RHETORICAL DIMENSIONS OF 20TH CENTURY DEPRESSION MEMOIRS: SYLVIA PLATH’S THE BELL JAR, WILLIAM STYRON’S DARKNESS VISIBLE, & KAY REDFIELD JAMISON’S AN UNQUIET MIND

BY

JERMAINE MARTINEZ

DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Speech Communication in the Graduate College of the University of Illinois at Urbana-Champaign, 2016

Urbana, Illinois

Doctoral Committee:

Professor Ned O’Gorman, Chair
Professor Peggy Miller
Professor John Murphy
Professor Michael Kral, Wayne State University
ABSTRACT

This is a rhetorical analysis of three popular autobiographical acts about depression from the American 20th century: Sylvia Plath’s *The Bell Jar*, William Styron’s *Darkness Visible* and Kay Redfield Jamison’s *An Unquiet Mind*. This dissertation explores the question: how do these memoirs of depression work as rhetorical texts? Two distinct, yet interrelated, levels of analysis are undertaken through an orientation of “deep reading” in an effort to illuminate the rhetorical dimensions of these enduring and best-selling autobiographical works. First, I review the ways these authors generate identification with readers in the face of a suffering that casts its agents as unreliable narrators. Second, I demonstrate how these texts enter into dialogue with technical and public discourses of their time, shifting the grounds of appeal towards more personal considerations. Both of these analyses work to illuminate how these popular books emerge as rhetorically powerful interventions in 20th century discourses on depression, mental illness, and meaningful living more generally.
ACKNOWLEDGMENTS

I’d like to acknowledge the following people for making it possible, enjoyable, and worth pursuing a PhD. I’m thankful for the support of my family. I’m thankful for the support of Peggy Miller, Michael Kral, and Susan Davis. I’m thankful for the support and patience of my adviser, Ned O’Gorman, and John Murphy’s willingness to serve on my committee. I’m thankful for all the people in the Department of Communication at U of I.

Last, I want to thank Corey Anton for introducing me to the study of human communication and continuing to be an inspiring scholar, mentor, and friend.
# TABLE OF CONTENTS

CHAPTER 1 INTRODUCTION .................................................................................................................................................. 1

CHAPTER 2 THREE TEXTS IN CONTEXT: AUTHENTICITY, DISORDERED SELFHOOD, AND PUBLIC AND TECHNICAL RHETORICAL EXIGENCIES OF MID-TO-LATE 20TH CENTURY U.S. CULTURE........................................................................................................................................ 24

CHAPTER 3 WHAT DISORDERED MOODS COMMUNICATE: RHETORICAL DIMENSIONS OF INTERRUPTION AND IDENTIFICATION ............................................................................................................................... 90

CHAPTER 4 THE RHETORICITY OF MOOD MEMOIRS: BIOMEDICAL DISCOURSE AND........................................................................................................................................................................................................ 125

CHAPTER 5 CONCLUSION: MOOD MEMOIRS, AUTHENTICITY, AND THE RECOVERY OF PUBLIC DISCOURSE IN THE WILLINGNESS TO BE PERSUADED ...................... 188

REFERENCES ........................................................................................................................................................................ 210

APPENDIX A............................................................................................................................................................................ 236

APPENDIX B........................................................................................................................................................................... 237

APPENDIX C........................................................................................................................................................................... 238

APPENDIX D........................................................................................................................................................................... 240

APPENDIX E........................................................................................................................................................................... 242
CHAPTER 1

INTRODUCTION

The following is a rhetorical analysis of three popular autobiographical acts about depression from the American 20th century: Sylvia Plath’s *The Bell Jar*, originally published in 1963, William Styron’s *Darkness Visible*, published in 1990, and Kay Redfield Jamison’s *An Unquiet Mind*, published in 1995. These national best-selling texts about depression are known in rhetorical studies as “mood memoirs,” or first person narratives of living with mood disorders (Pryal, 2010). Plath, Styron, and Jamison find themselves in the throes of a mood disorder that intensely changes their felt relationship with themselves, others, and the world. By narrating their experience in an autobiographical act, readers are provided an opportunity to experience these shifts for themselves. This opportunity for readers to identify with the narrative creates a rhetorical dimension to these authors’ works.

Each author felt called to share their personal experiences of depression in response to public and technical discourses of the mid-to-late 20th century. In the process of responding to external discourses, Plath, Styron, and Jamison articulated inner experiences that have had a lasting impact on readers. Today, these texts have secured the support of mental illness advocacy groups as tools for educating the public about depression, have enjoyed wide-spread readership as national best sellers, and, in the case of Plath, even secured cult followings. These texts are dynamically didactic. They have become required reading in many psychology and psychiatry seminars and are often given as personal gifts of consolation to persons touched by depression. In sum, these autobiographical acts have gained a culture-wide canonical status as narratives valued for their insight on the intimate experience of depression.
The question of how these three autobiographical narratives about depression have gained canonical status could be examined from any number of perspectives. I adopt a rhetorical perspective: how do these memoirs of depression work as rhetorical texts? What follows are two distinct, yet interrelated, levels of analysis that address this question. First, I explore how these narratives generate identification between reader, text, and author all in the face of a suffering that casts its agents as unreliable narrators. Second, I examine how these texts enter into dialogue with technical and public discourses by shifting arguments toward personal grounds. Both of these analyses work to illuminate how these popular works emerge as rhetorically powerful interventions in 20th century discourses on depression.

Why a Rhetorical Study of Memoirs about Depression?

In 2014, an estimated 15.7 million adults aged 18 or older in the United States have had at least one major depressive episode in the past year. According to the National Institutes of Mental Health (2014), this number represents 6.7% of all U.S. adults. One in 10 Americans are currently using antidepressants, and one in four of those are women in their ’40s and ’50s (Rabin, 2013). An ABC poll in 2002 reported that 15% of Americans felt depressed once a week or more (Shorter, 2013, p. 193). Despite scientific uncertainty about the specific causes of depression, rates of reported depression rose from 3% to 7.9% between the years of 1991 and 2002 (Compton, Conway, Stinson, & Grant, 2006). Decades prior to these developments, many scholars had already honed in on this “epidemic,” variously characterizing the 20th century as an age of melancholy (Blazer, 2005), depression (Costello, 1976; Horowitz, 2010), and insanity (Shumaker, 2001). Other scholars characterized depression as being as commonplace as the “common cold” (Seligman, 1975). Relatedly, other research suggested the prevalence of over-diagnosis and misdiagnosis of depression (Horowitz & Wakefield, 2007; Mojtabai, 2013).
Given these cultural developments it is not entirely unlikely that even the current reader of this dissertation has personally experienced some sense of depression in their life, be that in one’s own quiet concerns about a persistent down mood or in knowing someone close who either struggles with depression or has their own uncertainties about the clinical status of their moods. Depression, in short, has become a ubiquitous presence within the experiential terrains of contemporary selfhood.

A steady rise in clinical depression diagnosis occurred between the years 1950 and 2000, with particular accelerated increases between the early years of the 1980s and 2000 (Kessler, Beglund, Demler, Koretz, Merikangas, Rush, Walters, & Wang, 2003). Paralleling this rise in diagnosis was a rise in the use of antidepressants, and again with particularly accelerated increases between 1988 and 2000 (Pear, 2004). Historians of psychiatry story the years between 1950 and 1990 as a time when psychoanalytic diagnosis of mental illness gave way to biological diagnosis of mental illness and colloquially refer to this time period as the “biomedical revolution” in psychiatry (Shorter, 1997; Whitaker, 2010). This biomedical shift in psychiatry was solidified in earnest by the publication of the 3rd edition of The Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980. A biopsychosocial nomenclature gave way to medical diagnostic nomenclature when shaping its list of mental disorders. To give a sense of this “shift” in language take for instance the entry for depression neurosis in DSM-II published in 1968:

300.4 Depressive neurosis

This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession. It is to be distinguished from Involutional melancholia and Manic-
depressive illness. Reactive depressions or Depressive reactions are to be classified here. (p. 40)

Note its classification as “neurosis.” This can be attributed to the influence of Sigmund Freud’s psychoanalytic theories, which permeated the second edition of the DSM. Freud’s theories argued that the symptoms of disordered psychology occur as reactions to some precipitating event, either external or internal. This is a biopsychosocial view of mental distress requiring some form of clinical training in interpretive analysis of internal and external circumstances and conditions to arrive at diagnosis. Now consider the entry in the DSM-III (1980) for the “same” disorder now called, “Dysthmic Disorder.”

300.40 Dysthymic Disorder (or Depressive Neurosis)

The essential feature is a chronic disturbance of mood involving either depressed mood or loss of interest or pleasure in all, or almost all, usual activities and past times, and associated symptoms, but not of sufficient severity and duration to meet the criteria for a major depressive episode (full affective syndrome). For adults, two years’ duration is required; for children and adolescents, one year is sufficient. (p. 220-221)

No longer a definition and no longer concerned with what “causes” depression, this entry is now a list of symptoms. Psychiatrists no longer needed to conduct interpretive analysis about external or internal causes to derive diagnosis but only needed observe symptoms to arrive at diagnosis, as if diagnosing a biological illness. As the chief architect of the DSM-III, Robert Spitzer, observed of the new diagnostic categories, “Clerks rather than experts can make this kind of classification of patients” (Wilson, 1993, p. 406).

Some scholars believe that this shift in diagnostic practice from interpretation to clinical observation contributed to the statistical rises in depression diagnosis in the late 20th century

…The basic flaw…of the DSM definition of MDD, as well as of all efforts that rely on it, is it simply fails to exclude from the disorder category intense sadness, other than in reaction to the death of a loved one, that arises from the way human beings naturally respond to major losses. (p. 14)

These authors attribute the rise in depression diagnosis and antidepressant use directly to a too-broad definition of depression that subsumes the causes of normal sadness. Along with this perspective, other scholars argue that the rise of depression diagnosis is a cultural phenomenon in at least two different yet interrelated senses. First, there are those who argue that pharmaceutical advertisements generate a culture of “self-doctoring” wherein individuals are constantly encouraged to monitor their emotions and look out for depression symptoms (cf. Emmons, 2010; Whitaker, 2010). The most robust arguments from this position come from those attacking the biomedical science undergirding public claims in direct-to-consumer advertising that “chemical imbalances” are the cause of depression. These positions argue that though scientific research has yet to definitively prove depression is caused by chemical imbalances, pharmaceutical companies continue to perpetuate that view of depression (Greenberg, 2010; Valenstien, 2002; Whitaker, 2005). Second, other scholars believe that American culture’s value of “the pursuit of happiness” causes stressors that not only contribute to frustration, demoralization, and fatigue but also provide the rationale for people’s decision to
use medical, “quick fix” remedies for such down moods (Elliot, 2003; Hirshbein, 2009). These views understand depression as socially constructed and often express concerns about the medicalization of normal human behavior (cf. Good, 1994; Obeskeryre, 1985; Watters 2011). Given depression’s uncertain status as a socially constructed experience, a biological fact, and a drug marketing go-to, it is perhaps all too understandable that people today feel compelled to monitor their down moods if only because there is so much uncertainty surrounding the clinical status of any singular bout of intense sadness.

Contemporary rhetorical scholars have long noted the power of communication and language, that is, of rhetoric, to shape what we know, experience, and feel to be “reality.” Through whole-bodied and cultural discursive practices, human beings manage the uncertainties of a world in pure motion and flux through the use of words, discourses, explanations, accounts, and narratives (Berger & Calabrese, 1975; Fisher, 1987; Goodnight 2012; 1975; Scott, 1967). This contemporary perspective can be traced to any number of theoretical developments, particularly those of social construction and symbolic interaction (Berger & Luckmann, 1966; Mead, 2015). In such a view of human existence, we live in a world not simply of things and material stuffs, but a world of the meanings about the material, motion, and flux-filled stuffs of existence. Kenneth Burke (1969b) brought this symbolic action perspective to contemporary rhetorical studies when he argued, “Wherever there is persuasion, there is rhetoric. And where there is ‘meaning,’ there is persuasion” (p. 172). Rhetoric was defined, by Burke, as the use of symbolic activity to suasively order the uncertain flux and motion of existence in goaded efforts “to induce cooperation in beings that by their nature respond to symbols” (Burke, 1969b, p. 43). Much of what is taken to be “reality” is the spinning out of possibilities implicit in a choice of
terms. In short, human symbolic activities in the form of communication practices help create the very meanings of reality.

