my heart. While Gillman at times presents potentially problematic gender and racial dynamics, the script itself is wholly built on an interrogation of the performance of mental health. I certainly encountered challenges while working on this production. Points of overwhelming confluence—where A and A’ intermingled—were jarring, and potentially dangerous. Similarly, after considering the script in light of the gendered nature of its presentation, I cannot help but note points of sharp dissonance that leave me wondering if I as a female performer playing a female artist might be read as an equally capable creator when compared to a male performer playing a male artist.
These points of overwhelming confluence and sharp dissonance represent two extreme poles that, like the forces of mania and depression in my everyday life, influenced my performance of mental health in *The Sweetest Swing*, as well as my understanding of self and disorder. The very presence of these two tensions served to draw my attention as a bipolar performer to the ways in which mental illness is constructed in context. While Dana’s initial episode occurs as a result of particular circumstances, throughout the course of the script, we see Dana intentionally craft and enact an alternate identity that meets the clinical expectations for a “mentally ill performance.” It is not the verifiable presence of multiple personality disorder that keeps Dana in the clinic. It is her *performance* of multiple personality disorder that keeps Dana in the clinic. Furthermore, her performance as Darryl Strawberry creates a semiotic disjunction that draws the audience’s attention to the absurdity of this construction, and the performative extremes the clinic at times demands.

In terms of my personal understanding of self and disorder, I was gifted with the rare opportunity to interact with my disorder in an active, material fashion. Bipolar disorder can be a frustrating diagnosis. Not only is the disorder unmarked, it has no material presence with which I might interact. I cannot see it. I cannot touch it. I cannot ask it to sit in a chair while I berate it. However, in this performance, I was able to engage in a material world ghosted by my own experience. In the moments of transition, I saw through Dana’s mind my mind, through her fears my fears, through her desires my desires. Through her dialogue, I rolled my eyes and sarcastically responded not only to Dr. Stanton, but also to every shaming “helpful” experience to which I’d ever been subjected. And I was able to frequently experience the support of caregivers past, as well as my peers. These encounters were not present in the script, but were the result of a friendly ghosting, the product of the consonance and dissonance of self and character.
held in tension. Thus, in my experience, the performance functioned as episteme, providing an opportunity for me to more deeply know my disorder and myself through performance (Taylor, xvi).

This process of knowing through performance has spilled over into other performances. While my work on *The Sweetest Swing* helped me to begin to recognize constructed performances of mental health, I have also found power in the very act of performing. In the clinic and the home, I often encounter moments where I as a bipolar woman feel unable to exercise agency in my own care, be it through my unintentional performance of bipolar mood states in everyday life, the clinical performance criticism I must undergo as a part of my care, or the nonconsensual relegation of my bipolar performance to isolated areas within my own home. Despite my best efforts, I am rarely in control of my own performance. The stage offers an opportunity to combat that lack of control, presenting the actor with the ability to craft a performance, to enact that performance with control and intent, and to expect her/his performance to be viewed based on its theatrical merit, free from the neurotypical assumptions that often imbue clinical performance criticism with a moral sting. At the very least, performance allows the patient to, in part, step into a new context, a new identity, and a new critical framework. Performance is, in many ways, the best treatment I’ve received thusfar.

I will close with one more anecdote from my time working on *The Sweetest Swing in Baseball*. The final scene always confused me. Dana, having successfully convinced everyone that she truly has multiple personality disorder, looks around a gallery room after everyone has left. She then says, “Fuckers,” and the curtain falls.

The word seemed so out of place, so out of context… it made no sense. I had been saying it as a throw away line all throughout rehearsal, mostly because I didn’t know what to do with it,
until one day, the director called me over and whispered in my ear, “Just turn, face the audience, and scream it at the top of your lungs.” I did. And it worked. It worked in that way that you don’t really understand; you just feel.

It’s been several years since I worked on that piece. It was only a few months ago that I think I figured that line out. Here’s a woman, having a hard time. Her boyfriend leaves her, her art gallery manager dumps her, she attempts suicide and is left alone in a mental ward with no one; she is completely alone. One psychiatrist tells her she’s fine; the other tells her she’s got issues. Her insurance runs out in a few days, and they’re going to kick her out. So she pretends to have a disorder so she can stay in the unit and continue to receive care. She had handfuls of friends before she went into the unit, and in the last scene, one by one they pass by, exchange awkward pleasantries, and then leave. It’s like the parable of the Good Samaritan, except the titular character never arrives.

