‘DEFINED NOT BY TIME, BUT BY MOOD’:
FIRST-PERSON NARRATIVES OF BIPOLAR DISORDER

by

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*We also certify that written approval has been obtained for any
proprietary material contained therein.
I dedicate this dissertation to Isabelle, Genevieve, and Little Man for their
courage, unconditional love, and constant companionship, without which none of
this would have been achieved. To Angie, Levi, and my parents: some small piece of this
belongs to you as well.
# Table of Contents

Dedication .................................................. 3
List of tables .............................................. 5
List of figures ............................................. 6
Acknowledgements ........................................ 7
Abstract .................................................... 8
Chapter 1: Introduction .................................. 9
Chapter 2: The Bipolar Story ......................... 28
Chapter 3: The Lay of the Bipolar Land .......... 64
Chapter 4: Containing the Chaos .................... 103
Chapter 5: Incorporating Order ....................... 136
Chapter 6: Conclusion .................................. 173
Appendix 1 .................................................. 191
Works Cited ................................................ 194
List of Tables

1. Diagnostic Criteria for Manic and Depressive Episodes  
2. Therapeutic Approaches for Treating Bipolar Disorder  
3. List of chapters from table of contents
List of Figures

1. Bipolar narratives published by year, 2000-2010  
20

2. Graph from Gene Leboy, *Bipolar Expeditions*  
132
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‘Defined Not by Time, But by Mood’:
First-person Narratives of Bipolar Disorder

Abstract

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This dissertation explores the ways in which bipolar narratives attempt to compensate for the chaos inherent in the illness they document. After defining “the bipolar story” as it appears in the texts, the project examines 20 corpus texts in detail, identifying how they cohere as a sub-genre and pointing out the primary features and themes of the group. My analysis then considers how, in seeking to define and describe bipolar disorder, bipolar narratives encounter rhetorical problems with credibility and textual problems involving causation, coherence, and closure. These problems are partly a result of the texts’ ongoing negotiation of the paradox of mental illness (that people with severe mental illness are simultaneously “too crazy” to be believed and “not crazy enough” to be reliable). The project looks at two specific strategies, framing and embedding, used by the texts to offset the disruptive power of the bipolar story. Close attention to both the texts and the bipolar story itself promises to shed light on a sub-genre of illness narratives that is rapidly growing but not well understood.
Chapter 1: Introduction

A recent episode of Fox Television’s mega-hit *Glee* featured guest star Gwyneth Paltrow as substitute teacher Holly Holliday. Halfway through the hour-long episode, Holliday appears before her class dressed in 19th-century clothing. The script, quoted in full in the National Alliance on Mental Illness’ (NAMI) “StigmaBusters December 2010” newsletter, reads:

HOLLY HOLLIDAY. Mary Todd Lincoln in the house! My husband was probably gay and I’m bipolar, which makes me yell things like [pointing to a teapot], ‘That teapot is spreading lies about me!’ Or, ‘that can’t be my baby because I don’t love it!’ [throws imaginary baby over shoulder]

*Mr. Schuester knocks on the door and asks Holly Holliday to speak with him for a moment.*

HOLLY HOLLIDAY. Guys, practice your bipolar rants. See, history can be fun!

This episode caught the attention of NAMI and generated pages of negative responses on *Glee*’s online community boards. The missteps are numerous: misinformation about the symptoms of bipolar disorder (which do not commonly include hallucinations or problems with attachment), the association of mental illness and violent behavior,¹ and the trivialization of bipolar disorder as something “fun” that can be practiced. This example may be recent but it is far from unusual; NAMI’s monthly “StigmaBusters” newsletter is full of similar examples. From television commercials to print

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¹ Severe mental illness is often linked to violent behavior, despite the fact that research has shown repeatedly that people with mental illness are not prone to violent acts. Despite scholarly evidence disproving the link, it remains one of the most ingrained cultural stereotypes about people with severe mental illness. The mass media does much to further this stereotype, as we saw in the recent coverage of the shootings in Arizona. The suspect, Jared Loughner, had a history of mental health issues and his mental illness featured prominently in the media coverage of the shootings. For more information on the association of mental illness and violent behavior, see Wahl, Chapter 4.
advertisements to Disney movies, it seems mental illness has become part of the cultural conversation. That conversation can sometimes feel somewhat one-sided, dominated by offensive comments and stereotypical assumptions akin to the Glee episode. But the last ten years have brought another voice to the conversation: that of people actually living with a diagnosis of severe mental illness. This is especially true in the case of bipolar disorder. A mere ten years ago, only a handful of published bipolar narratives existed. But in 2009 alone, 35 bipolar narratives were published. The publishing boom of the past decade suggests that people living with bipolar disorder and other severe mental illnesses do not want Glee and Gwyneth Paltrow to have the last word about mental illness. Despite growth in publication and popularity, scholars have yet to attend to these important texts. As I will show, publishers, the media, and consumers seem to be paying attention to these texts and to bipolar disorder generally, but the bulk of the publicity around mental illness is negative (as seen in the Jared Loughner case, and, to a lesser extent, in the situation with Charlie Sheen). There are exceptions, of course; the “CBS Cares” public service announcements provide one prominent example of positive media attention regarding mental illness.

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2 In this dissertation, I will use the term ‘narrative’ to refer to “the representation of a series of events” (Abbott 13). I have also chosen to refer to the texts under discussion as ‘bipolar narratives’ rather than ‘bipolar books’ or ‘bipolar texts.’ This decision echoes pathography scholars’ use of ‘illness narrative’ to refer to “writing about the episode of one’s illness” (Couser 6). For my purposes, a bipolar narrative is a text that focuses on the experience of bipolar disorder.

3 Sheen has been in the news lately after he was fired from his television show for erratic and irrational behavior. Despite concerns about his mental status and the possibility that the behavior was the result of a manic episode, the media has focused almost exclusively on the irrationality as part of Sheen’s personality and star quality. Sheen has capitalized on the negative attention by recently embarking on a multi-city comedy tour. A recent MSN.com article reported that people bought tickets in hopes of seeing Sheen’s “colorful rants” (“Crowd boos Sheen”). As one member of the audience put it, “He's a wreck. That's half the draw.” Instead of expressing concern about Sheen’s fragile mental state and increasingly erratic behavior, media outlets are focusing on how the “crazy” version of Sheen can fill theaters.

4 As part of their “CBS Cares” campaign (which began in 2000), CBS airs public service announcements on a range of topics, including bipolar disorder. To view the ads, visit the CBS web site at http://www.cbs.com/cbs_cares/.
narratives the careful and focused scholarly attention that they deserve, ensuring that these key voices don’t get lost amid the media chatter about mental illness.

Accordingly, the purpose of this dissertation is to explore this group of unattended and understudied narratives as a sub-genre of pathography, paying special attention to how bipolar narratives attempt to compensate for the chaos inherent in the illness they document. Pathographies tend to focus on the experience of physical illness as written by ill people and sometimes by their friends, family, or care providers. Although bipolar narratives can be categorized as pathographies, physical illness and mental illness produce very different kinds of stories. For example, cancer is a recognized illness, even if the illness experience of cancer differs from person to person. That is, there are established treatment protocols, studies and statistics about mortality and recovery, and doctors who specialize in diagnosing and treating cancer. When receiving a diagnosis of breast cancer, for example, most patients would likely know something about cancer and how it is treated, because breast cancer is a culturally and medically recognized illness. As such, even though breast cancer produces a narrative in which the individual’s experience may vary (in terms of response to treatment, experience of symptoms, or understanding of illness), there is an established medical narrative in place for breast cancer. Though the beginning and middle of the story may change, the end is predictable: cure, remission, or death. A conventional pathography about breast cancer, then, will combine individual experiences and the established medical\textsuperscript{5} and cultural narratives together into “a coherent whole” (Hawkins 11). And whether the individual recovers or passes away, the outcome of both the illness and the narrative is most often predictable.

\textsuperscript{5} In this dissertation, I will use the terms ‘medical narrative’ and ‘clinical narrative’ interchangeably, as both capture that this part of the bipolar story originates in a clinical context with psychiatrists, psychologists, and other medical professionals.
Conversely, bipolar narratives focus on a mental illness that most people know very little about. Bipolar disorder lands somewhere between curable and fatal—there is no cure and the illness itself is not fatal.\(^6\) The cultural and medical narratives about bipolar disorder are woefully incomplete. On the medical side of things, criteria for diagnosis exist, though they are notoriously vague and open to interpretation.\(^7\) Treatment tends toward the complex, as it is individualized and often involves a combination of medications and therapies. The course of bipolar disorder is unpredictable—episodes come and go without warning and duration, severity, and type of episode vary widely from person to person. As the examples given at the start of the introduction illustrate, bipolar disorder’s cultural narrative is murky. Taken together, these factors produce a far more unpredictable narrative for bipolar disorder than for other illnesses that are better understood.

Perhaps in part because of the inherent confusion of mental illness, scholars have chosen to focus their collective energy on narratives about physical illnesses rather than mental illnesses. A robust body of work on pathographies exists, beginning with Anne Hunsaker Hawkins’ influential text, *Reconstructing Illness: Studies in Pathography*, one of the first book-length studies of what was then (in 1993) a relatively new and unexplored genre. Hawkins finds that book-length texts about personal illness were extremely rare before 1900. She offers several possible reasons for this, such as the inclusion of illness stories with stories of religious conversion and the consideration of illness as a regular and expected part of life. This sentiment has faded as the Western

\(^6\) Though bipolar disorder is not fatal, the Depression and Bipolar Support Alliance reports that as many as one in five people with bipolar disorder die by suicide (“Bipolar Disorder Statistics”).

\(^7\) For more information on *DSM*-related controversies, see Kirk and Kutchins.
world has moved toward a biomedical model of health and illness in which health is the de facto condition and illness is a temporary deviation from health (Hawkins).

Similarly, pathography scholarship tends to view illness as an interruption or a disruption of one’s life, and for many, creating an illness narrative is one way to deal with the disruption and reestablish control and order after the disorder of illness (Hawkins, Adame and Hornstein, Frank, Couser). Though writing about one’s experience of illness can serve many different purposes, pathography’s chief goals include restoring the ill person’s voice (which is often lost or drowned out by the medical “voice” of doctors, charts, and scientific labels) and establishing order after illness. These goals are common across most illnesses as illness of any kind is disruptive and most involve the medical world at some point. Although some illnesses may demand greater accommodation or attention, even minor illnesses (such as the common cold or the stomach flu) require adjustments to the daily routine. Hawkins claims that pathography “restores the person ignored or canceled out in the medical enterprise, and it places that person at the very center. Moreover, it gives that ill person a voice” (12). Pathography can serve as a powerful way to “talk back” to the medical narrative, and an increasing number of people are using their voices to add to (or challenge, deny, or subvert) the existing medical narratives of illness.

Some illnesses are more disruptive and life-changing, and thus a greater threat to the individual voice, than others. In most cases, illness narratives tend to focus on illness as acute—writing everything down can sometimes help an individual make sense of a confusing and perhaps traumatic (but nonetheless finite) time. But for some, illness stretches into months and years. G. Thomas Couser’s work in *Recovering Bodies: Illness,*
Disability, and Life Writing extends pathography to include narratives written about chronic illness and disability. Couser finds that people write illness narratives “to demystify and destigmatize various conditions” (291) and “to take their lives literally into their own hands in part to reestablish their subjectivity in the face of objectifying treatment” (11). If the medical world, and perhaps even society at large, has a specific stereotypical idea of people with mobility impairments as helpless, then it makes sense that writing an illness narrative could counteract incorrect assumptions and generalizations, thereby giving the text an additional educational component.

Couser’s work also relates to a second key goal of pathography: that people write pathographies to gain control over the chaos of illness. He proposes that illness has the power to “[disrupt] the apparent plot of one’s life” (5), and writing illness narratives may help people find their way into new narratives that include space for illness and disability. Sociologist Arthur Frank suggests that people often try to translate their experience of illness into words so that they may better understand it. For Frank, illness creates “narrative wreckage,” and pathography is one way to counter the wreckage (55). Additionally, Frank contends that writing can “repair the damage that illness has done to the person’s sense of where she is in life, and where she may be going” (53). Organizing the illness experience into an orderly narrative sequence can help the person to move forward and find purpose in the illness. As one might expect, mastering chaos through narrative is more difficult in the case of chronic illness and disability, and Couser finds that narratives that document these conditions often tend to focus more on the person’s entire life rather than an isolated episode of illness.
Although bipolar narratives may also work toward achieving these goals, they must also deal with issues specific to the illness that they document. Authors with a psychiatric diagnosis of bipolar disorder must address the central paradox of mental illness: they are simultaneously “too crazy” and “not crazy enough.” That is, bipolar disorder is a severe mental illness and thus people with this diagnosis are perceived as unreliable authors or lacking the agency to tell their own stories (Baldwin 20). They are, in essence, “too crazy” to be taken seriously. On the other hand, people with bipolar disorder have no conclusive way to prove their illness, and they risk being told that their symptoms or episodes are imaginary or “all in their head.” Bipolar disorder is an illness conveyed through language, most often via patient descriptions, and the potential lack of external or physical symptoms, coupled with the lack of reliable diagnostic instruments such as imaging or blood tests, adds up to “not crazy enough” to be proven medically.

This paradox means that bipolar narratives must do more work than conventional pathographies, in that they must constantly negotiate the credibility continuum to avoid moving toward either extreme (“too crazy” and “not crazy enough”). That is, the texts must define and describe bipolar disorder as a valid and debilitating illness in a way that does not reflect badly on or diminish the credibility of the authors as people with an important story to tell. Bipolar narratives pose a special challenge to credibility because mental illness involves the body and the mind and may raise doubts about narrative credibility and reliability. The texts must then address these doubts as well as teach readers about mental illness.

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8 I am grateful to Professor Jonathan Sadowsky for sharing this insight.
9 Research is working toward reliable diagnostic tests for bipolar disorder. For more information, see Le-Niculescu et al.
In mentioning the work done by bipolar narratives, I refer to the texts’ attempts to explain and communicate a severe mental illness that is not medically and culturally understood. People with bipolar disorder are not immediately recognizable as ill in part because there is no external marker of illness. Many physical illnesses include culturally recognizable clues, such as a wheelchair, a cast, or a bad case of hives, that may help others (and the ill person him- or herself) to see and understand the illness. Without these cues, illness becomes more elusive and harder to decipher or understand. Whereas a breast cancer survivor may bear a scar from surgery or a bald head from treatment, people with bipolar disorder may appear physically healthy and functional even during a very severe episode. The lack of visible or concrete illness markers can contribute to stigma and misunderstanding about bipolar disorder as an imaginary illness without clear symptoms. And so part of the work done by the texts is providing clues and helping readers make sense of an illness that may not be immediately recognizable as illness at all.

These texts must also shore up or add to an incomplete medical narrative. Most illnesses have a medical narrative that includes a label, symptoms, a diagnosis, and a treatment plan often administered by a medical professional. The medical narrative for bipolar disorder is incomplete, in large part because bipolar disorder lacks clear medical markers, such as diagnostic tests or blood work, to conclusively prove the diagnosis. The illness is currently diagnosed using the *Diagnostic and Statistical Manual of Mental Disorder, Fourth edition, Text Revision (DSM-IV-TR)*, commonly known as the psychiatrist’s bible. The diagnosis relies upon the expertise of a trained professional and requires a set of symptoms to continue for a specific time. Diagnosis is a key part of the
medical narrative, but the process of diagnosing bipolar disorder is far from straightforward or simple, as evidenced by the frequency with which misdiagnosis occurs. A Depression and Bipolar Support Alliance (DBSA) survey found that nearly 70% of people with bipolar disorder were misdiagnosed one to three times, and respondents saw, on average, four doctors before receiving a diagnosis of bipolar disorder ("The Face of Bipolar Illness"). Many bipolar narratives mention misdiagnosis, and some authors endure multiple misdiagnoses. The lack of a clear-cut medical narrative for bipolar disorder demands more of the texts in that they must fill in the gaps of the medical narrative with personal experience. This practice is not necessarily uncommon in pathographies, but bipolar narratives have more gaps to fill: as indicated, some of those gaps originate in the medical narrative, while others relate to the incomplete cultural narrative about bipolar disorder.

Lack of cultural understanding of bipolar disorder cannot be ignored in relation to the work these texts do. Despite ongoing public awareness campaigns and attempts by advocacy groups to educate the public, bipolar disorder remains one of the least understood severe mental illnesses. A second DBSA survey found that one-third of those surveyed believed that people with bipolar disorder were not “normal” or capable of living “normal lives” (“Fighting Stigma”). The survey also uncovered respondent misconceptions about medications used to treat bipolar disorder, the origin/cause of the illness, and the severity and duration of the illness. Thus, in addition to allowing authors to reclaim their own illness experience, bipolar narratives also serve a crucial educational role for a largely ignorant public. These texts, then, are called upon to do more work than conventional pathographies. Although they may be a vehicle for personal enlightenment
and education, they also strive to achieve public enlightenment and education. So if bipolar narratives do such important and necessary work, we might ask why scholarship focused on these texts is absent from the pages of the major psychiatric and psychological journals. By way of answering this question, I continue with a short overview of the existing scholarship on illness narratives.

Scholarship on pathography tends toward the interdisciplinary, as doctors, sociologists, psychologists, and literary scholars have all explored illness narratives. Some have organized pathographies into typologies,\(^{10}\) while others have focused exclusively on one illness such as cancer (Armstrong-Coster) or psoriasis (Kennedy). Doctors and medical professionals have considered the ethics of working with patient narratives, as well as the various ways that narratives may enhance the practice of medicine.\(^{11}\) Humanities scholars such as Tom Couser and Shlomith Rimmon-Kenan have looked at how illness narratives function in both fiction and nonfiction. As noted earlier, Couser’s work stretches the bounds of pathography to include people with chronic illness and disability, and numerous others have examined how chronic illness may affect narrative.\(^{12}\) There has also been work on the political dimensions of illness narratives.\(^{13}\)

Among this distinguished group, regrettably few scholars have chosen to expand their focus to include mental illness narratives. Although mental illness may well be considered a chronic illness and/or a disability, both Couser and Hawkins (among others) base their definitions of pathography on narratives of physical illness. A rare exception, Susan Hubert casts a wider net by examining narratives of mental illness in order to

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\(^{10}\) For more information on typologies relating to pathography, see Hyden, Bury, and Frank.
\(^{11}\) See Charon, Eggly, Sakalys, and Brody.
\(^{12}\) See Williams and Charmaz.
\(^{13}\) See Sakalys and Hubert.
outline a history of the psychiatric treatment of women. Hubert’s work looks at both fiction and nonfiction, focusing on the shifting political aspirations of women’s mental illness narratives through the nineteenth and twentieth centuries. The project is historical in nature and somewhat dated, as the most recent text is Susanna Kaysen’s *Girl, Interrupted*, published in 1993. Marta Caminero-Santangelo approaches mental illness narratives from a literary standpoint to discover the ways in which madness has been used as a metaphor for resistance. As evidenced by her book title, *The Madwoman Can’t Speak, Or Why Insanity Is Not Subversive*, Caminero-Santangelo ultimately rejects the metaphor of madness as resistance in late 20th-century literary texts by women. The work of sociologist Clive Baldwin continues in this generalist vein, as Baldwin considers how narratives of mental illness may challenge narrative expectations and forms. By focusing on the ethical consequences of helping people with severe mental illness tell their stories, Baldwin’s work considers narrative’s role in constructing personal identity. He finds that mental illness narratives are especially complex in that they originate from authors who may lack narrative agency.\(^\text{14}\) Hubert, Caminero-Santangelo, and Baldwin share a broad focus on how mental illness can complicate narrative agency, and although my work shares this focus to a point, I am more interested in the ways bipolar narratives make sense of an unpredictable illness story.

Unlike the scholars just mentioned, Alexandra Adame and Gail Hornstein chose to focus their work around a specific set of mental illnesses, including bipolar disorder. They chose ten mental illness narratives written by men and women with various

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\(^{14}\) Baldwin writes that severe mental illness may significantly impede “the ability and opportunity to author one’s own narrative” (20). The authors examined in coming chapters have certainly been granted opportunity to tell their own stories, but the ability piece of the equation (as it relates to authorial credibility) is still very much contested.
psychiatric diagnoses and published from 1908-1999. Adame and Hornstein then created detailed narrative profiles for each text in order to uncover thematic similarities. Adame and Hornstein are among the first scholars to argue that mental illness narratives are fundamentally different from physical illness narratives in that narratives about physical illness draw a clear line between the person and the illness—that is, the person is seen as intact and blameless and the body is seen as “broken” or needing treatment (137). There is no such line in mental illness narratives, as the brokenness extends from the body into the mind, affecting identity and credibility. Adame and Hornstein also identified several types of mental illness narratives, including mental illness as traumatic interruption and mental illness as purposeful suffering. Their work exists as one of few scholarly attempts to classify mental illness narratives, and despite being more than a decade old, the work provides a useful starting point in discussing the fundamental difference between physical illness narratives and mental illness narratives. Although I do not use their typology, Adame and Hornstein’s work grounds this project, which imagines a separate space for bipolar narratives within the realm of pathography.

Evelyne Keitel’s work offers perhaps the closest parallel to my work, as Keitel seeks to define and explore a new sub-genre of literature that she dubs “psychopathographies.” Keitel wants to determine how “human borderline experiences,” such as those originating in psychosis and severe mental illness, are translated into literary forms (13). Her work considers how literary texts can “overcome certain specific limits of verbalization, while at the same time allowing for a psychotic experience to be communicated” (3). Her text, Reading Psychosis, delves deeply into psychotherapy and
focuses on psychosis rather than severe mental illness generally. Although Keitel’s work is dated, it can serve as a touchstone for this project via a shared interest in how severe mental illness shapes texts. Similar work has been done with groups of illness-specific texts, including depression and obsessive-compulsive disorder, but, to date, scholarship on bipolar narratives is limited.

The work briefly mentioned here explores the connection between narrative and severe mental illness. This project goes a step further by considering the rhetorical consequences of the connection. That is, I want to examine how bipolar disorder shapes narratives while also paying attention to the ways in which the texts navigate the paradox of mental illness. These texts seek to persuade readers that bipolar disorder is both treatable (thus, these authors are not “too crazy” to be helped) and serious (they should not be dismissed or labeled fakes for appearing “not crazy enough”). This dissertation is a first small step toward addressing this developing group of texts and adding to the conversations already underway about other mental illness narratives.

It is not immediately clear why scholars have ignored bipolar narratives, though it may be a combination of the complexities of describing the illness, the sudden surge of published texts, and the relative newness of the sub-genre. It seems likely that unpredictability and the lack of a clear narrative may lead bipolar narratives to be categorized as “chaos narratives” (Frank). Arthur Frank organized his study of illness

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15 Keitel’s choice of psychosis as a focus reflects the dated nature of her work. When her text was published in 1989, psychosis was considered a distinct mental illness and the *DSM-III* was just beginning to come into use. The most recent revision of the *DSM* does not categorize psychosis as a distinct mental illness. For more on how the *DSM-III* radically shifted the diagnosis and definition of mental illnesses, see Kirk and Kutchins.

16 As of writing, two notable exceptions include Emily Martin’s *Bipolar Expeditions*, which focuses on bipolar disorder at both a personal and scholarly level; and Katie Rose Guest Pryal’s recent article, “The Genre of Mood Memoir and the Ethos of Psychiatric Disability,” which argues that people with mental illness are using memoir to respond to what Pryal identifies as “rhetorical exclusion” caused by severe mental illness (479).
narratives into three categories: restitution narratives, quest narratives, and chaos narratives. Of the three, chaos narratives were those Frank deemed too chaotic to understand. A chaos narrative exemplifies suffering so extreme that it “cannot literally be told but can only be lived” (Frank 98). Frank argues that constant suffering prohibits narrative altogether, as the individual is so consumed by surviving each moment that “reflection, and consequently, storytelling, [become] impossible” (98). On the surface, bipolar narratives may seem to resemble chaos narratives, especially those that include unedited sections written during an episode. More commonly, bipolar narratives describe past episodes and reflect on the effect of mental illness, which makes the texts more orderly. But even at a distance, bipolar disorder is chaotic, and I’m suggesting that close attention to bipolar narratives can reveal how these narratives rise to meet the textual and rhetorical challenges presented by the bipolar story. Instead of overlooking this group of difficult and sometimes incoherent texts, I will focus intently on the disruption and what we can learn from it.

Another possible reason for the lack of scholarly attention could be the rapid publication of mental illness narratives. Couser hints at this in Recovering Bodies: Illness, Disability, and Life Writing. Couser analyzes narratives about cancer, HIV/AIDS, hearing loss, and paralysis but passes on mental illness narratives because he finds that the field was growing too quickly for him to keep up. Although pathographies date back to the early twentieth century, bipolar narratives have a shorter history. A handful of bipolar narratives were published before 2000, the most notable (and widely popular) among them being Kay Redfield Jamison’s An Unquiet Mind: A Memoir of Moods and Madness, published in 1995. An Unquiet Mind tells the story of Jamison’s lifelong experience with
bipolar disorder both as patient and as a professor of Psychiatry at Johns Hopkins School of Medicine. The text spent more than five months on the *New York Times* Best seller List (Vastag). But Jamison’s text stands alone until the turn of the millennium. The dearth of comparable texts is most likely a combination of limited treatment options (meaning that fewer people with bipolar disorder were functional enough to tell their stories) and the reality of living with a disabling mental illness (people may be too busy dealing with the illness and treatment to take time to reflect on and recount their stories).

As treatments for bipolar disorder have improved, the number of bipolar narratives has increased drastically. At most book stores, Jamison’s foundational text can now be found alongside numerous first-person accounts of living with bipolar disorder, as well as second-person accounts written by family and friends of people with bipolar disorder. Texts vary greatly in size, scope, focus, and popularity, and there are more of them than ever before. A cursory search at any popular internet bookstore will generate thousands of results based on keywords such as ‘bipolar disorder’ and ‘memoir/biography.’ My extensive searches in WorldCat and Books In Print turned up nearly 200 bipolar narratives published since 2000. The end of the decade saw a particularly notable increase, as seen in Fig. 1.
In 2008 and 2009 alone, nearly 80 bipolar narratives were published. I selected the corpus for this project in early 2008, at the height of the bipolar narrative boom, but I could have doubled the corpus with texts from 2009 alone. The number of bipolar narratives in print grows daily, as publishing options increase and more people share their bipolar narratives with others. Self-publishing in particular has opened many doors to people who have never written or published a book before, and a large number of bipolar narratives are either self-published or published by small presses. The rapid growth and the volume of texts indicates an increasing cultural awareness of and interest in bipolar disorder and bipolar narratives, marking them as texts worth attending to.

I describe the corpus selection process in greater depth in Chapter 3, but I will briefly introduce the texts here. In order to examine bipolar narratives as a sub-genre, I needed a critical mass of texts: large enough to reveal trends and themes but small enough to allow for comparison and close textual analysis. My initial searches turned up almost 200 published bipolar narratives, and I applied numerous filters based on author, date of publication, and geographic location to arrive at a 20-text corpus. I chose book-length texts because I wanted to explore the complexities that were likely to emerge in
longer, potentially more detailed accounts of bipolar disorder. Because the project is concerned with reasonably current medical and cultural narratives, I chose texts published from 2000 to 2008. I excluded texts published after 2008 because an article published that year revealed the discovery of a blood test that could possibly be used to diagnose bipolar disorder using biomarkers. This sort of testing would clearly affect the medical narrative about bipolar disorder, and for the sake of uniformity, I chose texts that were published before this breakthrough. I also eliminated all texts written by anyone other than the individual with bipolar disorder in order to focus more intently on how mental illness can affect authorial credibility. As I will show in Chapter 3, the corpus texts are diverse in terms of focus, writing style, and subject. But they also share key events in the illness experience, including diagnosis, episodes, and treatment. They comprise a rich archive that can teach readers much about bipolar disorder and how this illness shapes how people represent and understand their life stories.

In the coming chapters, this dissertation will attend to bipolar narratives in the following ways: first, I will define and describe what I identify as “the bipolar story.” Second, I will examine the corpus texts in detail, identifying how they cohere as a sub-genre and pointing out the primary features and themes of the group. With a firm understanding of both the bipolar story and the corpus in hand, my analysis will consider how, in seeking to define and describe bipolar disorder, bipolar narratives encounter rhetorical and textual problems. These problems are partly a result of the unruliness of the illness they document. But the texts also struggle to deal with the paradox of mental illness mentioned earlier and the dangers of oversharing (and being labeled “too crazy”) and undersharing (and being accused of faking or lying). The bipolar story can cause
textual problems with causation, coherence, and closure as well as rhetorical problems with credibility. On a textual level, recounting episodes may make a text seem incoherent, as readers struggle to make sense of episodes that appear and disappear without warning. Causation can be problematic in texts in terms of onset of illness, because very few people can pinpoint a moment when they first experienced symptoms. And closure in bipolar narratives tends toward the artificial, as the illness experience is ongoing and threatens to overspill the textual boundaries. The coming chapters will consider how these narrative features are troubled by the bipolar story and how the texts seek to boost these “good-narrative” features using framing and embedding. Close attention to both the texts and the bipolar story itself promises to shed light on a sub-genre of illness narratives that is rapidly growing but not well understood. Bipolar narratives can teach us a great deal about both their namesake illness as well as the ways in which bipolar disorder can challenge and change narratives.

**Chapter Summaries**

In this chapter, I have provided a general introduction to the project’s location and focus. The background on pathography and the lack of scholarly attention to bipolar narratives were provided to illustrate and justify this project’s intervention. The project will continue as follows. Chapter 2, “The Bipolar Story,” more fully describes bipolar disorder, including its diagnosis, symptoms, and treatment. This chapter weaves together the existing medical and cultural narratives on bipolar disorder with numerous textual examples from the corpus to present a comprehensive picture of this complex illness. Chapter 2 will also briefly touch on the textual features of coherence, causation, and
closure and the ways in which the bipolar story can undermine or challenge these features. With an understanding of the bipolar story in hand, Chapter 3, “The Lay of the Bipolar Land,” continues by more fully fleshing out the corpus. This chapter constitutes the “tour” of the sub-genre, including textual summaries. Each text tells a different version of the bipolar story, and the chapter highlights the primary features and themes of the sub-genre.

Chapters 4 and 5 focus on two ways that the texts work to recreate coherence, closure, and causation. Chapter 4, “Containing the Chaos,” investigates how bipolar narratives use textual framing and paratexts to counteract the disruption of bipolar disorder, creating a sense of coherence as well as providing a measure of closure. Chapter 5, “Incorporating Order,” examines how texts make use of a secondary genre to minimize the damage done by the bipolar story. Choosing to embed the bipolar narrative within a more established narrative genre results in a less threatening, more recognizable narrative. Chapter 5 specifically considers three secondary genres: traditional autobiography, travel narrative, and conversion narrative. Both Chapters 4 and 5 include discussion of how these strategies affect causation, coherence, and closure. Chapter 6 sums up the previous chapters and considers the larger stakes of bipolar narratives and what they can teach us about the illness they document.
Chapter 2: The Bipolar Story

H. Porter Abbott defines a story as “the event or sequence of events” (15) that forms part of a narrative, and my use of the word in this chapter’s title is far from accidental. At first glance, it may seem odd to assert that a mental illness has a story, but I’ve chosen the phrase “bipolar story” to underscore the idea that bipolar narratives are composed of shared events: a cycle of moods including mania and/or depression that is part of all bipolar narratives. Shared does not mean universal, however, and bipolar disorder is experienced differently by each individual with the diagnosis. It follows, then, that each text documents an individual experience of the cycle of moods in a way that may or may not resemble anyone else’s experience. For example, some texts may choose to describe episodes in great detail and others may omit almost all description of episodes; regardless, episodes are part of every bipolar narrative.

As a group, the corpus texts include two distinct but connected layers that make up the bipolar story. The definitional layer communicates the “facts” of bipolar disorder. Briefly, this part of the bipolar story covers the medical basics of the illness, including types of episodes, the frequency and duration of episodes, the symptoms required for diagnosis, and approved treatments for bipolar disorder. Although the medical facts of bipolar disorder are listed in various scholarly texts (including, most notably, the DSM), the formal and generic language of these texts rarely appears in the corpus texts for reasons I will discuss shortly. The second part of the bipolar story, the experiential layer, focuses on the day-to-day experience of bipolar disorder, including the process by which

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17 The DSM-IV-TR (the fourth edition, revised) is the most authoritative diagnostic tool currently used in the psychiatric community. The so-called “psychiatrist’s bible” has become indispensable to the degree that insurance companies now require DSM-IV-TR diagnostic codes on medical charts and insurance forms to give patients access to services and insurance coverage. This requirement further heightens the status of the text in the health fields.
people understand and live with the “facts,” including misdiagnosis/diagnosis and the trials and errors of treatment. Together, the layers form a bipolar story that is both shared (through the definitional) and individual (through the experiential).