The uncertainty surrounding the meaning of intense experiences of sadness mandates an exploration of how popular autobiographical accounts of depression both create certainty and uncertainty about that meaning of disordered sadness. This dissertation views published autobiographical narratives about the experience of depression as public moral arguments that perform the rhetorical work of creating meanings about the “reality” of depression. This dissertation attempts to make sense of the affects autobiographical accounts of disordered realities have on readers in this age of depression, as well as examine what rhetorical opportunities derive from such affects. By exploring popular autobiographical accounts of depression published prior to the biomedical revolution, shortly after its occurrence, and in the years following its adoption, this dissertation offers a rhetorical perspective on this significant moment in the 20th century.

**Deep Reading as an Orientation: It’s Like Close Reading but Not**

As mentioned, these authors share their stories in ways that engage and respond to technical and public discourses of their day. As such, I will study these texts as narratives that present an argument narratively.¹ My overall thesis is simple to state. I argue that these autobiographical works invite readers to empathize with narratives about disordered shifts in the sense of reality and predisposes readers to affectively appreciate the arguments these authors are making about public and technical discourses of their time. In this sense, each text presents an

---

¹ Walter Fisher (1984) set the stage for viewing narratives as public arguments. Narratives can and do in fact argue, despite not taking the form of clearly identifiable, logical propositional presentations of an argument. The narrative paradigm offers a theory of “symbolic actions – words and/or deeds – that have sequence and meaning for those of live, create, or interpret them” (p.2). Narratives argue by way of “suggestion rather than ‘logical’ direction” (Fisher, 1987
argument in two very interrelated senses. The first sense of argument is instrumental, meaning these authors share their personal stories in hopes of shifting debates toward personal considerations as they engage public and technical discourses of particular historical moments. The second sense of argument has to do with the generation of identification, meaning these narratives dispose readers to empathize with these authors’ depictions of disordered realities. Taken in tandem, the instrumental aspects and identification aspects of these texts offer a useful perspective for illuminating rhetorical dimensions of these autobiographical acts.

Given this two-tiered orientation of wanting to explore both instrumental and identification strategies and processes, I needed a way of orienting myself to these works that accommodates a reading of rhetorical figures and elements employed in these texts as well as a reading of broader conceptual matters. As such, I made use of a practice of “deep reading” that is influenced by, but not identical with, the rhetorical practice of close reading.

Stephen Lucas (1988) writes that the practice of close reading allows the critic to “slow down” the action within a text (p. 249). A text is treated as a polysemic act with particular textures, dynamics, and densities of active interactions of external discourses, arguments, imagery, reader biases, or, in short, the social forces and influences that compel rhetorical acts. A close reading orientation “‘slows down the reading experience so that ‘events’ one does not notice in normal time, but which occur, are brought before our analytical attention’” (Fish, 1972; quoted in Slagell, 1991, p.155). Textual works are placed at the center of critical activity, lingered over and appreciated by a trained or informed reader. James Jasinski (2001a) writes that, “Close reading lingers over words, verbal images, elements of style, sentences, argument patterns, and entire paragraphs and larger discursive units within the text to explore their significance on multiple levels” (p. 93). It was important for my project that I was able to linger
over “multiple levels” because I was interested in examining two interacting levels of rhetorical action in these mood memoirs. One level was the instrumental level of analysis: namely, surveying how these authors make use of and position themselves in relation to public and technical discourses of their time. The second was a conceptual level: specifically, how narrative depictions of disordered realities generate identification between author and reader. Close reading allows the rhetorical critic to “vibrate theory against the text and text against theory” in a hermeneutical practice of “abduction” wherein the critic takes a “back and forth tacking movement between text and concepts” (Jasinski, 2001b, p. 256; Jasinski, 2001a, p. 94; also Leff, 1983). As such, close reading practices allow a sensitive and informed reading that is well suited for exploring both strategic practices in the text and extra-textual conceptual questions.

However, there are problems with employing close reading to memoirs. The practice of close reading in rhetorical studies usually examines public address, such as Leff’s (1983) analysis of President Lincoln’s “House Divided” speech, or Murphy’s (1997) analysis of Bill Clinton’s 1993 address to African-American ministers in Memphis, Tennessee. Public addresses and public speeches are relatively short in length when compared to published memoirs and novels. The mood memoirs of Plath, Styron, and Jamison are hundreds of pages in length. It would not have been very efficient or probable to linger over every significant word, image, or element of style. For this reason, I diverged from a strict practice of close reading and instead adopted the spirit of close reading, that is, its general sensibility of “lingering” and “abduction,” but practiced it on representative passages found within each text rather than the whole of each work. Here is how I determined which passages were relevant for analysis.

I began finding which passages to use for further deep reading and analysis by first following a “useful misreading” of Kenneth Burke’s concept of “representative anecdote” (cf.
Crable, 2000, p. 319; Jasinski, 2001a, p. 493). The representative anecdote was Burke’s way of building a case for dramatism as a proper terminology for assessing human motives (cf. Burke, 1969a, p. 60). Jasinski (2001a) and Crable (2000) both review how rhetorical critics have, rightly or wrongly, transformed Burke’s approach into a critical practice. Essentially, many scholars have taken the concept of a representative anecdote to be a descriptive term for organizing and unifying “otherwise disconnected bits of discourse” (Crable, 2000, p. 319). For instance, John Lucaites (1997) argued that James Agee and Walker Evans’ famed speech, “Let Us Now Praise Famous Men,” stands as a “‘representative anecdote’ for the problem of representing social and political consciousness in an age of mechanical reproduction” (p. 270). Or consider Barry Brummett’s (1984) practice of “anecdotal” media criticism as identifying “a representative anecdote as immanent within a number of media discourses as a summing up the essence of a culture’s values, concerns, and interests in regard to some real-life issues or problems” (p.164). These “misuses” seem to be rooted in a misreading of Burke’s (1969a) words about what makes an anecdote “representative” of a whole symbolic event or text.

Burke’s (1969a) actual words about the representative anecdote are, “Dramatism suggests a procedure to be followed in the development of a given calculus, or terminology. It involves the search for a ‘representative anecdote,’ to be used as a form in conformity with which the vocabulary is constructed” (p. 59). Again, Burke was making the case that the terminologies of drama (act, scene, purpose, agent, agency) are representative anecdotes for understanding human motivations. He contrasted his choice in pentad terms with behaviorists’ “use of experiments with conditioned reflex” in animals “as the anecdote about which to form his vocabulary for the discussion of human motivation” (Burke, 1969a p. 59). Burke (1969a) found those behaviorists terminologies “informative” but not “representative” of the whole of human motivation because,
“animals lack the property of linguistic rationalization which is so typical of human motives” (p. 59). This led Burke (1969a) to assert, “if the originating anecdote is not representative, a vocabulary developed in strict conformity with it will not be representative” (p. 59). And without such internal conformity “one cannot expect to get representative terms” (Burke, 1969a, p. 324). Taken together, these selective passages from Burke have been appropriated to create a critical method for treating parts of discourse or texts as representative of the whole of those discourses and texts. For instance, Madsen (1993) works to investigate “linguistic acts” or “discursive forms” in a text that can “stand for” or “fully represent the text” (p. 209) or the discourses of which it is embedded as a means of summing up an essential quality of the text or world discourse (Brummett, 1984). In my reading of mood memoirs, I followed this “useful misreading” to find representative passages that could then be utilized in a practice of deeper reading.

Procedures for finding sufficiently representative anecdotes in the mood memoirs I studied followed Burke’s (1984a) views on “trained incapacity,” specifically that any way of seeing is also way of not seeing (p. 49). Any way of seeing, like metaphor, thus “brings out the thisness of a that and the thatness of a this” (Burke, 1969a, p. 503). This meant that my reading of Plath, Styron, and Jamison has been shaped by my purposes for studying these specific works. In many ways, offering a perspective on something is a “placement” of that thing within a context tied to particular presuppositions and intellectual commitments about what I hope to find. As a result, I found “representative anecdotes” passages appeared as “suited to the subject matter it is designed to calculate” (Burke, 1969a, p. 59). In this case, the “subject matters” were questions I had in mind about how these works do the things they do rhetorically.
In Chapters 2, 3, and 4, I identify different “subject matters” that my reading of these memoirs is designed to “calculate.” By calculation I mean its most basic meaning as “to evaluate by practical application.” Thus in my initial reading of these texts I followed content analysis methods for “unitizing” any and all narrative incidences that intuitively appear to have heuristic value to my analysis and questions (Lincoln & Guba, 1985, p. 340). As a next step I compared these incidences across all three texts and searched for both commonalities and differences so as to ensure the passages were representative and not merely reductive similarities. Then, “vibrating” theory against the text, in this case narrative incidents of engaging public and technical discourses and narrative depictions of disordered experiences, I conducted a back and forth reading between text and conceptual questions. The point was to ensure that my representative anecdotes were “grounded in a starting-point, which is adequate to its intended subject matter—it is an anecdote that is constructed in such a way that it fully conforms to its subject matter” (Crable, 2000, p. 325). Having deduced representative passages, my close reading of these particular passages involved a deeper “vibrating” of conceptual questions against the textual elements of these texts. And because my presuppositions are trained upon not only the rhetorical instrumental aspects of these narratives but also affective aspects of rhetorical identification accompanying the expression and reception of inner disordered moods, my methodological orientation subtly transformed the practice of “close reading” into “deep reading.”
Contributions to Rhetorical Studies and Related Studies

There were a number of conceptual questions or “matters of subject” that I vibrated against my reading of these texts in the course of my rhetorical analysis. My deep reading of these mood memoirs offered an opportunity to extend, critique, and explore conversations in two bodies of scholarship. The first is an emerging area of work on mental health and illness in rhetorical studies. The second is scholarship from disability studies, illness narrative studies, or in general, the medical humanities.

The rhetoric of mental health and illness is a burgeoning area of rhetorical scholarship. But it holds its roots in earlier rhetorical explorations of embodiment and disability. One early edited work often used as introduction to the interdisciplinary questions and issues implied when examining the materiality of the body and “bodies of material” that characterize a variety of rhetorical situations is Sharon Crowley and Jack Selzer’s (1999) *Rhetorical Bodies*. The essays of this collection explored the rhetorical dimensions of material like the geography of public protest (Hass, 1999), visual pictures and objects (Dickson, 1999; Faigley, 1999), and even unseen materials like DNA (Condit, 1999). The essays also explored the material dimensions of rhetoric like how rhetorical contexts influence 19th century women physicians (Wells, 1999), the shifting meaning of cannibalism (DeVinne, 1999), and the political meaning of physical monuments (Blair, 1999).

This book was followed by another widely cited edited book, *Embodied Rhetorics: Disability, Language and Culture* (Wilson & Lewiecki-Wilson, 2001). The editors of this work more explicitly tied disability and embodiment to rhetorical practice. They argued that conditions of physical or mental disability share with rhetoric a “common position.” Each are positioned as embodied activities, and both often have their respective identities devalued as a
result of an “assumed” dualist tradition that privileges the mental over the material character of discourse (Wilson & Lewiecki-Wilson, 2001, pp. 2–7). Echoing this sentiment, the journal *The Rhetoric Review* published a special edition with a focus on “representing disability rhetorically” in large part because disability has been “underrepresented” and “neglected” by rhetorical studies (Morse, 2003, p. 154). Scholars in this special section explored the rhetorical construction of physical disability (Lindbloom & Dunn, 2003), of “mainstreaming” (Brueggemann, 2003), the policies affecting the hearing impaired (Stremlau, 2003), and the rhetorical construction of disability stigma (Wilson, 2003).


Rhetorical approaches addressing the specific area of psychiatric conditions and issues can be found in each of these early edited works on embodiment and disability as well as these special journal issues. For instance, one chapter in *Rhetorical Bodies* (1999) collection explored the shifting meanings of the autobiographical act in an age characterized by the use of personality shifting chemicals like Prozac (Schlib, 1999). Consider also the book *Embodied Rhetorics* (Wilson & Lewiecki-Wilson, 2001). It is divided into three parts with the first part including essays on “Identity and Rhetoricity.” This part includes examinations of the autobiographical situations of the “(Dis)Abled Subject.” Within the essays in this volume, Catherine Prendergast (2001) examined the “rhetoric of mental disabilities” with an autobiographical focus trained upon how diagnosis of schizophrenia can “supplant one’s position
as a rhetor” (p. 191). In the special issue of The Rhetoric Review (2003), one scholar tackled psychiatric issues. Cynthia Lewiecki-Wilson (2003) argued for a “rethinking” of rhetorical theory by “thinking through mental disabilities,” a suggestion that inspired my methodological orientation of “vibrating” rhetorical theory against a reading of the mood memoirs of Plath, Styron, and Jamison. And in the special section of Disability Studies Quarterly (2011) six of 15 essays treat the topic of mental impairments, with five focusing on autism and one on mood disorders (cf. Pryal, 2011). I should mention that one other rhetorical account of psychiatric issues occurring during this time. Carol Berkenkotter (2001) offered an analysis of shifts in psychiatric note taking upon the publication of the DSM-IV. This short list of articles and chapters represents early rhetorical approaches to psychiatric issues and conditions that, in my opinion, beg for more research. Indeed, of the sources just reviewed, only four scholars brought specific awareness of autobiographical or first-person experience to their analysis of psychiatric issues or concerns: Lewiecki-Wilson (2003), Prendergast (2001), Sclib (1999), and Pryal (2011). There seems to be a disproportional dearth of research on psychiatric issues of mood disorders, at least in this still early moment in rhetorical research on mental illness.