But that’s what stigma does. It silences and disconnects. I suppose there are some situations wherein screaming the f-word in a theatre is an appropriate response. Perhaps then, slowly, through each restorative performance, I too can be there… To be there at the moment… The moment I leave blue behind…
I can count on one hand the number of times I have been to counseling.

The pattern is always the same. Mom makes me go. Mom gets the bill. Mom doesn’t want me to go any more.

Not that I want to go either. Counseling and I—we got off on the wrong foot.

I was thirteen. Mom took me to a child psychologist. I remember feeling incredibly awkward, incredibly judged, and for some reason, equally embarrassed for both the counselor and me. I don’t know if the doctor specialized in bipolar. I do know that her advice to “just stop panicking” whenever a panic attack should arise did not prove helpful.

My mom and I sat in the small, humid waiting room. She filled out the papers, as I was (and in many ways, still am) woefully ignorant of my medical history. Suddenly, to my surprise, she handed me the clipboard.

“It’s a confidentiality form. I’m not allowed to know anything you tell the counselor. But if you sign it, we can talk about...things... and I want you to sign it.”

I did not want to sign it. I didn’t want my mom knowing what I said. What if I wanted to talk about her? Everything in my body screamed no. I felt the hot breath stuck in my throat, that static-y feeling clinging up my face, the same feeling I got whenever I stifled a punch meant for my sister but characteristically lacked the resolve to throw it.

And then I felt guilty. She looked at me. I took the pen.

But I didn’t want to sign it.

Initially, I did not want to write this thesis—at least, not on this subject. I began graduate school thinking that I would write about theatrical improvisation and non-scripted performance, two subjects very close to my heart. I suppose I should have known better, that my bipolar specter would not let me ignore its presence so casually. I am like Alice, who in her adventures in Wonderland comes upon the Cheshire Cat:
“But I don't want to go among mad people,” Alice remarked.

“Oh, you can't help that,” said the Cat: “we're all mad here. I'm mad. You're mad.”

“How do you know I'm mad?” said Alice.

“You must be,” said the Cat, “or you wouldn't have come here.” (54)

And so I am. Like my thirteen-year-old self faced with a signature line on confidentiality form, I am reluctant to pick up the pen. Having surveyed the clinic, the home, and the stage, I have discovered much about my disorder and my self, as well as the performative elements that challenge and construct my bipolar identity. While I have wrestled with the stigma my bipolar performance often incurs, I have also found power in meeting that performance head on:

in challenging the felicitous performatives and binary logic that supports naturalized notions of neurotypicality,

in embracing the vocabulary gifted to me in the clinic as a means of participating in my own care,

in grounding myself in a supportive lineage that seeks to upend stigmatizing discourse,

in calling out the patriarchal control of my home that seeks to corral my performance of bipolarity into isolated spaces,

in uncovering the relationship between stereotypical portrayals of “mad artists” and
“hysterical women” present in the two theatrical texts I examined in parsing through the dangers of overidentification and ghosting in performances in celebrating my ability to embody a character and craft a performance, recovering a sense of my performative agency, and ultimately, embracing my bipolarity as an identity constantly in-flux, running the gamut from performativity to performance while ever haunting my person.

Here, I find no pat answers, only a pantheon of performative possibilities comingled in counterpoint. While the binary construct of selfsame and other that undergirds the neurotypical natural, the singular narrative of normative neurology proffered by this binary does not match the reality of my bipolar experience. In place of monophony, I find polyphony, sometimes harmonic, sometimes dissonant, but always moving to a sharply shifting tempo. And so, the question remains—how am I to navigate these various performative pulls that operate on my bipolar self?

