THE RHETORICS OF RECOVERY:
AN (E)MERGING THEORY FOR
DISABILITY STUDIES, FEMINISMS,
AND MENTAL HEALTH NARRATIVES

DISSertation

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By

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* * * * *

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ABSTRACT

My dissertation project explores different discursive spaces (memoirs, online magazines, local art galleries) in which women and men narrate their recoveries from various mental disorders. I argue that these narratives, and the discursive spaces in which they are told, are rhetorically strategic, and ultimately allow the authors agency within a broader climate of surveillance, oppression, and stigmatization. These writings resist, transgress, and at times, (re)construct the medical model of recovery and sociocultural expectations of people, particularly women, with disorders. Their narratives also complicate our current understandings of writing spaces, especially those coupled with the power of digital technology. Memoirs and online discursive spaces mark a shift in the voices of women with mental disorders, from persons oppressed by their illness, doctors, and society at large, to women challenging the medical model of mental illness, and ultimately creating their own models of recovery.

These recovery narratives engage the medical model in interesting ways, such as by resisting it from within, as with those medical practitioners diagnosed with mental disorders themselves (Jamison, Slater) who write about their experiences in very public spaces (memoirs). Other narratives are seemingly compliant with conventional modes of treatment prescribed by the medical
model, such as the Fresh A.I.R. Gallery artists who exhibit their works in a space funded by a comprehensive mental healthcare organization. Still others construct their own models of recovery by navigating through contradictory medical information (Reader’s Digest) and voicing their opinions against medical authority in online spaces. I call upon Adrienne Rich’s notions of revision and recovery as the theoretical framework I employ throughout my dissertation project. My project seeks to open a dialogue between rhetoric, feminisms, and disability studies so that an enabling theory of mental health discourse will emerge.
For Charlotte, Kitten Kat, Little, Tanya, and Spa'am: for being there.
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INTRODUCTION

Recovery Emerging

This study begins the necessary work of analyzing the role of recovery in mental health narratives. By employing the critical strategies of rhetoric, feminisms, and disability studies to memoirs, visual art, and digital discourse, my project reveals the emergent role of recovery in mental health discourse and by doing so, also then offers a re-consideration of these three disciplines. I argue that although feminisms, rhetoric, and disability studies productively triangulate at the subject of recovery, they nevertheless, at times, recapitulate the repressive regimes of power and knowledge structures of the previous medical model of mental disorder.

My need to write about recovery stems from several places. Although recovery is not a new concept, past constructions of recovery have been less than inclusive in their visions. In disability studies, the body has been the locus for most theorizing about recovery. Emotions, behaviors, and biochemistry may be a tangential concern in these theories, but mental health, as a primary category for analysis, has been less present. Particularly in terms of theorizing the social model of disability, the reality that mental illness (and disorder) is not
just a phenomenological experience, or even an epistemology, but also a complex of biochemical and physiological material reality seems a reluctant subject.

Recovery in general has not been a primary focus in disability studies. Recovery might be seen as belonging to the province of the medical model of disability, and perhaps as an unrealistic view of disability—not all disabilities are, in fact, “recoverable.” Current definitions of recovery are, I believe, more sophisticated in their views of what is possible to recover, and how. Additionally, though I believe there is a growing amount of scholarship about invisible disabilities, particularly cognitive, psychiatric, and emotional disabilities, in texts foundational to disability studies as a discipline, there is a lack of scholarship on these identity categories, or at least, a disparity between the amounts of scholarship on visible and invisible disabilities. For instance, in The Disability Studies Reader (Ed. Lennard J. Davis, 1997), Handbook of Disability Studies (Eds. Gary L. Albrecht, et al, 2001), Disability Studies Today (Eds. Colin Barnes, et al, 2002), and An Introduction to Disability Studies (David Johnstone, 2002), psychiatric disabilities are mentioned, but do not receive the same attention as other disabilities. Because of the disparity of attention, I want to add to what scholarship there is about mental illness in disability studies by offering what may likely be a contested term: recovery.
Feminisms have been more inclusive in theorizing women and mental health in general,¹ but as with disability studies, recovery² has been less of a focus. Undoubtedly, the historical scope of feminist theories and literary criticism has greatly contributed to our understandings of the gendered nature of mental health, from diagnoses to methodologies and practices. Much of this work focuses on recovery from abuse and trauma, which, I think, can be markedly different than (though as equally important as) recovery from (or recovery with) mood and thought disorders. Likewise, scholarship addressing recovery from eating disorders³ is a current focus in feminisms and mental health discourse, but again, even while there are marked similarities between eating disorders and other mood/thought disorders, including concomitant or dual diagnoses, I want to focus on what I see as the less theorized disorders.


² For instance, please see: Judith Lewis Herman’s *Trauma and Recovery: The Aftermath of Violence—From Domestic Abuse to Political Terror* (1997); Catherine Garrett’s *Beyond Anorexia: Narrative, Spirituality, and Recovery* (1998); and Melissa Pearl Friedling’s *Recovering Women: Feminisms and the Representation of Addiction* (2000).

³ Susan Bordo’s work, for example, continues to be a central presence in feminisms’ consideration for eating disorders, from *Unbearable Weight: Feminism, Western Culture, and the Body* (1993) to *The Male Body: A New Look at Men in Public and Private* (1999).
Addiction culture has, until recently, cornered the historic market on “recovery,” making terms like AA, twelve-step, rehab, and relapse commonplace language. In popular culture, there are headlines every day announcing another celebrity in rehab; we now have a reality show, in fact, called Celebrity Rehab, and its precursor documentary style program, Intervention. The current principles behind substance abuse and addiction recovery are based on the “recovery model,” a concept emerging mainly from the 20th century practices of Alcoholics Anonymous, and epitomized in the Big Book. First published in 1939, this text is currently in its fourth edition, including an online edition, and has been translated into forty-three languages. Each of the four editions to the Big Book retained the original mission, which the 2001 Preface states as:

To represent the current membership of Alcoholics Anonymous more accurately, and thereby to reach more alcoholics. If you have a drinking problem, we hope that you may pause in reading one of the forty-two personal stories and think: ‘Yes, that happened to me,’ or, more important, ‘Yes, I’ve felt like that’; or, most important, ‘Yes, I believe this program can work for me too.’


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4 By addiction culture, I mean the entirety of the discourse of alcohol and substance abuse and addiction. Following addiction recovery, recovery from loss or trauma (death, rape, incest) or disaster (for the US, especially post- September 11th and Hurricane Katrina) have become commonplace (yet under-explored) ideas in American culture. And currently, the language of data and hard drive recovery has surfaced since access to the Internet and digital technology has been on the rise. Another complication to the ways in which “recovery” has configured in our cultural consciousness is the therapeutic practices of “memory repression/recovery.” While these practices may (or may not) be legitimate, they have come under such fire legally and medically that they are stigmatized culturally as well. So then, recovery-oriented practices and theories in relation to mental illness are still in an exploratory stage.
Implicit in AA’s mission is the hope for recovery, and a reliance on personal experience as a means to persuade, particularly shared experience. Also implicit here is a turn away from a medical model that foregrounds doctor authority and towards the individual taking agency in his or her own recovery. In fact, shared experience (the experience of alcoholism) has a greater impact towards recovery than anything or anyone else. So intrinsic is a sense of forming unity and educating through personal experience to the recovery process that by the third edition of the Big Book, the Foreword states: “Each day, somewhere in the world, recovery begins when one alcoholic talks with another alcoholic, sharing experience, strength, and hope” (par. 3). Since the inception of AA, the Big Book, and twelve-step programs, the term recovery has been the impetus for an ever-widening medical approach to healthcare, and even reactions against this model of recovery.


7 Rational Recovery, a quasi motivational/instructional self-help for-profit organization founded by Jack Trimpey in 1986, is one such reaction. Rational Recovery vehemently opposes the “recovery group movement,” treatment or rehabilitation centers, group meetings, or reliance on a “higher power,” and the belief that alcoholism is a disease. Instead, Trimpey favors the belief that substance addiction can be cured through AVERT (Addictive Voice Recognition Technique), which can be purchased online, along with the attendant subscription to the online resources of Rational Recovery. Trimpey and his followers also differ from AA in their attitude towards abstinence; the latter maintains total abstinence is the only way for real recovery (a term which in itself is fluid, never final, as in, “I’m a recovering” but never a “recovered” alcoholic). Rational Recovery,
My interest in the recovery model is based not so much on the ways it manifests for addiction and substance abuse, but for the process it encourages. The recovery model is, in many ways, a drastic departure from the older medical model of disability with its steady fixation on the curability of disorder and disease. The recovery model differentiates between symptomatic/syndromal recovery and functional recovery, the former being a manifestation of the medical model, and the latter, of the social model of disability. And though addiction and substance abuse was the impetus for the recovery model, by the end of the 20th century, mental health care professionals of all stripes have moved toward recovery-oriented care.

The call for moving towards recovery-oriented care came with approval of the highest governmental orders. At the behest of the National Institute of Mental Health and the Library of Congress, then President George H. W. Bush proclaimed 1990 to be the “Decade of the Brain.” This initiative called for public awareness of and continued research into the brain and all its possibilities and limitations. At the time, there was little public fanfare in reaction to the President’s declaration. Nearly twenty years later, however, the medical community has prospered considerably in relation to neuroscience. One of the most significant advancements in the field of mental health in particular is the emergence of recovery as an accessible, viable goal for people with chronic or serious mental disorders.

However, aims for complete abstinence from the additive substance but recognizes that some people are able to maintain recovery even if occasionally using it in moderation.
Twelve years after his father announced the “Decade of the Brain,” in April 2002, current President George W. Bush announced the formation of the New Freedom Commission on Mental Health (NFCMH), as a part of the New Freedom Initiative launched in February 2001 by Bush and the US Department of Health and Human Services (HHS). In 2003, the NFCMH announced their findings in a final report, “Achieving the Promise: Transforming Mental Health Care in America.” As the NFCMH relates, “After a year of study, and after reviewing research and testimony, the Commission finds that recovery from mental illness is now a real possibility.” This declaration in turn produced “The Federal Action Agenda: The First Steps” in 2005, which called for “nothing short of a fundamental transformation of the mental health care delivery system in the United States—from one dictated by outmoded bureaucratic and financial incentives to one driven by consumer and family needs that focus on building

8 The New Freedom Initiative is committed to “fulfilling America’s promise to Americans with Disabilities” as set out in the Americans with Disabilities Act. The NFCMH was established to “conduct a comprehensive study of the United States mental health service delivery system … [and to] recommend improvements to enable adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities.” For the US Department of Health and Human Services official outline of the New Freedom Initiative, please see <http://www.hhs.gov/newfreedom/>. For the Office of the Press Secretary’s release statement, please see “Executive Order: President’s New Freedom Commission on Mental Health <http://www.whitehouse.gov/news/releases/2002/04/20020429-2.html>.

resilience and facilitating recovery." By 2006, the HHS and SAMHSA issued a National Consensus Statement on Mental Health Recovery (NCSMHR), outlining the ten fundamental components of recovery. The Director of SAMHSA's Center for Mental Health Services, A. Kathryn Power, hailed this advancement as “nothing short of revolutionary.”

Enabling Recovery: Ten Fundamental Components for Transformation

More than a hundred “expert panelists” (1) convened in 2004 to define what SAMHSA calls its “single most important goal”: recovery. While earlier visions of recovery focused on seemingly simpler outcomes (survival, basic functionality), current visions moved well beyond mere stability. The conception that recovery was only achieved primarily through medicine and medical intervention was replaced by the understanding that the consumer held the most vital role in the recovery process. In fact, one of the most promising elements of SAMHSA’s 2006 statement is that recovery is constructed by and through the person with the illness. The NCSMHR definition includes ten components fundamental to recovery, some of which are specific to the consumer, and the others are specific to health care systems and the community as a whole. For the

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11 At the 2004 National Conference on Mental Health Recovery and Mental Health Systems Transformation, the experts included “mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others” (1). Lifespan, cultural contexts, and cross-diagnoses were factored into recovery’s definition.
consumers, recovery is dependent on self-direction, empowerment, peer support, responsibility, and hope; for the systems and community to aid in consumers’ recoveries, they must adopt an approach that is individualized and person-centered, holistic, non-linear, strengths-based, and which affords respect.

From this model of recovery, consumers have access to agency, autonomy, and dynamic choices about which paths their lives will follow in the process. The NCSMHR specifically details the ways in which each fundamental component of recovery fosters independence: recovery requires self-direction in consumers, so that they “lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life” (1). Recovery requires empowerment, so that “consumers have the authority to choose from a range of options and to participate in all decisions … that will affect their lives, and are educated and supported in doing so.” Empowerment of the consumer means also recognizing their “ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations.”

Consumers in recovery are also encouraged to engage in peer support, “including the sharing of experiential knowledge and skills and social learning” (2), and to “encourage and engage other consumers in a recovery and provide each other with a sense of belong, supportive relationships, valued roles, and community.” Similarly, consumers in recovery should have “a personal
responsibility for their own self-care and journeys,” for which the NCSMHR acknowledges takes “great courage.” And, finally, consumers in recovery should have hope, or, “the catalyst of the recovery process.” The experts note that “Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them.” For consumers, hope is not just an individualized act—it is a communal effort: “Hope is internalized; but can be fostered by peers, families, friends, providers, and others.” Ultimately, however, consumers are not the only ones to gain from mental health recovery, as it

not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier nation. (2)

By acknowledging that people with mental disabilities are vital to a healthy economy, the NCSMHR aligns with arguments from disability studies scholars about the economic impact of disability in general, and psychiatric disabilities in particular.¹²

Although the fundamental components of recovery encourage a personal sense of agency within the consumers themselves, they also hold the healthcare system and the community repressible as well. An approach that is strengths-based, individualized, and person-centered is encouraged in the process.

Strengths-based practice originated in social work theory, and emphasizes the clients’ strengths rather than focusing on perceived weaknesses. For mental health recovery, it means focusing on “valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals” (2), so that consumers might “leave stymied life roles behind and engage in new life roles (e.g., pattern, caregiver, friend, student, employee).” Similarly, an approach to recovery that is individualized and person-centered would recognize the consumers’ “unique strengths and resiliencies as well as [their] needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations” (1).

Two other fundamental components of recovery suggest that the approach should be holistic and non-linear, both of which support the idea of recovery being a journey. The NCSMHR recognizes that “recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience” (2). I also suggest that a non-linear approach is appropriate given that many disorders are cyclical, particularly disorders from the affective spectrum (e.g., bipolar disorder, seasonal affective disorder, premenstrual dysphoric disorder, anxiety disorders). For these disorders, recovery happens in increments, and is often accompanied by setbacks in

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13 This approach has been adopted by many health-related fields, such as in special education, and working with at-risk youths, people with cognitive and developmental disabilities, and even marital counseling. Interestingly though, a strengths-based approach has also been adopted in unrelated areas such as marketing, business, management, and life coaching.
progress. Diagnostic difficulties, trial and error in medication efficacy, maintaining medication compliance, and even difficulties in accessing and navigating the health care system all add to impeding the recovery process. Fortunately, the NCSMHR accounts for the contingencies of recovery by recognizing the need for a holistic approach that safeguards the consumer. Because “recovery encompasses an individual’s whole life, including mind, body, spirit, and community,” the process should embrace all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addiction treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Family, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumers to access these supports. (2)

Again, this is a comprehensive course of action requiring a mutuality of support. And, equally important, the NCSMHR acknowledges that respect is a crucial component of recovery. Not only is “self-acceptance and regaining belief in one’s self…particularly vital” for the consumer, but so is “acceptance and appreciation of consumers” by the community, systems, and society, “including protecting their rights and eliminating discrimination and stigma.”

All of the criteria the NCSMHR suggests as fundamental to recovery constructs the person with the disorder as agent: agent of her illness, agent of her recovery, agent of her future. I suggest that the language in the statement, such as “protecting their rights and eliminating discrimination and stigma,” also politicizes mental illness, and by extension, politicizes the identity of those who
are recognized as having a mental illness. This suggestion of an identity politics of mental illness was also signed into law in the 1990 Americans with Disabilities Act. Yet, by 1999, these protections were negated by a series of rulings stating that disabilities that can be mitigated (such as by medications, hearing aids, or other devices) should not be considered disabilities, and thereby cannot receive protection under ADA law. The Amendments Act of 2008 (H.R. 3195), however, reversed these decisions,\(^{14}\) re-addressing a longtime problem of discrimination against the very people the 1990 act set out to protect. Just as being agents of our own recovery offers a further sense of balance and security, beyond the recovery process itself, having legal recognition that discrimination against disabilities exists is vital to the process of recovery, as it legitimizes the need for protection.

**Recovering Rhetoric, Disability Studies, and feminisms**

Contextually, recovery is a multivalent term. I have explored some ways in which the medical community, particularly mental health care, constructs recovery as both a communal and individual act, a process that takes time and perseverance. I want to extend this exploration to the ways in which academic

\(^{14}\) Please see the US Department of Justice Americans With Disabilities Homepage [http://www.ada.gov/]. For background information on H.R. 3195 and what the amendments cover, please see the US House of Representatives Committee on Education and Labor update. 25 June 2008 [http://edlabor.house.gov/issues/adaaa.shtml].
scholarship constructs recovery. I am referring to the rhetorical process of recovering women’s writing, specifically the long and monumental process of feminisms recovering literary and rhetorical works of women and placing them rightfully in their respective canons. Andrea A. Lunsford’s *Reclaiming Rhetorica: Women in the Rhetorical Tradition* (1995), Cheryl Glenn’s *Rhetoric Retold: Regendering the Tradition from Antiquity through the Renaissance* (1997), and Joy Ritchie and Kate Ronald’s *Available Means: An Anthology of Women’s Rhetoric(s)* (2001), are some of the comprehensive examples of collections which have sought to recover works by women. As previously noted, disability studies has had less of an emphasis on the concept of recovery, though I would argue that the antipsychiatry and psychiatric survivors’ movements\textsuperscript{15}, which address many of the same concerns as disability, have offered significant scholarship on the lack of adequate commitment to recovery within mental health care. The works my projects focus on rest solidly, if not so comfortably, in between.

Historically, mental illness has confounded models of health and recovery. For decades before SAMSHA issued the National Consensus Statement on Mental Health Recovery, some of the primary concerns about recovery have

\textsuperscript{15} See, for instance, see the body of works co-authored by Peter Beresford and Jan Wallcraft, as well as Anne Borsay’s “Personal Trouble or Public Issue? Towards a Model of Policy for People with Physical and Mental Disabilities.” *Disability and Society* Volume 1, Number 2, January 1986, pp. 179-196(18); and Geoffrey Reaume’s “Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940.” *Bulletin of the History of Medicine*. 2003, Vol 77. Part 2, pp. 445.
been aimed at answering questions such as what, exactly, constitutes recovery? Who defines it? What actions or events will lead to recovery? How is recovery achieved? Implicit in these questions is that, at any given time, the ways in which recovery is constructed (medically, legally, socioculturally) are contingent upon how mental illness and mental health care themselves are constructed. As Braddock and Parish tell us in “An Institutional History of Disability,” “Throughout Western history, disability has existed at the intersection between the particular demands of a given impairment, society's interpretation of that impairment, and the larger political and economic context of disability” (11). For instance, the Early Middle Ages viewed disability largely in terms of inability to work, yet widespread disease and lack of adequate healthcare produced a large population of people with disabilities. Begging was considered prudent, and a “part of the natural order” (18). Charitable institutions at this time were available for people with disabilities mostly “only [for] providing assistance until an individual was sufficiently recovered to leave the hospital and beg for alms.” So historically, recovery was equated more with one’s ability to labor than with a personal state of functionality.

Though medieval views of recovery (and disability and disorder) were relatively benign, treatment and perceptions of people with disabilities shifted radically and quickly. For instance, during the Renaissance, many held the view that the mentally ill were of “bestial nature” or possessed by demons, beliefs preached by Reformation leaders Martin Luther and John Calvin alike (21). Thus,
treatment for a range of perceived mental disabilities from depression to epilepsy included beatings to the head, boring holes in the skull, or purging to “release the ‘stones’ or ‘black bile’ thought to cause illness.” Certainly these measures would not qualify as “best practices” by mental health care today, but at the time, as Braddock and Parish remind us,

[T]hey focused on biological etiologies and treatments and therefore signified a change in the prevailing beliefs that the causes of disability and illness were supernatural. Cures during this period were related to primitive understandings of anatomical functions and to physicians’ abilities to intervene to address bodily difference and dysfunction.

While the leading physicians of the day may have had mostly beneficent intentions, and many of their efforts were groundbreaking in what we now call neuroanatomy and neuropsychiatry, the results were less about therapeutic recovery and more about symptom management and patient containment.16

Even later, when the prevailing beliefs urged for morally correct17 treatment of the mentally ill, recovery was often elusive. The advent of moral

16 As Braddock and Parish point out, the history of mental illness and all its attendant functions is a complicated one. There are many instances in every recorded era of what could logically (and contextually) be considered humane treatment of people with mental illness and other disabilities, just as there are numerous instances of inhumane treatment. Sometimes competing views existed even simultaneously, varying by region, or religious or economic climate. See also Albert Deutsch’s The Mentally Ill in America: A History of their Care and Treatment from Colonial Times (1949).

17 The advent of ‘moral treatment’ is accredited to the 19th century mental health practitioners and asylum superintendents who turned away from violent and degrading treatment of the mentally ill, and towards treatment that was more humane, focused on kindness and compassion, and sensitive to the patient’s health and safety. The leading reformists are Jean-Baptiste Pussin and Philippe Pinel in France, the Quakers William and Samuel Tuke in England, and Benjamin Rush in the United States. As with all leaders in mental healthcare, their corpus of works have been both lauded and castigated. For fuller descriptions of the rise of moral treatment in America please see
treatment (or moral therapy or moral management) also gave a quick rise to the “cult of curability” in the US. In *The Mentally Ill in America* (1949), Albert Deutsch tells us, “despite the encouraging experiences of [the moral therapists], it was widely believed that insanity was an incurable affliction, ‘Once insane always insane,’ went the popular adage” (130). Yet in the 1930s, “the pendulum of opinion on this subject swung violently to the opposite extreme. The old notion that none, or at very best few, of the mentally ill could be cured was suddenly discarded.” This fatalistic view was replaced with “the conviction that all, or nearly all, were curable,” and that “[i]nsanity is the most curable of all diseases.” Yet, as Deutsch points out, most of the figures that physicians and, more often, institutional superintendents, were advancing as proof of recoverability as a probability came from “doctored” reports, misinterpreted or miscalculated figures and ill-defined terms, and otherwise faulty data. Even though the belief that insanity was curable held for several decades based on erroneous research, once “the cult of curability” was dismantled, the consensus quickly returned to the belief that “once insane always insane” after all.

Other contradictions about the state of mental health care existed during this time as well. For example, in the 1840s pioneering reformist Dorothea Dix pushed for the construction of more American and European hospitals for the mentally ill when she found the conditions of current care to be inhumane (32).
Yet soon after these demands were met, the new and expanded hospitals became the receptacles for overcrowded prisons, particularly the “most dangerous and disturbed” (33). In turn, the hospitals became overcrowded and the superintendent-patient ratio faltered. Managing larger institutions meant less time for patients, and, “cure rates concomitantly dropped” (33). Interestingly, while mental illness has been believed to be alternately “curable” and “incurable” throughout history, institutionalization represents an important example of how “psychiatrists reported that mental illness was largely incurable” in direct reaction to a failed system rather than from quantitative and qualitative evidence that cure (or recovery) was obtainable or not.

Disability studies has a complex relationship with recovery. Current scholarship in disability studies contends that “overcoming” and “inspirational” narratives of disability are ableist and antithetical to the goals of viewing disability as a socially constructed site for analysis. Present and historical images and accounts of people with disabilities (PWDs) often circulate to invoke pity and compassion, with the implication that PWDs need and deserve charity. For people with physical, visible disabilities, these images have arguably been replaced to some degree. Narratives and images of disability have moved away from inspiring fear, pity, and the image of the “Supercrip,” towards awareness, acceptance, and integration.\(^{18}\) Invisible disabilities (e.g., mental and emotional

\(^{18}\) See, for instance: José Alaniz' "Supercrip: Disability and the Silver Age Superhero" in International Journal of Comic Art, Vol. 6, No. 2, 2004; and Leslie A. Fiedler’s "Pity and
disorders, Autism Spectrum Disorders), however, have only recently been at the forefront of these liberatory changes. I contend that disabilities of the mind, particularly those deemed psychiatric in nature rather than cognitive or developmental, remain subordinate to those of the body within the hierarchy of disability, in both theoretical and discursive practices as well as in the larger cultural consciousness.

Others scholars in disability studies have addressed this general lack of analysis regarding mental illness. In "On the Rhetorics of Mental Disability," Catherine Prendergast writes of “brokering a shared understanding” (45) of schizophrenia, the illness her close friend, Barbara, is diagnosed with, when Barbara tells her that “she was aware of her mind as having been reconstructed by the discipline of psychiatry.” That Barbara and Prendergast “believe, along with [NAMI], that schizophrenia is a no less a brain disorder than Alzheimer’s disease or multiple sclerosis” (46), does not resonate well with the “poststructuralist leanings” of the “theoretical climate” in which Prendergast’s and my own scholarship circulates. Prendergast recognizes that “a poststructuralist perspective suggests that insanity is a discursive construct, expressed, reinforced, and sometimes subverted by public discourse, the discourse of experts, and by institutional structures which themselves can be viewed as discursive constructs” (47).

While Prendergast’s view certainly aligns with the social model of disability, and describes the oftentimes highly oppressive nature of the medical model and all its attendant minutiae, according to noted literary scholar Carol Neely, the effect of this “theoretical orientation” is that it “rend[ers] insanity at once ‘ubiquitous and irrelevant’” (46). I, for one, find this positioning of ‘insanity’ troubling, as it only partly accounts for the experiences of people with mental illness. Yet, as Prendergast attests, suggesting in academic circles that disorders are as much a brain disorder or disease as a discursive construct “sounds at best conservative and at worst theoretically unsound,” and makes her “suddenly culturally unintelligible” when voicing this view to her colleagues. I wonder what, then, is the language necessary for discussing both the discursively constructed nature of mental illness, and the real, lived experiences of people with disorders? Prendergast tells us,

The growing literature on disability would seem a natural place to turn to find such language, yet it seems that disability studies, with its emphasis on the body and not the mind, creates fissures through which attention to the mentally disabled easily falls. One might ask if there are any discourses in which people with severe mental illness might comfortably reside. (46)

Despite these fissures, I believe that disability studies is exactly the academic ken that could contribute to better understanding the province of disorders and recovery.
While I am grossly oversimplifying the complex relationship between physical/nonphysical, visible/invisible disabilities, I maintain that narratives of inspiration and recovery function differently for disabilities of the mind than they do for entirely somatic disabilities. Additionally, the pathology of psychological and emotional disabilities necessarily lends itself to spaces of recovery; in psychiatry, there is a pervasive idea that while mental disorders may have a biological root, they are incurable. Comparatively, the idea that a cure is obtainable and desirable has been the impetus for widespread narratives and images of physical disabilities in the marketing sector, entertainment industry, and literary world. For physical disabilities, recovery equates to/as cure. For disability studies, which locates “disability” primarily as a social construct, ‘cure’ can reductively equate with erasure of agency, subjectivity, the person, and his or her experiences as a whole.

Recovering, Reclaiming, Revisioning

In the provinces of rhetorical, feminist, and disability theory/praxis, “recovery” takes on convergent and divergent meanings. Related descriptors such as recuperative and reclaiming have also received attention in what I see as connective discursive practices. For instance, in The Wounded Storyteller: Body Illness, and Ethics (1997),

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19 Here, again, I am grossly generalizing. Physical and mental disabilities are not so easily separated, nor are visible and invisible disabilities. The relationship between the body and mind (and how the body responds to mental disabilities, and how the mind responds to bodily disabilities) is far too complex to flesh out here. For the sake of simplicity, I am calling attention to the larger picture, the general “feel” that disability studies is more heavily invested in physical disabilities than mental disorders, and that there is a general reluctance to discuss the biochemical, biophysiological agents of mental illness.
Arthur W. Frank explores the importance that “reclaiming” plays in Audre Lorde’s *The Cancer Journals* (1980). Frank reminds us that “In postmodern times ‘reclaiming’ has been used to the point of cliché, but like most clichés it carries a significant kernel of truth about the times in which it is so often repeated” (64). To reclaim something (in Frank and Lorde’s case, illness stories), suggests that something has been taken away. Frank connects Lorde’s “reclaiming of that language which has been made to work against us” (Lorde 22) as central to the process of the “quest narrative,” the illness story that for him (and Lorde) is the only kind that “affords the ill person a voice as teller of her own story, because only in quest stories does the teller have a story to tell” (115). In other words, only the quest narrative affords the teller agency, whereas in other narratives Frank describes (restitution and chaos stories), either the doctor/medicine/services are the active players, or, the suffering is so great as to render the “self” untellable (115). It is interesting, to me, that the more severe the illness or disorder, the less one is perceived able to tell his or her story.

Catherine Prendergast notes that because her friend Barbara has schizophrenia, she is at times unable (and the medical model is unwilling to listen to her) tell her own story. I am reluctant to agree that there are untellable stories, or people unable to tell them; rather, it is either the audience who is not listening or watching closely enough, or the rhetorical context does not privilege that story being told. The medical model of disability has traditionally fallen into both of these dismissive categories, often silencing or erasing illness narratives that are seemingly uncomfortable, disturbing, or unintelligible. This project in general opens up a larger conversation about these untellable stories. More specifically, I address (and seek to reclaim) such a narrative in the chapter analyzing Lauren Slater’s *Lying: A Metaphorical Memoir* (2000).
Returning to Lorde’s description of reclaiming, she connects the act of reclaiming to absence, as in, the absence of a thorough examination of the ways in which women are oppressed differently because of race, class, sexuality, and age. Lorde’s reclamation includes, then, the histories of women’s intellectual work, and women’s writing, that have been hidden, silenced, erased, and the subsequent efforts to retrieve them. Andrea Lunsford’s collection *Reclaiming Rhetorica: Women in the Rhetorical Tradition* works in this vein. According to James Murphy the collection shows the “glimmer of possibilities, an array of glances—an enthymeme” (x) of women’s writing and women’s voices making “important theoretical contributions” which, I and many others believe, revises the tradition of rhetoric. Similarly, in *Claiming Disability: Knowledge and Identity* (1998), Simi Linton explores, among other things, the relationships between language and disability, and the “dominant cultural narrative of disability and the academic narrative” (1). Linton casts a light on disability studies and “disability” as an identity category, both of which are neglected in larger academic theoretical frameworks. Both *Reclaiming Rhetorica* and *Claiming Disability* rely heavily on the notion of bridging the gaps within grand narratives, of theorizing gender and disability from within these identity categories, rather than without them. Recent work has augmented (if not corrected) the early stages of feminisms, however, in terms of being inclusive within its own goals and the voices that structured those goals.
More specifically, Lorde (like many others) charges early feminism, rightfully so, for neglecting to include the voices of all marginalized women, and not just white, middle class academic women, in its agenda. In 1979, Lorde’s comments at “The Personal and the Political Panel” during the Second Sex Conference in New York set the stage for a powerhouse of scholarship about the transformative ability of feminisms and language:

Those of us who stand outside the circle of this society’s definition of acceptable women; those of us who have been forged in the crucibles of difference – those of us who are poor, who are lesbians, who are Black, who are older – know that survival is not an academic skill. It is learning how to stand alone, unpopular and sometimes reviled, and how to make common cause with those others identified as outside the structures in order to define and seek a world in which we can all flourish. It is learning how to take our differences and make them into strengths. For the master’s tools will never dismantle the master’s house. (112)

While these are vital instructions for what was then an emerging feminism strongly rooted in naming and theorizing an identity politics, I also see Lorde’s words as precursory to current disability theory, and in particular, the processes of healing and recovery. While “the master’s tools will never dismantle the master’s house,” not knowing the master’s tools can result in certain demise for people with mental illness. Lack of knowledge is not only dangerous; it renders self-advocacy and the process of recovery improbable. Biological survival is not a uniquely academic skill, but I would argue that academic skills might aid in one’s survival, and that survival is inextricably bound with recovery. Moreover, disability has historically stood outside the circle of social acceptance, and has not only
been “forged in the crucibles of difference,” but is the definition and illustration of difference. Physical and mental disabilities have always been cast in the dichotomous role of normal/abnormal, acting as the standard for measuring deviance, deficiency, freakishness, and undesirability. Even in terms specific to the individual (rather than, say, a population), ‘normal’ is a fluid and contingent state. What a doctor deems normal may conflict with what the individual feels to be her own sense of normalcy. Other vital terms rest on this same contingent (i.e. rhetorical) positioning.  

“Reclaiming” is, in fact, the very language employed by some in the psychiatric community in defining recovery. At the 2002 “Innovations in Recovery and Rehabilitation: The Decade of The Person” conference sponsored by University of Boston’s Center for Psychiatric Rehabilitation, participants collaborated on the following definition of recovery:

Recovery is an ongoing, dynamic, interactional process that occurs between a person’s strengths, vulnerabilities, resources, and the

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20 The multivalency of Lorde’s word choice here is significant, as a crucible can be a vessel for collecting and heating metal, or a severe test (of beliefs, of patience), or “A place, time, or situation characterized by the confluence of powerful intellectual, social, economic, or political forces” (AHD). In other words, difference (race, gender, disability, sexuality) acts as both catalyst and hotbed for analysis, it challenges the hegemonic norm, and is forced to the forefront of the powerful confluence by the very powers that define and oppress it.

21 The term ‘functional,’ for instance, underpins the legal and medical frameworks determining who is covered by the American with Disabilities Act, who receives insurance benefits, who is protected from discrimination in the workplace, and who receives accommodations in the workplace and in school. Yet the ADA’s definition of ‘functional’ may conflict with the realities of living with any given disability. Likewise, the ADA sets out standards for “reasonable accommodations” for employees with disabilities, but often the employee’s actual experiences are not accounted for.
environment, it involves a personal journey of actively self-managing psychiatric disorder while reclaiming, gaining, and maintaining a positive sense of self, roles, and life beyond the mental health system, in spite of the challenges of psychiatric disability.\(^{22}\)

What is equally as interesting to me is that this definition of recovery can be applied similarly to many current narratives about mental health, that the texts I explore in this project are among the growing number of memoirs and autobiographies on the market today framed around this very definition. In order to illuminate the importance of writing about mental health in terms of recovery, I offer a map of some discursive projects that center “recovery” as a vital tool for analysis and theory.

Adrienne Rich, celebrated contemporary of Audre Lorde, offers perhaps the earliest and most influential understanding of recovery as crucial to feminist projects. For Rich, recovery is deeply embedded in her larger analysis of revision, the fabric of which is woven into most every project set out by feminisms, and feminist rhetoric in particular. I want to highlight two of her works I feel are theoretically and rhetorically vital to feminisms and disability studies, and to my project in particular: “Diving into the Wreck” (1972) and “When We Dead Awaken: Writing As Re-vision” (1971).

In “Diving into the Wreck,” from Rich’s same-titled collection of poems (1971—1972), she offers a meditative search – a recovery – of women’s voices. Briefly, the poem’s speaker (the diver) strikes out alone to view the wreck, after

\(^{22}\) From Kate Mulligan’s “Recovery Movement Gains Influence in Mental Health Programs." *Psychiatric News* January 3 2003 38:1.
considering “the book of myths,” the received conventions men have historically bestowed on women, the literary canons from which women have been excluded. The diver notes the constraints of the diving gear; what should typically aid a person in underwater exploration is “absurd,” “awkward,” and “cripp[ing]” here.\(^\text{23}\) The gear Rich describes here are rhetorical tools: the longstanding traditions of male writing (e.g. forms, styles, structures, content). These tools will not help Rich’s diver find or rescue the cargo hidden in this wreck, women’s voices left “obscurely inside barrels / half-wedged and left to rot” (55). Yet the “treasures that prevail” (54) amidst the “damage that was done” are recoverable: “we are the half destroyed instruments / that once held to a course,” and therefore, still salvageable, but in need of a new book, a new language, with women’s voices and women’s writing.

I want to make a comparison here between the book of myths Rich describes and the medical model of disability. I liken this book to the canonical model of literature, where literature includes all discursive practices that we academically analyze or culturally appreciate. The canonical model of literature and the medical model of disability are both steeped in tradition, largely constructed by males (or at least, historically constructed by males). Both include

\(^{23}\) A disability studies reading of this term, crippling, might go one of two directions. One, this is an example of the ways in which everyday language further stigmatizes disability, that it is used in a pejorative sense to highlight how the prospect of being immobilized is nothing more than terrifying to people without disabilities. Or two, this is less about a careless, albeit ableist, word choice and more about emphasizing how socially, politically, even legally patriarchal, hegemonic language has destroyed and displaced women’s language, women’s voices.
women but have not always accurately represented women or been constructed by women’s voices. Likewise, people with disabilities might be included but misrepresented or excluded altogether from these models. Recovery is in order, then, for the voice (and writing voices) of women and people with disabilities.

In “When we Dead Awaken: Writing As Re-Vision” Rich solidifies her views on recovering women’s voices. This groundbreaking essay set forth an agenda for decades to come, not just for feminisms, but writing and theorizing in general. Rich describes revision as “the act of looking back, of seeing with fresh eyes, of entertaining an old text from a new critical direction” (167), an act that is crucial for women: revision is “more than a chapter in cultural history; it is an act of survival.” It is a call to woman to “stop being haunted … by ‘convention and propriety’” (169). Again, I extend this to include people with disabilities and specifically a rhetorical theory of recovery for feminisms and disability studies.

For Rich, this recovery is possible in the early 70’s because at that time, there is an “awakening consciousness,” a “collective reality” (167). The feminist movement both provided for and was a result of “the availability of knowledge, of vital texts, the visible effects on women’s lives of seeing, hearing our wordless or negated experience affirmed and pursued further in language” (166-7). To me, this is a powerful statement, resonating, again, across decades and disciplines, and speaking directly to the emerging theories of disability.

The body of works drawing upon Rich’s idea of revisioning is abounding and multidisciplinary; giving an exhaustive list here would be impossible. Briefly
though, I offer a few current examples. In *Feminist Rhetorical Theories* (1999), Karen A. Foss, Sonia K. Foss, and Cindy L. Griffin tell us from the outset that “Adrienne Rich’s notion of re-visioning is the inspiration for this book, which is about seeing rhetoric in new ways and, in particular, through the lens of feminist perspectives” (1). Oddly, though this groundbreaking text explores nine notable feminists and their “orientation to the world and some of the particular experiences that have influenced the development of [their] ideas” (11), their own personal definitions of feminism, and their power to potentially transform rhetorical theory (12), Rich, however, is not included as one of them. Yet her contribution to rhetoric is unmistakable: her dream of a common language (outside patriarchal codes), her call to writing, reading, and educating as women (outside traditional gender prescriptions), and her persuasion to understand sexuality/identity as both personal and political locations are all rhetorical stances undergirding a great many discursive practices today.

Relevant scholarship in disability studies comes from G. Thomas Couser’s framework for recovery in *Recovering Bodies: Illness, Disability, and Life Writing* (1997) His envisioning of recovery is both different from and similar to Adrienne Rich’s. As I see it, *Recovering Bodies* is about bodies in recovery from illness, and, recovering “personal narratives of illness and disability” (3) into the body of

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24 Another current example of Rich’s influence is found in *Feminism and Composition: A Critical Sourcebook* (Kirsch, et al, 2003). Numerous contributors either directly name or are clearly informed by Rich’s works in this collection, calling upon her views on writing, teaching writing, women students, feminist ethics, and so on, and again illustrating how consequential Rich’s scholarship has been.

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works called life writing, as well as into the field of disability studies. Both purposes are vital for sustaining analyses of disability in academic scholarship, but the scope of Couser’s text is very particular. Nancy Mairs tells us in her Foreword to Couser’s text that this is a “brave beginning,” that Wisely…Tom has limited the scope of his study to books dealing with HIV/AIDS, breast cancer, paralysis, and deafness. He couldn’t have covered every physical catastrophe that has occasioned a memoir, and these are good choices for representing the variety of issues associated with illness or disability, which are not necessarily synonymous. … Though fully realized in its own terms, Recovering Bodies remains in some sense preliminary. That is, because some conditions not considered here – mental disabilities like Down syndrome, autism, and bipolar illness, say or the limitations imposed by aging – have inspired works that may augment or modify the conventions Tom has identified, ample room remains for further investigation. (xii)

I take Mairs’ suggestion for further investigation as a personal invitation, then, to “modify the conventions” Couser presents, here and elsewhere in his scholarship on disability. If, by Couser’s admission in Recovering Bodies, illness and disability narratives are produced more often by white, upper middle class males than females (4), then Slater and Jamison (and their works) represent that marginalized gendered body. Curiously though, Couser states, “(though most of us rarely reflect upon it) … we have our being in the world, and act upon it, through our bodies” (4-5). I suggest that this is unfailingly false, when considering the enormous bodies of work by and about women who have reflected on this very point, in terms of reproductive labor, prescriptive gender roles, and the sexual/sexualized body. Whether Couser’s point was meant singly in terms of the ill or disabled body, or was a more general statement about bodies, it suggests
more of an attentiveness to a disability studies than a feminist framework, a source of neglect I wish to rectify in my own project.