A short history of the last two decades of book-length rhetorical investigations on psychiatric issues shows room for further rhetorical studies on mood disorders and psychiatric issues and conditions. Prior to the publication of the works reviewed above, the only book-length rhetorical study of psychiatric diagnostic practices was, The Selling of DSM: The Rhetoric of Science in Psychiatry (1999). This book examined the persuasive affects of the shift from Freudian nomenclatures to biomedical nomenclatures in diagnostic categories for psychiatric illness. In 2011, Margret Price’s Mad at School: The Rhetoric of Mental Disabilities & Academic Life offered a book-length treatment of when mental impairments clash with
exclusionary discourses and ableist expectations of academia. And one scholar, Kimberly Emmons (2010), explicitly tackles depression from a rhetorical perspective in her book, *Black Dog, Blue Words: Depression and Gender in an Age of Self Care*. This latter turn to the rhetorical study of depression is an encouraging development.

There are further rumblings of interest in the rhetorical study of mood disorders, depression in particular. For instance, Jenell Johnson (2010) examined the failed vice-presidential campaign of Thomas Eagleton in 1972. She identified the social and moral conditions of “rhetorical disability.” Upon disclosing that he had been admitted to psychiatric hospitalization for depression, Eagleton resigned from the race as George McGovern’s running mate amid social and political pressures as public perception about the “soundness and stability” of someone with mental illness. Public moral sentiment regarding mental illness contributed to a character stigma that situated Eagleton as an unreliable narrator. As Johnson (2010) argued, “He was forced to resign because his presence was perceived to ‘cripple’ the campaign, an issue of ethos rather than competence or qualifications” (p. 467). Another scholar explicitly examining depression through rhetoric is Katie Rose Guest Pryal (2010). Pryal identified and outlined the rhetorical conventions of the mood memoir genre. Her study made use of Jamison’s *An Unquiet Mind* and William Styron’s *Darkness Visible* to argue that those who might otherwise suffer rhetorical disability can make use of the genre of memoir as a strategy for responding “to rhetorical exclusion.” Pryal (2010) argued that such generic choreography reclaims reliable social ethos for the mentally ill, at least in certain spheres” (p. 480). This burgeoning interest in the rhetorical study of depression is a useful first step toward future study.

Though rhetorical scholars have only recently turned to mood memoirs, scholars in the medical humanities have been studying autobiographical acts about illness and bodily
breakdowns at least since the publication of Author Kleinman’s *The Illness Narratives: Suffering, Healing, and the Human Condition* in 1988. The kinds of illness narratives studied most are about terminal illness, chronic illness, or physical disabilities (Couser, 2009). There has been some theorizing about the ways illness narratives have rhetorical dimensions, not only as ways of “talking back” to dehumanizing medical experiences but also as ways of inducing an “extrospection of suffering” whereby authors invite readers to participate in a dialogical “rounding out” of an always unfolding and unfinished project of suffering (cf. Frank, 2002). For instance, Avrahami (2009) has forcibly demonstrated how the “breakdown of the body” is more than a colloquial phrase. Surely it references unwelcomed and uncontrolled changes in the way a person senses themselves in their whole existential world. But there are rhetorical opportunities for writer and reader interactions in this “breakdown.” Avrahami showed how narrative accounts of bodily breakdowns

Engages the writer in the real, while reading self-disclosures of the lived-experience of illness at once implicates the reader in her own mortality and aims to obliterate the between the referential, “extratextual” reality of the sick writers and the ideological and linguistic constructs of their illness. They do so not because they manage to establish a simple and direct link between text and the experience of suffering “out there” but because they create a sense of imaginative identification so powerful that its effect is to point the reader outside the text. (Avrahami, 2007, p. 7)

Under such radical conditions of breakdown of a writer’s world, illness narratives offer readers proximal contact with a “self-in-crisis…confronted with serious and life-threatening illness” (Hawkins, 1993, p. 17). This is a move that also invites readers to appreciate how the “possibilities, fictions, metaphors, and versions of self” recounted in such narratives become
“contracted into a ‘hard’ defensible ontological reality…” (Hawkins, 1993, p. 17). When the “hard reality” of metaphorical, figurative, and evocative expressions found in illness narratives meet with the hard reality of non-depressed and healthy-bodied readers, a rhetorical situation is created in the “communication between simultaneous differences” (Frank, 2000, p. 153). Specifically, this “invasion of the real” (Avrahami, 2007, p. 3) provokes disruption and interruption (Frank, 2000) of non-depressed and able-bodied realities that open up spaces for deliberation upon taken-for-granted communal and personal practices.

Scholars in the medical humanities have also identified obstacles that can cut off the specific rhetorical possibilities of illness narratives. Jurecic (2010), for instance, has offered a book-length treatment of the ways that scholarly critics have tended to view highly emotionally charged narratives with suspicion. There is also a long-standing history in Western views of rhetorical practice that privilege logos appeals over pathos appeals. At best, pathos appeals are seen as “weak arguments” and at worst pathos appeals are understood as a nefarious and politically dangerous force. When the issues and theoretical work by rhetorical scholars on “rhetorical disability” are brought into conversation with medical humanist’s view on narrative disruption, both are enriched. For instance, what is the function of a narrative that “disrupts” readers if not what rhetorical scholars have known as a “deliberative narrative” (Jasinski, 2001a, p. 397), a narrative that invites readers to reconsider value positions within contested spheres of discourse? And what is the function of a narrative that “invites participation” if it is not what contemporary rhetorical scholars have known as an appeal for identification? How, in short, do narratives about the suffering of illness function as rhetorical texts?

While the source of illness in most studies on illness narratives is something clearly bodily and biological, mood memoirs about depression present narratives about a contested
diagnosis. Depression is not yet clearly and definitively identified as a biological disorder in either psychiatry or in public sentiment. As such, public and professional discourses on depression since the mid-20th century have trafficked in both moral and biological explanations of the causes of depression. This is oddly rhetorically fortuitous. A deep rhetorical analysis of how “depression” comes to be expressed in mood memoirs and comprehended by readers is important because ambiguity seems to characterize the phenomenon of depression through and through. It’s time to work towards some clarity. My study of mood memoirs about depression offers opportunities for “vibrating” rhetorical models, theories, and concepts against rich and affective rhetorical performances of human sense making responding to anxiously urgent public, technical, and personally intimate uncertainties.

What follows is a project that aims to contribute to and extend early work in the rhetoric of mental illness by offering a deep reading of how sufferers express and comprehend their own lived-experience of depression and how such stories function as public arguments. I focus on exploring how autobiographical accounts of disordered realities “work” upon readers and how such personally grounded appeals work rhetorically to question public and technical discourses. In the course of this analysis, I also aim to offer an account of how “embodiment” and affect are presented in first-person expressions of depression. This is a perspective on the narrative experience of mental illness that has yet to be explicitly mined for rhetorical insights.

There are three specific contributions to rhetorical studies this study of the mood memoirs of Plath, Styron, and Jamison offers. First, in Chapter 2, this study offers an account of how narratives about disordered experiences appeal to non-depressed audiences despite changes in how depression is understood in both personal and technical spheres over the course of a 50-year history. Second, in Chapter 3, an account is offered of how narratives about disordered
moods communicate with readers and how such identification is used to perform rhetorical work. Third, in Chapter 4, insight is offered into how scientific and technological innovations impact personal senses of self and others, or rhetorical invention more generally. Lastly, in the concluding chapter of this project, the study as a whole is placed within the context of rhetorical scholarship’s enduring preoccupation with raising the civility and efficacy of public discourse. Here is a preview of these chapters in greater detail.

In Chapter 2 I start my study with a broad question about what makes Plath, Styron, and Jamison’s narratives so enduring. In general, this chapter includes a review their critical reception during their publication as well as a review of how these texts enjoy continued relevance in contemporary times. More specifically, this chapter offers a review of the historical context of each author’s narrative that is couched in the perspective of Charles Taylor’s view of the 20th century as an “Age of Authenticity.” I suggest that what in part makes these texts continually relevant are the disruptive natures of their form as autobiographical expressions of disordered experiences. These authors experience a disruption in their normative ways of being. By writing about those disruptions, readers are invited to experience those disruptive shifts in world experience themselves. In so doing, a reader can become mindful of the everyday moods of selfhood, allowing for mode of self-reflection that Taylor argues is vital for the pursuit of deeper forms of personal authenticity.

In Chapter 3, I dive deeper into the disruptive form of these texts. In this chapter, I pose the question of how disordered moods communicate. Each author faces the rhetorical challenge of giving expression to extraverbal realities that meet against socially constructed rhetorical resources. In this chapter I offer representative passages that demonstrate how each author figures the disorder of their disorder in the face of “rhetorical disability” and the “inexpressibility
thesis” by identifying the figurative and metaphorical forms each author uses to narrate these extra-verbal rhetorical challenges. In this chapter I also suggest that such being “at-a-distance” from cultural rhetorical resources and normative moods function as existential grounds for critique because each author finds themselves vividly aware of the meanings of cultural practices precisely in the mode of their breakdown.

Chapter 3 also explores how such figurative and metaphorical framing communicates with readers. Specifically, given the disruptive nature of mood memoirs I reconsider and refigure somewhat the common understanding of Kenneth Burke’s idea of identification. The figurative accounts of breakdowns of selfhood do not communicate simply by identification because there is no stable model of selfhood with whom an able minded reader can identify. Instead there is a very different self with whom a reader might meet in what I call, “radical relation.” Figurative narrative passages about disordered realities continually interpose a distance between normative understandings and disordered experiences. This generates symbolic divisions that catalyze non-depressed audiences to interpretatively bridge the gap through juxtaposition of their own normative reality alongside the disordered experiences of Plath, Styron, and Jamison. As such, this chapter suggests that narrative depictions of disordered experiences communicate more akin to a process of “pure persuasion” than mere identification.

In Chapter 4 I demonstrate how the figurative framing of disordered experiences functions rhetorically by offering a deep reading of representative passages of The Bell Jar, Darkness Visible, and An Unquiet Mind. This chapter offers a deep reading of the personal sphere as an existential site for exploring the way the biomedical model influences rhetorical invention. In many ways, this chapter heeds Thomas Goodnight’s (2005) call for exploring public controversies involving scientific innovation. Goodnight (2005) argues that
The production, performance, and reception of science and technology from positions of provider and user form the hub of modern communication controversy. Generally, providers of science information and technological products and services engage in practices that invite publics to accept, adapt, and comport with changing state-of-the-art justifications, standards, and procedures. This process may be difficult when a gap emerges between the quick pace of scientific development and the longer time it takes to reach normative consensus in times of innovation or change. Even if stable, however, sometimes a field will go through a period of systematically distorted, failing, disabling, or alienating relationships with clients and interested publics. Science and technology controversy as a field of inquiry examines, exposes, and questions the state-of-art communicative reasoning through ethnography, case study, counterfactual analysis, or explorations of critical fiction. (p. 29)

By examining autobiographical accounts of disordered experiences prior to, during, and after the biomedical shifts in the technical understanding depression, the personal sphere becomes a gravitational nexus of analysis. My mode of deep reading is one way to “close the gap” between the quick pace of scientific innovation and normative consensus because deep reading remains attuned to the interanimation of public and technical spheres with Plath, Styron, and Jamison’s concretely lived personal experiences.