In his essay, “Performing as a Moral Act: Notes on the Ethnography of Performance, ethnographer Dwight Conquergood elucidates the various tensions that operate when a performer attempts to engage in a performance of others. In order to render an empathetic representation of the other in performance, Conquergood stresses the importance of navigating these tensions with empathy and awareness. When a performer is able to successfully navigate these tensions, she/he creates an ethical performance of the other, one aimed at dialogue and understanding. Conquergood terms this position the “Dialogical Center” writing,
One path to genuine understanding of others, and out of this moral morass and ethical minefield of performative plunder, superficial seriousness, curiosity-seeking, and nihilism, is dialogical performance. This performative stance struggles to bring together different voices, world views, values systems, and beliefs so that they can have a conversation with one another. The aim of dialogical performance is to bring self and other together so that they can question, debate, and challenge one another. It is a kind of performance that resists conclusions. It is intensely committed to keeping the dialogue between performer and text open and ongoing. Dialogical understanding does not end with empathy. There is always enough appreciation for difference so that the text can interrogate, rather than dissolve into, the performer. (151)

While the Dialogical Center is the most ethical position to hold on the moral map, it is often the most challenging, as it requires holding various polar positions in tension. In my own desire to find a way to maintain a dialogical stance with my disorder—one that is characterized by an ability to dialogue with and navigate the tensions present in bipolarity—I find Conquergood’s moral map to be a helpful paradigm in parsing through the various tensions I navigate in managing my bipolar performance. Here, I am repurposing and reframing the moral map not as a means of navigating the tensions that inform the performance of others, but rather as a means of navigating the tensions that inform my performance of bipolarity. The following figure is a reconfiguration of Conquergood’s moral map. While I have retained the structure of the map and initial terms used by Conquergood, I have altered the meaning of each pole in order to better describe the tensions I encounter in navigating my bipolar performance in everyday life (see fig. 1).
I struggle between the poles of Identity and Difference. When I am pulled to the extreme position of Identity, I take a position in relation to my disorder that allows my diagnosis to completely overtake and define all I am and all I do. Not only am I bipolar, everything I do is also inflected with my bipolarity. In this stance, my bipolarity becomes a parasite that threatens to overtake my identity. Bearing some resemblance to Levitical laws for menstruating women, I am unclean, and everything I do or touch is unclean. But, unlike Israel’s daughters, there is no mikveh to wash me clean after each cycle. And so, this pole becomes a very desperate place. It is at this pole of Identity that I feel most sick. On these days, it can be very hard to get out of bed.
The opposite pole, Difference, is a rare but at times desirable stance in relation to my disorder. At this extreme, I distance myself from any aspect of my disorder, feeling as though I am “normal,” a victim of the cruel patriarchal structures of Big Pharma. Believing my diagnosis to be a complete construction, I seek to dismantle the construction. I don’t go to doctor’s visits. I don’t take my medicine. I refuse these acts in an effort to refuse the “false” diagnosis that has made war on my person. I am angry, reminded of Fulke Greyville’s *Mustapha*, in which he writes that humanity is “…created sick, commanded to be sound…” (137). Despite my own self-righteousness, this position is a difficult stance to maintain. While I often enjoy the unburdened and empowering feelings I get from this pole, it is a dangerous position to maintain, as foregoing my care regimen never ends well. Furthermore, this position of Difference is only possible when I am euthymic, or in the “normal” state, that so briefly exists between manic and depressive episodes. Or, perhaps I am so mired in an episode that I do not recognize the presence of my own affectation—a most dangerous place indeed.

On the horizontal axis, I experience the extreme poles of Detachment and Commitment. When I am pulled to the far end of Commitment, I attempt to contextualize my experiences of mental health and honor them. At this pole, there is little critical reflection; rather, my memories and experiences of episodes are recounted in a documentary-like fashion. My position to bipolarity is very detailed, analytical, and free from any selective forgetting that might soften the hard edges of my episodes. In this stance, I feel trapped by my disorder and often embarrassed by my behavior. I feel exposed, as though everyone around me recognizes my bipolar performance as bipolar. I worry that people I encounter are confused, irritated, or amused by my bipolar performance. It is an unforgiving stance, prone to feelings of worthlessness.
When pulled to the opposite end of the horizontal axis, Detachment, I attempt to recontextualize and reframe my episodes, often employing an optimistic perspective in order to support my selective rememberings. In this stance, I find joy in my bipolarity. According to *DSM*, I frequently experience moods far beyond the realm of normative human experience. In my swings of mania and depression, I am somewhat of a neurological cosmonaut, testing the limits of human experience one episode at a time. I may revel in the speed at which I write, or my near-photographic memory, attributing these qualities to my diagnosis, even if the relationship between these cognitive qualities and my diagnosis are correlative, and any causality remain indeterminate. However edifying this place might be, I typically take this stance when thrown sky-high in manic flight, unaware of the melting wax of my wings, and the approaching tumble to sharp rocks below.