In his Epilogue, Couser tells us that “generic illness narrative is, understandably, so invested in recovery that the achievement of closure often takes precedence over consideration of what dysfunction feels like and how it alters self-perception” (294). Again, with psychiatric illness narratives, I believe that this process plays out quite differently than with other illness narratives. Slater’s *Lying* is a case in point for two reasons. One, as with Jamison’s *An Unquiet Mind*, both author and reader know that at any given point the writer may relapse (voluntary or involuntary cessation of medication assures this, as does cessation of the medication’s efficacy, which unfortunately sometimes happens). And two, since the reader never really knows for certain what illness or disorder (and to what degree) Slater is diagnosed with, it is impossible to know for certain that she has recovered, or even has the ability to do so. Arguably, Slater’s writing tends toward revealing more intimate (or seedy) details, paints a picture more likely to cause the reader to squirm, than Jamison does, but I wonder to what degree being so heavily trained and invested in the medical profession impact their writing styles. Likewise, I can only speculate to what degree their individual diagnoses influence particular details regarding their mental health based on what they choose to share and what they choose to leave out of their writing.
Situating Recovery Narratives: A Brief Backdrop

The turn of the 20th century brought with it a relatively new subgenre of memoirs. As previously noted, memoirs, autobiographies, and biographies about recovering from addictions such as alcohol and other drugs, food, gambling, and sex, proliferated on bestseller lists across America. Arthur Frank’s description of the “quest narrative” in *The Wounded Storyteller* (1995) calls upon language often evoked in the realm of mental health narratives. Consider the titles of mental health memoirs both current and predating Frank’s text: Kate Millett’s *The Loony-Bin Trip* (1990), Lori Schiller and A. Bennett’s *The Quiet Room: A Journey Out of the Torment of Madness* (1994); J. Alyson Hastings’ *Voices in the Storm: A Personal Journey of Recovery from Mental Illness* (1999); Ken Steele and Claire Berman’s *The Day the Voices Stopped: A Schizophrenic’s Journey from Madness to Hope* (2002); Jonathan Aurthur’s *The Angel and the Dragon: A Father’s Search for Answers to His Son’s Mental Illness and Suicide* (2002); Lizzie Simon’s *Detour: My Bipolar Road Trip in 4-D* (2002); Chad Stafford’s *The Sublime Detour: My Experience with Madness, the True Story of Chad Stafford’s Hallucinations* (2004); Pete Earley’s *Crazy: A Father’s Search Through America’s Mental Health Madness* (2006); Elyn R. Saks’ *The Center Cannot Hold: My Journey Through Madness* (2007).

For Frank, the quest narrative offers the storyteller agency in an otherwise trying and oppressive experience. Similarly, the National Consensus Statement on Mental Health Recovery incorporates similar language evoking movement
towards personal agency: “Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (1). The above memoir titles also evoke a sort of mapping out of the illness, a trek guided by hope as well as despair, and ending with some shining light. But the metaphor of mental illness as a journey also evokes images of uncharted territory, of a possibility of getting indefinitely lost, of a wildness needing to be tamed, or at least contained—a metaphor which resonates more clearly in earlier accounts of mental illness, particularly by the asylum writers.25

Mapping out Journey: Chapter Summaries and Text Rationale

I have chosen to focus on memoirs, works of art, and online articles and commentary as the primary texts for my dissertation rather than fictional literature because of the wealth of scholarship already available about the latter. Fixed in the longtime British and American literary landscape are tropes of madness, particularly “madness as a metaphor,” where characters, events, and works

25 The discursive environment surrounding mental illness has historically included autobiographies and memoirs written by service users, clients, consumers, ex-patients, and asylum survivors, dating as far back, in fact, as the fifteenth century (Sommer 1261). More importantly, these texts have functioned pedagogically within the medical model, serving as “corollary readings in psychopathology classes,” and to “provide a valuable archival record of the phenomenology of mental disorder and the changes that have occurred in diagnosis, treatment, and public response over several centuries.” These texts are understood as viewing “mental disorder from the inside looking out, drawing upon the human capacity for self-description and self-analysis,” that they “complement research and case studies performed from the outside looking in,” and that they emphasize issues that the writer, as distinct from clinician, deems important.” In this light, I see a social constructionist attitude towards mental illness at work in the institutional underpinnings of the very model of disability (the medical, or biomedical model) that disability studies castigates.
stand in for larger social, political, or religious problematics. While these works are foundational in constructing the ways “mental health” circulates in our culture, often missing from this landscape are first person narratives of real people with disorders. Therefore, I want to focus specifically on those real, lived experiences of mental illness. More importantly, I want to illustrate how, as Sidonie Smith and Julia Watson tell us, “Women’s autobiography is now a privileged site for thinking about issues of writing at the intersection of feminist, postcolonial, and postmodern critical theories. …If feminism has revolutionized literary and social theory, the texts and theory of women's autobiography have been pivotal for revising our concepts of women’s life issues”\(^{26}\) (5). Smith and Watson’s introductory comments to *Women, Autobiography, Theory* do more than map the terrain of women’s autobiography; they mark an important direction in writing practices for other marginalized people, specifically, people with disabilities and disorders. What follows is my own map of this project.

**Chapter 1: An Unquiet Experience: Recovering a Space Between feminisms and Disability Studies**

This chapter confronts the problems of intersecting a feminist theory with disability studies readings of disorder by exploring the ways in which Kay Redfield Jamison constructs “recovery” in *An Unquiet Mind: A Memoir of Moods and Madness* (1997). Jamison’s narrative draws upon “experience” as a

rhetorical category that situates her as both authority of and audience for the medical model of disorder. I address the tensions within feminisms regarding experience as a category that, on the one hand, affords authority, and on the other hand, becomes reductive and universalizing. Within disability studies, the effect of using experience as a rhetorical category mirrors that of feminisms; I want to resist reading this strategy as being wholly negative.

Chapter 2: Invention, Intention, and a Conversation about Lying: A Rhetoric of Reading for Recovery

The publication of Lauren Slater’s *Lying: A Metaphorical Memoir* (2000) drew criticism from the disability studies community for its portrayal of epilepsy, or more specifically, Slater’s “lying” about having epilepsy and the ways she claimed to experience this. In “Disability as a Metaphor: What’s Wrong with Lying” (2005) G. Thomas Couser takes Slater to task for misrepresenting an already stigmatized disability. Using Adrienne Rich’s early views on “re-vision” and “recovering women’s writing,” I argue that Slater’s intentions are not so much to draw upon a frequently but inadequately used literary and rhetorical device (metaphor). Instead, in this text Slater invents the metaphor of epilepsy as a stand-in for two other disorders many in the psychiatric community (and elsewhere) would argue register lowest on the scale of treatability and highest on the scale of socioculturally stigmatized: Borderline Personality Disorder (BPD)

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and Munchausen Syndrome. Slater indicates throughout *Lying* that she is, in fact, lying, and that she likely does have BPD or Munchausen Syndrome, along with other related disorders (obsessive compulsive disorder, anxiety, depression) she writes about elsewhere. Interestingly, both Munchausen Syndrome (also known as factitious disorder) and BPD are characterized, in part, by lying about one’s mental or physical health and manipulative behavior, respectively. Finding truth in *Lying* is a complicated endeavor, but a goal necessary for disability studies and feminisms to understand the spectrum of mental disorders typically labeled as women’s disorders.

Chapter 3: Disordering the Politics of Visualizing Disability

Southeast, Inc. Recovery and Mental Health Care Services has an artistic vision: “Through art, [they] educate the community and work to break down the stigma of mental illness and substance abuse by bringing focus to the artistic vision.” In Columbus, Ohio their Fresh A.I.R. (Artists in Recovery) Gallery exhibits works monthly by “individuals affected by mental illness and those with substance abuse disorders.” This chapter analyzes the works of two Fresh A.I.R. artists in order to explore “recovery” in the gallery’s promotion of social change through art.

The first Fresh A.I.R. artist I explore is Chris Mohler, who is self-described as being an artist *because* he is bipolar. Mohler’s metal sculpture “Shrine to the Grand Iron God” serves as the centerpiece for an analysis of the popular trope of “madness as genius.” I connect this notion in Mohler’s work to some popular film
and literary representations of similar constructions of mental illness, as well as 
the ways in which mental health becomes the measuring point for constructions 
of normalcy

The second Fresh A.I.R. artist I address in this chapter is Adele Mattern. In her “Recovery” exhibition, Mattern depicts her own views of her mother’s 
efforts to regain a functional life after episodes of schizophrenia. While Mattern’s 
portrayal borders uncomfortably close to reductive, essentialist notions of 
domesticity, I work to recover a more empowering reading of her art.

Chapter 4: Impatient Doctors and Self-Educating Patients: Reading the Writing 
on Reader’s Digest’s Walls

I end this project with a trek into popular culture. I take a print article, “41 
Secrets Your Doctor Would Never Share (Until Now)” (Dermody and Curtis) from 
the July 2008 issue of a popular magazine, Reader’s Digest, and put it into 
conversation with the more than 280 digital comments from public responses to 
the article. What emerges from these discursive practices is that the 
contradictions in the article translate into contradictions in healthcare; 
consequently, iatrogenic behaviors are ever present among doctors, and 
patients’ lives are at risk.

With the online publication of many official reports, such as the Institute of 
Medicine (IOM) Committee on Quality of Health Care in America’s To Err is 
Human: Building a Safer Health System (2000), knowledge traditionally relegated 
the private sphere of medicine becomes easily accessible in the public sphere of
the Internet. And as the *Reader’s Digest* article travels in this online discursive environment (from print to digital comments to blogs to video and back to digital comments), its readers partake in repeated practices that are self-educating and self-empowering.
CHAPTER 1
An Unquiet Experience: Recovering a Space Between feminism and Disability Studies

The most salient category at which disability studies and feminisms intersect is, I believe, the category of experience. Experience is the impetus for every rights movement (women’s, disability, civil, human); it is the fundamental, instructional, connecting, and differentiating part of everyone’s identity. Yet, personal experience as a governing category is still widely neglected in the arena of healthcare (including policy and law making). In academic scholarship, however, experience is a continually theorized category. I would like to add to this conversation by showing here how in An Unquiet Mind: Memoir Of Moods and Madness, Kay Redfield Jamison uses the invention of experience—which negotiates into authority—as a rhetorical strategy throughout the process of her recovery as well as her narrative. Jamison’s persuasive work to destigmatize mental illness also aligns her specifically with one of the goals of disability studies: troubling the medical model of disorder by showing how anyone, doctors included, can become disabled at any time. And finally, Jamison occupies a triangulated subject positioning (woman/doctor/disordered) that she continually
negotiates (and sometimes resists) throughout her memoir, and which, when read through a disability studies and feminisms analysis, can provide opportunities for subverting the categories of gender and disorder. I have divided this chapter into two parts; the first part provides a brief backdrop for the analysis, and the second part moves to the reading of *Unquiet Mind*.

**Part 1 — Disability Studies, feminisms, Disorder, and Healthcare: An Impasse or a Four-Way Intersection for Framing Experience?**

Before moving to an analysis of Jamison’s *Unquiet Mind*, I want to situate the category of experience as authority into a larger conversation about disability studies, feminisms, disorder, and health care, and then specifically, psychiatry. Calling upon authority figures or “expert witnesses” to establish credibility in an argument is a common rhetorical strategy in practically any discursive environment. Joy Ritchie and Kate Ronald’s introduction to *Available Means: An Anthology of Women’s Rhetoric(s)* notes that, for Aristotle, the “discovery of the available means was … an act of invention that always assumed the right to speak in the first place, and prior to that, assumed the right to personhood and self-representation, rights that have not long been available to women” (xvii). In *Mutuality in the Rhetoric and Composition Classroom* (2000), David L. Wallace and Helen Rothschild Ewald offer some valuable terminology for thinking about experience. For them, “interpretive agency involves bringing one’s prior experiences to bear in the construction of knowledge. An individual’s interpretive agency depends on his or her unique perspectives, which, in turn, is based on
the set of life experiences that each person brings to the classroom discourse or other communicative events” (16). In An Unquiet Mind, Jamison illustrates interpretive agency by situating her experiences (as doctor and as patient) as being vital to her recovery—a recovery that is shaped sometimes by being compliant with institutional forces, and by sometimes resisting them.

While experience as a location for analysis (and analyzing) is foundational to both academic (and activistic) disciplines, there are several standout arguments; not surprisingly, sometimes these disciplines converge. For instance, Rosemarie Garland Thomson imports standpoint theory, a useful tool for theorizing experience, into her scholarship. In Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature, she informs us that “feminism’s most useful concept for disability studies is standpoint theory, which

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28 I want to provide a brief backdrop of the ways in which feminisms and disability studies have theorized personal experience. Certainly, Adrienne Rich’s (and others’) advancement of “the personal is political” in her poetry and theory paved the way for tremendous scholarship from all frameworks of feminisms as well as for disability studies. Other significant scholarship on theorizing experience comes from Gayatri Spivak’s “Can the Subaltern Speak?” (Marxism and the Interpretation of Culture 1988), Joan W. Scott’s “The Evidence of Experience” (Critical Inquiry 1991), Linda Alcoff in “The Problem of Speaking for Others” (Cultural Critique 1991), Chandra Talpade Mohanty’s “Feminist Encounters: Locating the Politics of Experience” (Destabilizing Theory: Contemporary Feminist Debates 1992), Thomas C. Holt in “Experience and the Politics of Intellectual Inquiry (Questions of Evidence: Proof, Practice, and Persuasion Across the Disciplines 1994), Paula Moya’s Reclaiming Identity: Realist Theory and the Predicament of Postmodern (2000) and Learning from Experience: Minority Identities, Multicultural Struggles (2002). From disability studies, there are numerous works that either theorize “experience” or call upon it as crucial to their theory. See, for example, David T. Mitchell and Sharon L. Snyder’s anthology The Body and Physical Difference: Discourses of Disability (1997), and Simi Linton’s Claiming Disability: Knowledge and Identity (1998). See also Part II – “Experiencing Disability” of The Handbook of Disability Studies (2001), edited by Gary L. Albrecht, Katherine Delores Seelman, and Michael Bury. 
recognizes the immediacy and complexity of physical existence” (24). She further states: “Emphasizing the multiplicity of all women’s identities, histories, and bodies, this theory asserts that individual situations structure the subjectivity from which particular women speak and perceive.” Standpoint theory is, in fact, useful for disability studies, particularly for opening up a conversation about mental health. Garland Thomson tells us that “The strands of feminist thought most applicable to disability studies are those that go beyond a narrow focus on gender alone to undertake a broad sociopolitical critique of systemic, inequitable power relations based on social categories grounded in the body” (21).²⁹ I extend this to a theory of psychiatric disabilities, which has historically been a gendered endeavor.³⁰

Feminist theory and disability studies provide us with what are ostensibly antithetical accounts of how the medical world treats women. On the one hand, some feminist scholars point out that women have historically been left out of

²⁹ For other important works connecting feminisms and disability studies, please see “Special Issue: Feminism and Disability” Eds. Eva Kittay, Anita Silvers, Susan Wendell, and Alexa Schriempf. *Hypatia* 16:4, Fall 2001.

³⁰ Standpoint theory stems from Marxism, and has been explored by other theorists such as Nancy Hartsock in “The Feminist Standpoint: Developing the ground for a specifically feminist historical materialism” (*Discovering Reality: Feminist Perspectives on Epistemology, Metaphysics, Methodology and Philosophy of Science*. Harding, Sandra and Merrill B. Hintikka, eds. 1983.). *Extraordinary Bodies* focuses on bodies specifically, and Garland Thomson’s works collectively apply standpoint theory: her own subject positioning is as a woman with a physical disability. In “Integrating Disability, Transforming Feminist Theory” (*NWSA Journal* Volume 14, Number 3 2002) she again argues for the interconnection between the two frameworks. Neither of these works addresses psychiatric disabilities. Yet, this too reflects her subject positioning. I do not take her to task for writing (primarily) from her own experiences, nor is it any wonder that I would choose to write about psychiatric disabilities given my own experiences.
medical experiments, that healthcare specific or pathologic to women has
received less funding and exposure than healthcare for men, and that the
doctor/female patient relationship is typically hierarchical and infantalizing. On
the other hand, some scholars believe feminisms’ claims for women needing
better representation in healthcare are overstated, that they neglect evidence
that great advances already have been made in this arena. For instance, Cathy
Young\textsuperscript{31} tells us in her Salon.com article “Medical Gender Wars” that

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… this seemingly wholesome women’s crusade has a dark underside. It has used fictions and half-truths to polarize the sexes and promote fear and resentment among women. Combining elements of radical feminism and traditional paternalism, it has turned healthcare into a battleground for gender politics in which men, too, are now vying for the title of victim. …
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(\url{http://dir.salon.com/health/feature/2000/09/20/womens_health/index.html})\textsuperscript{32}

Young’s sentiment is extreme and laden heavily with feminist backlash, in which
feminisms once again becomes “the F word,”\textsuperscript{33} and of little value to women and

\begin{footnote}{31} I am referring to Cathy Young, the freelance journalist, noted for her alliances with men’s rights activists, and not Katherine Young, independent scholar and author of \textit{Presence in the Flesh: The Body in Medicine}.\end{footnote}

\begin{footnote}{32} I want to note here early on the problematics of using online sources. Young’s basic claim that women’s healthcare needs have already been met is, in fact, dangerously dismissive. Yet, her access to (e)journalism is also the average reader’s access to false claims (or, bad feminism). Though print sources are equally suspect in terms of accuracy, authority, and validity, digital sources are typically more accessible. Young’s speciousness makes her, in my opinion, an unlikely source. Unfortunately this problematic also extends to other online sources still struggling to make cyberspace a legitimate playground, academic or otherwise.\end{footnote}

\begin{footnote}{33} Much scholarship on feminist backlash has ushered in the 21\textsuperscript{st} century, notably, \textit{The F-Word: Feminism in Jeopardy} edited by Kristin Rowe-Finkbeiner (2003), and \textit{Theorizing}\end{footnote}
their everyday health needs. The rhetoric of this feminist backlash, however, is overly optimistic, and, problematic—it ignores the reality that many women have experienced dangerous gender disparities in healthcare, and it ignores the reality that academic, medical, and personal narratives can account for these disparities.\textsuperscript{34} Equally important, Young’s statement also negates the reality of women’s tireless and costly work to better their lives.\textsuperscript{35}

Even when we turn to theories more productively grounded in feminisms, we encounter dichotomous thinking. In \textit{Body Talk: The Material and Discursive Regulation of Sexuality, Madness and Reproduction}, Jane M. Ussher outlines

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\textsuperscript{34} Another way to look at the gender disparities in healthcare is internally. In the \textit{Reader’s Digest} article “41 Secrets Doctors Would Never Share,” a physical Medicine and rehabilitation doctor form Royal Oaks, Michigan, shares this: “Many patients assume that female physicians are nurses or therapists. I can't tell you how often I've introduced myself as Dr. M. and then been called a nurse, therapist, or aide and asked to fetch coffee or perform other similar tasks. I have great respect for our nurses and other ancillary personnel and the work they do, but this doesn't seem to happen to my male colleagues.” If the physicians treating us experience gender disparity, it logically follows that their patients do, too.

\textsuperscript{35} I want to further point out here the particular illogic of the argument Cathy Young presents. The notion of “medical progress” means exactly that, that the knowledge of medicine and those it treats is further progressed day by day. So then, when \textit{UCLA News} reports on July 7, 2006 that a “UCLA Study Finds Same Genes Act Differently in Males and Females; Discovery May Explain Gender Gap in Disease Risk, Drug Response,” and they acknowledge that there are genetic differences in the way the male and female livers metabolize medication, they also acknowledge that “The UCLA findings support the importance of gender-specific clinical trials. Most medication dosages for women have been based on clinical trials primarily conducted on men.” I am unaware of how Young views supporting evidence like this UCLA study, but I believe it shows exactly how dangerous gender disparity in healthcare is, and, how necessary feminist analyses of healthcare still are.
two of the most pervasive ways we think about women's bodies, that they exist in
“the perennial material-discursive divide”:

Those who stand on the ‘material’ side focus on the physical aspects of
experience – on the corporeal body, the literal implementation of
institutional control, the impact of the social environment, or on factors
such as social class or economic status. Those who focus on the
‘discursive’ look to the social and linguistic domains – to talk, to visual
representation, to ideology, culture, and power. [Both sides of the divide]
have seen the body as their rightful domain. To one camp it is a matter of
physical flesh, to the other it is a matter of symbols and signs. … which is
the truth, which way should we turn? (1)

The material is relegated to “science, psychology and the law,” while the
discursive belongs to theories of language and psychoanalytics. Ussher’s
anthology moves to bridge the discursive-material divide, as the authors write in
unity “towards a position which allows us to recognize the interaction and
interrelationship between the two” (1). The idea of conflicting camps of feminisms
at odds with each other is nothing new; throughout each wave we’ve seen
essentialists and social constructivists vying for power of authority over such
questions as why are women oppressed, how are women oppressed, and even
are women really oppressed anymore?

What is interesting in Ussher’s statements, however, is that she makes a
further distinction about dichotomous ways of analyzing women’s bodies. She
notes that in opposition to (or, resistance to) the materialist tradition of western
healthcare,36 many have “turned their attention exclusively to the cultural and

36 Ussher includes in this the disciplines of science, psychology, and the law, and notes
that these have all “traditionally examined human experience from a realist perspective,
within a positivistic framework which focuses on observable ‘facts.’ The aim of the expert
communicative aspects of ‘the body,’ often treating it as a phenomenon virtually unrelated to the biological processes traditionally studied in science and psychology” (4). In a similar vein, disability studies took a turn towards a social constructivist model in the late 1960s as the disability rights movement developed, itself an offshoot of the human and civil rights movements. The social model of disability has undoubtedly made a significant impact on the ways in which disability is viewed, theorized, legalized, and politicized. Yet, the social model of disability has also, in some ways, disenfranchised psychiatric disabilities from being properly theorized and adequately represented in academic and scholarly work, including in the humanities.

Ussher’s charge that feminist analysis has become exclusively discursive in the wake of poststructuralism, and at the reductive risk of women being merely “signs and symbols,” is applicable to disability studies post disability rights movement. While the turn from the medical model of disability to the emphasis on disability as a social construction is necessary and desirable for people with disabilities, it also shuts down an even more necessary conversation between disability and disorder. Despite recent legal turns in the way we view mental health, there is still a massive rhetorical and theoretical gap between visible

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has been to uncover objective ‘truth,’ and to narrowly delineate the boundaries of the scientific or legal gaze. This is never more clear than in areas of expertise which focus on sexuality, madness or reproduction, where the material body stands at the center of the scene” (2).

37 See, for instance, U.S. District Judge Henry H. Kennedy Jr.’s 2002 ruling in Fitts v. Federal National Mortgage Association, which finds that because there is scientific proof
and invisible disabilities. In the texts foundational to disability studies, there is scant mention of mental illness, and by virtue, even less about recovery. Many historical texts outline the births of institutionalization in early European and twentieth century American societies, yet stop short of much serious theorization about mental illness, except, of course, in relation to literature. While there is ever-growing scholarship securing disability as a category deserving the same theorization as other identity categories (i.e. race, class, gender, sexuality), mental illness (or psychiatric disabilities) has not been included.

In “Depressed and Disabled: Some Discursive Problems with Mental Illness,” Susan Gabel points to the necessity of bridging the visible/invisible gap as well as the material/discursive divide. One problem she sees is the “longtime focus on physicality” inherent in disability discourse. Another “problematic discourse in disability studies,” Gabel states,

Bipolar Disorder is genetic, visible on brain scans, and is a neurological disorder based on biochemical imbalances, it is therefore a physical illness and subject to the same disability and health benefits. This decision both legitimizes mental disorders and potentially relegates them to the same essentialist territory as physical disabilities.


39 In “Disability History: Why We Need Another ‘Other,’” Catherine J. Kudlick offers a compelling argument about why disability and its history needs serious scholarly attention cross-discipline. She notes, “Not since Joan Wallach Scott heralded a new age with her ‘Gender: A Useful Category of Historical Analysis’ have historians faced such an exciting time to rethink what we do” (17). Kudlickforegrounds the spatial/temporal importance of gender and disability as identity categories both deserving attention and capable, even necessary, of changing the face of academic scholarship.
has been the notion that disability is a social construct … The risk of a constructivist framework for understanding disability, and therefore its narrowness, is in its tendency to conceptualize the social construction of disability as *happening to* disabled people rather than *controlled by* them. By this I mean that constructivist theories too often place disabled people in the role of social victim … or as members of a social group oppressed by the able-bodied, or as stigmatized individuals. (39)

Gabel makes this distinction to analyze further the language of “mental illness,” stating that from her own experiences with double depression; there are times when she feels neither mental nor ill. Yet the whole of the experience is disabling, and there are as many physical symptoms as there are cognitive or emotional. Gabel’s description of the constructivist nature of disability parallels the discursive/material divide within feminisms on many levels. From the nature/nurture debate to the essentialist/oppressive patriarchy camps, the body/mind dichotomy has historically functioned to illuminate women’s position in society, even (and especially) within the frameworks seeking to overthrow oppression. To me, this driving demand to separate our experiences as women, as people with disabilities, into a category of either materially predicted or discursively written only further casts a regulatory eye on us, rather than illuminating how we have agency over our own lives.

Interestingly, these are the same dichotomies that exist within the institution of medicine. One problematic within disability studies (and feminisms, to some degree) is the steadfast refusal to acknowledge that psychiatric medicine, along with alternative medicine, is subordinated to the privileged somatic medicine. The oppressive factors of psychiatry and psychology
notwithstanding, in the whole of human health medicines, these have traditionally occupied dubious positions. In *The Myth of Psychotherapy: Mental Healing as Religion, Rhetoric, and Repression*, Thomas Szasz relies heavily on the use of rhetorical analysis to debunk the legitimacy of psychotherapy, all under the auspices that, by the 1970’s, “an appreciation of rhetoric has all but disappeared from contemporary consciousness” and that Sigmund Freud’s development of psychotherapy was greatly influenced by the Socratic Dialogues (9). Ultimately Szasz views Freud “as a great rhetorician rather than a great scientist” (127), and that psychotherapists are doing the equivalent of what politicians do: persuade their audience (12). Despite the praises for appreciating rhetoric, Szasz’s critique of Freud relies on the still popular misconception that rhetoric (like feminisms) is a “dirty word,” synonymous with manipulation and control, a stratagem of any given politician.

Szasz’s critique represents the extreme of the antipsychiatry movement, yet he does highlight an important point: “In the relationship we now call psychotherapy, there are two persons, patient and therapist, both of whom talk. The patient talks mainly in the language of symptom and illness; the therapist, in that of treatment or cure.” This is a marked turn from previous medical practices that avoided such equipotent doctor-patient communication or emphasis on the patient’s experiences. And, though Szasz also reminds us of the many ways Freud and Jung resisted the medical model of mental health (Jung preferred to
face his patients rather than sit behind them, for instance), Szasz is nonetheless dismissive of them both, and of psychiatry as a whole.

The medical model is, intractably, at the center of critique in current scholarship on disability. Susan Wendell reminds us in The Rejected Body: Feminist Philosophical Reflections on Disability that “the social authority of doctors, researchers, and other medical professionals derives partly from their cognitive authority within and outside their profession and partly from their positions within powerful institutions, their social status, and their professional and social status” (117). She further reminds us that medical authority “operates far beyond medical institutions – inside and in relation to government bureaucracies, insurance companies, courts, schools, charities, rehabilitative organizations, and institutions of long-term care” (117). Wendell then points to a driving force behind disability studies, Irving Kenneth Zola, to show that in the 1970’s psychiatry came under attack. Zola and others charge the psychiatric profession with “becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law. [Medicine] is becoming the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts” (118), noting that this extends to the medical profession in its entirety. As Wendell

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40 Thomas Szasz and R. D. Laing are the primary figures in initiating the anti-psychiatry movement, who, paradoxically, are both psychiatrists. Their claims, too, strike a certain legitimacy as they are imbricated in that which they debunk. At the same time, their extremism is what makes them equally less credible amongst other psychiatrists and patients who willing (and necessarily) rely upon psychotropic medicine and healthcare.
points out, Western societies are far more likely to contest scientific medicine’s cognitive authority to describe our minds than they are our physical bodies. Moreover, it is this suspicion of psychiatry’s scientific validity, and its conflicting views on cause and treatment among its practitioners, that puts the field at odds with the medical model of disability (118).

Part 2: Setting Some Standards: Kay Redfield Jamison’s Heroics in Recovering Psychiatry

The contradictions in feminisms and disability studies bear much weight on their relationship to psychiatry and the field of mental health care. What further then can be said of these fields at odds with one other? What momentum can be gained by placing them in conversation with each other? Of all the memoirs and autobiographical accounts of mental health written within the past two decades, I believe Kay Redfield Jamison’s *An Unquiet Mind: A Memoir of Moods and Madness* strikes the most fascinating blow to the stigma surrounding mental illness, likely because of the contradictory subject position in which she, as both doctor and patient, is located. Following Wendell and Zola’s view, Kay Redfield Jamison and her works occupy both positions of medical authority and medically authorized, as she both *writes* the medical discourse and is *written by* it. Most importantly though, I find this intersection extremely valuable in paving the way towards a praxis and theory of good mental health care. The danger of an all or nothing focus on a medical/social model is that real lives are at stake, recovering lives that need not just empowerment but betterment and wellness.
The corpus of Jamison’s research has contributed significantly to bridging the gap between the medical and social models of disorder, as well as establishing her authority on mental illness. Jamison co-authored *Manic-Depressive Illness*, which became the “standard medical text on manic-depressive illness,” chosen in 1990 by the America Association of Publishers as the “Most Outstanding Book in Biomedical Sciences.” *An Unquiet Mind* was a 1995 *New York Times* best seller for five months. In 1997, *Time* magazine named her a “hero of medicine;” in 2002 she won the $500,000 Genius Award from the John D. and Catherine T. MacArthur Foundation for her contributions to medical science. Of her status at the John’s Hopkins Medical Institutions as a full professor teaching only one day a week, Department of Psychiatry Director Raymond DePaulo states, “Although very few people who take part-time faculty positions at Hopkins advance to become full professors…With her … it was a slam dunk. I mean, she was the world expert” (Vastag).\(^4^1\) Jamison does, it seems, have medical clout. She is an expert on an elusive illness, and she is an expert in communicating what the experiences of this illness are like. Jamison readily tells her audience, however, why it was such a difficult story to tell, why “coming out” was, in fact, a serious risk she was compelled to take.

Jamison is not, of course, the first physician to write an autobiography or memoir about their experiences as doctor or patient. Specifically, in 1952

Eustace Chesser published *Unquiet Minds: Leaves from a Psychologist’s Casebook*. What is important about this work is it marks the standard practice of the day, a doctor’s analysis of his patients’ troubles (or, case study), in the midst of emerging asylum reform work such as Olivia de Havilland’s *The Snake Pit* (1948) and Erving Goffman’s *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961). More interesting, though, is William Sargant, who wrote *The Unquiet Mind: The Autobiography of a Physician in Psychological Medicine* in 1967. A promising “London-bred … Methodist,” Sargant experienced fatigue and depression in 1934 due to, he claims, a then undiagnosed tuberculosis lung infection, and again in 1954 post-diagnosis. Overall, his autobiography is more a categorical description of his experiences with his patients and the history of psychiatric healing pre- and post-World War II, and not a reflection on his own experience as a patient. Sargant speaks

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42 Chesser’s contribution to psychology was in his liberal sex therapy, whose efforts towards the decriminalization of homosexual acts eventually opened way for the gay liberation movement. His 1956 *The Sexual, Marital and Family Relationships of the English Woman* was likened to the American Kinsey Report, and was the largest UK report on women.

43 Case studies are undoubtedly problematic to disability studies. They typically construct the person as a patient who is nothing more than the sum of the illness, symptoms, and curability, and a means to a publishing end. Leonard Cassuto, however, makes a compelling argument in “Oliver Sacks and the Medical Case Narrative,” praising the much contested Sacks “as someone who is trying to open a new authorial space for talking about disability” (118). I argue the same praise, or *epideictic*, for Kay Redfield Jamison. For Cassuto’s work please see *Disability Studies: Enabling the Humanities*, eds. Sharon L. Snyder, Brenda Jo Brueggemann, and Rosemarie Garland-Thomson. New York: MLA, (2002).

44 These dates are of some consequence to the history of mental illness. Historians of psychiatry commonly agree that World War I marks the beginning of war pensions being
intermittently about his own “unquiet mind” and his strong drive to work and personal commitment to psychiatry. Yet, current scholarship points to a more intriguing reading of Sargant’s experience with depression.

In “Self, Crisis, Illness: Medical Narratives in the Autobiographies of British Male Authors From the Nineteenth and Early Twentieth Centuries,” Michael Neve points out that at the time of his first tuberculosis crisis, Sargant was most likely experiencing severe depression as a reaction to a stressful environment. At the onset of his medical career, Sargant had prodigiously proposed scientific research involving high-level iron doses for pernicious anemia. At the age of 25, he had become a radical interventionist amongst his peers. Unfortunately, the treatment failed, and Sargant reacted to the fallout by failing to show for the Royal Society for Medicine meeting in which the matter was to be discussed. Instead, he showed up as a locum at Hanwell Mental Asylum, where he later reroutes his career to psychiatric medicine. Neve states that those close to Sargant were “convinced that he disguised his mental illness as unresolved TB not only because of stigma. Much more alarmingly, an ambitious young doctor and an ambitious new therapy had gone badly wrong. He kept his mental illness

paid out for neurological and psychiatric disabilities as distinct from physical disabilities, though there are contradicting reports that during World War II these pensions were withheld. It is also of great consequence that Sargant’s most recognized work was in mind control, brainwashing, and implanting false memories. See “War Pensions 1900-1945: Changing Models of Psychological Understanding” in The British Journal of Psychiatry (2002) 180: 374-379. http://bjp.rcpsych.org/cgi/content/full/180/4/374.

private but, within the autobiography, named a physical foundation for it.” Neve points out that Sargant names the illness but is silent as to its real origin, succumbing to the stigma of mental illness, though the very event prompts him to build his career on suppressing that same stigma. Sargant became an advocate of bridging somatic medicine with psychiatry, evangelically supporting psychosurgical medicine such as electroconvulsive shock therapy and psychotropic medications over psychoanalysis or talk therapy, and, ultimately, resisting the medical model of psychiatry at the time. While his own experiences with an unquiet mind do not revolutionize the practice of psychiatric medicine, his work does, though arguably for the detriment of psychiatry.

This information serves as a microcosmic backdrop of autobiographic works preceding Jamison’s *An Unquiet Mind*. While the authors garnered notoriety for their practices, Chesser and Sargant were not celebrated for writing about them as Jamison has been. The most obvious way in which Jamison resists the medical model of autobiographic medical accounts is by writing about her experiences as both doctor and disordered patient. The primary subject of her memoir is, of course, herself. She injects sporadic anecdotal stories of her patients to illustrate a larger point, usually about herself, but does not present a traditional case study of either her or her patients. More remarkable, though, is the way she establishes her authority: by positioning her experiences of resisting traditional medical education, her own diagnosis and treatment, and the
macrosoms of institutions (all of which are part of the medical model of disorder) as fundamental to her recovery as well as her narrative.

Resisting and Rebuilding Institutional Forces: The Authority of Disorder

Jamison begins her memoir recalling one of her first major manic episodes, where at 2 a.m. she and a colleague are running through the UCLA medical center parking lot. When a police officer spots them and questions, “What in the hell are you doing running around the parking lot at this hour?”, her colleague has the answer: “We’re both on the faculty of the psychiatry department.” As Jamison (perhaps wryly) puts it: “Being professors of psychiatry explained everything” (4). Indeed, Jamison was always acutely aware of institutional authority. Her father was both scientist and air force pilot, and Jamison grew up in the military environment: schooled at the air force base, candy-striping at the air force hospital (and later the DC psychiatric hospital), and attending numerous military social functions, Jamison was happily, though sometimes defiantly, wed to the institution. For Jamison, the military represented the best and worst of tradition. It offered insulation, security, and comfort to have such a structured existence, yet it also made her very aware of what it meant to be an intense, somewhat mercurial girl in an extremely traditional and military world. Independence, temperament, and girlhood met very uneasily in the strange land of cotillion … where officers’ children were supposed to learn the fine points of manners, dancing and other unrealities of life. (27)

Here Jamison also learned of the staunchly gendered nature of the military, for instance, when she was sorely reprimanded for resisting to curtsy like the rest of
the “Sheep.” Refusing to obey an adult in this hierarchical context of “military custom and protocol,” especially for a little girl, was “a declaration of war.” Yet Jamison ultimately believes the military to be “a society built around a tension between romance and discipline: a complicated world of excitement, stultification, fast life, and sudden death” (29). This is a world she will always be drawn to because there, “Expectations were clear; excuses were few” (28).

Resistance of/in Education and Learning from Resistance

The same contradictions within the conservative military that Jamison ambivalently embraced as a young girl, she later found embedded within the institution of education. When her father retired from the Air Force, her family moved from Washington to California, uprooting Jamison when she had only just begun to “[feel] firmly rooted” “in the midst of … changes and paradoxes” (30). During high school, she was ever more keenly aware that she experienced life differently than her peers: disappointments and enthusiasms more profoundly effected her, however great or small. She spent much of her youth “pass[ing] as normal”46 in silence, as her WASP upbringing dictated “that you kept your

46 The notion of “passing” really deserves at least a chapter unto itself. Like other identity categories (race, class, gender, sexuality), passing has played a tremendous role in the lives of people with disabilities, particularly those with invisible disabilities, and especially those with psychiatric disorders. I'd suggest disordered people are, in fact, always already passing, a state that suggests the fluidity of (in)sanity, the mutability of “normalcy.” For further discussion on disability and passing please see Brenda Jo Brueggemann’s Lend Me Your Ear: Rhetorical Constructions of Deafness, Rosemarie Garland Thomson’s introduction to Freakery: Cultural Spectacles of the Extraordinary Body, and Tanya Titchkosky’s “Coming Out Disabled: The Politics of Understanding” in Disability Studies Quarterly Fall 2001 21:4 131-139. For examples of current memoirs that tangentially (and uncritically) address “passing,” please see Amy S. Wilensky’s
feelings to yourself” (39). Undercutting the structure and traditions of intellectual life were intermittent cycles of “a light, lovely tincture of true mania” (37) chased by torturously black depressions. In a sense, her indebtedness to institutional traditions aided in her resistance to tell family or friends of what she knew internally was “quite terrible wounds to both [her] mind and heart” (39); she suffered in silence, though later she wonders how she ever managed to survive on her own, when, during those months, she “aged rapidly ... as one must with such loss of one’s self, with such proximity to death, and such distance from shelter” (40).

College life at UCLA brought further struggle for Jamison; it was “a recurring nightmare of violent and dreadful moods spelled only now and again by weeks, sometimes months, of great fun, passion, high enthusiasms, and long runs of very hard but enjoyable work” (42). During these bouts of immobilizing depression and cosmic manias, however, Jamison encountered her first serious progression into the mental health field. During a psychology course in personality theory, her vivid written responses to a Rorschach test elicited interest by the course professor, who found her answers extremely “imaginative.” Here Jamison points out her indebtedness to the professor’s authority, his kindness in calling her “creative” rather than “psychotic”: “It was my first lesson in appreciating the complicated, permeable boundaries between bizarre and original thought, and I remain deeply indebted to him for the intellectual tolerance.
that cast a positive rather than pathological hue over what I had written” (47).

This led to a job offer for Jamison, as the professor’s lab assistant, which she found “not only a source of education and income, but escape as well” (47).

Nonetheless, the independence and flexibility found in the research component of academic life aside, Jamison struggled with her moods.

Disordering the Academy, or Does the Academy Disorder?

A recurring problem for some academics with psychiatric disabilities is that our time clocks are set differently than most others. We live by the quarter or semester system, our workloads double, treble, in waves. Our schedules are never consistent. Pressures to “publish or perish,” “conference or collapse” loom over us constantly. For any academic, these demands can produce stress, anxiety, and depression; for the person with a disability requiring accommodations, it can be twice as time consuming and twice as stressful to

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47 I am not suggesting all academics with psychiatric disabilities encounter difficulties with adapting to their work or schooling, nor am I suggesting that people with disabilities others than psychiatric do not also experience adaptation difficulties. I do suggest that college is a primary stressor, particularly for students predisposed to certain disorders. Developing consistent routines in one’s life is vital for people with disorders, students and teachers alike, and that may be difficult given the oftentimes unpredictability of academic life.