In the concluding chapter, I take what I have learned from my deep reading and engage those insights with a long-standing preoccupation of rhetorical scholars who study public controversy, namely their sense that public discourse is eroding. In keeping focus on the “personal sphere,” I too am concerned with declines in the civility of discourse. But rather than assign the causes of such declines to factors outside of the personal sphere, I turn to the work of
Wayne Booth (1974) who identifies a personal approach that reassigns the cause and solution to declining civic discourse upon the personal sphere. The study of mood memoirs provides opportunities for practicing what Booth identifies as a willingness to listen, an essential practice of sensitivity that we as readers and scholars must take on as our full responsibility if we are to recover the civility of discourse. I conclude with brief remarks about the authenticity personally required when studying (and merely reading) mood memoirs if work as rhetorical scholars (and as a listening public) is to be as empathetic as the suffering found in mood memoirs demands.
CHAPTER 2

THREE TEXTS IN CONTEXT: AUTHENTICITY, DISORDERED SELFHOOD, AND
PUBLIC AND TECHNICAL RHETORICAL EXIGENCIES OF MID-TO-LATE 20TH
CENTURY U.S. CULTURE

There are many historical perspectives we might adopt to contextualize the autobiographical acts of Sylvia Plath, William Styron, and Kay Redfield Jamison. This chapter, however, begins by drawing a broad historical background on the 20th century through Charles Taylor’s (1992) book *The Ethics of Authenticity*. Taylor’s historical philosophical account of a shifting character of selfhood toward an “ethics of authenticity” that emerges in the 20th century provides useful vantage for examining the meaning of autobiographical narratives about disordered selfhood. It is useful because by examining these works in light of these broader considerations we are invited to consider how the sharing of the experience of disordered selfhood might be usefully characterized as a kind of communicative calling, or an authentic response to public and technical moral discourses about mental illness. Somewhat like, but not completely like, Lloyd Bitzer’s (1968; 1988) characterizations of rhetorical situations, disordered moods are themselves rhetorical exigencies that call for stories, stories that, in addition, can be seen as both arising from and directed towards unique rhetorical situations. Through a broad understanding of an 20th century affective aegis shaping the inner terrains of selfhood, we are encouraged to consider how autobiographical acts mobilize what is different about the lives of Plath, Styron, and Jamison that offers new meanings about mental illness and selfhood. These texts have been successful in crafting new meanings on the suffering of mental illness that continues to activate public and professional discourses on the meaning and value of mental
illness. Thus, by reviewing these texts in context of their past and continued relevance for culture and society, we can set the stage for the rhetorical analysis to follow.

**Plath, Styron, and Jamison’s Rhetorical Responses: Authenticity and Disordered Selfhood**

This chapter reviews the historical context of each text “telescopically” beginning with a wide-scope discussion on the historical development of authentic selfhood as a moral imperative emerging in the modern era. Then, this chapter narrows its scope to focus on the specific histories of public and technical discourses surrounding the creation and publication of each text. Finally, a wider focus provides a few exemplars of continued contemporary relevance *The Bell Jar, Darkness Visible*, and *An Unquiet Mind* in shaping public and technical discourses on mental illness and authenticity more generally.

In his book *The Ethics of Authenticity*, Charles Taylor (1992) argues that a moral ideal of “authenticity” has entered deep into modern consciousness. What activates the moral weight of this ideal is its ground in a “modern sense of self.” Identifying an early articulation of this ideal in German philosopher Gottfried Herder, Taylor writes, “Herder put forward the idea that each of us has an original way of being human” (p. 28). Taylor goes on to observe that prior to the late 18th century, it was not common to consider differences between human beings as being especially morally significant. Today, however, it is hard not to reflect on one’s own selfhood without some consideration of how one is different from others. According to Taylor (1992), a central assumption activating this modern sense of selfhood is a deeply felt sense that there is “a way of being that is my way,” indeed one that, if I fail to be “true to myself” amounts to missing “what being human is for me” (pp. 28–29). In short, the modern ideal of selfhood is characterized by an inescapable deep, deep inward sense of “being called” to be true to one’s own unique sense of existence.
Interestingly, Taylor (1992) argues that though authenticity is a motivating ideal shaping culture and society it is nonetheless rarely spoken of. The rhetorical inarticulacy occurs because public deliberation about authenticity is often stifled in part because of the ideal of authenticity itself. That is, insofar as people feel called to self-actualization, the presumption is that this is a deeply personal matter. As a result, a rhetorical haze of soft-relativism or moral neutrality diffuses any kind of meaningful public deliberation about authenticity. However, this is not to say that authenticity is not talked about at all. In fact, Taylor (1992) identifies both those who “boost” the culture of authenticity and those who “knock” the culture. But both boosters and knokers are limited in what they can say regarding how “best” to pursue the good life. On one hand, the boosters argue that self-fulfillment is different for each individual and thus one ought not dictate to anyone else how best to pursue the good life. On the other hand, the knokers of the culture feel no need to reason about authenticity seriously because their position dismisses authenticity as merely a form of egoism, moral laxity, and narcissism. As Taylor (1992) observes, “It’s opponents slight it, and its friends can’t speak of it” (p. 18). Under a cultural aegis of authenticity, neither its supporters nor its opponents can articulate a position about the moral ideal and shape of authenticity itself.

For Taylor (1992), this inarticulacy over the idea of authenticity is founded on a mistake of focus. He argues that the struggle should not be over what authenticity “is” but about how we can enable higher and richer forms of authenticity. Taylor identifies shallow forms of authenticity as those that tend to focus on the self per se, as though it were an atomistic kind of thing. He also identifies higher and richer modes of authenticity. For Taylor (1992) higher modes of authenticity can be cultivated by taking account of selfhood’s constitutive foundations, namely that the self is embodied, lives in social and dialogical conditions, and inhabits time in a
mode of a narrative sense making (Taylor, 1992, p. 105). In his book *Selfhood & Authenticity*, Corey Anton (2001) deepens Taylor’s project by examining how shallower forms of self-fulfillment can give way to deeper forms through a thoroughgoing awareness of selfhood’s existential phenomenological constitution. These “conditions” of selfhood follow those identified by Taylor (1992), that is, embodiment, sociality, and temporality, but to these Anton (2001) adds symbolicity. He then proceeds to offer a rigorous account of how, “…people are, in a sense, perpetually outside of themselves, actively caught up attending to and caring for things that matter to them” (Anton, 2001, p. 7). Though it may sound a bit odd to suggest that we are “outside ourselves” or that we are “caught up caring for things,” this is simply Anton’s way of directing a reader’s attention to the ways we experience our daily lives, that is, as pragmatically preoccupied with important concerns, tasks, causes, “to do’s,” and ever-rising and falling desires. In short, the self is best understood as a “care taker” of a world and others that matter and the phenomenal character of selfhood reveals a tendency to “lose itself” in meeting the demands of one’s life.

For Anton and Taylor, pursing self-fulfilling identities in ways that are not trivial (i.e., simply and only “doing your own thing”) involves passionately accepting these phenomenological conditions of the self as a “care taking” being, that is, as fundamentally outside of and losing itself in horizons of significance that emanate beyond the self. The self is not an atomistic thing. Cultivating non-trivial self-fulfillment avoids a specific focus on the self, per se, and instead acknowledges one’s uniqueness in relation to social, symbolic, embodied, and temporal conditions. As Taylor (1992) writes,

…I can define my identity only against the background of things that matter. But to bracket out history, nature, society, the demands of solidarity, everything but what I find
in myself, would be to eliminate all candidates for what matters. Only if I exist in a world in which history, or the demands of nature, or the needs of my fellow human beings, where the duties of citizenship, or the call of God, or something else of this order matters crucially, can I define an identity for myself that is not trivial. Authenticity is not the enemy of demands that emanate from beyond self; it supposes such demands. (pp. 40–41)

Authentic selfhood means passionately taking on responsibility for selfhood’s ecstatic conditions that are equally social, embodied, symbolic, and temporal. In the end, existing authentically means caring about the world because the world “matters.” There is not both self and world and others as separate things dispassionately encountered. There is a passionate caretaking, an active participative relating to the whole temporally unfolding event of self-and-others-and-world.

Plath, Styron, and Jamison’s autobiographical acts can be seen as deeper modes of authentic selfhood, and as appealing to this specifically modern moral ideal, because each book appears to address issues that “critically matter” through accounts of phenomenological breakdowns of moods that disclose a world that no longer matters. These authors’ works help shape public discourses on mental illness toward what Plath, Styron, and Jamison feel are “higher” discourses and practices. There is an elephant-in-the-room irony, however. Each author’s narratives can be read as offering rich demonstrations of lived-experiences and situations where “nothing matters,” or at the very least matters very differently than what is considered normal. And this is precisely why these autobiographical acts matter. These authors’ narratives are rooted in disordered moods that disrupt easy, forgetful flights into daily concerns. The ecstatic character of their selfhood, that is, its tendency to lose itself in practical demands of life, is held in a kind of narrative relief. An able minded reader of disordered realities is invited to encounter this narrative “relief” of normative involvements of mood. A reader encounters not
only the experience of depression but also the embodied, social, temporal, and symbolic conditions of selfhood precisely in the mode of their “breakdown.” I cautiously suggest that what in part explains the enduring appeal of these works is perhaps that they offer the kind of illumination of selfhood’s conditions that appeals to the moral ideal deeply animating modern selfhood, the audience’s inner drives for deeper modes of authenticity.

From this broad historical perspective, I suggest that one reason why these texts should, can, and often are viewed as enduring, useful, and popular texts is because they can activate an important rhetorical role in public, technical, and personal inarticulacy surrounding the idea of meaningful living. If we entertain that Taylor (1992) is correct in his assessment of 20th century selfhood as having this inner drive to live a personally meaningful life, then narratives about disordered selfhood might appeal to audiences’ inner sensitivities for opening conversation and provoking deliberation on the conditions of significance that give rise to meaningful selfhood. Plath, Styron, and Jamison’s narratives of disordered selfhood might tacitly invite readers into moods of reflection on selfhood’s conditions of significance and about what it means to live daily. In an age when many people feel it inappropriate to openly endorse a way of living or critique how other people are living their lives and in an age when authenticity talk is limited (though greatly needed), each author presents some vision of “the good” about the meaning of living. Both in their act of writing and what they write about, these late 20th century descriptive accounts of experiences with depression are responsive not only to their historical moments but also to an inner inarticulacy surrounding what it means to live meaningfully more generally. These texts offer narratives of disordered being in the world that shed a light on the phenomenological character of self, others, and world in an age where the pursuit of deeper authenticity is illuminated by just such an existential light.
The Bell Jar in Context: Then and Now

Prior to publication of The Bell Jar, Sylvia Plath mostly wrote poetry and short fiction and was published in magazines and literary supplements. Her first collection of poems, *The Colossus and Other Poems* (1962), was published when she was 28. It is difficult, as Nelson (2006) observed, to understand the long-lasting relevance of *The Bell Jar* without also accounting for the “biographical scandal” that was Plath’s attempts and eventual success in committing suicide. Acknowledging that the work was autobiographical, including her very real fall into depression and attempts at suicide (in fact, an original draft of the novel was titled, *Diary of a Suicide*), Plath had felt it necessary to use a pseudonym so as to avoid embarrassing her mother and others who appear as characters in the novel (Jordison, 2013). For this reason, *The Bell Jar* was published in England in 1963 under the pseudonym Victoria Lucas.

Much of the autobiographical content of *The Bell Jar* were remembrances of the 1950s when Plath attended the all-girls Smith College. Plath began writing the autobiographical novel in 1961 by re-reading her early journals from 1950–1955 (cf. Plath, Hughes, & McCullough, 1982, p. 343). Plath’s early journals are filled with passages detailing gendered, personal anxieties about public expectations of domesticity as well as her decent into depression. By 1961, when Plath begins writing *The Bell Jar*, she had survived a suicide attempt, institutionalization, and electroconvulsive therapy (ECT). Now married, a successful poet, and with child, Plath offered a novel that kept company with discourses about 1950s domesticity norms and burgeoning anti-psychiatric discourses of the 1960s.

Months after the book was published, Plath committed suicide on February 11, 1963. In a letter to her mother about what she had aimed to accomplish in the novel, she writes,
What I have done is to throw together events from my own life, fictionalizing to add color – it’s a potboiler really, but I think it will show how isolated a person feels when he is suffering from a breakdown…I’ve tried to picture my world and the people in it as seen through the distorting lens of a bell jar. (cited in Dunkle, 2012, p. 62)

By the time the work was published in the United States in 1971, not only was her real name known and titled as author but also Plath’s suicide was also well known, particularly as she was married to famed poet Ted Hughes. Given this “biographical scandal,” as well as the fact that this was Plath’s only published novel, it is perhaps not too surprising that the book was instantly listed on best-seller lists in the United States upon its U.S. publication (Dunkle, 2012 p.63).