The bipolar story presents a real challenge to authors and texts because neither layer is complete or well-defined. That is, bipolar narratives must define and describe the illness experience as well as the illness itself. The former is a familiar challenge for pathographies, but most illness narratives don’t have to address the latter because the illness (be it cancer or diabetes or multiple sclerosis) has established medical and cultural narratives. Bipolar disorder has neither, making more work for these texts and their authors. As I will show, the definitional version of bipolar disorder is vague and deceptively straightforward. The clinical texts present symptoms, treatments, and diagnostic criteria as universal and absolute when they are far from either. The experiential version, on the other hand, rejects the idea of bipolar disorder as a generic, black-and-white illness (as seen in the DSM-IV-TR). Instead, this part of the story presents bipolar disorder as an illness with infinite shades of gray, complicating the clinical idea of the illness as a straightforward grouping of symptoms. Rather than include or repeat the DSM-IV-TR’s vague clinical description of mania, bipolar narratives draw from personal experience to create their own facts about episodes, symptoms, and treatments. The two layers include the same shared events, but they offer different perspectives on them: the definitional layer lays out criteria for diagnosis and the experiential layer focuses on the response to diagnosis. The layers are certainly connected, and, as I will show below, where the DSM-IV-TR falls short, the texts fill in the gaps with personal experience.
As if the challenge of defining and describing both layers of the bipolar story were not enough, bipolar narratives tell this complex story while negotiating the paradox of severe mental illness, trying to land at a safe point on the credibility continuum—to reveal enough to justify the diagnosis but not enough to be disregarded as incoherent nonsense. This chapter will delve more deeply into the bipolar story at both the definitional and experiential levels, as well as consider the relationship between the bipolar story and authorial credibility. The chapter ends with a discussion of how the multi-layered bipolar story can create textual difficulties with causation, narrative coherence, and closure. These features are hallmarks of “good” narratives and they can be problematic in bipolar narratives that fail to negotiate the paradox successfully and wind up on either extreme of the credibility continuum.

**Defining Bipolar Disorder**

The definitional part of the bipolar story is grounded in the clinical description of mental illness which, according to Marneros and Goodwin, originated in the first formal classification of mental disorders created by Hippocrates and his physician colleagues. In ancient times, mania and depression had several plausible causes including bodily humors and the divine. Emily Martin cites Plato’s *Phaedrus* as declaring that mania could arise from numerous sources of inspiration such as God, literature, or romantic love (16). The first person to link mania and depression was

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18 Emily Martin reports that the shift in terminology (from ‘manic depression’ to ‘bipolar disorder’) happened in the third edition of the DSM, published in 1980. Martin writes that bipolar disorder replaced manic depression because people were frightened by the latter and the former seemed less threatening. She includes a major advocacy group as an example: the National Depression and Manic Depression Association is now known as the Depression and Bipolar Support Alliance, and the organization claims that the name change was partly to keep up with the DSM-III and partly to address the fear associated with the term ‘manic depression.’ For more information see Martin 25-28. To avoid confusion, I will use ‘bipolar disorder’ because I believe the term better captures the polarity of the illness.
Emil Kraepelin, who described “mixed states” of mania and depression in a textbook in 1896 (Marneros and Goodwin 8). Martin indicates that Kraepelin’s work set the foundation for modern psychiatry, in that he divided mental disorders into two distinct groups: maladies of the intellect (dementia praecox, or schizophrenia) and maladies of the emotions (manic depression) (18). This dichotomy persists today in psychiatry’s distinction between cognitive and affective disorders (Martin 18). Bipolar disorder was present in the early versions of the DSM, but Kraepelin first used the term “manic-depressive insanity” in his 1896 textbook (Marneros and Goodwin 8).

With this historical background in hand, I will now discuss the definitional layer as it appears in the DSM-IV-TR. As mentioned earlier, very few corpus texts include medical specifics, in part because the DSM-IV-TR’s bipolar “facts” are too clear-cut and tidy to match up with the lived experience of the illness. The definitional layer provides important background about the basics of bipolar disorder, which ultimately helps readers to make sense of the experiential part of the story.

Diagnosis & Symptoms

The defining feature of bipolar disorder is cyclicity or an ongoing shifting of moods. The most current version of the diagnostic manual, DSM-IV-TR, defines two types of bipolar disorder: Bipolar I Disorder, which includes at least one Manic or Mixed episode, often followed by a Depressive episode; and Bipolar II Disorder, which must include at least one Depressive episode, often followed by mania or
hypomania. The DSM-IV-TR entry for bipolar disorder also includes Cyclothymic Disorder, which features symptoms similar to mania or depression that are not severe enough to count as a major episode. A diagnosis of bipolar disorder is most often made by a mental health professional, such as a psychiatrist or a psychologist. The full diagnostic criteria for both depressive and manic episodes are summarized in Table 1.

Table 1

Diagnostic Criteria for Manic and Depressive Episodes

<table>
<thead>
<tr>
<th>Manic Episode</th>
<th>Major Depressive Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least three symptoms lasting for at least one week, in conjunction with a significant mood disturbance (defined as “abnormally and persistently elevated, expansive, or irritable mood” [APA 362]):</td>
<td>At least five symptoms present nearly every day for at least two weeks. One of the first two is required for the diagnosis.</td>
</tr>
<tr>
<td>• inflated self-esteem or feelings of grandiosity</td>
<td>• depressed mood</td>
</tr>
<tr>
<td>• reduced need for sleep</td>
<td>• loss of interest in all areas of life</td>
</tr>
<tr>
<td>• increased talkativeness</td>
<td>• significant fluctuation in weight (either loss or gain)</td>
</tr>
<tr>
<td>• racing thoughts</td>
<td>• sleeping problems</td>
</tr>
<tr>
<td>• easily distracted</td>
<td>• observable physical agitation or slowed down movement</td>
</tr>
<tr>
<td>• intense focus on goal-oriented activities</td>
<td>• feeling tired</td>
</tr>
<tr>
<td>• physical agitation</td>
<td>• feelings of worthlessness or guilt</td>
</tr>
<tr>
<td>• over-involvement in enjoyable activities with potentially damaging consequences (shopping sprees, drug/alcohol binges, sexual quests, questionable financial transactions)</td>
<td>• trouble concentrating or thinking</td>
</tr>
<tr>
<td></td>
<td>• indecisiveness</td>
</tr>
<tr>
<td></td>
<td>• repeated thoughts of death and suicide, possibly including formulation of plan</td>
</tr>
</tbody>
</table>

Source: Compiled from American Psychiatric Association. DSM-IV-TR. “Criteria for Major Depressive Episode” (356); “Criteria for Manic Episode” (362).

19 At the time of writing, scholars are working on a newly revised version, DSM-5, with a projected publication date of May 2013. The revision team includes a workgroup on Mood Disorders, so DSM-5 could plausibly include revised diagnostic criteria for bipolar disorder.
In order to count toward a diagnosis, the symptoms must be “clinically significant”; that is, they must cause significant personal distress and interfere with a person’s ability to function in various areas of life (APA 356). Although Table 1 indicates some degree of separation between manic and depressive episodes, the line between the two is fluid enough to permit two “in between” conditions: hypomania and the mixed state. Hypomania is characterized by extended elevated mood and most of the symptoms of mania, but the symptoms are often present in a lesser degree, so that the person is still functional (APA 368). Mixed states involve both manic and depressive symptoms in quick succession for more than one week, and psychotic symptoms may also be present (APA 362).

This short overview constitutes the most prevalent clinical definition of bipolar disorder. The symptoms listed above are general and surprisingly common (many people experience insomnia or indecisiveness on a regular basis). Although the list lends the appearance of thoroughness, it is very broad—an individual must display only five of the 10 symptoms listed for a depressive episode, and the variation from person to person could be substantial. For instance, a depressive episode including feelings of tiredness and worthlessness would presumably have a different impact than one that included suicidal thoughts and a 60-pound weight gain. But the DSM-IV-TR would give both episodes the same label. So for all of its diagnostic power, the label does not tell readers much about bipolar disorder. This imprecision explains why the majority of texts do not use the language from the DSM-IV-TR, instead opting to expand upon the basic symptoms with personal examples.
**Treatment**

Clinical views on treatment have changed drastically in the past 30 years. Before the rise of psychopharmacology in the early 1980s, few treatments for bipolar disorder existed. As physicians became more open to treating mental illness with medication, the pharmaceutical industry began creating and testing drugs in earnest. Prior to 1993, lithium was the only FDA-approved medication to treat bipolar disorder (Keck), and it remains the “oldest, simplest, least expensive, and best-studied mood stabilizer” (Thase and Sachs 564). Although lithium is oftentimes the first drug prescribed when a person is diagnosed with bipolar disorder, it requires ongoing monitoring and blood work and causes numerous negative side effects. Thase and Sachs report that a full 10% of patients who try lithium find the side effects to be unbearable (564), and Johnson and McFarland found that half of patients prescribed lithium stopped taking the medication in less than three months (qtd in Sachs and Thase 574). Fortunately, the final decade of the twentieth century yielded a wealth of new treatment options.

The late 1990s brought approval of numerous anti-convulsant and atypical antipsychotic medications to treat bipolar disorder, and the results from large-scale studies on these medications began to appear in psychiatric and medical journals in early 2000.\(^20\) The number of new medications, coupled with the approval of existing therapeutic groups to treat bipolar disorder, drastically expanded treatment options. Current treatments are summarized in Table 2.

Table 2

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\(^{20}\) Thase and Sachs cite two key placebo-controlled studies, published in 1999 and 2000, as the early proof that bipolar disorder could be treated using newer medications.
Therapeutic Approaches for Treating Bipolar Disorder

<table>
<thead>
<tr>
<th>Therapeutic Group</th>
<th>Specific Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants</td>
<td>SSRIs, bupropion, venlafaxine, nefazodone, mirtazapine, reboxetine, tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs)</td>
</tr>
<tr>
<td>Mood stabilizers</td>
<td>Lithium, divalproex, carbamazepine, lamotrigine, gabapentin</td>
</tr>
<tr>
<td>Neuroleptics</td>
<td>Atypical antipsychotics</td>
</tr>
<tr>
<td>Somatic</td>
<td>Electroconvulsive therapy (ECT), phototherapy, sleep deprivation, thyroid hormone</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>Cognitive behavioral therapy, interpersonal therapy, social rhythm therapy, group therapy, family-focused therapy</td>
</tr>
</tbody>
</table>

Source: Thase and Sachs.

Thase and Sachs also point out that 50 years’ worth of research on antidepressants has yet to offer up a single well-controlled trial focused on bipolar patients (568). Clearly, there is more work to be done on the pharmacological treatments for bipolar disorder.

Table 2 lists several non-pharmaceutical treatments, including psychotherapy and electroconvulsive therapy (ECT). Multiple treatment options are a necessity for bipolar disorder, as there is no established treatment that works for everyone. This is another way in which the clinical narrative for bipolar disorder is incomplete—treating bipolar disorder is still very much trial-and-error. Bipolar narratives, then, must also define and describe treatments for the illness because doctors and researchers are still learning about how the medications interact with and influence each other.

In addition to filling in knowledge gaps for treatment, bipolar narratives actually work to educate readers on the benefits of more controversial treatments such as ECT. ECT is usually considered a treatment of last resort when a patient sees no
results from any combination of medication and therapy. ECT can be extremely effective in treating medication-resistant bipolar disorder but it is still stigmatized and generally not well understood due to blockbuster films’ dramatic (and most often inaccurate) interpretations of ECT.\(^{21}\) If ECT is part of the author’s treatment experience, then his or her bipolar narrative will also have to attend to an incomplete and inaccurate cultural narrative about that treatment. ECT is the most salient example, but treatments for bipolar disorder are not culturally well-known, so bipolar narratives must provide this information while also trying to present potentially controversial treatments in a more informed and accurate light. Although other pathographies may also undertake this task, we must remember that this is yet another challenge facing texts that are already dealing with the paradox of mental illness.

**Experiencing Bipolar Disorder**

As discussed at the start of this chapter, the bipolar story at the center of these texts can be roughly divided into two parts: definitional and experiential. Whereas the definitional aspect of the bipolar story was grounded in the clinical explanation and treatment of bipolar disorder, the experiential layer focuses on the process of how people come to terms with the illness. This part of the bipolar story describes how individuals experience the clinical “facts” of illness and treatment. In addition to more evocative and detailed descriptions of the illness itself, the experiential layer also addresses common events such as diagnosis and misdiagnosis and ongoing adjustments to treatment. This part of the story is far less generic and much more

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\(^{21}\) Notable examples include *The Snake Pit* (1948), *One Flew Over the Cuckoo’s Nest* (1975), *Frances* (1982), *House on Haunted Hill* (1999), and *A Beautiful Mind* (2001). For an extended list and discussion, see Walter and McDonald.
individualized, as each person’s illness experience is different. The texts share events, such as episodes and diagnosis and treatment, but each defines and describes these events differently. Like the definitional layer, the experiential layer of the bipolar story is incomplete and not well-understood by readers or by most medical professionals. There is no generic or standard version of a manic episode or a reliable, established treatment regimen for bipolar disorder. The story is still evolving, and the texts make important contributions to the medical and cultural narratives about bipolar disorder by offering personal perspectives on both the illness and its treatment. The experiential layer of the bipolar story focuses on the same events discussed in the definitional section but in far greater detail and complexity. As a result, this section includes many textual examples in order to illustrate the myriad ways in which authors present their own illness experiences.

**Diagnosis**

Diagnosis appears in every bipolar narrative in the corpus, and it is a crucial part of the bipolar story. The time and space given to diagnosis varies widely among texts, with some devoting considerable attention to the event and others mentioning it only in passing. Regardless of how it is presented or acknowledged, the moment of diagnosis matters. Although an individual may have experienced symptoms and episodes before diagnosis, the texts indicate that the illness takes on a more concrete form after the person receives the psychiatric label. Prior to diagnosis, the texts tend to disregard symptoms as personality quirks or as normal reactions to stressful or difficult life events. Following the diagnosis, things that may have escaped notice
before may now receive more attention and thought, as the author tries to sort out what is illness and what is not. In many texts, diagnosis marks the beginning of a lifelong process of accepting bipolar disorder. For others, diagnosis provides confirmation of long-held fears or suspicions. The diagnosis itself is part of the definitional story, whereas the text’s presentation of diagnosis and the individual’s response to that moment are part of the experiential layer of the bipolar story. The texts respond differently to the shared moment of diagnosis, reminding readers that this event is also deeply personal.

Several texts in the corpus discuss diagnosis and misdiagnosis in great depth. Andy Behrman’s text, for example, catalogs visits to seven different psychologists and psychiatrists, each of whom offers a different take on Behrman’s illness. The misdiagnoses range from narcissistic personality disorder to stress and they intensify Behrman’s distrust of the medical system and its ability to successfully treat his mental illness. The string of misdiagnoses also pushes Behrman to seek second, third, and even fourth opinions about his illness, and the text presents these events as fueled by a desperation to find another answer. Only after Behrman travels to Washington, D.C. to meet with an international expert on the illness does he finally accept bipolar disorder as “the final diagnosis…[by] the chief expert” (260).

Marya Hornbacher also experiences misdiagnoses and, as a result, struggles with untreated bipolar disorder for many years. When she is finally diagnosed with bipolar disorder, the text describes her reaction in tremendous detail, illustrating the importance of this moment in Hornbacher’s text. The text follows Hornbacher’s rapid stream of thought as she tries to process the new information. Initially, the diagnosis resonates and
Hornbacher finds a kind of reassurance or safety in the label. Naming the unknown provides a sense of certainty that “Now it will be better” (67), implying that lack of knowing (or, specifically, lack of a name) has exacerbated her difficulties. Whereas before, her struggles and hospitalizations were interpreted as “an utter failure on [her] part” (67), after the diagnosis, these events are proof of severe mental illness. But Hornbacher’s relief quickly changes to horror:

All that time I wasn’t crazy; I was, in fact, crazy. It’s hopeless. I’m hopeless. Bipolar disorder. Manic depression. I’m sick. It’s true. It isn’t going to go away. All my life, I’ve thought that if I just worked hard enough, it would. I’ve always thought that if I just pulled myself together, I’d be a good person, a calm person, a person like everyone else. (67)

Whereas seconds before, she was thankful that her symptoms and feelings weren’t just figments of her imagination, she now realizes the consequences of real symptoms and real feelings—they are concrete proof of her illness. The quick shift from “It’s hopeless” to “I’m hopeless” negates any reassurance felt moments earlier. She longs to be “a person like everyone else” and is horrified to discover that the psychiatric label makes that impossible. Hornbacher’s text spends much time describing the diagnosis and Hornbacher’s response, in part because the event was life-changing for her. These examples reveal far more about diagnosis than the definitional version of the event, and we learn Hornbacher’s personal experience. Diagnosis is central in this narrative, and the level of detail in this section underscores the importance of that moment in Hornbacher’s bipolar story.

Behrman and Hornbacher are somewhat unusual in their focus on diagnosis, as
most of the corpus texts touch briefly on diagnosis and then move on. The scene is often still emotionally charged, as when Bruce Goldstein reacts to the diagnosis by jumping up and down screaming “No! No! No!” at his psychologist. The scene is vividly described, including long chunks of dialogue and Goldstein’s interpretation of his own behavior. The text refers back to the exaggerated response several times, marking it as important and conveying the gravity of the moment to the reader. John Forkasdi’s reaction is less intense, in part because Forkasdi was diagnosed as a teenager at a time when less was known about bipolar disorder. His diagnosis comes during a hospital stay prompted by his parents’ concern for his well-being. The text recounts the moment in an even tone:

He [the doctor] told me something I’d have to deal with the rest of my life.

“You’ve been diagnosed as having manic-depressive illness, sometimes called bipolar disorder. There’s no cure, but it can be treated with a medication, Lithium carbonate.” The first thing that came to my mind was that I was crazy. I was also scared. Because I didn’t understand the diagnosis, I thought I wasn’t normal anymore. (20)

Although confessing a lack of understanding about the illness, Forkasdi still senses that the illness will affect him “for the rest of [his] life” (20). The importance of the diagnostic moment becomes apparent when Forkasdi reflects on his larger narrative, and the time and distance allow an adult Forkasdi to see that this was, in fact, a definitive moment in his life. A small group of texts devotes minimal attention to defining and describing response to diagnosis. Lora Inman’s diagnosis, for example, occupies a single sentence within her text: “After years of misdiagnosis, I was eventually diagnosed as bipolar II, rapid-cycling” (110). Although the text discusses
Inman’s illness throughout, this diagnostic moment is dramatically downplayed. The text offers nothing beyond the lone sentence—Inman does not even share when it happened, only that the diagnosis was preceded by false diagnoses. The text offers only one clue, in the word ‘eventually,’ which reveals that diagnosis was an ongoing process that required some patience and perseverance. Jane Thompson’s text takes a similar hands-off approach, as the diagnosis is conveyed indirectly via a letter from a previous doctor addressed to her current doctor. Thompson expresses surprise at the diagnosis because she had many appointments with the old doctor and he never once mentioned bipolar disorder. The text recounts the appointment very matter-of-factly, and when the doctor declares that she has bipolar disorder, Thompson confesses her ignorance but stays quiet. Patty Dean’s text indicates that she was diagnosed at 21 and offers limited information about her family’s reaction: her mother took the diagnosis “at face value,” her grandmother believed she was a victim of demonic possession, and her father was somewhere in between the two (43). These examples lack the drama of the previous examples, but the texts are still doing the work of defining and describing (in differing levels of detail) the author’s response to this important part of the bipolar story.

Symptoms

The experiential layer of the bipolar story describes and defines the symptoms of mania, depression, and mixed states, and many texts offer evocative and compelling descriptions of episodes. Whereas the symptoms appeared in the definitional layer in list form and without explanation or examples, the experiential layer builds on and
expands the one-word symptoms into specific descriptions of mania as each author experiences it. Andy Behrman invokes a familiar fairytale land to make mania recognizable: “It’s an emotional state similar to Oz, full of excitement, color, noise, and speed—an overload of sensory stimulation—whereas the sane state of Kansas is plain and simple, black and white, boring and flat” (xix). This environment is intoxicating and Behrman’s admission that he constantly seeks the stimulation casts mania in a somewhat positive light. Other texts refer to the symptom of heightened sensory experiences, as when Holly Hollan recounts an episode in which she “actually could see the rings of Saturn with [her] naked eye” (226). When she is manic, Marya Hornbacher’s hearing is so finely tuned that “I can hear my thoughts zipping and whistling through my head, and see them snap and sizzle in streaking red lines on a complex grid that was designed by God and given to me personally” (75). Alistair McHarg declares simply that he “loved it” (48). McHarg’s text continues with the admission that the author’s illness got so bad in part because he was “hooked on [the] highs” (48). These textual examples are far more descriptive than the vague, one-word symptoms listed in the DSM-IV-TR, but both try to convey to readers the basic symptoms of bipolar disorder.

Impulsivity, another generic symptom, is described in the texts as one of the more enjoyable aspects of mania. Terri Cheney describes one memorable manic episode in which she buys fourteen giant kites on a whim. As she drives home, a sudden gust of wind from a strong thunderstorm jostles the kites and Cheney thinks, “what better time to fly a kite than in a storm? Why should anything ever be tethered?” (149). She pulls over and flies the kites, staring with fascination as they
whip and twirl amid thunder, lightning, and pouring rain. Although most readers can relate to flying kites, only the manic mind longs to fly fourteen kites standing on the roadside in a roaring thunderstorm. Though these examples demonstrate several of the *DSM-IV-TR* criteria, they also go a step further to show how symptoms are not entirely negative. The implication that mania brings with it a loss of control that can be liberating and exhilarating as well as damaging presents mania, and bipolar disorder generally, in a more nuanced and complex way that reveals much about the illness experience for Cheney.

The texts offer different takes on symptoms, and the range reinforces bipolar disorder as a complex and potentially disabling illness that affects people differently. Behrman’s text, for example, describes mania very positively in one chapter and then declares that “Pure mania is as close to death as I think I have ever come” (xix) just a few pages later. Other texts include less dramatic examples of the undesirable side of mania, as when Jane Thompson complains of an embarrassing need to talk nonstop, trouble concentrating, and an inability to focus. Thompson adds that mania feels “like someone is playing pool in my brain. My thoughts carom off each other, bouncing off each other. I can’t think in a straight line” (29). Cheney describes the racing thoughts and feelings “so brutally strong it seems like there is no way to endure them” (97). Hornbacher’s text offers perhaps the most frightening description of mania as an evil, invasive entity “under my skin, borrowing my body without asking: my hands are its hands, and its hands are filled with an otherworldly strength. Its hands feel the need to lash out, to hit something, so it tightens its white-knuckled fists on the wheel, its bare foot slamming the gas” (56). This serves as an example of the impulsivity mentioned
in the clinical definition, but it is also much more, as the text describes a terrifying loss of control. Here again, the texts go beyond the one-word clinical symptoms to define and describe the illness as well as the lived experience of bipolar disorder.

The other side of the bipolar equation, depression, also factors prominently in bipolar narratives. Bruce Goldstein’s depression is intense, stifling, and dangerous—the knives call out to him from his kitchen and he feels Satan threaten to push him in front of an approaching subway train. Lizzie Simon recalls less fear and more pain: “I had never been so tortured; I felt a mass of pain at every instant, and it was deepening, thickening. I could not speak of it because I had lost the consciousness needed to identify that something was wrong” (13). Simon’s experience lacks the paralyzing fear described in Goldstein’s text, underscoring the individualized nature of the disorder.

The pain Simon refers to here is physical and mental, beyond merely feeling sad or lost, and several other texts include similar descriptions. Patty Dean describes feeling as though her heart had been replaced “by a sharp rock…[that] weighs more than all the rest of me put together” (97). As the episode gets worse, the rock “gets heavier and heavier and its weight drags me down until I am prostrate on the floor” (97). The passage goes on to reveal that Dean spends hours on the floor, choking on sobs, unable to speak at all. Lora Inman’s text brings the depression to life as a sickening monster with “tentacles [that] spread themselves like a cancer through my body into my brain, feeding on the life that was once there and leaving behind a frightened, desperate shell of a human who crawls through each day certain that this time it will not leave” (13). These evocative descriptions convey the terror and emptiness behind the generic symptom list, demonstrating that bipolar disorder is far
more complex and varied than the straightforward list of symptoms offered in the 
*DSM-IV-TR*.

The bipolar story also includes two in-between conditions: hypomania and mixed states. These types of episodes occupy a strange middle ground between mania and depression, and although they were not well explained in the definitional layer, the experiential layer offers several examples that reveal much about this middle place. The two states are described in some detail in Terri Cheney’s text. Cheney identifies hypomania as “that idyllic interlude just before mania when all of your senses are in a state of heightened arousal. But they don’t overwhelm you. Nothing overwhelms you. The sun never shines too bright, but you feel its warmth on your skin. The wind never blows your hair awry, but it whisks the clouds away. Life is liquid and even; it balances” (205-206). For Cheney, bipolar disorder is an illness of increments: she spends much of her time on the extreme ends of depression or mania, but just before mania comes hypomania, described as “three-quarters of the way to mania” (141) and “every manic-depressive’s dream” (205).

Cheney’s text also describes the mixed state, and it is vastly different from the pleasure of hypomania. The text recounts a weekend getaway in which Cheney first learned about mixed states. Cheney feels “prickly, irritable. Like I’m depressed, but I can still move” (182). Her boyfriend reassures her that a good night’s sleep will fix things, but the next day, she is “as irritable as a drenched cat” (183), so she heads to the local bookstore in search of answers. There, she figures out what her strange feelings mean and she begins to understand “the mixed state’s awesome power of destruction” (188). Mixed states are especially dangerous, in Cheney’s estimation,
because “you have all the relentless, agitated drive of mania, but none of the euphoria. Instead, you feel depression’s misery and self-loathing. …No longer protected by depression’s inertia, you now have the ability to act upon your despair” (185). Again the text presents the states as almost fluid and ever-changing, a far cry from the static descriptions in the *DSM-IV-TR*. But Cheney’s examples seem to include both layers, offering some of the basic “facts” while also considering Cheney’s response to hypomania or the mixed state. The text is doing twice as much work in defining and describing both layers of the bipolar story at once.

*Treatment*

The clinical narrative provides basic information about treatment, but there is far more to treatment than names of drugs or lists of side effects. The experiential side of the story includes information about how individuals respond to and deal with the ongoing process of treatment. Chapter 3 explores how treatment is presented in the texts, so this section will include a limited number of textual examples. The length of this section is not meant to imply that treatment is a less important part of the bipolar story. Rather, the fact that it plays such a major role in Chapter 3 proves otherwise. All of the corpus texts include information about treatment, which, for most, involves medication. Some texts include names and/or dosages of drugs but most do not mention medication by name.

The one exception to this statement is lithium. As mentioned, lithium is the oldest pharmaceutical treatment for bipolar disorder, predating other medications by more than twenty years. Because it has been used for so long, most patients have some familiarity
with lithium before they begin taking it. Several of the texts mention assumptions or generalizations about lithium, as when Goldstein mockingly refers to lithium as “the miracle salt” (24) in a passage bemoaning his experience with lithium as all side effects and no improvement. When the doctor prescribes lithium for Lizzie Simon, Simon’s mind kicks into overdrive: “Lithium. I imagined zombies in loony bins. I imagined wealthy pill-popping housewives. I imagined indie rockers. Get her on lithium…What would it turn me into? That was the big question. … Lithium was a very serious-sounding drug. It sounded so sinister. And any reassurance of its safety sounded like nonsense” (22). The associations here are multiple—on the one hand, lithium is sexy and illicit, a recreational drug for wealthy housewives and rock stars. On the other hand, lithium is sinister, bringing to mind “zombies in loony bins.” Simon’s response reflects the cultural narrative for lithium, but the text continues by showing how Simon’s own experience with lithium does not match those generalizations. It is, for her, a life-saving drug; after only two days on lithium, Simon is “fine by most people’s standards. Lucid, calm, sleeping regularly, eating regularly. Not crazy, not at all” (23). This is an example of the ways in which a text supplements and redefines the incomplete or inaccurate cultural narrative around lithium.

If lithium is the most common treatment for bipolar disorder, ECT is the least common. ECT appears in only five corpus texts and it is presented as a “treatment of last resort” (Inman 39), used only when all else has failed. The treatment itself appears in vague and ambiguous terms, as the texts focus on the response to ECT. After 30 treatments, Inman still experiences episodes, and though she credits ECT with ending her suicidal depressions, she refuses to continue the treatments. Patzer’s results are
even bleaker—the ECT “did nothing to help [his] condition” (86) but it did harm his short-term memory, his long-term memory, his learning processes, and his facial and spatial recall. Cheney’s text mentions similar side effects, though in her case, the ECT also caused a psychotic break that led to “the most severe manic episode of [her] life” (158). The text doesn’t indicate if the ECT helped, but the fact that it was the genesis of a severe manic episode certainly seems to support Cheney’s assertion that ECT was, for her, “devastating” (2).

Behrman has a more complicated relationship with ECT. Although his text describes the process as demeaning and “barbaric” (222), ECT changes things for Behrman. Although he is initially confused and disoriented following the treatment, Behrman declares almost immediate relief, “like the hard concrete that filled my brain has been liquefied and drained from my skull” (226). A few pages later, Behrman notices that “the manic depression that was cycloning in [his] head hours before is now sleeping like a baby” (229). He admits that he is afraid of waking the sleeping demon and worries about the number of treatments required to make the demon go away forever. But the side effects are difficult: significant memory loss, difficulty with balance and gait, and loss of basic reading and language comprehension skills. Although the treatment is intended to stabilize his condition, Behrman feels less stable with each treatment, and by the time he is discharged, his brain feels “like a piece of Silly Putty” (233) and he is unable to remember where he is or how long he’s been there.

Hornbacher’s text describes ECT similarly. In the course of explaining the treatment, Hornbacher admits that “It has saved my life more than once, a simple
electric current breaking through the walls of madness, bringing me back from wherever my mind has stranded me now” (200). The text downplays the drama of the actual ECT treatment, stating that “They send an electric current through my brain, inducing a seizure. The seizure is tiny. Only my toes curl” (200). Despite this mild description, Hornbacher’s response is more dramatic, as she is haunted by “the image of myself flopping around like a beached fish” (200). The treatments cause Hornbacher to forget things both big (the city she lives in) and small (how to get from her bedroom to the kitchen). But Hornbacher’s text is very clear: ECT is safe, effective, and worth the side effects.

The representations of ECT are varied, as some texts praise it and others condemn it and still others land somewhere in the middle. Regardless, the treatment is defined and described in much richer, more interesting ways than it was in the definitional layer. The experiential part of the bipolar story builds on and expands the basics (symptoms, treatments, etc.) offered by the definitional layer, resulting in a more comprehensive representation of bipolar disorder. Although these layers together make for a more engaging and complete bipolar story, dealing with both layers is a lot to ask of these texts and bipolar narratives tend to struggle under the weight of these demands.

Discussion

Both the definitional and experiential examples demonstrate the complexity of the bipolar story, in that neither layer is well-defined or complete. As the examples from the *DSM-IV-TR* demonstrated, the definitional layer presents bipolar disorder as a cluster of
vague, static symptoms that can be treated in various ways. The clinical text focuses on
the “facts” of bipolar disorder, but these facts are still under construction as researchers
work to understand how medications work and how the brain behaves during episodes.
It’s likely that the forthcoming revision of the *DSM-IV-TR* will include a revised entry for
bipolar disorder, as the clinical narrative is still evolving. The experiential layer is
incomplete because readers are only just recently starting to hear about the illness
experience from those who are living it. Although the texts may refer to shared events
(episodes, diagnosis), each author responds to those events differently, meaning that this
part of the bipolar story is also in a constant state of evolution. Whereas other illness
narratives may share an established treatment regimen or a common set of diagnostic
tests, bipolar narratives have far less information to draw on or from.

As a result, these texts must not only define and describe the illness experience
(the experiential layer) but also the illness itself (the definitional layer). Although most
pathographies must deal with both layers, those dealing with a more familiar and less
stigmatized illnesses tend to spend less time on the definitional layer (because it may
include information that is considered common knowledge), instead allotting the bulk of
the textual space to the experiential layer of the story. By assuming some degree of
familiarity with the medical basics of the illness, the text can provide basics and then
focus on the individual’s lived experience. The burden of fully addressing both layers is
specific to mental illness narratives that focus on illnesses that are not well understood
either medically or culturally.

As discussed in the introduction, bipolar disorder seems to be coming up more
frequently in the cultural conversation. Medical and cultural narratives of these illnesses
are still incomplete and not well-defined. Medications used to treated bipolar disorder are not widely advertised to the general public and numerous studies by Otto Wahl and his contemporaries have shown that the general public knows very little about severe mental illness, including bipolar disorder. And although bipolar disorder may be appearing more frequently in the mass media, the references are not always positive or accurate, as seen in the *Glee* example. Bipolar narratives, then, face significant challenges in terms of general lack of knowledge or understanding about bipolar disorder. They are trying to educate readers about the illness, and to educate, the texts must be viewed as reliable and credible. This is no easy feat for texts that focus on an illness that is still shrouded in a great deal of misunderstanding and stigma.