48 Accommodations for students with disabilities is a complex enough issue, but when moving to graduate students and professors with disabilities, the complexities multiply. While a great deal of conversation regarding this latter issue takes place on academic list serves and message boards, not as much as been written about it. I suspect this is in part due to the relatively tenuous position graduate students and untenured professors hold. Not rocking the boat may be a strategy to simply gain entrance into the boat. I also suspect that the difficulty in accessing accommodations for academics with disabilities is similar to the experiences of women in the workforce during pregnancy. Seeking paid
keep to the academic time clock. And for academics with depression or anxiety already, the rigors of academia can be overwhelming. Jamison is no exception. She notes: “University administrators do not consider the pronounced seasonal changes in behavior and abilities that are part and parcel of most manic-depressives. … My mercurial moods and recurrent, very black depressions took a huge personal and academic toll during those college years” (48). For a year, though, Jamison found solace in studying at the University of St. Andrews in Scotland, where she thrived personally because “The medieval traditions of learning and religion were threaded together in a deeply mystifying and wonderful way... It was, it is, a mystical place” (51).

It is also at St. Andrews that Jamison reads Williams James’ *The Varieties of Religious Experience*, “the great psychological study” that captivates her into choosing psychology for her career. Equally important, though, is the rhetoric of experience (or rather, the rhetoric of experiencing the disorder) at work here. She realized her “mercurial temperament and physical restlessness were going to

maternity leave is an obstacle many women face today, despite significant health care reform over the past few decades.

49 This point may seem anecdotal, yet it is actually crucial in understanding and preventing mental illnesses. The college years are problematic for several reasons. One, this is typically the age when predispositioned mental illnesses will present themselves. Two, the stress, lack of sleep, new environment, temptation towards risky behaviors such as drugs, alcohol, and sex, all play a role in provoking or exacerbating any type of disorder. Add to this the demanding schedules for both college students and teachers, and the unforgiving timelines, and you have a potential for disaster. I will further address these points in my chapter on cyber support groups, but please see Richard D. Kadison and Theresa For DiGeronimo’s *College of the Overwhelmed: The Campus Mental Health Crisis and What to Do About It*(2004).
make medical school … an unlikely proposition” (53). Additionally, her love of research and writing, and her preference for learning on her own led her away from traditional medical school and towards a psychology Ph.D.

Upon return to UCLA from Scotland, furthering this choice was Jamison’s “extraordinary experience” as a research assistant for a professor who “was immensely creative, curious, and open-minded; difficult but fair in his intellectual demands; and exceptionally kind in understanding [her] own fluctuating moods and attentiveness” (53-4), facilitated in part because he “was himself inclined to quick and profound mood swings.” Jamison and her professor, however, shared another less benign experience, the experience of stigma. Neither sought professional help during these black times, and were extremely resistant to trying psychotropic medications. They believed their “depressions were more complicated and existentially based than they actually were … Antidepressants might be indicated for psychiatric patients, for those of weaker stock, but not for us” (54). It was an attitude Jamison would later recognize as costly: “our pride and upbringing held us hostage.” Indeed, the traditions of the military and her admittedly WASP upbringing resounded in a medical profession already particularly shrouded by the stigma of mental illness. When she finally decides she should seek psychiatric help for her moods while in graduate school, she instead buys a horse. Her logic: “Since almost everyone I knew was seeing a psychiatrist, and since I had an absolute belief that I should be able to handle my own problems, I naturally bought a horse” (55). Despite Jamison’s “insider’s
view” of psychiatric illnesses, she was not yet able to mesh academic with personal experience.

The Professional Meets the Patient: Denial as Resistance

As Jamison moves from the study of experimental to clinical psychology, her professional and personal experiences remain painfully at odds:

Despite the fact that we were being taught how to make clinical diagnoses, I still did not make any connection in my own mind between the problems I had experienced and what was described as manic-depressive illness in the textbooks. In a strange reversal of medical-student syndrome, where students become convinced that they have whatever disease it is they are studying, I blithely went on with my clinical training and never put my mood swings into any medical context whatsoever. When I look back on it, my denial and ignorance seem virtually incomprehensible. I noticed, though, that I was more comfortable treating psychotic patients than were many of my colleagues. (58-9)

Denial is a strange sort of resistance, and often consequentially devastating. And while Jamison doesn't directly name stigma here, this is what she is glossing. During her candystriping days as a teen, she remarks similarly of an outing to St. Elizabeths, the federal psychiatric hospital in D.C. Remembering their childhood taunt, “You'll end up in St. Elizabeths” (22), the candystripers “were nervous during the bus ride over to the hospital, giggling and making terribly insensitive school-girlish remarks in a vain effort to allay our anxieties about the unknown and what we imagined to be the world of the mad.” Yet during the tour, Jamison tells us that through her fascination and fright, she feels some kinship: “Some part of me instinctively reached out, and in an odd way understood this pain,
never imagining that I would someday look in the mirror and see their sadness and insanity in my own eyes” (25).

Throughout her schooling, Jamison is undoubtedly aware of the long and tortured history of the stigma of mental illness. Coupled with her conservative upbringing, it is no wonder that she cannot connect her own personal experiences with a medical context, pathological or otherwise. Yet, she increasingly connects with medical patients. Indeed, “[m]ost of [her] real education came from the variety and large number of patients [she] evaluated and treated during [her] predoctoral clinical internships” (61).

Writing and Unwriting the Language of Disorder

As a doctoral student, Jamison also begins to flesh out the accuracies and inaccuracies of medical language. For instance, the same Rorschach test that had earlier won Jamison a confidante and some credibility now met her with an “entirely humorless and doctrinaire psychoanalyst … interpreting in the most fatuous and speculative manner” (61) the personality tests taken by Jamison’s then husband. Her superior psychopathologized him as sociopathic and deeply disturbed, while Jamison knew him to be an artist, honest, and “quite singularly straightforward and gentle” (61). The absurdity she found in this misdiagnosis is not lost on the many people familiar with psychological testing and diagnostic practices in general. It is, in fact, one of the primary complaints by the anti-psychiatry movement and psychiatric survivors. Similarly, I suggest this is a place where disability studies is most likely to concern itself with mental health and the
doctor/patient relationship. Rightly suspicious of medical diagnoses, which rely steadfastly upon seemingly arbitrary but dangerously rigid medical language, a disability studies analysis would charge psych-iatry/ology with enforcing the medical model of disability.

In “Institutionalizing Disability Studies: Research Methodologies and the Quandary of Over-Analyzed Populations” (2005), David T. Mitchell reminds us that “Michel Foucault spent his research career arguing that excessive diagnosis and the evaluation of bodies within categories of pathology proved to be the characteristic form of oppression in the modern period” (par. 3). This oppression, of course, continues into the 21st century, as “people with disabilities recognize the oppressive force of diagnosis and evaluation all too viscerally for many have spent their lives beneath the judgmental surveillance of medicine and rehabilitation” (Mitchell). What is oppressive is not just the diagnosis itself, but the cultural weight it carries, the stigma and stereotypes. With the Rorschach tests, Jamison experiences both the benefits and the detriments of diagnosis. But Jamison makes, I believe, a more compelling distinction about the language of disorder. She tells us that while she is indebted to her training in psychotherapy, she also

shed much of the psychoanalytic language as time went by … [she’d] never been able to fathom the often unnecessarily arbitrary distinctions between ‘biological’ psychiatry, which emphasizes medical causes and treatments of mental illness, and the ‘dynamic’ psychologies, which focus more on early developmental issues, personality structure, conflict and motivation, and unconscious thought. (59-60)
By medical language, she is a psychiatrist; in practice, her methodology (or, her pedagogy), is that of both psychologist and psychiatrist. More importantly, Jamison is pointing here to a holistic look at the “patient,” rather than a reductive materialist or constructivist view.

A downfall of 20th and 21st century medicine is that it came to be organized and regulated more and more by insurance companies, pharmaceuticals, and corporate business in general. A hard distinction was drawn in patient care: the fifty minute hour that Freud brought to psychotherapy was “effectively” replaced by the five to ten minute meeting with a licensed pharmaceuticals dispenser. This great divide is less regulated, and a patient may expect either little to no control over how she uses the system, or she may be given unrestricted (and therefore, less informed) control over her care. In a university setting for instance, a student seeking mental health services may have the option to see only a neuropsychiatrist (and if so, for either medication management only or with light therapy), or she may additionally see a counselor or therapist. Further complicating these restrictions is that most services are available only within the network. In another setting, the choices may be less apparent. If one enters the mental health care system for the disenfranchised, there are limited resources. With limited or no insurance, finding doctors that both work for sliding-scale fees and provide adequate care leaves one with fewer still options. In some cases, a county or state’s system may have stipulations of its own, e.g. medication management must be accompanied by additional therapy administered by the
agency’s set of counselors. Jamison would appreciate, as I do, that these systems do not offer an option for medication management only.

A Lesson in Treating Disorder

In *An Unquiet Mind* Jamison rightly makes an important distinction between types of psychiatric treatment, yet amidst her own resistances to institutional forces, she also initially resists her own disorder and subsequent treatment for it. Ultimately, though, the consequences of this resistance persuade her to make the most important argument of all: manic depression is a real illness with pathological and environmental causes, but mostly, it is an illness needing pharmaceutical treatment. Despite the “tensions and unpleasantries” of the “arcane … and highly romantic” (62) academic world Jamison emerges a doctor, a label that garners much authority, even in the most tenuous of situations. Up to this point in her personal and academic life, Jamison has been able to pass as healthy. The frenetic manias Jamison experiences as a high school and medical student, with crystal clear thinking, an abundance of energy, grandiose thoughts, elation and euphoria, only foreshadow, however, the agitated, aggressive, psychotic mania she experiences three months into her professorship. Soon after being questioned while running around the psychiatry parking lot, Jamison spiraled past her “familiar levels of exuberance and into florid madness” (70). At the chancellor’s garden party Jamison exhibits all the classic telltale signs of mania: she flits from conversation to conversation, exhibits excited speech, is dressed uncharacteristically provocatively, thinks herself “splendid” and
“captivating” while others remember her as “frenetic and far too talkative
...manic” (71). And soon after the party, her “enthusiasms going into overdrive”
(72), she photocopies Edna St. Vincent Millay’s poem “Renascence” and gives
them to thirty or forty of her colleagues, along with copies of an *American Journal
of Psychiatry* article about religion and psychosis, and a prominent psychologist’s
article on “Why I do Not Attend Case Conferences.”50

These acts are not so unusual in themselves, except that the poem was
meant to enlighten her colleagues with a “metaphorical description of the
psychotic process and the important possibilities in a subsequent renewal” (73),
and the article was an elucidation of all “the reasons why teaching rounds, when
poorly conducted, are such a horrendous waste of time.” While her colleagues
enjoyed the descriptions (and break from hard scientific reading), Jamison
doesn’t make the connection between the poem and her own increasing mania,
or the excessiveness of her actions; rather, she just knows that these all have
some “prescience” and “meaning” for her. In the midst of these telltale signs,
however, Jamison steadfastly resists even the thought of a manic-depressive
diagnosis. After mounds of bills piled up from excessive and Unaffordable
shopping sprees (twelve snakebite kits, three Rolex-type watches, twenty
Penguin books to “form a colony,” possibly shoplifted blouses, a stuffed fox
despite being an animal lover, etc.), fragments of unexplainable poems or notes
(“God is a Herbivore,” found in her refrigerator by the spice collection), the

50 That Jamison chose to circulate a resistant text is again telling of the ways she (and
other people with bipolar disorder) might gravitate towards an episteme of resistance.
increasing inability to finish a thought or listen to music for more than three minutes, Jamison experiences a delusion so frightening she calls a colleague who immediately administers lithium, thus beginning her “mind being reigned in, slowed down, and put on hold” (74-79, 83).

In 1974, lithium had only had FDA approval for four years in the United States.51 While she is also temporarily given antipsychotics52 and other drugs for this initial mania, which is common when treating mania aggressively, it is the lithium Jamison repeatedly resists. The side effects are harsher (some are even permanent) for antipsychotics than for lithium, and benzodiazepines are addictive. Yet, like so many others, Jamison repeatedly falls into the cycle of believing the medication works for her, then believing she no longer needs it once it remains effective long enough. This is a chaotic dance I, too, have many times courted. For Jamison, not the violent mania she experiences which ultimately cost her her first marriage, and not the attempt to take her own life with a lithium overdose convinces her she needs to remain on the drug. Nor is it that lithium is an ineffective or unsafe medication, as she repeatedly states there is compelling evidence to the contrary (101); it is, in fact, a greatly effective and

51 By 2005, this means Jamison has been on lithium for thirty years, which, I strongly believe, makes her an authoritative voice of experience for lithium’s efficacy, both personally and professionally.

52 She is given Thorazine, which actually is an antipsychotic, as well as Valium (a benzodiazepine), and barbiturates. To be clear, antipsychotics are exactly that: they stop psychosis. Psychosis is a multi-layered term in psychiatry, with specific criteria that has to be met for each particular diagnosis, including mania or depression with psychosis. In this context, Jamison’s hallucinations constitute mania with psychosis.
safe drug. Instead, Jamison is caught up in the “rhetoric of enthusiasm”: she does not want to lose her manic self.

The Rhetoric of Enthusiasm: A Life Beholden to Moods

Jamison steadfastly believes in a rhetoric of moods, and that this comprises our sense of self. For her, “moods are such an essential part of the substance of life, of one’s notion of oneself, that even psychotic extremes in moods and behaviors somehow can be seen as temporary, even understandable, reactions to what life has dealt” (91). And, depression and mania are certainly persuasive. It was actually the rhetoric of enthusiasm, of the manic self, that led Jamison to initially resist psychopharmacological therapy, and not any intrinsic inefficacy on the part of lithium. Euphoric mania is intoxicating, so much so that it seduces one to believe the profound depression that without fail follows a manic episode is worth it. For Jamison, she felt “a horrible sense of loss for who [she] had been and where [she] had been. It was difficult to give up

53 For this phrase I am indebted to Clement Hawes, who has written one of the most compelling accounts of mania in relation to literature, Mania and Literary Style: The Rhetoric of Enthusiasm from the Ranters to Christopher Smart (1996). Hawes envisions the “manic text” to be not just infused with “a … claim to supernatural authority” (a clinical definition) but also “invoking, through the key theme of divine election, a historical arena of ideology and political struggle” (2). It is noteworthy that in his “Epilogue: Beyond Pathology,” Hawes draws attention to Jamison’s Touched with Fire: Manic-Depressive Illness and the Artistic Temperament, stating that it “is best read as a cautionary tale about the reduction, in the context of a neuropsychiatric disciplinary imperialism, of one level of reality to a supposedly more elementary, more real level. Thus for Jamison the neurobiological level is understood as prior to, and far more important than the psychological and social levels” (231). What is more important here, or at least more troubling, is that nowhere in Touched with Fire does Jamison name herself as manic-depressive, though it was published in 1993 and she devotes a section on lithium treatment, noting how common patient noncompliance is for this drug.
the high flights of mind and mood, even though the depressions that inevitably followed nearly cost [her her] life" (91). She admits that she compares her different selves: her best self is when she is mildly manic; her ‘normal’ self is when she is compliant with lithium. Lithium (or ‘normalcy’) made her “blend into a three-piece suit schedule, which, while comfortable to many, is new, restrictive, seemingly unproductive, and maddeningly less intoxicating” (92), and is “far removed from when [she was her] liveliest, most productive, most intense, most outgoing and effervescent.” As Jamison puts it, “for myself, I was a hard act to follow.” Even the clinician and scientist part of Jamison’s identity couldn’t accept all the research literature spelling out “the inevitable, bleak consequences of not taking lithium” because “the intensity, glory, and absolute assuredness of [her] mind’s flight made it very difficult for her to believe, once [she] was better, that the illness was one [she] should willingly give up” (91).

So for Jamison, taking lithium started out as “a war,” with “an army of reasons … gathered in [her] mind to form a strong line of resistance to medication” (92). And resist she does, for a number of years and a number of reasons. The persuasiveness of mania, with all its expansive enthusiasms, high energies, and ecstatic moments, is, for some, addictive. Addictive enough to persuade Jamison she doesn’t need to take medication, who “had become dependant on [the] intensity, euphoria, assuredness, and [the] infectious ability to induce high moods and enthusiasms in other people” that being manic provided her (98).
This is not to say that other factors weren’t involved in Jamison’s “war with lithium.” Unfortunately, there really were some extremely harsh side effects when Jamison started lithium treatment. Currently she takes a controlled release version, as do I, which allows for far fewer disruptions in our everyday lives. Initially though, the worst side effects for Jamison were the inability to read for more than a few minutes at a time, and the inability to focus on, comprehend, and remember the academic and medical materials she was accustomed to. This, of course, furthers the sense of “losing one’s self,” and in turn further builds a case for resistance. Jamison’s response to this loss of ability is interesting, in that she takes a relative standpoint: “Few medical treatments, as [her doctor] pointed out, are free of side effects, and, all things considered, lithium causes fewer adverse reactions than most. Certainly it was a vast improvement on the brutal and ineffectual treatments that preceded it – chains, bloodletting, wet packs, asylums, and ice picks through the lobes” (103). I have to agree. I much prefer the weight gain, memory loss, and skin disruptions that lithium has caused me than to have an ice pick through any of my lobes, frontal, temporal, or otherwise.

If the Moods Betray You, Can Compliance Save You?

The brutal side of mania, though, finally won out. Eventually Jamison does practice medication compliance, and reaps the benefits of it. Recall that the National Consensus Statement on Mental Health recovery includes non-linearity as one of the ten fundamental components of recovery: “Recovery begins with an
initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to full engage in the work of recovery” (1). In addition to the lithium balancing her moods, it shows Jamison that her medication provides opportunities: the opportunity to find relief, to heal, and to make choices. Because lithium works for her, she can imagine the choice of having manic-depression, or not. In the end, she would choose to have it (though treated), because she recognizes the rhetorical power of the illness. It is a persuasion of many sorts, of many directives: “It is, at the end of the day, the individual moments of restlessness, of bleakness, of strong persuasions and maddened enthusiasms, that inform one’s life, change the nature and direction of one’s work, and give final meaning and color to one’s loves and friendships” (216). And again, Jamison’s personal and professional experiences with manic-depression and psychotropic medication influence her methodology.

Jamison takes to task “those individuals - especially psychiatrists and psychologists – who oppose using medications for psychiatric illnesses” (102) as well as “those clinicians who somehow draw a distinction between the suffering and treatability of ‘medical illnesses’ such as Hodgkin’s Disease or breast cancer, and psychiatric illnesses such as depression, manic-depression, or schizophrenia.” Jamison’s fervor that manic-depression be treated as any other illness echoes the tension within the disability community and within disability studies itself. By 2005, one could argue that over-medication is now the problematic norm, that perhaps something rings true in the emphatic yet deluded
pleas of popculture celebrity Tom Cruise and antipsychiatry cults such as Scientology. While better medication management is almost always needed in psychiatric healthcare, I also tend to agree with Jamison’s sentiments that “with rare exception, it is malpractice to treat [manic-depression] without medication” (102). It is not necessarily the medication itself that is problematic, but rather the administration of it. Those in the anti-psychiatry movement typically disavow psychopharmaceutical therapy wholesale, which, in my opinion, renders their practices and theories suspect.

In Radical Feminist Therapy: Working in the Context of Violence, for instance, psychologist and academic Bonnie Burstow offers nothing therapeutic for those who have chemical imbalances, and in fact agrees with Szasz that mental illness is “a metaphor that is treated as if it were a literal truth and is backed up by the power of the state” (22). She spends the whole of her book denouncing psychiatry and psychotropics, and offering advice for therapy based on the assumption that psychiatry is wholly evil. In Irit Shimrat’s collection Call Me Crazy: Stories from the Mad Movement, Burstow tells of her own personal experiences with psychiatry, which include a couple of forced hospitalizations and a father who repeatedly (and voluntarily) had electroshocks. Understandably, Burstow dismisses psychiatry in its entirety. But for every person who suffered at the hands of psychiatry, there are hundreds, thousands more who have been
helped.\footnote{Martha Manning, clinical psychologist and author of Undercurrents: A Life Beneath the Surface (1995), describes her own experiences with depression so severe and medication resistant that she turned to Electroconvulsant Shock Therapy (ECT), which she credits as saving her life. ECT is still considered a last resort treatment, despite great improvements in its safety. Yet to completely discredit ECT, is to discredit those who have been helped by it.} While Burstow does offer salient strategies for understanding and dealing with particular mental health issues (e.g. the coming out process for lesbians, histories of violence and abuse, demystifying terms such as “histrionic personality disorder” by replacing it with “being more emotional or spontaneous than androcentric males are comfortable with”\footnote{Burstow includes a list on “Demystifying the Psychobabble” (248-249) which is simultaneously humorous, instructive, and erroneous. All terms buy into the assumption of psychiatry having complete power over the person. This, in effect, reifies a position of power: the antipsychiatry movement knows better than the “patient” what is wrong with her, what helps her, and what does not. Who, then, is the agent in this context?}, Burstow is also greatly anti-feminist in her approach.

I do not negate the horrific treatment thousands of women (and men) have suffered at the hands of psychiatry and institutionalization, nor do I negate that these abuses still exist to a lesser degree. Yet, the assumption that all women are incapable of determining whether their state of health is either rooted in something biological, or if it is, as Burstow puts it, “existential” and “rooted in systemic oppressions-classism, sexism, and racism in particular” (1, xvi), and the assumption that these origins are mutually exclusive, is as totalitarian as those institutions and people who are systemically oppressive. What is unfortunate is that otherwise, Burstow is very much on the right track, and even offers a section on “women with disabilities” in Radical Feminist Therapy, in which she...
understands the real disabilities to be socially constructed and are related to issues of access of various sorts. That she cannot make that connection towards understanding the experiences of those who do comfortably and voluntarily identify as having real mental illness, or are in real need of and will benefit from medication, is problematic.\textsuperscript{56}

\textit{A Thin Line, A Sliverish Gap: The In-between Spaces of the Doctor/Patient Relationship}

The side effects of lithium and the stigma of mental illness notwithstanding, it is also the diagnosis itself that Jamison initially resists, then comes to terms with.\textsuperscript{57} Telling each new boyfriend or husband to be that she was manic-depressive were dreadful experiences, lithium or no. Fortunately, Jamison’s intimate relationships were mostly with other doctors, and upon breaking the news she was often met with clinical questions of how she experienced the illnesses, how she treated it, and so on. While Jamison appreciates the medical interest, she is nonetheless very concerned “with how knowing that I have manic-depressive illness will effect people’s perceptions of

\textsuperscript{56} Jamison credits lithium for many valuable things, including “[making] psychotherapy possible” and keeping her from “ruining [her] career and relationships,” but perhaps more importantly, for keeping her “out of a hospital, alive” (88). Jamison steadfastly refuses hospitalization, knowing she would not benefit from this. She is, after all, acutely aware of the inner workings of psychiatric wards. But again, I see (or, I experience) lithium as offering that choice, that clarity of mind to make a choice.

\textsuperscript{57} Perhaps it is really the stigma of mental illness that persuades Jamison to write a strictly “scientific” reading of “manic-depressive illness and the artistic temperament” in \textit{Touched with Fire} rather than include her own experiences or personal interest in the subject.
who I am and what I do” (202). “There is a thin line” she tells us, “between what is considered zany and what is thought to be –a ghastly but damning word- ‘inappropriate,’ and only a sliverish gap exists between being thought intense, or a bit volatile, and being dismissively labeled ‘unstable’.” That Jamison dreads being labeled “weak” or “neurotic” because of her suicide attempt and depression far more than she fears “being seen as intermittently psychotic” further points to the ways in which Jamison resists being misrepresented.

During the initial years of living with manic-depression, Jamison is particularly haunted by the fear of losing clinical privileges and disrespect from her colleagues because of her illness. She recounts numerous occasions such as when she is told by a tearful male colleague that he was “deeply disappointed” that she had attempted suicide, that he had thought she “was so wonderful, was so strong,” and “it was such an act of cowardice” and “selfish” (200). Yet nowhere does this fear of loss take stronger hold than that space between being both doctor and patient. Jamison provides us a window into the damningly binaristic world of manic-depression, laid over by that equally intense positioning of doctor-patient.

“[W]ithin three months of becoming a professor, I was ravingly psychotic” (63) Jamison tells her readers. Seeking treatment for Jamison meant also crossing the great divide between doctor and patient in a terribly unpleasant way: “I was not only very ill when I first called for an appointment, I was also terrified and deeply embarrassed. I had never been to a psychiatrist or psychologist.
before. I had no choice. I had completely, but completely lost my mind” (84). Fear, of course, is one of the greatest persuaders: fear of losing her job and reputation, as well as her life, persuaded her to cross that divide. That same fear made her shake for what the doctor could, or could not tell her. And this is exactly the same fear any patient might feel when seeking medical treatment. The domain of a doctor’s office or hospital is sterile, off-putting, and for some, intensely nerve wracking. The waiting room is a singularly reductive space, where the patient becomes a surname, a set of symptoms, and is left to decode the etiquette particular to this space: should one make eye contact, or where to divert one’s eyes; if another patient is talking, singing, or moaning too loudly, should one ask the receptionist to shut him up or is it polite to do this oneself? Jamison has an added worry: she has become one of us. She notes: “Two other patients were waiting for their doctors, which only added to my sense of indignity and embarrassment at finding myself with the roles reversed – character building, no doubt, but I was beginning to tire of all the opportunities to build character at the expense of peace, predictability, and a normal life” (85). In the changing of guards, so to speak, from doctor to patient, Jamison passes from comfortable and confident to “confused and frightened and terribly shattered in all [her] notions of [her]self” because, she tells us, “[her] self-confidence, which had permeated every aspect of [her] life for as long as [she] could remember, had taken a very long and disquieting holiday.” Jamison’s sense of self and her building of character here does not just rest upon being confident and oriented;
rather it is rooted in the authority she has for being a doctor. As a patient, this authority is usurped, and she is well aware that “being on the wrong side of the desk was not going to sit very well with [her].”

That “thin line” and “sliverish gap” between being zany and inappropriate, intense and unstable, is the same space that exists between doctor and patient, particularly in Jamison’s case. It is the difference between being right and wrong, sick and well, pill-taker and pill-prescriber. More importantly here is that the experience created between Jamison-as-patient and her doctor led Jamison to later practice the kind of good doctoring she had experienced as a manic-depressive patient, and ultimately to her own optimal recovery. Jamison, in fact, has the strongest praises for her psychiatrist: “He was tough, disciplined, knew what he was doing, and cared about how he did it. He genuinely loved being a doctor, and was a superb teacher. … He turned out to be an island of rational thought, rigorous diagnosis, and compassion” (83-4).

Many of these characteristics, one could argue, are beneficial in any person, but especially so in a doctor. In fact, these characteristics sound strikingly like Jamison herself. More telling, though, is the impression his methodology has on Jamison:

Although he was adamant about the importance of early and aggressive medical treatment for psychotic patients, he also had a genuine and deep belief in the importance of psychotherapy in bringing about healing and

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58 This collapsing of the space between doctor and patient is played out in the lives of many people with psychiatric disorders. Being informed about one’s diagnosis and treatment is habitual when one needs prolonged medication or medical attention, as the chapter on cyberspace communities shows.
lasting change. His kindness to patients, combined with an extremely keen knowledge of medicine, psychiatry, and human nature, made a critical impression on me. (84)

This line of treatment aligns with Jamison’s distaste for “the often unnecessarily arbitrary distinctions between ‘biological’ psychiatry … and the ‘dynamic’ psychologies” (59-60) in diagnosis and treatment. Jamison attests to the need for both medication and psychotherapy, which is a great departure from the realities of medical practice today. The corporatization of mental health often leaves little space or time for joining psychopharmacology and psychotherapy, yet this is an important factor for many people with disorders in rebuilding a sense of self and agency. Jamison is insistent on the efficacy of both medication and therapy, that she “cannot imagine leading a normal life without both taking lithium and having had the benefits of psychotherapy” (88). To lithium she attributes prevention: from “disastrous but seductive highs,” depression, disordered thinking, career and relationship destruction, hospitalization. To the other, she assigns the power of restoration: “ineffably, psychotherapy heals. It makes sense of the confusion, reins in the terrifying thoughts and feelings, returns some control and hope and possibility of learning from it all. Psychotherapy is a sanctuary; it is a battleground.”

Finally, though, Jamison is beholden to both: “It is an odd thing, owing life to pills, one’s own quirks and tenacities, and this unique, strange, and ultimately profound relationship called psychotherapy.” And while Jamison eventually learns compliance, like many people with disorders, she initially resists, and hard.
For Jamison, the experience of being the patient is unnerving; unnerving to have to answer the medical history questions she is used to asking her patients, unnerving not to “know where it all was going” (86), and “unnerving to realize how confusing it was to be a patient.” Yet, this process gained her “a new respect for psychiatry and professionalism.” As a patient/doctor, this renewed faith in medicine also teaches Jamison good doctoring skills. These are invaluable lessons for her, as she occupies both subject positions continuously, and sometimes even simultaneously. Jamison is constructing here the ethos of a “good doctor,” in which she is imbricated as well. Again, experience is deeply rooted in what constitutes for her a good doctor: “Gradually, his experience as a physician, and self-confidence as a person, began to take effect, much the same way that medications gradually hold and calm the turmoil of mania” (87). His experience as a doctor also allows him another important characteristic: clarity. In receiving a diagnosis a patient, as Jamison was, may be frightened yet relieved:

He made it unambivalently clear that he thought I had manic-depressive illness and that I was going to need to be on lithium, probably indefinitely. … The thought was very frightening to me … but all the same I was relieved: relieved to hear a diagnosis that I knew in my mind of minds to be true. Still I flailed against the sentence I felt he had handed me. He listened patiently … to all my convoluted, alternative explanations for my breakdown ... and he remained firm in his diagnosis and

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59 This is not to say that all (or even most) doctors are clear, or unbiased, or that their straightforwardness is always productive. Rather, in this instance, from one doctor to another (and from doctor to patient), Jamison appreciates this clarity.

60 Jamison notes the possible causes for her “breakdown”: “the stress of a stressed marriage, the stress of joining the psychiatry faculty, the stress of overwork” (87). I don’t
recommendations for treatment. I was bitterly resentful, but somehow greatly relieved. And I respected him enormously for his clarity of thought, his obvious caring, and his unwillingness to equivocate in delivering bad news. (87)

Jamison’s resistance to and relief from diagnosis are common. Resistance is, after all, a double-edged sword. To know you might resist something means to know (or at least, believe) that what you are resisting is wrong, either totally or in part. Logically then, you know something else to be better or more right than what you are resisting. But there is that space in between that says maybe what you are resisting isn’t entirely wrong, or your alternative is not entirely right. It’s this friction that, in some ways, makes resistance possible (and desirable) in the first place. In *Yearning: Race, Gender, and Cultural Politics*, bell hooks tells us:

Resistance is that struggle we can most easily grasp. Even the most subjected person has moments of rage and resentment so intense that they respond, they act against. There is an inner uprising that leads to rebellion, however short-lived. It may be only momentary but it takes place. That space within oneself where resistance is possible remains: It is different than to talk about becoming subjects. That process emerges as one comes to understand how structures of domination work in one’s own

want to downplay the gendered nature of her comments, because there is a certain reality to this. The 70’s undoubtedly were still rife with gender inequality in the medical professions, as Jamison tells us when her parents “never tried to discourage [her] from becoming a doctor, even though it was an era that breathed, If woman, be a nurse” (21). And even within the psychiatry profession, women tended towards child psychiatry while Jamison was in adult psychiatry. When she makes tenure, which Jamison notes “is the closest thing to a blood sport that first-class universities can offer: it is intensely competitive, all-consuming, exciting, fast, rather brutal, and very male” (124), a colleague tells her ruefully: “Congratulations Professor, …Welcome to an all-men’s club” (135). Gender tensions are inevitably a factor in Jamison’s life and illness. Yet, Jamison rightly asserts that while women are seemingly more likely to experience and seek treatment for depression than men, manic-depression is equally likely to occur in men or women (122-123). Of course, current research shows that the disparity between depression in men and women is likely due to the differences in cultural gender roles, expectations, and so on.
life, as one develops critical thinking and critical consciousness, as one invents new alternative habits of being, and resists from that marginal space of difference inwardly defined. (15)

Again, that space within (or in between) is that space where Jamison is constructing the “good doctor,” as well as inventing her own ethos of experience. As the rhetoric of enthusiasms persuades her to resist compliance with medication for the first decade of treatment, her doctor “was never seduced into losing sight of the overall perspective of how costly, damaging, and life-threatening [her] illness was” (88), and because he was “at ease with ambiguity, had a comfort with complexity, and was able to be decisive in the midst of chaos and uncertainty,” Jamison finds in him not just good doctoring, but good teaching as well:

Although I went to him to be treated for an illness, he taught me, by example, for my own patients, the total beholdeness of brain to mind and mind to brain. My temperament, moods, and illness clearly, and deeply, affected the relationships I had with others and the fabric of my work. …my moods … were powerfully shaped by the same relationships and work. The challenge was in learning to understand the complexity of this mutual beholdeness and in learning to distinguish the roles of lithium, will, and insight in getting well and leading a meaningful life. It was the task and gift of psychotherapy. (88)

By pointing to both the difficulties and the payoffs of psychotherapy (and by extension, psychopharmaceutical therapy), Jamison delivers what the prospects of having good medical attention might be at the same time as humanizing the medical profession of which she is a part.

When she is “absolutely and single-mindedly determined to make a difference in how the illness was seen and treated” (126) Jamison helps to set up
and run the UCLA Affective Disorders Clinic, where again she emphasizes medication therapy in conjunction with talk therapy, and she not only relies on but is encouraged by her colleagues to use her own experiences as a patient to inform her methodology: “Rather than using my illness as a reason to curtail my clinical and teaching responsibilities, [my chairman] – after being assured that I was receiving good psychiatric care … encouraged me to use it to try to develop better treatments and to help change public attitudes” (130). In many ways, Jamison’s sentiments regarding what made her experience as a mental health patient beneficial are akin to the social model, or more particularly, a feminist social model of disability. For instance, in the trialogue “What Her Body Taught (or, Teaching about and with a Disability: A Conversation,” Brenda Jo Brueggemann, Rosemarie Garland-Thomson, and Georgina Kleege offer insight into “accessing the academy” that I believe applies to Jamison’s subject position as doctor/patient. Part of the agenda for disability studies, they remind us, is a two-pronged integration: for people with disabilities to have access to positions of authority, representation, and persuasion, and for disability to be recognized cross-discipline as a valid and valuable category for critical analysis (27). Brueggemann, Garland-Thomson, and Kleege embody this integration, then, being professors with disabilities in higher education and in classrooms teaching disability studies. For Jamison, this extends to being a disordered

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61 Feminist Studies 31, no.1 (Spring 2005).
doctor teaching and treating people with disorders. In these contexts, the integration is successful.\(^6^2\)

I want to point out that while Jamison does offer us a model of good doctoring in *An Unquiet Mind*, she also presents an idealized version of good doctoring that I think is akin to the ways in which academic feminisms have historically excluded those not in such privileged and valued positions (women of color, lesbians, the working class). Because Jamison is a doctor herself, she both can and cannot afford the best of medical attention. In this instance, good doctoring is ideal, if not essential, to recovery. Admittedly, she receives optimal attention from her doctor, who over the years was there through every monumental part of her life. Jamison tells us that “He kept me alive a thousand times over. He saw me through madness, despair, wonderful and terrible love affairs, disillusionments and triumphs, recurrences of illness, an almost fatal suicide attempt, the death of a man I greatly loved, and the enormous pleasures and aggravations of my professional life” (87). That Jamison’s doctor can see her “through the beginnings and endings of virtually every aspect of [her] psychological and life” is a rare feature specific to the sort of doctor/patient subject position in which Jamison is located. More importantly, it is atypical to the

\(^6^2\) In *The Rejected Body*, we see another context of successful integration. Here, Susan Wendell, a professor who has Chronic Fatigue Syndrome (Myalgic Encephalomyelitis), defines herself as writing as both feminist philosopher and disabled. Similar to Jamison, Wendell also distinctly defines disability as being both biologically and socially constructed, maintaining that “the distinction between the biological reality of a disability and the social construction of a disability cannot be sharply made, because the biological and the social are interactive in creating disability” (35).
medically impoverished reality in which most people with disorders find themselves, where just finding a trustworthy, competent doctor can be a daunting experience, especially for disenfranchised patients. Healthcare is frustrating even under the best of circumstances, but often people with disorders find themselves disenfranchised and dispirited. A particularly salient piece of advice comes from the sardonic list Jamison gives us, “Rules for the Gracious Acceptance of Lithium into Your Life”: “Contemplate the similarity of ‘being patient’ and ‘being a patient’” (97).

Jamison’s eventual acceptance of a consistent medication regimen may seem to fall in the category Arthur Frank calls “restitution narrative,” or, stories that are marked by the “triumph of medicine” (115) rather than the narrator having agency in her or his own recovery. However, given the nearly universal experience of medication side effects ranging from uncomfortable to fatal, and the equally as likely subsequent refusal of medication, I suggest that when treating severe mental illness, the real triumph is not the medication itself or compliance with a medically regulated approach to healing. The triumph is in being willing to take medications that, for as much as we know about how and why they work, there is still that much more that we don’t know about them and the disorders they are meant to treat. The triumph is in being willing to endure the side effects long enough to let the medications do their work, to allow the medications the time to show us there is life outside the disorder so we can put our lives back together again.
Many of the ways in which Jamison sees manic-depression informing her life seem to be an essentialist reading of the self. She provides a rather materialist reading of the disorder and its effects on her feelings, her behavior, her profession, and her methodology. Yet, I take these accounts to mean she locates herself in a position to have agency, rather than the illness itself being the agent. In *An Unquiet Mind*, writing and informing are two of the most powerful actions she performs. Jamison’s experiences as both doctor and patient of manic-depressive illness not only gives her authority to write about the disorder, they give her occasion, a motive for writing. Jamison is clear from the beginning about why she is writing such an intensely private experience to be laid open by the public. She tells us how imbricated her experiences are:

> For as long as I can remember I was frighteningly, although wonderfully, beholden to moods. …by the time I began my professional life, I became, both by necessity and intellectual inclinations, a student of moods. It was the only way I know how to understand, indeed accept, the illness I have; it also has been the only way I know to try and make a difference in the lives of others who also suffer from mood disorders. (4-5)

I want to emphasize the layers of experience and understanding Jamison points to here. In order to understand herself, she had to understand the illness. In order to treat her patients, she has to understand her illness, which is also their illness (or akin to). That she is in the field of clinical psychiatry is because of her illness. And, some may argue, herself included, that she is who she is (intelligent, curious, motivated, persuaded by moods) because of manic-depression.
Jamison’s construction of herself as a person, a student, and a doctor heavily rests on being manic-depressive, and vice versa. In posing to herself the prescient question, “So why would I want anything to do with this illness?”, Jamison answers:

Because I honestly believe that as a result of it I have felt more things, more deeply; had more experiences, more intensely; loved more, and been loved more; laughed more for having cried more often; appreciated more the springs, for all the winters; worn death ‘as close as dungarees,’ appreciated it - and life – more; seen the finest and the most terrible in people, and slowly learned the values of caring, loyalty, and seeing things through. (218)

Here Jamison constructs herself as a having a life beneficially accentuated by illness, despite the tyranny of depression and the throes of mania. There is a recuperative value in this illness, so that the omnipotence Jamison feels because of her illness outweighs the pitfalls, counters the stigma of mental health, and sets Jamison as an example of good patient/good doctor. Jamison’s knowledge of herself and knowledge of her limits are what she can bestow on her patients, or, her audience:

I have seen the breadth and depth and width of my mind and heart and seen how frail they are, and how ultimately unknowable they both are. … And I think much of this is related to my illness – the intensity it gives to things and the perspectives it forces on me. I think it has made me test the limits of my mind (which, while wanting, is holding) and the limits of my upbringing, family, education, and friends. (218)

Jamison points to humanizing issues that would likely come up for any consumer in psychotherapy, or, “talk therapy,” and which do come up on her own road to recovery. And while Jamison does make clear her intentions for writing this memoir, she also illuminates the risks she takes in being so public about such
intensely private experiences, an appeal to both pathos and ethos, as well as logos:

I have had many concerns about writing a book that so explicitly describes my own attacks of mania, depression, and psychosis, as well as my problems acknowledging the need for ongoing medication. Clinicians have been, for obvious reasons of licensing and hospital privileges, reluctant to make their psychiatric problems known to others. These concerns are very well warranted. I have no idea what the long-term effects of discussing such issues so openly will be on my personal and professional life, but, whatever the consequences, they are bound to be better than continuing in silence. I am tired of hiding, tired of misspent and knotted energies, tired of the hypocrisy, and tired of acting as though I have something to hide. One is what one is, and the dishonesty of hiding behind a degree, or title, or any manner of and collection of words, is still exactly that: dishonest. Necessary perhaps, but dishonest. (7)

In effect, Jamison is saying here “I am tired of passing,” and her need for honesty disrupts the normalcy constructed by the institution of medicine as well as by culture at large. Even though by the time An Unquiet Mind is published Jamison still has concerns about “outing” herself so publicly, we again see that certain benefits come with having manic-depression when she tells us “one of the advantages of having had manic-depression for more than thirty years is that very little seems insurmountably difficult. Much like crossing the Bay Bridge when there is a storm over the Chesapeake, one may be terrified to go forward, but there is no question of going back” (8). Her determination and endurance notwithstanding, it is her forthrightness which asks us: “I find myself somewhat inevitably taking a certain solace in Robert Lowell’s essential question, Yet why not say what happened?” (8). Why not indeed?
As part of her audience, I want to “say what happened” as well as give testament to the validity of Jamison’s (and others) claims for medication compliance. For many years I knew about *An Unquiet Mind* and *Touched by Fire*, and for many years I ignored these books. I didn’t think they applied to me: I wouldn’t be taking medication for very long, I didn’t believe I needed it, and there was certain fear that if I read these books, somehow I, too, would need to comply. It wasn’t until some time after I had read Jamison’s works, struggled with it, battled it in my mind, that I came to realize the doctors were right: I needed lithium, and likely some other medication, and I needed these indefinitely. My stories of mania may not be as beautiful as Jamison’s “gliding through starfields and dancing along the rings of Saturn” (221), or my stories of depression as grave as intentionally overdosing. But as Jamison points out, “People go mad in idiosyncratic ways” (90). Yet, I have my stories only because I learned to yield to compliance and balance this with my own intuition. Jamison tells us: “It took me far too long to realize that lost years and relationships cannot be recovered, that damage done to oneself and others cannot always be put right again, and that freedom from the control imposed by medication loses its meaning when the only alternatives are death and insanity” (6).