Each of these poles represents an extreme tension that pulls on my positionality. At each end, I take radically different stances towards my disorder, each with radically different consequences in the management of my bipolarity. These tensions are not either/or binaries; rather, each axis represents a spectrum from end to end on which I may find myself. Additionally, both the horizontal and vertical axes work in tandem, creating diverse combinations that further inflect my position in relation to my disorder.

In all cases, I find myself navigating not only my disorder, but also my performance of self in everyday life. My “bipolar map” is intended to chart the various tensions that pull on my positionality in relation to my disorder, however, when held up to the light, the watermark of stigma shines through. When I am pulled towards Identity—feeling that I am bipolar and all that I do is bipolar—I tend to hide, feeling that I might be discovered in classrooms, in restaurants, in offices.
When I am pulled towards Difference—feeling that I am not bipolar and nothing I do is bipolar—my stance is often colored by an internalization of the stigma surrounding my disorder, and the want to publicly proclaim that I am not deserving of the consequences of a bipolar hail.

When I am pulled towards Commitment—attempting to contextualize my experiences of mental health and honor them—I fall into a sea of self-loathing. Here, my mother’s well-intended pleas for me to come home, that whatever I happen to be doing is “too hard” and that I’m “clearly depressed” hold most water. It can be tempting to jump ship, but I am usually too mired in tears to do anything but replay visions of my past transgressions and future failures. I truly believe that I am all the sensational images of lunacy that pervade popular culture.

Finally, when I am pulled towards Detachment—attempting to recontextualize my experiences of mental health and reframe them—I tend to lose touch with reality, putting myself in potentially dangerous situations characterized by a string of late-nights fueled by Monster energy drinks and Bollywood playlists, resulting in utterly indecipherable notes characterized by logical jumps and strings of numbers I don’t remember writing, and whose meaning I’ve forgotten. Here, I also encounter stigma, attempting to distance myself from the spoiled bipolar identity, absolving myself of any undesirable consequences—and any responsibility to manage those consequences—in favor of presenting a public image that proudly proclaims, in the words of the great actor and rhetorician Charlie Sheen, “I’m not bipolar. I’m bi-winning!” (Daily Mail).

Given the presence of these poles, much of my time is dedicated to navigating each of the pulls on my “bipolar map” in order to find my own Dialogical Center—a position wherein I hold each of these extremes in tension and dialogue with my disorder. When I use the term “dialogue,” I mean that I hope to be able to exert agency in the navigation of my disorder,
actively participating in my care and making intentional decisions in how I choose to understand my disorder, as opposed to allowing the fear of stigma to blindly whip me from one end to the other without my consent. In an attempt to find my way to the dialogical center of my “bipolar map,” I am deeply attuned to my performance of self in everyday life, and the performative power of words that shape my bipolar experience. This particular relationship to the performative power of words is perhaps best illustrated by ex-space princess, Family Guy favorite, and patron saint of bipolar disorder Carrie Fisher, who in her self-penned performance titled, Wishful Drinking, says:

Mania is, in effect, liquid confidence… when the tide comes in, it’s all good. But when the tide goes out, the mood that cannot and should not be named comes over you and into you. Because to name it would be an act of summoning. (Fisher 128)

She ends this moment by placing a single finger to her lips, a barely audible “Shhh” emitting from her breath, marking an absence too terrible to speak. There is stillness.