The paradox of mental illness adds yet another piece of complexity to the definitional and experiential parts of the bipolar story as texts seek a balance between offering too much (and appearing “too crazy”) and offering too little (and seeming “not crazy enough”). At first glance, the definitional layer seems to address the concern of appearing “not crazy enough” to be believed, as a psychiatric diagnostic label from the *DSM-IV-TR*, assigned by a licensed mental health professional, proves illness even if other details are withheld. However, despite the *DSM-IV-TR*’s authoritative status, the diagnosis and treatment of bipolar disorder are in large part subjective and rely upon the physician’s ability to “read” or interpret the individual’s symptoms. Each doctor interprets symptoms differently, and the individual experiencing episodes may have difficulty communicating symptoms effectively, which could also delay diagnosis and treatment. Successful diagnosis and treatment rely solely upon the doctor’s judgment, as at this time, no established diagnostic test for bipolar disorder is widely available. The
lack of conclusive tests makes bipolar disorder seem less authentic or real than a host of physical illnesses for which concrete tests exist. For example, upon receiving a diagnosis of cancer, most people would demand that the doctor provide proof of this diagnosis through biopsies, blood work, and imaging tests such as MRIs that would show the presence of a tumor. When a doctor diagnoses bipolar disorder, there is no visible proof available, and this can undermine the status of bipolar disorder as a significant and disabling illness. Although the DSM-IV-TR presents diagnosis as an orderly process of identifying certain symptoms which appear with some regularity, the texts more often show it as a complex and difficult process that can test the authority of both the doctor (who must have the experience to recognize symptoms and diagnose properly) and the patient (who must be able to articulate possible symptoms).

The experiential part of the bipolar story relates to the other side of the paradox in which the bizarre descriptions of symptoms and episodes can mark the individual as “too crazy” to be taken seriously. Bipolar disorder is a severe and potentially disabling mental illness. But if the author shares too much information, he or she risks being dismissed as unreliable, someone who is not in his/her right mind and therefore unable to be trusted or believed. Take, for example, Alistair McHarg’s “really hideous” confession that, during an episode, he “cannot truly trust [himself]” (183). This revelation provides insight into McHarg’s feelings of helplessness and fear, but he risks losing credibility. After all, if he cannot trust himself, why should readers trust him? Texts that delve too deeply into the bipolar story to reveal detailed descriptions of episodes and severe symptoms, such as a psychotic break, may become so extreme and strange as to appear to be part of an episode. That is, the text may cease to become a coherent and rational account of illness
and instead become an incoherent and unrecognizable episode itself. For example, an increased need to talk is one symptom of mania, most often mentioned in the texts as a tendency to overshare or a disregard for what is appropriate. So it is plausible that very detailed textual descriptions of episodes or symptoms could be viewed as manic ramblings or proof of illness. In either case, the texts face the real danger here of being too honest about the difficulties of diagnosing and treating bipolar disorder, thereby alienating readers and failing in their larger mission of teaching the audience about bipolar disorder.

This section has examined the definitional and experiential layers of the bipolar story, using textual examples to show the messiness of the bipolar story. Unlike many stories, the events that make up the bipolar story are not always arranged in a coherent way. Instead, the bipolar story is dynamic—in some texts, it is pure chaos, and in others, it is a quick interruption. However the bipolar story appears in a text, it shapes how the narrative is written, read, and understood. The next section will explore how the challenges of defining both the illness and the illness experience as well as navigating the paradox of mental illness can create problems relating to authorial credibility and causation, coherence, and closure.

**Credibility**

Bipolar narratives’ presentation and description of the bipolar story have much to do with the way these texts are read and understood. As readers, we are accustomed to encountering narratives rather than stories; when we read a book about a trip to Africa or a near-death experience, we do not expect a numbered list of events. Rather, readers
prefer narratives that introduce, contextualize, describe, and perhaps reflect on the event. The same applies to illness narratives: readers expect a conventional narrative with recognizable features and a familiar organization. But even narratives that describe more established and readily understood illnesses include authorial interpretation of the events, and readers’ opinions or beliefs about illness may be informed by these representations. Authorial credibility becomes even more important in the case of bipolar narratives because they focus on an illness that is not well understood by the general public. Without personal experiences from which to draw, readers rely more heavily upon the text’s representation of the illness to form opinions.

The bipolar story is, in some ways, both problem and solution for credibility. It can be a solution because the psychiatric label provides instant credibility. An individual who has experienced bipolar disorder firsthand is able to present an intimate and honest portrayal of the illness. It must be lived to be fully understood, and this living of the illness makes the author inherently credible. But the diagnosis is equally a problem because severe mental illness affects the brain, and an author with a compromised brain is hardly reliable. This paradox means that the texts must do more work than traditional pathographies: bipolar narratives must provide enough information to prove that the author has an intimate knowledge of the illness without providing too much. The constant tension to maintain a balance between “too crazy” and “not crazy enough” affects the texts in various ways. This tension requires ongoing negotiation by the texts, as allowing the balance to tip too far in either direction may have a negative effect on the author’s credibility.
Narrating mental illness is inherently tricky, in part because, as Bruce Goldstein admits, “It was very hard for me to keep track of me” (48). Certainly, some individuals with bipolar disorder are not functional enough to write about or cognitively examine their illness experience. And authors with severe mental illnesses are often deemed unreliable by virtue of the diagnosis itself, so that their voices may be ignored from the start. There is also the expectation of truthfulness as based in the reputation or character of the author. As mentioned earlier, authorial character is even more crucial in unfamiliar situations, when readers have little or no experience with the subject. Very few readers have direct experience with bipolar disorder, which means that we rely on the author to an even greater extent than we might when reading a pathography about a more familiar illness. The chaos of the bipolar story requires the reader to lean more heavily on the author’s explanation of events, but in this case, the author is reporting symptoms and problems firsthand, simultaneously helping and harming credibility. The illness experience is largely internal and the author is the only one with full access to these thoughts and experiences. Pathography seeks to restore the voice to the person experiencing illness, but the chaos of the bipolar story in these texts may raise questions about the accuracy or reliability of that voice.

Many of the texts address the issue of credibility, as when Faye Shannon writes, “After a lifetime of trusting my mind, I did not know where to turn. Could I ever trust my mind again? A mind is a link to your soul” (159). In this example, the unreliability of her mind causes Shannon to question its trustworthiness, and she mourns the loss of what is, for most, an automatic trust in one’s mind. Jane Thompson admits a similar loss of trust as her behavior becomes increasingly strange: “I’d say to myself, ‘Self, this is nuts. You
need to stop this,’ but I’d keep right on doing whatever crazy stuff I was doing” (114).

Although this kind of information may help the reader to better understand bipolar disorder, it also creates problems with authorial credibility. When authors openly admit these kinds of struggles, they raise questions about their own fitness as authors. When Lizzie Simon wonders, “how much of me is me, and how much of me is this illness?” (210), readers can’t help but wonder the very same thing, and this questioning affects Simon’s credibility.

The credibility concerns are one textual result of focusing on such a difficult and unpredictable illness story. The messiness of the bipolar story creates further textual difficulties with the basic narrative touchstones of causation, coherence, and closure. These three features are all part of “good” narratives and, as I will discuss below, readers expect to find these features in narratives for a variety of reasons. The bipolar story, along with the paradox of mental illness, works against the simple integration of these features in bipolar narratives. The result is texts that struggle to find causation, coherence, and closure within the potential chaos of the bipolar story.

Each feature represents a distinct challenge so I will discuss them individually.

The Bipolar Story & Causation, Coherence, and Closure

Caution

Caution is based in an innate human need to find the causes of things. As readers, we are used to stories with clearly defined causes and effects, and narratives, including conventional pathographies, most often meet these expectations. Abbott finds that narrative, “simply by the way it distributes events in an orderly, consecutive fashion,
very often gives the impression of a sequence of cause and effect” (41). Human beings seek out causes for both positive and negative events and we tend to appreciate narratives that provide some kind of explanation or chain of causality for important events. Readers prefer linear progression when it comes to narratives, and texts that include causation or clear linear structures are preferable to those that are organized in other ways.

Given what we know of the bipolar story, it is not difficult to see that causation could pose a problem. The illness experience presented in the texts is generally disorderly and, in some cases, downright chaotic. The texts describe severe, life-endangering episodes that begin without warning and medications that stop working for no apparent reason. The cause/effect connection is also difficult in bipolar narratives because the bipolar story varies from person to person. So even if Behrman could arrange his text in a way that provided a clearer cause/effect connection, his organization would not map onto Cheney’s text or McHarg’s text, as each text includes a distinct bipolar story.

Because there is no established etiology for bipolar disorder, causation most often appears in the texts related to onset of illness. A beginning is not a cause but it is one way the texts try to address causation. The need for the cause/effect connection is so great that some texts reach back and provide distant background on erratic relatives or childhood experiences that could be related to the onset of mental illness. Behrman claims that he was never “an ordinary kid. I was obsessive-compulsive and neurotic from the start….From the time I was seven, I felt different, uncomfortable, out of place” (7). Simon traces the roots of her illness to childhood mood swings, while Staursky identifies the onset of illness as simultaneous with his mother’s death when he was eight years old.
The texts offers the death as the defining moment in Staursky’s life, when “the trigger of a brutal mental illness was now pulled” (5). There is no way to conclusively prove that childhood trauma or mood swings caused or contributed to bipolar disorder, and these examples may seem tenuous at best and impossible at worst.

Other texts are less definitive in establishing cause, but not for lack of searching. Behrman claims he became “addicted” to his weekly therapy sessions, which involved hundreds of useless hours with his therapist, “free-associating, exploring my dreams, making stick-figured drawings of my family, and sharing anything I could think of in the hopes of coming up with answers to the crazies” (23). He later admits the answers never materialized and his illness continued to intensify despite the therapy. Similarly, Lora Inman bemoans spending many years “digging into my past thinking that my problems, my mood swings, were somehow connected” (35). These examples underscore the importance of causation in narratives and the sense of loss that comes with the loss of a clear cause/effect relationship. Causation is crucial and the bipolar story makes it difficult to discuss causation in any but the most vague terms. As a result, most bipolar narratives mention the onset of illness briefly if at all. And without any beginning point, readers may feel disoriented or confused about the overall progression of the narrative, which may harm credibility.

*Coherence*

The desire for clear-cut causes is closely related to narrative coherence. Coherence functions in narratives by helping a reader to see how things fit together. Abbott finds narrative coherence to be one of the most salient features of most
autobiographical writing, as people often wish for their lives to be seen and understood in specific ways. Life is unpredictable, and coherence is usually achieved only in retrospect, as an individual is able to look back at his or her life and discern some kind of pattern that was invisible at an earlier point. Assembling what might otherwise seem to be unrelated and disconnected events into an orderly narrative sequence normalizes them, which can highlight connections and relationships.

Narrative coherence, then, can be created by the careful organization of events and details. Hawkins suggests that this organizing can be therapeutic, in part because “it builds narrative bridges between the sufferer and other human beings. To tell the story of one’s affliction becomes a way to distance it from oneself, to move beyond it, to repair its damages and return to the living community—in a word, to heal” (190). In a life disrupted by illness, the importance of restoring order and returning to “the way things used to be” cannot be underestimated, and organizing a difficult experience into a narrative with a clear narrative trajectory can be very therapeutic.

Careful organization to create coherence may work with an acute episode of bronchitis or a single cancerous tumor, but order is far more elusive for those facing incurable mental illness. Although most of the texts attempt to create a coherent sequence of events, there is still a certain randomness, insofar as episodes rarely happen with any predictability and symptoms may change drastically from one episode to the next. We can see this most clearly at moments in the text when things seem to be moving along a familiar route only to veer off in an unexpected direction. For example, Andy Behrman’s text describes various manic symptoms, such as rapid speech and increased movement. These symptoms correlate to mania and are among
the basics of the illness as laid out in the clinical texts. Behrman then makes a leap into the metaphorical, stating that when floridly manic, he imagines “chewing on sidewalks and buildings” (xix). The jump from concrete to abstract is disorienting, disrupting coherence. The text presents the symptoms one after another, but they are clearly not equal in severity or in recognizability. Behrman does not explain what the impulse means or feels like, and as a result, readers have no frame in which to make sense of such a bizarre symptom. This failure to relate and understand is a loss of coherence.

Alistair McHarg offers a comparison that also shows the ways in which coherence can cause a reader to pause and wonder about what he or she just read. McHarg compares “the polite world” with the world of mental illness and, not surprisingly, he finds the two to be separated by a vast ocean. Whereas most people might struggle if they take even “one step off the path,” McHarg claims that for those with severe mental illness, “Prison, asylums, police, doctors, mood drugs, sleeping in cars, the occasional beating, it’s just not a big deal. It goes with the territory” (155). Although most readers would likely agree that living with severe mental illness has a profound effect on one’s life, McHarg’s casual list of problems is too extreme to escape the reader’s notice. The juxtaposition of more mundane experiences (perhaps spending a night in a car, being picked up by the police) with threatening and extreme events (institutionalization, being beaten) is jarring and disrupts coherence in the text. Again readers may experience difficulty making sense of the comparison, and without further explanation from McHarg, the text may become very difficult to follow (at best) or incoherent (at worst).
One last example demonstrates the usefulness of coherence at a more global level. Several texts in the corpus reject a linear organization and instead seek to translate the unpredictability of bipolar disorder to the page. In these texts, the confusion of bipolar disorder translates directly to the structure of the texts, resulting in narratives that are not organized in a recognizably linear or chronological way. These narratives can become increasingly fragmented when chapters have no direct connection to one another and readers must struggle to put together the narrative pieces. Terri Cheney’s text is the most notable example and will be discussed in some depth in Chapter 4.

Closure

Like causation and narrative coherence, the final touchstone is also tied to reader expectations about what narratives should look and sound like. Most narratives have a beginning, middle, and end, and readers may accept questions and uncertainties in narratives with the expectation that the loose ends will be tied up. Abbott finds the desire for closure to be innately human, a key aspect of reading and of daily life. For this reason, closure has “great rhetorical power” in that it drives reading, providing “satisfaction to desire, relief to suspense, and clarity to confusion” (Abbott 64). Although very few texts provide full resolution of all questions and concerns, stories that end suddenly and perplexingly are rarely described as “good” stories.

Closure can be elusive in bipolar narratives because the bipolar story does not end. It is ongoing, as cure is not part of the story and any recovery is only partial and temporary. Of course, the texts must have some type of closure because they do end.
But bipolar narratives struggle to achieve closure that is anything more than an arbitrarily chosen endpoint in the story. The texts may trail off without any real conclusion, as is the case with Olivia Burnett’s text, which admits that “Any day could be the day some chemical change trips the switch that throws me into the depressed phase and lands me back in the mental hospital” (55). Inman removes the possibility of true closure within the first ten pages of her text, as she states flatly that, “We are prisoners of this malady, and our sentence is life” (10). Others build suspense and confusion and achieve closure in providing an update on author’s condition (most often revealing that he/she has been episode-free for months/years). Even in performing closure on the last few pages, the texts are telling a story that must continue as the author manages medication regimens and watches for the return of symptoms. Without closure, the text trails off into a frightening future, in which McHarg admits “I’m never totally safe. I can’t ever completely relax…[because] when I build up a little confidence, the illness cuts me off at the knees” (9-10). Statements such as these mark closure as temporary and unsatisfying, if possible at all.

This sort of limbo in bipolar narratives is fundamentally different from the sort of missing closure found in other narratives. It is a relatively common narrative practice to delay or prevent closure in order to build suspense or to surprise the reader; in these cases, the text may tease and frustrate a desire for closure. But the struggle in bipolar narratives is not suspenseful. After cataloguing so many episodes and hospitalizations, the texts convey the message that people with bipolar disorder do not get better. Even when treatment is working, Simon reveals that “manias and depressions ‘leak’ through our meds and continue to remind us of our mercurial
nature” (95). Good days or bad days, everything is temporary. Although some texts attempt closure through reflection or by attempting to make sense of the illness within the larger life context, even this kind of closure feels unsatisfactory in light of ongoing episodes.

Conclusion

This chapter has provided a foundation on which the rest of the chapters will build. The bipolar story lies at the heart of every bipolar narrative, and this chapter has demonstrated how complex a story it is. The corpus texts describe the bipolar story in two layers: the definitional, which arises from the clinical/medical narrative, and the experiential, which attends to the lived experienced of bipolar disorder. These two layers work together to convey a comprehensive representation of the complexities of the illness experience. The paradox of mental illness comes into play here as well, as the texts balance between revealing too much and too little. This chapter also considered credibility and the ways in which the bipolar story can be damaging to credibility. When texts reveal difficulties with basic narrative touchstones such as causation, coherence, and closure, readers may begin to question authorial credibility. The messiness of the bipolar story complicates these familiar narrative features and in order to regain credibility and recoup these losses, the texts employ specific rhetorical strategies. Before looking more closely at these strategies in Chapters 4 and 5, the next chapter will first focus on the corpus texts in order to provide a more comprehensive picture of bipolar narratives.
Chapter 3: The Lay of the Bipolar Land

This chapter will introduce the corpus texts and provide a sense of them as a group before later chapters focus more specifically on selected texts. I’ve chosen to organize the chapter around how the texts represent treatment. As Chapter 2 pointed out, treatment is a key event that appears in both layers of the bipolar story. Representations of treatment can demonstrate the different layers at work in a text: for example, the texts share a similar definitional layer, as all mention specific medications and treatments. But the differences abound in the experiential layer of the texts, as each author responds to treatment in a different way. The paradox of mental illness comes into play again here, as texts must beware the dangers of revealing too much about treatment (and appearing “too crazy”) and holding back too much (and appearing “not crazy enough”). The groupings in this chapter reflect three presentations of treatment: as linear, as recursive, and as chaotic. I will discuss these in greater depth below, but for now, note that these groups loosely correspond to the credibility continuum mentioned in previous chapters. Rather than mapping the three groups directly onto the continuum, I will use representations of treatment to demonstrate that credibility is not a matter of landing at the center of the continuum and belonging to the respective group. Rather, credibility in bipolar narratives is nuanced and the three distinct ways in which the texts describe and define treatment demonstrate the complexities of negotiating the paradox of mental illness. I will begin with the logistics of corpus selection before moving to the explanation of the groupings.
As indicated in the introduction, the corpus is comprised of 20 texts selected from multiple searches in WorldCat and Books in Print. These searches resulted in a master list of nearly 200 published bipolar narratives. I chose book-length texts because the bipolar story is a complex story that demands space within a text. Although blog entries or short articles may provide valuable information about bipolar disorder, I wanted to focus on how this illness experience specifically shapes narrative and most books are long enough to get a sense of the larger strengths or problems of the narrative. A blog entry, on the other hand, might be so brief as to preclude the presence of a unified narrative, and I wanted to deal with the complexities that were likely to emerge in book-length accounts of illness.

To arrive at the final corpus of 20 texts, I applied several filters. Initial searches revealed only a handful of bipolar narratives published before 2000, and these widely scattered texts seemed unlikely to come together as a group. On the other hand, the number of bipolar narratives published each year since 2000 has increased significantly, and I felt a larger sampling of texts was needed in order to identify pervasive themes and textual issues. I chose the end year (2008) as a result of current research on bipolar disorder. Specifically, in early 2008, an article in Molecular Psychiatry described a blood test that could potentially use biomarkers to diagnose bipolar disorder. In a related interview, one of the researchers indicated that this kind of testing could be “the dawning of a new age in psychiatry” in which genetic testing is used not only in diagnosis but also in evaluating effects of medication (Mitchell). Clearly, this kind of testing has the

22 Search keywords: “bipolar AND memoir,” “bipolar AND biography,” “manic-depression AND memoir” and “manic-depression AND biography.” I also searched based on BISAC subject header “Psychology/Psychopathology/Manic-Depressive Illness” and “Biography and Autobiography/General.”
23 Please see Appendix 1 for this master list of texts, organized by author last name.
24 For more information, see Le-Niculescu et al.
potential to radically alter the entire bipolar story, from diagnosis to illness experience to treatment, so that texts that precede the testing would likely be quite different from later texts. Choosing to limit the sample to texts published between 2000 and 2008 ensured that all of the corpus texts were in publication before the announcement of these new research findings. The eight-year span also seemed the most effective way to find texts that shared a common cultural and medical context, and as seen in the previous chapter, available medical and cultural narratives on bipolar do influence the texts.

I also eliminated all texts written by friends or family of those with bipolar disorder, texts written by medical professionals about patients with mental illness, or texts that included a co-author, because I was most interested in the firsthand experience of bipolar disorder as narrated by the individual with the diagnosis. As I am interested in the specific challenges of narrating the bipolar story, I wanted to examine texts that were as close to the lived experience of the illness as possible, and no family member or physician, no matter how intimate the relationship, can reliably describe the illness experience of bipolar disorder. This project investigates the self-narration of bipolar disorder, so family- and/or physician-authored texts are inappropriate and were excluded.

I continued to narrow the field by excluding texts that focused on multiple mental illnesses or psychiatric diagnoses. The bipolar story is complex by itself and I wanted narratives that focused intently on this illness. Also, multiple diagnoses would likely present their own challenges in terms of narrative. Lastly, I chose texts that were published in the United States, because the diagnostic standard here (currently the DSM-IV-TR) differs slightly from the international standard of psychiatric diagnosis. Texts

25 The International Classification of Diseases of the World Health Organization, 10th edition (ICD-10) diagnostic criteria for bipolar disorder differ from the DSM-IV-TR classification in two ways. First, the
published in the U.S. were assumed to fall under the purview of the *DSM-IV-TR*, meaning that authors have all dealt with the same labels and criteria for diagnosis.

As a next step, I consulted bookselling web sites, such as Amazon.com and Barnesandnoble.com, to get a stronger sense of the texts that were in print and readily available, as they appeared most likely to reach the widest audience and thus have the most impact within the genre of pathography. I also considered sales data when available, again trying to select texts that were being most widely read. From the remaining texts, I selected 25 texts as the preliminary corpus in 2008. After an initial read-through, five of the original texts were eliminated for the following reasons: no diagnosis provided (2), dual diagnosis (1), and international publisher (2).

The final corpus includes 20 texts, each of which is introduced and summarized in this chapter. All texts include a medical/psychiatric diagnosis of bipolar disorder, some kind of treatment, and descriptions of episodes. Text length varies considerably, from 103 pages to 333 pages, with 11 texts authored by women and nine written by men. Three-quarters of the texts allude to or directly mention bipolar disorder in the title. The majority of the texts were self-published using a publish-on-demand press; only three texts were published by major presses. Interestingly, two of these three texts were also best sellers. The texts are diverse in focus and in subject and the tone ranges from professional to novice. Most texts are the first publication of the author.\textsuperscript{26}

\textsuperscript{26}Marya Hornbacher is the notable exception, as she has previously published a best-selling memoir about her experience with an eating disorder as well as a novel.
I have chosen representations of treatment as the organizing principle for this textual summary chapter. The texts are loosely organized in three groups based on how treatment is represented. Each group of texts faces challenges to credibility as it struggles to balance between sharing too much and sharing too little. For example, if treatment is represented as simple and successful, readers may infer that bipolar disorder is easily treatable and not very severe. This response moves the text toward the “not crazy enough” end of the continuum and may cause readers to wonder about the legitimacy of bipolar disorder. In the same way, endless textual descriptions of failed treatments and dismal outcomes may highlight the foreignness of bipolar disorder as “too crazy” to treat or understand, thus damaging the author’s credibility and the believability of the text. But both of these examples could also benefit credibility—the first by portraying the author as stable and reliable and completely in control of the narrative, and the second by offering intimate details and knowledge that are available only to those who have experienced bipolar disorder firsthand. Thus, representations of treatment provide an opportunity to explore the nuances of establishing credibility in bipolar narratives.

The first group of eight texts (Group A) describes treatment as a relatively linear and straightforward process: the individual is diagnosed, medication is prescribed, and the episodes stop. This group seems to fall on the “not crazy enough” end of the continuum, in that the texts offer very little in the way of detailed examples and thus risk being dismissed as false. A second group of texts (Group B) describes treatment as a more recursive and ongoing process. In these seven texts, treatment is portrayed as a difficult, recursive process involving repeated stops and starts. Group B texts seem to land near the center of the continuum, in that they include some damaging details but
ultimately present treatment as successful and positive. The third group of texts (Group C) depicts treatment as an endless litany of useless medications and failed therapies. In these texts, treatment is a demanding, exhausting process, almost as chaotic as the illness experience itself. The last group of texts skews to the extreme end of the credibility continuum, the place where “too crazy” is a very real threat. In providing so much detail about treatment and presenting the process as harrowing and unsuccessful, Group C texts open themselves up to significant questions about credibility.

As we might imagine, the author’s personal experiences with treatment influence the role that treatment plays in the text. Those who have had difficult treatment experiences may devote more time and space to describing the challenges or triumphs of medication and therapy, whereas other authors may mention treatment only in passing because there is little else to say—the individual was given drug X, it worked, end of story. The discussion of texts will begin with plot summaries, followed by attention to how each group presents treatment and where the texts land on the credibility continuum.

**Group A: Treatment as Linear**

*Summaries*

At 113 pages, Ivy Berry’s text, *My Life... Welcome To It: Living With Bi-Polar Disorder (Also Known as Manic Depression)* is one of the shortest in the corpus. The text is divided into 15 chapters, each dedicated to one aspect of Berry’s life, including childhood, family, and work history. The last three chapters directly address Berry’s illness experience. The text does not connect the various people and events presented in the chapters, and this strict separation of subjects results in a text that is more an
informational picture of Berry’s life and less a coherent, plot-driven illness narrative. The moment of diagnosis is brief and thinly described and the text provides very limited information about bipolar disorder generally or Berry’s illness experience specifically. The most salient theme in Berry’s text is the supernatural, specifically past lives and unexplained presences and feelings. The final chapter of the text goes so far as to posit that “we are not just living with bi-polar (sic), but in fact are also reliving some past life experiences as well. Maybe we do not have a mental illness but rather a mental ability and are unaware or do not believe in these abilities” (110). Much earlier, the text describes several of the author’s past lives, including one in a town in the Wild West and another in which Berry was murdered by her mother. This type of information reminds readers of the paradox of mental illness: the idea of mental illness as reliving past lives is far from scientific or medically relevant and may mark Berry as someone “too crazy” to believe. The text ends by proposing that the confusion of reliving past lives can hinder an individual’s ability to “express their thoughts in a stable way. This may make professionals think these people are mentally unstable. Hence the label of bi-polar disorder” (111). Here again, the imprecision of the language, as well as lack of context or explanation, results in confusion and a mostly incomplete picture of the author’s illness experience.

The Secrets Within: A Memoir of a Bipolar Man is just a few pages shorter than Berry’s text, but John Forkasdi’s 108-page bipolar narrative devotes far more time and attention to describing bipolar disorder. The text is organized chronologically, beginning with Forkasdi’s childhood and moving forward through his adult life. Forkasdi attended Catholic school and grew up in a very devout family, and his faith plays a large role in
his treatment and recovery. The text mentions that Forkasdi was diagnosed with bipolar disorder in high school, at which point he began taking lithium. Although lithium works, Forkasdi does not reliably take it and continues to have episodes which cause fallout in his jobs, his relationships, and his ability to parent his children. The book ends with Forkasdi’s decision to travel abroad, and the trip is described in a series of short, journal-like entries in the appendix. Oddly, the appendix does not mention bipolar disorder or treatment at all, making it an interesting way to end the bipolar narrative. Forkasdi states that he included the travel journal to show that there is hope for people with bipolar disorder: “I was in the hospital for ten days in July and two months later, I’m in Africa. Don’t be afraid! There’s hope and there’s help” (76). Nonetheless, the ending feels disconnected and unrelated to the text proper and the bipolar story.

Whereas the first two texts in Group A were under 120 pages, the third text lands on the other extreme of the spectrum: Gene Leboy’s *Bipolar Expedition* numbers a hefty 333 pages. *Bipolar Expedition* includes a number of informational paratexts, including several reference lists and an extensive bibliography. The table of contents lists a staggering 190 titled chapters. Similar to Berry’s text, the chapters tend toward the anecdotal and are not clearly connected. The text begins at birth and moves through Leboy’s childhood and early adulthood. Leboy works as a physicist until his first suicide attempt, at which point he is hospitalized and diagnosed with depression. Leboy begins treatment, returns to work, and meets and marries his first wife. As Leboy details their eventual separation, the text’s focus turns toward the sexual and it continues in this vein for the remainder of the text. After his divorce, Leboy begins a long series of affairs with married and single women. The central (and largest) portion of the text, from roughly
page 70 through page 300, describes these relationships in graphic and inappropriate
detail. Nowhere in the many pages of relationship details does the text connect Leboy’s
sexual behavior with mania; rather, the affairs are presented as typical male behavior and
proof of Leboy’s incredible magnetism. The intense focus on intimate relationships
ultimately detracts from the bipolar story. Despite being one of the longest text in the
corpus, *Bipolar Expedition* spends very little time discussing Leboy’s illness
experience—fewer than ten of the 190 chapters directly deal with bipolar disorder.

Alternately, the bipolar story takes center stage in the fourth text in Group A.
*Invisible Driving*, by Alistair McHarg, is divided into 41 titled chapters written in
alternating voices: Sane McHarg and Manic McHarg. The chapters by Manic McHarg are
funny, outrageous, and nonsensical, full of wordplay, rhyming, and free association. The
chapters by Sane McHarg are more grounded, serious, and plot-driven. The text tells the
story of one of McHarg’s major manic episodes, which begins when he loses his job. As
the mania intensifies, McHarg pursues women constantly and elects to stop paying bills
because he would rather spend his money on alcohol and art. He moves in with a
girlfriend and eventually loses custody of his daughter, which amplifies his downward
spiral. McHarg is ultimately hospitalized after living in his car and being assaulted by the
police. The story told by Sane McHarg is frequently interrupted by Manic McHarg, and
the end result is certain chapters that seem to *live* the manic episode followed by chapters
that *explain* the manic episode. The alternating voices are purposefully confusing and
conflicting, as McHarg states that the text is written “from the inside out” (10) in order to
provide a behind-the-scenes glimpse of bipolar disorder.
Marc Pollard takes a similar approach in his text, *In Small Doses: A Memoir about Accepting and Living with Bipolar Disorder*. Early on, the text announces that events will be presented anecdotally rather than in a linear fashion, so that “the reader will be making this trek in the shoes of the mentally ill” (xii). *In Small Doses* is the shortest text in the corpus, with only 103 pages spread over five chapters.\(^{27}\) The text begins with several anecdotes that demonstrate Pollard’s erratic behavior, as he seeks refuge in a church and later in Alcoholics Anonymous. Pollard is diagnosed while pursuing a Ph.D. in Economics but he rejects both the diagnosis and all medication. His mental state continues to deteriorate, leading to a 21-day hospitalization. He eventually meets several good friends who take turns caring for him during episodes. The many gaps in the narrative aim to make the reader feel both “uninformed and misinformed” in order to create a sense of disorientation that “mimics that of the author” (vii). Near the end, the text comments on the need for wider public education about and acceptance of mental illness and Pollard admits that, before his hospitalization, he felt that mental illness was the stuff of horror movies that “[could] not afflict someone considered by all a success story” (11). This comment is especially salient in that Pollard is a success story in most senses and therefore considers himself “immune” or safe from the “tragic flaw” of mental illness (xiv). During his extended hospitalization, Pollard initially mocks the other people on the ward but after just a few days, he begs the staff to allow him to stay with the patients because they are “like family” (27). The text serves, in part, a larger mission of education and acceptance.

\(^{27}\) In my copy of *In Small Doses*, pages 95 and 96 are missing. I was unable to determine if this was a printing error or an error unique to my copy of the text.
Raising awareness and educating people about bipolar disorder is also a strong theme in *Manic by Midnight* by Faye Shannon. The organization is roughly chronological but the text frequently moves between present events (such as caring for her aging father) and past events (childhood, Shannon’s wedding). This movement makes the text difficult to follow at times. The text begins with Shannon providing her diagnosis followed by a short overview of her family history, which includes several immediate family members with mental illness. As Shannon travels home to care for and later bury her ill father, the text mixes present with past as Shannon recalls meeting her husband and early episodes before her diagnosis with bipolar disorder. When she returns home after her father’s funeral, she is consumed by a delusion involving the FBI and a top-secret mission. She files for divorce and gives up custody of her children as the delusions intensify, resulting in hospitalization and diagnosis. On medication, the delusions begin to recede and Shannon tries to make amends to her husband and children. Shannon writes a short article about her illness for *Good Housekeeping*, and despite serious reservations about making her illness public, Shannon is showered with positive attention and she and her husband make it their mission to educate people about bipolar disorder. The text ends with several short chapters focused on how Shannon manages her bipolar disorder, with special attention to faith and the importance of support from family and friends.