The book was well received by critics (Badia, 2006, p. 126). Wagner-Martin (1992) noted how the novel was first compared to J.D. Salinger’s *The Catcher in the Rye* and Joseph Heller’s *Catch-22* (p. 10). Like those works, Plath’s work was seen as a coming-of-age story. Other scholars of literary history note how the book was grouped with texts about “adolescence-as-social misfit,” such as *One Flew Over the Cuckoo’s Nest* and *Huckleberry Finn* (Molesworth, 1988, p. 1031). And still other scholars astutely recognized that *The Bell Jar* was “prescient of later critical theory,” particularly of feminist critiques of culture (cf. Boyer, 2004; McPherson, 1991; Peel, 2002; Wagner-Martin, 1992, pp. 47–54). Still other critics observed the dramatizing power of the novel to narratively create disordered moods and worlds for readers. One review in the *Times Literary Supplement* (1963) read, “Few writers are able to create a different world for you to live in; yet Miss Lucas has done just this” (“Under,” p. 53). Another reviewer wrote, “There are criticisms of American society that the neurotic can make as well as anyone, perhaps better, and Miss Lucas makes them triumphantly” (cited in McCann, 2012, p. 4).
The Bell Jar might be usefully characterized as both arising from a rhetorical situation of being a young career-aspiring woman amongst cultural expectations of feminine domesticity in 1950 America (Wagner-Martin, 1992), and as a response to moral exigencies about psychiatric practices that emerge in the late 1960s. The book’s opening passage, for instance, alludes to key exigencies of which the book can be seen as a response. Plath (1996) writes,

It was a queer, sultry summer, the summer they electrocuted the Rosenbergs…the idea of being electrocuted makes me sick, and that’s all there is to read about in the papers…It had nothing to do with me, but I couldn’t help wondering what it would be like, being burned alive all along your nerves. (p. 1)

This opening passage foreshadows the public and technical discourses with which Plath’s narrative enters into dialogue. First, she alludes to the Rosenbergs, Julius and Ethel, a Jewish couple who were tried, convicted, and executed for espionage in 1953. Their trial was representative of public sentiment of Cold War paranoia that influenced gendered anxieties about domesticity as a public good. Second, she alludes to Esther Greenwood’s (Plath’s alter in the novel) experiences with institutionalization and ECT as a treatment for her depression. At the time of the book’s publication in 1963, proponents of the anti-psychiatry movements vilified institutionalization and ECT as exemplars of inhumane treatment.

The Bell Jar entered a complex history with multiple discourse currents: The Cold War, norms of 1950s domesticity, and anti-psychiatry movements in the 1960s. In order to better situate Plath’s book within these historical currents, first I explore briefly the Cold War discourses influencing the public good of female domesticity ideals and then move on to explore public and technical sentiment on psychiatry.
In her history, *Homeward Bound: American Families in the Cold War Era*, Elaine Tyler May (1988) storied how the pursuit of domesticity and a hetero-normative nuclear family was considered a public good in the 1950s. May grounded her argument in the psychological theories of Paul Boyer (1985) and Robert Jay Lifton (1982) regarding “nuclear numbing,” a kind of denial reaction to the overwhelming evidence that technological innovation has created atomic weapons that can annihilate all of humanity. One’s family, garden, home, wife, and kids offer a sense of stability amid the uncertainty generated when a public senses that world powers are just “stopping short” of war (cf. Scott, 1997). The start of the Korean War in 1950 only exacerbated these fears, and the “public shared President Truman’s belief that World War III was at hand” (May, 1988, p. 22). The ushering in of Cold War atomic anxieties, according to May’s research, set up domesticity as a defiant response to the ever-present insecurity of potential annihilation. The moral ideal of domesticity became a personal mode of self-expression that was publically perceived and portrayed as a public good, a way of coping with public dangers.

Private anxieties and public dangers merge, and this tension was depicted in the 1950 movie *Marty*, a popular movie nominated for an Academy Award. The movie told the story of a young man living with his mother and aunt only to leave to create his own life after falling in love and marrying (May, 1998, p. 25–26). One superficial reading of the message of this film is that Marty’s life is now his own destiny, that is, he is living on “his terms” in a way that is “his.” Love and marriage, the domesticity ideal, were portrayed as vehicles for self-actualization. National census statistics at the time revealed that people in their early-to-mid 20s following World War II were the most “marrying generation” with 96.4% of women and 94.1% of men (May, 1988, p. 20). For many in the 1950s, domesticity offered a personal palliative to Cold War realities, a kind of defiant response to the potentiality of disrupted personal destinies. That
is, post-war prosperity brought on notions of upward mobility, and pursuing suburban life became a way to cultivate a sense of control over one’s destiny. This perceived public good contributed to an uprooting of more traditional family kinships, as individuals would leave farms and extended families for cities and suburbs (May, 1998, p. 24). Thus, in addition to atomic-anxieties, post war prosperity made the nuclear family a public good over previous eras where one’s destiny and kinship were often perceived publically as apiece.

In the tense climate of the Cold War, the Soviet Union and the United States embarked on a diplomatic project to ease militaristic tensions. On the heels of what is known as the “Lacy-Zaroubin Agreement” signed in 1958, the U.S.S.R. and the U.S. agreed to an exchange of cultural exhibitions in the spirit of “mutual understanding” (cf. U.S. Treatise and Other National Agreements, 1958, p. 13). This demonstration of “cultural exchange” was diplomatically offered as a hopeful way of achieving a subtle détente. In July of 1959, the U.S.S.R. offered the Soviet Exhibition in New York, and the U.S. offered the American National Exhibition in Moscow. Both exhibitions were met in host countries with large crowds (cf. “On U.S. show,” 1959; “U.S. Fair Viewed,” 1959). Among the technological, artistic, and educational world-fair style exhibits, both exhibitions featured mockups of Soviet and American homes complete with the latest appliances. Prominently covered by the U.S. media, Richard Nixon visited the American exhibition in Moscow and meet with Nikita Khrushchev in what has come to be known as the “Kitchen Debate.”

The New York Times ran a transcript of what they termed a “lively and unprecedented debate” as Nixon and Khrushchev debated the merits of socialism and capitalism near a mockup American kitchen. In the course of the debate, Nixon directed attention to the superiority of American washing machines, adding that Americans want to make things easier for their women
(cf. “Two Worlds,” 1959). Khrushchev reportedly responded that Soviets did not share that “capitalist attitude towards women” (“Two Worlds,” 1959). A *US News & World Report* commentary on the American Exhibition in Moscow described Soviet women as “hard” and showing “few of the physical charms of women in the West” (Cited in May, 1988, p. 19). Shapers of public opinion in the 1950s, like Eric Johnston who served as head of the U.S. Chamber of Commerce, President of the Motion Picture Association of America, and was an official with the Truman and Eisenhower administrations, openly described a de-feminized image of Soviet women. Writing of his tour of Russia in 1944, Johnston (1948) observes how his interpreter, a Russian woman, exclaimed, “…there wasn’t anything worthwhile in the world except to learn to work…no Russian woman look forward to the time when she will be without a job…” (p. 59). And, expressing his “capitalist attitude,” Johnston wrote that “Russian women, like all women in underdeveloped countries, have always done the hard work,” and with some incredulity he recounted seeing women as “miners,” “oil operators,” “truck drivers,” and “police” (p. 60). The implied “capitalist attitude” toward women Khrushchev responded to during his debate with Nixon, it would seem, was that in America women need not work hard but be supportive (and attractive) housewives for their men, living up to a domestic ideal.

The Cold War mid-1950s has also been well identified for its “paranoid style” of discourse and action (Hofstadttler, 1965), perhaps most publically embodied in Joseph McCarthy’s anti-communist crusade. Under such a rhetorical climate, the conviction of Ethel and Julius Rosenberg added even more tension between personal anxieties and public dangers in pursuit of domesticity. Here were a seemingly “normal” domestic couple tried and convicted of espionage and being active communists, thus upsetting the deep safety of one of domesticity’s idyllic cornerstones, the haven of suburbia as a public defense against personal anxieties.
Indeed, shortly after her husband’s arrest, newspaper interviews of Ethel Rosenberg were accompanied by images of her in their kitchen drying dishes and appearing much like any other housewife (Schneir & Schneir, 1965). With so much personal and public anxiety resting on the public good of domesticity and at the feet of women to be “home makers,” the Rosenberg trial exacerbated public uncertainties and fueled paranoia.

Read in context with these moments in history, we are invited to consider The Bell Jar in terms that highlight the moral purposes that shape its narrative elements. As public dangers merged with private anxieties during the time-period when Plath was attending Smith College, it is not surprising then that we find in her journals her anxiety about a domestic future, marriage in particular. Indeed, in Plath’s early journals we find passages demonstrating her ambivalent and at times explicitly defiant response to the norms of domesticity, particularly in passages detailing gendered anxieties. For instance, Plath (1982) wrote:

Frustrated? Yes. Why? Because it is impossible to be God – or the universal woman-and-man…I dislike being a girl, because as such I must come to realize I cannot be a man. In other words, I must pour my energies through the direction and force of my mate. My only free act is choosing or refusing a mate. And yet, it is as I feared: I am becoming adjusted and accustom to that idea… (p. 23)

She also wrote:

Why should they [women] be relegated to the position of custodian of emotions, watcher of the infants, feeder of the soul, body and pride of man?...I’m jealous of men…I envy the man his physical freedom to lead a double life – his career, and his sexual and family life… (Plath, 1982, pp. 29–30)
And one more:

I could hold myself, close my eyes, and jump blindly into the waters of some man’s insides, submerging myself until his purpose becomes my purpose, his life, my life, and so on. One fine day I would float to the surface, quite drowned, and supremely happy with my newfound selfless self. (Plath, 1982, p. 36)

These passages suggest her attitude toward the public expectations assigned to her gender. Given the national significance placed on the role of the housewife in supporting the anti-communist ideal of a capitalist suburbia, Plath’s career aspirations perhaps reveal a feeling of moral questioning, if not a sense of failing, that is, of failing to want to live up to the highest ideals of domesticity seen as an important public good.

The influence of the Cold War is not the only context undergirding the rhetorical situation of *The Bell Jar*. I now explore a related history to which the book might be seen as a response, namely a burgeoning academic, technical, and public sentiment of anti-psychiatry. This history is extremely complex because it involves two senses of “psychiatry” that parallel two historical approaches to mental illness: the psychodynamic and the biological (cf. Lurhman, 2001). As such, the term “anti-psychiatry” is somewhat of a misnomer. It might be more accurate to speak of anti-*biological* psychiatry. In the 1950s, psychodynamic approaches dominated the profession, characterized by group therapy, Freudian analysis, and talk therapy. It was these practices that largely shaped public sentiment of psychiatric practice. However, in the 1960s biological psychiatry involving institutions, mental hospitals, asylums, and typically involving treatment of mental illness through direct bodily treatments with drugs or ECT, came under public, academic, and professional scrutiny. *The Bell Jar* keeps company with both currents within this complex history.
Early American psychiatry was dominated by psychodynamic approaches and flourished in terms of favorable public opinion in the early years following WWII. Perhaps the uncertainties of potential annihilation and the anxious consensus on domestic ideals made it sensible to acquiescence to expert opinion. May (1988), for instance, cites a 1981 retrospective longitudinal study of American attitudes and habits, circa 1957 and 1972, as finding that “long term individual therapy…reached unprecedented popularity” (p. 27). She further quotes the researchers as remarking, “Experts took over the role of psychic healer…directing the behavior, goals, and ideals of normal people…Science moved in because people needed and wanted guidance’ (May, 1988, p. 27). Essentially what made this “unprecedented” was that for centuries prior to this latter part of the 20th century, public perception of mental illness was nearly synonymous with images of insanity and being locked up in an asylum.

The years following WWII helped to demystify public perception of the “crazy person” in light of psychotherapeutic successes and discourses that leaked into public culture through popular presses. Public faith in psychiatry at that time was rooted in widely publicized wartime success of psychotherapeutic psychiatry to help soldiers cope with the stresses of battle and other war neuroses (cf. Grob, 1991; Herman, 1995; Issac & Armat, 1990). The public learned about the prevalence and treatment of varying degrees of mental illness as popular media war coverage included stories about soldier’s war neuroses (Herman, 1995). For instance, *Time* magazine’s article “War and Mind” reported on a mass number of U.S. military discharges due to mental illness that was often hidden from view until the stresses of war brought them out (“War” 1943, p. 42). The public also gained first-hand experience with psychiatrists as part of the military draft. For instance, a 1944 *Collier’s* article, “Doctor’s Dilemma,” observed an upsurge in the “last two years” of public interest in psychiatry in part because “the workings of the Selective
Service has brought millions of Americans face to face with psychiatry for the first time” (Zolotow, 1944, p. 73). Grob (1991) cites one wartime psychiatrist who said, “The lesson we learned in the combat zone will be applied in rehabilitation at home” (p. 16). The postwar public sphere became more trusting and familiar with psychiatric practices and the notions of mental health than at any previous time in American modern history.