I believe Jamison without a doubt intends for her memoir to effect change, to matter, to persuade her audience that the theories of lithium are sound and should be put into praxis. Again, Jamison is very clear in her intentions for writing
a memoir as well as for practicing her own profession, and again, both rest on having manic-depression:

I am fortunate that I have not died from my illness, fortunate in receiving the best medical care available, and fortunate to have the friends, colleagues, and family that I do. Because of this, I have in turn tried, as best I could, to use my own experiences of the disease to inform my research, teaching, clinical practice, and advocacy work. Through writing and teaching I have hoped to persuade my colleagues of the paradoxical core of this quicksilver illness that both kills and creates; and, along with many others, have tried to change public attitudes about psychiatric illness in general and manic-depressive illness in particular. (6-7)

The scope of Jamison’s intentions is laudable. Most of us do not have the opportunities or even desire to occupy such a multivalent space as theorist, practitioner, educator, disordered. I want to emphasize here a particular action. Jamison wants to inform, to educate, but more importantly, to persuade. When she tells us in the acknowledgements to her memoir that there were two people who were most influential in “[her] decision to be open about [her] manic-depressive illness” (221), she reminds us again of the necessity of support.

Facing the stigma of mental illness Jamison surely found in her personal and professional life required not just her own strength but the power of support from others. To “Frances Lear, a longtime friend and generous supporter of [her] work” (221) she credits her encouragement: “She … made possible my mental health advocacy work and is, in many significant respects, responsible for my decision to write this book. Her support and belief in my work have made a critical difference in what I have been able to do during the past eight years.” I’d like to call attention to the nuances of advocacy work here. While Jamison likely
means the many ways in which she advocates in the out-patient manic-depressive clinic she set up because she was “absolutely and single-mindedly determined to make a difference in how the illness was seen and treated” (126), or in her class lectures, guest speeches, personal medical practice, and so on, I take this to also mean the way she advocates in her writing, particularly in *An Unquiet Mind*. Many of her other works are equally as compelling, but for different reasons.

*Touched with Fire*, for instance, is important because it historicizes and legitimizes the longevity of mental disorders through a scientific account of some of the greatest artists in the humanities, all of whose lives and works were affected by some kind of disorder. *Manic-Depressive Illness*, which she co-authored with Dr. Frederick Goodwin, is instrumental because it became the standardized scientific text on manic-depression, and was written by someone who has manic-depression, using some of Jamison’s own patients as case examples. But in the literal sense of “advocacy,” Jamison argues many important points in *An Unquiet Mind*. She argues for the efficacy of lithium, the importance of compliance, and generally that manic-depression exists and is treatable.

Yet, even with the best doctoring (and her doctor is the first person she credits in the acknowledgments, though oddly, this is also the first and only place she fully names him), she needs support from elsewhere, support that makes “a critical difference.” The other close friend who greatly influenced her to write this book is Julian Norwich, who she tells us “for some time, encouraged me to
discuss my manic-depressive illness more openly, and repeatedly stressed his belief that good will come from writing such a book” (222). Jamison assures us that the decision to be so public still did not come so easily, that Norwich “has countered all of my arguments for privacy with yet stronger ones for straightforwardness. He has been a wonderful friend, and I am indebted to him for his persuasiveness.” I should add here that her readers are then indebted to Norwich’s persuasiveness as well. The rhetoric of support then is more persuasive than the rhetoric of fear, such as the fear Jamison describes of losing her clinical privileges, or that her “professional anonymity in teaching and researching would be compromised” (203). Her fear lies in the thought that the residents and interns she teaches might defer to what they believe are her views rather than speak their minds, or that her colleagues might question her academic objectivity. Jamison’s fear that others see her as having an agenda, “a personal ax to grind” is not unwarranted. After all, her work is heavily touched by her personal life, and vice versa. And, this subject positioning is akin to other marginalized people: feminists, people with disabilities, people of color, and so on. The fear of being seen as “the bitter crip” or “the man-hating feminist” is widespread in academic and political circles alike.

Ethically Speaking, Just What is A “Good Doctor”?  

Finally, Jamison has to ask herself a potentially incriminating question: “Do I really think that someone with mental illness should be allowed to treat patients?” (204). That Jamison does treat patients, does practice medicine, does
write about her illness implies the answer: emphatically, yes, she really thinks someone with a mental illness, her in particular, should be allowed, encouraged even, to treat patients. And if we consider her reading audience her patients by extension too, then we have just participated in being treated by Jamison as well. Yet, Jamison points towards an even more important issue in questioning her own abilities to practice good medicine. While in disability studies (and in some ways, feminist studies) we commonly theorize about stigma, an almost always-overlooked area is stigma within the community of medical authority itself. Jamison’s fear of losing clinical privileges or being deemed unfit to treat patients is still very relevant. By the publication of her memoir, Jamison feels there is a certain turn towards an acceptance of disorders within the medical profession, yet statistics show otherwise. When she first tells her chair at Johns Hopkins she is being treated for manic-depression, she feels a strong sense of relief when he responds, "Kay dear … I know you have manic-depressive illness … If we got rid of all the manic-depressives on the medical school faculty, not only would we have a much smaller faculty, it would also be a far more boring one" (209). Yet the rhetoric of fear is strongly infused in the medical community, and as Jamison

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63 With a nod towards classical rhetoric, note that as Diotima once authoritatively passed her wisdom of love onto Socrates in the Symposium, so too does Jamison pass her wisdom of medicine onto her readers. And in return, as Socrates passes this wisdom along to his friends, so too should Jamison’s readers.

64 I hold the same sentiments for Departments of English, large or small; I suspect all the department lore of oddballs and eccentrics really owes much to various diagnosable disorders.
points out, there is a higher propensity towards disorder in the medical community than in the general population, and most physician suicides are due to the very treatable depression and manic-depression (208). That doctors turn towards self-medicating is not surprising (who has better access to drugs than doctors?), but these addictions can be as deadly as simply leaving a disorder untreated; the consequences can be deadly for both the doctors and their patients. Jamison makes a general appeal to healthcare to address this stigma: “Hospitals and professional organizations need to acknowledge the extent to which untreated doctors, nurses, and psychologists present risks to the patients they treat” (208), and then moves to a more direct appeal towards good doctoring: “But they also need to encourage effective and compassionate treatment and work out guidelines for safeguards and intelligent, nonpaternalistic supervision.”

Susan Wendell outlines an ethic of care in The Rejected Body, drawing from the two trends current feminist philosophy grapples with and which, she notes, “have important implications for the lives of people with disabilities” (139):

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65 I want to point out here the idea that medical professionals are at higher risk for having depression or manic-depression than those in the arts directly contradicts the general theme for Jamison’s research in Touched with Fire. The main premise for her research in this text is that writers, painters, poets, and so on have a greater propensity for these disorders, and it is these disorders that fuel their work. Nowhere in this work does Jamison claim she herself is manic-depressive, which I suspect is because she is not “out” in her profession at the time of its writing. But the very fact that she is also in the sciences and that she can accurately claim doctors are at a higher risk directly undercuts the importance of her work in An Unquiet Mind when read with Touched with Fire, unless one actively employs a certain rhetoric of reading, which I will address in full in the chapter on Lauren Slater’s Lying and Welcome to My Country.
The first is the question of how to combine an ethic of care, which emphasizes relationships and responsibilities to care for others who need care, with the traditional morality of justice, which emphasizes individuals and their rights, duties, and freedoms. The second is a question of what to do about the traditional ethical ideals of autonomy and independence, which feminist ethicists have criticized for reflecting the lives of some men far more better than the lives of most women: should these ideals be retained, revised or rejected? (139)

For Wendell, and for many disability scholars and feminists alike, “analyses by people who have some experience of disability, especially those with feminist perspectives, must be considered in any adequate treatment of these questions.”

More than anything, I want to (re)emphasize the importance of experience here, and suggest that this ethics of care extend to include those experiences of people with disabilities who are also caregivers. The larger scope of Wendell’s ethics and politics of care does include considering the perspective of those who are both caregivers and in need of care, rather than the typical and singular vantage point of the person giving the care. However, most of Wendell’s structuring for this ethic focuses on familial caregiving, or otherwise “physical disabilities” caregiving. A larger question would be, “how does this apply to mental health caregiving?” especially when someone occupies the dual role of patient/caregiver, as Jamison does, and, as she suggests, thousands of people secretly do. We can further see the state of affairs in healthcare when Jamison assures us that

Doctors, of course, need first to heal themselves; but they also need accessible, competent treatment that allows them to heal. The medical and administrative system that harbors them must also be one that encourages treatment, provides reasonable guidelines for supervised practice, but also one that does not tolerate incompetence or jeopardize
patient care. Doctors, as my chairman is fond of pointing out, are there to treat patients; patients should never have to pay - either literally or medically – for the problems and sufferings of their doctors. (208)

Jamison’s beliefs are strikingly similar to those of disability studies and the disability community. “Accessibility” and “reasonable guidelines” are directly related to the language of the ADA. Yet, in the province of disability studies, there have been few steps to envision the inaccessibility of mental healthcare as an important place of critical analysis and progressive praxis.66 While volumes of scholarly works castigating lack of access to education, employment, architectural space, and so on, are in the forefront of disability studies, its social constructivist eye has not yet truly acknowledged what I see as the greatest social disability of all: the 46 million Americans who lack health insurance.67 I also see this dangerous lack of access to health insurance (and therefore health care, diagnostics, medications) as a violation of human rights, as well as another reason why we need doctors who are themselves patients to speak up, to acknowledge their need for treatment and a better system of care for all.

66 Cynthia Stankiewicz of the Equal Employment Opportunity Commission (EEOC) has written much about accessibility and rights in the workplace for people with psychiatric disabilities, and there are numerous scholars who have addressed mental illness in general, particularly depression and women with depression. Likewise, there are healthcare and mental healthcare’s inaccessibility, but not enough from within disability studies itself.

67 These statistics are from August 30, 2005, according to CBS News.com, though they vary, much the same way estimates of total Americans with disabilities vary. Yet, regardless of whether it’s 45, 54, or 34 million people, this is still an outrageous number.
CHAPTER 2

Invention, Intention, and a Conversation about *Lying*:

A Rhetoric of Reading for Recovery

In “Resisting Readers and Reading Effects: Some Speculations on Reading and Gender,” Julie Rivkin tells us:

Any convincing account of reading as a woman would have to account for the process by which one comes to a certain critical stance. Moreover, the term ‘stance’ is misleading, because it implies a unity and stability that is utterly alien to the experience of reading. What I would wish to substitute for stance is a sense of the historical layering and complex and often conflicting cultural investments that condition any given act of reading.

(15)

While I do not take issue with the term “stance” as Rivkin seems to indicate here, I do wonder what exactly she finds to be misleading: is the physicality of the term “stance” deceptive, or is she cautious of stance as a metaphor? Taking a stance is the rhetorical act we as readers do/choose/perform, and as audience, we constantly take a stance that may rightfully and helpfully be unified. Although we may not be able to occupy every possible stance, we can (and have) come to understand, both in feminisms and disability studies, that there are neglected, privileged, and biased stances within our works. Hence, the emergence of
feminist race theory, queer theory, and other identity-based theories. Second and third wave feminisms are predicated upon this idea of difference, as is disability studies and disability theory. In *Feminist Stylistics*, Sara Mills explores the ways in which “those concerned with the representation of gender relations might draw on linguistic and language analysis” in order to “develop a set of tools which could expose the workings of gender” (198) from multiple levels within a text. Mills draws upon Rivkin’s point in “Resisting Readers” that, when we discover a dominant reading which positions us as male readers, this reading may not always be something to avoid. I suggest Rivkin’s criticism here of resisting a reading of a text because of its embedded ideological messages also means that “any convincing account of reading as a feminist critic, scholar, or practitioner would have to account for the process by which one comes to a certain critical stance.” This includes acknowledging whatever positions of privilege we might hold. Are we, as feminists, learning how to “read against the grain” in such a way that we are not just resisting the dominant readings, but reproducing the ways in which dominant readings are themselves produced? That is, do our critiques of feminists’ works take as their model a masculinist stylistics of reading, one which locates a dominant positioning within the text and forces the reader to read against this? So, for example, when I read Hélène Cixous’ “The Laugh of the Medusa,” and I locate a dominant positioning that is markedly essentialist, do I have to read against the grain of essentialism if I am a constructionist?
From a disability studies perspective, a similar argument might be made about the antipsychiatry movement. One the one hand, it is absolutely necessary to recognize those moments throughout history when the discourse of psychiatry, a decidedly masculinist discourse, has oppressed, abused, neglected, disenfranchised, erased, silenced, and otherwise harmed people with mental illnesses. At the same time, it is equally vital to recognize that this same discourse has helped many others with mental and emotional illnesses to find their way through recovery, to find their own voice in chaotic moments, and ultimately to give them safety, stability, and refuge when terrifyingly unsettled. Psychiatry has both taken and saved lives. Reading its discourse, then, becomes increasingly precarious, particularly when trying to merge a feminist and disability studies reading of a text into one.

To illustrate the ways that “against the grain readings” can be both useful and harmful for the progression of feminisms and disability theory, I will explore a text that has been called ethically problematic by disability scholars, but that I see as potentially trisecting feminisms, rhetoric, and disability: Lauren Slater’s *Lying: A Metaphorical Memoir*. Throughout this chapter, I will draw upon a feminist rhetoric of reading, which I define as having the following currents: multivalency, multi-intentionality, inclusiveness, recognition of differences both to celebrate and appreciate, while simultaneously seeking similarities, acceptance of a

68 The term “celebrate” has a distinct function in discursive practices of identity politics, particularly feminisms. I want to use this term loosely here to include understanding, recognition, and validation, as well as to observe, respect, and honor.
multiplicity of identities or non-identities, revisioning women’s lives, past, present, and future, and ultimately critiquing, appropriating, and subverting (when and if necessary) systems of power formerly and currently used to exploit, marginalize, oppress, silence, erase, and devalue humans, particularly women, and their myriad concerns. This articulation of a cross-cultural, transtemporal project(s) is pervasive and mutable, and might mean, at times, resisting explicit definitions of how one might go about practicing the theory(s).

In her video *Cultural Criticism and Transformation* (1997), bell hooks tells us “Being enlightened witnesses means becoming critically vigilant about the world we live in.” For me, this means not just the typical critical analyses I do in my everyday academic life, such as feminist theory, disability theory, and so on, but also to be hypersensitive towards teaching people to be aware of what disability is really like, particularly those disabilities I experience myself. And sometimes, eradicating the stigma of mental illness is a battle even within the disability and disability studies communities. When I discovered that there was to be a special issue about disability and prose for the journal *Prose Studies*, and that G. Thomas Couser, noted author of *Recovering Bodies: Illness, Disability, and Life Writing*, had written an article for this issue about Lauren Slater’s *Lying: A Metaphorical Memoir*, and that his reading of her text was less than
appreciative, I felt a call to be critically vigilant. So I wrote my own review of
Slater’s memoir to appear in that special issue of *Prose Studies*.69

Reading Couser Reading *Lying*: An Exercise in a Feminist Rhetorics of Reading

In “Paradigms’ Cost: Representing Vulnerable Subjects,” Couser notes the
types of life-writing texts concerning disability and illness that have emerged over
the past decade. A subset of these is

a related, but distinct, set of narratives in which the portrayal of aberrant
somatic states is not autobiographical. Such representation poses ethical
problems, especially when the conditions in question render the subjects
unable to represent themselves or even to collaborate in an informed way
with others who undertake to represent them. (20)

Therapists’ narratives about their patients are of course suspect, and Couser
names Slater’s *Welcome to My Country* as one such text “involv[ing] great risk
and invasion of privacy.” Herein lies a problem, though, as disability studies
criticizes the medical model of disability for its very lack of personalness, its
detachment from its subject. By writing about their subjects who have similar
disabilities, Lauren Slater, and in some cases, Kay Redfield Jamison are the
avenue for their narratives. These are stories otherwise left untold, rendered
unintelligible without the conduit of the writer’s voice offering their interpretation
of severely disordered language.

69 My review is woven into the remainder of this chapter. For the original review, please see: “When Rhetoric Meets Psychology: Invention, Intention, and the Epileptic Personality in Lauren Slater’s *Lying*.” *Prose Studies: Theory, History, Criticism. Special Issue: Disabilities and/in Prose.* Volume 27, issue 1 & 2 April & August 2005.
In “Disability as a Metaphor: What’s Wrong with Lying,” Couser tells us “for [him], the ethical crux of Lying is not that Slater may be lying about having epilepsy, but that in exercising prose license she commits herself to an essentializing and mystifying characterization of a still stigmatic disability,” and that her memoir “unnecessarily risks harm to a whole class of individuals through its central trope.” While I appreciate the problematics that Couser suggests are at stake by using epilepsy as a metaphor for another disability, I suggest that the metaphor really lies in another factor of Slater’s memoir: that is, in lying itself. Sometimes lying is about not telling the truth because, at that moment, in that place, the truth may hurt you. And telling the truth about being mentally ill can be sticky, precarious, and painful. Slater’s memoir describing her life as an epileptic is, in fact, woven together with bits and pieces of accurate information about epilepsy, as well as fragments of fantastical details that may or not be so accurate. Drawing again on Aristotle’s view of rhetoric, Slater’s most available means of persuasion is not just the experience of epilepsy as metaphoric for some other experience, but lying (and Lying) as a means of persuasion in and of itself. Lying is not a breach of ethics between writer and reader, physical disability and mental disability; it is an appeal to pathos\textsuperscript{70} by the means available to Slater: invention.

\textsuperscript{70} Lying is every bit an intricate appeal to both ethos and pathos. In the wake of other current memoirists such as James Frey (\textit{A Million Little Pieces}), Augusten Burroughs (\textit{Running with Scissors, Dry}), JT Leroy (\textit{Sarah}), Kaavya Viswanathan (\textit{How Opal Mehta Got Kissed, Got Wild and Got a Life}), Nick Sylvester (“Do You Want To Kiss Me,” \textit{Village Voice}), and Stephen Glass (\textit{The New Republic}), Slater’s work is the only one that clearly
Rhetoric Meets Psychology: Invention, Intention, and the Epileptic Personality in Lauren Slater’s *Lying*

I want to address the issue of lying first. Much scholarly work has been written about the act of lying, what it means, what its consequences are. The notion of an obtainable, desirable “truth” permeates virtually every discourse from history to culture, from politics to religion. If we are to believe the Greek Stoic philosopher Epictetus, “Liars are the cause of all the sins and crimes of the world.” A less damning view comes from philosopher and ethicist Sissela Bok, in *Secrets: On the Ethics of Concealment and Revelation*: “While all deception requires secrecy, all secrecy is not meant to deceive.” The former view is akin to early historical views of both the disabled and women as morally weak, criminal, or defect, particularly those with psychiatric and developmental disabilities. \(^{71}\)

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states (from its title no less) that it is not meant to be read as straight fact. Not only does she advise us throughout the book she may or may not be telling the truth (and subsequently, she may or may not be telling lies), she theorizes (and complicates) the notion of truth throughout *Lying*. Alcoholism plays a large role in Frey and Burroughs works. But unlike the others, with the exception of Burroughs (who, incidentally, is facing a lawsuit by the psychiatrist’s family he depicts in *Running with Scissors* in ways they claim are largely sensationalized and fictional), Slater did not plagiarize or appear on international television claiming all the events of *Lying* are true or even accurate. To me, her character is intact precisely because she did lie and did clearly state that she was lying. The others, particularly James Frey, had no intention of getting caught lying, rather, they meant for their work to be their own words, their own experiences, as written. Their character, rightly or wrongly, is in question. The very genres of memoir and autobiography have always necessitated questions of *ethos*. By the 21st century, however, access to the Internet and blogging have made it far easier (for readers and writers) to build or destroy one’s character.

\(^{71}\) Consider the earliest models of disability, the moral or religious models. Disability was often constructed as a punishment for real or perceived sins. Not only was the person with the “defect” accountable, but the entire family might be shamed. Please see Deborah Kaplan’s “The Definition of Disability.” Also, consider the emergence of insane
Bok’s view of deception perhaps sheds some light on Slater’s intention in *Lying*: while she keeps secret what (and why) her deception really is (does she have epilepsy, or does she not), she does not do this to deceive her readers, rather, to get at harder, less speakable truths.

Other important scholarship on lying comes from Adrienne Rich. In “Women and Honor: Some Notes on Lying” (1975), she tells us “It is clear that among women we need a new ethics” (195). As important as this sentiment was when Rich first wrote it, I believe it holds true even more thirty years later. For instance, despite the positive results of feminisms over the past three decades, media representations of women (and girls) still depict them as bitchy and backstabbing as ever. For evidence of this, we only have to turn to such popular television shows as *Desperate Housewives*, or reality shows that are anything but real, such as *Flavor of Love* and *The Bachelor*, where dozens of women compete for the “ultimate prize,” a man—or at the very least, the possibility of fame and fortune.

asylums. These were built to house people with a broad range of disabilities in the Middle Ages (mental illness, intellectual disabilities, poverty). Asylums functioned as jails or prisons, not as places for treatment or recovery. Centuries later, right up until deinstitutionalization in the 1950s, patients were often treated like inmates (See, for instance, Erving Goffman’s 1961 collection, *Asylums: Essays on the Condition of the Social Situation of Mental Patients and Other Inmates*). An interesting twist to this is that jails have become the asylums now, with studies showing that “More than half of all prison and jail inmates have mental health problems” <http://www.ojp.gov/bjs/pub/press/mhppjipr.htm>. Views of women as liars, sinners, criminals, or morally weak or defective permeate literature, philosophy, and religion throughout history. Some of the foundational texts on the construction of women include: Christine de Pizan’s *Le Livre de la Cité des Dames* (1405); Mary Wollstonecraft’s *A Vindication of the Rights of Woman: With Strictures on Political and Moral Subjects* (1792); Susan Griffin’s *Woman and Nature: The Roaring Inside Her* (2000); Gale A. Yee’s *Poor Banished Children of Eve: Woman as Evil in the Hebrew Bible* (2003).
These media representations of women are not nearly as problematic, however, as the reality of being a teenage girl in the 21st century. In 2002, Rosalind Wiseman’s *Queen Bees and Wannabes: Helping Your Daughter Survive Cliques, Gossip, Boyfriends, and Other Realities of Adolescence* became a bestseller, and in 2004, Tina Fey of *Saturday Night Live* adapted Wiseman’s book into the hit film *Mean Girls*. Wiseman and Fey foreground a serious issue in American culture: teen violence, and particularly violence amongst girls.\(^7\) Given

\(^7\) I offer the following headlining (and disturbing) events not simply as anecdotal evidence of the subculture of mean girls, but to reinforce just how prevalent, visible, and dangerous acts of female-to-female cruelty, hatred, and violence are in American culture: 1) Glenbrook North High School, Illinois – In May 2003, a ritual off-campus powder puff football game between junior and senior girls turned into a brutal hazing videotaped by student onlookers. 5 of the juniors required medical attention (stitches, fractured and broken bones), 28 senior girls received punishment by the school, and 12 were charged with misdemeanor assault and given probation and community service hours. During the hazing, the junior girls were slapped with dead fish, punched, kicked, choked with pig intestines, shot at close range with paint ball guns, hit with buckets, made to eat such things as human feces, mud, turpentine, Tabasco, and garbage. 2 mothers were also charged for providing beer for the event.

[http://www.cnn.com/2003/LAW/06/11/hazing.hearing/index.html?iref=newssearch](http://www.cnn.com/2003/LAW/06/11/hazing.hearing/index.html?iref=newssearch); 2) St. Louis, Missouri – In October 2006, 13 year old Megan Meier hung herself after a 16 year old boy she met on MySpace she believed had an interest in her sent her derogatory messages. The boy was actually a hoax made up by Lori Drew, the mother of one of Megan’s friends. Drew knew Megan was being treated for depression and ADD, but believed she was Megan was gossiping about her daughter, so she used “Josh” to find out what she was saying. Drew was indicted with conspiracy and fraudulence charges in 2008.

[http://www.cnn.com/2008.CRIME/05/15/internet.suicide.ap/](http://www.cnn.com/2008.CRIME/05/15/internet.suicide.ap/); 3) McKinney North High School, Texas – In 2007, reports surfaced about a group of cheerleaders dubbed the “Fab Five” who harassed and terrorized students and other teachers, including their coaches, and who posted illicit pictures of themselves in their cheerleading uniforms on MySpace. Their behavior was sanctioned by their many of the teachers, their parents, and even the principal (also mother of one of the Fab Five).

[http://www.associatedcontent.com/article/119469/mckinney_texas_school_being_terrorized.html?cat=8]; 4) Lakeland, Florida – In March 2008, a 16 year old girl was ambushed by 6 girls while 2 boys acted as lookouts. For over 30 minutes someone videotaped while Victoria Lindsay was beaten, harassed, and terrorized by the girls because of statements she made about them on her MySpace page. Lindsay sustained
the generational differences in views about what behaviors, actions, and representations are empowering for women, I believe that constructing a new ethics would be incredibly complicated. Similarly, Rich would agree that the notion of truth is equally complex:

In speaking of lies, we come inevitably to the subject of truth. There is nothing simple or easy about this idea. There is no ‘the truth,’ ‘a truth’ – truth is not one thing, or even a system. It is an increasing complexity. The pattern of the carpet is a surface. When we look closer, or when we become weavers, we learn of the tiny multiple threads unseen in the overall pattern, the knots on the underside of the carpet. (197)

_Lying_ gives us many threads to follow, to untangle, to reweave into a larger, clearer picture. And while Rich speaks directly to “relationships between and among women” (195) in “Notes on Lying,” the weight of her words impresses me as I read Slater’s work.

Though _Lying_ is overtly about epilepsy, the strongest undercurrents are about borderline personality disorder (BPD) and obsessive compulsive disorder (OCD). Rich offers a compelling point about lying that I want to extend to reading Slater’s work: “The liar lives in fear of losing control. She cannot even desire a relationship without manipulation, since to be vulnerable to another person

cuts, bruised, ear damage, and unconsciousness. The taped attack was uploaded to YouTube and MySpace videos, inviting public outrage, and criminal charges. All involved were initially charged as adults with battery and false imprisonment, but the charges against 3 (the two lookouts and the girl filming the attack) were eventually dropped. <http://www.postchronicle.com/cgi-bin/artman/exec/view.cgi?archive=65&num=141140>;

means for her the loss of control” (197). Throughout her memoirs, Slater reminds us that control is a key issue for people with OCD, that control of thoughts, behaviors, and emotions is something she (as well as her patients) struggles with. Throughout Lying, Slater also tells us that she exaggerates. In an interview\textsuperscript{73} with Alys Culhane, Slater reminds us that she stated this fact “almost obsessively” (Culhane 169) throughout the memoir. And, she takes ownership that she is an unreliable narrator, that from the beginning “the terms of the contract” are “spelled out clearly”: “An unreliable narrator lets the reader know that they’re not to be trusted and to let the reader beware. You proceed at your own speed and you shouldn’t feel angry about it because you’ve decided to take this trip with them” (169). I read Slater as giving up great control by allowing the reader to take this trip, to choose when to trust her and when not to.

Leigh Gilmore provides another strategic framework through which to read Slater’s works (and to some extent, Kay Redfield Jamison’s) in Autobiographics: A Feminist Theory of Women’s Self-Representation. For Gilmore, the term autobiographics describes not only “the elements of self-representation which are not bound by a philosophical definition of the self derived from Augustine, not content with the literary history of autobiography” (42), but also “those elements that instead mark a location in a text where self-invention, self-discovery, and self-representation emerge within the technologies of autobiography – namely, those legalistic, literary, social, and ecclesiastical discourses of truth and identity

\textsuperscript{73} Please see: Culhane, Alys. Slater, Lauren. Interview with Lauren Slater. Fourth Genre: Explorations in Nonfiction. Volume 7, Number 1, Spring 2005, pp. 157-172.
throughout which the subject is produced.” In inventing, discovering, and representing some truth, Slater positions herself as fluid, mutable, and not bound by a traditional narrative code of ethics. It is not that Slater is unethical; rather, she constructs her own code.

Reading with the Grain: Recovering Lying by Resisting Being a Resistant Reader

Couser is not alone in his criticisms of Lying and Slater’s representations of epilepsy. Since its publication, her memoir has received mixed reviews. In “Stranger than Fiction” (New York Times), Rebecca Mead states “Sickness demands compassion, yet one can be forgiven for wanting to throttle the narrator of [Lying] … This must be [Slater’s] intention, because Lying is a willfully slippery book” (par. 1).74 And in “It Could Be Fact or Fiction . . . or Something Else,” Janet Maslin merely wonders, “For what reason would [Slater] have concocted this book’s lovingly detailed auras and seizures? And…what would induce the reader to play along?” (par. 2).75 Still others are impressed with Slater’s memoir. Jeffrey L. Geller, Professor of Psychiatry, cites Lying as “her best outing to date”76 (par.

74 Mead’s review of Lying wavers between describing Slater as a “gorgeous writer,” and writing a book “reek[ing] of rat from the very first page” that “might appeal to a dedicated deconstructionist,” or might be found “unrewardingly wearing.” Please see: Rebecca Mead’s “Stranger than Fiction: Lauren Slater’s Latest Book Questions the Traditional Boundaries of a Nonfiction Memoir.” The New York Times. 16 July 2000 <http://www.nytimes.com/books/00/07/16/reviews/000716.16mead.html>.


76 Geller’s book review “Three Women Speak Again About Experiences With Mental Illness” also looks at Elizabeth Wurtzel’s More, Now, Again: A Memoir of Addiction and
12). He amplifies his praise in “Three Women Speak Again about Experiences with Mental Illness” by noting that

*Lying* can be highly recommended for a general readership. It should prove particularly interesting to therapists of all disciplines whose treatment is based on oral autobiographical material, notably psychoanalysis, psychodynamic psychotherapy, and narrative therapy. (par. 18)

Perhaps even more interesting are reviews from blogs entries such as “Lies, Lies Lies, Yeah: Lauren Slater’s Book *Lying,*”77 where British poet and novelist Sadi Ranson-Polizzotti tells of the secrets of her own temporal lobe epilepsy and the seizures that accompany this, how she was “shining the light away from [them]” (1), and how she “doesn’t want to talk about it anymore, and that is a lie of sorts.” Ranson-Polizzotti also tells us that “The world of the temporal lobe epileptic is a curious one in which the truth does not have a capital T. Instead, it bends and twists and curves, because what is experienced when you have epilepsy and what is actual are often divergent” (2). She grants many scenarios for why Slater knows so much about the experience of epilepsy: Slater does have it; someone she intimately knows has it; she has read a great deal about it, Susanna Kaysen’s *The Camera My Mother Gave Me*. Interestingly, Geller cites Wurtzle’s work as “too long,” that she “could have written the entire book in three sentences that she includes in the over 300-page account: ‘For all my life I’ve needed more.’ ‘I don’t want to wait for the answer.’ ‘I’ve already used everyone up.’” Geller also notes that of all the negative ways Wurtzel characterizes herself she forgets to add “entitled, narcissistic, self-centered, self-destructive, and a user, more of people than of drugs.” Geller is more appreciative towards Kaysen’s book about vaginal pain, primarily, and denouncing antidepressants secondarily, stating that “All health care practitioners should read this book.” Please see *Psychiatric Services*. 53:1338-1339, October 2002 <http://www.psychservices.psychiatryonline.org/cgi/content/full/53/10/1338>.

and so on. Ultimately, Ranson-Polizzotti finds Slater to be “eloquent and convincing in her telling of the topsy-turvy world of TLE,” noting that “One could just as easily take Slater’s symptoms and put them into a Borderline Personality template, or manic depression, and yes, TLE too.” What is interesting here is that others readers can also easily see Slater’s work as open to multiple interpretations, or, multiple intentionalities on the part of the author and reader.

Insomuch that Couser sees Lying as a “prejudicial misrepresentation” of epilepsy, I see it as settling a different truth: that mental illness diagnoses, particularly borderline personality disorder, are unsettling, they are damning, and they are evasive. In fact, BPD is the resurgence of the female hysteric (or is that redundant?) all over again. The disorder is widely misunderstood, misrepresented, and misdiagnosed. Like other disorders, such as bipolar and schizophrenia, the symptoms that constitute BPD have far reaching effects.

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78 Two other diagnoses that, like BPD, share an unsettling location in the DSM IV and in our culture are Munchausen and Munchausen by proxy syndrome, and postpartum depression and postpartum psychosis. Occupying the media’s limelight recently is the 2001 Texas case that “stunned the nation,” when Andrea Yates drowned her five children in their bathtub during a recurrent and severe episode of untreated postpartum psychosis. Initially she was found guilty of capital murder and imprisoned for life, but the decision was eventually reversed and Yates was committed to the Skyview Psychiatric Unit, division of the Texas Department of Criminal Justice. While these horrific events opened up a sorely needed conversation, the real question, for me, is why Andrea’s husband and caregiver, Andrea’s doctors at that time, the hospital that didn’t retain her, and the insurance that didn’t cover a longer hospitalization, were not held legally accountable. Their unaccountability points to a gravely flawed system of justice, as well the need for better awareness and understanding of these serious disorders. Another complication in the Yates case is that Andrea and her husband, Rusty, had been followers of fundamentalist Michael Peter Woroniecki, a fire and brimstone spiritual mentor likened to other cult-like leaders such as those in Scientology. Both religious groups, as well as many other extremist groups, hold a dangerous relationship to disorders that bears serious investigation.
Family members, caregivers, friends, even strangers will experience many of these difficult effects in relation to the person with the disorder. But borderline personality disorder lacks the upshot of mood or neurological/biochemical based disorders such as bipolar or schizophrenia. While we have a cultural belief (misguided or not) that “madness is connected to genius,” that certain disorders fuel the temperament and creations of artists, there is no corresponding belief about BPD.

In even the most innocent of circumstances, personality disorders in general are stigmatized, particularly because their symptoms are likely to be considered unwelcomed or annoying by others in relation to those with the disorders. Yet, many of the symptoms, separately, are a part of everyday experience. Consider Nancy Mairs foreword to Couser’s Recovering Bodies. She hypothesizes the doctor visit in which the patient receives news of a devastating illness. She describes the lonely wait in the cold, sterile office. The detachment far too many doctors hide in when delivering such news (for Mairs, multiple sclerosis; for me, bipolar disorder). And then, the reaction to such news: feeling “utterly alone” (ix), “lopped off from the social body” regardless of knowing how many others have been diagnosed with exactly the same illness, given the same prognosis of recovery. I follow Mairs’ logic up to here. I have experienced the same in my healthcare, and with the healthcare of others close to me. But Mairs’ next point gives me pause: “Fortunately, this histrionic state tends not to last. You set about doing whatever has to be done: buy a cane, go to physical or
occupational theory, schedule surgery, join a support group, revise your will” (ix). While I agree, again from my own experiences, that self-indulgent wallows in pity are not nearly as helpful as moving on to whatever the diagnosis necessitates, I do think it doubly questionable to label as histrionic the immediate crisis upon which one enters when told her life has infinitely changed.

“Histrionic” is a loaded term no matter how one approaches it. From a disability studies perspective, narcissistic pity is as deplorable as the pity invoked by rampant misrepresentations of people with disabilities as suffering and dependent.79 From the camps of feminisms, women’s feelings, actions, and thoughts have historically been stigmatized as whiney, complaining, and irrational, and constantly relegated to the realm of hysterics. A response from the medical community would call upon the DSM-IV-TR for the diagnostic criteria of histrionic personality disorder, which tells us “The essential feature of histrionic personality disorder is pervasive and excessive emotionality and attention-seeking behavior” (711). Other features are “theatricality,” believing relationships to be more substantial and reciprocated than they actually are, and being easily influenced (711-13). The differential diagnosis warns that this disorder is easily confused with other personality disorders, and sometimes even coexists with other disorders. As with most disorders, HPD should be distinguished from Personality Change Due to A Medical Condition, but this distinction only

accounts for circumstances “in which the traits emerge due to the direct effects of a general medical condition on the central nervous system” (713), and not feeling excessively unhappy, scared, or confused about experiencing a life-altering illness. Again, however innocent Mairs’ intention, and I do not think she means to invoke any of these particular troubling definitions; “histrionics” is as overdetermined a word as it is a state of being, carrying with it a history of stigma.

Reading Against the Grain: What’s at Stake?

What is at stake for feminisms when we “read against the grain” of feminists’ works? For me, in this particular set of discursive practices, reading against the grain works to illuminate women’s experiences with disability and disorder. Specifically, in Lauren Slater’s Lying, reading against the grain gets at that slippery slope of truth, the inarticulable, painfully mutable truth. For other readers, this active reading stance may give them a better insight into something they are unfamiliar with personally but understand is an experience that is both gendered and inscribed culturally and historically. I see a feminist rhetoric of reading as being both descriptive and prescriptive. It must work to align praxis with theory, to give discursive agency to those writing and reading about particularly painful experiences, to offer theoretical and practical support to women diagnosed with what might seem like baffling and damning disorders. In my reading of Lauren Slater’s texts, she demystifies the dominant reading of disorder by giving structure, giving face, to what is on the one hand constructed
as a death sentence, and on the other, a life sentence of chronic turmoil and colorfulness: borderline personality disorder.

Tania Modleski furthers Rivkin’s assumption that we can and should follow these dominant textual positionings: “For feminism it is not simply a question of affirming or denying the accuracy of patriarchal representations but of understanding what texts ... do, how they produce the very resemblances they are then seen to reflect” (51). Modleski encourages feminists to read for multiple positionings within a text, so that “the reader is never interpolated in a simple way as only a woman or only as a man; there will be multiple positionings and multiple negotiations with them” (Mills 79). When we extend this notion to feminists’ criticisms and our readings of these as feminists, we can opt not to interpolate ourselves into a singular positioning (e.g. a dominant reading which is markedly essentialist, when one is reading as an anti-essentialist), when there are the possibilities of negotiating a reading from multiple positionings. This is not to say we need to align ourselves entirely with the multiple positionings; rather,

80 And this holds true for disability studies: discourse analysis goes beyond recognizing misrepresentations of disability, seeing these as a symptom and a cause for the social construction of disability.

81 Modleski’s reading strategy lends itself well to reading Lauren Slater’s text Lying: A Metaphorical Memoir, as “lying” and “metaphor” by definition alone invite a plurality of readings. My reading of Lying comes from multivalent positioning (feminisms, rhetoric, disability studies), but I do not believe this multivalency renders my reader merely pluralistic; rather, it illuminates the complexities (and simplicities), by which these theoretical frameworks are connected. Many theorists cross-discipline have written in favor and against pluralism, but I take Lisa Ede’s review of Clifford Geertz’ On Rhetoric and Writing as a definitional starting point for this conflict. Geertz posits that “[p]luralism can encourage healthy diversity and conflict,” with the “resulting atmosphere of debate . . . making for a vital and alive field,” while Ede maintains it “can also be a dodge; it can leave important questions not just unanswered but unasked.” JAC 12.1 (1992)
we need to recognize the possibilities of those positions other than our own. Moreover, reading against the grain and reading for pluralities or multiple positionings need not be in contest with one another. Like Aristotle’s view of “rhetoric as the discovery of the available means of persuasion” (Available Means xvii), a feminist rhetoric of reading would allow a critique of the possibility of locating all of these readings simultaneously or separately. This is a rhetoric more about understanding all possible locations rather than insisting that one must situate oneself (or not situate oneself) as a feminist within a singular or multi-locality. Annette Kolodny addresses this very issue of accepting a multiplicity, or, plurality, of readings. In “Dancing through the Minefield: Some Observations on the Theory, Practice and Politics of a Feminist Literary Criticism,” she tells us:

Adopting a ‘pluralist’ label does not mean... that we cease to disagree; it means only that we entertain the possibilities that different readings, even of the same text, may be differently useful, even illuminating, within different contexts of inquiry. (251)

Though a pluralist reading can and should extend to any feminist’s readings of a text, I direct this, again, specifically to the ways in which feminists read other feminists’ texts. Because “possibilities” are something relatively new to women and feminists, in all areas of our lives, shouldn’t we let as many possibilities remain as open as possible for us, particularly when most systems of oppression are still in place? If feminisms are dedicated to enacting change for the betterment of women in all areas of life, however individually one defines
“betterment,” shouldn’t we also devote our energies towards bettering the academic field?