Although Lizzie Simon does not find strength in faith, her bipolar narrative does mention the importance of balance and support. *Detour: My Bipolar Road Trip in 4-D* tells the story of Simon’s cross-country journey to find other successful young people with bipolar disorder. The 216-page text begins with a flashback to Simon’s senior year studying abroad in Paris, during which she experiences a severe manic episode. She
comes home, is diagnosed with clinical depression, and begins taking an antidepressant. Simon then returns to Paris and becomes floridly manic. A full psychotic break forces her to return to the U.S. and seek immediate treatment. After the psychotic break, she is diagnosed with bipolar disorder and begins taking lithium, which controls her episodes completely. Following her college graduation and a few years of success at her first job, Simon embarks on a cross-country journey to meet and interview other successful young people with bipolar disorder in order to provide road maps, information, and encouragement to other young people with the illness. The remainder of the text documents the journey, including interviews in New York; Washington D.C.; Parkertown, VA; Atlanta; New Orleans; several unnamed small Texas towns; Phoenix; and Los Angeles. The stress of traveling and the misinformation she encounters force her to take a brief hiatus before completing her final interviews and returning home to mend her relationships with her family. The text describes bipolar disorder as “a journey outside the prescribed path” (206) and this journey has been both rewarding and difficult for Simon and those she interviewed. The text closes with the observation that there are different kinds of detours—some take you down paths in different directions but ultimately lead you back to where you began, and others take you down paths that are so powerful and amazing that you decide not to return to the road you were originally on. Simon’s text presents bipolar disorder as the latter, as both blessing and curse and utterly inseparable from the way Simon experiences the world.

Whereas bipolar disorder was a detour that led Simon in unexpected directions, George Staursky experienced the illness as a terrifying journey down “a path of self-destruction” (37). The final text in Group A is Staursky’s Goodbye Mom: My Bipolar
*Journey Through Trauma Tragedy and Recovery.* The text begins with an explanation of the title, which hints at the untimely death of Staursky’s mother when he was eight years old. The text repeatedly returns to this childhood event, identifying it as the start of the author’s mental illness. The text then moves to Staursky’s hospitalization and diagnosis after a manic episode before circling back to the events leading up to the hospitalization. The text frequently quotes other texts ranging from first-person narratives to depression workbooks to medical dictionaries, and this intertextuality is a major theme in the text. In addition to sharing Staursky’s illness narrative, the text also discusses the illness experiences of several famous people, including Andrea Yates, Jane Pauley, Patty Duke, and Kay Redfield Jamison. The second half of the text is focused mainly on celebrities and a more general discussion of bipolar disorder.

**Discussion**

From a formalist standpoint, the texts in Group A are fairly cohesive. Six of the eight were self-published using a publish-on-demand press. As a result, these texts are slightly less polished and more likely to include significant typographical and grammatical errors. Group A includes the shortest (103 pages) and longest (333 pages) texts in the corpus; the median length is 207 pages. All eight of the texts include paratextual materials, ranging from epigraphs to reviews to bibliographies. Thematically, these texts fit the conventional pathographic pattern of diagnosis, treatment, cure/recovery. As a group, these texts do not provide a detailed version of the bipolar

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28 Publish-on-demand presses vary widely in terms of services provided; some web sites offer contracts that include editors and graphic artists and others provide little beyond the physical publication of the text. All involve paying to be published rather than the traditional publishing model of a publisher purchasing and distributing a text.
story, in part because it is a straightforward story in these texts and thus does not require
a great deal of explanation or elaboration.

For example, Staursky’s text presents treatment as direct and successful—the
doctor gives him medication, and when he takes it, he experiences a full recovery. The
same is true in other texts in this group. Although each text presents a personalized
version of the illness experience, these texts share a representation of treatment as
relatively straightforward and linear. By straightforward, I mean that the texts describe
the symptoms, the individual seeks treatment, and the treatment (most often medication)
works successfully to control the illness. The majority of the texts mention only
pharmaceutical treatment, most often lithium in combination with other medication(s).
Medication is presented as life-saving and necessary: “I’ve got a shrink. I take my
Lithium. Every morning. Every evening” (McHarg 9). Simon’s text also stresses the
importance of lithium, which, after only two days, helped Simon to regain control and “a
functional brain” (23).

Despite sharing a largely positive view of treatment, some texts in Group A also
express ambivalence about medication. For example, even after being diagnosed with
bipolar disorder, Marc Pollard repeatedly refuses medication and insists that his erratic
behavior is not manic but merely energetic and driven. When he finally agrees to take
lithium, it works almost immediately. This would seem to be a good thing, but in
Pollard’s case, the “return to sound body and mind left me with the illusion that my
condition was curable, or more precisely, that it has been cured” (43). Accordingly,
Pollard stops taking medication. As might be expected, his condition deteriorates and
when he finally sees his psychiatrist, he receives a strong reprimand about discontinuing
medication. Simon also expresses ambivalence about lithium after a horrible experience with the heavy-duty antipsychotic drugs given to end her psychotic episode. She describes the “lovely drugs” as anything but, using the following analogy to explain how they work: “I imagine the brain like an outer space cosmos, with little ships and beams of light zipping around carrying messages and directives. I imagine my universe at the time in utter chaos, and the antipsychotics as a nuclear bomb. Like we haven’t developed humane sophisticated ways to deal with disorder, so let’s melt the whole thing down” (21). The comparison of the medication to a nuclear bomb is unexpected, as nuclear bombs are associated with violence, death, and total destruction and treatment is generally viewed as a useful thing. The text declares that the antipsychotic drugs are neither humane nor sophisticated but sometimes necessary, as was the case with Simon. Simon does not dwell on this terrible experience, instead moving ahead with discussion of treatment and recovery. This brevity in responding to and discussing treatment is part of the linear treatment narrative presented in Group A.

Group A texts present treatment as a linear process that is mostly positive; the occasional moment of difficulty is not belabored or extended, as the texts touch on it and move on. On the surface, the simplistic treatment narrative may seem to threaten credibility, as the lack of details may cause readers to question the severity of the author’s mental illness or the accuracy of the illness experience. The lack of details may also imply that the author has something to hide, which could damage credibility by making the author appear suspicious or not entirely honest. But the same lack of details could also work to the texts’ advantage in that lack of symptoms suggests that the mental illness is part of a distant past rather than something the author is actively dealing with.
Portraying treatment as straightforward and successful reinforces the idea that the author is reliable and in command of the narrative. So when Lizzie Simon writes positively about her experience with lithium “a functional brain” (23), readers are encouraged to trust that functional brain. A functional brain is far more reliable than a dysfunctional, ill brain. And readers may be able to overlook the reason behind the functional brain (severe mental illness treated by a lifetime of prescription drugs) if the author seems fully reliable.

Even when the texts express ambivalence about treatments, as we saw in the previous paragraph, they ultimately resolve the tension by accepting the medical treatment. So although Marc Pollard refuses medication several times, the onset of a severe episode and a scolding from his psychiatrist teach him that medication is a good thing and he writes that he has faithfully taken his medication since that day. Pollard’s credibility is actually enhanced by his adherence to medical treatment and even the ambivalence is merely a temporary stumbling block on Pollard’s road to recovery. If present, the ambivalence is short-lived and quickly resolved; this too may actually help credibility in presenting the author as human and prone to stumbles or struggles but still able to overcome them. In any case, these texts do not automatically have increased credibility by virtue of presenting treatment as successful. Group A texts may find themselves on the “not crazy enough” end of the continuum, as readers expect proof of illness by way of details. But the same missing details can also improve credibility by distancing the illness from the author and making him or her appear to be fully in charge of the narrative and quite reliable. The situation is more complicated in Group B texts, which present treatment as a recursive process with numerous steps and missteps.
Group B: Treatment as Recursive

Summaries

Group B begins with The Edge of Sanity by Olivia Burnett. The 156-page text is both bipolar narrative and travel narrative documenting Burnett’s cross-country adventures over a period of years. The text begins with Burnett and a friend, Davy, leaving Yellowstone National Park. They are unemployed and broke, living in a trailer attached to Burnett’s Saturn and camping illegally in various national parks. A sense of movement permeates the text, as Burnett is always on the road driving somewhere—the text includes at least three cross-country trips between Montana and Connecticut, as well as numerous other road trips. Burnett’s bipolar disorder seems to follow a seasonal schedule, and every fall, regardless of where she lives, Burnett spends time in a hospital or a crisis center. Along the way, she meets a cast of wacky characters and experiments with drugs, alcohol, and the supernatural. The text glorifies this nomadic existence, asserting that Burnett’s most authentic and honest story “begins and ends with the road” (vii).

The search for a place to belong is also an important theme in Ruth Cohen’s Remains of a Cloud. Cohen’s text begins with the announcement that she is “a child of exile” (15) and this proves to be a key theme in the text. Cohen grew up living on several continents and witnessed her parents’ own mental health struggles with depression and anxiety. Shortly after graduating from college, Cohen marries and has a son. After the baby is born, Cohen experiences intense postpartum depression and is hospitalized for four weeks, during which time she begins psychotherapy. Cohen longs to return to Israel
(which she views as her home land) but her husband refuses. A trustworthy psychologist and therapy get Cohen through several more episodes, though her condition seems to worsen. Near the end of the text, the writing becomes more stream-of-consciousness and difficult to follow, as Cohen writes about trying to find her lost self, a childhood alter ego named Machou. She and her husband divorce after many years of unhappiness and the book ends with the re-discovery of Machou and a series of increasingly incoherent observations about life and spirituality.

Whereas Cohen turned to faith to heal, Avery Conner turned to science. His bipolar narrative, *Fevers of the Mind: Tales of a Roaming, Wounded Critter*, includes Conner’s elaborate scientific theories about medication and mental illness. The first part of the text provides basic background information, leading up to Conner’s enrollment in graduate school at Johns Hopkins University. His emotional and social struggles take him to a psychiatrist, who prescribes Prozac. Conner, a dedicated scientist, then reads everything he can find on Prozac, including well-known books by Peter Kramer and Michael Norden. After his research, he considers himself an expert on the drug and begins to negotiate his treatment with his doctors as though they are colleagues in consultation. When they do not agree with his theories, he simply makes the medication adjustments without telling them. Conner graduates and returns to Indiana to be close to family, at which point he becomes hypomanic and develops several very expensive and far-fetched business ideas. He is hospitalized twice and when his psychiatrist does not tell him what he wishes to hear, Conner gets second and third opinions and tries alternative therapies. Eventually, he goes back on medication and continues to adjust doses based on
his complex theories about brain chemicals. Despite his endless meddling, the medication works and the text ends with Conner in stable condition.

Patty Dean’s bipolar narrative, *A New Song: Confessions of a Joyful Manic Depressive*, shares Conner’s distrust of doctors. Dean’s text begins with her childhood and proceeds quickly into adulthood and Dean’s first marriage at the age of 18. She has a son but the marriage doesn’t last. Following the divorce, the text indicates that Dean’s life begins to swirl out of control, as she runs away with a lover, is hospitalized for four months, and then has several traumatic experiences that exacerbate her mental illness. The text follows Dean through six marriages altogether, most of which last fewer than six months. The text also documents Dean’s ongoing struggles with recurrent episodes and medication that does not work. Non-compliance and quitting medication altogether are dominant themes in the text, as Dean alternately accepts and rejects treatment, in part because of doctor negligence that resulted in Dean’s near-fatal lithium poisoning. This event does little to boost her faith in doctors, and the text laments the difficulty of finding “a doctor with a brain and a little compassion” (99). After a number of suicide attempts, alcohol-induced accidents, and hospitalizations, the text ends with Dean finally in a place of stability and happiness.

Whereas the previous two texts expressed significant doubts about medical treatment, Holly Hollan’s text views an empathetic and understanding doctor as the most vital factor in recovery. *Soaring & Crashing: My Bipolar Adventures* begins with an introduction packed with scholarly research and information on bipolar disorder. The text begins with clear definitions of bipolar disorder, as well as information about possible

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29 As Dean succinctly explains, because “the therapeutic dose [of lithium] is fairly close to its toxic dose, it has to be monitored often” (55). Dean’s doctor at the time did not properly monitor her lithium levels and she nearly died from lithium poisoning.
causes and treatments. This introduction serves as a solid foundation for the narrative that follows. Hollan experienced panic attacks as a child, and they intensify when she is expelled from college for attempting suicide. She marries a good friend but her hypomania makes her hypersexual and numerous affairs destroy the marriage. Shortly after the death of her best friend, Hollan experiments with drugs and starts having delusions about special missions from God. A recurrent delusion involving Neil Diamond pushes her to move cross-country to Los Angeles. She is hospitalized and begins to recover, only to experience another severe manic episode with more Neil Diamond delusions. After successful treatment during a second hospitalization, Hollan marries again and moves to Texas. After several more episodes and the sudden death of her husband, Hollan reaches a point of stability, and the text shares an anecdote about Hollan’s appearance on the Delilah radio show after she wrote the host a letter explaining how Neil Diamond saved her life. Hollan speaks with Diamond during the radio show and the text ends with great optimism and gratitude for all of the medical help Hollan received to get to a functional place.

A network of supportive doctors and friends is also important in Bruce Patzer’s text, *The Pill Box: One Man’s Hopeful Struggle To Overcome Manic Depression*. The text includes a lengthy, 32-page appendix of resources from the National Depressive and Manic-Depressive Association\(^\text{30}\) as well as books, videos, organizations, websites and internet resources, and state-by-state contact information for NAMI affiliates. This information is part of the text’s overall mission of education and awareness raising, which Patzer reveals early on. The text begins with Patzer’s struggles to adjust to a new job as a junior high band director. When he starts to have panic attacks, he goes to a

\(^{30}\) Now known as the Depression and Bipolar Support Alliance.
psychiatrist, who prescribes medication and sends Patzer to a mental hospital for one week. Patzer recovers enough to find a new job and he marries his girlfriend, Cyndee. On a fishing trip in Canada, Patzer has a serious depressive episode and attempts suicide repeatedly. He gets treatment but begins abusing the medications and eventually ends up back in the hospital after another episode. After several stops and starts with medication, Patzer’s doctors finally find a combination of medication that works and the epilogue reveals that Patzer has been stable for the last six years. The treatment narrative in this text is a mix of Patzer’s actions and the difficulties of finding medications to control his episodes. The drug abuse and non-compliance add additional layers of complexity to an already involved treatment narrative.

Jane Thompson’s text, *Sugar & Salt: My Life with Bipolar Disorder*, also addresses the issue of medication compliance. Thompson’s 164-page text begins with a short introduction in which Thompson declares “I’m bipolar, or manic-depressive, but I’m stable on medication” (xiv). This announcement underscores the importance of treatment in the text, but getting to a point of stability has been far from straightforward or simple for Thompson. The text begins with Thompson’s childhood and touches on her family history of mental illness before moving to her school and college years. Thompson meets her husband, Bill, in graduate school. A short time into the marriage, he becomes abusive, pushing Thompson to withdraw and attempt suicide. They separate and she begins to look for a doctor. Her medication stops working and the episodes become more frequent, interfering with her ability to keep a job. After a short hospitalization, she becomes an activist and advocate for her own mental health care. After many years of struggling to find a combination of medications that will control her episodes, the text
ends with Thompson in a good place both mentally and emotionally. The text repeatedly expresses distrust of doctors and medical professionals, as Thompson encounters doctors who refuse to see her as an individual and base their decisions on stereotypes about people with mental illness.

Discussion

As a group, these texts share several textual properties. All but one of Group B’s seven texts were self-published using publish-on-demand presses. Group B texts are, on the whole, shorter than those in Group A, averaging right at 190 pages. The texts generally follow a chronological organization, with the majority beginning at childhood and providing extensive background information on the author. Four of the texts include a foreword or preface written by a doctor or medical health professional and half of the texts include some kind of reference or resource materials. The presence of these outside voices of authority may be one way in which the texts try to improve credibility, but, as I’ll discuss in a moment, the turn toward a medical authority is not always beneficial.

The texts in Group B represent treatment as a recursive but ultimately successful process. The recursive nature of treatment comes through clearly as the texts describe the cycle of medication adjustment—hopeful optimism, the waiting period, and, sometimes, bitter disappointment when the combination of medications fails to work as hoped. Although treatment is a complex and difficult experience in these texts, it must be noted that Group B texts do present treatment as effective. Although the description of treatment is not as linear as we saw in the Group A texts, these texts all end with some type of recovery. Complex treatment in some ways reflects the complexity of bipolar
disorder, and these texts begin to demonstrate the challenges inherent in trying to tell this particular story. But there is also some danger in telling a more truthful story about treatment, as mental illness that does not respond to treatment may seem extreme and difficult to understand. And with each passage about a failed treatment, the text becomes a bit less comprehensible, as frustration and disappointment build and the texts themselves express anger or resentment, as when Olivia Burnett complains that she and her hospital friends feel like “lab rats and the doctors are mad scientists experimenting on [them]” (45). Though the end result for Burnett (and the other Group B authors) is positive, these texts do not ignore the costs of treatment or the fact that the treatment process is not as linear as in the Group A texts.

Accordingly, this group of texts devotes more time and space to descriptions of treatment. In addition to weaving treatment into the narrative, Holly Hollan’s text dedicates an entire 16-page chapter to a thorough discussion of her treatment history. The history itself is far too complex to summarize, but it begins with small doses of lithium and then fluctuates almost constantly until Hollan and her doctors find a combination of medications that work nearly 25 years later. The chapter certainly invokes the “lab-rat” feeling mentioned in Burnett’s text, as Hollan moves from one doctor to another, adding and subtracting pills like candy. Jane Thompson’s text includes a similar laundry list of medications, ranging from antidepressants to lithium to antipsychotics. The text describes Thompson’s skepticism in great detail when her doctor repeatedly promises “that if we kept adjusting the dosages of these drugs along with the lithium and antidepressant I was on, I would become stable. I didn’t seem to feel better inside my head, and told him so. He told me just to have faith in him” (114). The only thing that changes for Thompson is
her way of interacting with doctors, whom she views with distrust for the remainder of the text. And the frustration is not unwarranted—each adjustment prompts a new wave of side effects, including weight gain, shuffling, drooling, confusion, and intense thirst.

In addition to detailing the many physical challenges of treatment, these texts also provide examples in which individuals are discounted or dismissed because they are seeking treatment for a severe mental illness. Thompson describes several demeaning encounters with physicians, and she is repeatedly discouraged from participating in her own treatment. Thompson’s text includes one especially telling example: “The doctor insisted that it [lithium] was the drug that would help me. When I objected that I was not getting any help from it, he told me that I was ‘crazy’ and couldn’t know what was good for me. Only he, the doctor, was capable of making that judgment” (108). This example explicitly demonstrates the paradox of mental illness: Thompson attempts to speak up about her treatment and the doctor responds by ignoring her because she is a “crazy” person who is not capable of commenting on her own treatment. Instead, she must leave that to the medical experts who are more capable than she could ever hope to be. Examples such as this are more common than not, and this kind of mistreatment further complicates the representation of treatment.

In some cases, the texts express such disgust with medical professionals that individuals take control of their own treatment. This is the case in Avery Conner’s text, which describes numerous appointments with an array of doctors, each of whom offers a treatment plan that Conner does not follow. In addition to changing doses and quitting medication, the text also mentions that Conner frequently adds vitamins or supplements to his treatment. In this text, treatment is presented as an exercise in negotiation, as the
text shows the back-and-forth between the doctor (who writes a prescription and gives instructions) and Conner (who immediately challenges the doctor). For example, here is Conner’s description of a meeting with Dr. Fillmore: “We discussed my treatment history…and he suggested that we might try Zoloft again. I vetoed this, told him of my norepinephrine deficiency theory, and we eventually settled on an old tricyclic antidepressant, Desipramine, which is thought to boost norepinephrine” (151). Most readers are not accustomed to bargaining with doctors in quite this way, but it is the norm in Conner’s text. When the medication works and Conner’s depression lifts, he makes the sage decision “to quit both the Wellbutrin and the Zyprexa cold turkey, though I didn’t tell Dr. Fillmore. I figured these two meds weren’t doing much anyway, so why keep taking them?” (151). As these two examples demonstrate, Conner’s treatment challenges are at least partly self-induced, and the text provides numerous such examples, as Conner repeatedly trust his own opinion over that of his doctors. Treatment here is a recursive process, as Conner seeks out professional help but then takes treatment into his own hands and ends up far worse than he started out. Unfortunately, the text does not indicate that Conner is aware of his own role in the treatment difficulties, and near the end, Conner blames his continued episodes on the fact that he has “always been somewhat unresponsive to therapy” (157). Though it’s not clear if he is referring to his brain chemistry or his attitude toward medication, it is clear that his many elaborate theories of pharmacological interactions and the brain do little to accelerate his recovery.

Although Conner’s text presents an extended example of ongoing treatment, all of the texts in Group B describe multiple unsuccessful attempts at treatment before finally hitting upon a successful combination of medication and, in some cases, alternative
therapies. Ruth Cohen, for example, becomes almost fanatical about psychotherapy, to the point that she declares that “only psychotherapy can correct the damages done by a disorder of moods” (78). Initially, Cohen rejects medication, going so far as to throw out the pills because she “believed the healing was more a matter of psychological strength” (64). Eventually, Cohen agrees to take medication but only in conjunction with psychotherapy. Even at that point, she insists on the power of psychotherapy: “Previous doctors had said that medicine saved my life, and even though I will have to agree with them partly, I will also have to say that only good psychotherapy could erase the damage done by my mental illness” (58). The medication seems to be only a small part of the ultimate solution, and the text repeatedly praises the power of psychotherapy. Even when she continues to experience episodes, Cohen maintains that “the medicine would never do the wonders that psychotherapy did” (65). Eventually, the combination of intensive psychotherapy and medication controls Cohen’s episodes, but the text points out that the path to success was far from linear or simple.

Although medication can be ineffective, the texts also present examples in which the ill person’s behavior interferes with treatment. This was certainly the case in the above examples from Conner’s text, which showed how his strong opinions and theories undermined the treatment plans provided by his doctors. But Bruce Patzer’s text demonstrates that overreliance on medicine and medical expertise can be equally damaging. After his diagnosis, Patzer’s doctor prescribes “a strict regimen of mood stabilizers, anti-depressants, anti-anxiety medicine and sleeping pills” (68) totaling 32 pills. Ironically, the very thought of taking this much medication causes Patzer to experience additional anxiety and he begins to abuse the anti-anxiety medication (in his
case, Xanax). The text reveals that, at his worst, Patzer took up to nine extra Xanax every day, more than three times the prescribed amount. Like the others in Group B, Patzer’s text ends with the author in a place of relative stability in which his episodes are well-controlled by medication. But the text arrives at this success only after describing two hospitalizations, a long list of useless medications, a stint of drug abuse, and four ECT treatments. The text does not take a negative view of Patzer’s numerous attempts at treatment, instead pointing out that the years of failed treatment were important steps on the road to effective treatment for Patzer.

Although these texts would appear to be in an ideal place in terms of credibility—enough details to prove illness but not so many that readers start to ask questions—this midway point is not an easy place to be. On the whole, the presentation of treatment as recursive can both hurt and help credibility. As with Group A, these texts present treatment as necessary and successful, albeit in a less linear or straightforward way. The success of treatment enhances credibility by relegating illness to the past, implying that the author is in full command of the narrative. The idea of taking control of one’s treatment can also increase credibility by making the author appear empowered and willing to do whatever it takes to get well. As I mentioned, several of these texts begin or end with a short piece written by a doctor or medical professional, and this association can work for and against the author, in that readers may view the alliance as beneficial if they perceive medical professionals as trustworthy and helpful. But if readers pick up on the resentment and anger toward doctors and therapists, they may wonder why an author would choose to include a medical voice in his or her narrative. This choice may cast doubts on the author’s state of mind and credibility, as readers can’t help but wonder why
patients who have been mistreated by doctors would create a space for them within the text.

A greater focus on treatment can also benefit credibility by providing greater detail about response to medications, and details constitute valuable proof of illness. This becomes even more crucial when we recall that bipolar disorder does not have external, verifiable symptoms and is diagnosed solely through patient reports of symptoms and feelings/thoughts. The fact that Group B texts end with successful medical treatment also reinforces credibility by creating a separation between the episodes or difficulties (the past) and successful treatment (the present).

Conversely, presenting treatment as recursive and difficult can also damage credibility by moving the text toward the “too crazy” end of the continuum. For example, most readers would likely view Avery Conner’s personal theories and medication experiments as irresponsible and perhaps even as confirmation of mental illness. Patient interference in treatment runs a high risk of being interpreted negatively, as readers may struggle to understand why patients would presume that they know more than the trained professionals. This resistance to medical intervention, however short-lived, may still harm credibility and mark an author as unable to determine what is really best for him/her. Both the medical and cultural narratives around illness center on seeking treatment from medical professionals, and resisting or refusing treatment may be viewed as malingering or even as attention-seeking behavior. When treatment is described as difficult and damaging, readers may fail to understand why anyone would want to prolong suffering by interfering with or resisting treatment.

31 For more information on medical and cultural narratives of illness and the sick role, see Genton.
As with Group A, credibility in Group B texts is nuanced and shifting. Offering details about and responses to failed treatments is not automatically damaging to credibility. The texts are constantly negotiating the paradox and trying to avoid moving too far toward either extreme on the credibility continuum, and the Group B texts seem to have the best of both sides: they include some of the details and information needed to avoid the charge of “not crazy enough” while avoiding the appearance of “too crazy” by ultimately finding success in medical treatment. But these texts demonstrate that credibility is not as simple as avoiding extremes. Even in the middle space, questions of credibility may intrude in ways readers find hard to ignore. The intrusions become even louder in the last group of texts.

**Group C: Treatment as Chaotic**

*Summaries*

Andy Behrman’s bipolar narrative, *Electroboy: A Memoir of Mania*, is the first text in Group C and an excellent example of a text that presents treatment as chaotic and extraordinarily difficult. Behrman first experienced “the crazies” (6) when he was a young child, and the text remarks that Behrman’s childhood was dominated by feelings of difference and discomfort. These feelings intensify when Behrman moves away to college, pushing him to seek therapy for the first time. Unfortunately, even though Behrman does his best “to compress eighteen years of obsessions, compulsions, anxiety and depression into fifty minutes” (16), treatment does nothing for him. After graduation, Behrman moves to New York City and works numerous odd jobs including hustler/stripper, buying assistant for Giorgio Armani, filmmaker, and PR consultant.
Behrman then takes a job working with Mark Kostabi, a famous artist who pays others to create his paintings. As an art dealer, Behrman travels internationally and lives a fast-paced life that suits his mania. One of Kostabi’s painters approaches him with a plan for creating and selling fake Kostabis, and the two make a lot of money on the counterfeits before they are caught. Behrman is prosecuted and serves time in a community corrections center, where he receives treatment but continues to get worse. Near the end of the text, Behrman connects with a psychologist/psychiatrist team who works to stabilize his condition to little success. He has a series of ECT treatments and the text ends without answers about the success or failure of Behrman’s treatment.

Conversely, Terri Cheney’s text, *Manic: A Memoir*, ends with a clear statement of Cheney’s treatment as successful. But the text describes the path to success as chaotic, leading Cheney to declare that the treatment she received for bipolar disorder was perhaps more damaging than the illness itself. Cheney’s 245-page text is organized episodically; each chapter describes an episode but the chapters are not arranged in any discernible order. The text begins with violence, when Cheney is viciously raped and then attempts suicide on Christmas eve. From this point, the text jumps around unpredictably, touching on many different parts of Cheney’s life including her childhood, college years, and her career as a celebrity lawyer. The text reveals that Cheney has been hospitalized several times and has taken many different medications. There is also a chapter that describes Cheney’s experience with ECT. The chapters are not connected and each takes place at a different time, in different locations, with different people. The only connective thread is Cheney herself. Otherwise, the text lacks an overarching narrative trajectory and the information offered is scattered enough to make it nearly
impossible to place the episodes or events in relation to one another, resulting in a text that feels like a disorganized collection of anecdotes from a very difficult life.

After the disarray of Cheney’s text, the roughly chronological organization of Lora Inman’s text is comforting and familiar. *Running Uphill: A Memoir of Surviving Depressive Illness* is just under 150 pages long and begins with a brief explanation of Inman’s dysfunctional childhood, including her Christian Scientist parents’ refusal to believe that Inman’s mental illness was real. Inman graduates from high school, marries, and divorces. She marries a second time and after the birth of her son, she experiences severe postpartum depression, causing a second divorce. She retains custody of her son but is unable to care for him due to a breakdown and hospitalization. After a brief period of stability, Inman is again hospitalized but it is an overwhelmingly negative experience. The text includes many pages of furious commentary detailing the ways in which Inman was mistreated. With some help from a decent doctor, the episodes taper and Inman meets and marries her third husband. After another negative hospital experience, she undergoes ECT, which does not work well. The final section of the text becomes a journal with dated entries that describe Inman’s preparations for the upcoming Christmas holiday. In the last few paragraphs, the text reveals that Inman has been episode-free and stable for six years. However, the text is dominated by Inman’s negative treatment experiences, which is why it is part of Group C.

Bruce Goldstein’s text, *Puppy Chow Is Better Than Prozac: The True Story of a Man and the Dog Who Saved His Life*, is also dominated by Goldstein’s seemingly endless attempts to treat his bipolar disorder. The 287-page text is divided into three parts: the first part details Goldstein’s illness experiences, including his search for
effective treatment; the second part focuses on his decision to adopt a puppy; and the third part demonstrates how caring for the puppy became part of his treatment and helped him to recover. The text does not offer much background information, beginning instead with a particularly difficult episode during a holiday camping trip with friends. Goldstein is nursing his wounds after being dumped by the love of his life and the weekend proves to be more than he can handle. When he returns home, he sees a psychologist who diagnoses him with bipolar disorder. Goldstein initially refuses medication because he is afraid it will “take the Bruce out of Bruce” (59). He relents after repeated hallucinations involving Satan and the knives in his kitchen daring him to commit suicide. The medication makes him physically sick and intensifies his Crohn’s disease, and no matter what they try, Goldstein and his doctor cannot find a combination that works. When he feels he has exhausted all options, Goldstein decides that a puppy is his “last chance at therapy” (168). The responsibility of owning a puppy in New York City forces him out of his apartment and puppy ownership becomes therapeutic. Even his doctors buy into it, telling him, “It all works together. Ozzy [the puppy] and the therapy and the medication” (222). The text ends with an epilogue written ten years after the text, in which Goldstein credits Ozzy with saving his life.

The final text in Group C also presents treatment as chaotic, and a significant portion of Marya Hornbacher’s bipolar narrative deals with Hornbacher’s lifelong struggle to treat her bipolar disorder. *Madness: A Bipolar Life* is divided into four parts and features a significant number of paratexts, including a prologue, an epilogue, and 19 pages of informational resources at the end. The text is arranged chronologically and each part covers a specific date range (for example, Part I is comprised of 15 chapters that
cover 1978-1995). The text begins with four-year-old Hornbacher experiencing “the crazies” for the first time (15). From there, the illness intensifies as Hornbacher begins to have episodes and is hospitalized repeatedly. The text details Hornbacher’s treatment, as she is diagnosed and she and her doctor work together to find medication that will control her episodes. There are moments of meta-commentary woven into the narrative, as Hornbacher reflects on her decisions and the length of time it took her to fully accept the diagnosis and to receive effective treatment. Serious episodes are interspersed with significant life events, including Hornbacher’s marriage and the publication of her first book. Part III documents a two-year period in which Hornbacher is hospitalized seven times. The text ends with an epilogue in which Hornbacher wishes to be free from the illness and hints that she is only just beginning to accept her diagnosis. The end is far from optimistic or upbeat and the improvement that is present feels very precarious.

Discussion

The texts in Group C have much in common on both formalist and thematic levels. All but one of the texts were published by a major press, and two texts appeared on the New York Times Best seller List. These texts are the longest in the corpus, averaging 250 pages. With the exception of Behrman’s text, all of the texts were published in 2007 or 2008, making this the group with the largest number of recently published bipolar narratives.

The texts in Group C represent the extreme end of the continuum that began with Group A (treatment as linear) and continued with Group B (treatment as recursive). In a word, treatment in these texts is presented as turmoil. Whereas the previous group of
texts described treatment as somewhat difficult, involving numerous failed attempts leading up to a successful end, the texts in Group C describe treatment as frustrating, exhausting, and futile. All of these texts include at least one hospitalization as part of treatment and several texts also involve ECT.

Each of the texts presents treatment as a complex and constantly changing process, and a lengthy example from Behrman’s text illustrates this:

I’m walking down Broadway to the cash machine when all of a sudden I start feeling a razor blade slicing my tongue from all different angles. I twist my face in agony and hope that nobody notices. The psychotic episode only lasts for about thirty seconds, but I can’t get the image of razor blades out of my head, or the belief that my tongue is a bloody mess. …After I call Dr. Fried in a panic, she puts me on the antipsychotic Risperdal, which relieves me of these visions but has several bizarre side effects. For instance, I become very stiff and walk with a shuffle, I lose facial expression and don’t blink, and I can’t urinate in a straight line any longer… I’m put on Propranolol to counterbalance the tremor, which seems to help a bit, and Symmetrel for the stiffness. I am taken off the lithium and put on a different mood stabilizer, Tegretol, but it makes the backs of my hands itch and gets me revved up, so I have to stop using it. (189)

In this example, the episode begins with a hallucination which is treated with Risperdal, an antipsychotic. But that drug causes multiple undesirable side effects and Behrman must then take three additional medications to counteract the side effects of Risperdal. And although Tegretol may work to stabilize Behrman’s moods, it also makes him itch and feel nervous, so his doctors must continue to search for another mood stabilizer that
will not cause these side effects but will work with Behrman’s other medications. In this example, medication becomes a double-edged sword: it may relieve a negative symptom while simultaneously introducing a new negative symptom. Behrman’s text provides many similarly dramatic examples of the ways in which treatment can become chaotic.