I know the summoning power of words. I hear their echo in the walls of the clinic, the home, and most publicly, the stage. I fear the power of my speaking, as though “depression” might hear me and suddenly arrive, thinking it was wanted. I fear the power of performance. Perhaps that is why I write. Over the course of this project, I have come to better understand the fundamental differences between writing something and performing it, between speaking and becoming. In performance, I have not yet found a way to gain the “critical distance” Marianne Hirsch describes in her discussion of postmemory. I can attempt to perform a memory from ten years ago, or even inhabit a fictional bipolar character, but no matter how much chronological or circumstantial distance I build into the process, the memory written into my body remembers and rebels.
At times, this rebellion also happens in my writing. There have been times when I, under threat of a deadline, have offered snapshots of my experience I, in hindsight, did not want to share but did not have time to mediate, to shape. In working on this project, I at one point assembled stacks of journal entries, paintings, photographs, and most troubling, a stack of legal pads I had filled in the early morning hours—senseless scrawlings causing me to say aloud when coming across them, “Dear god, I really am crazy.” But such things in the light of day allow me to know that some things are just for me. I find great power in mediating my archive, in participating in some small way in a withholding that grants me a sense of reclaimed agency.

It is not therapy.

It is not confession.

It cannot save me.

Maybe I don’t need saving—a difficult concept for a Church of Christ girl. And so I take up the charge of the dialogical center, finding not balance, but necessary struggle:

I struggle in The Clinic.

I struggle in The Home.

I struggle on The Stage.

Here, I struggle on the page. In searching these various contexts, I too often find little of myself in them, only refractions of an identity I’ve yet to fully piece together. My identity cannot be found in the clinic, in the home, or on the stage. Rather, it lies somewhere in between. I have fought so hard for a cogent self, searching for something or someone with whom I could identify. However, the expeditions I’ve undertaken on my “bipolar map” have caused me to question the value in finding such a something or someone. What good would it do? The binary of selfsame
and other that informs stigmatizing narrative of neurotypicality is built on principles of identification, an assumption that one can only empathize with a mirror-reflection of oneself.

And so, I write, albeit with few answers. Here, at the end, I find no end, but rather an ever-present beginning that first appeared eleven years ago. If I am to cross from twenty-four to twenty-five still intact, I cannot declare an “end;” I haven’t the luxury. I am locked in a hundred years war of my own kind, free to pick up the weapon of my choice. Some weapons are more tempting than others, but it is the pen I find most favorable. In writing, I have found a speaking space that blends space and time, allowing me to form and reform myself from all sides.

There is so much I want to say to that lanky and awkward thirteen year-old me, a girl who still favored knee socks and olive green cardigans paired with her bulky glasses and frizzy red locks, forever caught in a quest to survive seventh grade. I want to tell her she is loved, that she is safe. I want to tell her she will be okay, and that the world doesn’t end at Westglades Middle School. But I would not lie to her as grownups so often do. I would tell her that it will not go away, that there are trials to be faced and mountains to summit, that the monsters are real. I would tell her not to dwell in these places, but to take comfort in knowing that there is in this vast universe someone who cares for her very much, who desperately longs to hold her while she cries, and knows with every ounce of her being that that little girl is stronger than the wind that whips her. I would tell her to bend, to breathe, to be.

Or perhaps my words might reach into the future, to one much older than I, whose frizzy red locks shelter a mind that still bears her bipolar blows. To that soon-to-be-self: I cannot say that I am surprised you have come here. But I cannot offer you what you seek. It is I who should be coming to you, and I had hoped you would have come nearer to it than I. All I can give you is the warm greetings of April 12, 2015. Know that you are happy and cared for, and in spite of
what has been a very hard and episodically active two years, I have done my best to make you proud. May you find peace, joy, and calm. Call your mother. Get some rest. You have not failed.

But my rhetorical fantasy has its limits. My message cannot reach my younger self, and the future is as indeterminate as my disorder. But I will not desert my charge. As Jonathan Fox writes in *Acts of Service: Spontaneity, Commitment, Tradition in the Nonscripted Theatre*,

> There are many people...who are not always listened to. Even more are the people whose stories in one way or another are too terrible for others to want to hear. If oppressed persons can be defined as those who have nowhere to tell their story, our mission has been to provide a space for anyone and everyone to be heard. There is a spiritual aspect to this calling. This is not a question of proclaiming a manifesto. It has to be lived... (6)

Perhaps I might find another who, like me, longs for a story space. I hope that she or he might similarly take comfort in the sharing. The diagnosis lasts a lifetime, and there is great risk in speaking of such unfriendly spirits. And yet, a lifetime lasts much longer in this world when one does not speak alone.