Was That in My Job Description?: Towards the Responsibility of Feminisms

Patricia Williams’ *The Alchemy of Race and Rights: Diary of a Law Professor* explores the tenuous reconciliation of race and rights, and makes a compelling statement that lends itself to my exploration of feminist rhetoric of reading. Williams reflects,

...one of the things I find most valuable about the insights of literary theory as applied to law is the recognition of some relation between reader and text, of looking at what the reader does to transform meaning: the issue of what you do with what you read is very important in textual interpretation. (81)

I see Williams here as calling attention to something very important to feminisms: that what we do as readers with what we read *matters*, that something happens outside of the text we are reading, even if we are reading a feminist(‘s) text. How we critique the internal text becomes itself an external text, one that is comparable to a text (or, character construction) lawyers might present in a courtroom to defend their client. The client and the client’s actions are the internal text(s), and the representation of the client the lawyer gives the judge and jury is the external text. At this juncture, the secondary text becomes as important as the primary; in fact, it may be as important as someone’s life or death.

Following this vein of literary criticism and responsibility of actions, I turn to a critic’s work on a celebrated literary text. In “The House a Ghost Built: Nommo,
Allegory, and the Ethics of Reading Toni Morrison’s "Beloved," William R. Handley offers a compelling exploration of “the ethics of responsibility” in reading certain texts. Briefly, Handley proposes that we as readers have an ethical and moral responsibility when reading Beloved’s story of slavery and its aftermath: “To know her, and to know this historical loss, is to know that we can’t know her or the historical loss she embodies” (687). In other words, we have to know that we want to “know” the experiences of African Americans during slavery and post-slavery, but to know these experiences we have the ethical responsibility of knowing that, as white and/or late 20th-century readers, we cannot possibly know the atrocities the same way those who actually lived them could. Additionally, a “recognition of otherness...is involved in responsible reading,” (694) according to Handley. So then, this ethics of responsibility aligns with what I see as possible feminist rhetoric of reading. Reading responsibly is about reading for understanding and appreciating differences, including theoretical differences.

In “Liberation Scenes,” bell hooks also takes to task critiques that do not carefully distinguish “a sense of conflict between pleasure and analysis” (7). When teaching her students the utility of cultural critiques, hooks feels that, as

82 I think it is interesting to note here hooks’ distinction between “critic” and “critique.” One could easily replace one word with the other in her reading, and the only difference in meaning would be that she takes to task the person rather than their words and ideas. I think her approach here is important for two reasons. For one, it shows a way in which we can be less “trashing” in our analysis’ of others’ works. She is not naming critics here, not generally or particularly - she removes herself from that counterproductive space. And, by not naming critics, bell hooks shows us that our work is something separate from us, at times, and that we have control over our critiques, as well as a responsibility to anticipate how these will be read.
with “any liberatory pedagogy, students should learn how to distinguish between hostile critique that is about ‘trashing’ and critique that’s about enriching and illuminating our understanding” (7) of the text and all its intricacies. Moreover, if social transformation is a goal of feminisms, then “Engaging in intellectual exchange where people hear a diversity of viewpoints enables them to witness first hand solidarity that grows stronger in a context of productive critical exchange and confrontation” (6). I stress here the productivity of these exchanges, because feminist engagements with other feminists’ texts can, at times, devolve into a masculinist, competitive grudge-match, or build up to a soapbox on which we stand to espouse our views. This happens across the board, I feel, in undergraduate classes, in graduate seminars, at paper conferences, and even in university elevators and hallways.  

Putting it on the Table: When Feminists’ Positioning as Readers Is On the Line  

When reading Patricia Williams’ *The Alchemy of Race and Rights*, I find Rivkin’s statement that we need to understand “the historical layering and complex and often conflicting cultural investments that condition any given act of reading” (15) an integral part of my response as a feminist. I need to acknowledge that Williams and I occupy, at times, very different spaces in terms of identity, whether I want to name categories or not. I can have an idea of what it  

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83 I base these comments on my own experiences as well as on scholarly reports or conversations “through the grapevine.” Admittedly, I have engaged in the kinds of trashing (and therefore, nonproductive) critiques I reference above, and I have been on the receiving end of such critiques.
means to be an African American woman who is a lawyer, but I cannot “know” this the same way Williams can. Therefore, to hold her views and actions (or non-actions) to the same scrutiny as I hold my own is to be unethical and irresponsible in my reading of her text. While reading *The Alchemy of Race and Rights*, if I wonder why Williams does not seem to fully “follow through” on her own example of dissidence by taping a sign proclaiming Benetton to be a racist clothing establishment because she doesn’t sign her name on the cardboard, then I need to look for alternate readings of this event. Not only can (and should) I acknowledge the very different public and personal spaces Williams and I occupy, as well as my own ignorance of what is at stake for an African American woman lawyer to tape such a sign to a public window, I can (and should) look at her publication of this story in *The Alchemy of Race and Rights* (where it is retold numerous times, from various perspectives) as an example of the ways in which Williams is signing her name on the proclamation against Benetton’s racist employees, a signature in indelible ink.

This is not to say that we must accept uncritically anything written or spoken by a woman, particularly a feminist, or to say an author is not accountable for her words. Instead, it is to ask that we qualify our positionings, our intentions, and that we consider how what we read and write affects others. This cannot be done, I feel, if we endorse a wholly competitive, self-serving vision of why we read feminist texts in the first place. There is a difference between trying to identify and locate oneself within feminist frameworks, needing
to occupy some space of one’s own within some rhetorical or theoretical positioning, and demanding a space for oneself that is announced singularly as the space, the positioning, the standard by which all other feminists are held. This tactic denies the possibility of differences, and reinscribes that self-centered location as a “dominant othered” positioning. This self-centeredness forecloses the possibility of moving any other feminists to the center of theory, rhetoric, or life, and ultimately creates an impasse for feminist progressions. 84

Why Do We Do What We Do?

Do we read feminist texts to gain credibility as well-read scholars in feminist arenas? Do we read and critique as a means to get our own work published, or to theoretically one-up other feminists? Or, do we read other feminists’ works to better our understandings of the myriad ways women are oppressed and to understand the solutions they offer to transcend these

84 An extreme example of a self-serving positioning would be Camille Paglia’s tactics in Sex, Art, and American Culture. Her text is a lengthy self-laudatory, antifeminist diatribe about the myriad ways in which she sees that feminisms have devalued American culture, and by doing so, ultimately destroyed any chances for feminist progression. For instance, Paglia dismissively claims that in rape crimes, women are as equally (if not more) implicated as men: “My kind of feminism stresses personal responsibility. ...The girl in the Kennedy rape case is an idiot. You go back to the Kennedy compound late at night and you are surprised at what happens? She’s the one who should be charged - with ignorance. Because everyone knows that Kennedy is spelled S-E-X. Give me a break, this is not rape” (58). It is American feminism’s “Puritanism and suffocating ideology...which is stuck in a whining mode” (4) that perpetuates rape, according to Paglia, and pop-culture icon Madonna and Paglia are the future of feminism, because their “theories of sex are more in tune with world culture” (xiii). Moreover, “American feminism has a man problem. ...The academic feminists think their nerdy bookworm husbands are the ideal model of manhood” (5). These ad hominem attacks render Paglia unreadable by many feminists, which is problematic in that Paglia may actually have something meaningful to say, but her text and tone (her inflammatory trashing of ALL American feminists/isms) prevents a charitable reading.
oppressions? I am asking that we examine why we critique what (and whom) we critique. I do not suspect that any of us believe that we individually have the answers of how to end all oppression, exploitation, objectification, devaluation, and other ills of the world. Rather, we critique because we believe we’ll find others who align with our beliefs, who challenge us to think about these further. At the core of a feminist rhetoric of reading, then, is understanding, acknowledging, and appreciating other viewpoints, but also knowing that disagreement need not be cause for wholesale dismal of those views.

Is There a Feminist Text in This Feminist’s Text?

If a goal of any given brand of feminism is to empower women, however simplistic or complex this may be, then a feminist rhetoric of reading enables us (and I use “us” loosely here) to enact this empowerment for ourselves and for other women, particularly for feminist writers or performers. If I am to be woman-oriented, then shouldn’t I try to loosen that masculinist method of critique which calls the critic to divide and conquer, vehemently attack, and otherwise trash any text and author who doesn’t align with my own specific goals for feminisms? Couldn’t we then read Aristotle’s statement that “[the function of rhetoric] is not to persuade but to see the available means of persuasion in each case” (35) as an invitation to find also the available threads of feminism within any given text that will enable the betterment of all women and their lives? Acknowledging that

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some of these threads are sturdier than others and will better hold the weaving together, does not mean that we have no room for those threads we find weaker; in fact, that thread you find fragile may be the very thread that holds my life together.

One way of looking at this notion of a feminist rhetoric of reading is by exploring what feminist theories and feminist literary criticisms have already done. Transforming the way we read literature is an immediate goal of contemporary feminist literary criticism. Maggie Humm, noted author of comprehensive introductory readers of feminist theories, literary criticisms, and movements, offers a compelling statement about what the term “feminist literary criticism” might mean, providing for complexities that vary from country to country and historical moments in which these strands of criticism might be practiced:

My own feeling is that feminist literary critics must enjoy being women and being with other women. They must enjoy reading the work of women writers and helping other women enjoy reading women’s literature. They must be women choosing to read women as women. (x)

That Humm very specifically names the critic as part of the critique lends itself to my understandings of a feminist rhetoric of reading. The critics are responsible for the feminist parts of their identity that they bring into their critique, and into feminist spaces, and accountable for how other feminist critics might perceive their attitude.
Subverting the historically socially constructed representations of women in literature, by male authors as well as female authors deeply invested in male systems of power, is a project of feminist literary criticism. By revisioning these misrepresentations of women, writing and reading as a feminist becomes resistant, transgressive, and transformative. Key to contemporary feminist literary criticism, as well as to a feminist rhetoric of reading, is this present day consciousness raising, which [questions] the long-standing, dominant, male, phallocentric ideologies (which add up to a kind of male conspiracy), patriarchal attitudes and male interpretations in literature (and critical evaluation of literature). ...In addition it challenges traditional and accepted male ideas about the nature of women [which is a masculinist construction in the first place]. (Cuddon 338)

Consciousness raising readings place the burden of women’s oppression not on feminist critics but on the oppressors: masculinist ideologies, texts, and institutions. One can practice this feminist criticism (or reading these feminists’ criticisms) without resorting to the masculinist tactics already employed in male dominated fields of literary criticism. In other words, if we can locate and reinterpret the erasures and misrepresentations of women (in writing and in everything else external) from an historical past, then we can integrate this sort of

86 Feminist literary criticism and feminist theory are, for me, convergent ideas. Because they are often synonymous, take the same goals for women as their projects, and function so similarly, it is at times difficult to flesh out how the two diverge in meaning. There are fine lines that differentiate the two, but for the purposes of this project, the former primarily looks at all forms of literature to see how women are portrayed, recuperatively examines the historical erasure of female authorship, and uncovers and revises how the traditional canon originated as a masculinist construction. The latter might do the same, but also moves its analysis outside of what might be called literature and literary conventions, characters, or writers.
recuperative reading into our own current readings of feminists’ texts. Unless we are willing to accept complete separation as the optimal move towards a non-oppressive future (which would mean, of course, separation between women as well as separation of men and women), then we need a new praxis to align with our theories. In fact, we need to realign ourselves with the goals of all threads of feminisms, in addition to aligning with those we hold most important to our own lives. By being divisive within feminisms, we are only furthering the devaluation and silencing of women under the guise of academic and scholarly pursuits.

Without doubt, this inclusive vision applies to disability studies. While the tensions between the medical and social models of disability are deeply rooted, even as I write, now, the divide between the different strands of theory grows wider and stronger. There are numerous ways in which disability studies has become divisive. For instance, just as second and third wave feminism experienced conflict when scholars and activists wanted to foreground race, sexuality, and global issues, these categories are still emergent in disability studies. And, just as physician-assisted suicide is a divisively explosive topic in the arenas of medicine, politics, and the law, it has all but torn asunder disability studies. With such a complex issue, and such persuasive arguments (it’s a human rights issue, it’s a civil rights issue, it’s about the terminally ill, it’s about people with disabilities, and so on), there can likely never be consensus.

Memoirs, the Stories We Tell Ourselves, and the Challenges of Lying
Michel de Montaigne, traditionally considered the inventor of the personal essay, tells us in his essay “On Experience,” that “There is no desire more natural than that of knowledge. We try all ways that can lead us to it; where reason is wanting, we therein employ experience.” I have employed my own experiences in everything I have written, for conference or for publication, in everything I teach, in every heuristic device I apply as a catalyst for learning. In this way, then, all my work is memoir, an autobiographic snapshot of myself. Over the years, I have gravitated towards memoirs, autobiographies, and biographies as a genre precisely because I want the inside story, the secret scoop of any given author’s life. I admit it: I am infinitely nosey, dangerously curious, and in turn, irrepressibly candid about my own secrets, my own life stories. Logically, I love stories about people like me, people who have lived similar experiences as I have. I take their storied lives, file them away in my memory, and soon their experiences become intertwined with my own, as if perhaps I too have somehow lived them. And so I also become fiercely protective of these stories, as if any negative review or criticism is a personal reproach, against my experiences and me.

But I didn’t always feel this way. I didn’t always have such openness to reading about other people’s life stories, especially those about mental health. As recently as the summer of 2000, in a graduate English course aptly titled “Writing Lives,” I wrote a section of my own memoir as a class assignment. Brenda Brueggemann was the professor, and my newly appointed advisor, as I was just
formally coming into disability studies. I also had just rejoined the living, so to speak, after a voluntary hospitalization and subsequent medical leave of absence from my Ph.D. program. I thought this memoir writing assignment would be a breeze; I had plenty to tell after all. And I did have much to tell, in a very scattered sort of way. Yet what most stands out now, six years later, is what I would not tell:

I’ve read, but I can’t read. I have shelves full of books telling what it is like to be bipolar, what it’s like to be depressed, manic, hypo-manic, obsessive-compulsive, anxious, panicky, suicidal, grieving, recovering, addicted, institutionalized, hospitalized. But I know these things in my own way, so why should I read someone else’s misery? That is a lie. What I really mean is that because I am all these things, I am too afraid to read Kay Redfield Jamison’s An Unquiet Mind: A Memoir of Moods and Madness or Touched by Fire or Night Falls Fastly: Understanding Suicide, I cannot bring myself to open Elizabeth Wurtzel’s Prozac Nation, and Lauren Slater, I do not want to read Welcome to My Country. But mostly, I want to hurl Susanna Kaysen’s Girl Interrupted into the trash. My respect for books keeps me from doing so, but I am sickened nonetheless. Where’s my version of being involuntarily hospitalized? And where is my telling of later voluntarily hospitalizing myself? If I read their tales, will it erase my own experiences, subsuming all people mad and moody into one great discursive illness? Or will it flay me open to the bone again, spilling blood and tissue and bizarre thoughts, pushing me to the edge again? And if I write this now, what will it do to me?

Looking back at my writing at age twenty-nine, I am amused at how angry I was with memoirs, particularly memoirs about mental health. I am also a bit disheartened, because those books I was so afraid of eventually came to hold a terribly important place in my life, my work, and my personal ethics of recovery. It wasn’t as if I did not understand the transformative power of memoir, in fact, quite the opposite was true. As bell hooks tells us in Remembered Rapture: the Writer at Work, “writing and performing should deepen the meaning of words,
should illuminate, transfix and transform.” There is no doubt of the transformative power of memoir; the question is who is transformed more, the reader or the writer? By admitting, on paper no less, my fear of these memoirs and their ability to even transform me, somehow, was a step towards letting go of something to let something else in. Eventually some of these books became the focus of my dissertation, and the process of writing about them is the hardest I will ever have to endeavor. But their stories I have filed away with my own, their experiences woven into the epistemic fabric of my being.

While much has been written in autobiography studies about the “autobiographical pact,” to me, the larger burden of proof Slater bears is not about whether she broke that pact, but, primarily, why she did so, and secondarily, the subject necessitating this break. Perhaps this multiple-intentionality is available because Lauren Slater’s *Lying: A Metaphorical Memoir* is a work of psychological and rhetorical complexity. All memoirs ask a lot of their readers. Authors bear candid witness to the catastrophic details of their intimate lives, and voyeuristic readers indulge their exhibitionism. Slater’s narrative asks more. The title itself is instructive and should resonate deeply with the reader from page one. Slater is, after all, telling us point blank that as her audience, we bear the task of deciding when her memoir is merely pushing the boundaries of traditional autobiography, and when her narrative is an all-out fabrication.

Moreover, if we are to take Slater at her word, she may not only be lying about

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having epilepsy, but also, she may be lying about what the experience of having epilepsy really is.

It is not so much that we are challenged to decide if she is lying, about what, and when, as we are to discover her intentions. Slater begins *Lying* with an introduction written by Hayward Krieger, imaginary Professor of Philosophy at University of Southern California. From the outset, Slater guides her readers’ reading of *Lying* when (s)he tells us that it is “a daring meditation on creative nonfiction” (ix), implying the reader, too, will have to think through this work, and that the art of writing this work itself is as important as the narrative. This invented Dr. Krieger allows Slater a detached form of authority, while also instructing the reader on the ambiguity of her work. (S)he tells us that,

Perhaps more unsettling and exciting is the writer’s insistence on not revealing to us which aspects of her disease are factual, which symbolic, which real, which fantastical, and by doing so asking us to enter with her a new kind of Heideggerian truth, the truth of the liminal, the not-knowing, the truth of confusion, which, if we can only learn to tolerate, yields us greater wisdom in the long run than packaged and parceled facts. (*Lying* ix–x)

This “greater wisdom” seems to be the payoff for skating that thin line between fact and fiction, symbolic and real. By including this statement by a fictionalized professor, Slater legitimizes her complicated notion of truth, telling us outright that we, as readers, will have to work through the confusion. The complexity of “truth” is cemented throughout her memoir, as she reminds us she is, or *may* be, “spiritually bankrupt, a liar, a thief, a plagiarist” (157).
The question, I think, is why lie? Invention, according to Aristotle, is central in finding the best possible means of persuasion. In her Afterword, Slater tells us: “I am more interested in using invention to get to the heart of things than I am in documenting actual life occurrences” (219). And while Slater does document actual life occurrences in at least two other of her memoirs, in *Lying* she presents readers with the subtle difference between historical truth and narrative truth. For Slater, the former truth “fades and stutters as our neurons decay and stutter,” and matters not so much in “knowing and telling yourself.” The latter, by contrast, is “delightfully bendable and politically powerful.” I wonder then, which is more accurate: a truth faded by memory, or a truth constructed by experience, hope, imagination, and desire? Perhaps the crux of this quandary is in the writer’s intention. In “Memory and Imagination,” Patricia Hampl describes the process of remembering details in memoir writing in terms similar to Slater’s. She tells us:

> We seek a means of exchange, a language which will renew these ancient concerns and make them wholly and pulsingly ours. Instinctively, we go to our store of private images and associations for our authority to speak of these weighty issues. We find in our details and broken and obscured images, the language of symbol. Here memory impulsively reaches out its arms and embraces imagination. That is the resort to invention. It isn’t a lie, but an act of necessity, as the innate urge to locate personal truth always is. (265)

With Hampl’s vision of the memory process, lying becomes a rhetorical strategy, a call upon invention as a means to make a complicated story available to her readers.

Invent, Slater does. She invents not just her own experiences and diagnoses, but also people, places, and even texts. The middle chapter of the
memoir "reproduces" an abstract written about Slater by Dr. Carlos Neu, M.D. and Patricia Robinson, P.T. This meta-text serves a purpose for the reader. While the authorship of "The Biophysical Consequences of a Corpus Callostomy in the Pediatric Patient" (98) is dubious, a five-minute Internet search will show that many of the theories are not only accurate, but greatly beneficial for understanding the nuances of disorders. For one, the "biopsychosocial" model, first introduced by psychiatrist George Engel in 1977, is now emerging as "the new disease paradigm." Unlike previous reductive models, it takes into account the interactions between the biological, psychological, and social factors of a person in understanding health and disease. Dr. Stephen Soreff, Editor in Chief of eMedicine’s Psychiatry Section adds to the psychosocial model and additional component: information. The biopsychosocial information model accounts for the fact that "information plays an ever increasing role not only in our appreciation of disease—its diagnosis and treatment—but also in its prevention." Soreff notes that "the application of information takes many forms," but most importantly, it is a shared process:

Physicians and other healthcare providers now use computers and the Internet in addition to journals (many of which are available online) to determine a diagnosis, select a treatment and follow the impact of their interventions as well as for charting their work electronically on medical records. Similarly, patients and consumers are turning to the Internet as well as magazines and books to help them find out about their ailment and to learn about their medications’ effects and side effects. A patient within

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hours of after being started on a new drug can potentially know as much as the doctor about that preparation. Patients also use information they produce for themselves in the form of journal therapy and other daily logs. (Soreff, pars. 7-8)

Soreff’s acknowledgement that patients do in fact have the ability to monitor their own health and treatment marks a monumental shift in thought about what defines healthcare. What Soreff implies here is that doctors have not cornered the market on healthcare knowledge, they do not have all the answers to all the questions patients might ask, but they do have access to information that will better inform both doctor and patient, Soreff also implies that patients have a responsibility to monitor their healthcare along with the medical professional. I see this model as rhetorically strategic in that it places the burden and benefit of knowledge on both doctor and patient, so that both might be culpable and credited for the treatment outcome, and both are agents in constructing health and recovery. For Slater, the liberties she’s taken in constructing her own diagnoses are also the liberties her readers might take in deconstructing her.

Slater describes Dr. Norman Geschwind’s Temporal Lobe Epileptic personality profile (interictal personality disorder), a theory which could account for much of Slater’s behavior. While hypergraphia, grandiosity, and hyperreligiousness are symptomatic of the TLE personality, they are also part of the experiences of those with bipolar disorder, schizophrenia, obsessive compulsive disorder (scrupulosity), and borderline personality disorder. Many people with these disorders take anticonvulsants that double as a “mood-
stabilizer," and seizures are a side effect of certain psychotropic medications. In *Lying*, epilepsy is not a careless metaphor for illness in general; it is a translation of a larger base of mental disorders that Slater herself experiences—either directly as a patient or by proxy as a therapist. While this personality profile in some ways medicalizes Slater’s experiences, it also authorizes why she uses epilepsy as a metaphor. Either the corpus callosum Slater claims to have undergone will rid her of the TLE personality characteristics, or it will further legitimize them. In *Lying*, Slater points to theologian Sally McFague’s *Models of God* (1988) for a description of metaphor: “What a metaphor expresses cannot be said directly or apart from it, for if it could be, one would have said it directly. Here, metaphor is a strategy of desperation, not decoration” (33). Slater’s use of epilepsy as metaphor is necessary in this narrative because there is no such operation for personality disorders, there is no pill to alleviate the symptoms.

89 This not to say that Slater has or has not experienced seizures as a side effect of psychotropic medications, but as a mental health care professional, she would certainly be aware of this potentiality.

90 While this is a legitimate surgery, the more common medical spelling of it is *corpus callosum*, not *corpus callostomy*, as it appears throughout *Lying*. The demographics for this type of surgery is typically children with atonic seizures, though is it is used for a range of people and seizure types. While some have speculated it is a rare procedure, according to *The Encyclopedia of Surgery*, there were over 800 corpus callosotomies performed between 1895 and 1990 alone, with the numbers continuing to increase. The misspelling can easily be dismissed as an editorial or even an authorial error. Yet if it is intentional, what exactly is Slater intending to communicate here? To me, this “mistake” further underscores how lightly we should hold Slater to the “truth.” She has a Masters and a doctorate in psychology, and is a professional writer. How could she misspell such a serious surgery she claims to have undergone, if not for further wordplay with the bounds of truth, fact and fiction? Likewise, there is no “Epilepsy Society,” which Slater claims funded the “special school in Topeka, Kansas… [to] learn how to fall the right way” (31). But there is an “American Epilepsy Society,” and their spelling of it, at least online, is *corpus callosotomy*. 
Borderline personality disorder holds no truck with credibility, while epilepsy accounts for seemingly bizarre behaviors.

The Sickness of Lying, or Lying about Sickness?

“You’re only as sick as your secrets.”
–Dr. Tara, on *Oprah*, to a guest panel of three women with a crystal meth addiction, obsessive-compulsive disorder, and bulimia

“AAers liked to say, ‘You’re only as sick as your secrets,’ and how well I understood that.”

I mention these references to the AA mantra because it raises a vital question, particularly in relation to Slater’s text: if you *tell* your secrets, are you no longer sick? *Lying* is a crucial text for disability studies scholarship exactly because it calls attention to the hierarchies of and within disabilities. Psychological disorders, especially personality disorders, are doubly stigmatized because they are subordinated to the visible physical disabilities that are most often represented in disability discourses, as well as criminalized, even demonized, in a larger cultural consciousness. Slater gives body to the bottom of the heap of mental health diagnoses: doctors, patients, and Slater herself freely admit to the lack of credibility afforded those with personality disorders. You can’t cure them, treatment is difficult and lengthy, and even the existence of this diagnosis is speculative. An example of how greatly BPD is stigmatized can be seen in *Get Me Out of Here: My Recovery from Personality Disorder*, published by Hazelden, the renowned addiction treatment center. The author took a pseudonym, Rachael Reiland, perhaps to protect her three children and
husband, or her career as an accountant. Taking a pseudonym is a measurement for protection, a means to narrate your experiences, your pain, without having it connected to you personally.

Despite Couser’s concerns with Slater’s use of epilepsy as a metaphor, he acknowledges the importance of narratives from marginalized positions. In “Paradigms’ Cost: Representing Vulnerable Subjects,” he tells us,

Those who represent their own experiences with disability are often consciously countering ignorance about or stigmatization of their conditions. In any case, insofar as they initiate and control their own representation, they become less vulnerable subjects. Indeed, their narratives may seek to reduce their vulnerability to prescribed narrative. (par. 3)

I suggest that this acknowledgment should include even those narratives that may or may not be pleasing to us. I believe Slater’s Lying is, after all, not just a symptom of, but a performance of a greatly stigmatized disability.

Chaotic Control: Reading Between the Narratives

What is at stake in Lying (and Couser’s reading of it) is the inarticulability of experiencing mental illness. I want to return to Arthur Frank’s The Wounded


92 As I note in the introduction, there is a longstanding belief, within the medical model and otherwise, that the more severe the illness, disability, or disorder, the less able the person is to articulate an intelligible narrative about their health-related experiences. This (mis)belief becomes particularly true with neurological-based illnesses such as severe mental illnesses or other clinical cognitive or neurological disabilities and disorders (for example, Alzheimer’s, autism spectrum disorders, Down Syndrome, traumatic brain injury). A person whose communicative faculties are compromised is likely to experience stigma both socioculturally and medically, despite the extensive work and research put
Storyteller to complicate further his notion of chaos narratives. While Lying qualifies far more as a quest narrative than a chaos narrative (as Frank describes them), there are elements of the latter that I believe are significant, even necessary, to the style and structure of Slater’s text. For Frank, chaos narratives are, among other things, too full of suffering for “a self to be told” (115), they are also “hard to hear because they are too threatening” (97-8), so much so that “the anxiety these stories provoke inhibits hearing” (98). Also at the heart of chaos narratives is control: “Control and chaos exist at opposite ends of a continuum. …The chaos story presupposes lack of control, and the ill person’s loss of control is complemented by medicine’s inability to control the disease. Chaos feeds on the sense that no one is in control” (100). To me, being not just informed but analytical and self-reflexive about one’s health or diagnoses is a form of control.

I see at least some elements of the chaos narrative as vital in understanding the larger discourse of mental health. In what might be termed a forgiving reading of Lying, one could employ Leigh Gilmore’s notion of autobiographics.93 For her, “Autobiographics, as a description of self-

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93 At the heart of it, reading a text for Gilmore’s autobiographics is a way of “[discerning] in the discourses of truth and identity those textual places where women’s self-
representation and as a reading practice, is concerned with interruptions and eruptions, with resistance and contradiction as strategies of self-representation" (42). Slater’s text demands “interruptions and eruptions.” If one reads it for the truth, literally, then stopping, starting, fact checking, double checking, and Internet searching are necessary (and, much like Soreff’s biopsychosocial information model, requisite) parts of the process. This sort of interactive reading is, for me, a better partnership. By affording me control over how I read, and what I believe when I read, the layers of “truth” emerge as that much richer.

To read Lying simply as if on a scavenger hunt for truth and tall tales, would be to miss the mark of Slater’s agenda: to be understood. From the outset, Slater asks (through the guise of Hayward Krieger) her readers “to enter with her a new kind of Heideggerian truth, the truth off the liminal, the not-knowing, the truth of confusion, which, if only we can learn to tolerate, yields us greater wisdom in the long run than packaged and parceled fact” (x). To read Lying as an accurate portrayal of experiencing epilepsy is also a mistake. Perhaps “metaphor” doesn’t serve her purpose well. Epilepsy is analogous to the panoply of symptoms, side effects, and phenomenology of mental illness, which she writes of in her other memoirs, Prozac Diary and Welcome to My Country: A Therapist’s Memoir of Madness. When read as a trilogy, Lying, and the

representation interrupts (or is interrupted by) the regulatory laws of gender and genre” (45). I extend this to include the regulatory laws of disability and genre as well.

94 And indeed, even Couser reads Slater’s works as such, that “Lying is best understood in the context of the other [works] … As different as they are in their concerns, they share one characteristic: all approach her experience rather obliquely or indirectly”
invention of her life as an epileptic, works to “express subtleties and horrors and gaps in [her] past for which [she has] never been able to find the words” (219). Slater wants to express emotional truth, not factual truth, and questions: “Why is what we feel less true than what is?” (162). When Slater tells us she inadvertently joins an Alcoholics Anonymous group, without really, truly, being an alcoholic, she stays because she is drawn to their empathy of her suffering, of her telling the tale of “pains and humiliations and illnesses so subtle and nuanced [she] could never find the literal words” (192). Slater shows a hyperawareness of her audience, both the AA group and her readers, by her continual appeals for understanding. The persuasiveness of Lying connects to this need for sympathy, or more importantly, empathy. Slater’s position as both mental healthcare professional and consumer persuades me that whether or not she has personally joined an AA group, she has been in a position to understand the structurings of the system: as listener (therapist), as authority (to diagnose, to treat), and as empathic (ability to connect her own inner struggles with those of someone who is an alcoholic).

And, as a “consumer” in the mental health system, Lying persuades me to empathize. I relate to the struggle to be understood, to articulate mental and emotional pain so deep and ambiguous there are no words to describe it, no experience to compare it to. It is not an easy story to tell, by analogy or by

("Disability as Metaphor" 142). I emphasize those two final adjectives to point further towards Couser’s charges against Slater’s honesty, as if collectively, her work is one serial lie.
metaphor. Ancient Greek philosopher Plato noted that necessity is the mother of invention (*The Republic*. Book II. 369C). For Slater, I suggest her invention was born out of necessity, out of the lack of a more accessible vehicle to tell her tale. While this memoir is not without its problematic, even trying, moments, it is a tale in need of telling, and I believe it is well told. Arthur Frank points out in the *Wounded Storyteller* that “[p]eople tell stories not just to work out their own changing identities, but also to guide others who will follow them. They seek not to provide a map that can guide others—each must create his own—but rather to witness the experience of reconstructing one’s own map” (17). Like Kay Redfield Jamison’s reconstruction of her own map of recovery, I see Slater’s narrative as a guide for both herself and others, particularly for people with complicated illness stories to tell.

Lauren Slater ends her metaphorical memoir with a telling comment on style and intention: “When all is said and done, there is only one kind of illness memoir I can see to write, and that’s a slippery, playful, impish, exasperating text, shaped, if it could be, like a question mark” (221). I see this statement as indicative of more than just the ways *Lying* stylistically takes us through ambiguous half-truths and figurative language. The kind of illness memoir Slater writes embodies the cognitive choices and directions that come with the experience of living with chemical imbalances. In an interview with Penguin Books, Slater tells us that she “self-consciously set out to avoid a linear illness narrative, a structure that would have placed as much weight on sickness as on
health” (6). Her purpose, she states, is to “write about an emergence, not a descent.” As convoluted and questionable as Slater’s experiences may seem, they are her experiences. Arthur Frank notes in *The Wounded Storyteller*, “The truth of experience is malleable” (21). And finally, memoirs also have unstoppable recuperative powers, as Slater’s work and her critics spurred me to find something worth recuperating in *Lying*. 
CHAPTER 3

Disordering the Politics of Visualizing Disability

This chapter considers a vital and ever-growing aspect that intersects feminisms and disability studies: visual representations of marginalized identities. Whether these visual images are in the form of film, sculpture, painting, television commercial, magazine advertisement, or a street sign, how (and by who) categories such as race, class, gender, sexuality, and disability are configured justifiably continues to be a location for analysis for theorists and activists alike. Currently there is a substantial body of work that situates, interrogates, and complicates images of race, class, gender, and sexuality, yet there is still a growing need for the same practices in relation to disability, and more

95 Given that the body figures as a primary site for analysis in disability studies, there is a considerable amount of scholarship about images of physical disability. Some of the foundational texts from this perspective are Rosemarie Garland-Thomson’s Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature (1997) and “Seeing the Disabled: Visual Rhetorics of Disability in Popular Photography” (2001); Carrie Sandahl and Philip Auslander’s Bodies in Commotion: Disability and Performance (2005); Bonnie Sher Klein’s SHAMELESS: The ART of Disability (2006); Marilyn Dahl’s “The Role of the Media in Promoting Images of Disability—Disability as Metaphor: The Evil Crip” (1993); Alan Gartner and Tom Joe’s Images of the Disabled, Disabling Images (1987); David Hevey’s The Creatures Time Forgot: Photography and Disability Imagery (1992); Simi Linton’s My Body Politic: A Memoir (2006). Please also
specifically, invisible disabilities. Through the frameworks of feminisms and disability studies, I offer in this chapter an analysis of two specific visual representations of mental illness: the iconic figure of the straightjacket, and the commonplace of “madness as genius.” The popculturalization of the former, and the overdetermined nature of the latter (especially as it is paired dichotomously against the ideology of normalcy), complicate the efficacy of these images. In an effort to find a medium between these extreme representations of mental illness, I suggest looking at recovery as a location for better understanding and representing mental illness. I then introduce the works of Chris Mohler and Adele Mattern, two artists from the Fresh A.I.R. Gallery in Columbus, Ohio, and situate their works into the larger landscape of representations of mental illness. By connecting Mohler’s “Shrine to the Grand Iron God” to the film The Fisher King, a journey or quest (much like the process of recovery) emerges. By employing


96 The works of Traci Parks, a legally blind photographer, occupy a unique position in relation to visual representations of invisible disabilities. In a project titled “What’s Wrong with this Pictures” funded by The Ohio arts council, Parks goal “is to graphically show the community that architectural barriers affects us all – not just those with disabilities.” Her exhibit contains images such as broken sidewalks, dangerously sloped wheelchair ramps, and inadequately labeled Braille on ATM machines. The images themselves are arresting, calling attention to the social and attitudinal barriers that so frequently complicate the everyday lives of people with disabilities. More interesting, to me, is that Parks’ attributes her interest in photography as the “therapeutic hobby” she took up after a voluntary hospitalization for clinical depression and suicidal thinking. This hobby became a part of her recovery process, and eventually, her livelihood. To view Parks’ works, please see: <http://www.miracleimages.com/>.
revisionary efforts in the spirit of Adrienne Rich, domesticity, functionality, and normalcy as a contingent emerge as useful tools in the process of recovery.

Mental disorders are often excluded from certain discourses, or are inadequately theorized about, because they are seemingly “invisible,” in that they bear no obvious signs on the body. They do not mark the body (and its territory and functions) the same way as might a wheelchair, white cane, dog on a harness, prosthetic, and so on.\(^97\) The lexicon for mental disorders does not have any visible registers\(^98\) for sites of disorder: We do not have an corresponding picture of a cigarette with a big red circle and line through it to display the boundaries of where this activity is allowed. When we wish to indicate what “crazy” looks like, there are no signs comparable to those with wheelchairs on

\(^{97}\) Where the physical and mental converge, however, are some exceptions. Eating disorders and emotional disorders present themselves on the body through self-mutilation such as starvation, cutting, or burning one’s own skin. Diagnoses and public awareness of these disorders are on the rise, in both males and females. The Lifetime Movies Channel routinely airs made-for-TV programs about such disorders, though as with all filmic representations about the experience of mental illness, the accuracy and integrity of these representations are sometimes questionable. For an insightful textual analysis of the ways the female body is “tyrannized by the contemporary slenderness ideal,” please see Susan Bordo’s work, particularly Unbearable Weight: Feminism, Western Culture and the Body (1993).

\(^{98}\) Undoubtedly, there are countless filmic representations of people with mental disorders, some of which are seemingly accurate, but far more that are sensationalistic. For an impressive cataloging of such films, please see “Movies and Mental Illness: Psychology, Psychiatry and the Movies” compiled by Susan Nicosia. \(<http://faculty.dwc.edu/nicosia/moviesandmentalillnessfilmography.htm>\). Nicosia categorizes the films by what particular disorder(s) they depict, dating from the beginning of the 20\(^{th}\) century. Please also see David Greenhalg’s site \(<http://www.disabilityfilms.co.uk/mentaltoc.html>\>, which categorizes numerous disabilities, including mental disabilities, by major and minor films. Another important site directed towards the medical humanities is the New York School of Medicine’s “Literature, Arts, and Medicine Database,” which cross-categorizes works by genre (film, video, art, poetry, and prose) and by keywords about disability and disorder.
them indicating accessibility, or with pictures of crutches signifying hospital zones, nor are there lettered signs equivalent to the ones asking for caution because schools for the Deaf or blind are in close proximity. Symbolically, there are three signs that most people are likely to recognize as representational for “crazy.” Make small circles with the index finger placed adjacent to the head indicates that someone is “cuckoo.” The others are textual frames of reference: drawing stars around a person’s head in a cartoon fashion (which may also indicate that the person is in pain), and the picture of the “mad” scientist, which typically entails a thick-glasses wearing, hair askew, wide-eyed, disheveled looking, older man in a white lab coat. Reminiscent of this image, is the enactment and performance of crazy that is fully embodied in Dr. Jekyll and Mr. Hyde, the stock character(s) of insanity. Other variations of the latter include the monster as mad, as seen in films and photographic images of such characters as Frankenstein, Dracula, the Wolfman, and other like monsters.

A related icon that is fraught with a complicated history and is representational of insanity and madness in general is one which, like a wheelchair or white cane, is tangible, but unlike the latter it is not so easily transferred to a sign or poster. The straightjacket functions as signifier for the entrapments placed upon the mentally disordered, as it signifies the desire to constrain and restrain the erratic and irrational mental patient. It does not promote mobility the way a wheelchair or white cane may for the physically disabled person. The latter are both objects that in some ways map out
disability’s territory. And, one does not actively choose to don a straightjacket as a means to lead a more productive, functioning existence; rather, a straightjacket is a materially binding means of surveillance and enforcement of disablement passed down from the power structures of medical and institutional discourses and onto the disenfranchised disordered individual. Occasionally the straightjacket is referenced in popular culture, but typically in ways that do not acknowledge or empathize with the traumatic history of institutionalization.

A current example of the popculturalization of the straightjacket is the Vermont Teddy Bear Company’s “Crazy for You Bear” (Figure 3.1), which NAMI and other mental health advocates have protested.99 Issued for Valentine’s Day in 2005, the toy “features a 15-inch bear in a straitjacket. It comes with a ‘Commitment Report’ that includes the symptoms ‘can't eat, can't sleep, my heart's racing. Diagnosis: Crazy for you!'”