But the texts in Group C do more than just demonstrate that treatment can be difficult, going beyond difficulty to describe treatment as damaging. Behrman’s text mourns the loss of the excitement and adventure of his manic episodes, explicitly declaring “My recovery represents a tremendous loss” (261). But other texts admit losses that go beyond Behrman’s nostalgia for his action-packed lifestyle. Both Hornbacher and Cheney comment on the devastating effects of ECT, which harms short-term memory and leaves Hornbacher to “reconstruct [her life] from the wreckage of [her] mind” (217). Cheney’s text is the most directly critical of treatment, stating that “the illness, ironically, has impaired me far less than the treatment. I’ve long since lost track of all the psychotropic medications I’ve had to take over the years, or the nature and number of their side effects” (2). This statement offers the clearest example of how treatment can be damaging, and although this sentiment is echoed in other Group C texts, Cheney’s text states it most directly.

Goldstein’s text also addresses the failures of medication, declaring that the “only alternatives left were being institutionalized or a bullet in my temple” (109). This example demonstrates the incredible frustration that surfaces time and again in the Group C texts. After repeated attempts to adjust his medication, Behrman bemoans the process: “Every week there is something new to mix into the cocktail. I’m utterly hopeless. It’s all making me sick” (258). And the frustration isn’t limited to medication—as Inman’s text
illustrates, it extends to alternative therapies as well, including “homeopathy, herbal remedies, changes in diet, acupuncture, sleep deprivation, counseling, yoga, [and] faith healers” (38-39). Each text includes multiple examples of failed treatments, and as the examples accrue, the possibility of recovery seems less and less viable. In addition to considerable frustration, Behrman’s text also describes feelings of shame and fear that “Nobody can help me. The next episode is going to kill me” (220). It is not difficult to see how repeated treatment failures could contribute to a sense of disarray and a perceived loss of control, and these difficult feelings must be addressed repeatedly in these texts in which successful treatment is almost never realized.

And for the few Group C texts that do report treatment success, the success feels unsteady, “like such a precarious thing, dependent on just the right dose by just the right doctor” (Cheney 242). Even so, Cheney’s text represents treatment as ultimately beneficial, as the author reflects on the last few years of her life and the peace she has found. Hornbacher’s text also mentions fear and concern about the future, in part because her version of bipolar disorder, “ultra-rapid-cycle type I, is tough to treat, and the doctors have warned me that it will probably put me in the hospital again. But they can’t say how often, or when it will happen next” (215). This quotation underscores the reality that there is no cure for bipolar disorder. There are periods of remission and episode-free days, but these temporary blessings can be lost in the blink of an eye. Inman’s text captures this instability: “We are prisoners of this malady, and our sentence is life. Nonetheless, in the absence of hope we must keep struggling to survive—as many do—by the skin of our teeth” (10). And, as these texts illustrate, it is not just the illness that must be survived, but the treatment as well.
On first glance, Group C texts may seem doomed to face serious questions about credibility and banished to the “too crazy” end of the continuum. There is certainly much in the texts to diminish credibility. The presentation of treatment (by licensed professionals, no less) as chaotic suggests a lack of control over the narrative, as though the authors are fully at the mercy of the illness and its treatments. And readers will have a hard time trusting an author who is not in control of the narrative. Treatment as a constantly shifting, changing process with more downs than ups is also damaging, as each successive treatment failure marks treatment success as less likely. When Andy Behrman expresses frustration that nothing is working, it is easy to pick up on the hopelessness in his words. Some texts come right out and declare that treatment is hopeless, and this certainly undermines credibility by implying that the author will forever be in the grips of severe mental illness.

But these “too crazy” texts also possess the resources to boost credibility, and even things that seem negative can be useful. Group C texts present the most detailed and intimate version of the bipolar story, bringing readers closest to actually seeing and hearing what mania and depression feel like, and this proximity to the illness experience increases credibility. Sharing this kind of information is an act of bravery and courage and readers may respond well to these characteristics and give the author credit for choosing to lay him- or herself bare for a reading audience. The representation of treatment as constantly in flux can also work to benefit credibility, as the worst and most damaging episodes are temporary and short-lived (in some cases). If moods are always changing, there is always the chance for improvement or treatment success, and the dynamic version of bipolar disorder in this group of texts leaves this possibility wide
open. This also applies to the perception of treatment success as short-lived or temporary; if a treatment has worked once, there is perhaps a greater chance it may work a second or third time. These texts may offer some proof of success as a sign of better things to come, thereby reducing the negative affect of delayed treatment success. Although the Group C texts would seem to be the most hopeless in terms of credibility, we can actually see that landing on the “too crazy” end of the continuum is not irreparably damaging, as the chaotic examples and the painful honesty can humanize the author and improve credibility. As with the other groups, credibility here is nuanced and constantly in play.

**Conclusion**

This chapter has provided an in-depth look at 20 bipolar narratives, including rough plot summaries as well as examples of how the texts vary in their presentation of treatment. The chapter has also considered where each group of texts seems to fit on the credibility continuum. The first group of texts, Group A, presented treatment as linear and somewhat straightforward. Group A texts write of treatment is a mostly complementary way, as an uncomplicated and direct process—one is ill, one takes medication, the medication works, and life continues. Group A texts tend to skew toward the “not crazy enough” end of the continuum, as they lack details and the presentation of treatment may seem too tidy and linear to be accurate. Treatment is more complicated in Group B texts, which describe the process as recursive but ultimately still beneficial. These texts may include longer passages describing treatment struggles or challenges, but they often end with praise for treatment. Group B texts appear to land in the middle of the credibility continuum, as they include
features from both extremes. The final group of texts land on the “too crazy” end of
the continuum. Group C texts paint a picture of treatment as chaotic and damaging.
These texts include lengthy descriptions of failed treatments and the ongoing search
for the most effective combination of medication and therapy.

As mentioned earlier, treatment is one of few shared experiences in bipolar
narratives, and representations of treatment can and do influence how a text negotiates
the paradox of mental illness. If the text describes treatment as helpful and effective,
this may increase authorial credibility by making the author appear less ill and more
reliable. On the other hand, if treatment is described as an ordeal full of frustration and
hopelessness, the author may be perceived as “too crazy” for even the most extreme
treatments. Extended descriptions of treatment also reinforce bipolar disorder as a
severe and disabling mental illness that requires treatment, and authors may suffer
from such an intimate affiliation with the illness. In all cases, the negotiating of the
paradox is dynamic and ongoing, as each example and detail can shift the balance.

With a more cohesive sense of the corpus in hand, the next two chapters
explore some of the more complex and challenging texts in greater depth. Like all
bipolar narratives, these texts struggle to maintain the delicate balance of disclosure
and avoid serious damage to credibility. The bipolar story in each of these texts creates
problems relating to basic narrative touchstones. These concerns are common among
bipolar narratives, but the following chapters look at a group of texts that employ two
specific rhetorical strategies to balance the paradox and to address problems with
causation, coherence, and closure.
Chapter 4: Containing The Chaos

The previous chapter examined the corpus texts as a group in order to demonstrate the varied ways in which bipolar narratives struggle to maintain the delicate balance of disclosure while also attending to issues of authorial credibility. Bipolar disorder is an illness conveyed through language (patient descriptions, most often); consequently, the patient/author’s words carry tremendous weight and risk making an already complicated story that much more so. Much of this complexity is a result of the paradox at the center of my argument: in representing the signs and symptoms of mental illness, bipolar narratives must balance between telling too much (and appearing “too crazy” to be believed) and telling too little (and seeming “not crazy enough,” implying some kind of fraud or deception). This paradox means that bipolar narratives must do more work than conventional pathographies, which often deal with illnesses that can be conclusively proven with tests and data. For example, cancer pathographies tell an illness story that is somewhat medically and culturally familiar; that is, most people possess a generic understanding of the symptoms (tumors, growths) and treatments (chemotherapy, radiation) even if they have never personally been diagnosed with cancer. Comparatively, bipolar disorder is not well understood medically or culturally. The potential lack of external or physical symptoms, coupled with the lack of established diagnostic instruments such as imaging or blood tests, adds up to “not crazy enough” to be proven medically. And very few people are familiar with the vocabulary of severe mental illness, so that symptoms and treatments are strange and even confusing. The lack of cultural and clinical understanding presents a significant challenge, in that the bipolar story demands more explanation than many other illness stories.
This paradox creates a rhetorical problem that the texts must negotiate. Some texts include detailed descriptions of extreme treatments (ECT being the most obvious example) that are difficult to fully understand or even imagine. These texts may come across as “too crazy” to be credible accounts of illness: when an author confesses that ECT significantly impairs his memory and ability to do very basic tasks, readers cannot help but wonder how someone who struggles to pour coffee could possibly write a book-length narrative about his illness. In this way, detailed examples can raise questions about credibility. But less is not always better, as texts that include fewer details about bipolar disorder offer only a vague bipolar story and risk being dismissed as inauthentic or fake. Texts that omit the complexities of the bipolar story may fail to provide the proof demanded by readers (most often provided in detailed descriptions of episodes or treatments). These tensions are the textual expression of the paradox of mental illness mentioned above and in previous chapters: authors of these texts are called upon to provide proof of their illness but the proof must not be so damning as to undercut the author’s credibility as a reliable storyteller. The next two chapters consider two specific rhetorical strategies that bipolar narratives use to stabilize the text while also enhancing authorial credibility.

This chapter explores framing as a rhetorical strategy that bipolar narratives use to downplay the disruption of the bipolar story. Framing is defined as surrounding the text proper with a preface/introduction and/or a postface/conclusion.\textsuperscript{32} Framing works to strengthen coherence and closure, two important narrative touchstones associated with

\textsuperscript{32} In this chapter, I will use the following terms: \textit{text proper}, to indicate the body of the text only, sans any paratextual materials; \textit{preface}, to refer to the text that immediately precedes the text proper but not including title page, acknowledgments, or table of contents; and \textit{postface}, to refer to the text that immediately follows the text proper, including both textual and graphic elements. The latter two terms are taken from Gerard Genette.
“good” or recognizable narratives. Chapter 2 discussed how the bipolar story prevents the easy incorporation of these features, and texts that focus intently on the bipolar story tend to struggle with these basic narrative touchstones. In an effort to strengthen these good-narrative features, the corpus texts may employ framing and paratexts. Every text in the corpus includes some kind of frame, and 15 of the 20 include paratextual materials both before and after the text proper. My discussion in this chapter focuses specifically on two texts that use framing to great effect: Terri Cheney’s *Manic: A Memoir* and Marya Hornbacher’s *Madness: A Bipolar Life*. Both texts were best sellers and both tip to the “too crazy” end of the credibility continuum by providing vivid and personal details about each woman’s illness experience. In deciding to focus so intensely on the bipolar story, both texts risk being dismissed as incoherent and unreliable illness narratives or as non-narrative altogether. Cheney and Hornbacher use framing to strengthen familiar narrative features such as closure and coherence as a way of moving the texts from the “too crazy” extreme to a more neutral place. The strengthening of these narrative touchstones in combination with an identifiable frame also helps to revive authorial credibility, which is negatively affected by many vivid, damaging details. My analysis begins with a short overview of each text before moving to a more careful examination of the ways in which each text demonstrates the unruliness of the bipolar story, as well as how framing helps to address this. Although the textual frame lacks the power to fully offset the damage done by the bipolar story, it can create the illusion that the chaos of bipolar disorder can be confined to the narrative space of the text. This illusion can go a long way toward restoring authorial credibility and addressing the narrative vulnerabilities created by the bipolar story and related to coherence and closure.
Containing such a disorderly illness is no easy task, and the ongoing nature of bipolar disorder further complicates things. The chronicity of mental illness constitutes one important way in which bipolar narratives differ from many conventional pathographies. These texts do not follow what Arthur Frank describes as the most common trajectory in pathographies: the restitution narrative, or “Yesterday I was healthy, today I’m sick, but tomorrow I’ll be healthy again” (77). This sort of illness narrative is finite and bounded—the illness may be disruptive, and the individual may experience a period of self-examination and perhaps even a redefining of values and goals, but the disruption is temporary. Frank claims that this type of narrative is “culturally preferred” (83) and for good reason. Illness can be frightening, and pathographies offer vital proof that the “crises [of illness] may be overcome, survived, and understood” (Hawkins xix). No one likes to be sick, and even if the diagnosis is a simple common cold, everyone wishes to feel better sooner rather than later. Imagining an end to the illness may offer comfort, as one can look beyond his or her current suffering and envision a return to health. People with severe mental illnesses, including bipolar disorder, live with a diagnosis that eliminates the possibility of a complete return to health. As indicated, no cure exists for bipolar disorder. The best one can hope for is a reprieve of symptoms, but a reprieve is not a cure. The chronic nature of bipolar disorder promises ongoing disruption, and the expectation of future episodes shapes bipolar narratives. A chronic illness narrative does not easily accommodate narrative basics like closure, because closure through cure is not an option. In order to have closure, then, bipolar narratives must find it in other ways.
Whereas many pathographies adhere to a clearly defined narrative trajectory similar to the restitution narrative mentioned above, the texts in this chapter may begin with this sort of organization but disintegrate into a blow-by-blow account of each terrifying moment or episode. Rather than looking back at illness or forward to health, these texts stay rooted in the continuous present with all of its attendant highs and lows and without much reflection. In allowing bipolar disorder full narrative reign, these texts begin to mimic the illness, shifting and changing suddenly without warning or explanation. The lack of narrative trajectory and fluctuation between extremes marks these texts as “too crazy” for readers to understand or make sense of. Both texts tell life stories that are, in large part, ruled by bipolar disorder. That is, when Hornbacher reflects on her childhood, she does so noting her bipolar tendencies, and when Cheney remembers a major promotion, she recalls earning it by working at night so as to better conceal her illness. Although both women were diagnosed later in life, bipolar disorder becomes the lens through which they view their full life stories—past, present, and future. To sum up, bipolar disorder is more than merely a part of these texts; rather, the fluctuations and extremes of the illness prevent a familiar or cohesive narrative trajectory. The chaos of the illness translates to a chaotic narrative with no clear beginning or end and a very jumbled middle.

**Textual Response to Chaos**

When faced with a confusing or unpredictable illness experience, most pathographies work to find or create order, and this act of organization can actually be healing. Physical and mental illness is most often viewed as an interruption, and writing
the story of illness is one way to make sense of this interruption. But some illness stories, including the bipolar story, are unpredictable and difficult to narrate. As we saw in Chapter 2, the bipolar story involves two layers (definitional and experiential) and tends to be highly individualized. It is a complicated story to tell, and the texts struggle to maintain a balance of disclosure that will ensure authorial credibility while still conveying the illness experience. When they fail to attain this balance, texts begin to display problems with closure and coherence. To counteract the negative effect of the illness story and strengthen these key narrative features, some texts employ a textual frame made up of paratexts. These materials bookend the confusion of bipolar disorder and force the unruly details into a recognizable and bounded frame. This frame creates coherence and closure, moving the text back toward the a more balanced place on the credibility continuum. Adding extra materials to the text is not a new strategy; rather, authors have long been using paratextual materials to enhance or alter how a text is read.

In his foundational work on the subject, Gerard Genette describes the paratext as “an ‘undefined zone’ between the inside [of the text] and the outside” (2). Philippe Lejeune calls this space “a fringe...which in reality controls one’s whole reading of the text” (qtd in Genette 2). Broadly, the paratext includes everything and anything outside of the text proper. Genette extends the boundary to include items physically separate from the book, but I will limit my discussion to the materials located within the bound book. More specifically, my discussion focuses on what Genette calls “preludial or postludial” (161) texts—the materials that come immediately before and after the text proper. Genette labels these materials as preface and postface but they may also be known as prologue/epilogue or introduction/conclusion. To avoid confusion, I will use Genette’s
terms in the discussion, and when texts use different names for these materials, I will indicate as much but will continue to use the selected terms in order to ensure continuity. Paratexts are worth exploring in part because their close proximity to the text implies a greater influence on the text itself and how it is read. They are part of the bound texts, and a reader must get through them one way or another in order to reach the text proper; even if a reader quickly flips through the preface, the flipping itself demonstrates an acknowledgment of the preface.

These extra materials have the potential to change the reading of a text, and authors are well aware of this. Genette proposes that the space “between text and off-text [constitutes] a zone not only of transition but also of transaction ... a privileged place of ... strategy” (2). That is, the materials that may at first glance appear extraneous or unnecessary can actually do a great deal of work for the author in terms of reception or interpretation of the text. In order to properly identify and define paratextual materials, Genette posits five questions that most readers associate with journalism: where? when? how? from/to whom? to do what? (4). The ‘where’ relates to location, either within the physical boundaries of the text or at a distance. The ‘when’ involves the date of inclusion, as paratexts can be added or subtracted at any point in the publication process. ‘How’ addresses the mode of existence of the paratexts, which can range from linguistic to visual and beyond. The question of ‘from/to whom’ focuses on the sender (most often the author but possibly also the publisher or a third party) and addressee (the reading public) of the paratext. And, lastly, ‘to do what?’ seeks to identify the purpose or function of the paratextual material. I will return to these questions when I discuss the individual texts.
My discussion begins with the most common type of paratext: the original authorial preface or postface.\footnote{Genette does not differentiate between preface and postface in any significant way, stating instead that the differences between the two are irrelevant. For more information see Genette, Chapter 9. I will distinguish between the two in my discussion because I believe they serve different purposes in these texts.} As the name suggests, original authorial prefaces are composed by the author, are original, and appear immediately before or after the text. The main function of this type of paratext is “to get the book read and to get the book read properly” (Genette 197). One way of ensuring a “proper” reading is to use the preface or postface to convey information that the author feels is key to understanding the text. This information may range from commentary on the title to information on the origination of the idea to the intended audience. In addition to directing readers in a “correct” reading of the text, authors may also use prefaces/postfaces to convince the reader why he or she should read the entire text. Genette suggests that there are many ways to add value to the subject of the text, including pointing out the usefulness of the information contained in the text. The preface/postface serves as a potentially powerful “instrument of authorial control,” a way of indicating to the reader, “Here is what I meant to do” (Genette 223). Although these materials exist outside of the text proper, paratexts affect how we read and understand both the text and its author. The paratexts in bipolar narratives are doubly important, as they come from authors with compromised credibility and they surround texts that may be literally dependent upon them in order to make sense of things. In the extended discussion that follows, I have chosen to discuss the texts individually, because they use paratexts differently and to different effect. Each section includes a brief plot summary to orient the reader before more in-depth analysis.
Chaos in Cheney

Terri Cheney’s text stands out from the larger corpus in part because chaos seems to be one of Cheney’s chief goals as she writes about her life with bipolar disorder. The text is purposely non-linear and does not adhere to a conventional chronological narrative format. Instead, it is arranged episodically and composed of a series of disconnected stories or vignettes. There are sudden and unaddressed shifts in time and place, as the text moves forward and backward through Cheney’s life, picking and choosing moments to expand and explain. In this way, Cheney makes illness the driving force in the text. That is, the text does not try to normalize or organize the episodes by arranging them in a coherent, recognizable way. Although several other corpus texts lack strong narrative coherence, Cheney’s text is the only one to reject coherence so pointedly. Rather than relying on a chronological or linear organization, Cheney instead uses illness to anchor the chapters—whether recounting a romantic weekend away or a writing workshop in Big Sur, the thread of bipolar disorder runs strongly through the chapters. As the illness changes from episode to episode, the text becomes unstable and, eventually, so discombobulated that assembling the fragments into a recognizable whole is impossible.

Bipolar disorder is the star of this text, and when the central character is notoriously unpredictable, it is not surprising that the text follows suit. The text becomes even more intriguing when we consider that it can be interpreted in distinctly different ways. Either it is purposeful chaos, carefully constructed by a masterful author in hopes of attaining some larger goal, or it is accidental chaos, the product of an unreliable author at the

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34 Cheney prefers the term ‘manic depression’ over ‘bipolar disorder.’ To ensure consistency across chapters, I will refer to the illness as bipolar disorder. When the alternate designation is used in direct quotations, I have left it intact in order to be true to the text’s intention.
mercy of her illness. Both possibilities raise questions about credibility, with the latter option possibly marking Cheney as “too crazy” to be taken seriously.

The first two chapters illustrate the text’s haphazard arrangement while also serving as an example of the unexplained shifts in location that contribute to the confusion of the text. Chapter 1 begins in a specific location (Santa Fe, NM) with the story of Cheney’s complicated suicide attempt. The chapter describes Santa Fe in rich detail rarely granted to places in a text that tends to offer vague details (“the warm California sun”) or withhold detail altogether. But Santa Fe in December is bustling and artsy, with “snow [that] fell thick and deep on the cobblestones” (6). Cheney rents a “charming little hacienda” near Canyon Road and within walking distance of several bars (6). The text describes the weather, the time of year, the clothes Cheney is wearing, and the sales clerk who waits on her on Christmas eve. The story is clearly situated in this specific time and place—Christmas eve, Santa Fe, the rented house, five months after her father’s death. The text details Cheney’s preparations for the suicide, as well as the harrowing story of her brutal rape by a locksmith. The result is a first chapter full of vivid details and a story that happens in a well-defined place and time.

And then Chapter 2 begins, and time shifts backward to a few years before Cheney’s father’s death. Cheney is working as a successful attorney for a prestigious firm, searching for an expert witness for a case involving Michael Jackson. She finds a witness but when he casually discloses his bipolar disorder, the legal team dismisses him and the lithium jokes circulate through the firm. Unlike the first chapter, this chapter does not include details about the location of the action, and the few time-related details are fuzzy—a few years before her dad’s death, but well into her law career. The story is not
firmly rooted in a specific time or place. There is no real drama, no blood, no doctors or hospitals, and no violence; the chapter is more of an anecdote about choosing the expert witness than a fully fleshed-out story, which may account for the lack of details. Despite spatial proximity, the chapters share very little and seem to exist independently of one another; the only thread of continuity between the two chapters is the author and her father.

This feeling of disconnectedness persists throughout Cheney’s text and is underscored by repeated shifts in date and time. Chapters 14 and 15 provide a second useful example of the confusion found in Chapters 1 and 2. Chapter 14 finds Cheney and her boyfriend, Rick, on a short vacation in Big Sur. While on the trip, she finds a book about bipolar disorder and realizes that she is experiencing a mixed state, in which “mania and depression meet and collide” (185). When she rushes back to the hotel to tell Rick, they fight. The chapter winds down with a break-up and the revelation that Cheney has experienced a mixed state several times since Big Sur, and each time it has been devastating.

Chapter 14 closes with Cheney mourning the lost relationship and Chapter 15 begins with an unexpected discussion about bipolar disorder and food. The text swings all the way back to Cheney’s childhood to investigate her complex relationship to food, from middle school through high school and college, including Cheney’s experience at a behavioral modification center where she underwent aversion therapy. The chapter is written in past tense, as the text reviews Cheney’s history of disordered eating. Toward the end, the tense shifts to the present to address Cheney’s current eating problems and how they relate to her bipolar disorder. In the short space of a 14-page chapter, the story
reaches back decades to childhood, high school, college, and then Cheney’s adult life and present feelings. Though the chapter covers a large time span, few details are provided. And once again, almost nothing connects this chapter about disordered eating to the previous chapter on mixed episodes and her then-boyfriend Rick.

Independently, the chapters make sense. But as an illness narrative, they seem oddly out of order. Although the text includes several chapters that delve more deeply into Cheney’s past (specifically her childhood and college years), it still lacks the concrete details needed to organize the narrative. To give those details would be to impose order on a life that lacks order, and the text instead conveys the ways in which bipolar disorder has profoundly disrupted the author’s life. The random assemblage of chapters accomplishes this—they seem like episodes, disconnected and self-contained. The illness anchors the chapters, but it also changes from episode to episode and this shifting destabilizes the text. If the shifting happened sporadically, it would not be so disorienting. But each and every chapter is a shift of some sort—in time, place, or mental state. This haphazard presentation of events makes it impossible to follow Cheney’s narrative in a linear way and, of course, linearity is not the goal. The choice to organize the text episodically can be read as an outright refusal to make the narrative fit the conventional pathographic mold. Instead of seeking to restore order, the text highlights the unpredictable world of bipolar disorder. Order is unavailable, so Cheney chooses to narrate chaos. Although the text is a fascinating read, the lack of narrative coherence and closure are so extreme at times that the text threatens to dissolve into a heap of disconnected details. This is clearly not the desired result, and since Cheney is keenly aware of the destructive power of the bipolar story, her text does not leave the reader to
sort through things alone. Instead, she offers a textual frame as a way of containing and controlling the chaos of the text proper.

**Framing in Cheney**

Cheney’s text is organized episodically and lacks chronological or thematic connections, resulting in an unpredictable narrative in which each chapter stands alone. On its own, the text is confusing and disorienting, as readers struggle to place the chapters in relation to one another. The text lacks key connective details, preventing the overarching narrative of Cheney’s life from fully materializing. The chaotic bipolar story drives this text, causing difficulties with both coherence and closure and moving the text in the direction of the “too crazy” side of the credibility continuum. The use of paratexts to frame the narrative is one way to offset this damage. In Cheney’s text, the textual frame (preface and postface) actually helps to define and explain the narrative. Without any other recognizable organization (i.e. chronological, linear, event-driven), the paratexts create a clear beginning and end, relegating the unruliness to a confusing middle. This bounding of the text increases narrative coherence and provides a kind of closure (however artificial). I will consider the preface and postface independently before addressing the larger question of their overall effect on the text.

My discussion of Cheney’s text begins with a brief return to Genette’s five-question mode of defining paratexts outlined at the start of this chapter. Cheney’s text begins with a three-page preface located within the physical space of the book. The text has only one published edition, which includes the preface, indicating that it was written and published with the original edition. The preface is textual and includes the author’s
name and location (Los Angeles, California) at the end, indicating authorship. As is
typically the case with prefaces, the intended addressees here are readers of the text (or
those already in possession of the text) rather than the general public. In Genette’s terms,
the preface functions mainly to instruct the reader on the interpretation of the text. This
function closely links up with the larger goal of the preface, “to put the ...reader in
possession of information the author considers necessary for ... [a] proper reading”
(Genette 209). Purpose/function will be the main focus of my analysis below.

The first paragraph of the preface is excerpted below in full because each
sentence contributes to the interpretative function of the whole:

If you come with me on this journey, I think a word of warning is in order: manic
depression is not a safe ride. It doesn’t go from point A to point B in a familiar,
friendly pattern. It’s chaotic, unpredictable. You never know where you’re
heading next. I wanted this book to mirror the disease, to give the reader a
visceral experience. That’s why I’ve chosen to tell my life story episodically,
rather than in any chronological order. (1)

The text announces itself as a journey, a metaphor that provides a familiar narrative
structure of beginning, middle, and end. Although a journey may involve surprise and
confusion, there is usually an endpoint or goal, and in many cases, this end involves a
return to home or another safe place. The word and its positive connotations establish a
structure for the text by marking the preface as the beginning of the journey and by
implying that there will be an end.

The preface continues by warning readers what to expect from this journey.
Words like ‘chaotic’ and ‘unpredictable’ provide strong clues regarding the body of the
text. Chaos and unpredictability are no strangers to narrative, but when they are the
dominating characteristics of a text, the reader must work much harder to make sense of
things. These qualities are not often associated with “good” narratives (that is, texts
immediately and obviously recognizable as narratives). And when the reader must work
harder to find the narrative or even to recognize the text as narrative, the author’s
credibility may be called into question, most especially in the case of severe mental
illness and the ways in which it is known to impair mental and emotional functioning.
The excerpt above also indicates that things will not unfold in a “familiar, friendly
pattern.” Because this warning appears as the first sentence of the preface, the text is
presented as unfamiliar, strange, and perhaps even hostile or antagonistic. Beginning a
preface in this way can be risky, especially since the preface can be “an unbalanced and
even shaky situation of communication” in which the author tells readers what to expect
before they have even seen the text (Genette 237). Although it turns out to be absolutely
necessary for the our understanding of the text, the warning loses some of its punch for
the very reason stated by Genette: readers don’t know what they are dealing with yet.

The initial paragraph continues by offering further interpretative information
about the author’s intention to “mirror the disease” and provide readers with “a visceral
experience” (1). Following the description of bipolar disorder as chaotic and unfriendly,
‘visceral’ assumes a negative connotation. The intent seems to be evoke pain or at least
confusion and discomfort. In order to more faithfully mirror the illness, the text is
organized episodically rather than chronologically. This decision proves somewhat
alienating, as it is difficult for most readers to imagine thinking about life in any way but
chronologically. And even if the organization is an accurate representation of Cheney’s
experience, structuring the text in a nonchronological, nonlinear way is still a bold move. When Cheney declares that her life is ruled by moods instead of time, we may appreciate the eloquence of such a statement while still feeling uneasy about what, exactly, she means, or how such a definition might shape the text itself. However the preface comes across, the risk of being perceived as “too crazy” is certainly present.

The explanatory preface does much to offset the confusion of the text by presenting it as the purposeful choice of a reliable author with a specific purpose (to mirror the illness). The warning, however unexpected, serves a key purpose by putting readers on alert. If it had been omitted, the plunge into turmoil without any explanation would have been disorienting. But Cheney has opted to reign in the chaos, to a point, by offering a clue to this daunting puzzle. And if the chaos still takes over in the text proper, at least readers may have some sense of why things are so out of control. The preface also serves to counterbalance the plethora of damaging details in the text proper by presenting Cheney as a careful and purposeful director of her own story. At no point does the text apologize for the confusion; rather, Cheney declares “[t]his book is what I remember. This book is my truth” (3). There is strength in this assertion, again casting Cheney not as helpless mental patient but as resilient and unapologetic survivor. The preface clearly creates a beginning for the text proper, which is necessary because Chapter 1 starts without any background or guidance. Cheney’s preface certainly fulfills Genette’s purpose of conveying what the author “meant to do” (223), which is to prepare readers for a close-up view of a life dominated by bipolar disorder.

Eighteen chapters and numerous episodes later, the text ends with a short postface. As with the preface, the postface appears in the first edition of the text, so it is
original, and it was written by Cheney. The audience is presumably the readers of the text, and because it is placed at the very end, it is to be read after the text. In terms of function, the postface provides closure in ways I will discuss in a moment. Cheney’s perplexing narrative draws to a close almost idyllically, as she sits at a cafe working on the manuscript of the text. Like the previous chapters, the postface is not thematically connected to the chapter that precedes it. However, unlike the text proper, it provides a date (April 18, 2007) and a place (Los Angeles, CA). These details of time and place stand out because they are preceded by nearly 250 pages of constantly shifting and rarely identified time and place. Unlike the text proper, both pieces of the textual frame include a location, which creates a connected geographical frame around the messiness of the text proper. The postface also includes a date, and these contextual details create the illusion of closure at the end of the text. There can be no real closure through cure, as cure is currently a medical impossibility. But the text must end, even if the bipolar story continues in Cheney’s lived experience. The postface acknowledges the precarious nature of closure, when Cheney writes that one day is “all you can really count on when you’re manic-depressive: this day, and no more” (242). This comment brings to mind the unpredictable and chaotic text proper, while also suggesting a kind of temporary closure on a day-to-day basis. The quotation is also a timely reminder that Cheney’s text is working to find a balanced spot on the credibility continuum; the fact that there are good days reinforces the idea of Cheney as a credible author. But, conversely, one day is only one day, and tomorrow could bring a horrific episode that would severely damage Cheney’s credibility. The balance is precarious and even in calm moments, the ominous shadow of bipolar disorder looms large.
But the postface also offers very real closure in Cheney’s admission that she has been episode-free for several years. This revelation comes as a surprise following the series of dramatic episodes described in the text. The decision to defer this disclosure until the postface keeps the reader in suspense and compels one to keep reading to see how Cheney’s narrative will end. Though Cheney’s remission is certainly a positive thing, this delayed revelation may also appear deceitful, diminishing Cheney’s credibility. When the postface reveals that Cheney is not currently experiencing manic or depressive episodes, the drama of the preceding 240 pages almost feels contrived, as though the text leaned toward the dramatic in part to make the sudden revelation at the end more striking. And it raises important questions about the text and Cheney’s credibility: was Cheney symptom-free when she wrote the preface? Was the entire text written in retrospect, from a place of relative health? Though the pain and suffering of the text are undeniably real, the closure offered via remission seems less satisfying amidst so many questions about perspective and intent. The dissatisfaction is not so great, however, as to cancel out the closure offered in the postface. Although the text withholds information regarding precisely how recovery has happened, the recovery itself is still significant.