The dominant wartime psychiatric practices were psychodynamic in nature and often proceeded in small support groups and community settings behind front lines (Gillon, 2000, p. 90). This means that the psychiatric practices introduced to the public sphere through media were largely Neo-Freudian forms of psychotherapy. Indeed, returning to the Collier’s piece mentioned previously, the author introduces psychiatric practice to the American public when writing,

The psychiatrist diagnoses and treats the neurosis with certain definite and proved weapons. These weapons, although invisible, are nonetheless as real as the emotion you feel when you watch your child or kiss your wife. He does not use the stethoscope or the scalpel. His weapons are subtle human characteristics – a sensitive intuition which aids him in feeling out the complicated unconscious conflicts of the neurotic; a knowledge of the symbols in secret meetings of the dream – the key to basic patterns of the personality; an understanding of family relationships and the emotional struggles within families; a knowledge of the relation of a person to his environment and his work. He employs these weapons as fully as he understands them. (Zolotow, 1944, p. 78)

In fact, the author goes on to speak about the psychiatrist’s ability to “retreat into the childhoods” of the neurotic. These are allusions to some of the basic concepts of Freudian psychoanalysis. Interestingly, in 1959 an article titled, “Psychiatry and Beauty,” appeared in
Cosmopolitan magazine, an article that Plath says she read “cover to cover” on the day she decided to begin work on The Bell Jar (cf. Plath & Kukil, 2000, p. 495). The article reported on how some hospitals are exploring therapeutic role that “beauty care” serves in the rehabilitation of mentally ill women. In one particularly interesting passage, psychiatrist Dr. Bergler observed that some women “refuse to look beautiful,” that they “go right on dressing themselves in their unconscious defense mechanisms” (Fleming, 1959, p. 35). Dr. Bergler continued,

She bought clothes only when she needed them. In her mind she only needed them to keep warm and covered. To complete her grim costume, she wore thick eyeglasses, even though her vision was normal. The woman was neurotically resolving an anxiety-provoking childhood conflict. Way back then, she had been in competition with her beautiful mother for her father’s affection. Guiltily, she “solved” her problem by telling herself, “you have no right to be like mother and replace her.” (Fleming, 1959, p. 35)

“Guilt,” “Oedipal Complexes,” “unconscious” and “defense mechanisms” were all popularizations of Freudian concepts at mid-century, to say nothing about the normative expectation of feminine beauty as a sign of mental health. It was seemingly the case that in the early years following WWII “many Americans had access to the language of mental symptoms, from the popular versions of Freudian concepts to the language surrounding the increased use of treatments such as shock therapy” (Hirshbein, 2009, p. 22).

Interestingly, it is precisely “shock therapy,” along with institutionalization, that would become iconic issues for the loss of faith in biological psychiatric practices and of the very public anti-psychiatric discourses of the 1960s. At this time, powerful professional critiques of biological psychiatric practice by Erving Goffman, R.D. Laing, and Thomas Szasz began to gain assent among intellectual communities. Such critics argued that psychiatric illnesses are not
medical in nature but social and often marred with political implications. In addition to these professional critiques, congressional reports from The Mental Health Study Act of 1955, which yielded the Action for Mental Health Report of 1961, found institutional treatment of the mentally ill largely ineffective and an “outdated” model of “custodial care” that was costing taxpayers more than a million dollars a year. The popularization of these arguments seemed to warrant the passing of public legislation like the Community Mental Health Act of 1963, championed by President Kennedy as “a bold new approach” to mental illness (Gillon, 2000, p. 94). Largely grounding its arguments in economic benefit, the report was decidedly favorable to those arguments that stress importance of social context and community to the rehabilitation of the mentally ill. The “bold new approach” would be a process of deinstitutionalization in favor of community health programs where the “cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability” (Kennedy, 1963).

The Bell Jar keeps company with this burgeoning anti-biological psychiatry movement and even extends its critique further to encompass psychodynamic approaches. As the private experience of mental illness and its technical treatment became matters of public interest and discussion, Plath sought to capitalize on this growing anti-psychiatry public sentiment with The Bell Jar. In a letter to her family in 1959, Plath tells how she has just finished reading the most recent Cosmopolitan and continues:

…Two mental health articles. I must write one about a college girl suicide. THE DAY I DIED. And a story, a novel even. Must get out SNAKE PIT. There is an incredible market for mental-hospital stuff. I am a fool if I don’t relive, recreate it. (Plath & Kukil, 2000, p. 495)
In this letter, we gain a sense of one moral purpose informing some of the writing *The Bell Jar*. There are three key features of this excerpt that are relevant. First is Plath’s reference to Mary Jane Ward’s popular novel *The Snakepit* (1946), a story that depicts horrendous conditions of mental hospitals. The novel appeared in *Reader’s Digest* in shortened format in 1946 and was made into a movie in 1948 (Grob, 1994). It followed Albert Q. Maisel’s (1946) *Life* magazine article “Bedlam 1946,” which provided gruesome pictures and detailed accounts of how “the vast majority of mental institutions are dreary, dilapidated excuses for hospitals, costly monuments to the states’ betrayal of the duty they have assumed of their most helpless wards” (p. 103). Both commentaries inspired public deliberation on the usefulness of psychiatric hospitals. Secondly, Plath expresses that there is an “incredible market” for “mental-health stuff.” By the time the anti-establishment tinged 1960s arrived many in the public had joined the anti-psychiatric movement. *The Bell Jar* enters as a “pot boiler” into this rhetorical situation of psychiatric and public history.

As the ’60s approached, the early influence of psychotherapeutic models within the technical sphere of psychiatry began to wane as increasing pressures to secure federal funding required that psychiatry demonstrate itself to be a real, hard science (Wilson, 1993). As a result, biomedical solutions to mental illness problems continued to be pursued. For instance, in 1954 biological research led to the introduction of Chlorpromazine, known as Thorazine, which “made it possible to modify and to alleviate the symptoms associated with schizophrenia, manic-depressive psychosis and other severe disorders” (Grob, 1994, p. 228). *Time* magazine (1955) soon proclaimed, “Psychiatry is in the throes of a revolution” (“Pills” p. 65). This tranquilizing drug, as Isaac and Amat (1990), write, “transformed the atmosphere of mental hospitals…Bedlam was laid to rest” (p. 20). Ironically, however, these pharmaceutical
developments helped support growing anti-psychiatric sentiment in the public sphere. As the historian of psychiatry Edward Shorter (1997) observes, the discovery of effective new medications for psychosis and neurosis, “may have induced a certain insouciance toward the patient’s need to feel cared for” (p. 273). Given shifts in the public sphere in the 1960s that gave way to hostility toward authority, the cold, detached, medicalized approach to psychiatry couldn’t have been more poorly timed (Isaac & Amat, 1991, pp. 19–44; Shorter, 1997, p. 272).

Adding to this already complex history were popular and highly influential anti-psychiatric images from books and films that helped shape public sentiment. The book *The Snake Pit*, which Plath makes reference to in her letter above, became a feature film in 1948. A memorable image from that film depicts the story’s heroin being sent to a mental hospital with hellish conditions, and at one point, the camera is positioned high above her peering down as if into a pit as she is surrounded by “mad” patients (Grob, 1994, p. 274). In 1962, Ken Kesey’s book, *One Flew Over the Cuckoo’s Nest* became a national bestseller and depicted institutional life as a form of control, as its main hero is lobotomized because his behavior disrupts the hospital’s regimen. And in 1964, the novel *A Fine Madness* was published, which “presented psychiatry as the nemesis of those sensitive and usually victimized loners…” (Gabbard & Gabbard, 1999, p. 120). Intellectual, legislative, and popular media representations of deplorable treatment of psychiatric patients functioned to make private mental states a public concern.

Read in the context of these historical moments, Plath’s disordered moods served as both an exigency that called for a story and as one that further discursively engaged the exigencies of a public and technical rhetorical situation. *The Bell Jar* richly describes the personal consequences of alienation in psychiatrist-patient relationships. For instance, Esther Greenwood finds herself at a public mental hospital where she is poorly treated, served cold food, and
verbally ridiculed by hospital staff. The cold and alienating experience is expressed in Esther’s choice to metaphorically de-humanize the staff by referring to them as “Doctor Soandso” “Nurse Mole,” and “Dr. Syphilis.” Later in the narrative, after Esther’s suicide attempt, she is transferred to a private mental hospital that is depicted as having many of the amenities of a posh country club. Esther receives shock treatments there, but this time under the supervision of a female psychiatrist, Dr. Nolan, whom Plath identified with a personal name. Dr. Nolan is depicted as caring and supportive. She hugs and holds Esther and genuinely asked questions. The shock treatments are depicted as peaceful and much like falling asleep. Esther recovers from her depression under Dr. Nolan’s care. These narrative episodes of alienated and humanizing psychiatry-patient interaction found receptive audiences in a public sphere already soured on biological psychiatric practices.

By considering this historical context, we are encouraged to consider how *The Bell Jar* engages a rich rhetorical situation that can also appear as a first kind of feminist critique of Freudian psychodynamic models (cf. Farland, 2002). Feminist readings of *The Bell Jar* note that though Plath had died prior to the publication of *The Feminine Mystique* and did not seem to own a copy of Simone de Beauvoir’s *The Second Sex*, the book contains “…those qualities which have been associated with *l’écriture feminine,*” that is, “that women can write themselves into being through a resistance to the patriarchal, male sexuality privilege (Peel, 2002, p. 21). Second-wave feminists perspicaciously noted the patriarchic values imbedded in psychiatry in the 1950s. One feminist scholar observed that women who rejected stereotyped sex-roles or resisted their therapy found themselves vulnerable to being labeled psychotic or neurotic, even perhaps “isolated, straight-jacketed, sedated, and given shock therapy” (Chesler, 1972, p. 36). *The Bell Jar* richly describes Esther Greenwood’s experience of these alienating patriarchic
values at both societal and clinical levels. As for instance when Esther tells her boyfriend, “Buddy Willard,” that she never plans on being married. And Buddy responds, “you’re crazy” (Plath, 1996, p. 93). Esther even refers to herself as “neurotic” for not complying with gendered roles. And after prolonged bouts of depression, Esther sees a psychiatrist, “Dr. Gordon.” He is depicted as “conceited,” patronizing, and lacking empathy. For instance, Dr. Gordon asks Esther, “Suppose you try and tell me what you think is wrong” (Plath, 1996, p. 129). Esther responds,

I turned the words over suspiciously, like round, polished pebbles that might suddenly put out a claw and change into something else. What did I think was wrong? That made it sound as if nothing was really wrong, I only thought it was wrong. (Plath, 1996. p. 131)

Dr. Gordon is depicted as uncaring. When with a “dull, flat voice” Esther opens up about her struggles with not eating, not sleeping, and not reading, Dr. Gordon responds by telling a story about himself and laughing self-amused. Needless to say, Esther is suspicious and distrusting of Dr. Gordon. Dr. Gordon prescribes ECT for Esther. And in the seconds following her first harrowing, painful shock, Esther is depicted as wondering, “what terrible thing it was that I had done” (Plath, 1996, p. 143). For a 1960s audience, Plath’s account of this episode (based on her own real-life personal experience) would give a personalizing flesh to feminist critiques of patriarchic values of psychiatry.

The rich rhetorical milieu of 1950s domesticity ideals in the Cold War era and a growing anti-psychiatry sentiment surrounds The Bell Jar. Years after its publication, the text’s popularity has not waned. Both its status as a feminist critique and as radical perspective on the experience of depression in cultural context justifies its use as canonical reading in high school literature.
classes and beyond. The book is often taken as a symbol of youthful resistance and societal criticism. As Perloff (1972) wrote, *The Bell Jar* would,

become for the young of the early seventies what *The Catcher in The Rye* was to their counterparts of the fifties: the archetypical novel that mirrors, in however distorted a form, their own personal experience, their sense of what Irving Howe calls ‘the general human condition.’ (p.507)

As exemplars of this appeal to a “general human condition,” Badia (2006) and Dunkle (2012) review numerous appropriations of the book in American popular culture, as the book is visually placed in everything from *The Simpsons* and *Family Guy* to *Natural Born Killers* to *10 things I Hate About You*. For instance, in an episode of *Family Guy*, Meg Griffin, the adolescent daughter figure on the show is seen reading *The Bell Jar*. The plot of this particular episode finds Meg Griffin sulking about not having plans for spring break and feeling particularly ostracized, out of touch with her peers, and complaining about her lack of social life. The book is also seen in the hands of Kate Stratford, the cynical, depressed, and angry protagonist in the film *Natural Born Killers*. Indeed, the book itself was slated to appear as a movie in 2012 (Dunkel, 2012), though the actress Julia Stiles, who was to star in the film as Esther Greenwood, reveals that the movie is not likely to appear anytime soon. In either case, we can see how the book has functioned as a rhetorical resource as female characters are found reading or referencing the text to portray moments of rebellion, depressed mood, or societal disenchantment. In many ways, *The Bell Jar* has achieved American cult status.