Mental health advocates and consumers from all over the nation responded, urging the company to consider that the straightjacket is more than a symbol of restraint; it is responsible for years of abuse, and oftentimes the deaths, of mental health patients young and old. According to NAMI, on January 26, 2005, the company apologized, stating they meant no offense, and they acknowledge
"the serious nature of mental illness." However, they would continue to sell the remaining inventory of the bear. Though they removed radio commercials and front-page promotion of the bear from their website, they continued to sell the bear in the Valentine’s Day section. To date, the bear no longer appears on their website, yet whether the Vermont Teddy Bear Company stopped selling the straightjacket bears or whether they simply sold out is disputed. In its place, however, is the equally problematic “Mad About You” bear (Figure 3.2), which effectively replaced the straightjacket with “a white lab coat, heart-pupil glasses, and a crazy red wig," and a Love Potion hangtag touting “I stayed late at the lab making a love potion for two, cuz I want you to understand that I’m mad about you!” (http://shop.vermontteddybear.com/madaboutyou.html).
What both bears fail to include is an indication of what comes with the diagnosis of “mad” or “crazy”: endless doctor visits, mind and body altering medications, loss of freedom, and tremendous, infinite stigma, all of which are likely not as marketable as hearts and stuffed animals. Instead, it commodifies a serious and deadly set of illnesses, and at the expense of the real people who experienced institutional traumas, abuses, and deaths.

Occasionally, pop cultural symbols of madness serve a greater purpose than the previously mentioned clichéd mass-marketing attempt. The Union of Concerned Scientists: Citizens and Scientists for Environmental Solutions (UCS)
holds an annual Science Idol contest online, where members can vote for their favorite image. The logo for the Scientific Integrity Editorial Cartoon Contest is in the fashion of hit reality/singing contest television show, *American Idol*, except here the audience votes for the cartoonist whose art best speaks out “against the corruption, distortion, and censorship of federal government science.” This year, one of the images the audience can vote for is by political cartoonist Justin DeFreitas (Figure 3.3).\textsuperscript{100} The image is of two white lab coats, hung separately on orange hangers. On the left, the coat is unbuttoned and labeled “Standard-issue lab coat.” On the right, the arms of the coat are crisscrossed and tied in back, with straps hanging off the cuffs. This coat is labeled “Federal Government Standard-Issue Lab Coat.”

\textsuperscript{100} As of August 20, 2008, DeFreitas’ image was not chosen as winner of the Science Idol Contest. It will, however, appear in the 2009 Scientific Integrity Calendar <http://www.ucsusa.org/scientific_integrity/science_idol/>.
Undoubtedly, as a member of the UCS and as a viewer, I can understand DeFreitas’ cartoon to be a satirization of the stronghold the US government has on science, including its interference in scientific research and findings, and its manipulation of data to suit its own political purposes within the Food and Drug Administration, the Environmental Protection Agency, and other climate and environment related agencies. Given this context, I can recognize DeFreitas’
implication that the US government surveils, disciplines, restrains, binds, and immobilizes scientific freedom and integrity. After all, as an institution, the government is one neighborhood away from the institutions of medicine and mental health. DeFreitas’ figure replaces one straightjacket for another, arguably with all its history embedded deeply in the image. At the same time, though, the image in the UCS contest is metaphorical, a symbol of the political abuses inflicted on scientists, and by extension, the American public. It neglects to signify that while scientists become scientists voluntarily, the majority of people put in straightjackets did so not just involuntarily, but forcibly against their will. However unjustifiably scientists and their work (and by extension, the American people) are governmentally abused, the assumed absence of physical force involved negates the balance of this representation—the cartoon straightjacket cannot reproduce all of its history, despite the otherwise efficacious\(^{101}\) nature of the image. If the image of the straightjacket, arguably one of the most recognized symbols of madness, is overdetermined, I wonder how then might we visually represent disorder without reducing the symbol to an oppressive (or even an innocuous) stereotype of mental illness?\(^{102}\) I suggest the answer to this question lends itself to another common stereotype, the artist or genius as “mad.”

\(^{101}\) I want to note that I do think this is an otherwise particularly effective image, especially if one considers the degree of neglect, abuse, and secrecy the FDA alone has practiced. For instance, withholding information about the side effects of any given medication is a form of control, one that unfortunately has all too often resulted in death.

\(^{102}\) I find it problematic that we have public protests about cultural images of the straightjacket, such as the “Commitment Bear,” but not about pharmaceutical
Drawing that Fine Line: The Relationship between Madness and Genius

Countless references to the connection between madness and creativity or intelligence permeate the discourses of art, literature, music, film, mental health, and science. One current landmark text exploring this relationship is Kay Redfield Jamison’s *Touched with Fire: Manic Depressive Illness and the Artistic Temperament*, where she traces a history of writers, composers, and artists with documented mental illness, and others who she speculates may have a diagnosable mental illness (based on contemporary understandings of disorder). Critics of *Touched with Fire* range from lauding its intelligent treatment of an idea Jamison is intimately acquainted with, to questioning the legitimacy and necessity of “diagnosing” people (some dead for centuries) by contemporary constructions of disorder. I do not refute Jamison’s work in *Touched with Fire*; to the contrary, I believe it supports the long-held views that many writers and musicians are fueled by their passions, however disordered those may be. The humanities have often been in the business of writing madness good—or, at least, of pointing out the good that can come from the conditions of madness, of connecting madness to genius and creativity and celebrating the idea of passion.

companies’ rampant attempts to sell drug unmonitored and even unsolicited. On any given day I could open up my email inbox and find no less than a dozen spam goading me into buying (illegally) the latest trends of the pharmaceutical industry. Yet, these advertisements offer no guidelines how to take the pills, nor do they insist they should be taken under a doctor’s supervision. Many of these ads are bogus, yet far too many are real. The fact that one could lose money purchasing a scam or by purchasing something illegally means this product trucks power. Pharmaceuticals circulate widely enough in our culture for the wool to be pulled over our eyes, or for us to consider obtaining them illegally. Worse still, pharmaceuticals wield enough power that we may really need to bypass FDA regulations (and pricejacks) and purchase them out of the country.
and inspiration drawn from suffering and disorder. In poetry, in fiction, in drama, madness is redeemable. Yet this redemption does not account for the fact that today, poetry, fiction, and drama are not the valuable commodities they once were. The humanities in general are neglected by government funding as well as a disinterested national public. Does this make literary madness less redemptive now? And, what does it say about the lived experiences of mental illness? Ultimately, the relationship between mental health and genius (or, what I would call intellectual and emotional intelligence) remains a difficult and contested terrain.

Despite extensive research in academics and medicine establishing a discernable connection between the two, the specifics of this connection are still unclear. Clinical psychologist Maureen Neihart notes in her considerable research on gifted children and their emotional and social development that the 1980s saw a rise in evidence of the ancient belief that madness and creativity are imbricated, even contingent upon each other. By the 21st century, substantial scientific investigations have validated the following paraphrased views outlined in Neihart’s “Creativity, the Arts, and Madness,” and “The Impact of Giftedness on Psychological Well-Being: What Does the Empirical Literature Say?”

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103 The former article appears in Roeper Review. September 1998, Vol. 21, No. 1, pp. 47-50. The latter article, which appears in Roeper Review. Sep. 1999, Vol. 22, No. 1, pp. 10-17, is directed more towards gifted children, but I extend this to all gifted people. Collectively, Neihart’s cataloging of research establishes a relationship between gifted ability, creative ability, and disturbance of psychological well being.
The question of whether gifted people are more or less at risk for psychological problems or instability than their non-gifted peers is dichotomous, and empirical evidence supports both conclusions.

The most accurate predictors of the psychological well-being of gifted people are the type of giftedness, the educational fit or lack thereof, and characteristics of the person such as self-perception, temperament, and life circumstances of the person. These factors interact synergistically.

Specific disorders lend themselves to specific outcomes. For example, studies conducted with adult populations show compelling evidence that there are higher rates of mood disorders and suicide among creatively gifted writers and visual artists, and that the pursuit of exceptional artistic achievement among adults with creative giftedness has associated psychological risks.

Artistic endeavors tend to "heal" the artist, whose work in turn tends to heal others. Particularly true of writers, dancers, musicians, and visual artists, their art is a means to self-understanding, emotional stability, conflict resolution, and a means to structure or reframe pain and suffering.

Conversely, the creative process can lead to psychological disturbances among those predisposed to psychological disturbances.

I include these findings because they are, to me, interesting, vital, but also fraught with a few inaccuracies or half-truths. For instance, giftedness, creativity, and madness are too loosely defined in this research. Here, Neihart defines giftedness is defined as "high ability (typically defined as high IQ)," though elsewhere she and other scholars offer more fleshed out definitions of the term, usually qualified in part by adeptness at intellectual, artistic, and creative pursuits. Though I believe Neihart and others realize the connections between other types of giftedness (e.g. math, science), and I see the necessity of placing creativity, giftedness, and madness in conversation, I also see that it reifies the belief (and stigma) that "people in the arts" are prone to insanity—a long-held
idea that oversimplifies, romanticizes, and glorifies both art and disorder in ways that are spectacular and macabre.

If Neihart’s definition of “gifted” is oversimplified, then her definitions of creativity and madness are reductive. In “Creativity, the Arts, and Madness,” Neihart states that “Creativity is defined as the production of something both new and valued and madness is defined as a self destructive deviation in behavior.” This definition, however, lacks intellectual, experiential, and scientific rigor. Despite the studies of Neihart, et. al. stating that a great deal of evidence for their research comes from gifted people, artists, and disordered people themselves, this definition bespeaks a lack of critical understanding of how these terms are really constructed and lived. Qualifying creativity by the production of something new and valued is a definition that is both too inclusive and not exclusive enough (who defines “value” here, and how? In a postmodern world of reproduction and mimicry, can anything really be new?). More problematic is that this definition of madness is depreciative, lumping all disorders and disordered thoughts and behaviors into one deviant package.

**Positioning Normalcy**

I do not want to erase the possibility (no, probability) that with certain disorders come self destructive or so-called deviant behaviors, but it is vital to note that these outcomes (and what precipitates them) are contingent on countless other factors. Moreover, not all disorders result in problematic behaviors, and not all problematic behaviors are the result of a disorder.
Likewise, not all intelligent or creative people are disordered, and not all disordered people are creative or intelligent (with ‘intelligent’ being as overdetermined a term as ‘creative’). More importantly though, is how are “self destructive” and “deviant” being defined here, and by whom? I would argue that this definition of madness is likely not one shared by artists with disorders; rather, it belies the medical model of disorder that disability studies rightly takes to task.

Questioning the “ideology of normalcy” underpins a significant part of disability studies scholarship. For instance, the corpus of Rosemarie Garland-Thomson’s work interrogates masculinist and medical constructions of the “normal” body, and here she espouses a feminist disability studies that “‘denaturalizes’ beauty and normalcy to transcend the usual way of thinking about these value systems – as an aesthetic quality of bodies” (“Re-shaping, Re-thinking, Re-defining”). The same premise undergirds Lennard Davis’ work, particularly Enforcing Normalcy: Disability, Deafness, and the Body: that “the very concept of normalcy by which most people shape their existence is in fact tied inexorably to the concept of disability” (2), and that “normalcy is constructed to create the ‘problem’ of the disabled person” (22) rather than the person with a disability being the problem.

In the arena of psychiatric disorders, other scholars have anthologized works investigating the construction of normalcy. Carol C. Donley and Sheryl

Buckely edited the collections *The Tyranny of the Normal: an Anthology*¹⁰⁵ (1996) and *What’s Normal?: Narratives of Mental and Emotional Disorders* (2000), both of which intersect clinical essays with literature (prose, poetry, fiction, non-fiction), that supplants, subverts, and structures the ways in which normalcy is constructed medically and culturally. And, in ““The Psychiatric Gaze: Deviance and Disability in Film,”” Elizabeth J. Donaldson calls attention to the hierarchy of normalcy existing even within the psychiatric community: ““There are no television ads for schizophrenia medications, and no schizophrenia self-assessment tests on drug websites. The schizophrenic subject remains deviant, the abject element that categories of normalcy and mental health are positioned against” (45).

Certain disorders are considered more difficult to treat, and with less potentiality for recovery, such as schizophrenic and related disorders, and personality disorders, which I discuss in my chapter on *Lying*. Donaldson notes that because ““people disabled by schizophrenia remain the abject that sustain out concepts of the normal” (45), there cannot be a ““truly therapeutic” (45) alliance between consumers and psychiatry.

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¹⁰⁵ The title of this anthology comes from Leslie Fiedler’s 1984 essay in *The Hastings Center Report*, ““The Tyranny of the Normal,”” and his later work, *The Tyranny of the Normal: Essays on Bioethics, Theology and Myth* (1996). Fiedler’s works foreground the problematics of humans striving for normalcy (e.g. the Cult of Slimness and the Cult of eternal Youth) often at the cost of pity, fear, amusement by, or elimination of the non-perfect: freaks, dwarfs, the disfigured, the disabled at large, even our own imperfect bodies. I would also argue that, if a former goal of recovery was a return to normalcy, then for those who resist constructions of normalcy (particularly for those who identify themselves within a counterculture), recovery is an impossibility.
Somewhere between the ideology of normalcy and the construct of madness as genius, I want to find a medium for visually representing mental illness. With the knowledge that disorders exist on a wide-ranging spectrum, each with their own subset spectrums, it seems that a resolution is an impossibility. Yet, by revising the question—from “how do you visually represent mental illness?” into “how do differing disorders connect, and how best visually represent this?” — I suggest there is a location for such images that are more accurate and even empowering for the creators, even while oscillating between the construction of madness as genius and the ideology of normalcy. Recovery, and the process it entails, is just such a location.

Getting Some Fresh A.I.R.: Southeast, Inc., and the Rhetorics of Recovery in Downtown Columbus, Ohio

In downtown Columbus, at the corner of High St. and Long, sits an unimposing space, the Fresh A.I.R. Gallery. The gallery’s sponsor, Southeast Inc. Recovery and Mental Health Care Services, serves a population diverse in economic status, race, and gender, and emphasizes growth, change, wellness, and recovery. The offices of Southeast Inc. are attached to the gallery, so when visiting, one sees the whole of the system at work. Fresh A.I.R. (or, Artists in Recovery) showcases the works of people who have a disorder or who address disorder in their art. In their 2003 Annual Report: Celebrating 25 Years of the Art

106 For information about Southeast Inc., the Fresh A.I.R. Gallery, and images of the postcards announcing current and recent artists’ exhibitions, please see: <http://www.southeastinc.com/fresh_air.php>.
of Recovery, Southeast Inc. notes that after the deinstitutionalization of people with mental illness, “treatment technologies, community support and community acceptance were insufficient to meet the needs of many people moving from institutions back to the communities” (1). Since then, these situations have vastly improved [because of] evidence-based treatment practices, new generation medications, knowledge of specialized treatment for dual disorders and acknowledgement that treatment must meet the needs of diverse populations. (1)

I take Southeast’s statement to mean that these improvements for people with mental illness have also enhanced their understandings and experiences of recovery. In fact, Southeast emphasizes that “[c]lients have been on the forefront of teaching providers that recovery is not only possible but should be expected; that hope is the essential ingredient of all treatment processes and that they, like all human beings, are unique and have much to offer.” The Fresh A.I.R. Gallery offers a space for artists with mental illnesses to present their own unique experiences with recovery. Of the many talented and insightful artists who

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107 The 2003 Annual Report also stresses that “clients, family members, advocates and treatment providers...recognize there are still many barriers to treatment and community acceptance that work to interfere with the clients’ recovery process,” despite whatever advances have been made. It’s not mental illness that needs to be overcome, but “[c]ommunity ignorance about mental health and addiction.” The report also calls for an end to “the stigma and discrimination that ignorance fosters,” and an opening of “the doors of employment, housing and insurance parity.”

108 The Fresh A.I.R. Gallery is in good company. In addition to the hundreds of exhibits featuring mental health across the country on a regular basis, there are other permanent galleries specifically for artists with mental illness. For example, please see South Carolina Department of Mental Health’s Art of Recovery Gallery and Virtual Gallery
have presented at this gallery, I will address the works of two: Adele Mattern and Chris Mohler.

The Gift and the Curse: Chris Mohler and the “Shrine to the Grand Iron God”

Chris Mohler's installment at the Fresh A.I.R. Gallery, “A Gift and A Curse,” impresses me as created essentially from the experience of being bipolar, an experience which for him, I imagine, comfortably resists the ideology of normalcy, is neither deviant nor defective, may or may not be marked by genius, but is absolutely the core of his creativity. For example, Mohler is unequivocally explicit about what role this disorder plays in his life and in his creative process. He tells us that he has “often thought that art is the application of insanity,” and that he “wouldn’t be an artist if it weren’t for the bipolar.” What is significant here is that for Mohler, the creative process and the experience of being bipolar are one and the same. He tells us “art has given [him] life,” and that “if not for the art,” being “bipolar would have killed [him] years ago.” Simply put, he is “grateful to be alive.” “[He] was given a mission. [He] accepted it and ran with it.” That the two, art and mental illness, are so imbricated, is an idea that runs deep and wide in the art and literary worlds.

Please also see NARSAD Artworks <https://www.narsadartworks.org/default.aspx?ssl=true>, which sells “museum-quality art by talented artists whose lives share or have shared the common bond of mental illness,” as well as free E-cards.

In *Origins of Genius: Darwinian Perspectives on Creativity*, Dean Keith Simonton points out that,

ever since the times of the ancient Greeks, genius has been linked with mental disturbance. Aristotle is said to have claimed, ‘Those who have become eminent in philosophy, politics, poetry, and the arts have all had tendencies towards melancholia.’ Similarly, Seneca held that ‘no great genius has ever existed without some touch of madness.’ (94-95)

Simonton notes that the connection between madness and genius continued throughout the ages, such as when “Shakespeare wrote, ‘The lunatic, the lover, and the poet / Are of imagination compact’” (95). I add that Shakespeare further complicates this idea when Hamlet tells us in an aside, “Though this be madness, yet there is method in’t” (Act II, Scene II). Still others have reinforced the connection between madness and genius, without which we would not have Van Gogh’s *Sunflowers* and *Starry Night*, Edvard Munch’s *The Scream*, Beethoven’s *Moonlight Sonata*, and Tchaikovsky’s *Swan Lake*. Knowing this, I wanted to consider this connection in Mohler’s work. One of Mohler’s pieces in particular, “Shrine to the Grand Iron God” (Figure 3.4), demonstrates that fine line between madness and genius.
Figure 3.4: Chris Mohler’s 1989 sculpture, “Shrine to the Grand Iron God”
Mohler made “Shrine to the Grand Iron God” in 1989, and though it does not appear in the Fresh A.I.R. Gallery exhibit, it categorically embodies his mission. This painted steel sculpture is four feet wide, and fourteen feet high. Its intricate base resembles a tent-top made of green and brown vines. The top is a square sunburst of reds, yellows, and oranges, and looks like a giant stencil, with seemingly random swirls and shapes. The sculpture as a whole seems to me more organic than abstract. In Mohler’s blog, he describes some of the influences for this piece: living in a New York City covered in unreadable graffiti “meshed into a wallscape similar to a jungle” before coming to Columbus; his own extensive and illegible writing habits at the time (pre-computers). Eventually, his memories of that “urban jungle” moved to acrylic lacquer paintings, and then to the steel shapes that became “The Grand Iron God.” For Mohler, “Painting is much, much faster than sculpture.” Remembering that the Fresh A.I.R. Gallery showcases art about or made during recovery, I wonder then at what point in Mohler’s recovery (or, likely, recoveries) did he make this piece. He states it is part of series from 1988-1992, and that “[t]he shapes that were cut into steel

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Over the years, Mohler’s work has debuted in vacant lots in the short North district of Columbus. Mohler works primarily with steel, and has many sculptures that are phenomenally large in proportions. In an Ohio State University and public Broadcasting System documentary on his work, which appears on his website, Mohler tells us his work is large because he himself is 6’8”. The Shrine is representational of the epic type pieces Mohler creates.

were developed the 6-8 years prior to working this series.” Creating this piece was a lengthy process, and likely a journey similar to that of recovery.

Defying Description: Homage to the Literary Giants

This piece reveals the limits of my own imagination, my own vocabulary, and even my own experienced-based lexicon of disorder. Technical terminology aside, I am at a loss at how to describe “Shrine to the Grand Iron God” outside of its physical attributes because this sculpture is not so much representational as it is suggestive. Additionally, since this is a somewhat current and local work of art, the existing body of literature or reviews from which to form an analysis on Mohler’s work is relatively small. I can, however, make some concrete comparisons about what I see in his Shrine. Mohler’s piece evokes two figures from the art world, both of which embody journeys I imagine to correlate with Mohler’s recovery process (and thereby, the process of creating his work). One is a throwback to the Arthurian legends, The Red Knight from the 1991 film The Fisher King, directed by Terry Gilliam. The other is Miguel de Cervantes’ legendary Don Quixote.

In Gilliam’s redemption film, the nightmarish Red Knight strikes an imposing figure, literally and metaphorically. The two main characters, Jack and Parry, meet in the unlikeliest way. Jack, played by Jeff Bridges, is a cynical New York City shock-radio host of the Howard Stern style. Arrogant and uncaring, he offhandedly gives some advice to a caller, who consequently, brings a gun to a popular restaurant, and murders some diners before killing himself. Jack loses
his job because of this and ends up destitute and bitter. One night when Jack has decided to kill himself, he is rescued by a band of homeless people, led by Parry, played by Robin Williams (who is, in real life, bipolar).

As the story unfolds, former history professor Parry displays an array of symptoms from different disorders, including paranoia, delusions, hallucinations, anxiety and panic, all resulting from the trauma he experienced when he witnessed his wife being killed in the very same restaurant massacre Jack’s listener caused. A guilt ridden Jack then helps Parry look for the Holy Grail, which Parry believes is housed in the 5th Avenue townhouse of millionaire Langdon Carmichael. There are some obstacles in their quest, however.
Figure 3.5: The Red Knight, from Terry Gilliam’s 1991 *The Fisher King*.

The Red Knight (Figure 3.5), an amalgamation of Parry’s worst fears and evil incarnate, keeps Parry from finding the grail. Physically, the film presents a beautifully frightening figure, one as imposing as Mohler’s giant “Shrine to the Grand Iron God”: the Red Knight sits atop a 2,200 lb. henna-painted horse, and is adorned in massive body armor, accompanied by a 16 lb. flame thrower. On screen, Red Knight always appears in a dark fog with blurs of red, and seems
ethereal despite the weighty medieval weaponry and garb he wears. Much like the vision of the Fresh A.I.R. gallery though, *The Fisher King* is a film about recovery and healing. Eventually Jack redeems himself by playing cupid for Parry and equally quirky Lydia, played by Amanda Plummer. Parry then ascends from his own fantastical but lonely world to live and function in the reality most others around him already inhabit. This quest film is rich in subtext and in visual representations of human frailty, hope and grace, the individual vs. society, the relationship between guilt and ethical responsibility, and the limits and scope of madness and genius.¹¹²

**On a Mission, Or Chasing Windmills?**

Ironically, the other literary figure Mohler’s “Shrine to the Grand Iron God” evokes for me also represents these same elements. Embodied in the steel sculpture is Cervantes’ Don Quixote, chasing after windmills that in his mind are giants. Like Parry, Don Quixote is delusional, from sleep and food deprivation, along with the feverish imagination that comes with over-reading. Also like Parry, Quixote finds some psychic resolution, though it results in his death, by which Cervantes means to signify the death of chivalry. Interestingly, the *Fisher King* director Terry Gilliam wrote and was scheduled to make the film *The Man Who Killed Don Quixote* in 2000, but a series of odd mishaps has kept this production

on hold. Gilliam is also writer and actor for the epic Monty Python troupe, his credits including The Quest for the Holy Grail. These connections strike me as representational of how cyclical the quest in art for so-called sanity really is. Parry, Quixote, and Mohler all configure mental illness as a quest narrative. On the one hand, we have an adaptation of the medieval narrative of a wounded knight in need of healing, the quest for meaning, and even the power of asking questions. On the other hand, we have the quest narrative Arthur Frank describes in The Wounded Storyteller: Body, Illness, and Ethics: “Quest stories meet suffering head on; they accept illness and seek to use it. Illness is the occasion of a journey that becomes a quest. Exactly what isquested for may never be wholly clear, but the quest is defined by the ill person’s belief that something is to be gained through the experience” (115).

While the quests Frank describes are “never wholly clear,” Parry and Quixote’s chivalric quests are seemingly more visible, more graphic, and more harrowingly marvelous as only print and the large screen can magnify, and they connect well with Mohler’s quest. Additionally, his quest is the sort of real-life application I like to give my students when I teach about disability and disorder. Remember that Mohler tells us simply: “I was given a mission. I accepted it and ran with it.” This mission is both fueled by, and is an alleviation for, having bipolar disorder, but it also acts as a pedagogical tool for others who experience or who teach about the realities of a mental disorder. In “Mohler’s Teutonic Scale,”113 the

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only review of Mohler’s work I could locate, fellow artist Walter King notes that “Shrine to the Grand Iron God” also reminds him of the Red Knight in *The Fisher King*, more so visually than symbolically. For King, Mohler’s work “sometimes...takes on a mathemetic machine like quality with a virtual robotic life of its own. There is almost always the sense that these giants are striding or rolling forward both metaphorically into a future only hinted at.” King’s impression that Mohler’s sculptures are ambulatory correlates with the vision of recovery as a journey; a slow-moving, self-built journey, but one suggesting hope for the future.

**Revising Normalcy and the Art of Recovery**

The process of recovery is complex. Some aspects of it translate well into symbol and metaphor-driven films like *The Fisher King*, or can be artistically rendered into such visually arresting sculptures as “Shrine to the Grand Iron God.” More often, though, the process of recovery from mental illness is less than glamorous, is not Oscar-worthy, and likely does not belong on the silver screen. Despite the need to move from a model of recovery where functionality and mere survival are the goals, both aspects are necessary for even the most empowering model of recovery. In fact, normalcy is not always a negative, medically constructed term. Sometimes normalcy indicates what is normal to a given person and her experiences at a given time. Another artist at the Fresh A.I.R. Gallery illustrates the importance of normalcy, of functionality, in an otherwise chaotic time. In her “Recovery” exhibition that ran at the Fresh A.I.R.
Gallery from April 13th to June 2nd, 2006, Mattern presents a series of eight installation pieces she describes as “an exploration of my mother's effort to journey back to a functional domestic life after a schizophrenic break” (Figure 3.6).
Figure 3.6: Postcard of Adele Mattern’s “Recovery” exhibit at the Fresh A.I.R. Gallery, April 13\textsuperscript{th} to June 2\textsuperscript{nd} 2006.
Recovery and the Reign of Domesticity: Adele Mattern’s Fresh A.I.R. Exhibit

In terms of identity politics, the works of Adele Mattern bring me full circle in that her exhibit ostensibly falls into the category of artistic expressions about mental illness that are created by someone who does not herself experience this. These representations are, of course, the ones with which popular culture is most familiar. There are countless stories, paintings, poems, films, memoirs, manifestos, even television commercials that are about mental illness but created by someone who doesn’t experience any particular disorder, or does so only tangentially, as a sibling, offspring, parent, friend, or doctor in relation to someone who has a mental illness. Because creating art from this perspective requires a particular distance that results in a reproduction of a given experience, theorists might find the work questionable: either the artist has appropriated the experiences of someone else, typically a marginalized identity in terms of race, class, gender, sexuality, or disability, and exploited those experiences (perhaps exoticizing the ‘other), or, the artist provides an inaccurate (and typically unfair) representation of that experience, which ultimately perpetuates stereotypes and stigma of that population. At the very least, I believe an ethical critical theory (whether it was feminist, rhetorical, or disability related)

114 One of the problems of reproducing an experience is that one can never fully or adequately reproduce the conditions in which the original experience was produced. In this context, while Mattern may experience very particular moments of her mother experiencing schizophrenia, she is not herself experiencing the disorder, but only the byproducts of it, a derivation of the original. In this sense, Mattern’s art is a secondhand experience, a gesture towards her mother’s.
would encourage the theorist to qualify her subject position in relation to who or what she is theorizing. The enterprise of feminist theory, feminist literary criticism, and women’s studies is, in fact, built upon the knowledge that, historically, representations of women in literature, art, politics, and beyond have often been inaccurate, oppressive, exclusionary, and misogynistic, yet received as authoritative wisdom. The problem of speaking for others\(^\text{115}\) has plagued feminist theory even within itself—hence feminisms. Likewise, critical race theory, queer theory, disability studies, and other identity-focused academic factions have similar agendas. None of these schools of thought would endorse a singular subject positioning as a stand in for a whole; there is no monolithic stance that speaks for all subject positions, rather, each representation is just that: a representation of an experience. Additionally, as a subject position, disability (like disorder) has always inspired narratives by others: family members, friends, all manner of physicians, and others textual and visual accounts about the disabled, but not by them.\(^\text{116}\)

As a theorist, then, it was with some skepticism that I considered Mattern’s work. It is difficult to ignore not just the gendered nature of Mattern’s focus, but

\(^{115}\) I write this in reference to Linda Alcoff’s 1991 essay, “The Problem of Speaking for Others,” which I further address in my *Unquiet Mind* chapter.

\(^{116}\) There is much scholarship within disability studies addressing how the voices and experiences of people with disabilities are both othered and appropriated, currently and historically. Please see especially James I. Charlton’s *Nothing about Us Without US: Disability Oppression and Empowerment* (2000), Joseph P. Shapiro’s *No Pity: People with Disabilities Forging a New Civil Rights Movement* (1994), and Mary Johnson’s *Make them go Away: Clint Eastwood, Christopher Reeve, and the Case Against Disability Rights* (2003).
the seemingly regressive nature of it. Domesticity has historically figured as a central trope of the feminization of hysteria and women’s descent into madness. This is configured in many distinct ways, such as by the submissive and devoted woman who is overworked and how the rigors of domestic life break her down – or – how the woman has broken down, cannot engage in the duties of the private sphere, and subsequently is kept from the rigors of domestic activities – or – how the woman resists being tied to the private sphere altogether, and is therefore constructed as mad. All three tropes manifest in the Victorian Angel of the House, who so irritated Virginia Wolf that she killed her. Some American women, like Wolf, shared the latter radical position that women should break free of prescriptive gender roles, as Charlotte Perkins Gilman exemplifies in *The Yellow Wallpaper*. When the narrator experiences what we would now call postpartum depression with psychosis, she is consigned to “rest cure” by her doctor. She’s forbidden from any activity, especially those that may be intellectually stimulating, and particularly she is not allowed to write. This in turn exacerbates her dissociation from reality. For any artist, writer, or creator, being denied access to their work would be the cruelest form of punishment, and certainly not a cure. Though the events in *The Yellow Wallpaper* are not themselves complimentary to a positive image of break free from the chains of domesticity, Gilman’s telling of the story, and her subsequent canonizing by feminisms, is.

This framework for domesticity seemingly casts a pallor over Adele Mattern’s exhibit, save for two other possible positionings. First, the stories her
installation pieces tell are reproductions of her mother’s experiences, and as viewers, the gift and burden of interpreting her mother’s experiences falls as equally on us as it does the artist. For me then, these yellow latex gloves with the words “Your father really helps me by doing the dishes, which is wonderful!” might be written sardonically in red thread, with the thread still dangling from the thumb, and an absent but implied needle punctuating the silent black background. This is my first impulse. I am, after all, incredibly un-domestic, and am hard-pressed to find much redemptive about housework or cooking besides their obvious utilitarian functions. And, Mattern’s exhibit reduces her mother to a particular, dichotomous experience: recovery, which connotes health and wholeness, and the illness from which she recovers, which does not. The viewer cannot deduce who or what Mattern’s mother was before recovery, before the illness, or what her relation to domesticity was; instead, the images fix her in a position of perpetual domesticity. But there is a second saving grace, and I find it in Adrienne Rich’s revisionary efforts. As I note in the introduction, poet and theorist Rich introduced the concept of “writing as revision” in 1971, which has been a mainstay in most critical enterprises driven by theory and identity politics ever since. She tells us in “When We Dead Awaken” that re-vision is “the act of looking back, of seeing with fresh eyes, of entertaining an old text from a new critical direction” (167). For Rich, it was a woman-oriented project, “an act of survival” at a time when women’s writing, culture, history, were unequivocally erased, silenced, forgotten, and the patriarchy’s interpretation of women was
sacrosanct. I’d like to extend this idea of revision to the ways we interpret representations of mental illness, and more specifically, to Adele Mattern’s work.

Mattern notes in her self-description for The Pulitzer foundation for the Arts that she “is interested in the power of materials and objects to conjure, evoke, and bear witness to stories and narratives that may otherwise go unnoticed.” If I am looking at the old text of gender prescription from fresh, critical eyes, if I am considering this *an act of survival*, then Mattern’s work does evoke an understanding of the importance of trying to return “to a functional domestic life after a schizophrenic break.” While the spectrum of mental disorders varies as much in kind as it does in degree, there is one thing all disorders have in common: the desire, or at least the need, for recovery.

**Recovering Domesticity**

Mattern’s exhibit, then, is aptly titled “Recovery,” for there are few other processes in life that not only welcome the mundane, but thrive upon it. What this image evokes in me are memories: visual, tactile, even auditory images of the numerous occasions of recovery I have experienced. An adrenaline filled six-month recovery from a panic disorder, the on-again off-again recovery from generalized anxiety that requires an inordinate amount of energy spent “passing as normal,” and the unparalleled draining, repetitive, lengthy, and costly recoveries from manic and depressive episodes. Specific to each of these experiences is the need to loosen myself from the paralysis of the symptoms, and regain the ability to do the once prosaic but now welcomed activities of
everyday life: going to the grocery store, doing my laundry, dining in a busy restaurant, all of which are welcomed simply because engaging in these activities is a distraction that proves I am still alive, despite how dead I really feel, and despite how draining these simple tasks can be in this particular context. And then I repeat these activities until I no longer notice the dictates of anxiety, depression, or agitation contaminating my every move.

The process of recovery for mental illness is always acknowledged as temporal; there is an ever silent recognition that the disorder’s symptoms could reoccur in full force—and with a crushing blow, return you to the beginning of the painfully confusing process all over again. A shift in medication, a change in climate, any alteration in your everyday world could leave you unsettled and suffering. For Mattern, “recovery may be measured by the successful return to the everyday, to the daily habits and chores that stabilize our lives and families.” For me then, Mattern’s project does not evoke images of constraining domesticity so much as it evinces determination, focus, steadfastness, control, survival, and even faith in the unseen.

In Journey Into Healing Deepak Chopra notes that, “Before the art of medicine comes the art of belief,” and in Anatomy of an Illness As Perceived By the Patient: Reflections on Healing and Regeneration, Norman Cousins states: “Drugs are not always necessary, but belief in recovery always is.” Both views lend themselves to the idea of recovery being mystical, an almost religious experience, an idea that likely comforts some, but perhaps repels others. Still, it
also suggests that a truly concerted effort is crucial, and that recovery does not necessarily happen spontaneously or without a struggle. The works of Mohler and Mattern share two distinct commonalities, despite their significant differences. One, there is no indication in either of their exhibitions what, if any tools Mohler or Mattern’s mother used in recovery, whether it was medication, therapy, or otherwise. The viewer has no frame of reference as to what constitutes recovery for them individually, or at what point in their recoveries they were at when the works were created, or where they are at now. For Mohler, we do not know if he creates art only when he has a manic or depressive episode, or if he produces work regardless of where he is at in his illness. For Mattern’s mother, we don’t know if domestic chores are something she does before, during, after, in spite of, or because of having a schizophrenic break. There is a lot absent from these Fresh A.I.R. images. But the second thing they have in common is that by virtue of their stories being presented to the public, they become a shared and educational experience about recovery for others to connect with and learn by.

The Long Haul of Recovery: A Light at the End of the Tunnel

At the 2007 ADA: Multiple Perspectives on Access, Inclusion, and Disability Conference, in his panel on Disclosure and Identity, Steve Kuusisto made an intriguing statement about the politics of disability, that can certainly apply to all identity politics, but more specifically I want to extend to the process of recovery from a disorder: “One can come out in a memoir, but one will have to keep coming out, almost every day.” Here, the process of coming out is akin to
the process, or quest, for recovery: it is capricious, cantankerous, and continuous. It is a starkly private and humiliated public process. And ultimately, it is crucial. For both Mohler and Mattern’s mother, recovery is (and will likely remain), an elusive process, marked by the specificity’s of their own disorders, symptoms, and treatments. But if art is to them as memoir is to Kuusisto, then the process of coming out, acknowledging their recovery (and therefore their disorders), is also a communal act, shared by a viewing audience, discovered (and rediscovered) recursively in our gaze as we identify with, critique, and interpret their work. If we believe Neihart et. al. that artistic endeavors help heal the artist, and in turn help heal the viewer, (and I do believe this, unequivocally), then Mattern and Mohler’s works serve the ultimate humane purpose. Couched at the end of “Creativity, the Arts, and Madness,” Neihart raises some intriguing and vital questions. She asks:

Are people with certain types of difficulties (e.g. mood disorders, substance abuse) more attracted to the creative fields than are people without such difficulties? Is there something about the creative process itself that over time, contributes to disintegration? Or are the struggles for health the result of the cumulative effects of repeated interactions with others who lack understanding or tolerance?

What is interesting is that this set of questions both supports a social model of disorder, specifically, and disability in general, and contradicts the previous definition of madness as deviant. Here, the deviation resides in those who are not empathic with “disordered behavior” or people with disorders. At the very least, I read Neihart’s statement as an indication of hope: hope that the medical community will undertake further research to support the views of disability
studies (i.e. that disability and disorder are constructed, that stigma exists in relation to both, and that these produce attitudinal barriers that are typically far more disabling than the actual disability or disorder itself).
CHAPERT 4

Impatient Doctors and Empowered Patients:
Self-Educating by Reading the Writing on Reader’s Digest’s Walls

The discursive space I want to explore in this chapter comes from perhaps an unlikely source. In 1922, Lila Bell and Dewitt Wallace co-founded the monthly magazine, Reader’s Digest. It currently has a circulation of 23 million a month, appears in 60 countries and in 21 different languages, with a readership of 95 million. Extending this readership was the 1996 launching of Reader’s Digest World (now www.rd.com). Its mission is “to create products that inform, enrich, entertain, and inspire people of all ages and cultures around the world.”

117 Finding accurate statistics for Reader’s Digest presents some difficulties. Not only do outside sources quote varying numbers for circulation and readership, but the RD website provides contradicting statistics also. Additionally, ascertaining an accurate readership count is difficult since there is no way to predict how many people incidentally read the magazine, particularly given that RD is a common waiting room periodical found in the offices of doctors, lawyers, and dentists globally. What we can be certain of, is that Reader’s Digest is, in fact, read by a great many people. For further breakdown of readership by gender, age, and household income, please see.

118 Along with the monthly magazine, which comes in several editions, they carry books, videos, and music, home decorations and accessories, as well as various types of insurance.
Undoubtedly, *Reader’s Digest* holds a visible place in our cultural imagination. It is an historical record of popular culture, of national and international political affairs, a mirror of quotidian life in America, and some would say, a significant force in shaping American identity. For instance, in *Condensing the Cold War: Reader’s Digest and American Identity* (2000), Joanne P. Sharp credits the magazine’s coverage of the Soviet Union before and during the Cold War as having significant influence on American perceptions. The *Digest* repeatedly presented a Soviet Union as *different*, reifying a location of “us” and “them” both geographically and culturally (x-xi), so that,

this influential cultural production’s changing representations of the communist threat to America produced a particular image of Americanness for its readers, …readers were drawn into the story to become complicit subjects of this political identity. (xv)

The power of mass-circulated texts such as *RD* is far reaching, both reflecting and upholding the way America views itself in relation to the world. Typically, Sharp tells us, “*Reader’s Digest* presents itself as guardian of American values. The *Digest* does not simply describe events but always offers a moral to the story” (xiv), so that along with its wide and loyal readership, it is of “[great] significance in the reproduction of a sense of identity” to the American people.

*Reader’s Digest*’s images and accessible articles offer a discursive space for readers to identify with global affairs, politics, business, technology, and the medical world in ways they otherwise may not have. In relation to politics, Sharp argues that,
*Reader’s Digest* offers insight into the way in which politics works in America; into how individuals are drawn into political issues and gain an identity from their perceived location within these images of American society. *Reader’s Digest* constructs models of how the world works, of what America could and should do as a major player in this international political geography, and of what the individual American could and should do to help this national mission. (vx)

What is most important to me here is Sharp’s analysis of *Reader’s Digest* as constructing models of how the world works. Scholars of critical theory, including disability theory and feminisms, who understand knowledge as being constructed in certain ways and by certain forces (social, political, cultural, medical, legal), might be interested in whether or not the magazine also constructs its own models for why the world works the way it does, and to what extent the readers of *RD* themselves understand the possible ways in which knowledge is discursively constructed for them and by them. I suggest that the digitalization of *Reader’s Digest* creates a space for discovering exactly what the readers do understand, and, in effect, an unexpected space for self-advocacy and self-education emerges.