In the larger context of the reader’s interpretation and understanding of this text, both the preface and postface represent key pieces of the textual puzzle. Without the preface, the abrupt beginning and lack of chronology would baffle most readers, perhaps to the point where they would stop reading altogether. Without the postface, the narrative trails off without updating the reader on Cheney’s mental health at the time of the book’s publication. The paratexts bookend the text, providing firm boundaries and taming the
unruly bipolar story. Having a clearly marked beginning and end provides much-needed narrative coherence that would be otherwise absent. And, unlike numerous other bipolar narratives, the closure offered in the postface is tangible and validated by Cheney’s symptom-free years. Ultimately, the paratexts help the reader to make sense of, or at least understand the rationale behind, these confusing texts while adding narrative coherence and closure. Though the episodic organization of the chapters is still disorienting and unsettling, we may forgive the ambiguity when rewarded with closure in the postface. Whereas the textual frame in Cheney’s text actually helps to define and explain the narrative, the frame in the next text enhances the narrative but still leaves important questions unanswered.

**Chaos in Hornbacher**

*Madness: A Bipolar Life* is not Marya Hornbacher’s first foray into the world of illness narratives. Prior to *Madness*, Hornbacher published *Wasted: A Memoir of Anorexia and Bulimia*, which spent many weeks on best-seller lists. *Madness* followed suit, rocketing to best-seller status. The text documents Hornbacher’s lifelong struggle with Type I rapid-cycle bipolar disorder, which means that her moods can, and often do, change from hour to hour, even moment to moment. Hornbacher’s text provides a clear and often painful image of the destructive force of bipolar disorder: the illness has been absolutely disabling, at times nearly destroying her. The text describes Hornbacher’s desperate attempts first to cure herself and later to numb herself via starvation, substance abuse, sexual conquests, and self-mutilation. Despite ongoing treatment, the illness still claims entire years of her life. The text is emotional and honest, and though it provides
information about family, childhood, career, and past lovers, bipolar disorder always occupies center stage. The omnipresence of the illness influences the narrative, as the text records the author’s struggle to accept the diagnosis and the lifelong management it requires.

Part I of the text is arranged chronologically, beginning with four-year-old Hornbacher and moving through her childhood and adolescence and the early onset of bipolar disorder. Part II shows the progression of the illness as it increases in severity and Hornbacher becomes less functional; Part III documents seven hospitalizations in less than two years; and Part IV describes the years leading up to publication, including Hornbacher’s “current” state of being. Although the narrative is generally complicated and chaotic, the text becomes more so as it draws to a close. The final two sections provide the clearest examples of the textual chaos that bipolar disorder can produce, so the analysis begins there.

Part III begins with the chapter “The Missing Years,” an appropriate title for a section that describes a time when Hornbacher was “caught in the revolving door of madness” (175), enduring seven hospitalizations over the course of 19 months (from January 2004 – July 2005). The nine chapters in this section of the text are fractured and incomplete, each fewer than six pages long, and Part III occupies just over 40 pages altogether. In these chapters, the text presents Hornbacher as exceedingly fragile, almost childlike, and completely absorbed in the institutional world. The hospitalizations come quickly, one after the other, sometimes even in consecutive months. With each hospitalization, the text recreates the same nightmare of padded walls and confusion. The chapters include a handful of memories, offered up “to fill the hole in [Hornbacher’s] life
that madness made, and will not repair” (175). The span of time combined with the brevity of the chapters make for fragmented bits and pieces of stories rather than connected, event-driven stories. The text moves through 2004 and 2005 with dizzying speed, contributing to the sense of confusion in this section.

Part III is also disorienting because it takes place in the unfamiliar world of the institution. The section begins with Hornbacher’s admission that, during this difficult period, “the weird world of the [locked psychiatric] ward bec[ame] more familiar to me than the one outside” (175). This statement delivers a major blow to Hornbacher’s credibility; this reality is hard to grasp, as the psychiatric ward would seem to epitomize the opposite of the “real” world in which most people operate. The lack of a consistently event-driven story exacerbates the confusion, as Part III features unrelated vignettes offering brief glimpses into the institutional world. The vignettes sometimes provide information or insight into Hornbacher’s experience of bipolar disorder: the ritual of her favorite pajamas in “Hospitalization #2,” a worried rant about medication that has made it impossible for her to read anything in “Hospitalization #7,” a fight with a fellow patient over a seat by the window in “Hospitalization #1.” The numbered titles imply an attempt at organization but the titles are generic to the point of meaninglessness: they reveal nothing about the event. Aside from the location (the hospital) and the illness, Part III lacks a connective thread; characters appear in intense detail and then vanish. Sometimes the text indicates that Hornbacher is able to focus and understand what is going on, but then one page later, she must relearn how to go down the stairs. The feeling of disconnectedness persists in this section of the text due to the vignettes and the loss of a defined sense of time. In the hospital setting, days become weeks and time is measured
by visitors or interactions with other patients or staff. Without clear events or more detailed descriptions, the seven hospitalizations blend into a template of sorts, where each is a variation of a past or future stay. This blending results in a fusing together of these years, which prevents a clear narrative arc grounded in linear and chronological time. The lump of time is, as the first chapter title states, simply lost.

In the final section (Part IV), the text falls into a predictable pattern: manic episode, meeting with psychiatrist (Dr. Lentz), change in medication, trip to the ER, extended hospital stay for additional medication and ECT, short respite. The repetition frustrates both the reader and Hornbacher, who declares, “I want to scream. I did what they said. I tried. I did my best. And it wasn’t good enough” (258). The futility comes through clearly here—despite medication compliance and a concerted effort to avoid triggers and difficult situations, the madness comes anyway. The text proper ends with Hornbacher’s return home after a month of hospitalization and ECT treatments. She wakes up disoriented, and her response to the confusion demonstrates the way this repetition stymies closure: “I have no idea what day it is, or even what season of the year. I dimly remember a hospital, but I can’t remember if I was in it yesterday or if I am remembering the last time, or the time before that. I wonder how long I’ve been gone” (271). This kind of personal confusion permeates the text and ultimately becomes the reader’s confusion, as we struggle to orient ourselves and place one episode in relation to the many others before it. Hornbacher faces the confusion by stumbling downstairs, where she finds a kitchen full of family and friends rendered speechless by her sudden appearance. She asks, “How long was I crazy?” and her husband shrugs and answers, “A few weeks” (271). The matter-of-factness of this exchange is both comical and
discouraging, implying a familiarity with this conversation. In the larger life story presented in the text, madness becomes routine, and the repetition creates a sense of hopelessness and futility that destroys any sense of closure at the text’s end. There can be no satisfying closure when Hornbacher’s bipolar story so clearly continues.

**Framing in Hornbacher**

Much like in Cheney’s text, paratexts do important work in *Madness: A Bipolar Life*. The text includes 36 pages of paratextual material including preface and postface. Returning for a moment to Genette’s five questions of definition, the paratexts are included with the sole edition of the text, written by Hornbacher, and addressed to the actual readers of the text. The postface may aim for a wider audience, as I will discuss in a moment. The preface and postface function as bookends, anchoring the chaos of the story that fills the pages between them.

The text begins with a preface titled “Prologue: The Cut: November 5, 1994.” It is seven pages long and separated from the text proper by several empty pages, physically separating it from Part I, which begins with the story of Hornbacher’s childhood. The preface is preparatory in that it shows the reader what to expect from the text and it introduces Hornbacher’s experience of bipolar disorder. It begins with action: an accidental suicide attempt by 20-year-old Hornbacher. While cutting to relieve the pressure in her head, she hits an artery and ends up in the hospital. The description here is even and unemotional, as Hornbacher narrates the scene as calm observer: “The blood is making a mess on the floor (note to self: mop floor) while a raccoon clangs the lid of a dumpster down below. …I study my handiwork. Blood runs down my arm…dripping off
my fingers onto the dirty white tile floor‖ (1). The detached tone is all the more disrupting when we absorb the intense reality of the situation—a very sick young woman probing her forearm with a dull razor blade. It is a sobering introduction to Hornbacher and to bipolar disorder. The preface makes it clear that bipolar disorder will be a major part of this story and, more often than not, a matter of life and death.

This vignette is followed by a section with a more reflective tone. Unlike the suicide vignette, which is written in present tense and features evocative details, the tone in the later part of the preface is direct and even, discussing the significance of mixed episodes and the correlation between mixed states and accidental death. Beyond one short paragraph, the preface does not explain bipolar disorder or refer to the text that follows (in the way that Cheney’s preface did). The text does hint at what is to come in the statement “No one even thinks bipolar...because no one knows enough. Later, this will seem almost incredible, given what a glaring case of the disorder I actually have and have had nearly all my life‖ (7). The use of the word ‘later’ alerts the reader that there will be a later, that the story will continue and Hornbacher will survive to reflect on her illness experience. The quotation prepares readers for a “glaring case” of bipolar disorder, as well as offering some insight into Hornbacher’s choice to begin the text with her childhood. The quote also prepares readers for misunderstandings and confusion, as this misrecognition is not the last; rather, misdiagnosis happens time and again in the text. The preface also indicates that lack of information led Hornbacher to a life in which many people believed that she was “just a disaster, a screwup, a mess” (7), and her friends and family kept waiting for her to “grow out of it” (7), as though her severe mental illness was a bad haircut or an embarrassing case of acne.
Recalling that authors most often use the preface to convey intention or instruction, the preface to Hornbacher’s text differs from most, in that it does not directly instruct readers or provide important clues about the author’s intent. Rather, the preface prepares readers for the unruly and chaotic years that fill the following pages. The lessons here are several: bipolar disorder can have devastating consequences, which the author has experienced first-hand; bipolar disorder is not just an illness that one can be cured of but rather an integral part of one’s identity and life; and the struggle for Hornbacher has been lifelong and continues to present day. Taken as a whole, the short preface sets the stage, providing a preview for the remainder of the text, which will mix episodes with commentary and past with present with future. The preface also announces bipolar disorder as the main character of the text, when Hornbacher writes that instead of growing out of her illness, “I grew into it. It grew into me. It and I blurred at the edges, became one amorphous, seeping, crawling thing” (7). In uniting author and illness, the preface instructs readers to look beyond the bizarre and terrifying episodes to the person within the illness, while at the same time questioning the credibility of that person.

The preface shows readers how to read the narrative that follows, but in this particular text, the postface is of even greater importance because it creates closure. As discussed, narratives about bipolar disorder tend to lack closure in part because they are based on a chronic illness with episodes that may be controlled but still occur for a person’s entire life. Without the promise of closure in the text proper, the postface plays a crucial role in fostering the illusion of closure. The presence of a postface suggests a future and a time removed from Hornbacher’s incredible cycle of hospitalizations. The postface is part of the first edition of the text and written by Hornbacher. It is 27 pages
total but is broken up into eight distinct chapters or sections: “Epilogue,” “Bipolar Facts,” “My Bipolar Facts,” “Useful Websites,” “Useful Contacts,” “Research Resources,” “Bibliography,” and “Acknowledgments.” The postface’s functions to close the text while offering the reader some sense of satisfaction that is usually found at the end of a story. After the chaos of the text, the postface also serves to reassure the reader of Hornbacher’s health and well-being. Without the postface, the text simply ends on the home side of the hospital-to-home cycle that engulfs the last part of the text, leaving readers to infer that Hornbacher remains stuck in that devastating rotation. And it is hard to imagine anything more damaging to authorial credibility than this kind of inference—a stint in the mental ward every six months does not promote Hornbacher as a reliable author. The postface attempts to achieve closure by providing information ranging from factual to very personal.

The postface begins with a section that describes Hornbacher’s daily medication regimen. The text presents this information in a very matter-of-fact, no-fuss way, but the details are overwhelming: “450 mg of Wellbutrin, 600 mg of Lamictal, 800 mg of Tegretol, 200 mg of Geodon, and a handful of supplements…[plus] a milligram of Ativan” (273). This combination adds up to 21 pills, and the text states that every day starts with Hornbacher “tossing back pills like they’re candy” (273). This list of medications reinforces the severity of bipolar disorder and although readers may appreciate the honesty, this disclosure does not help Hornbacher’s credibility. Although the tone here is light, as the text jokingly refers to medication as ‘candy’, 21 pills is still a serious matter. The text continues with an overview of a typical day, including an hour-by-hour plan, a mood chart, a medication log, a rating scale for feelings, and a scale
indicating level of impairment ranging from “Without Impairment” to “Psychosis” on the far end. The text rattles off the daily routine without commentary, as though it is too banal to deserve explanation. Here again, despite the cavalier mention of the scale, the information revealed underscores the severity of bipolar disorder and the ways in which it constantly shapes Hornbacher’s daily life. The effect here extends beyond the margins of the text to Hornbacher’s credibility. This section of the preface is a key moment of disclosure where the risks are very apparent: in revealing names and amounts, Hornbacher risks being dismissed as “too crazy,” because common sense would decree that no one taking 2000+ milligrams of psychiatric medication can be a reliable author.

The text then shifts to consider the future, a move that may help Hornbacher’s credibility, but the future is equally dominated by illness. Hornbacher wants “to think that the impossible can happen” (275), even as she knows that a cure (the “impossible” just mentioned) is distant and unrealistic. Even when the text looks toward the future, present reality intervenes, as on page 276 when the text imagines freedom from the illness and a life of relative normalcy. The phrase “I could be normal” is followed by a “but,” and for Hornbacher, there is always a “but.” The sentence continues, “But I know this illness, I know its cycles....The things I do, the choices I make, the places I go are limited to an extent by this illness” (276). So even as the text tries to create closure, the reality of bipolar disorder interferes with the illusion.

Despite the looming presence of bipolar disorder, the postface does achieve closure on some levels. There is a pulling back in perspective, as the text skips around to highlight progress and forward movement. In the midst of the reflection, Hornbacher reveals that at various points in the last few years, “the madness leaves me alone for long
enough to be with the people who make my life my life” (278), and comments like this suggest a partial respite from the intensity of illness. But “long enough” falls well short of forever, and bipolar disorder will be part of this life forever. These brief respites are as close as the text comes to recovery or cure. In the final paragraphs of the postface, the text sums things up:

This is the way it is: a balance, maybe an uncomfortable one. It’s about doing all the necessary, frustrating, boring, exasperating, annoying, banal everyday tasks to keep the episodes at bay, but accepting that they’ll come at some point anyway; structuring my life tightly in order to function well, but being flexible enough to deal with the unexpected; embracing the bizarre notion that sometimes things might go wrong—but other times they might not. I try to build a future out of contradictions; madness is only a small part of my life, yet sometimes it completely takes over and tries to destroy me. (279)

This excerpt exemplifies the tension in the postface, as the text seeks closure but cannot quite achieve it. On the one hand, there is power in the small things that have worked to “keep the episodes at bay,” and the postface seems proof positive that this strategy is working, as Hornbacher writes about vacationing with her husband and helping friends through surgery and divorce. But on the other hand, no amount of flexibility banishes the episodes completely. The phrasing sounds almost glib, as the text flatly acknowledges that the episodes will return. Although everyone feels some measure of uncertainty regarding the future, the feeling is intensified in Hornbacher’s text as she anticipates not only the good times but also the very, very difficult times. The reality that the only future available is one full of contradictions stymies real closure in the text, as closure dictates
resolution of contradictions and tying up of loose ends. And there can be no resolution of the contradiction that is bipolar disorder, here or in other texts.

In addition to the preface and the postface, Hornbacher’s text includes numerous other paratextual materials, all of which appear at the end of the text, after the chapter “Epilogue” discussed above. These chapters contain information and research on bipolar disorder and they bring a relatively chaotic text to an orderly close. A chapter titled “My Bipolar Facts” lists Hornbacher’s medications as well as recent side effects caused by the medications; weekly cost of medication and other treatments, including therapy and psychiatric appointments; and the costs of her last hospitalization. The percentages and statistics reinforce the severity of bipolar disorder, while adding a staggering financial dimension to the already-considerable emotional and physical demands of the illness. These facts tend to undermine Hornbacher’s credibility, as the list of side effects and the number and frequency of appointments show bipolar disorder’s daily impact on her life.

The text then includes two short chapters, “Useful Websites” and “Useful Contacts.” The list of web sites occupies six pages and runs the gamut from professional sites to chat rooms and online communities. The contacts section includes NAMI and several organizations focused on bipolar disorder. The inclusion of these resources demonstrates a desire to help others, a main goal of conventional pathography. And there is another, less tangible benefit of such an organized and well-researched section: this quasi-scholarly information boosts Hornbacher’s credibility by proving that she is well enough to collect information and advise others on useful resources. These last few chapters in the postface do much to reestablish Hornbacher as a reliable and coherent author, which
helps to restore balance to a text that leans notably toward the “too crazy” end of the spectrum most of the time.

Conclusion

This chapter has examined the ways in which two bipolar narratives attempt to truthfully represent the bipolar story while simultaneously counteracting the disruption of the story. The bipolar story complicates coherence and closure, and loss of these good-narrative features creates problems with credibility. In conventional pathographies, these narrative features act as touchstones—readers know to look for them and they work to create recognizable narratives. Without coherence and closure, both Cheney’s and Hornbacher’s texts risk being dismissed as the nonsensical ramblings of madwomen. The texts use textual frames to increase coherence and closure, thereby moving the texts from the “too crazy” end of the continuum to a more balanced place. Both texts rely on paratextual materials to frame and bound the unruly story of bipolar disorder. Both are unpredictable and hard to follow at times; the fractured telling and lack of organization of Cheney’s text thwart the reader’s desire for narrative coherence and closure, and although Hornbacher’s narrative is organized in a recognizable manner, the endless cycle of her illness substitutes repetition for closure, leaving readers stranded and wondering what (besides more of the same) happens next. Closure matters because readers want to know how the narratives end, and these texts initially refuse to link up the ending with any kind of closure. In both cases, the movement between the hospital and home, between dysfunctional and functional, marks any recovery as temporary and incomplete and the cycle makes full closure and full recovery impossible.
In Hornbacher’s text, the chaos of illness sets a truly manic pace for the narrative, and repeated trips to the psychiatric ward create a cycle that seems unbreakable. The text proper ends with Hornbacher’s return home after yet another extended hospital stay and no indication that the cycle will end anytime soon. However, the postface imagines a future in which bipolar disorder “had backed off a little, so that my thoughts were my own, my moods were just moods” (276). Hornbacher feels “dizzy” at the possibility of freedom from the illness, and although that freedom is not realized in the text, the postface creates an artificial boundary for Hornbacher’s illness. It includes small glimpses into Hornbacher’s life at the time of publication, and things seem to be looking up. The text imagines a more stable future and this looking forward works to enact closure in the chaotic and illness-driven part of her life and her text. Although Hornbacher claims that she “can write [her] future” (278), the drama and difficulty of the previous 250 pages linger and the closure feels very temporary. The constant threat of recurrence prevents any firm closure, but the postface conveys a degree of wistful optimism, indicating the possibility of a healthier future. While acknowledging the ongoing nature of the illness, the postface provides a measure of closure, thereby improving Hornbacher’s credibility and making the text more balanced.

There is no doubt that the paratexts do important work in Hornbacher’s text, but this is doubly true in Terri Cheney’s text. The chapters appear episodically, resulting in a text that literally enacts the chaos and disorientation of bipolar disorder. The utter lack of a coherent organization implies an unreliable author, and without the paratextual materials, it is plausible to say that Cheney’s text would risk being perceived as non-narrative and disregarded. On a textual level, Cheney’s larger life story is fragmented
beyond recognition, resulting in a series of standalone vignettes without a linear or chronological trajectory. On its own, Cheney’s text lacks the narrative touchstones of coherence and closure.

Fortunately, the text includes short but highly instructive and useful paratexts: both the preface and the postface provide guidance in how to read and interpret the text. The preface discloses both the chosen organization and the rationale for an episodic text, and although the chapters are still confusing and hard to figure out, readers would be completely lost without this insight. With a general expectation of what’s to come, readers are better equipped to encounter the confusion of Cheney’s text. And although it cannot restore the lost coherence, the preface reveals the incoherence of Cheney’s text to be intentional. That is, once the preface reveals that the chaos serves a function, readers may be more likely to press onward through the perplexing assortment of episodes and vignettes that comprise the main body of the text. Equally important, readers view the disruption as an authorial choice and not as a reflection on Cheney’s credibility.

The postface officially wraps up Cheney’s text, and after such a messy text proper, this wrapping up is much needed. Because the chapters are not organized chronologically, the text ends without a clear sense of where the narrative ends. That is, readers have no idea where or how Cheney is at the time of publication, as the text does not identify chapters nearest in time to the present. The postface relieves some of this anxiety by firmly grounding the text in the present with a date and a location. The postface also reveals that Cheney is episode-free and has been for several years. This revelation provides a significant measure of closure to a text that seemed to offer no hope of closure. As in Hornbacher’s text, the postface here creates an artificial boundary for
the illness experience, making it seem finite and containable although it is actually neither. But the postface in Cheney’s text goes a step further and creates more meaningful closure by returning Cheney to a state of relative health and calm. Though complete recovery and cure are not possible with bipolar disorder, remission is possible and the postface indicates that Cheney’s illness is in remission. Thus the postface firmly places the episodic chaos in the past (when Cheney was quite sick), contrasting the dramatic past with a stable and unremarkable present (when Cheney seems to be healthy). The relegating of chaos to the past provides closure to the narrative, and this closure enhances Cheney’s credibility and almost eliminates the risk that the text could be perceived as “too crazy.” In both texts, the use of an alternate strategy (framing) successfully counterbalances the damage done to authorial credibility by the bipolar story. The next chapter looks at a second strategy used by bipolar narratives to minimize the damage caused by the bipolar story and reinforce authorial credibility.
Chapter 5: Incorporating Order

At first glance, the texts at the center of this chapter seem to be the opposite of the texts in the last chapter. Whereas *Manic: A Memoir* (Cheney) and *Madness: A Bipolar Life* (Hornbacher) featured the bipolar story in a starring role, the texts discussed in this chapter relegate the illness to a supporting role within the larger narrative. The texts do not build the narrative around illness; rather, the bipolar story is one of several stories told in these texts. To return to the paradox of mental illness, these texts, like other corpus texts, seek to maintain the delicate balance of disclosure by simultaneously withholding information and carefully packaging or representing the information that is revealed. Whereas Cheney’s and Hornbacher’s texts were literally built around (and destabilized by) the bipolar story, the texts in this chapter embed the bipolar story within a recognizable secondary narrative genre in order to reduce its negative force.35 Secondary genres such as traditional autobiography, travel narrative, and conversion narrative are established and more familiar (and therefore less threatening) than bipolar narratives, which, as we’ve seen, can be unpredictable, strange, and difficult to follow or understand. The secondary genres also tend to have established and reliable narrative trajectories with clear beginnings, middles, and ends which lend stability to the narrative. When severe mental illness becomes part of one of these narratives, it is only one small piece of the text (versus occupying a significant portion of Hornbacher’s and Cheney’s texts). This chapter analyzes texts that rely on a secondary genre in order to neutralize the potentially disruptive bipolar story and restore diminished authorial credibility.

35 Although I will refer to the alternative narratives as secondary genres or narratives, these narratives often occupy a primary role in the text. In most cases, the texts are structured to fit the alternate narrative genre, thus relegating the bipolar story to a much smaller role in the overall narrative trajectory.
The bipolar story can be chaotic. And the challenges of telling the bipolar story can translate into textual difficulties with basic narrative touchstones such as causation, coherence, and closure. Briefly, causation refers to the common textual practice of assigning causes to events. Causation can be problematic in bipolar narratives because any textual link between cause and event (as relates to illness) can be tenuous at best, and false or misleading at worst. Many bipolar narratives speculate about causes for bipolar disorder and its episodes, but the speculation may damage credibility because it cannot be supported. Currently, the lack of established clinical narrative for bipolar disorder means that all textual descriptions of cause/effect are speculative and may cause the author to appear uninformed or out of touch with reality. In a textual sense, coherence amounts to order, and if a text lacks order, readers may struggle to make sense of things. Bipolar narratives often lack coherence due to the ongoing strain of negotiating the paradox of mental illness—if they reveal too much or too little, the text risks being dismissed. The unruliness of the bipolar story seems to stand at odds with the orderliness most often expected of narratives, and many texts struggle with this. The final narrative touchstone, closure, relates to the need for stories to have endings. The need for closure is both innate and learned, as readers are used to stories with clear beginnings, middles, and ends. It is certainly not unusual for texts to raise questions and uncertainties to build suspense leading up to resolution or closure. Closure can be a problem in illness narratives, and especially so in bipolar narratives, because closure is arbitrary in an ongoing story. Manufacturing closure can also harm credibility in that the closure may be artificial and unsatisfying—there is little resolution in the reality of continual episodes and lifelong
treatment. As I argued in Chapter 2, the bipolar story is neither complete nor well-defined, further making closure a challenge.

Together and independently, these three features are narrative touchstones that authors employ and readers expect. The case of bipolar narratives is trickier than other illness narratives due to the paradox of mental illness and the risks relating to credibility. Struggles with narrative basics have a negative influence on credibility. Most narratives have little trouble with causation, coherence, or closure, but bipolar narratives may struggle with all three. To boost these features, many bipolar narratives turn to rhetorical strategies such as framing and embedding. The previous chapter discussed how Hornbacher’s and Cheney’s texts attempt to navigate the paradox and considered framing as a way to make these texts more recognizable and boost authorial credibility. This chapter looks at a second strategy to contain the bipolar story and its unruly cycles: embedding the bipolar story within a secondary type of narrative. Embedding the often messy bipolar story within a more recognizable narrative genre may help to reduce the story’s destabilizing power, thus rendering the texts more readable and providing a welcome boost to authorial credibility.

Although this discussion is limited to the three genres that were most prevalent in the corpus, my analysis identified several other genres working in the texts. These genres appeared in portions of the texts but were not dominant enough to warrant a textual classification other than bipolar narrative. Six texts included some kind of conversion narrative: three (Cohen, Forkasdi, and Hollan) were grounded in organized religion, whereas texts by Berry, Burnett, and Dean approached faith and belief from a predominantly supernatural/paranormal perspective. A substantial portion of the corpus

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36 These examples are not necessarily established and researched genres.
texts (eight) could be classified as traditional autobiographies, in which the author covers the entirety of his or her life. These texts varied in focus and breadth; some provided ample information about their recent past but not much about their youth, while others offered extensive background on family and childhood but ignored adult relationships. Several other genres were represented in sections of one or two texts, such as pet ownership narrative (Goldstein), sexual narrative (Leboy), anti-psychiatry narrative (Thompson), and diary (Leboy, Inman). Although these genres were interesting, none of them were substantial enough to justify a change in classification.

Interestingly, seven of the 20 texts listed a genre classification on their covers or dust jackets. These categories are not standardized, which may be a direct result of fact that most of the corpus texts were self-published. It is possible that authors are allowed to select, or even create, a classification for their text as part of the self-publishing process. The classifications are as follows: Cohen, Self-Actualization; Forkasdi, Memoir; Burnett, Biography; Dean, Human Development; Behrman, Memoir/Psychology; Staursky, Mental Illness; and Simon, Biography/Autobiography. The range of genres demonstrates the evolving nature of the genre of mental illness narratives as well as providing some clues as to substantial differences in the ways authors might categorize their own work. Although this list is intriguing, the focus of my discussion here will be the three alternative genres that appeared most frequently within the corpus: traditional autobiography, travel narrative, and conversion narrative. I selected these genres because they are established narrative genres with defined features and themes. In order to demonstrate the stability offered by alternative genres, it was imperative that I choose genres that were historically grounded and well-established.
Secondary Genres

Traditional Autobiography

Sidonie Smith and Julia Watson begin their study of autobiography with an overly simple definition, in part because they find the genre to be “a moving target” (3) that resists classification. Their definition of autobiography as “self life writing” captures the heart of the genre—writing about one’s life and experiences from a first-hand perspective (1). Autobiography is a foundational type of life writing, with a history that extends to Greco-Roman times. Though there are many possible definitions, I will shape my discussion around Philippe Lejeune’s broad but useful description of autobiography as “the retrospective narrative in prose that someone makes of his own existence when he puts the principal accent upon his life, especially upon the story of his own personality” (qtd in Smith and Watson 1). Smith and Watson refer to this form of writing as traditional or canonical autobiography, and as indicated in the Lejeune quotation, it involves a wide-lens recounting of one’s life experiences. Traditional autobiography is often retrospective and reflective, as one looks back over the course of a lifetime and reflects on major points in one’s life story. The autobiographical formula varies from person to person, and the author of this type of text may choose to focus more intently on certain events or people that were especially meaningful or memorable, while omitting events that may cast the author in a less-than-ideal light. That is, when an individual sets out to write his or her life story in a traditional autobiography, he or she makes purposeful choices about what is highlighted and what may be ignored.
It is easy to see why traditional autobiography might be useful to those writing narratives about mental illness. The whole-life focus allows for a broader perspective with potentially fewer highly-detailed scenes. Taken in this whole-life context, mental illness may be one aspect of the narrative instead of the defining characteristic or the driving theme (as seen in the texts discussed in the previous chapter). In traditional autobiographies, bipolar disorder can be relegated to a smaller role, sometimes appearing only once or twice in the entire narrative. The illness becomes a single aspect of a whole-life story, an experience that is important but not to the exclusion of other experiences. That is, bipolar disorder goes from being the most salient personal characteristic to one of many characteristics. Situating the illness within the broader context also defuses some of the destructive power of the bipolar story. Whereas Cheney’s text is driven by the chaotic rhythm of episodes to the point where the text flirts with disintegration, these texts have a different rhythm that is more recognizable to most readers, as it is the rhythm of everyday life. Granted, the texts still chronicle lives that include chronic mental illness, but they do not allot that mental illness more or less space than other important life events such as childhood memories or first jobs or divorces. Relegating the bipolar story to a lesser role helps to normalize the disruptive force of illness and contributes to coherence within the narrative. I will consider two textual examples of traditional autobiographies that include the bipolar story in order to demonstrate how this genre can improve the author’s credibility by demoting the bipolar story to a lesser position and by situating the text on a neutral point on the credibility continuum discussed previously. Each text will be considered individually, followed by a short discussion of how embedding can stabilize
the texts and improve authorial credibility. But first, some background on the texts and their quirks.

Gene Leboy’s huge 333-page volume, *Bipolar Expeditions*, announces itself as “a guide for coping with the serious disease of depression and dealing with the prejudices many people still hold against mental illness” (back cover). The back cover also promises a text that “explains how one can successfully survive serious suicidal manic depression.” This statement prepares the reader for a narrative dominated by mental illness, similar to the texts by Hornbacher and Cheney discussed in Chapter 4. But from the moment one opens the text, this assumption is challenged. In reality, the text devotes minimal space to its eponymous illness. The “serious suicidal depression” mentioned on the back cover never materializes, and the text does not offer any coping strategies or guidance. Instead, Leboy’s version of the traditional autobiography begins with his birth in 1935 and documents many events in the 69 years between birth and the publication of the text in 2004. The table of contents lists an astounding 190 chapters, most one page or less in length. The text moves through Leboy’s life in chronological order, devoting chapters to matters both large (his relationships with women) and small (the memory of not understanding a joke told by a childhood friend). Within the first two pages, Leboy declares that the text is an attempt to isolate and identify the cause of his bipolar disorder, to “unscramble my genetic background from the possible influences of other factors in my life” (2). The text then tries to live up to this promise by briefly touching on many influences and events in Leboy’s life.

Leboy’s text meets the criteria of traditional autobiography as retrospective, as the text begins with the author’s childhood and moves in lock-step through adolescence,
adulthood, and middle age. The whole-life focus is absolutely present and Leboy is selective in what he chooses to highlight. The text includes reflection in one of the last chapters, which shares the book’s title. In this chapter, Leboy mentions that medical professionals have told him that his mental illness was a result of “adverse events in [his] life” (286). To test this observation, Leboy offers a half-page graphic representation of the last 40 years of his life, from 1960 to the present (the last date on the graph is 2000). This graph is reproduced as Fig. 2 below.

Fig. 2. Graph from Gene Leboy, *Bipolar Expedition*. 286.

The graph axes are mood and time, and Leboy plots his mood in relation to major life events, including marriages, new jobs, divorces, and bankruptcy. The chart also lists the names of women that Leboy was involved with at various times, as well as his medications (lithium, MAOIs, and Valproic acid). The events plotted on the chart fill the 286 pages of text leading up to this chapter, and the graph leads Leboy to conclude that his bipolar disorder has been caused by a genetic predisposition rather than major life...
events. This chapter is clearly reflective, as Leboy looks back at important life events charted on the graph in relation to his illness experience and tries to see the connection between the two.

The graph and Leboy’s plotted events indicate that relationships have been a dominant event in his life story. In a 40-year span, the graph plots 33 events, and more than half (18 total) relate to relationships. This mirrors the overwhelming textual focus on relationships and sexuality. The prevalence of chapters focused on relationships with women indicate that these encounters have been an important part of Leboy’s life story. In introducing the graph, Leboy writes that the graph shows “the forty years of my experience with Bipolar Disorder” (286), but, in actuality, the chart does not identify any episodes. The graph does indicate two points when Leboy’s mood veers far into the negative (which we assume to mean depressed), in 1960 and again around 1995, but the graph does not include corresponding labels such as “major depression.” Nonetheless, the chapter does visually sum up Leboy’s life while also arranging the many preceding chapters in relation to one another, and these two acts mark the text as retrospective.