UNTITLED 5

*The scene: A large ballroom at a conference, Ohio. The four walls are painted a generic-hotel-tan. The two windows are covered with generic-hotel-gold drapes. The floor is patterned a generic-hotel-green. The light is soft; the moon rising as the night takes shape. The room is full.*

My presentation is over. I stand next to a singular friendly face; a former professor, fellow panelist, and artistic mentor all in one. He turns to me:

“Is that scary? Doing that? Telling people?”

“Always.”
APPENDIX A

THE BIPOLAR PENDULUM

Fig. 2. The Bipolar Pendulum

Bipolar disorder is characterized by the fluctuation of moods from one extreme to the other. However, in addition to experiencing polar moods, the bipolar also suffers the range in between. These symptoms are fluid, like a pendulum swinging back and forth from one extreme to the other. Emotional states are classified as major depression, dysthymia (or mild depression), depressive temperament, mixed state (wherein the patient simultaneously experience symptoms of mania and depression) OR eurythmia (a “normal” mood state), hyperthymic temperament, hypomania (mania without psychotic features), and mania (with psychotic features) (Stahl 2-4).
THE BIPOLAR SPECTRUM

<table>
<thead>
<tr>
<th>Soft Bipolar/ Cyclothymia</th>
<th>Bipolar II</th>
<th>Bipolar I</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7</td>
<td>10</td>
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<td>7</td>
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</tbody>
</table>

←Least Severe Symptoms ........................................................................................................ Most Severe Symptoms →

Fig. 3. The Bipolar Spectrum

The range of symptoms and severity of moods experienced by patients varies from person to person. To better describe these variations, bipolar disorder is classified as a spectrum disorder. Patients are classified based on the severity and frequency with which they experience symptoms, ranging from cyclothymia (also known as soft bipolar) to bipolar I. Additionally, a patient whose symptoms do not conform to traditional criteria for cyclothymia, bipolar II, or bipolar I may be classified as bipolar not otherwise specified, or N.O.S.. Efforts to nuance the bipolar spectrum have lead some clinicians to further divide the spectrum, adding bipolar \(\frac{1}{4}\), bipolar \(\frac{1}{2}\), bipolar I \(\frac{1}{2}\), bipolar II \(\frac{1}{2}\), bipolar III, bipolar IV, bipolar V, and bipolar VI, to the “not otherwise specified” category (Stahl 9).

COMORBIDITIES

Additionally, a patient may be diagnosed with additional features, called comorbidities. The bipolar pendulum might be considered an x-axis on which the pendulum swings, while the particular position the bipolar diagnosis holds on the bipolar spectrum limits the length of this axis, and the range of the pendulum’s swing. In this model, comorbidities are additional diagnostic features that affect when and how the pendulum swings. Comorbidities include: anxious
distress, mixed features, rapid cycling, mood-congruent psychotic features, mood-incongruent psychotic features, catatonia, rapid cycling, peripartum onset, and seasonal patterns. In-depth descriptions of these comorbidities and their criteria can be found in *DSM-V* on pages 149-154.

**SHIFTING DIAGNOSES**

A bipolar diagnosis is not concrete. Oftentimes, the symptoms change based on environmental factors. A person who is initially diagnosed as having soft bipolar may in ten years begin to show symptoms more characteristic of bipolar I. While there is no cure, the variability and potential for change that characterizes the disorder make regular treatment and maintenance a priority for a successful prognosis (Carter 23).
APPENDIX B

BIPOLAR II DIAGNOSTIC CRITERIA

For a diagnosis of bipolar II disorder, it is necessary to meet the following criteria for a current or past hypomanic episode and the following criteria for a current or past major depressive episode:

HYPOMANIC EPISODE

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from behavior, and have been present to a significant degree:
   1. Inflated self-esteem or grandiosity.
   2. Decreased need for sleep (e.g. feels rested after only 3 hours of sleep).
   3. More talkative than usual or pressure to keep talking.
   4. Flight of ideas or subjective experience that thoughts are racing.
   5. Distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli) as reported or observed.
   6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
   7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the psychological effects of a substance (e.g., a drug of abuse, a medication, or other treatment).