In the July 2008 print and online issues of *Reader’s Digest* appears a telling article, “41 Secrets Your Doctor Would Never Share (Until Now).” As staff writers Cynthia Dermody and Patricia Curtis tell us,

*Reader’s Digest* offered two dozen doctors a chance to tell it like it really is, and general practitioners, surgeons, shrinks, pediactricians, and other

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119 It is interesting that even amongst the other professional titles included, such as general practitioner, pediatrician, and surgeon, Dermody and Curtis chose “shrink” (a term loaded with stigma and devaluation) rather than the appropriate title of psychiatrist also, despite the fact that of the twenty-four doctors who contributed, one identifies himself as a psychiatrist.
specialists took the challenge. Some wanted to be anonymous; some didn’t care. But all of them revealed funny, frightening, and downright shocking things that can help you be a better, smarter patient. (122)

As Sharp points out, many RD articles include a moral or value judgment. This particular article, however, does not. Instead, it simply includes a few “Shocking Stats” (125), the “Anatomy of a doctor’s bill” (126), and the forty-one secrets, which Dermody and Curtis divide into the following six sections: “We’re Impatient; Pills, Pills, Pills; Bills, Bills, Bills; Free Advice; The Darker Side; The Sensitive Side.” Because of the lack of identifying information, the article itself forces readers (myself included) to draw their own conclusions regarding the rhetorical context in which these secrets were told. We do not know many of the important features about the doctors’ contributions, such as intention, intended readership, tone, motivation, or even the full extent of authorship. We also do not necessarily know if each doctor includes her or himself in their statements, or if they believe their statements are only true regarding other doctors. We have little sense of whether or not the doctors believe themselves justified in their thoughts and behaviors, or if they are just as appalled as the RD readers are that some doctors practice medicine with the beliefs they reveal. This contextual gap (or, lack of informational features necessary for analyzing the comments) further emphasizes the ambivalence and contradictions inherent in the doctor-patient

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120 Out of the twenty-four doctors who participated, all of them disclose their respective medical specialties, but only six of them disclose their names (five men, one woman). Over half of them only contributed one secret, while the other half contributed between two and five secrets. There is evidence that two of the contributors are women, and one secret implies the doctor is female, but because of the general anonymity, it is uncertain if there are more.
relationship, and highlights the destabilization of medical power and knowledge, as agency increasingly shifts between them.

**Who’s Responsible? Shifting Power and Authority in Health Care**

Two of the factors the National Consensus Statement on Mental Health Recovery (NCSMHR) lists as fundamental to recovery\(^{121}\) are self-direction and empowerment:

Consumers lead, control, exercise choice over, and determine their own paths of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. ...Consumers have the authority to choose from a wide range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in doing so. ...Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life. (1-2)

According to several of the contributions in *Reader's Digest*, some doctors agree with patients exercising choice over their health care, even offering advice on how best to do so. For instance, one heart surgeon in New York City advises to “Avoid Friday afternoon surgery. The day after surgery is when most problems happen. If the next day is Saturday, you're flying by yourself without a safety net, because the units are understaffed and ERs are overwhelmed because doctors'..."

\(^{121}\) While these fundamental components were originally defined in relation to mental health, I believe they extend equally to recovery from any illness, including the process of maintaining good health by preventative measures. Taking the NCSMHR’s position on recovery as “an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health,” I suggest that routine medical interventions from general physicals to annual gynecological, mammograms, or cardiovascular exams constitute maintenance and preventative medicine, and thereby, are a part of the process of recovery.
offices are closed” (125). To me, this is a logical and informative contribution, one that will help people make better choices about their health care, and one that informs the patient how to gain some control over the organizational structure of her health care in particular. This heart surgeon also advises on choice of physician: “Often the biggest names, the department chairmen, are not the best clinicians, because they spend most of their time being administrators. They no longer primarily focus on taking care of patients” (125). For many readers, this information may be surprising. The public often associates fame with power, prestige, and capability, thus positioning the famous with a certain kind of authority. In this case, however, the heart surgeon advises his readers to subvert that position, which is actually a position of double prestige (prestigious as both doctor and quasi-celebrity). These instructional contributions align with another fundamental component of recovery—empowerment. By identifying the time least beneficial for people to schedule a surgery, and the rank of doctor least effective in caregiving, the contributor opens up an opportunity for patients to be educated about their choices in health care.

Interestingly, I was told the exact same information by a resident in psychiatry regarding a specific doctor in a different department. The resident had scheduled a procedure for me in this department, which was assigned to the chair. Unfortunately, because of the chair’s negligence, the procedure failed, and I had to repeat it again on a different occasion. When I reported this to the resident in charge of my psychiatric care, he revealed that though this person was chair of his department, he was recognized as nothing more than a figurehead by most people at this hospital, and would likely not give the best care. Had I known this beforehand, I likely would have chosen a different doctor to facilitate the procedure, rather than wasting time and money and being put into an unnecessarily stressful situation. An informed consumer would be able to make choices to avoid situations like this, but an uninformed consumer might easily buy into the idea that the best practices come from the oldest, most established physicians.
Still other contributors offer unsettlingly contradictory advice about the self-direction and empowerment of patients. For instance, an ER physician in Colorado Springs, Colorado offers two secrets: “I wish patients would take more responsibility for their own health and stop relying on me to bail them out of their own problems” (122), and “It really bugs me when people come to the ER for fairly trivial things that could be dealt with at home” (123). The first part of the first statement (“I really wish patients would take more responsibility for their own health problems”) is again, a logical and somewhat instructional statement. In fact, the NCSMHR lists responsibility as one of the ten fundamental components of recovery. Yet, the advice is completely undercut by the derisive tone of everything else that follows. There are no qualifying remarks as to what constitutes the “trivial things” this doctor wishes patients would handle on their own, or how this doctor “bail[s] them out.” Nor does the doctor define what kind of “problems” his patients have. Without this knowledge, the doctor comes across as callous, disaffected.

Another set of contradictory secrets comes for James Dillard, MD, a pain specialist in New York City. He tells us:

One of the things that bug me is people who leave their cell phones on. I’m running on a very tight schedule, and I want to spend as much time

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123 The NCSMHR states that “Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identity coping strategies and healing processes to promote their wellness” (1). As I see it (and experience it), self-direction, empowerment, and responsibility are interconnected. The ER physician, however, seems to have a different definition for responsibility than I do.
with patients as I possibly can. Use that time to get the information and the process you need. Please don't answer the cell.
--James Dillard, MD, pain specialist, New York City

Your doctor generally knows more than a website. I have patients with whom I spend enormous amounts of time, explaining things and coming up with a treatment strategy. Then I get e-mails a few days later, saying they were looking at this website that says something completely different and wacky, and they want to do that. To which I want to say (but I don't), 'So why don't you get the website to take over your care?'
--James Dillard, MD

In many ways, doctors are held to an unrealistic standard. We are never, ever allowed to make a mistake. I don't know anybody who can live that way.
--James Dillard, MD

Dillard’s first statement is again, logical. Etiquette aside, talking on one’s cell phone while at an appointment with a doctor (or while sitting in class, waiting in the grocery store line, etc.) is a waste of time, for both doctor and patient—an example of how technology encroaches upon us in unexpected places. And from the first statement, Dillard seemingly has his patients' best interest at heart, advising them how to productively utilize their office visits. Yet the next statements, again, undercut the sincerity of his advice. Most people would agree that in the Information Age, it is advantageous for the lay public to arm themselves with as much knowledge as possible when visiting a doctor (or mechanic, or any professional one might hire), and that the proper websites can, in fact, act as intermediary between doctor and patient in what for some in a tension-filled experience.

I find Dillard’s final statement, though, the most baffling. If Dillard really worries about the standard to which doctors are held, why wouldn’t he concern
himself more with patients who want to exercise some agency in their health care decisions? If Dillard admits doctors are fallible, that they do not in fact know everything, then it is also fair to assume that their patients may have access to information their doctors do not. Considering how often new medications appear on the market, for instance, it is actually quite likely that a research-savvy patient could see a commercial advertisement for it, then access the Internet for information on their side effects, efficacy rate, recommended dosage, and so on.

**Through the Gaze of Medication**

In “The Psychiatric Gaze: Deviance and Disability in Film,” Elizabeth J. Donaldson notes that,

The current strategies of marketing antidepressants help transform psychiatric diagnosis into self-diagnosis. In so doing, psychiatric categories become occasions for educated consumers to exercise their (limited) freedom to choose what services and medications they receive from their health-care providers. Websites devoted to specific brand name antidepressants, such as Prozac and Celexa, include interactive self-assessment tools to encourage consumers’ interest in their product. Infomercial web sites, like WebMD, also include self-assessment tests and likewise reinforce this dynamic. This marketing strategy serves to further decentralize and expand the psychiatric gaze's power. (44)

Donaldson’s concerns about what power the production and distribution of psychotropic medication holds over consumers is legitimate. My larger interest here is that she finds, as I do, consumers’ access to websites, commercials, and
other kinds of information about medication (and therefore there side effects, contraindications, etc.) a means to freedom of choice.\textsuperscript{124}

In “Truth in Advertising: Rx Drug Ads Come of Age,”\textsuperscript{125} Carol Rados reports that FDA surveys (1999-2002) show Direct-to-consumer (DTC) advertising does have benefits:

...among patients who visited doctors and asked about a prescription drug by brand name because of an ad they saw, 88 percent actually had the condition the drug treats. This is important...because physician visits that result in earlier detection of a disease, combined with appropriate treatment, could mean that more people will live longer, healthier, more productive lives without the risk of future costly medical interventions. (par. 10)

DTC advertisements are not without faults, particularly when the information provided is faulty or missing crucial elements, such as fatality potential.\textsuperscript{126} Yet these ads help highlight under-treated and stigmatized illnesses (par. 5-6). I find

\textsuperscript{124} Considering that fifteen years ago, there were no prescription drug commercials, and that ten years ago, prescription drug commercials were not required to list possible side effects during the ad, I see the presence of these commercials in our culture as a welcomed necessity. I want to know what medications are available to me, and what will happen when I put them in my body. This is not to say that advertisements alone erase all potential dangers associated with prescription medications. Yet, with adequate regulation, I do believe that prescription drug commercials can facilitate in making the consumer an informed participant in their own treatment.


\textsuperscript{126} Since 2004, The Food and Drug Administration (FDA) has taken regulatory measures to ensure full disclosure of medications’ potential risks. Black box warnings are required in the package inserts for prescription medications known to pose risks such as suicidal ideation, heart failure, loss of bone density, or any other harmful or threatening side effect <http://www.fda.gov/cber/gdins/boxwarlb.htm>. The debate continues, however, on what drugs should require the warning, as well as on how consistently the labels are adhered. See, for instance, Laurie Barclay’s “Inconsistent Adherence to Black Box Warnings: A Newsmaker Interview with Anita Wagner, PharmD, DPH.” Medscape Today 18 November 2005 <http://www.medscape.com/viewarticle/517424>.
Dillard’s statement about patients obtaining information from websites particularly baffling when juxtaposed with the statement by the New York City heart surgeon: “At least a third of what doctors decide is fairly arbitrary” (127). If decisions about medical care are, in part, arbitrary, shouldn’t the patient be as likely (and as welcomed) a contributor as anyone else? Particularly considering the following statement from an oncologist in Santa Cruz, California: “The best doctors are the ones who aren’t afraid to say, ‘I don’t know’ or ‘I’m not sure.’ The most dangerous are the ones who think they know but don’t” (127). This particular statement is, to me, reassuring, in that it serves to humanize doctors at the same time that it confirms a belief long held by many, myself included. However, this statement does not include qualifying remarks about what exactly doctors do know, thus leaving the patient to speculate about the reliability of the entire body of medical knowledge.

(De)humanizing Doctors, (De)humanizing Patients

Other contributors share secrets that simultaneously humanize doctors themselves and their patients. A surgeon from Dallas/Fort Worth Texas reveals that, “If a sick patient comes to me with a really sad story and asks for a discount, I take care of him or her for no charge” (127), and a pediatrician from Chicago admits that “Though we don’t cry in front of you, we sometimes do cry about your situation at home” (127). Both of these admissions reveal that some doctors do have real empathy and compassion for their patients, that they do strive to serve their patients well and with dignity—a heartening thought undercut only by the
disheartening contributions of other RD doctors, and by the reality that doctors who offer such extensive free medical care out of the kindness of their hearts are few and far between.

Still other contributors, however, reveal a myopic vision of what it means to extend health care services. A cardiologist from Brooklyn discloses the utter disgust and frustration some physicians hold for their patients:

I am utterly tired of being your mother. Every time I see you, I have to say the obligatory ‘You need to lose some weight.’ But you swear you ‘don't eat anything’ or ‘the weight just doesn't come off,’ and the subject is dropped. Then you come in here complaining about your knees hurting, your back is killing you, your feet ache, and you can't breathe when you walk up half a flight of stairs. So I'm supposed to hold your hand and talk you into backing away from that box of Twinkies. Boy, do I get tired of repeating the stuff most patients just don't listen to. (122)

Certainly, I can understand the cardiologist’s frustration. The current surge of studies about obesity and its effects on the nation point to the very real urgency of maintaining a healthy weight for optimal wellness. However, this statement does not qualify what constitutes a healthy weight, nor does the doctor investigate the probable underlying causes of the unhealthy weight (and, I would argue, the resistance to exercise and the insistence on maintaining an unhealthy diet). The aches and pains this patient experiences indicate that he or she is likely not simply overweight, but also at an unhealthy weight, and likely unable to reverse this without some sort of intervention or motivation. Depression, anxiety, and stress play a significant factor in obesity, both as a cause for and as a result
Yet the cardiologist does not make this connection between causation and consequence for the patient, nor does he or she offer a referral to the kind of doctor who might make this connection. There is no reciprocity of information sharing here which might lead to the patient being informed enough to make better choices (and for the doctor to give better care); instead the cardiologist withholds information, and remains detached from the consequences of obesity behind his or her own medical specialization.

Withholding information from patients is, according to the doctors contributing secrets to *Reader’s Digest*, a common practice. The NCSMHR includes empowerment as one of the fundamental components of mental health recovery, and part of being empowered is for “Consumers [to] have the authority to choose from a range of options and to participate in all decisions…that will affect their lives, and are educated and supported in doing so.” As pain specialist James Dillard resents patients who research their own health care because he can provide them with all the necessary information, other doctors elect to leave out important information, or even outright lie. A cardiologist from Bangor, Maine admits that “Sometimes it’s easier for a doctor to write a prescription for a medicine than to explain why the patient doesn’t need it” (123-4). An oncologist from Santa Cruz, California reveals the strategy he uses for dealing with patients

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127 Please see: “Association between Obesity and Psychiatric Disorders in the US Adult Population.” Gregory E. Simon; Michael Von Korff; Kathleen Saunders; Diana L. Miglioretti; Paul K. Crane; Gerald van Belle; Ronald C. Kessler. *Arch Gen Psychiatry*. 2006; 63:824-830. To view the article online, please see [http://archpsyc.ama-assn.org/cgi/content/full/63/7/824](http://archpsyc.ama-assn.org/cgi/content/full/63/7/824).
who are too talkative. Rather than find out why the patient is compelled to
garrulousness (e.g. anxiety, nervousness, loneliness, depression), he lies: “I
used to have my secretary page me after I had spent five minutes in the room
with a difficult or overly chatty patient. Then I'd run out, saying, ‘Oh, I have an
emergency’” (123).

This blatant disrespect and lack of compassion is troubling, but even more
problematic are doctors who do not divulge their motivations for prescribing
certain medications or treatments. An internist from Rochester, Minnesota
reveals that “Ninety-four percent of doctors take gifts from drug companies, even
though research has shown that these gifts bias our clinical decision making”
(124). Though I do not think this particular revelation is news to the general
public, who has an increasing cultural understanding of how the pharmaceutical
industry operates, I do believe it is notable that an actual medical professional
admits to this. Such an omission of information leads patients to falsely believe
that doctors prescribe medication for the betterment of the patient. Instead,
doctors who prescribe medication to line their own pockets are complicit in the
commodification of illness, disorder, and disease, and in patient endangerment.
The drug companies with the best kickbacks may not produce the medication
best suited to a given patient’s treatment, or worse, that particular drug’s side
effects may further compromise the patient’s well-being.

Despite the clearly disrespectful and potentially dangerous practices the
above doctors disclosed, other physicians revealed a more compassionate side
to omitting information. A Hartsdale, New York pediatrician states: “When a parent asks me what the cause of her child’s fever could be, I just say it’s probably a virus. If I told the truth and ran through the long list of all the other possible causes, including cancer, you’d never stop crying. It’s just too overwhelming” (127). The ambiguity of this contribution humanizes the pediatrician in a particular way. The doctor moves from first person to second person in describing the emotional content of this experience. It is not clear who would never stop crying: the doctor, the parent, or both? Moreover, does the reality of illness and the prospect of a potentially sick or dying child overwhelm the parent or the doctor? Does the physician make a sacrifice for the patient by protecting him or her from unnecessary worry? It is not clear from this statement why exactly the pediatrician omits information (is it because it is less likely for the fever to be dangerous, or is there another reason?). What is clear is that by conflating the emotions of doctor and parent, the pediatrician appears to combines sensitivity with logic in treating patients.

Clinical detachment is a common positioning when medical practitioners want to remain objective in their caregiving. The principle behind this stance is that if the physician views the patient as a set of pathologies, rather than working to see the patient as a human, and thereby identifying with the patient as human, then he or she runs less of a risk of making a mistake in the patient’s healthcare based on emotive reasons. A case can be made that, in a specific context, adopting a clinical detachment could be prudent for both physician and patient.
The pediatrician from Chicago above sets such an example by reserving a visible emotional response for a time more appropriate. I do, however, argue that there is a difference between being clinically objective, where the patient becomes momentarily an object as a means to an end (e.g., that end being proper diagnosis, treatment, recovery), and when the patient becomes an object for the physician. Some of the secrets contributed to Reader’s Digest reveal just how dichotomously objective doctors can be. For instance, consider the following contributions (RD 124) that I categorize as being objective as a means to an end:

Taking psychiatric drugs affects your insurability. If you take Prozac, it may be harder and more expensive for you to get life insurance, health insurance, or long-term-care insurance.
--Daniel Amen, MD, psychiatrist, Newport Beach, California

Hospitals want physicians to send patients home faster, so some are given bonuses for getting their patients out of the hospital quickly.
--Evan S. Levine, MD, cardiologist, New York City

Doctors get paid each time they visit their patients in the hospital, so if you’re there for seven days rather than five, they can bill for seven visits. The hospital often gets paid only for the diagnosis code, whether you’re in there for two days or ten.
--Evan S. Levine, MD

On the one hand, Amen’s statement neglects to contextualize psychiatric drugs; the statement does not qualify what one should do if psychiatric medications are a necessity, or name it as an injustice that they affect a person’s insurability. The person taking the medication (and nuances about his or her life experiences) is missing from this statement. Yet, Amen gives insight into the realities of a healthcare system tainted by the pharmaceutical industry. By not offering advice and just making a factual statement, his straightforwardness allows the reader to
make his or her own choice: take the medication or not, report the medication on insurance forms or not, find alternative ways of obtaining medication or not. Likewise, Levine’s statements reveal the realities of a procrustean healthcare system overwrought by insurance companies, billable hours, HMOs, and understaffing. In Amen’s statement, the patient is reduced to a diagnostic liability, and in Levine’s, to a diagnostic commodity. None of the above statements, however, imply that Amen and Levine make these claims about themselves, their own practices or beliefs. Instead, the statements imply that Levine and Amen believe these injustices to be true about the practices of other people and systems, and they are informing the public about what is in store for them when making choices about their healthcare.

The flip-side to clinical detachment is that it moves quickly from viewing patients objectively to dehumanizing them as objects. Some secrets in RD are troublesome in that, rather than expressing a clinical objectivity in order to make a point, render services, or facilitate treatment, they reveal an increasingly overt view of patients as bodies that do not matter that become bodies that matter too much, and in problematic ways. A family physician in Washington, D.C. contributed the following secrets to RD:

Doctors are only interested in whether they are inconvenienced -- most don't care if you have to wait for them. (127)

It's pretty common for doctors to talk about their patients and make judgments, particularly about their appearance. (126)

In most branches of medicine, we deal more commonly with old people. So we become much more enthusiastic when a young person comes
along. We have more in common with and are more attracted to him or her. Doctors have a limited amount of time, so the younger and more attractive you are, the more likely you are to get more of our time. (126)

This physician is not simply reserving judgment, as is the case in Amen’s and Levine’s statements; in fact, the contributor is making discriminatory judgments that are nothing short of sexually objectifying. The patient is reduced here to a gratuitous object, existing merely to pass the time for the physician. The context of a doctor visit is, for some, already fraught with tension, anxiety, and frustration. As a patient, imagine knowing that if you do not fit the parameters of what your doctor deems worthy of spending time with, and thereby worthy of receiving adequate medical care, how much more distressing such a doctor visit can be.

Comparatively, in two of the statements, the DC family physician generalizes the thoughts and behaviors of doctors, so that all doctors might be said to exhibit such thoughts and behaviors. But, then, much as the pediatrician does, this contributor shifts from third person to first person, identifying him/herself into the collective “we,” as if all doctors base the quality of the care they give on what they deem attractive or unattractive about their patients. More than the intense distaste I have for these comments and whoever contributed them, I feel tremendous sympathy for this person’s patients. Unfortunately, this contributor did not include his or her name, so responses to these statements will likely be limited to the Reader’s Digest online version of this article.
Dr. Farrago’s Idiopathic Wit and Wisdom

The most compelling contributor is Douglas Farrago, MD. Farrago does not provide his medical specialty, but does note that he is editor of *Placebo Journal: Idiopathic Wit and Wisdom*, which I will further address in this analysis. Farrago contributed five secrets, all of which I read as being sarcastic and condescending in tone:

Thank you for bringing in a sample of your (stool, urine, etc.) from home. I'll put it in my personal collection of things that really gross me out. (122)

So let me get this straight: You want a referral to three specialists, an MRI, the medication you saw on TV, and an extra hour for this visit. Gotcha. Do you want fries with that? (122-3)

I know that *Reader's Digest* recommends bringing in a complete list of all your symptoms, but every time you do, it only reinforces my desire to quit this profession. (123)

Asking me about your rash or discharge at Wal-Mart probably isn’t the most appropriate thing to do. (123)

I really do know why you're bringing your husband and three kids, all of whom are also sick, with you today. No, they are not getting free care. (124)

Farrago’s statements compel me in two ways. First, I find them distasteful, disturbing, disrespectful, negligent, and offensive. Second, what I find more telling about Farrago’s character is that although many of the contributors’ comments attack the character of their patients, Farrago’s comments do so in a peculiarly defensive way. He positions himself in these statements as somehow a victim—the victim of patients who are charlatans, ignorant, lacking in social skills, and have repulsive bodily habits—and through his victimization, is entitled
to launch a character assassination against his patients. Farrago further maligns his patients in these comments by erasing possible moments of agency for them. What could be read as a patient trying to participate in his or her own health care is reduced to a patient overstepping boundaries between doctor and patient, and ultimately contaminating the doctor’s authority.

Farrago’s comments in *RD* are also confusing, and highlight the contradictory nature of this article (and medicine at large), since information abounds (everywhere from AARP\(^ {128} \) to the *Wall Street Journal*) telling patients to bring a list of symptoms, health history, current medications, and concerns to a doctor’s appointment. The Agency for Healthcare Research and Quality (AHRQ),\(^ {129} \) a section of the US Department of Health and Human Services (HHS), advises the same, and devotes a section on their website to being “an active health care consumer,” including “20 tips to prevent medical errors.” It baffles me, then, why a doctor would want to not just circumvent, but denigrate, his patients taking agency in their own healthcare. Dr. Farrago’s comments conflate himself (and presumably other doctors) as both victim and authority—the

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one who *should* be collecting the stool samples, obtaining the history of symptoms, and designating the appropriate time and place to disclose medical information.

In looking at the other contributed comments in the *RD* article, the construction of authority is, again confusingly, shifted from doctor to patient and back to doctor again. For instance, one obstetrician-gynecologist in New York City notes that “The most unsettling thing for a physician is when the patient doesn’t trust you or believe you” (123). Yet, a chiropractor in Atlanta reveals he/she “was told in medical school to put a patient in a gown when he isn’t listening or cooperating. It casts him in a position of subservience” (122). Still other doctors disclose secrets about medication that in reality is becoming a cultural understanding of an often rightly maligned pharmaceutical industry. An internist in Philadelphia tells us “Those so-called free medication samples of the newest most expensive drugs may not be the best or the safest” (124). A cardiologist in Bangor, Maine notes that “Doctors often make patients wait while they listen to sales pitches from drug reps” (126), and that “Sometimes it’s easier for a doctor to write a prescription for a medication than to explain why the patient doesn’t need it” (123-4). Though the internist’s secret is somewhat innocuous in that the teller is simply giving information, not placing blame on doctor or patient, embedded in this knowledge is the real danger that these new and possibly unsafe medications are prescribed on a daily basis. The cardiologist, however, inadvertently acknowledges causing unnecessary loss of
time and wages earned because of the patient’s doctor appointment, and more importantly, complicity in possibly causing future harm to the patient.

Unfortunately, although there are best practices and codes of ethics that theoretically unify how medical professionals render healthcare services, in praxis, it is at the discretion of the individual doctor how well (or unwell) each patient is treated. The threat of malpractice suits, as many of the RD doctors noted, curtail some inappropriate behaviors, as does the exorbitant cost of malpractice insurance. Yet, the health care industry remains largely unpolicied. Fortunately, online environments provide health care consumers significant information about the benefits and detriments of using medical services. Even those sites that offer the most basic information serve to educate consumers, and help them make better decisions in obtaining health care. As previously noted, Reader’s Digest currently appears online. Anyone with an Internet connection can access most of the stories from the print magazine, including Dermody and Curtis’ article, “41 Secrets Your Doctor Would Never Share (Until Now).” And, anyone with the time, patience, and a modicum of technological

130 This is not to say there are no codes of ethics, rather, enforcement of them is discretionary. The American Medical Association (AMA), and other international medical associations, has a clear set of medical ethics. As with any other profession, however, breeches of these ethics can and will occur. For the current AMA code of ethics, please see <http://www.ama-assn.org/ama/pub/category/2512.html>. For the World Medical Association International Code of Medical Ethics, please see <http://www.wma.net/e/policy/c8.htm>.

131 Please see, <http://www.rd.com/living-healthy/41-medical-secrets/article75920.html> for the article and comments.
savvy can post a comment in response to the 41 secrets—and in just one month’s time since the publication, over 280 people have.

**Reading Readers Reading Reader’s Digest**

I want to note why I find digital comments so compelling. I am the type of cyber-reader who spends a great deal of time getting news from online news sites. Out of the ever-growing hundreds of digital newspapers and magazines available, the same story will appear on hundreds to thousands of different sites. My news reading practices start by going to Google News, finding the seemingly best-reputed sources, and then narrowing the stories down to those that offer the ability to comment on the material. I do this, in part, admittedly because I am curious about what other people think of the material, how they read it, what they might have to say regarding it. But it is also, in part, because I love reading other people writing what I want to say. I want my opinion about a story or a writer confirmed in the minds of other readers, and in the electronic marginalia of readers’ comments, I often find this. In the case of the “41 Secrets,” I wanted someone, anyone, to call the doctors in this article out, tell them we aren’t amused by their comments, and that we believe many of them to be incompetent as caregivers. In an equally hopeful moment, I want to read someone’s opinion that differs from mine but can persuade me to rethink my stance. Many of the comments in response to the RD article did echo my views, and also reaffirmed my fears about the American health care system.
Recovering Voices: *RD* Readers Speaking Out, Or, My name is Tom

Some of the comments in response to the *RD* article show an interesting remix\(^{132}\) of the categories Curtis and Dermody use to structure the comments in the digital and print version. For instance, tntnb posted several responses on the RD.com site, including a succinct and accurate remix of the categories: “Docs to patients: Pay, obey, then go away. (Unless you're hot)” (06/20/2008 9:14a.m.). This same person posted another comment about the *RD* article, giving a website address for his response to the doctors’ 41 secrets. Tom identifies himself as tntnb on the *RD* website, but his own blog, Rejected by the Enquirer, reveals that he is from Cincinnati, Ohio, and is “A crank who writes more and more letters to the newspaper with every passing year.”\(^{133}\) From his list of “Ten Things We Don’t Tell Our Doctors,” many of Tom’s points are pointedly humorous and insightful:

\(^{132}\) [Eduardo Navas](http://remixtheory.net/?page_id=3) offers the following definition of “remix culture”: “the global activity consisting of the creative and efficient exchange of information made possible by digital technologies that is supported by the practice of cut/copy and paste” (par. 1)

[http://remixtheory.net/?page_id=3](http://remixtheory.net/?page_id=3). Initially an activity specific to music culture, remixing made its way into other technological practices, specifically, digital composition. Another remix comes from online community [MomLogic.com](http://www.momlogic.com), a safe place “where Moms from all walks of life and in all stages of motherhood come together…to get information [and share experiences],” especially for “Moms who want to know a little bit about a lot of things, but have very little time.”\(^{132}\) MomLogic reprints the RD article in their section on Health/Diet/Fitness, with no additional comments or changes except for the category titles, which I find accurate as well as humorous: “Do they get frustrated? (Yup) Care about your health? (Definitely) Gossip about you? (Oh, yes); Notice how you look; Wish you’d take care of yourself; Have a smarmy side; Don't play by the rules” 24 July 2008[http://www.momlogic.com/2008/07/the_truth_about_doctors.php](http://www.momlogic.com/2008/07/the_truth_about_doctors.php).

1. My name is Tom. Not Tim. Not Ted. Not Jon. I know you wouldn’t recognize me if we ran into each other at Kroger’s, but for Pete’s sake, my name is right on the chart.
2. We haven’t been under the illusion that you care about us for some time. Thanks for confirming that in *Reader’s Digest*.
6. We will never again worship you as gods. Get over it.
8. A lot of us presume you’re in thrall with the drug companies. Hope you buy something pretty with that kickback you got from prescribing that new, unproven medicine to me.

Point number 1 reflects the reality of the detached doctor with limited time to interact with his or her patients. Points 2 and 6 undermine the stronghold the myth of doctor as omnipotent agent still has on our culture (or at least in the minds of many doctors). Point number 8 reflects the growing cultural understanding of how drugs are (and are not) manufactured, regulated and dispensed. Still, one of Tom’s points is instructional as well as hopeful:

10. We love it when you’re humble enough (or brave enough) to give it to us straight—whether that means “I don’t know” or “Yes, as far as we can tell, you may have only another six months.” Come on, doc. Just act like a human being, and maybe we can bring back some of the love, or at least some of the trust, that we used to have in you.

Tom’s request for doctors to “act human” (and by extension, treat their patients like humans) is echoed throughout the 280+ comments on RD.com. Equally resounding, though, are the comments from the *RD* doctors’ own cheering section, consisting primarily of other doctors.

Dozens of medical professionals posted comments in large part agreeing with the 41 secrets the doctors shared. In fact, most echoed similar sentiments—that Dr. Farrago, the most obnoxious and seemingly lacking in compassion, is only telling the truth, stating the facts that most doctors feel but are too afraid to
voice themselves. This acknowledgement only further validates what I, and the majority of the non-doctor respondents feel—that collectively the medical profession has little patience for the patients. Though Tom called for a middle ground between doctors and patients, only a few respondents who are medical professionals made similar suggestions. One physician, dalmy55, argues, “I understand the frustrations stated in this article...take the comments with a grain of salt. By the way, these articles do NOTHING to help doctors and patients work together.” Another poster, nursebear, comments that, “Having been an RN for 20 years I realize humor is healthy, but this article does nothing to make cohesive pt/dr. relationships.” Part of making cohesive relationships between doctor and patient is delivering effective, safe services. A respondent named klbirkholz reiterates this sentiment with the following post:

Thank you, Dr. Farrago. I had a patient who commented that she appreciated my patience in responding to her list of problems...a moment of recognition and gratitude, because she read your comments. As a family physician I want to be a healing influence, and it helps when the person I’m working with also sees me as a person.

Again, doctors and patients alike recognize the need for a reciprocal relationship between health care giver and recipient. Yet, one of the most troubling themes characterizing many of the comments posted in response to the “41 Secrets” is admission of or recognition of iatrogenesis, or, adverse effects or conditions as a result of medical treatment. By definition, iatrogenesis is counterproductive to such a balanced relationship. Before I consider these particular comments, I give
you a brief historical backdrop of the patient safety movement, which brought iatrogenic complications to the forefront of our medical industry.

**Patient Safety and Iatrogenesis: Is to Err Human?**

The patient safety movement is on the rise, the roots of which many healthcare professionals will rightfully credit to the instructions of the 4\textsuperscript{th} Century BC Greek physician Hippocrates: “to help, or at least to do no harm” (*Epidemics*, Bk. I, Sect. V.). The emergence of the patient safety movement as we know it in the 21\textsuperscript{st} century, however, is credited to groups of anesthesiologists who, in the early 1980s began investigating the morbidity rate and mortality rate due to anesthesia complications. After the Harvard Medical School and the Royal Society of Medicine of England convened, and a symposium confirmed the need for widespread awareness of these statistics, the American Society of Anesthesiologists formed the Anesthesia Patient Safety Foundation (APSF) 1984. Some of the APSF’s goals are “to communicate and to disseminate information about issues of anesthesia safety,” and to “foster investigations that will provide a better understanding of preventable anesthetic injuries” (E.S. Silker, [http://www.apsf.org/about/brief_history.mspx](http://www.apsf.org/about/brief_history.mspx)).

By the 1990s, healthcare at large had turned its attention toward patient safety, and by 1994, health policy analyst, doctor, and Professor Lucian Leape initiated the second wave of the patient safety movement. His article in *The
Journal of the American Medical Association (JAMA), “Error in Medicine,” marks a shift in both the medical and public arena towards recognizing iatrogenic mortality as one of the leading causes of death in the United States. Nicolas S. Martin, Executive Director of The American Iatrogenic Association (AIA) provides the following current definitions: from the Greek iatros (physician) and genic (induced by), iatrogenic disease is meant to include:

… any adverse effect associated with any medical practitioner or treatment. The practitioner need not be a physician, he might be a nurse or a radiology technician, or any one of the scores of differentiated healthcare workers encountered in hospitals, clinics, nursing homes, or offices, or for that matter in the ambulance on the way to one of those places.

The AIA extends the term “practitioner” to be all inclusive, so that even those “whose association with medicine is negligible or antithetical:” are held accountable, “such as homeopaths, chiropractors, and psychologists (especially now that they are lobbying for the authority to write drug prescriptions). Or perhaps even Grandma, if she is the one handing out the pills.” The necessity of such a broad definition aside, even my own grandmother and her sure-fire southern remedies could be found guilty of iatrogenic behaviors.

Martin notes that another related term, treatment, might be defined too broadly:


135 Please see The American Iatrogenic Association’s website: <http://www.iatrogenic.org/define.html>. The AIA’s mission is “Promoting accountability for medical professionals and institutions.”
Treatment is a term stretched beyond reason. It might refer to something as tangible as surgery or as subtle as a conversation, if the person conducting the conversation is considered a health specialist. (And who isn't?) It might be a potent drug or a placebo.

Because of the seemingly too inclusive nature of the term, the AIA provides a more streamlined working definition: "iatrogenic illness refers to any adverse reaction caused by anyone thought or claiming to be a health specialist, using any treatment (or lack thereof if the thereof lacking causes the illness) in any setting."

Since Dr. Leape’s groundbreaking article, the medical community has responded. In 2000, the Institute of Medicine (IOM) Committee on Quality of Health Care in America produced To Err is Human: Building a Safer Health System. This 312-page study reports that as many as 98,000 people a year die as a result of medical error (1); in fact, more people per year die of iatrogenic causes than by motor vehicle accidents, or even breast cancer or from AIDS complications. Iatrogenesis accounts for more deaths per year than workplace injuries resulting in death (27). Medication-related errors (both in and outpatient) were highlighted as one of the most common types of errors, as they are widely

prescribed and because they are typically *handwritten*, thus allowing for a greater margin of error in both the writing and reading of the script (28). Wrong dosage, wrong drug name, contraindications, allergies and other adverse effects, and patient mistakes were all considered in the statistics.\(^{137}\)

In 2000, an article in *JAMA* reports that the original IOM statistics of iatrogenic deaths was conservative, and that, “If the higher estimates are used, the deaths due to iatrogenic causes would range from 230,000 to 284,000. In any case, 225,000 deaths per year constitutes the third leading cause of death in the United States, after deaths from heart disease and cancer” (Starfield 483-485).\(^{138}\)

In 2001, the IOM issued another report, “Crossing the Quality Chasm: A New Health System for the 21st Century,”\(^{139}\) stating that “Fundamental changes are needed in the organization and delivery of health care in the United States” (23).

The IOM notes that “The burden of harm conveyed by the collective impact of all

\(^{137}\) The IOM report also included a particularly frightening pharmaceutical statistic: “In a recent investigation of pharmacies, the Massachusetts State Board of Registration in Pharmacy estimated that 2.4 million prescriptions are filled improperly each year in Massachusetts. Eighty percent of the errors involved giving patients the wrong drug of the wrong strength” (39): Multiply these figures by each state in the US, and that number increases to well over 100,000,000 prescriptions incorrectly filled a year. For a more current publication on medication related error in mental health care, please see: “Medication Errors and Patient Safety in Mental Health.” Benjamin C. Grasso, MD, et al., *Medscape Today*. September 26, 2007. <http://www.medscape.com/viewprogram/7809>.


\(^{139}\) Please see: Committee on Quality of Health Care in America. Institute of Medicine. Washington, D.C.: National Academy Press, 2001. The committee “was formed in June 1998 and charged with developing a strategy that would result in a substantial improvement in the quality of health care over the next ten years” (1).
our health care problems is staggering” (23), and that the chasm between quality of care must be bridged. One of the recommendations for doing so is that “All health care organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable” (40).140

Additionally, in 2005, Leape revisited the initial IOM report in an article in JAMA, “Five Years After To Err is Human: What Have we Learned?”141 In assessing the progress made since 2000, Leape notes the following:

First, the IOM report profoundly changed the way many health care professionals and managers think and talk about medical errors and injury. It truly changed the conversation. Although a substantial minority among both clinicians and the lay public continue to doubt that injury and mortality rates are as high as the IOM claimed, subsequent data from various sources suggest that the IOM may have substantially underestimated the magnitude of the problem.

Nonetheless, the patient safety movement continues to gain momentum,142 with continual calls for the formation of committees, securing of funds, and adherence

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140 This report also called for consideration of the potential Information technology has in improving health care in all six of these aims, including implementing automated order entry systems, automated reminder systems, more online support groups and web sites with reliable information, computer assisted diagnosis, e-visits, telemedicine, and computer stored patient information (164).

141 Lucian L. Leape, MD; Donald M. Berwick, MD. JAMA. 293:2384-2390. 2005.

to the standards set out in the IOM reports and by the Committee on Quality of Health Care in America.

As Leape reminds us in “Five Years After to Err is Human,” a decade ago, patient safety was not a part of the conversation in medical or public discourse. Or, at least, not in a way that was significant or easily accessible. Since access to the Internet, emails, video upload and download, and other digital communications have become so widespread, it is easier to analyze just how aware the public is about patient safety and iatrogenic complications. The online responses to the Reader’s Digest article “41 Secrets Your Doctors Would Never Share” exemplify that the public is in great magnitude aware of how dangerous doctors and health care really can be.

Though the American Iatrogenesis Association offers a current definition of clinical iatrogenesis, earlier studies by social critic and philosopher Ivan Illich actually popularized the term, as well as his account for social and cultural iatrogenesis. In Medical Nemesis: The Expropriation of Health (1975), Illich describes the three kinds of iatrogenesis as follows:

First, clinical iatrogenesis, which results when organic coping capacity is replaced by heteronomous management; and, second, social iatrogenesis, in which the environment is deprived of those conditions that endow individuals, families, and neighborhoods with control over their own internal states and over their milieu. Cultural iatrogenesis represents a

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third dimension of medical health—denial. It sets in when the medical enterprise saps the will of people to suffer their reality.\textsuperscript{143} (127)

Illich’s understanding of clinical and social iatrogenesis provides a particularly useful framework for conceptualizing many of the responses\textsuperscript{144} to RD’s “41 Secrets.” Amidst the many angry and resentful, sarcastic and humorous responses, there are an alarming number of respondents who expressed they have either experienced iatrogenic complications, or their fear of doctors prevents them from utilizing a doctor's care, which I argue is a form of social iatrogenesis.

\textsuperscript{143} According to Illich, “Professionally organized medicine has come to function as a domineering moral enterprise that advertises industrial expansion as a war against all suffering. It has thereby undermined the ability of individuals to face their reality, to express their own values, and to accept inevitable and often irremediable pain and impairment, decline and death” (127). While human suffering is certainly a complex issue relevant to an analysis of recovery and iatrogenesis, I want to narrow my focus on clinical and social iatrogenesis for the purposes of this chapter. Both these terms serve to highlight the dichotomous nature and connection between the medical and social models of disability, as well as how health and recovery are constructed socially and medically.