The full-life focus results in greatly diminished attention to bipolar disorder and/or how the illness has changed Leboy’s life. If we consider that only 28 of the 190 chapters focus on bipolar disorder or mental illness broadly, we see that Leboy’s text is dominated by the details of his life story rather than his bipolar story. The bipolar story is part of this larger life story, but even when it does appear, it is not a main character. For example, the short chapter titled “A depressive episode 1985” is made up of two short paragraphs that focus on the woman mentioned in the preceding chapter (Phyllis) and her abrupt response to Leboy’s depression. Leboy writes, “I remember a dramatic scene
during this [depressed] period where Phyllis said something like, ‘You’re not going to lie around my house all day, get out’” (120). The text describes Leboy’s reaction as anger so intense that “[he] was ‘lifted out’ of [his] depression” (120). The depression itself is described only as “a period of serious depression” (120) and the text offers no additional information about physical, mental, or emotional symptoms or the length or severity of the depression. The chapter also omits any details about the sudden “lifting” of Leboy’s depression. The paucity of details here prevents the reader from understanding Leboy’s bipolar disorder in any but the most superficial way.

The lack of details causes this chapter to blend into the background of the narrative and, ultimately, this chapter (and the few others that discuss mental illness) is lost, literally buried in a the whole-life narrative. The decision to “hide” the chapters on mental illness in amongst chapters focused on relationships or employment or Leboy’s past minimizes the damaging power of the bipolar story. To illustrate this point, Table 3 lists the titles from one section of the table of contents, beginning with “Corinne, 1975.” Of the following 24 chapters, only two discuss non-relationship topics. Even those with titles such as “TV Set” focus extensively on women and Leboy’s sexual adventures.

Table 3

Excerpted list of chapters from the table of contents in *Bipolar Expedition*.

<table>
<thead>
<tr>
<th>Corinne, 1975</th>
<th>Dorothy 1979</th>
</tr>
</thead>
<tbody>
<tr>
<td>Searching for the Right Woman</td>
<td>Joan 1980</td>
</tr>
<tr>
<td>Architect</td>
<td>Abigail 1982</td>
</tr>
<tr>
<td>TV Set</td>
<td>The Betrayal 1982</td>
</tr>
<tr>
<td>Cali</td>
<td>Melanie 1982</td>
</tr>
<tr>
<td>Millie, 1976</td>
<td>Melanie 1982</td>
</tr>
<tr>
<td>Brenda</td>
<td>Phyllis 1984</td>
</tr>
<tr>
<td>Tragedy at Sea, 1978</td>
<td>A depressive episode 1985</td>
</tr>
<tr>
<td>Michelle</td>
<td>Kate 1985</td>
</tr>
</tbody>
</table>

Source: Leboy, x.
In this table, the mental illness-focused chapter is chronologically in line but topically anomalous; because it appears among so many chapters with a shared focus (women/relationships), it is easily overlooked, dwarfed by the sheer volume of non-mental illness chapters. Although the chapter itself does not reveal details sufficient to portray the depressive episode as difficult or damaging, what little influence the chapter may have had is ultimately lost amidst the thematically driven surrounding chapters.

Taken together, the lack of detail in and the location of “A depressive episode 1985” both serve to lessen the narrative impact of the bipolar story in this chapter and the text overall, as mental illness is relegated to one tiny part of the larger life story. The choice to detail some chapters (most often the relationship chapters) and not others is a conscious one, of course, and by reducing the beast of bipolar disorder to a vague and rarely seen creature, the text minimizes the negative impact of mental illness. After all, readers are unlikely to fear that which they have forgotten. Ultimately, despite visually announcing itself as a bipolar narrative, the text’s progression through Leboy’s entire life, culminating with the reflective chapter and graph at the end, result in a text that is more traditional autobiography than bipolar narrative. Bipolar disorder commands the greatest amount of attention on the front and back covers and in the title, but the table of contents reveals that mental illness is not a prominent subject in the text. Although this may frustrate the reader who chose the text based on the impression of the title and cover, readers may welcome the turn toward traditional autobiography (and away from bipolar narrative) as it moves the text onto the more familiar ground of new jobs and relationships. Despite appearing in the title, bipolar disorder turns out to be the needle in
Leboy’s haystack of a text. The next text in this section offers a second example of how the bipolar story can be embedded within traditional autobiography.

Patty Dean’s text, *A New Song: Confessions of a Joyful Manic Depressive*, begins with an Author’s Note in which Dean notes that she has dealt with bipolar disorder “while searching for life’s meaning from a foundation of twisted religious bigotry and dysfunctional family issues” (xiii), and this statement prepares readers for the eight chapters that follow. Dean’s text tends to intersperse description of the action and reflection on how the event shaped her larger life story, which follows the format of traditional autobiography. The text begins with Dean’s childhood and the memory of a brutal beating at the hands of her father. In addition to the physical damage, in the form of “nasty, red welts and bruises from [Dean’s] face to [her] ankles that stayed for more than a month” (3), the text indicates that the incident “left a deep scar in [her] soul…that would mold [her] life” (3). The physical damage was immediate, but the text also addresses long-term damage that would only become apparent many years later in retrospect. A few pages later, Dean describes her reckless and risky childhood behaviors as a cry for her mother’s attention and admits that, even as an adult, she is unsure why that attention was so needed. The text includes a great deal of looking back that is explicitly marked as reflection as Dean attempts to make sense of earlier events. This sort of back and forth, from event to reflection on event, is characteristic of autobiography as Dean first describes events and then situates them within the larger life context.

The main events in Dean’s text are the birth of her son, Jeff, and her numerous marriages and divorces (six in total), and much of the text documents her struggles to maintain custody of Jeff during times of turmoil. And Dean’s life is full of turmoil: the
beatings that began in her childhood are continued by several husbands, she is gang-raped and left for dead, she becomes involved in a pyramid scheme and goes bankrupt, and she loses several close friends to very tragic deaths. During most of this drama, Jeff lives with friends and family, as Dean is not able to care for him. These major life events occupy a large portion of the text, and description is almost always followed by reflection, as when Dean admits a tendency to jump head-first into new relationships even as she confesses that she still wonders about the “force [that] compelled me to keep getting married” (108) even as the divorces piled up. The text moves through Dean’s life chronologically, but the chapters are not solely thematic as in Leboy’s text. For instance, Chapter 5, “Modern Barber Shop,” covers the following events in 40 pages: several trips domestically and abroad, Dean’s career as a barber, the adoptions (and deaths) of several pet horses and dogs, three marriages, two divorces, the deaths of both of her parents, several episodes and one hospitalization, as well as numerous flashbacks to Dean’s childhood and teenage years. The amount of information in that single 40-page chapter is almost overwhelming, as time begins to blur and readers start to lose track of details.

Bipolar disorder appears in every chapter, but it occupies one sliver of space in otherwise very full chapters. In the example above, Chapter 5 mentions several episodes and one hospitalization, and the text does not gloss over these events. For example, during one of the episodes mentioned, Dean declares that she is “hopelessly tired” of dealing with depression, “tired enough to consider pulling the trigger on the blurry 45” she holds in her hand (98). This example is evocative and serious, reminiscent of the intense descriptions in Cheney and Hornbacher. And this kind of detailed example could harm Dean’s credibility by marking her “too crazy” to be a credible and reliable author.
But the half-page example is quickly lost in the 40-page chapter as the text surges forward to the next event in Dean’s life (in this case, a mountain-climbing adventure with her son). The sheer volume of information in each chapter relegates the bipolar story to a lesser role, which diminishes its destructive potential.

Although each text handles things differently, both Dean and Leboy embed the bipolar story within the more recognizable genre of traditional autobiography. The embedding effectively moves the text to a more central point on the credibility continuum, and this move has a positive effect on the narrative touchstones mentioned earlier. Coherence, causation, and closure are key aspects of successful or “good” narratives that may become compromised as these texts attempt to tell the bipolar story while negotiating the paradox of mental illness (“too crazy”/“not crazy enough”). The choice to embed the bipolar story within a secondary narrative can address the textual vulnerabilities relating to these narrative touchstones. For example, both of these texts have strong coherence and both are organized chronologically, as is often the case in traditional autobiography. In both texts, coherence comes via consistency. Though the reader may tire of Leboy’s endless line of short chapters, the text is orderly and quite coherent due to the unbending organization of the chapters. And though readers may find Dean’s digressions about her many marriages frustrating and the amount of information overwhelming, the text is completely coherent. The wide-lens focus of traditional autobiography tends to begin in childhood and proceed linearly through adulthood, and this chronological trajectory is reliable and recognizable. After all, almost everyone ages in a predictable way, so that the movement from child to adolescence to adulthood is familiar. Additionally, organizing things in this way supports authorial credibility, as the
sequence is orderly and controlled. Although unforeseen challenges or difficulties may arise, the author appears to be in complete control of his or her narrative.

Second, both of the texts also provide opportunities to explore causation, another narrative touchstone. Leboy argues for genetic predisposition as the cause of his bipolar disorder, but this declaration is not supported by textual examples or evidence, so it loses some of its punch. Nonetheless, the presentation of the entire life story (in both texts) makes determining a cause appear more plausible. Because the texts provide more background, readers are given more information relating to the individual’s personality and life exclusive of bipolar disorder. Both texts include chapters on family, friends, work, education, and childhood, and this additional information may contain clues relevant to the origin of bipolar disorder, or, at the very least, when Dean and Leboy first began to experience symptoms. As mentioned earlier, causation cannot fully be addressed in bipolar narratives because the clinical narrative for bipolar disorder is incomplete. Most texts speculate about possible causes of episodes, but without proof, readers are left to trust an author who may not be reliable. That said, credibility can be improved by the author filling in more blanks, thereby providing more answers.

Third, these two texts also provide closure on several levels. Of course, closure is not fully part of the texts because the author’s life story continues even after publication. But closure does come on the textual level in the relegation of the bipolar story to specific chapters. This happens most clearly in Leboy’s text. As discussed above, the text includes fewer than 30 chapters focused on mental illness, and when these chapters end, the focus shifts wholly to other topics. Confining the illness to a limited number of chapters provides some measure of closure because the discussion of bipolar disorder does not
bleed over into other chapters. The demarcation is not so clear in Dean’s text, but the text does limit discussion of bipolar disorder to several chapters, and the end of the chapter means the end of the illness, at least temporarily. Though this kind of closure is not akin to the closure that might come with, say, a cure, it is still better than the lack of closure seen in Marya Hornbacher’s text. This short-term closure may ease concerns about authorial credibility by presenting Dean and Leboy as self-aware authors who are able to provide information about their lives in totality. When readers compare a few missing details with Hornbacher’s admission that she has no memory of entire years of her own life, it becomes clearer how accumulation of details can promote the impression of a reliable author.

Nonetheless, these two texts initially seem to fall to the “not crazy enough” side of the continuum. The lack of illness-driven details and personal examples may make readers suspicious of Leboy (and to a lesser extent, Dean). For example, readers might wonder how or why Gene Leboy is qualified to write a bipolar narrative if he has never experienced a manic episode. In choosing how to present the bipolar story, these texts have chosen to err on the side of caution and to disclose very little. Embedding is, in part, a tool of distraction; rather than focusing on the missing details and questioning credibility, the texts direct the reader’s attention elsewhere, to divorces and children and careers. The texts are not devoid of all personal details—there is ample information about relationships, growing up, education, and career choices. The texts choose to omit personal details relating to the bipolar story and the illness experience. By keeping the focus on the details in other areas of their lives, Leboy and Dean divert attention away from the bipolar story and to other parts of their respective life stories. These texts, then,
minimize the challenges of the bipolar story by taking advantage of autobiography’s whole-life focus to steer the reader’s attention away from mental illness. Though these texts do risk appearing “not crazy enough” to be believed, the missing details are not as obvious when situated within a full-life narrative.

*Travel Narrative*

A second alternative genre is that of travel narrative. Travel narratives focus on travel or describe a journey. This genre is almost as old as traditional autobiography; Smith and Watson report that travel narratives have been part of Western culture since Greco-Roman times. These texts tend to be written in the first person and focus on the journey to the exclusion of other aspects of the author’s life. According to Smith and Watson, travel narratives usually document stories of “displacement, encounter, and travail” as well as the author’s “observations of the unknown [and] the foreign” (207). Because the author faces new experiences in an unfamiliar or unexplored setting, travel narratives can also provide opportunity to reflect on the relationship of the traveling person to his or her home (Smith and Watson). Pathographies frequently describe illness as a kind of journey, so it is not surprising that travel narratives would emerge as a useful alternative genre for bipolar narratives. This genre is an excellent fit for bipolar narratives specifically because, as I’ve argued in previous chapters, the medical and cultural narratives on bipolar disorder are incomplete and undefined, and dealing with bipolar disorder may involve questioning of identity as well as feelings of confusion and fear of the unknown. Within the corpus, many texts describe bipolar disorder as a frightening
illness that launches the individual into an alien world of episodes and medication. So the choice to embed a bipolar narrative within a travel narrative seems logical from the start.

Travel narratives may also explore issues of identity, offering another point of connection to bipolar narratives, which address the difficulty of accepting a life-changing diagnosis. Although travel narratives can be threatening in their unfamiliarity, most express only a vague sense of unease and disorientation that comes with exploring unfamiliar surroundings. But new places also offer new ways of seeing the world and of seeing oneself, and this is part of the allure of the genre. Whether the narrative is a painstakingly crafted account of a trip to Switzerland or a small child’s narration of the annual family trip to the beach, travel narratives have the power to transport the reader from the everyday routine of life into a world of new sights, sounds, and people. As a genre, then, these texts focus on exploration of self and location. It is no stretch to imagine the world of mental illness as a new landscape, and a diagnosis of bipolar disorder certainly involves a period of exploration and discovery.

This portion of the chapter will focus on two corpus texts that embed the bipolar narrative within a travel narrative. *The Edge of Sanity* by Olivia Burnett and *Detour: My Bipolar Road Trip in 4-D* by Lizzie Simon both tell stories of travel and adventure. The women in the texts share a diagnosis of bipolar disorder and both texts describe a journey to the exclusion of other aspects of the authors’ lives. Simon’s text features mental illness more directly, as it describes the author’s cross-country journey to find and interview other young people with bipolar disorder. Burnett’s narrative is less purposeful, as the author wanders from place to place without a strong sense of direction. Though the texts differ in notable ways, they both neutralize the disruptive narrative power of the bipolar
story by embedding it within a less threatening travel narrative. As a result, both texts present themselves as travel narratives that include some discussion or information about bipolar disorder. Olivia Burnett’s text provides an excellent first example.

The very first page of Burnett’s text announces that “[her] story begins and ends with the road” (vii) and this proves to be a true statement in the pages that follow. The text narrates a series of road trips through Montana, New Jersey, and Connecticut and the odd and interesting people that Burnett meets along the way. The text also documents several short stints in mental hospitals, where Burnett receives treatment for bipolar disorder. The text focuses almost exclusively on traveling, and tales of adventure far outnumber and overshadow the mental illness narrative in this text, making it primarily a travel narrative with some information about bipolar disorder.

Burnett’s text also addresses identity, another characteristic of travel narratives. The text presents her as a nomad and she embraces the label, perhaps because it fits her sense of disconnection. Although the text describes Burnett’s family as a caring support network, Burnett does not turn toward them for help. The text describes check-in phone calls with her parents but Burnett’s identity is not rooted in home or the family unit; instead, she feels that she is her truest self when she is on the road. But identity is not clear-cut for Burnett when it comes to mental illness. Although she resists the psychiatric label initially, Burnett gradually shifts to acceptance, as seen in this exchange with a fellow patient in the psychiatric ward: “‘I’m Bipolar,’ I tell him. ‘This place sucks so much. I hate the way they treat people like us.’ Funny that’s how I think of myself these days. Bipolar with a capital B” (37). The capitalization of ‘bipolar’ is significant, as the illness moves from noun to proper noun, from an illness that she has to a definitional part
of her identity. Of course, the acceptance is not this straightforward, and the text includes examples of Burnett struggling to come to terms with bipolar disorder as an integral part of who she is. This focus on identity fits the genre of travel narratives.

Although the text focuses mainly on descriptions of people and places that Burnett encounters on her trips, the bipolar story is still part of the text. When Burnett remembers high school, she comments that “instead of having a normal social life I’ve had therapists and Prozac and Neurontin and Risperdal” (10). Prozac, Neurontin, and Risperdal are medications frequently used to treat bipolar disorder, but the text lists them without any explanation, as one would list old friends. Burnett’s moods tend to cycle with the seasons, so that she is manic in the summer and depressed in the fall/winter, and this cycle repeats several times in the text. The endless repetition breeds desperation, as Burnett bemoans “Another year, another fall, another state. Same depression” (152). The text describes bipolar disorder in terms of physical confinement, and Burnett is “boxed in, trapped in my mind and within these walls” (152). So extreme is Burnett’s wish for relief that she longs “to lose myself between the dotted lines of the highway and never come back” (152). And this is what she does for most of the text—a road trip, followed by a period of relative stability that turns into mania (most often in the spring/summer), and then the downturn into depression and misery as the weather turns colder. The recurring cycle means that treatment does not work for Burnett, but the text does not dwell on this fact or on bipolar disorder.

When the text offers information or insight about bipolar disorder, it does so in fleeting moments of disclosure that hint at the dangerous and destructive power of bipolar disorder without going into too much detail. The following example, featuring a manic
Burnett, provides one of very few glimpses into the out-of-control world of the author’s bipolar disorder. Burnett is hanging out with friends, watching movies and eating junk food. The scene seems relatively innocuous at first:

That night we all hang out at Ginny’s house and eat Chinese food. We watch Miss Congeniality, which Davy loves, and have a jellybean fight on the couch. Daryl pole-dances on one of the pillar [sic] that runs through Ginny’s basements, and we tie Davy to the other pole. Ginny snaps a picture of him and Jen throws a fistful of jellybeans at Daryl. I dance around the room in a sombrero, waving a butcher knife. Davy mumbles something about Walker, Texas Ranger through the sock we’ve gagged him with. (23)

There’s nothing remarkable about a group of friends getting together for dinner and a movie, and the goofing around, the jellybean fight, and even the pole-dancing seem like standard college-kid fare. But when Davy is tied up and gagged with a sock, things take a turn toward the uncomfortable. The detail that really tips the scales is the mention of the author brandishing a butcher knife as she dances around the room. A butcher knife doesn’t fit with the scene of friends and fun, and the mention of the knife quickly shifts the tone from playful to threatening. It feels as though things are out of control, a feeling only intensified by Burnett’s declaration that “it feels so good to be manic” (23). The example appears in the text between a trip to see a performance of The Nutcracker and Christmas eve at a friend’s house. Although the text does not dwell on the example or the thin line between goofing off and accidentally injuring someone, the moment is a reminder that bipolar disorder can be disruptive to both lives and narratives. Passages
such as this one remind readers that the author is ill, that bipolar disorder is dangerous and damaging and sometimes treatment doesn’t work.

But these moments appear infrequently, dwarfed by passages describing lonely mountain roads and analyzing the social hierarchy of a group of homeless men she meets in Ventura, CA. Burnett is always seeking a new adventure, and the text documents many different adventures, including a summer in California studying condors, repeated trips to Yellowstone National Park, an internship with the U.S. Fish & Wildlife’s Red Wolf Recovery Program in North Carolina, and several attempts at college coursework. And each new place brings a new group of wild and wacky friends. The text describes these people almost like a circus sideshow where each new act is stranger than the last: Lobo, the 18-year-old nomad with testicular cancer and six months to live; John Motherfuckin’ Ryan, the “traveling gypsy/hippy/pirate” (133) who gets Burnett hooked on marijuana; a boyfriend named Ed who coaches Burnett through several out-of-body experiences via astral projection; Jenny and Polly, the three-hundred-pound lesbians with multiple personalities and baby-doll “children” named Heaven, Hannah, and Willie. The parade of bizarre characters and constantly changing scenery lend a sense of movement to the text. Add in the text’s fascination with driving, and the result is a narrative peopled with zany characters and random plot twists with a bit of mental illness sprinkled in. And although Burnett’s bipolar disorder is destructive and serious, the narrative never fully explores the illness or its consequences. In the end, the text’s focus on Burnett’s adventures “gallivanting around the country” (5) dominates and the travel narrative takes over as mental illness fades into the background of the text.
This fading away is troubling for readers who wish to know more about Burnett’s illness experience, but it benefits Burnett’s credibility. As discussed in previous chapters, when a text focuses very closely on bipolar disorder, basic narrative touchstones tend to falter and the balance of disclosure tends to tip toward the extremes of “too crazy” or “not crazy enough.” Travel narratives would seem to have avoid these troubles because they include a coherent narrative and closure (because every trip ends). Whereas bipolar disorder was the main character in both Cheney’s and Hornbacher’s texts, Burnett’s text is first and foremost a travel narrative and, as such, focuses on the journey. The highway is more than just a main character, though. It is a haven and an escape, a wonderfully complex world of its own and the only place that Burnett feels like herself. The text’s obsession with the open road shows up in several ways, from entire chapters devoted to the act of driving and the fantasy of the open road to the various breakdowns and patch-up jobs on Burnett’s loyal traveling companion, a much-maligned Saturn. Tellingly, the text describes the Saturn’s repairs in greater detail than any of Burnett’s hospitalizations, and this careful choice marks the text as travel narrative first, bipolar narrative second (or perhaps third or fourth). As readers might expect from a travel narrative, the road is portrayed as an idealized space, where “[p]ast and future cease to exist” (63). Wherever Burnett is headed and whatever she is going through, the focus is always on the journey, effectively diminishing the bipolar story’s destructive force and again diverting the reader’s attention from illness in the text.

Near the end, the text includes a moment of confession, in which Burnett wishes to drive into the sunset and vanish entirely. Lizzie Simon’s text includes a similar moment in the latter half of the text, when she gets into the car and simply drives
“heading West, no particular destination in mind” (167). Simon drives until she is ready to stop several days later. Here again, the text offers the open road and the car itself as an escape, a release valve of sorts. When life becomes too much, both Burnett and Simon get in, gas up, and drive. Simon’s text is another example of a bipolar narrative embedded within a more familiar travel narrative, though bipolar disorder features more prominently in this text.

The first 38 pages of Detour: My Bipolar Road Trip in 4-D offer a brief history of the author’s experience of bipolar disorder, including one severe manic episode and her diagnosis. On page 39, the text announces the beginning of a “cross-country adventure” that Simon dubs “my detour” (39). The detour stops in New York, Washington, D.C., Virginia, Georgia, Louisiana, Texas, Arizona, and California. Each stop includes a meeting or interview with someone with bipolar disorder, which means that the text discusses mental illness with some frequency. However, the text focuses extensively on others’ diagnoses, struggles, and successes as Simon assumes the role of objective reporter, asking questions and taking notes. This feature is a familiar part of travel narratives, which often include the author’s observations of new settings or people. This outward focus on the journey pulls the reader’s attention away from the bipolar narrative and toward the more familiar genre of travel narrative. After a brief glimpse into the particulars of Simon’s bipolar disorder, the text quickly moves on to focus on road trips and interviews, and, as I will discuss, the outward focus on others’ stories helps to defuse and normalize the bipolar story presented in the first section.

The text begins with an episode that Simon describes as “so horrific that it would become impossible for me to deny that I had a mental illness for the rest of my life” (3).
The text provides limited information about family history and childhood in these early pages, but readers learn that Simon was a moody, troubled child. The episode mentioned above occurs while Simon is in Paris attending a study-abroad program. According to the text, “[E]verything was perfect. For just a moment, a few hours really, a morning. And then I went insane” (11). The episode begins as “a little fuzz building in my head” (11) and ends with a fully psychotic Simon flying home to meet her parents. This part of the text is disorienting in part because of Simon’s complex and frightening hallucinations.

For example, the text describes Simon’s refusal to sleep (because CIA agents are nearby waiting to capture and kill her), refusal to eat (because the CIA has poisoned all food in order to kill her), and refusal to go to class (because her classmates have been brainwashed and are being held hostage by the CIA). In addition, the text goes into some detail about Simon’s delusional belief that she is a cat. This belief creates difficulty when Simon has to go through customs on her return flight to the U.S., as she rants and screams and refuses to fill out an embarkation card “because there was no box to mark ‘cat’ under gender” (19). This scene is mildly amusing but the tone is not light-hearted.

Hallucinations and believing oneself to be a cat are not things that most readers can relate to, making this early part of the text unnerving and fostering some doubts about Simon’s credibility. The situations are unfamiliar and bizarre as the text shows the extent of Simon’s illness. Simon herself describes this time of her life as “utter chaos” that could only be tamed by heavy-duty antipsychotic drugs, the pharmaceutical equivalent to “a nuclear bomb” (21).

The text continues with a brief mention of Simon’s diagnosis and very successful treatment with lithium before deciding to “put all things bipolar to the side” (28) and
focus instead on Simon’s transition to college and her first job as a producer for an obscure, undeveloped musical space called The Flea. The details are sparse but it is clear that Simon is very good at the job. The text begins to move in the direction of travel narrative when Simon suddenly quits her job to search for young, successful people with bipolar disorder, described dramatically as “sparkling little treasures of personality who harbor terrors in their bodies” (47). The journey begins in Providence, RI, and the remainder of text follows Simon as she moves West. The text describes stops in large cities and small towns, focusing on the interviews and the general ways in which bipolar disorder has affected the interviewees’ lives. These stories of adventure dominate the text, beginning on page 47 and stretching through page 200. But there are relatively few damaging details and the text presents them in a very factual and orderly way, thereby limiting the potential for narrative disorder.

Simon’s observations of the people she interviews structure much of the text. For example, “a big, normal as normal gets, looking guy” named Matt is Simon’s first interviewee (119). The interaction is simple and straightforward—Simon asking direct questions, Matt answering. When asked about his current mental state, Matt replies, “I have about three or four panic attacks a week, but I feel more rested than I have in years. Not in control, but less out of control” (121). The tone here is casual and matter-of-fact, and the delivery helps to normalize what Matt is actually saying. Four panic attacks each week is no small matter, and readers may struggle here to reconcile the declaration of feeling somewhat in control with multiple panic attacks (which would seem to be the epitome of losing control). A few pages later, in Matt’s response to a question about treatment, the text ticks off the names of drugs as easily as one might list the names of
classmates, but instead of focusing on that information, the text moves quickly along to the medications that finally worked for Matt. Matt’s entire psychiatric history is covered in the space of a few pages and there is almost no commentary. Rather, the writing here is pure reporting, as the text breaks down the back-and-forth of the interview. The chaotic details are buried within longer answers, and Simon does not pull them out, preferring instead to “find out what went right” (125) for Matt and the others she speaks to.

The choice to focus on others’ narratives creates some distance within the text, and this distance is also reminiscent of travel narratives, which may include the author’s observations of unfamiliar environments or cultures. That is, in recording other peoples’ bipolar stories, the text moves farther away from Simon’s own potentially threatening bipolar story. This distance, combined with the no-nonsense journalistic presentation of the external narratives, defuses the potential power of the bipolar story. The interviewees’ stories come to the reader secondhand and without many details, resulting in stories dulled by distance. And, to make an obvious point, Simon’s text is only interested in bipolar success stories, so the reader knows in advance that these stories will end well.

And a good ending means closure, which is a given in travel narratives. As a genre, travel narratives have built-in closure: the journey has to end. At some point, the prodigal daughter returns home and the prodigal son runs out of vacation time. Travel narratives may also include discussion about the relationship between the author and his or her home; Simon’s text ends with her return to her parents’ house in Connecticut. Though the text is devoted to the detour, the journey begins and ends at home. And though there is some fear and trepidation about returning, the text closes with Simon reconnecting with her parents and siblings after years of relative isolation. The definitive
end offered in the return home provides a significant amount of closure to the overall narrative.

Travel narratives also provide a sense of coherence that bipolar narratives often struggle with. Although adventures can be spontaneous and unplanned, the recounting of a journey is methodical and linear. That is, though it unfolds on a moment-by-moment basis in real life, a travel narrative can be plotted on a map in a clear, chronological way. Even if the route is circuitous, it can be mapped, and the ability to clearly define a route provides narrative coherence. Although Burnett seems to wander aimlessly between several Montana towns, her erratic movements could be linearly charted on a map. The fact that a road trip or journey is made up of physical locations also provides coherence, as, again, one’s movement can be visually traced and represented in a concrete way. The bipolar story has no such concreteness—although it is possible to track episodes, there is nothing concrete to anchor the episodes. They are events, abstract experiences that lack solid physical attributes. The physical aspect of travel narratives makes them an excellent frame for bipolar narratives, as they provide much-needed coherence and closure.

The travel narratives mentioned in this section seem to land at a midway point on the credibility continuum. Although the severity of Simon’s initial episode may mark her as unreliable, the fact that she only writes about one episode and then shifts the focus elsewhere minimizes the impact of the episode. The text presents others’ stories in a very professional and undramatic way, and this even-handed reporter-like tone does much to boost authorial credibility. Simon is presented as an engaged interviewer who asks thoughtful questions and is genuinely interested in her subjects’ answers. Along these same lines, a cross-country trip requires stamina, determination, and planning. Both texts
describe long, difficult trips that would be taxing for anyone. But Simon and Burnett come through the trips intact and even confess to loving the open road. The undertaking of such a major trip presents the authors as reliable, capable individuals with perhaps a touch of courage that pushes them to meet new people in new places with very little hesitation. These positive attributes outweigh the negative force of the bipolar story, and the adopted genre provides a critical boost to authorial credibility.

**Conversion Narrative**

On occasion, travel narratives involve some kind of transformation, in which the journey has a significant and lasting change on the traveling subject. This is also sometimes true in pathography in general. But transformation plays a central role in conversion narratives, the third and final alternative genre under consideration. The change from what Smith and Watson call “a faulty ‘before’ self to an enlightened ‘after’ self” (192) may happen instantaneously or gradually over time, but some kind of important change provides the foundation here. Conversion narratives are among the oldest recognized genre of personal writing and have much in common with illness narratives, including a focus on personal change (Hawkins). Briefly, conversion narratives involve a struggle with or descent into darkness, pain, or fear, followed by an awakening or change. The change often follows a struggle or battle, that, when won, moves the individual to recommit to life and faith (Smith and Watson). Although the fall can be frightening and overwhelming, the promise of revelation and personal growth overshadows the challenges faced. In these texts, the final outcome is positive as the

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37 For much more on the similarities between pathography and historical conversion narratives, see Hawkins, especially Chapter 2: The Myth of Rebirth and the Promise of Cure.
struggle pays off in a renewed sense of self and a sense of divine connection with the universe, God, or some other higher power. In the context of illness narratives specifically, Hawkins points out that conversion narratives tend to focus extensively on faith and its healing role to the detriment of information about treatment and the course of the illness. Similar to travel narratives, these texts document a journey of sorts as the individual moves from illness to health with the help of a higher power.

Ruth Cohen’s *Remains of a Cloud* provides the most relevant textual example of how a bipolar narrative can be embedded within a conversion narrative. The book jacket promises “an unforgettable and inspirational journey across four continents and through the vast abyss of her own bipolar disorder,” but the text offers relatively little information or insight about bipolar disorder. Cohen repeatedly refers to bipolar disorder as “the venom” and although certain chapters mention episodes of mania or depression, very few details are given. For example, in Chapter 25, “A Quick Review of a Long Suffering,” the text declares that the chief characteristic of bipolar disorder is “a big dreadfulness for life” involving the “terrible mental states” of mania and depression (210). The text goes on to define bipolar disorder as “a love-anger emotion that does not know how to stop” (215). The language here is interpretive and generic, revealing little about the specific ways that Cohen experiences bipolar disorder. Even when the text mentions an episode, it amounts to little but another vague event, as in the following description of depression: “When depressed, clouds of interpretations (the language of depression) start to build up and her awareness would gradually leave her. When depressed, the emotions became more active...She won’t be able to enjoy and will be too sad too often” (211-212). The
text never goes beyond this very superficial and imprecise level of explanation, resulting in a far less dangerous or damaging version of the bipolar story.