*The Bell Jar* was clearly a culturally relevant work during its time of publication and shortly after, but the book continues to inspire public deliberation and discourse even today. In 2013, the book’s publishers Faber and Faber reissued *The Bell Jar* in a 50th Anniversary edition.
Controversy quickly spread among critics and fans who took exception to how the publishers updated the book’s cover with a “chick lit” style (See Appendix A). Some argued that this cover “trivialized its content” and misrepresented the work (Schoenberg, 2013). Fatema Ahmed (2013), a contributor to the London Review of Books website, simply referred to the cover as silly. She furthermore reported how David Kurtz, a book marketer from Melville House Publishing tweeted, “How can this cover be anything but a big ‘Fuck you’ to women everywhere?” In response to such criticism, Faber and Faber were forced to issue a statement in defense of the cover that observed that such disapproval reveals the strength of feeling for Plath and her book. They continued by arguing that they view packaging as a way of “describing an old work afresh” and aimed at attracting readers who might “enjoy its brilliance without knowing anything about Plath’s other work.” One particular voice in this contemporary debate over the cover is particularly relevant for the current study and whose perspective brings this review of Plath full circle. Recall that early criticisms praised the book’s ability to create a depressed world. Given the “chick lit” cover, one critic observed, “I see nothing wrong with this [the cover] – except that some young woman seeking a lightweight beach read might get unexpectedly very depressed” (Grocott, 2013). And this is a fascinating aspect of why this text and other mental illness memoirs should be studied. How does this story give insight into the experience of depression? How do readers identify with such disordered accounts and to what rhetorical ends are such narrative demonstrations put to use? By offering a deep reading of *The Bell Jar*, I work towards an answer to these questions in the following chapters.
In what follows, I will be using the word “stigma” often. So before moving on, let me briefly define what I mean by “stigma.” In 1963, Erving Goffman published *Stigma: Notes on the Management of Spoiled Identity*. It has since become a standard reference for many analyses of social stigma of the mentally ill. His sociological account defines stigma as an interpersonal and social phenomenon where the reactions of others spoil normal identity by identifying an attribute of someone as “deeply discrediting” (Goffman, 1963, p. 12). Stigma occurs when there is a discrepancy between virtual social identity, such as stereotypes and expectations we bring to everyday encounters, and the actual social identity a person has (Nettleton, 2006, p. 95). “Deeply discrediting” is always that which is publically adjudicated or evaluated through a particular cultural and historical context. As Jenell Johnson (2010) writes, stigmatization is a rhetorical process enacted through language “rooted in culturally and historically contingent values” (p. 462). Stigma is the social process wherein an individual with some disability has their lines of expressive action and possibilities limited by social sanction and are thus deemed as living less than fully human lives (cf. Goffman, 1963). A brief history of the influence of public stigmatization in American culture will help provide a sense of the rhetorical context surrounding *Darkness Visible*.

Prior to the publication of *Darkness Visible* in 1990, Styron was already an accomplished and well-known writer. He was the author of *Sophie’s Choice* and *The Confessions of Nat Turner*, both works that have become classics within the contemporary canon of American literary culture. *Darkness Visible* was his only explicitly autobiographical work. The work itself tells the story of Styron’s fall into depression and his eventual recovery in 1984. Unlike *The Bell Jar*, however, the exigencies of disordered moods that call for stories are fundamentally
different. Styron’s personal exigency of depression engages a rhetorical situation that involves seismic shifts in diagnostic practices in psychiatry and increased public stigmatization of mental disorders. More still, whereas Plath’s work had not yet known of biomedical explanations of depression and often trafficked in moralistic sentiments of her own “neurotic” states, Styron’s *Darkness Visible* mobilizes biomedical discourses as a way of influencing stigmatizing views of suicide and depression.

In what follows I first review a short biographical note on Styron’s depression and the writing of *Darkness Visible*. Then, I review a short history of popular stigmatizing views of mental illness and the rise of the biomedical model of mental illness. And finally, I offer a short account of Styron’s early decision to share his story and the continued relevance of his memoir.

Like Plath, it would be impossible to understand the lasting influence of *Darkness Visible* without also addressing the biographical context of Styron’s depression. Styron’s biographer James L.W. West (1998) writes of the period leading up to Styron’s depression as one where Styron began experiencing severe bouts of writer’s block. In part, his creative struggles were related to something of a letdown following much-concentrated work on, and successful celebration of, his novel *Sophie’s Choice*. West (1998) reports a letter from Polly Styron, one of Styron’s daughters, that reveals something of Styron’s mood at that time. She wrote, “I sense your nights at home alone, now you are no longer living in chambers of Sophie…” (p. 431). Though his shift in mood seems understandable, such “letdowns” were something of a norm for Styron. In a candid memoir about her father, Alexandra Styron (2011) wrote that her father “had always been depressed,” and moreover, that he often used alcohol as a way of self-medicating (p. 3). William Styron never admitted to being an alcoholic, but he often referred to alcohol as an “invaluable senior partner of my intellect” and a “friend” (Styron, 1990, p. 40). But one
particular summer in 1985 he would have to treat his downward moods without the aid of alcohol, due to a poor functioning urinary tract.

Styron himself did acknowledge that he has always been a lifelong sufferer of varying bouts of depression. But unlike other times in his life, this particular bout of depression in the late 80s led to thoughts of suicide and eventually hospitalization. Upon his recovery, the author “thought for several months about…ways of making fiction from his experience of depression” (West, 1998, p. 450). And though he would begin writing just such an autobiographical novel, he abandoned the book because he felt ill prepared to “exhibit more of myself than either my sense of propriety or instinct for privacy would ordinarily allow” (West, 1998, p. 450). He further acknowledged that his hesitation was due in part to not wanting to publically chronicle his mental illness. Though Styron argued his hesitancy was based in a desire for privacy and nothing more, one cannot help but consider the influence of negative public sentiment regarding mental illness at that time in U.S. culture. In fact, Styron’s own psychiatrist advised him against hospitalization because of concerns about public stigma (West, 1988, p. 439). Public stigma of depression and mental illness were real concerns for those suffering mental illness in Styron’s time. *Darkness Visible* is in large part a memoir of this moment of recognition, the struggle of acceptance, and treatment of his depression.

*Darkness Visible* began as a talk at John’s Hopkins in the summer of 1989. The talk then became a long article first published in *Vanity Fair* magazine later that winter. Then, it was finally published as *Darkness Visible: A Memoir of Madness*. A national bestseller, the book tells the full story of Styron’s depression that summer in a way that the *Vanity Fair* article was unable to accommodate. Styron included further details about the circumstances surrounding his depression, the new biomedical view of depression, his experience with psychopharmaceuticals,
and his hospitalization. Scholars recognized the book as the first “depression narrative” that “opened the flood gates” for the emergence of the genre of mental illness memoirs (Atlas, 1996; Zimmerman, 2007). The book appeared to be well received by most reviewers, who, by and large, accepted the work as an act of “courage” (Storr, 1990). One reviewer called the book an “impressionistic corrective,” one that “invites the reader temporarily to abandon sunny delusions” and instead participate in “degenerative insanity” (Skenazy, 1990, p. 13). Still other reviewers wondered if Styron’s embracing of the “disease model” of depression shielded questions about the moral weight of suffering sadness (Iannone, 1990, p. 57), which somewhat echoed larger public sentiment about the moral status of mental illness. But on the whole, early reviews of the work acknowledged the rhetorical power of the book to provide a rich account of what depression “feels like from the inside” (King, 1991, p. 37). This last comment echoed those made about The Bell Jar as a text that brings readers into a “depressed world.”

Perhaps the greatest evidence of the book’s rhetorical power to “invite the reader” into the “world” of depression was the numerous letters from readers that were sent to Styron after its publication. Alexandra Styron (2011) described these letters as “raw outpourings of depression’s many victims…” (pp. 9–10). These letters were said to be very intimate, confessional, and overwhelming, as sufferers of depression and their families reached out to her father with a sense of relief in having someone articulate such an honest, clear, and learned perspective on depression. Alexandra Styron (2011) recalled times when people would accost her father on the street to seek advice and empathy on their own suffering or of a loved one. Apparently, her father was even contacted by the police on a few occasions in the process of “talking down” people intent on committing suicide (cf. Styron, 2011, p. 10). William Styron had become something of a lay-authority on the experience of depression and its public stigma.
In this short biographical note and history of the reception of *Darkness Visible*, I have wanted to give a sense of some factors influencing Styron’s decision to share his experience of depression. Styron suffered depression. He also hesitated to share his story because of concerns about public stigma. Styron, in short, was well aware of not only the pain of depression but also the suffering that can accompany stigmatizing and moralistic views of those who suffer.

*Darkness Visible* engages a complex history with multiple discursive currents. But two histories seem most relevant: the public moral stigmatization of mental illness and, second, the emerging biomedical view of mental illness in the late 1980s. First, I explore public discourses shaping stigmatizing views of mental illness. Then, I move on to explore the shifts in psychiatric diagnostic practices that can themselves be seen as responsive to these stigmatizing public sentiments. By examining a history of how mental illness has been stigmatized in popular culture during Styron’s time and the biomedical response, we are encouraged to consider how *Darkness Visible* can be read in the context of rhetorical situations that suggest some moral purposes at work in Styron’s memoir.

Not long before Styron’s first iteration of *Darkness Visible* appears as an article in *Vanity Fair*, John Hinckley Jr. attempted to assassinate President Reagan. *The New York Times* reported that just days before the assassination attempt, some of Hinckley’s family members suggested he be institutionalized because he was “depressed,” behaving erratically, and “totally out of control” (Taylor, 1982, p. D20). Hinckley was found not guilty by reason of insanity and sent to a psychiatric institution. This is not the first time the public sphere would encounter mental illness based violence. In October 1985, Sylvia Seegrist walked into a shopping mall, dressed in army fatigues and carrying a .22 caliber semiautomatic gun. She opened fire in the shopping mall and killed three people. Seegrist suffered from schizophrenia and had been in and
out of psychiatric wards for 10 years, prior to that day (Moore, 1985, p. A25). Days before her attack, she had attempted to call a “crisis” center to ask for help with a growing sense of rage (“Mom,” 1986, p. 12). She did not get through. The event sparked debate across the country about mental illness related violence and how best to care for the mentally ill. Ruth Seegrist, Sylvia Seegrist’s mother, became an advocate for changes in state mental health legislation that would make it possible for states to confine the mentally ill. Speaking to the state legislature’s “blue-ribbon” panel and addressing Pennsylvania’s mental health commitment laws, she pleaded:

Just as it was cruel and unjust to indiscriminately lock up the mentally ill years ago, so it is unjust and socially irresponsible to allow the severely ill with established records of violent behavior to fend for themselves. And then they are held criminally responsible. What a travesty of justice! You have not given the severely ill civil liberty. You have merely given them the right to be slaves to their own devastating and debilitating brain disease…you have given them every right except the most basic one: the right to get well. And that, dear legislators, is neither civil nor is it liberty. (“Mom,” 1986, p. 12)

Highly publicized events like these soon coalesced into stigmatizing public views that failed to distinguish between more psychotic forms of mental illness and lesser forms like depression.

Stories about the mentally ill “losing control” and turning violent were not only a part of the daily news, but also had for years been sensationalized in film. (Gillon 2000; Grob, 1994; Isaac & Armat, 1990; Wahl, 1995). Cinematic representations of mentally ill related violence have a long history, from 1906’s Dr. Dippy’s Sanitarium, where an asylum guard is chased, captured, and harassed by patients, to 1975’s Academy Award winning adaptation of Ken Kesey’s One Flew Over the Cuckoo’s Nest. Interestingly, that movie starred Jack Nicholson,
who would appear again in *The Shining* (1980), a story about a man who descends into insanity and attempts to murder his family. In a follow up to the 1960 Alfred Hitchcock film *Psycho*, the plot of *Psycho 2* (1982) depicts the social fear of the public in the age of deinstitutionalization. In this film, its lead character “Norman Bates,” having been held in a mental institution, is released after 22 years amidst protest from those who knew of his murderous past. He begins to murder once again. The original *Halloween* movie franchise, beginning 1978 and lasting until 1989, further dramatized the social fear of deinstitutionalization. Five separately successful *Halloween* films followed the life “Michael Myers” who escapes a mental institution and proceeds on murderous rampages. Public sentiment on mental illness is in part shaped by entertainment media’s long tradition of depicting persons “losing control” because of a deleterious mental condition.