NOTE: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

MAJOR DEPRESSIVE EPISODE

The following is quoted from DSM verbatim and can be found on pages 132-135. Information on coding has been omitted. These omissions are indicated by bracketed ellipses.
A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

NOTE: Do not include symptoms that are clearly attributable to a medical condition.

1. Depressed mood most of the day, nearly every day, as indicated either by subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (NOTE: In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day. (NOTE: In children, consider failure to meet expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, a suicide attempt, or specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the psychological effects of a substance or another medical condition.

NOTE: Criteria A-C constitute a major depressive episode.

NOTE: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should be carefully considered. This decision inevitable requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

BIPOLAR II DISORDER

A. Criteria have been met for at least one hypomanic episode (Criteria A-F under “Hypomanic Episode” above) and at least one major depressive episode (Criteria A-C under “Major Depressive Episode” above).

B. There has never been a manic episode.

C. The occurrences of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder,
delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Coding and Recording Procedures

[...]

*Specify* current or most recent episode:

- HYPOMANIC
- DEPRESSED

*Specify* if:

- WITH ANXIOUS DISTRESS (p. 149)
- WITH MIXED FEATURES (pp. 149-150)
- WITH RAPID CYCLING (pp. 150-151)
- WITH MOOD-CONGRUENT PSYCHOTIC FEATURES (p. 152)
- WITH MOOD-INCONGRUENT PSYCHOTIC FEATURES (p. 152)
- WITH CATATONIA (p. 152) [...]
- WITH PERIPARTUM ONSET (pp. 152-153)
- WITH SEASONAL PATTERN (pp. 153-154) Applies only to the pattern of major depressive episodes.

*Specify* course if full criteria for a mood episode are not currently met:

- IN PARTIAL REMISSION (p. 154)
- IN FULL REMISSION (p. 154)

*Specify* severity is full criteria for a mood episode are currently met:

- MILD (p. 154)
- MODERATE (p. 154)
- SEVERE (p. 154)
APPENDIX C

CHECKLIST OF NEUROTYPICAL PRIVILEGE¹

Safety

1. I have never been told, because of my neurology, that I am incapable of feeling pain.

2. If I have a medical problem, I do not worry that my doctor will dismiss it as part of my neurotypicality.

3. When attempting to purchase health insurance, I know that I will not be rejected because I am NT.

4. If I am bullied or abused, people will not assume that my neurology means I am at least partially to blame, or that the abuse would stop if I tried harder to behave like someone else.

5. I can assume that police officers will not become alarmed at my natural body language and find it necessary to subdue me in advance of any wrongdoing.

6. I do not have to carry a special card or bracelet with me to explain my natural body movements or the sounds I naturally make.

7. I am not considered more dangerous and more likely to commit a crime because of my neurology.

8. People of my neurology are not generally considered burdensome to our families or to taxpayers.

9. Nobody will murder me because of my neurology.

10. If I am murdered, my murderer will not be let off because my murder was deemed “an act of mercy,” or given a light sentence because of the stress caused by interacting with me.

11. I do not have to fear that important decisions about my life will be made by others who are considered more qualified based on their neurology.

12. I am not expected to accept seclusion rooms, restraints, or neuro-enhancing drugs as conditions of my educational experience.

Inclusion

13. For a child of my neurotype, everyday teaching of the skills they will need to live in this

¹ The checklist of Neurotypical Privilege is listed here verbatim and can be found at aspergersquare8.blogspot.com
society is called education or parenting—not therapy, treatment, or intervention.

14. If someone of my neurology can do something well, I will not be punished for being unable to do the same thing well or at all.

15. People do not constantly tell me that I need to work on the things which I am very bad at, at the expense of things which I am good at and enjoy doing.

16. People who have power over my education will probably not decide that, instead of receiving the academic education most of my peers receive, it would be best for me if my time in school were spent learning non-academic “skills.”