Instead of exploring the bipolar story, the text focuses on the author’s spiritual quest to uncover her past and reconnect with her exiled spirit. The exile is caused in part by mental illness but also by Cohen’s lack of knowledge regarding her Jewish history and identity. Much of the text focuses on Cohen’s faith-driven journey to find and communicate with her spiritual counterpart, Machou, described as Cohen’s joyful, childlike inner spirit. This desire sends the author to several different continents and the text recounts these trips as well as childhood incidents, covering Cohen’s entire life. But throughout, the spiritual quest takes center stage, and the textual organization mirrors that of conversion narratives just mentioned. The first part of a conversion narrative is the struggle or challenge, and this occurs within the first 100 pages of Cohen’s text, as she struggles to overcome “[the] cloud inside me” (50). In 1983, Cohen was married with two young children and attending graduate school when she experienced an “explosion” which marked “the beginning of [the] descent...through hell where darkness was my only color and tears were my language” (87). The text recounts the feeling of being “broke[n] into an infinite number of pieces” (87) and blames God for this great trial. The text compares the author’s struggle to that of Abraham when asked to sacrifice his only son, and although the comparison is overly dramatic, the intention at this point in the conversion narrative is to convey a falling from grace into a period of darkness. This darkness is described as “a fall into...degradation” (108) and a “journey to hell” (120), full of pain and misery. Cohen seeks treatment several times to no effect and the future seems bleak.
Through the haze of suffering, the text presents faith as a ray of light and opportunity. More specifically, the text states that “this faith [in God] had always been present in me, but heavy dust had prevented me from feeling it and from using it in my hard times” (121). It is unclear if the heavy dust is bipolar disorder or some other personal difficulty. Regardless, this quotation marks the first time that the text identifies faith as “something new that belongs to me more than anything else” (121). Upon rediscovering faith, Cohen vows to use it as a weapon against her venom, and the text optimistically predicts that faith will prevail. On one particularly bleak day, the vague idea of faith takes on concrete shape in the form of the voice of God. In the midst of difficult days, faith is a steady crutch, as the text affirms “the most important thing is that... I am closer to God and myself, day by day” (149). It is by strengthening her faith and drawing closer to God that Cohen also comes closer to finding herself. Thus, the text suggests that healing, recovery, and reclamation of self happen only through God.

The turning point or transformation happens after a very difficult time during which Cohen feels great despair. As she did earlier in the text, Cohen turns to God for help: “I called on Him and I saw the results and I wondered and I believe in Him a little more” (169). On this day, after receiving “a gift of value” from God, the text announces, “I became a new person again” (169). The change happens thanks to the gift from God: “a secret recipe sealed with His love for me” (170). Though this recipe is never fully explained, there is no denying the change in tone at this point in the text. Instead of focusing intently on negative moods or bad days, the text shifts to a more active story in which Cohen is able to “outmaneuver this part of my mood” (170). As expected, the text expresses gratitude for this gift, thanking and imploring “My God, You, who know the
way, show it to me always” (177). Here again, the connection to God and renewed faith are central to healing and recovery. Cohen declares that the lifelong struggles and suffering occurred because “I was not connected to my soul nor my soul to me” (177). God is the one who has facilitated this connection, which has literally been life-saving and life-changing for Cohen. Near the end of the story, Cohen praises God as “my help and my shield” (228), and declares that her faith was primarily responsible for bringing her through the ordeal of finding her soul and herself. The text also credits numerous psychologists and psychiatrists, but their skills cannot compare to those of God. The text proper ends with the following sentence: “Science and Faith, what a great combination!” (261). This sentence sums up the text, in that the mainstay of Cohen’s recovery was faith, assisted by medication and therapy. The text ends with a recommitment, declaring “in God I do believe more than ever, with an understanding greater than ever” (260). Cohen rises and sleeps in gratitude, ever thankful that “the venom was not in my head anymore” (261).

The conversion narrative comes through quite strongly in this text, in part because it is the most formulaic of the three alternative genres discussed here. Embedding the potentially disruptive bipolar narrative within the more recognizable and predictable conversion narrative relegates the bipolar story to a background character with limited disruptive power. The paradox is present in Cohen’s text, though in a slightly different way than in previous texts. The text does not provide enough details to risk being perceived as “too crazy” to be believed or taken seriously. The risk of being seen as “not crazy enough” may be more pertinent in Cohen’s text, but the confusing and vague descriptions of episodes (such as referring to bipolar disorder as an invisible venom
“capable of vile persuasions” [144]) seem to be written by someone plausibly in the grip of a serious illness. Cohen’s faith could also damage her credibility, most especially when the text claims implies that Cohen’s bipolar disorder was caused by a lack of faith in God (and then healed by recommitment to God and renewed faith). Her devout faith could also enhance her credibility with some readers, again demonstrating the nuances of the credibility continuum.

Although the centrality of the conversion narrative may affect Cohen’s credibility, the alternative genre does more good than harm in terms of the bipolar story. Although conversion narratives do not offer the firm closure found in travel narratives, the formula of the genre allows for some closure. At the very least, the triumphant transformation and recommitment to God can bring an end to struggle and difficulty. In the case of Cohen, her renewed faith provides closure in that the text ends with a reunion between Cohen and Machou, ending the search for this spirit who was part of Cohen’s past.

Conclusion

As illustrated in the texts discussed in this chapter, the choice to embed the bipolar narrative within an alternative genre can be very beneficial. On its own, the bipolar story has great disruptive potential, as texts must maintain a balance of disclosure somewhere between revealing too much and revealing too little. Details related to the bipolar story can have a profound influence on authorial credibility, and as texts struggle to maintain a balance, they may also have difficulties with basic narrative touchstones. Bipolar narratives are particularly prone to textual vulnerabilities relating to causation, coherence, and closure. But when coupled with a
more recognizable and stable narrative genre, the bipolar story can be stripped of much of its disruptive power.

This chapter considered three alternative genres, examining how each genre could work to downplay the bipolar story and repair the damage severe mental illness can cause to authorial credibility. Traditional autobiographies, also known as whole-life narratives, provide a strong chronological frame for the narrative, forcing episodes or hospitalizations into predetermined, finite time slots (such as March 1996 or the second week of October) and preventing the bipolar story from taking over the entire narrative. Traditional autobiography can also provide some closure, at least on the textual level, by confining bipolar disorder to a set number of chapters. That is, when the chapter ends, so does the episode, and the following chapter may move on to a different time or place. These narratives can also diminish the impact of bipolar disorder by treating it as one small piece of a larger life story.

Travel narratives help bipolar narratives chiefly by providing ready-made coherence and closure. The coherence comes by way of the recounting of a physical journey involving concrete locations that may be plotted on a map. Even if the route is determined randomly, the fact that the journey occurs in a concrete space and time creates a coherent narrative. Stories of adventure can also offer closure, in that all trips have to end. How they end is not important—some involve a return home, some segue into another adventure. What matters is that all journeys end. In the sample texts, the return home provides a temporary closure for one part of the narrative even as the bipolar story may resist any kind of ending point.
Similarly, conversion narratives can also provide coherence in their recognizable trajectory. Though the spiritual journey is different for each person, these texts are somewhat predictable, and that regularity can greatly minimize the bipolar story’s negative impact. Conversion narratives may also indirectly help with causation by stating that a return to faith and God solves a problem caused by the opposite behavior (turning away from faith/God). This chain of causation may not be persuasive for all readers but it does provide one plausible cause for the tremendous difficulties that can accompany a diagnosis of bipolar disorder. These texts may also offer the chance for closure via the recommitment of one’s life to God. Though the diagnosis will persist, for some, the struggle is resolved by strong faith, which can end a challenging stretch of time.

Though this chapter only considered three alternative genres, there are certainly other genres that could neutralize the bipolar story and move a text toward a more balanced point on the credibility continuum. As mentioned, several texts within the corpus situated a bipolar narrative within a romantic or relationship narrative, while others included a myopic focus on a spouse or a child. Bruce Goldstein’s text is entirely built around a narrative of pet ownership, and the bipolar story is effectively neutralized through the narrative power of the puppy. Nearly any genre could be adapted to work with a bipolar narrative, and most would probably have a positive influence by providing clear expectations and ideas about what particular alternative narratives should look and sound like. By shifting the focus to another subject and relegating bipolar disorder to a secondary (or tertiary) role in the narrative, the texts in
this chapter are far less chaotic, confusing, and threatening than those discussed in Chapter 4.

The end result is texts that seem to land in a neutral, balanced space on the credibility continuum: although these texts still include damaging details about episodes or behavior, the details are lost amid a sea of non-illness-related information. For example, Lizzie Simon’s psychotic delusion that she was a cat wanted by the CIA could be devastating to Simon’s credibility, as it is so extreme that most readers will not be able to identify with the experience. However, in the context of Simon’s entire text, her repeatedly thoughtful and careful interviews and observations dwarf the one damaging detail offered very early on in the text. The details of her cross-country trip are conveyed in a mature and grounded way, giving Simon great credibility and authority. By taking on the mantle of an alternative genre, bipolar narratives are able to have the best of both worlds: texts may include personal information related to the illness experiences without worrying too much about how that information may affect credibility. Authorial credibility is quite strong in these secondary genres, as authors seem to be in command of the material whether it is a lifetime of experiences and relationships that must be woven into a cohesive whole-life narrative or six months’ worth of stops and starts on a cross-country journey. As a rhetorical strategy, embedding works on multiple levels by making bipolar narratives more familiar and more predictable as well as helping the texts to navigate the paradox successfully and end up somewhere in the credibility “safe” zone.
Chapter 6: Conclusion

This dissertation has made an argument about the work that bipolar narratives do, claiming that these texts encounter textual challenges relating to credibility and basic narrative touchstones. I have also considered two ways in which bipolar narratives respond to those challenges (through framing and embedding). Bipolar narratives are a distinct sub-genre of pathography because they trade the traditional focus on physical illness for a focus on stories of mental illness. As relative newcomers to the genre, mental illness narratives are still exploring new territory and staking their claim to a share of the pathography landscape. The sub-genre is rapidly expanding, as more people share their illness experience with a widespread audience. Bipolar narratives share some traits with more conventional pathographies—notably, the desire to reclaim one’s voice and the need to speak back to the medical field—but they also extend this important work to include mental illness narratives. Although scholars have, for the most part, overlooked bipolar narratives, this dissertation suggests that these texts are attention-worthy and significant to both the lay reader and the medical professional.

Bipolar narratives face rhetorical challenges that arise from the paradox of mental illness: in representing the signs and symptoms of a severe mental illness, bipolar narratives must balance between revealing too much (and appearing “too crazy” to be believed) and revealing too little (and seeming “not crazy enough,” implying some kind of fraud or deception). This paradox means that bipolar narratives must do more work than conventional pathographies, which often describe physical illnesses with established medical and cultural narratives. The cultural and medical narratives for bipolar disorder are still evolving and are far from established or widely agreed upon. As evidenced by the
example at the start of this dissertation, many misconceptions about bipolar disorder still have great cultural currency and are widely circulated.

The paradox requires texts to walk a sort of disclosure tightrope, as they try to reveal enough to capture the complexities of bipolar disorder without irreparably damaging their credibility. Although 200 pages of detailed examples of the difficulties of treatment or the chaos of episodes can be very persuasive in terms of conveying the seriousness of bipolar disorder, this amount of detail can also destroy an author’s credibility. The details may work toward a more thorough and honest understanding of bipolar disorder but they may also mark the text and the author as an unreliable victim of a severe mental illness. Because it affects the brain and the mind, severe mental illness has the potential to wreak havoc on credibility, which is often associated with the author’s mind and character. Although someone with bipolar disorder is, de facto, a more credible author due to his/her proximity to the illness experience, the illness label that enhances credibility also threatens credibility.

Although all mental illness narratives must deal with this paradox, bipolar narratives encounter the paradox along with the additional challenge of narrating the bipolar story. As I argued in Chapter 2, the bipolar story is composed of two distinct but related layers: the definitional and the experiential, neither of which is well-defined or clearly understood. The definitional layer is based on the clinical/medical narrative of bipolar disorder as laid out in the *DSM-IV-TR*. This part of the story includes information on the frequency and duration of episodes and the symptoms required for diagnosis, as well as approved treatment options. In most texts, the definitional layer of the story is vague and almost generic—each version of the bipolar story will include the basics:
episodes, cycles, and treatment of some kind. Each author has a related psychiatric
diagnosis (there are a finite number of “versions” of bipolar disorder in the DSM-IV-TR)
given by a licensed medical professional. Although the definitional layer is important,
most bipolar narratives devote far more time and attention to the experiential layer. The
experiential part of the story deals with the ways in which people understand and live
with the basics of bipolar disorder, including difficulties with diagnosis/misdiagnosis and
the trials and errors of treatment. This part of the bipolar story is individualized, as each
text documents one individual’s response to illness and treatment.

This complex, multilayered story lies at the heart of bipolar narratives and texts
face the considerable challenge of telling the bipolar story while attending to the paradox.
In some cases, this challenge is intensified, as a treatment as complex as ECT may need a
fair amount of explanation and contextualization, and even as the text seeks to accurately
represent that experience, there is also the possibility that details about ECT may push the
text to the “too crazy” side of things. That is, in sharing details about failed and/or
damaging treatments, the texts must constantly negotiate the paradox in order to avoid
being perceived as “too crazy” to be reliable or believable. The repeated failure of
treatment might also imply that authors are “too crazy” to be helped or treated, which
would also hurt credibility. The task of telling the bipolar story is fraught from the outset,
as all details have the potential to be damaging to credibility. For most readers, severe
mental illness is not familiar or recognizable, and the more details a text discloses, the
higher the risk that the text may be dismissed as “too crazy” to understand. Texts must
remain vigilant in attempting to maintain the delicate balance of disclosure, and this
endless battle creates tension in the texts.
As discussed in Chapter 2, the stress of negotiating this balance shows up in specific rhetorical and textual ways. Rhetorically, the credibility concerns are one symptom of focusing on such a difficult and unpredictable illness story. Credibility can also be affected by textual struggles with causation, coherence, and closure. These narrative touchstones are found in most narratives and expected by most readers. Causation, coherence, and closure are features of “good” narratives, and they are troubled by the messiness of the bipolar story. Briefly, causation is the need to find cause/effect relationships, and when it is absent from the story, the result may be confusion. Causation comes through in the texts as a desire to identify the onset of illness, and most texts go to some length to trace some kind of onset, however vague. Onset does not equal cause, but onset provides a starting point, however vague or inexact. Without a clear beginning point, readers may feel disoriented or confused about the overall progression of the narrative, which may harm credibility.

Coherence helps readers understand how events in a story fit together. It can be tricky in bipolar narratives when the messiness of bipolar disorder translates directly to the structure of the texts, resulting in texts that are not organized in a linear or chronological way. When chapters seem disconnected and there is no larger sense of cohesion, bipolar narratives can become fragmented to the point where readers struggle to assemble the narrative pieces. The final touchstone, closure, provides a meaningful ending to a text. Although texts may delay closure to build suspense, the lack of closure in bipolar narratives is not suspenseful. Closure through documented recovery is only partially possible in the texts, as recovery is not cure. Although the texts try to achieve
closure, the endless list of episodes and hospitalizations thwarts real closure by implying that people with bipolar disorder do not get better.

The three narrative touchstones are important features of “good” narratives and, as such, they are important to bipolar narratives as well. The messiness of the bipolar story plus the tension of navigating the paradox come through at a textual level as problems with causation, coherence, and closure. Chapters 4 and 5 looked at two rhetorical strategies that bipolar narratives use to address these difficulties and improve good-narrative qualities: framing and embedding. Framing, discussed in Chapter 4, involves the use of paratextual materials to literally frame the confusing and messy bipolar story. Several texts use framing as a way of containing the bipolar story, which threatens to overrun the boundaries of the text by continuing indefinitely. Bipolar disorder cannot be cured but the texts need to bring closure to the narrative, and one way to create an ending is to add a textual frame (most often a preface and postface). The frame can work to enhance credibility by increasing both coherence and closure, as well as providing a physical separation between the potentially “too crazy” text proper and the more stable voice in the preface and/or postface.

Chapter 5 examined a second strategy: embedding. Embedding happens when an author places the bipolar story within an alternative genre, such as traditional autobiography, travel narrative, or conversion narrative. The borrowing of a more familiar and conventional genre stabilizes the text by relegating the chaotic bipolar story to a more minor role. The examples in this chapter demonstrated how the chaotic bipolar story can be downplayed within a more established genre. For example, in a full-life context (such as would be present in a traditional autobiography), the bipolar story may
become one of many stories the author wishes to tell, alongside stories about family, significant others, education, or career. When it does not command a lion’s share of the textual space, the bipolar story’s disruptive power may be diminished, as instead of the defining characteristic of a person, it becomes simply one among many relevant characteristics.

In different ways, these two strategies work to address some of the tension in the texts by improving causation, coherence, and closure. Framing and embedding also benefit bipolar narratives by boosting authorial credibility. Credibility is a tricky issue in bipolar narratives, as severe mental illness shapes how readers view the author and the text. On one hand, those with bipolar disorder are ideally positioned to tell this story because they have experienced it firsthand. On the other hand, bipolar disorder can have devastating effects on the mind, making it difficult to remember one’s story, let alone tell it in a coherent way. Disclosure can become a dangerous dance in these texts, as authors want to reveal enough to help readers grasp the fullness of the illness experience, but they must also present this potentially damaging information carefully so that they don’t come across as “too crazy” to be reliable.

Relevance

Exploring bipolar narratives in some depth has yielded a number of insights that may be useful to several audiences. This work is relevant to pathography scholars and those who study narrative because these fascinating texts prove the evolution of the genre of life writing. The statistics provided in the introduction demonstrate that mental illness narratives constitute a rapidly growly sub-genre of pathography, and as more of these
texts appear, scholars would be wise to pay attention to the textual and rhetorical complications that arise in documenting severe mental illness. People with mental illness are unique authors and scholars need to attend to mental illness narratives to learn more about credibility and how those with mental illness create credibility. Additionally, doctors and mental health professionals could learn much from bipolar narratives, including the finer points of the illness experience. These texts provide a rich counterpoint to the one-dimensional medical narrative about bipolar disorder, providing insight into how the illness shapes individual lives. Because the medical narrative on bipolar disorder is currently under construction, there is some urgency for health care professionals to carefully consider these texts so that they are able to better understand and treat people with bipolar disorder.

The medical field could further benefit from close consideration of bipolar narratives in terms of patient care. If doctors and nurses viewed patients as credible authors of their own stories, treatment may shift to a more active experience in which patients have a greater role in making decisions. Health care professionals could benefit from acknowledging the different layers of the bipolar story—medical professionals tend to focus exclusively on the definitional aspects of the illness, leaving the experiential aspects to counselors or psychologists. Considering both layers of the bipolar story could result in more holistic treatments and an improved doctor-patient relationship fueled by open communication and mutual respect. Very few of the texts in the corpus mentioned positive experiences with doctors, which suggests that doctors could benefit greatly from reading the patient’s take on treatment and diagnosis. A more robust understanding of
bipolar disorder would benefit all involved, from doctors to nurses to patients and their families.

The general public also has a great deal to learn from these texts. As mentioned throughout the dissertation, the cultural understanding of bipolar disorder is shaky at best and ignorant and downright degrading at worst. Lizzie Simon touches on this when she stresses a “need to examine every single way that society’s common sense about the mentally ill [and how it] is affecting us and determining our future” (211). Research shows that people tend to be more compassionate and empathetic about illnesses with which they have had some direct experience (Wahl). Bipolar disorder is not a particularly common mental illness and it is not diagnosed with the frequency of other mental illnesses (such as anxiety disorders), so very few people will have this experience firsthand. But each individual with bipolar disorder is part of a much larger social network including family, friends, co-workers, neighbors, and casual acquaintances. Bipolar narratives are an excellent resource for those directly affected by the illness, but they are also useful for those whose lives have not been touched directly by this illness. Some texts, such as Marya Hornbacher’s, devote entire chapters to detailed lists of web and print resources. These educational resources can work to promote a cultural narrative of bipolar disorder that more closely resembles the lived illness experience.

Although there is no replicating the exact illness experience because it is intensely personal and largely internal, bipolar narratives provide a more detailed picture of the bipolar story than the general public is used to encountering. To return to the Glee example for a moment, the version of bipolar disorder presented there was simplistic and one-dimensional. The illness was used to elicit laughter about the wackiness of Paltrow’s
character and to make history seem more relevant and interesting to apathetic high school students. Encouraging them to rehearse or invent “bipolar rants” trivializes a disabling mental illness by presenting it as something one can practice or try on for comic relief. Bipolar narratives begin to correct this response by offering real-life details of the illness experience. With several best-selling texts in the corpus, we can see the potential reach of these texts and imagine how an informational, compassionate, and accurate narrative could “shift people’s focus away from all the media attention on destructive and violent cases” (Simon 41). And when readers begin to get a clearer sense of the many ways bipolar disorder can disrupt an individual’s life, they may become more sympathetic readers and the cultural narrative may begin to shift to a more compassionate and informed place.

These texts have even more to offer for those whose lives have been directly shaped by bipolar disorder. For family and friends and even individuals with the diagnosis, reading others’ bipolar stories can be truly therapeutic. Mental illness can be isolating, in part because so much of the illness takes place in the mind and brain of the individual. Lizzie Simon states directly that one of her primary motivations in writing her narrative was to provide information for others with bipolar disorder. After years of checking the shelves at her local bookstore for any kind of new information on bipolar disorder, Simon resolves to fill the gap herself. As more bipolar narratives are published, there is greater opportunity for recognition and validation of experience. Illness can be difficult for anyone, and whether the individual is dealing with a broken leg or depression, it can be helpful and healing to know that you are not alone, and that others have dealt with and survived what you are now facing. Many of the corpus texts are proof
positive that people with bipolar disorder can live productive and fulfilling lives. In light of the shortcomings of the medical and cultural narratives (which tend to show people with bipolar disorder as out of control, violent, or in need of life-long institutionalization), bipolar narratives can offer positive models of success and hope for those with bipolar disorder and their support networks.

**Looking Forward**

As I mentioned in Chapter 2, researchers are working on ways to diagnose bipolar disorder using biomarkers. As this research progresses and doctors come closer to a conclusive diagnostic test for bipolar disorder, the medical and cultural narratives surrounding the illness will also shift. This kind of testing would alter the clinical narrative for bipolar disorder, which is, at the time of writing, incomplete. An accurate diagnostic tool could change the bipolar story in a radical way, possibly accelerating diagnosis and treatment. Research such as this could be transformative in several ways: by providing a concrete test to diagnose bipolar disorder, the process may become more consistent and accurate. Rather than relying on an individual’s subjective judgment to translate feelings and thoughts into symptoms, doctors could use an objective instrument to search for specific biomarkers. It’s hard to know if this kind of testing would increase the diagnosis of bipolar disorder, but it is plausible that it would cut down on the number of misdiagnoses. And, as the corpus texts show, misdiagnosis is a recurrent issue that can cause many years of difficult suffering and incorrect (and potentially dangerous) treatment.
As the bipolar story continues to shift and change, the texts that focus on this illness will also change. A biochemically-based test could also address the textual struggles with causation by providing a stronger link between cause and effect. The presence or absence of a biomarker is not something within an individual’s control—it is simply genetic fate. This could shift the way that diagnosis is presented in the texts, as well as the way that authors make sense of diagnosis. For instance, several texts struggle to identify the cause or root of the author’s illness, and when a cause is not found, authors tend to blame their own actions or behaviors. Andy Behrman experiences a great deal of guilt and shame for “bringing this illness on myself from all my neuroses, compulsions, and obsessions” (222). This kind of statement could be far less likely to show up in a text in which diagnosis happened via a scientifically-based test. Whereas Behrman may feel that he has brought the illness on himself, a genetic test has the potential to relieve this burden of responsibility because genetics are not within the realm of an individual’s control. Of course, any kind of genetic-based testing could also introduce more controversy and complicate the bipolar story in unforeseen ways. In any case, the link between cause and effect could be more direct, shifting the locus of responsibility from the individual to the individual’s genetic makeup. The difference is profound—bipolar disorder as genetic flaw rather than personal/character flaw could be life-changing for those living with the illness, likely producing very different bipolar narratives.

In addition to a more complete medical narrative, another change on the horizon is the physical shape bipolar narratives are taking. This dissertation focused only on book-length bipolar narratives in order to examine the bipolar story as presented within a single, bound text rather than a series of entries. Due to their episodic nature, blogs may
offer a different take on the bipolar story, and in this final section dedicated to possibilities, I will explore a blog titled *Karen: In Theory* that focuses on bipolar disorder. Although they may lack an overarching or linear narrative trajectory, bipolar blogs can nonetheless be a fantastic source of information for those interested in learning more about mental illness. And because they are readily accessible (free, require only an internet-connected computer) and updated frequently, they can be an excellent way to tap into how the bipolar story is shifting and changing. The short discussion that follows will demonstrate the ways in which my work can be applied in a different context; blogs are obviously quite different from published books, but the bipolar story shapes both genres.

Most definitions for ‘blog’ include the following characteristics: personal, unedited, shared, journal. These online journals are everywhere on the web, in part because they are easy to create and numerous sites (such as wordpress.com and blogspot.com) and templates exist to simplify the process. Anyone can start a blog, and in recent years, it has become a money-making prospect, as bloggers gain national visibility and corporate sponsorship. Blogs have grown into television shows, book deals, and entire product lines, and the genre continues to expand at a frenetic rate. In 2006, CNET.com reported that a new blog was started every half second (Lombardi) and the pace hasn’t slowed in the last five years. In its “State of the Blogosphere 2010” report, Technorati.com lists self-expression and sharing of expertise as bloggers’ primary motivations. These goals align well with pathography and illness narratives, many of which seek to share a personal story with a wider audience while also helping people who are experiencing illness. Certainly this is true with bipolar narratives, as several corpus

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38 Technorati.com’s report also includes a tremendous amount of information on blogging trends, themes, and statistics.
texts indicated a desire to provide information for others (the most notable example is Lizzie Simon). With this basic information in hand, I will move to a brief introduction of *Karen: In Theory*.

Visually, *Karen: In Theory* is quite plain: black text on a white background and a sedate banner made up of swirls of blue and the occasional sliver of pale yellow. There are six links on the menu bar: Home, About, Resources, Contact, Disclaimer, and Cheshire Alien. Home is the location of the blog entries, Cheshire Alien is a page dedicated to a handful of cartoon drawings of a goofy little alien creature, and the others are self-explanatory. The blog began in August 2009 and there have been more than 100 posts in the almost-two years since then. The number of posts per month varies from 11-15 posts some months to several months with only one post. A statistic at the bottom of the page reports more than 7,300 hits, which averages to more than 350 hits per month since the blog began. The sidebar also shows a Twitter feed with 89 followers, and I found *Karen: In Theory* because it was nominated as a top mental disorder blog in 2010 (“Top 30 Mental Disorders Blogs”). These facts all indicate that *Karen: In Theory* has an established web presence and a solid readership. The first post, dated August 16, 2009, announces that “Bipolar disorder has taken over my life, it rules my every waking minute. So this blog will be about who I am, manic depression and hopefully about getting better.” (“An Introduction”). Clearly, the bipolar story is a major force at work here, and this messy story shapes the blog.

The impact is not all bad; in some ways, the blog format actually suits the chaotic bipolar story. Blogs are works-in-progress, so the story comes to the reader one entry at a time. In a sense, then, blogs are fundamentally incoherent; readers get frequent posts
about diverse topics that may never come together into a larger narrative or organization. Although some posts may be thematically related, the topic may vary widely from post to post, making any kind of through-line or narrative trajectory tricky to find. Each entry may be a narrative itself, and as long as the author is writing, there is no ending per se. As an online diary, entries may be related but they are not required to be in the way readers expect chapters in a text to be related. But that is not to say that blogs are devoid of all organization—each post in *Karen: In Theory* is dated, providing a strong and coherent chronological organization. This organization happens without a great deal of effort on the author’s part—it is simply a matter of adding the date to the entry and telling the blog to display newer entries first. The de facto chronological organization, along with reduced expectations of coherence, make blogs a more hospitable space for the messiness of the bipolar story.

Blogs may also do a better job of accommodating the lack of closure in the bipolar story. As discussed in Chapter 2, the bipolar story can problematize closure in texts because it is ongoing. The lack of closure is less problematic in blogs, as they are inherently open-ended. Closure may come within specific entries, but *Karen: In Theory* does not actively seek closure or try to create an ending, in part because the purpose of a blog is to keep posting new content so that readers will continue to visit the blog. *Karen: In Theory* and other blogs are far more dynamic than a published text, with new content posted on a very frequent basis. An outdated blog is anathema in the online world, as readers will not continue reading if there is nothing new. So closure is not a sought-after quality in blogging, which perhaps means that blogs constitute a friendlier space for the ongoing story of bipolar disorder and other severe mental illnesses.
Nonetheless, the bipolar story troubles *Karen: In Theory*. The lack of structure or narrative trajectory mentioned above can be problematic; if the blog relies upon the bipolar story as the overarching theme, it’s not difficult to see how the end result could be disarray. In *Karen: In Theory*, entries are rarely related, and the lack of structure results in a text that seems discombobulated and disconnected. For example, the March 2011 folder shows 15 posts. The posts range widely in topic, from a word cloud to a drawing to a description of a recent shopping binge. One post is written as a stream of consciousness, with many words stacked up into one tight paragraph, separated by commas: “Chaos, hurts, splinters, gone, nothing, everything-all-at-once, need to, racing, eleven-thousand-strong, mush, noises, colours, noises, colours, gifts and intractable guilt, fidgeting, running, cold, ringing, almost enough, what, this concept, I am being, want to, forever, go and go and go” (“Chaos. Again. Still?”). This short excerpt is simply words next to each other without any connection to each other or to a larger narrative. The post before this one was about colors, and the one after it mentions a recent bout of the flu and missing medication. There is no overarching organization here—the disorder of illness has become the disorder of the story.

Another important factor is the public nature of this disorder. Although printed texts are public, there is a space of time between writing and publication. No such cushion exists in blogging. Entries are instantly available to anyone and everyone, and the format is incredibly dynamic. A majority of blogs include a commenting feature, allowing readers to read and respond almost instantaneously. The unpredictability of the bipolar story may result in entries that seem incoherent or confusing, causing an immediate negative reaction for readers. And although this response may not be unusual,
the ability to respond directly to the author seconds later is specific to blogging and social media. For example, the “word soup” post mentioned in the previous paragraph prompted four comments. Two of the comments explicitly voice concern for the author, ranging from “This collection of words worries me” to “You sound manic!” (“Chaos. Again. Still?”). The ability to give and receive instant feedback is both blessing and curse: it can be useful and good or it can be hurtful and damaging. In light of these comments, the constellation of words begins to take on a more ominous tone, as word play begins to transform into a possible symptom of mania. The comments could be accurate, but they could also be fraught with misunderstanding. Either way, they are visible to everyone within seconds of being posted. The comments become part of the entry, and this may represent a loss of control. This is not limited to bipolar blogs, of course, but the loss of control could be a greater concern for someone who is already fighting credibility issues.

Credibility is another place where we can see the impact of the bipolar story. The paradox of mental illness is very present in blogs, as these authors must still navigate the treacherous waters of disclosure. The diary-like quality of blogs poses a substantial threat to credibility, as this kind of intimate writing can very easily come across as “too crazy” to be reliable or relatable. The home page of Karen: In Theory includes a disclaimer that readers may continue to read “at your own peril.” This statement implies danger for the reader, but the author would seem to be the one in danger. Unedited posts and full disclosure put Karen in danger of being dismissed as “too crazy” to be believed. Certainly, entries like the one quoted above could undermine credibility. One distracting or confusing post could be overlooked, but the majority of the entries at Karen: In Theory focus on the bewildering turmoil of bipolar disorder. Karen writes unapologetically about
cutting, suicidal thoughts, medication failures, and delusions. One post includes a typed transcript of what the voices in her head are saying to her. Although this kind of intimate revelation accomplishes Karen’s goal of sharing her illness experience, it is devastating to her credibility. The admission that she hears voices is one thing, but to include a typed example of what the voices are saying pushes the entry from relatable to utterly bizarre and alien. Although this is an extreme example, the blog regularly includes entries with text and drawings that tilt the entire thing to the “too crazy” side of the continuum.

As these examples demonstrate, the bipolar story is complex across genres and it affects bipolar blogs in some of the same ways it affects bipolar narratives. There are other features of the genre, however, that seem to make bipolar blogs a more comfortable fit for the messiness of the bipolar story. Although bipolar blogs differ markedly from published bipolar narratives, both must navigate the paradox of mental illness and find a balance between “too crazy” to be credible and “not crazy enough” to be believed. And texts of all sorts must do this while trying to present a coherent version of the bipolar story (which is inherently incoherent). The bipolar story is the other major obstacle faced by bipolar narratives—as Chapter 2 demonstrated, it is a complicated, multi-layered story that is both shared and unique to the individual. And, at the time of writing, the layers are evolving and shifting as researchers move closer to more accurate diagnostic tests and as more people with bipolar disorder find ways to contribute to the cultural narrative about bipolar disorder. With so much going on, bipolar narratives are a rich archive that deserve far more scholarly attention than they have received thus far. Although this dissertation attempts to address that void, I have considered one small slice of the archive in
analyzing a group of bipolar narratives. And if the richness of the corpus texts is representative of the archive, the work will be exciting and thought-provoking.
Appendix 1

Master list of bipolar narratives (by author last name) generated from search results.

Number in parentheses is the number for that year. Total: 194. Corpus texts in bold.

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This table lists the names of individuals along with the year 2010, indicating a possible event or publication.
Works Cited


Berry, Ivy. *My Life...Welcome to It: Living with Bipolar Disorder (Also Known as Manic Depression)*. Bloomington, IN: AuthorHouse, 2008.


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