\textsuperscript{144} Comments posted on public spaces in response to articles from a digital newspaper or magazine or videos such as those on YouTube are different than other digital communications like blogging or private message boards in contained virtual learning environments (VLE) such as Web CT or Carmen. Structurally, the comments appear linearly, sometimes (but not always) with the option of sorting posts by date in ascending or descending order, or (depending on whether there is a voting option), in order of least or most popular. There may also be an option for reporting various types of abuses, such as profanity, vulgarity, personal attack, or impersonation. Depending on the forum, there may be regular posters as well as random posters, but commenting to an article is typically less conversational than communications in other digital environments. Posters to articles often are just “getting their two cents in,” rather than seeking a dialog about the given material, which makes their posts self-contained, a text within itself.
When Words Really Can Hurt You

The following are some examples of respondents who are moved to action, or, non-actions that unfortunately could have dangerous, perhaps even fatal results:

By oldmunchkin, 06/13/2008, 9:39 PM EDT
I read Anatomy of a Dr's Bill and was immediately angry. I make $10 per hour, but this person thinks they should get $41 for spending maybe 10 minutes with me? I have to work 15.5 hours to be able to afford an office visit. I am also wondering where you took the average price from. Where I live, it costs $155 to see the P.A., more to see an actual MD. Its no wonder many of us uninsured neglect our health and then end up in the ER.

By annaanastasia, 06/19/2008, 6:14 PM EDT
Apparently, doctors hate fat people, they hate old people, and they hate anyone with actual medical problems. Perhaps only thin, healthy, young people whom the docs find personally attractive should come and throw money at them for doing nothing? Thanks for confirming my decision to swear off going to the doctor for regular checkups.

By barbararara, 06/23/2008, 11:23 AM EDT
I was going to go into the clinic today because for the third time in as many months, my foot & leg have swollen to two times their normal size, with excruciating pain at times.....It may be too trivial...think I'll just stay home & keep icing

By driberif01, 06/23/2008, 3:45 PM EDT
Having never heard of Dr. Farrago until I read this article, I do not find his comments amusing. I wonder how many people will read this article and decide NOT to see their doctor for fear of inconveniencing him or her, to the detriment of their health. Maybe the humor that keeps doctors going in spite of baseless malpractice suits, insurance hassles, etc. is better kept between them & their colleagues.

By imdone412, 06/27/2008, 7:48 AM EDT

To preserve their integrity, I have reproduced these comments as they appear on the RD website. Based on my own cyber practices, in digital environments where comments or responses appear, grammatical errors and misspellings are frequent, including in my own comments. I attribute the errors to the mood and the moment. When I am in a rush to respond to something or someone, I often misspell words. Similarly, the majority of those who read the “41 Secrets” article and posted comments were angry and felt an urgency to voice their opinion, which lends itself to making such errors in their communications.
Wow. Now that I know the complete contempt in which my doctors hold me, I'm never going to any of them again. It's hard enough to maintain any sense of dignity in front of a fully clothed person while I'm wearing a ridiculous paper gown, but I had no idea that they actively hated and ridiculed me. Thanks for the heads up, Dr. Farragano. (And right back at ya, ya glorified mechanic!)

By boophus, 07/04/2008, 6:41 PM EDT
Talk about a whine. In a high paying job and complaining that patients aren't subservient. This is why i don't go to Doctors except for infections or broken bones. If I wanted to pay for lifestyle police and judgmental opinions that assume I am lying then I would see a Dr more than once every 4 years.

By skyey, 07/20/2008, 9:55 AM EDT
I read back 6 pages of comments and not one critical of the receptionist in the office? Really? Not every office to be sure but some are horrendous and in one I was even questioned about if I was really who I said I was! Really, she said this is supposedly {name}! But yes, the medical business (not profession) is awful and I haven't been to any doc for 9 years and regretted going then, they did nothing to fix the problem but wanted me to go to yet another doc in a different city. I didn't.

By bubbly12, 07/20/2008, 1:41 PM EDT
If I needed a doctor, I'd stay home and rather be my own doctor, if Dr. Farrago was the only one I could see. He sounds like a real jerk. why did he choose this profession anyway? Just to get rich?

By deafgurl07, 07/23/2008, 12:04 AM EDT
The only reason I don't go to doctors is because I am afraid they will not like me or be really annoyed by me. I guess I'm right after all.

By justamzungu, 07/23/2008, 7:32 AM EDT
The antipathy of physicians towards overweight or obese patients is real barrier to getting good. Obesity is a complex phenomena involving behavior, heredity and living conditions. As an overweight person I avoid care even when I need simply to the condescending interaction with a foot tapping MD. Eventually my Drs bias will probably kill me.

By somelady, 07/23/2008, 1:59 PM EDT
All this confirms my decision to see a Dr only when it's broken or infected!! I'm forced to go once a year so he can prescribe my BP meds. I can prolong that if I make an appt and then cancel after my scripts are filled. Hey, Doc, my revenge is to outlive you!!! lol
Posters like oldmunchkin who are uninsured (or underinsured) justifiably have two-fold concerns: bad-doctoring or no-doctoring. On August 29, 2006, the Democratic Policy Committee (DPC) issued the report, “Number of Uninsured Americans Continues to Rise on Bush Administration’s Watch.” According to the DPC,

More than 46 million Americans are living without health insurance. The number of uninsured Americans has increased each year of the Bush Administration. After decreasing at the end of the 1990s, the number of Americans without health insurance has increased from 39.8 million in 2000 to 46.6 million in 2005. [http://dpc.senate.gov/dpc-new.cfm?doc_name=fs-109-2-127](http://dpc.senate.gov/dpc-new.cfm?doc_name=fs-109-2-127)

Additionally, the DPC reports that there are 16 million Americans who are underinsured, with inadequate coverage for chronic or catastrophic illness. And, on August 5, 2008, the *Annals of internal Medicine* reported that there are an estimated 11.4 million uninsured Americans of working age with chronic illnesses such as cardiovascular disease, hypertension, and diabetes. Given that some of the barriers leading to lack of insurance or adequate coverage are social

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146 It is important to note that many respondents, both medical professionals and the public, hold the health care system and insurance companies equally (if not more) responsible than doctors themselves for the lack of adequate care and general compassion. I focused less on these posts not because I disagree with the profound role the corporatization of insurance and medicine plays in the downfall of American health care, but because these ideas were less coherent in the responses. In fact, I have many of my own insurance-related stories since I am one of those uninsured Americans. Perhaps the narratives on RD.com about health care professionals are more cohesive because for some people it is easier to recognize and articulate exactly how and why a person is disrespectful or negligent than a system or institution is.


(unemployment or part time employment, exorbitant premiums, unknowledgeable about how and why to get insurance), oldmunchkin and other posters should be angry—but, they should also be afraid. Having adequate health insurance does not ensure adequate health care, either on the level of interaction or practice.

Many posters, like annaanastasia and justamzungu, raise serious concerns about weight stigma. The previously mentioned Brooklyn cardiologist who complained of non-compliant overweight patients was not alone in voicing frustration with such patients. One other doctor echoed a similar opinion in the “41 Secrets,” but the doctors and public posting comments on RD.com in response to the article were numerous, and mostly derogatory. That the contempt American culture (within the medical community and out) holds for people who do not meet the standardized margin for “normal weight” actually prevents some people, such as annaanastasia and justamzungu, from obtaining health care is more than outrageous—it is a crime. Fortunately, some doctors agree that the overemphasis on a patient’s weight might be more damaging than helpful. On RD.com, Dr. Steve posted the following comment:

By drsteve, 06/26/2008, 10:39 PM EDT

… would the doctors out there stop with the unnecessary observation that patients "need to lose weight"? They know that they do - probably far better than the doctors. Losing 10 (or 50) pounds is NOT a panacea, and is unlikely to solve the issue for which they are visiting. And unless the issue is approached carefully, the patients see the doctor as either not understanding their visit issue or dismisses them as not having a realistic view of the average person's life.

Though a few other posters echoed Dr. Steve’s concerns that weight standards are arbitrary and not the best measurement for the overall health of a patient, the
majority of the weight-related comments were accusatory and degrading. Why then, indeed, would annaanastasia, justamzungu and others want to spend the time and money to have a health care professional mock, blame, and otherwise dismiss them? Like the many others who choose to avoid care altogether or self-diagnose, self-treat, or self-medicate, people who avoid seeking medical care are in the same boat as the uninsured. They risk misdiagnosis, chronic illness, and faulty treatment. Again, though, for those who actually do seek professional medical treatment, there is no guarantee that they will avoid the same risks.

Social iatrogenesis has far reaching effects, and poses risks that have the possibility of resulting in disaster. Clinical iatrogenesis, however, is often immediate and permanent, as the IOM statistics remind us. For instance, one poster, MisterMuckle, offered information about iatrogenic related narratives by directing readers of RD.com to Google another website, “Adventures in Cardiology: A Story All Invasive Cardiologists Should Read.”149 In this ongoing and well documented narrative, Dan Walter describes how in 2002 Pam, his wife and a cardiology nurse, underwent a heart related procedure (Catheter Ablation for Atrial Fibrillation) at one of the nation’s leading hospitals (Johns Hopkins) with disastrous results.

According to Walter, the Director of the Electrophysiology Lab at Johns Hopkins University School of Medicine who was to perform the procedure lied about the safety and number of times he had performed the procedure. The

149 (06/30/2008, 7:57 AM EDT).
procedure was actually botched when an electrophysiologist trainee (despite the director claiming he would and did perform the procedure) shredded Pam’s heart while trying to retrieve a wayward catheter. Consequently, Pam suffered a stroke, a coma, an additional emergency open-heart surgery, and was near-death multiple times during this hospitalization. The hospital and doctors, however, deny any wrongdoing, and Dan Walter continues to educate others by posting in every forum possible his narrative, as well as others’ stories of clinical iatrogenesis.

The IOM statistics of 98,000 iatrogenic deaths per year could easily have included Pam Walter. She survived, but she also suffered. Further affirming those statistics are the following comments from RD.com posters who report the reality of iatrogenic complications:

By ashtonsnana, 06/25/2008, 10:27 PM EDT
A pediatrician who thinks it’s being kind not telling a parent what a fever could be? It’s a virus! Try brain cancer like my grandson has after seeing doctors dozens of times and being told it was a virus causing his fevers and vomiting it took an ER nurse to finally catch the subtle signs of a massive cancerous brain tumor, had she not caught on that night they said he would have died that night. Maybe if the doctors had paid attention sooner we could have caught it sooner, DO NO HARM HUH!

By sharonsj, 06/26/2008, 2:30 PM EDT
I have spinal injuries and severe arthritis. Instead of treating me (that costs money and I have no insurance), I was told to lose weight. But it hasn't made a bit of difference; in fact, I'm worse off. My friend had a severe pain in her leg and doctors told her to lose weight too. It's a standard cop-out they use when you can't afford them or they have no answers. My friend didn't have time to lose weight--she died first.

By greggj, 06/26/2008, 3:56 PM EDT
For over ten years I was referred to multiple doctors to try to find out why I was so swollen. It was blamed on being over weight, that I was peri-menopausal, then, in later years that I had gone through menopause. I finally had to leave Cleveland and travel to the Mayo Clinic to find out that I had virtually no lymph
nodes or lymph channels in my body to remove excess water. Maybe those many doctors should have paid more attention to the list of symptoms I carried with me each time!

By christanewcom, 06/27/2008, 9:59 AM EDT
This article infuriates me but it’s right, Dr’s don’t want to listen, or know us by our fist names. My son was ill for 3 months & our pediatrician ignored his symptoms His only advocates were my husband & I. We looked on the internet - found out that it was leukemia. He died 2 years later with no follow up -ever- from his Dr. Guess what, we all have jobs, most make a lot less than an “average MD” at 155k/year. So stop complaining, use your education to help people or get out & drive a bus!!

By maryaleon, 07/15/2008, 2:48 AM EDT
My brother has stage 4 cancer. He was given a drug that not only made him violently ill, but had been recalled by the FDA and had many warnings against it's use in advanced cancer and patients exhibiting past heart disease. When my brother declined a second administration of the drug the doctor asked him, "Do you want another round of chemo, or would you just like to let nature take it’s course?" In other words, if you’re not doing what I tell you, then just go ahead and die. He’s in Pueblo, CO

By mischief99, 07/22/2008, 3:42 PM EDT
You know what? I don’t really give a flip what these Dr's think about what I say or do anymore. I am paying THEM not the reverse. After my experience of being basically humiliated and called a "hypochondriac" by 13 different "Doctors", One genius finally palpated my abdomen and found a huge tumor which required emergency surgery. Who cares what they think? 90% of them are worthless!

By rmsanti, 07/23/2008, 10:01 AM EDT
I once had a doctor who was so concerned about billable minutes that he lost sight of his purpose while in the office. I had bronchitis and he prescribed drug after drug to which I was allergic. He told his staff I had aids by the appearance of the chicken pox looking sores due to his negligence in prescribing drugs that I was clearly allergic to..it had taken 8 months to get healthy due to his screw up. He let his religious views get in the way of investigating & making a sound decision.

I am struck by how many of these comments further emphasize the stigma of being overweight. As Dr. Steve notes, losing weight is not a panacea, it is not a cure-all (though to a great degree, it has replaced an earlier blanket and inaccurate term physicians often used to describe behaviors and symptoms
about which they were ignorant or uncomfortable with: female hysteria).  

Additionally, not one doctor contributed a secret that connects doctors and patients as being in the same need of maintaining a healthy weight, despite the fact that the RD article includes the following “Shocking Stat” from the New England Journal of Medicine: “44% of doctors admit they’re overweight” (125).

The Real Burden of Weight

Bodyweight is a primary site for all manner of analyses, engendering so many contradictory statistics, that it is difficult to know what is accurate and what is not. For instance, the Centers for Disease Control and Prevention (CDC), a division of the US Department of Health and Human Services, uses the Body Mass Index (BMI) to calculate according to age, gender, and weight the standards for healthy body fat. The BMI is used by many health care facilities to meet diagnostic criteria (e.g. anorexia nervosa, bulimia nervosa), to determine who is at risk for certain diseases (e.g. heart disease, metabolic disorders, diabetes), and, consequently, by private insurance companies to determine

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150 Complicating this issue of weight is that many of the very medications doctors prescribe have weight gain as a side effect. Psychotropic medications are notorious for producing significant weight gain, so much so that many people cease medication therapy because of it. Jamison, and I, can attest to this fact, since lithium is a huge offender in this area. For me, an alternative way of viewing weight in this respect is that if I am not carrying an extra twenty pounds, then I am likely not taking my lithium, and therefore likely not mentally healthy.

insurability. Yet, substantial research\textsuperscript{152} shows that BMI calculations are an unreliable and inaccurate way to assess weight because it doesn’t account for muscle mass, frequency and duration of exercise, and lifestyle. One study by the Mayo Clinic\textsuperscript{153} shows that since muscle weighs more than fat, people who fall into the range the BMI considers overweight can actually be more fit, and at less risk for major illness such as cardiovascular disease, than people who fall into the normal weight range. I wonder, then, how exactly is the lay public (non-medical professionals) supposed to determine what weight is healthy and appropriate for them?

Medical Care Meets the Information Age: Finding Space for Better Practices

Contradictory information abounds in the world of medicine. Part of making technological advances means disproving or reconfiguring old theories and coming up with new ones—what medical science (and the public) believe today, a decade ago seemed an impossibility and a decade from now will seem outdated. I can, and I believe the public in general can, make allowances for the fickle nature of technological progress; making allowances for the widespread contradictory knowledge that confuses, frustrates, and compromises one’s health is more difficult, however. I am not suggesting that all doctors are dangerous,

\textsuperscript{152} See for instance, “Research Shows BMI Often Not an Accurate Indicator of Body Fat.” March 5, 2007. \texttt{http://news.msu.edu/story/1198/}.


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lacking compassion, disrespectful, or incompetent. Despite the overwhelmingly derogatory and condescending secrets the Reader’s Digest doctors revealed, and even despite my own troubling, even traumatic, experiences with the institution of medicine and the health care system, I believe these are recoverable—just not without significant systemic changes, a sentiment echoed in many of the Reader’s Digest comments. For instance, Gort1 predicts that,

... As far as the many posts regarding being sued for malpractice, if doctors would police themselves properly, make public their Morbidity and Mortality Panel Results, pressure hospitals and other care providers to stop hiring and allowing doctor’s with bad care practices to treat the public and take pride in referring their patient’s to specialists, as if they were sending a member of their own family. K Soesbe (07/28/2008, 8:09 AM EDT)

On a microcosmic level, many changes are already in effect. Again, the Information Age offers technology that potentially can improve upon healthcare in general, and doctor-patient relationships in particular. One example is the Agency for Healthcare Research and Quality (AHRQ). In February 2003, AHRQ launched “Web M & M: Morbidity and Mortality Rounds on the Web,”154 a site for health care providers to anonymously submit cases of medical error and other problems with patient safety and have them reviewed by expert physicians and other readers. Additionally, once a month,

the editors select one particularly interesting and illustrative case to be the ‘Spotlight Case’--an interactive learning module featuring an expanded

I find this site valuable (rewarding even) for doctors and patients alike. In the “41 Secrets” article and in the corresponding comments, many doctors emphasized that they too are human, they too make mistakes. Following this logic, doctors likely would be hesitant to present some of these cases in the traditional environment, i.e., Morbidity and Mortality Conferences (M & M’s). Regardless of whether or not presenting a case in an M & M is meant to punitive, there has to be some level of guilt or humiliation that might be persuasive enough to keep some physicians from taking ownership of their mistakes.

Adding a digital environment to the traditional oral environment for disclosing and discussing medical errors is not a cure-all, but I do suggest it promotes positive change. Osteopathic physician and health activist Joseph Mercola agrees, that though there are certainly limitations to Web M & M,

Ultimately, it is [his] hope and passion that this Web site will have a profound influence in facilitating the necessary transformation of the existing medical paradigm into one that is freed from the influence of the drug companies and can assist people in achieving the full measure of health that they were designed to have. (Mercola) http://articles.mercola.com/sites/articles/archive/2003/03/08/medical-errors-part-two.aspx

In addition to offering what I believe is a healthier environment for doctors to learn from their mistakes, the public can learn as well. The submitted cases are archived on Web M & M, so anyone with access to the Internet can read them and the commentary from expert physicians, which includes suggestions for
preventing these mistakes in future scenarios and continuing to minimize risks to patient safety.\textsuperscript{155}

Self-advocating, which includes self-educating, is to consumers what best practices are to health care professionals. Sites like Web M & M should encourage health care consumers to be continually aware of the real risks involved in health care as well as the risks in not taking proper care of one’s own health. Despite the mixed messages some of the RD doctors gave about self-advocacy, it is promoted across discipline and professions. The disability rights movement, for instance, is rooted in self-advocacy.\textsuperscript{156} Similarly, the consumer rights movement, and to a greater extreme, its predecessor the antipsychiatry movement\textsuperscript{157} hold self-advocacy as fundamental to their missions. As previously

\textsuperscript{155} Many other facets of health care take place online. For instance, The Semel Institute at UCLA offers “Psychiatry Grand Rounds, our weekly continuing-education conference that brings you cutting-edge information about the clinical neurosciences, human behavior, and mental health care. The conferences are held in the West Auditorium at the Institute on the UCLA campus, and have been webcast online since 1996 with streaming video. In 2007, we introduced a podcast summary edition. In 2008, we have begun a mobile/PDA/iPhone schedule page” <http://www.psychiatrygrandrounds.com/>. Many other medical divisions offer similar Grand Rounds web casts, such as pediatrics, women’s health, and trauma.


\textsuperscript{157} For antipsychiatry and self-advocacy related information, please see: “Evolution of the Antipsychiatry Movement into Mental Health Consumerism.” David J. Rissmiller, D.O. and Joshua H. Rissmiller (Psychiatric Services 57:863-866, June 2006). For information on the Consumer Movement (also known as Survivor Movement, Ex-Patient
noted, despite Dr. Farrago’s insistence that patients bringing in lists of their
symptoms (per the advice of Reader’s Digest, no less) makes him want to quit
doctoring, self-advocacy can be self-preserving. Many of the people responding
online to the RD article voiced that Dr. Farrago should indeed quit, if his
comments in the magazine were a reflection of how he treats his patients. In fact,
Dr. Farrago received so many comments castigating the five secrets he shared in
the RD article that he made his own video response.158

Not All Doctors are Created Equally

In Placebo Television #13: Reader’s Digest Response, Farrago states:

“Here is my response to all those readers that lashed out at physicians and
myself after they read the ‘41 Secrets....’ article in this July’s Reader’s Digest.

Take it as it is intended” (http://www.placebotelevision.com/). The video appears
on his Placebo Television, which is presented by Placebo Journal: Idiopathic Wit

Movement, and User Movement), please see “Technical Assistance Guide; The History
of the Consumer Movement.” National Mental Health Consumers’ Self Help

158 Of the six doctors who identified themselves by name in the RD article, five of them
have a web presence, Dr. Farrago included. Another doctor, Sean Khozin, reproduces
an essay written by Vance Harris in his weblog. Please see “Not in a Million Years,” May
8th, 2008 at <http://blog.seankhozin.com/2008/05/08/not-in-a-million-years/>. The
comment Harris made in the RD article actually come from this essay. Evan Levine, MD,
also has an essay that pertinent to the RD article, “How to Choose Your Doctor—What
Your Doctor Won’t (or Can’t) Tell You: The Failures of American Medicine -- and How to
Avoid Becoming a Statistic.” <http://www.enotalone.com/article/4994.html>. Dr. Daniel
Amen has a book with a corresponding website about brain imaging, The Brain Place.
<http://amenclinics.com/bp/atlas/> Likewise, Dr. James Dillard had a book and
corresponding website about chronic pain solutions <http://www.drdillard.com/>.
and Wisdom, a print and online of which Farrago is founder and chief editor. The goal of the journal is to illustrate that “physicians can and do have a sense of humor” by taking “a no-holds barred approach where we make fun of ourselves, our patients and medicine in general.” The journal offers an additional, seemingly admirable goal, yet immediately undercuts it:

We are crusading against all that is wrong with the practice of medicine and want to humanize medicine again, not only for doctors, but for everyone. The Placebo Journal has no socially redeeming value whatsoever. We have no delusions of grandeur of changing the world or the way you practice medicine. We just hope you laugh. 

If the journal’s goal seems contradictory, despite its humorous intention, the self-titled King of Medicine’s video response\(^\text{159}\) is annoying at best, and unsettling at worst.

Farrago complains that “Many of the comments in the article were anonymous, which is synonymous for ‘bullshit,’” and “This video response is not to defend my remarks because even though they were made in a sardonic manner I still stand by them.” He goes on to contextualize the comment about patients bringing in lists of their symptoms. Because doctors today have more patients with less time to see them, extra lists, “some of which are as long as the Dead Sea scrolls,” cut into that time. Farrago states that “It would be less painful to rub my scrotum across cheese grater” than to deal with those list of symptoms.

Some of the RD readers, took particular issue with both his dismissal of self-advocacy and his crass sense of humor:

\(^{159}\) <http://blip.tv/file/1032775>
By reader876, 06/18/2008, 7:07 PM EDT
Dr. Farrago's comment about bringing in a list of symptoms reinforcing his desire to quit the profession outrages me. I am a nurse and have frequently recommended to my patients & family to write down what is wrong so when the imposing figure of a doctor comes in, their mind doesn't go blank, and their questions can be answered, instead of waiting another 6 months before they see him again. If Dr. Farrago isn't interested in caring for his whole patient and their concerns, he should quit now.

By gluck7104, 07/28/2008, 11:01 AM EDT
I just viewed your#13 video defending your stupidity by MORE stupidity. Please I promise NEVER to bring in another 'list' if you will go ahead and 'rub your scrotum(vigorously) with that cheese grater! Just the thought makes me feel SUBSTAnTIALy better!!! Humor...so healing. Could I suggesat 'group grate" I have a number of doctors........ ;D

I appreciate gluck7104’s sense of humor here, especially given that in her other numerous (eight and counting) scathing comments, she reveals that she is dying because of years of misdiagnoses and faulty treatments, including a pain medication that led to psychosis. To me, her experiences lend a sense of authority to her comments, especially in her post on 07/25/2008, 3:18 PM EDT, in which the RD doctors who complained about malpractice suits are buying into "propaganda and falsehood," that malpractice suits “for the 'common' man who can't afford to pay an atty up front are rare, unless they are blatant errors and you have a physician willing to write out a statement incriminating his fellow Dr.s.”

Gluck7104 finishes this comment with a further charge and a statistic: “The more physicians that back up the...lack of/or misdiagnosis are by [their] own actions protecting one another. It's called Collective Negligence. 98,000iatrogenic deaths in 2005.” Gluck7104 has not only voiced her opinion regarding health care, she has given the other readers a bit of the same information this chapter
seeks to give its readers, an action I like to see (and do) in my own cyber practices.

In his Placebo Television video, Farrago notes that while some doctors are in fact bitter, burned out, and depressed, most are not, including him. He assures his viewers though that “no one is fighting against the medical acts of evil on [their] part, which is Big Pharma, lawyers, insurance companies, etc. more than [he] is.” He offers a list of advice for his viewers (images included), about when it is appropriate to change physicians. His list includes “if she pretends to be a magician and pulls out a never-ending handkerchief during your pap smear,” and “if she brings her dog in because ‘he has a better nose for finding venereal disease than any test I have.’” I do not think I am alone in finding Farrago’s sense of humor more misogynistic and vulgar than sardonic. In fact, I know I am not alone because some of the posters to the RD article saw Farrago’s video and posted additional comments to RD.com.

By imdone412, 07/16/2008, 8:29 AM EDT
Yes, Doug Farrago, MD (Mean Doctor) has posted a video response, in which he only digs himself deeper. Honestly, I wouldn’t keep promoting it if I were you, Doogie. He incorrectly tries to paint himself as the noble “John Hancock” of this article, claiming to have been singled out for criticism because of his courage in signing his comments with his real name. No, Dr. Potato Head, you were singled out because your comments were the cruelest, most humiliating in the article.

Farrago’s humor is akin to that of shock-jock Howard Stern and shock-comic Andrew Dice Clay. I would rather run the risks of self-diagnosing and self-treating than spend even the ten minutes of history-taking with this doctor or anyone like him. In fact, I would rather have a hot poker inserted in my eye than receive medical care from someone like Farrago.
By dodiad71, 07/26/2008, 6:30 PM EDT
I viewed the response video another poster mentions here. Frankly, I was not impressed with the video. I think the "King Of Medicine" (as he calls himself) did nothing more then make a joke out his comments and patients in general. I thought his video was downright sickening.

By dodiad71, 07/26/2008, 6:47 PM EDT
More on Dr. Farrago...
http://www.placebojournal.com/shopcontent.asp?type=dougfarrago
Apparently his show is supposed to make humor out of healthcare in general. He actually thinks he’s funny, I think he does a better job at irritating patients like a really bad rash.

Again, the *RD* readers use humor to highlight how un-funny Dr. Farrago’s comments really are in what is otherwise a tense environment.

Self-Education through Repetition in Digital Environments

I would like to come full circle here and return to a point Sharp makes in *Condensing the Cold War: Reader’s Digest and American Identity*. Sharp observes that “It is important to understand how people are drawn into political beliefs and spurred into action of any sort” (xvi), and I extend this to analyzing how readers understand medical advice and are spurred into action. Given that over 280 people posted comments to rd.com regarding the “41 secrets” article, I believe people do understand that there are serious problems with current health care in the US, and that these problems extend not just to physicians but to systems and institutions regulating health care. Sharp also points out that,

It is through various repeated practices, such as reading the *Digest*, that individuals are drawn into hegemonic culture as subjects of its constituent discourses. This means that certain values are accepted as natural or 'commonsense' and thus uncomplicated. These values can then be drawn upon by political leaders (either consciously or less manipulatively) in explaining a political situation and trying to generate public support. (xvi)
While I agree with Sharp’s analysis, I also believe that uncomplicated, commonsensical repeated practices\textsuperscript{161} have other, perhaps more beneficial uses than merely reifying hegemonic culture. Recovery from chronic mental disorders often happens in slow but exponential stages. Mental health therapy holds a common theory, and one I support, that by returning to everyday practices (in addition to other recommended therapies), a person can move through the process of recovery more comfortably and more quickly. The October 2002 National Research Project for the Development of Recovery Facilitating System Performance Indicators\textsuperscript{162} states that,

Concurrent with basic material needs, people need opportunities and supports to engage in the responsibilities and benefits of citizenship, of

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\textsuperscript{161} The idea of “repeated practices” is central to poststructuralist understandings of how identity, norms, performative acts and performative speech are constructed and theorized perhaps most completely in the works of Judith Butler. Please see especially Gender Trouble: Feminism and the Subversion of Identity (1990), Bodies that Matter: On the Discursive Limits of ‘Sex’ (1993), and Excitable Speech: A Politics of the Performative (1997). Disability studies scholars also address the construction of the disabled identity, often drawing upon the works of Judith Butler (and equally as often, citing Butler and other poststructuralists for assess disability as an identity category similar to gender and related categories), and Erving Goffman, particularly Stigma: Notes on the Management of Spoiled Identity (1963), and The Presentation of Self in Everyday Life (1999). See also Carrie Sandahl and Philip Auslander’s collection Bodies in Commotion: Disability and Performance (2005), and Ellen Jean Samuel’s “Critical Divides: Judith Butler’s Body Theory and the Question of Disability” (NWSA Journal Volume 14, Number 3, Fall 2002, pp. 58-76).
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\textsuperscript{162} This report was produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) and is supported by agencies such as the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Association of State Mental Health Program Directors. The report was prepared by Steven J. Onken, Jeanne M. Dumont, Priscilla Ridgway, Douglas H. Dornan, and Ruth O. Ralph, Ph.D. 
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membership to community. Recovery involves a social dimension—a core of active, interdependent social relationships—being connected through families, friends, peers, neighbors, and colleagues in mutually supportive and beneficial ways. Social and personal isolation, poverty, emotional withdrawal, controlling relationships, poor social skills, immigrant status, disabling health and mental health conditions, past trauma, and social stigma impede the recovery journey. (7)

For people recovering from mental illnesses, achieving full citizenship is vital, but doing so “expands beyond social relationships, however. Participants indicated that recovery is enhanced through engaging in meaningful activities that connect one to the community.” Meaningful activities can include many things, from work, school, volunteer or advocacy work, and so on. They can also include “engaging in knowledge development and educational opportunities,” which in itself has intrinsic value (44). I suggest that these activities include self-education through cyber practices such as researching, blogging, and comment posting. I also argue that there is meaning in the action of these activities, not just in their results. Recall that many of the posters on RD.com were repeat posters, and that some were posting in response to material outside of the article (Farrago’s video). The posters were not just spurred to action, but spurred to action repeatedly.

This particular mode of discourse (commenting to online texts, message boards, digital forums, etc.) perpetuates repeated practices. The reader and the writer most likely check and recheck what they have posted and the text to which they have originally posted many times. The nature of these digital environments is recursive; a poster will include an actual quote from the original post (whether
it’s an article or another message posted by another user), or a reference to this effect. And, literally, any given message board or forum will entice its members to log on, read, post, and keep watch relentlessly for the next poster to continue the conversation.

Conversations in discursive environments about controversial issues often come full circle, and in the digital environments of RD.com and YouTube, the same applies. In this case, what started simply as an article in an internationally distributed print magazine moved to reader response on a website, then to reader response on a video, and back to reader/viewer response on a website. The article itself was re-posted in other online environments, including personal blogs and online communities. People searching online for this article or keywords that happen to be in the article will come across multiple sites, multiple conversations, and multiple opportunities to voice their opinions. The repetition involved in this kind of digital research is exactly the kind of meaningful activity that passes time, requires focus yet is relatively easy to do, and typically provides moments of self-education—all of which are helpful in the progress of recovery. And, for posters like Gluck7104, voicing an opinion and educating others in the form of digital comments likely provides catharsis as well as a way of passing time.
A Brief History of Personal Space

Writing about online discursive practices in the last chapter of my project was a deliberate and nuanced choice. In 1995, my relationship with the Internet began innocuously enough. Initially, between the last year of my undergraduate and first year of my graduate education, my cyber practices were limited to emailing, occasionally researching random information, and perusing databases and listservs for academic purposes. As my career as a graduate student and teaching associate progressed, I spent increasingly more time online, researching and keeping in touch with family and friends now thousands of miles away. And though my early cyber practices certainly were helpful in making researching easier, and communication with the outside world more frequent, it wasn't until I was first diagnosed with bipolar disorder that the Internet became a major factor in my own ongoing recovery process.

By 1997, out of sheer desperation, I had turned to hours of scouring through website after website for information about symptoms, medications and their side effects, diagnostics, and anything related to the disorders I was
diagnosed with. Being degreed in literature and having an extensive background in music, I certainly had a familiarity with and deep appreciation for the arts and mental illness, and had more than a passing understanding of the history of psychiatry. Back then, I thought myself quite knowledgeable about mental health. In reality though, at that point, I didn’t know anyone intimately who had a severe, diagnosed disorder, and so wasn’t versed in the language of mental illness beyond the basic college courses in psychology I took as an undergraduate. I soon realized that my familiarity with mental illness was greatly based on either surface or antiquated information. Complicating my lack of knowledge was my location. At one of the nation’s largest universities, a teaching university, my health care was provided in large part by rotating interns, residents, and attending doctors rather than a stable team of doctors who could continuously monitor my progress and setbacks. During the five years I received healthcare from my university, I had no less than twelve doctors (or doctors-to-be) and related mental health professionals treating me, prescribing medication, and continuing diagnostic analyses of me. Consequently, there were competing views about diagnoses, medication therapy, what elements would decrease or increase the efficacy of the medications, and other such questions germane to the process of my recovery. Mostly, the choice of treatment was left up to me. Despite the benefits of having such agency in my healthcare, I often made unhelpful, even dangerous choices about medications, simply because of the trial and error
nature of treating disorders. Consequently, I turned to my available means of persuasion: the Internet.

Once I discovered that the Internet gave me access to countless medical journals, books, videos, and websites, and that I could find virtually everything possible about medications, diagnostics, alternative treatments, and the experiences of other people with the same or similar disorders, my own doctors seemed almost immaterial. My visits to them were perfunctory, necessary only for checking in and garnering prescriptions. In fact, even in the worst of episodes, my doctor and hospital visits became marked with very specific intentionality: to have a medical figure authorize aggressive psycho-pharmaceutical treatment. This hands-off strategy has served me well, and I have managed to recover from several serious episodes with the help of medication, friends, family, the Internet, and limited medical intervention. Likewise, there is a constellation of thousands of personal narratives about similar experiences in blogs, journals, and other online spaces convincing me I am not alone in these recovery practices. In retrospect, what is most interesting to me is not that the medical professionals encouraged me to be the agent of my recovery, but that not once, in the collective five years of university health care, or subsequent five years of county sponsored health care, did anyone mention the concept of recovery to me. Whether it was simply expected that I already knew the definitions, or that it was assumed my receiving medical treatment equated with recovery, is unknown to me. Did I understand the disorder to be cyclical, reoccurring, and preventable if
treated continuously and consciously? Vaguely. I certainly knew it was incurable. But, I think that like all profound illnesses, chronic mental disorders can only be fully understood by experiencing them or by giving direct care to someone experiencing them.

Ultimately, the Internet afforded me support from peers as well as self-advocacy through education about mental illness and recovery. Having a disorder, or disability in general, often forces one to self-advocate for many reasons, not the least of which is the many points of discrimination, systems of oppression, and attitudinal barriers that all people with all disabilities face on a daily basis. And, considering the 2000 IOM report about the 2.4 million yearly mistakes in Massachusetts pharmacies, I personally insist on keeping a frequent watch on all psychotropic medications by familiarizing myself with the same drug reference books and websites that doctors use.

I give you this information about my intentions for two reasons. First, the entirety of this project was conceived, researched, and written during two separate (and intense) recoveries from episodes of mania and depression. Focusing on, and fervently imposing structure on this project, was one reason I was successful in those recoveries. The other reason for success: medication and my own active management of it. Admittedly, my choice to cease lithium therapy was the trigger for both episodes. Like Jamison, despite my extensive knowledge on the benefits of psychotropic medications, the rhetoric of
enthusiasms was more persuasive for me than being compliant. Now, the possibilities of a functional life (however I define this) are more persuasive.

The second reason I offer this personal information, and my project, is that my experiences (and Jamison’s), are not uncommon. Unique, yes. Statistics show, however, that mental illnesses, especially untreated mental illnesses, are a growing problem, despite the increasing ability to treat or even prevent them.

A Call for Recovery-Oriented Practices

In 2001, the World Health Organization (WHO) issued a report, Mental Health: New Understanding, New Hope, stating that “mental health disorders represent four of the ten leading causes of disability worldwide” (3). Additionally, it states that “Major depression is now the leading cause of disability globally and ranks fourth in the ten leading causes of the global burden of disease” (x). The WHO predicts that over the next twenty years, “depression will have the dubious distinction of becoming the second cause of the global disease burden” (par. 7).\(^{163}\) This is a growing burden, which “amounts to a huge cost in terms of human misery, disability and economic loss” (par. 4).\(^{164}\) According to WHO, “Mental and behavioral disorders are estimated to account for 12% of the global burden of disease, yet the mental health budgets of the majority of countries constitute less than 1% of their total health expenditures. The relationship between disease


burden and disease spending is clearly disproportionate. More than 40% of countries have no mental health policy and over 30% have no mental health program” (par. 5).

The World Health Organization is an agency of the United Nations, and its independence from the institution of psychiatry and the pharmaceutical industry affords the information they gather and the suggestions they offer certain credibility. The WHO suggests that health is the locus and the continuum at which all humans exist. The principles set out in their Constitution\(^\text{165}\) state that “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,” and that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (1). Health, then, cuts across all boundaries of difference, unifying all bodies and minds.

On October 29, 2002, the *Interim Report of the President's New Freedom Commission on Mental Health* found that “America’s mental health service delivery system is in shambles,” and that “the system needs dramatic reform because it is incapable of efficiently delivering and financing effective treatments—such as medications, psychotherapies, and other therapies—that have taken decades to develop.” The commission determined that “a fragmented

\(^{165}\) For WHO’s Constitution, please see <http://www.who.int/governance/eb/who_constitution_en.pdf>. Both of these principles are part of the original Constitution drafted in 1946.
services system is one of the barriers impeding the delivery of effective mental health care,” that the distribution of responsibilities between too many agencies, programs, and government levels, all with differing rules and regulations, has rendered mental healthcare ineffectual. Along with a fragmented services system, “our Nation’s failure to recognize mental health care as a national priority” tops the list of reasons the commission cites for our needing a mental health care system transformation. The vision for this transformation is specific: it needs to be “oriented to the single most important goal of the people it serves—the goal of recovery.” Though initiatives like the National Consensus Statement on Mental Health Recovery are positive steps toward addressing the real need for reform, much work needs to be done. How are the goals for recovery being met, and where?

The College of the Overwhelmed: Addressing the Mental Health Needs of Students

One area in need of serious attention is the availability of adequate mental health care services for college students.¹⁶⁶ I suggest that for college students,

the location of recovery presents some unique complications, including the probability of them not seeking support for mental health issues at all. Students in the middle of writing papers and taking exams determining their course grades, developing new social circles, striving to achieve the approval of their parents, teachers, and peers, and worrying about their future livelihoods face very real and very time consuming pressures. Moreover, many disorders present themselves at specific ages, particularly college-age. Add to this factor that experimentation with drugs and alcohol, sleep deprivation, loneliness, isolation, and stress can also trigger disorders, and college becomes a likely environment for trigger disorders. For graduate, law, and medical students, there are added pressures. In “After Suicide, Harvard Alters Policies on Graduate Students” (1998), Carey Goldberg notes that these students face “significant financial pressures, significant research pressures, significant teaching obligations, and you have to layer on all of that the familial issues, because half the people in graduate school are married.”

In *College of the Overwhelmed: The Campus Mental Health Crisis and What to Do About It*, Richard Kadison and Theresa Foy DiGeronimo note the prevalence of (and need for) web resources available to a “generation of students [that is] computer savvy and far more comfortable seeking information

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by logging on-line than by walking into a counseling center and asking for a printed pamphlet” (180). By 2008, many colleges have links to free, anonymous websites for specific and general mental health concerns. Included among these are larger organizations such the National Mental Health Association and the National Institute of Mental Health. And, there are many sites, including NMHA, NIMH and WebMD, offering anonymous diagnostic screening for a non-exhaustive range of disorders. For some students, the privacy afforded by online screening and support will be of primary importance. For others, gaining peer support will be beneficial. During my time as a graduate student, I believe there were resources available to me, but I wasn’t as aware of them as I should have been. Future work needs to map out these locations of support, and provide an exploratory proposal for ways of further addressing the needs of “overwhelmed” college students in an accessible digital environment.
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