17. I can reveal my neurology to my boss and coworkers without fear of losing my job.

18. I can ask for technical or social support on the job without being seen as a troublemaker or charity case.

19. People do not automatically assume that the best place for me to live is an institution.

20. The majority of people who make the laws of my nation share my neurology.

21. The services that I need to survive not only already exist, but even if I use those services on a 24-hour basis, I will still be considered independent.

22. When I need help performing a particular task, I can ask for help without having to produce documentation to prove I actually need help with it. The help will most often be provided in a manner I can understand, and will not be considered an inconvenience or an act of pity.

23. No one sees my neurology as being in need of elimination or cure.

24. If I am visibly upset, people generally assume something must have upset me, and will generally try to help me.

25. People do not suggest that groups that are made for the benefit of people of my neurological type be led and ruled by people of a different neurological type, because mine is seen as inherently incapable.

26. I have never had to take a single test that determines, for my entire lifetime, whether I get to communicate.

Relationships

27. My family, friends, and significant others are not told that I am incapable of relating to other human beings.

28. If I am an adult, I can be a sexual being without the assumption that any partner attracted to
me must be a predator or pedophile.

29. I am never told that I should not have children lest I pass on the genes that cause them to share my neurological type.

30. No one speculates about whether I am competent to raise children based solely on my neurology.

31. People do not assume that living in the same household as me is inherently “tragic” or “devastating,” or that my family, friends and partner will need a support group to deal with living with me.

32. I will not be asked to leave a public place, or to change where I live, because people are uncomfortable with my neurotypical behaviors.

33. If I am unhappy, people do not automatically assume my unhappiness is the result of me being who I am.

34. My opinions on social mores and societal issues are not dismissed based on my neurology or on the assumption that I am incapable of understanding how these things work. Likewise, my gender identity and sexual orientation are not discounted because of my neurology.

*Respect*

35. I expect people to presume intellect and competence with me.

36. If I fail, most will encourage me by telling me that I will ultimately succeed.

37. If I fail to understand autistic people, this is attributed to a deficit inherent in autistic people rather than in me.

38. If I have a particular talent or ability, I can demonstrate that talent without being called an “idiot savant” or my talent being called a “splinter skill” or some other demeaning word.

39. The definitions of rude and irritating conduct were developed by and for people with my neurology.

40. I am not praised for acting less neurotypical or punished for acting more neurotypical.

41. I am not expected to alter or suppress my natural ways of moving, interacting, or expressing emotion in most circumstances.

42. If I fail to alter or suppress my natural ways of moving, interacting, or expressing emotion, I do not fear public ridicule or exclusion because of this.

43. When prospective parents and others speak of wanting a “healthy child,” I know that they
mean a child like me.

44. People don't accuse me of grandiosity or derisively dismiss it if I suggest that some admirable historical figure might have been neurotypical.

45. It is considered good for people who are not like me to try to act more like me.

46. My natural movements and traits are not used by my peers to ridicule others of their neurological type, either jokingly or maliciously.

47. I am never told that the fact I have a certain cognitive skill means that I am lying when I say I lack another cognitive skill. Nor am I dismissed as incapable of things I truly can do because I lack certain cognitive skills.

48. I can discuss my interests at length without this being viewed as a “symptom.”

49. When I communicate, people do not gather in crowds around me and gawk.

50. My behaviors, abilities, and skill levels at age 2 or 3 are considered indicative of an immature phase of life that will pass naturally, not as representative of my prognosis for the rest of life.

Definition of terms

Majority: The dominant group.

Minority: (1) A racial, religious, political, national, or other group thought to be different from the larger group of which it is part; (2) A group having little power or representation relative to other groups within a society; (3) a member of one of these groups.

Neurotypical: (1) Having a type of neurology that is expected and/or favored by the society in which one lives. (i.e., having a “normal” or “typical” brain, and the typical sensory processing/body movements/facial expressions associated with a typical neurological system.)

We: (1) The people who helped to create this document—most of us autistic or with other less typical neurology; (2) those who support the recognition of human rights for autistic people and others with less typical neurology.
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