To gain even further sense of America’s history with moralistic views of mental illness, consider a still earlier, highly publicized instance of stigmatizing depression. On July 25, 1972, Democratic presidential nominee George McGovern’s running mate Thomas Eagleton publically announced that he had undergone psychiatric treatment in the 1960s, including shock treatment on three occasions. This public announcement was for many Americans the first encounter with the idea of depression (Hirshbein, 2009, p. 60). McGovern claimed to have no knowledge of Eagleton’s past medical history. Of his announcement, both McGovern and Eagleton expressed they felt it would have no significant impact upon their campaign. Five days later during a television interview, Eagleton was asked if he felt his announcement would hurt the campaign, he said, “No. I’m convinced of exactly the opposite, that I’ll add one to 3 or 4 percentage points to the ticket” (“Eagleton Interview,” 1972, p. 13). When McGovern was asked if he would’ve hesitated at choosing Eagleton had he known of past depression, he strongly supported Eagleton
by stating, “I wouldn’t have hesitated one minute if I had known everything Sen. Eagleton told you today” (Lydons, 1972, p. 1). The night that Eagleton received the nod to run as Vice President, McGovern’s campaign director Frank Mankiewicz asked Eagleton if he had “any skeletons” in his closet. Eagleton answered “no” and added “because I did not consider the fact that I had had some hospitalization for a health problem to be a skeleton” (“Eagleton Interview,” 1972, p.13). Eagleton continued, “What’s a skeleton to Eagleton? A skeleton is something that’s dirty, filthy, corrupt, illegal, sinister. There’s nothing about having been fatigued and exhausted and being in a state of mild depression that I found sinister, dirty, or ugly” (“Eagleton Interview,” 1972, p. 13). For Eagleton and McGovern, depression was understood as a medical condition, the same as the common cold. What both men underestimated, however, was that public perceptions of mental illness shared their technically informed stance on the biological causes of depression. The public sphere was not conversant in the technical developments surrounding mental illness.

Eagleton eventually withdrew his nomination and quit the campaign on under the weight of public scrutiny and uncertainty about the nature of depression and mental illness. Questions arose about his “fitness” to serve given the rigors of the job, particularly with Cold War nuclear anxieties still at their peak. Even members of his own party felt genuine fear about having Eagleton in the White House. Matthew J. Troy, Queens County Democratic Leader, told one reporter that the nation could not afford “to have a man who had a breakdown under a nervous pressure or tension to have him have the right to control that nuclear button” (“Troy Would Not Vote,” 1972, p. 12). Eagleton was well aware that, “There is in the minds of some people a stigma attached to any kind of an emotional situation” (Lydons, 1972, p. 1). Indeed, as The New York Times reported,
…many Americans have continued to look upon mental problems as a sign of a character flaw rather than as an illness. There is a kind of shame that has been felt by the relatives and friends of the mentally ill; there has been resistance to psychiatrists and psychiatry; the language has come to be studded with euphemisms such as “nervous breakdown.” (“Eagleton Quits,” 1972, p. 34)

Eagleton was personally aware that as a Vice Presidential nominee he would have to “face the risk” of divulging the details of his past (“Eagleton Tells,” 1972, p. 1). He was aware of the potential stigma of his depression treatment, that people like Troy would worry about their children and not want to “see them destroyed because some unstable person might become president” (“Troy Would Not Vote,” 1972, p. 12). The public sphere judged and scrutinized Eagleton and by extension McGovern, as his support of Eagleton as fit to serve as V.P. was also met with scrutiny. Eagleton’s announcement had a contaminating effect on the ethos of both men and may have contributed to their failed campaign (Johnson, 2010). The reality of the ’70s was that there was very little public knowledge of biological psychiatric views of depression and mental illness more generally. Moreover, within the technical sphere of psychiatry there was widespread unreliability in diagnosing depression (Horwitz & Wakefield, 2007; Shorter, 1997). Add the recent 1960s anti-psychiatry and deinstitutionalization movements, and we gain a sense of the historical context leading to the depth of 1980s public stigmatizing views of mental illness.

The “Eagleton Affair” was a highly publicized example of stigmatizing views of depression in the 1970s. But even at the ground level of everyday living public stigmatizing views were taking root in large part because of mass deinstitutionalization of the 1960s. In 1977, President Jimmy Carter issued an executive order, The Presidential Commission on Mental Health, as a way of identifying “how the mentally ill, emotionally disturbed, and mentally
retarded are being served, to what extent they are being underserved, and who is affected by such underservice” (Carter, 1977, p.188). To a great degree, pressure from the public sphere created a need for this executive order. Deinstitutionalization may have addressed the issue of custodial, coercive, or forced commitment, but it also allowed some individuals suffering the most severe forms of mental illness, those needing the most care, into communities. In his book, “That’s Not What We Intended To Do:” Reform and its Unintended Consequences in Twentieth Century America, Steven Gillon (2000) surveys the many ways communities failed to offer infrastructures necessary to accommodate more difficult forms of mental illness. Thus, on a daily drive to work or walk through neighborhood communities, the public, particularly in large cities, had more encounters with persons with severe mental illness (Grob, 1994, p. 284). The result was an increase in social fears about mental illness related violence. By 1984, Robert Felix, the chief architect of the deinstitutionalizing Community Mental Health Act of 1966 would observe, “We psychiatrists saw too much of the old snake pit, saw too many people who shouldn’t have been there and we overreacted” (Gillon, 2000, p. 112). Mental illness was no longer only a private issue but had become a public concern.

What I’ve wanted to show in this brief history is that by the time Styron publishes his memoir in the late 80s, public sentiment about mental illness was already well rooted in habits of stigmatizing and moralizing accounts. Indeed, just a few months before John Hinckley Jr. would attempt to take her husband’s life, first lady Nancy Reagan characterized those who seek psychiatric treatment as “faddish.” She continued, “…some people use it as a crutch. I feel that getting psychiatric treatment means that you are not really trying to get hold of yourself. You are sloughing off your responsibilities” (Howard, 1981, p. 108). The First Lady’s view reflected the view of a majority of Americans. In 1986, over 55% of the public “did not believe that mental
illness exists” and a majority continued to believe that mental illness results from “weakness of character” (Holden, 1986, p. 1084–1085). What were missing in public discourses on mental illness were rhetorical resources not rooted in moralistic views of mental illness. An amoral discourse on mental illness would be made available in 1980 as substantive changes in psychiatric diagnostic practices would take effect.

I now explore a related history to which Darkness Visible might be viewed as engaging, specifically the burgeoning biomedical revolution in psychiatric practice. The history of how psychiatry adopted the biomedical view of mental illness can be traced as far back as ancient Greece. There is not enough space to cover that entire history here. Instead, I will focus on the late 20th century professional discourses that led to biomedical models. The development of an amoral perspective on mental illness, one rooted in a medical model, meant that now those who suffer depression could appeal to their disorder in amoral ways. They no longer needed to understand themselves as “neurotic,” as Plath had, instead they could now frame suffering as a medical condition. This meant that those suffering depression could interject uncertainty into discussions about any single example of seemingly “loss of control.” Did they act erratically because they are sick or because they are morally weak? This new facet of the rhetorical situation is important to explore because it provides context for reading Darkness Visible that assists in illuminating its rich appeal to biomedical views of depression.

Recall that from WWII through the 1970s the psychodynamic model of mental illness informed the majority of psychiatric practice. This model was also known as the psychosocial model because it viewed psychic processes in the context of social influence and personal history. The psychosocial model relied on specialized training in psychoanalytic interpretation and presupposed knowledge of the ultimate causes of a mental disorder. Diagnosis was more of
an art than a science. In the 1970s, federal funding for psychiatric research was decreasing largely due to a lack of empirical advancement in the understanding of the causes of mental illness (Wilson, 1993, p. 403). These “interpretive” practices were seen by many within the profession as the reason why psychiatry was losing its funding. The psychosocial model failed to offer empirical grounds for scientific investigation or classification of mental disorders. Not surprisingly, after a presidential report revealed that there was little professional agreement on the causes of mental illness as well as a lack of uniform methods in diagnoses (“Presidential Commission,” 1978), health insurance companies pulled back their coverage for psychiatric services (Wilson, 1993). Without a means for uniform assessment of mental illness and no professional agreement on the causes of mental illness, the professional status of psychiatry was shaken.

Largely due to these status and economic concerns, “Psychiatric scientists,” writes Luhrmann (2000), “were determined to create a psychiatry that looked more like the rest of medicine” (p. 225). The problems of psychiatric accountability and reliability greatly influenced the creation of the third edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-III) published in 1980. Unlike DSM-II which included nomenclatures built upon psychodynamic concepts and Freudian concepts like “neuroses,” “hysteria,” and “symbolic underlying conflicts,” the DSM-III stylized a more clinical, medical, and symptom-based approach (Shorter, 1997, pp. 299–300). This meant that diagnosing mental disorders would no longer depend upon psychoanalytic interpretation but would instead have a “strictly behavioral orientation and make little attempt to relate the syndromes it described to etiology,” or as one collaborator would write, “Clerks rather than experts can make this kind of classification of patients” (Wilson, 1993,
This move from interpretative practices to more observational ones increased psychiatry’s credibility as a medical science.

Robert Spitzer, the main architect of the DSM-III, openly claimed this edition of the model would be “a defense of the medical model as applied to psychiatric problems” (Wilson, 1993, p. 405). The architects of the DSM-III sought to address the challenges facing psychiatric practice by using statistical advances to produce a manual that was descriptive and emphasized classification of easily observable symptoms with scant mention of causes. In practice this meant that diagnosis no longer depended on a specialist who can interpret that one’s depression was caused by an “inferiority complex,” but rather, diagnosis “should be made if the criteria for that diagnosis are met” (Luhrmann, 2000, p. 228). Idiosyncratic interpretations about the “cause” of a disorder were no longer required. The DSM-III allowed for a universal classification of symptoms that gave psychiatric providers reliability in diagnosis. Mental illnesses were now diagnosed by observing amoral symptoms much like diagnosing the common cold.

The publication of the DSM-III in 1980 also paralleled advances in psychopharmaceutical research. Research had found a number of drugs that could alleviate the symptoms of mental disorders, the antidepressant Prozac being the most popular (cf. Kramer, 1993). The DSM-III treated depression as an illness with a very clear typology of symptoms. A patient exhibiting symptoms could be prescribed Prozac just as one prescribes penicillin for an infection. Depression was now considered an illness as any other. The functional effect of this biomedical approach was that illness was now considered something separate from the suffering person. As a result, “there should be no more embarrassment about depression…than there is about diabetes” (Luhrmann, 2000, p. 275). The biomedical view had attacked public stigma of
mental illness by undercutting the public sentiment that mental illness is caused by moral failure. Mental illness had become known as a biological condition treatable with medicines.

William Styron would be a central figure in a highly publicized clash of older moralistic discourses meeting against the newly emerging biomedical views. On April 11, 1987, Primo Levi, a popular writer and a survivor of the WWII Jewish prison camp Auschwitz, committed suicide by throwing himself down the stairwell of his apartment building. Given Levi’s status as survivor of concentration camps, it was perhaps expected that his death could be framed as one man’s succumbing to “the ghosts of Auschwitz” (Kakutani, 1989). However, Levi, this strong survivor, was also known to be suffering a deep depression at the time of his suicide. Levi’s depression was precipitated by having to deal with an increasing series of health problems both with himself and his family, especially his mother’s battle with cancer. As one biographer noted, in addition to the past wounds of internment and torture, Levi now had much more to deal with (Thompson, 2002, pp. 473–496). Levi had never made known his intention to commit suicide, that is, he left no suicide notes nor made any explicit suggestions of his intent. Yet, a mere 10 minutes prior to his death he had contacted a rabbi and shared: “I can't go on with this life my mother is ill with cancer, and every time I look at her face I remember the faces of those men stretched on the beaches at Auschwitz” (Gambetta, 1999, p. B7). The concierge of his building found Levi dead at the foot of a stairwell soon thereafter.

A year after Primo Levi’s death, writers and literary critics held a symposium seeking to “reconcile” the writer’s life and death (Kakutani, 1989, p. C23). Many of the participants expressed their “shock” and “surprise” at his death, that a man who had endured and survived the hardships of Auschwitz could in the end commit suicide under the weight of life’s pressures. As one participant would comment, “It is difficult for me to credit a will to blackness and self-
destruction in a writer so happy and full of new projects” (Kellerman, 1988, p. 11). The public sphere, in short, expressed its uncertainty about Levi’s strength of character. This moral judgment also appeared in *The New Yorker* magazine where one observer wrote, “The efficacy of all his words had somehow been canceled by his death — that his hope, or faith, was no longer usable by the rest of us” (Stille, 1987, p. BR5). Styron is said to have read these accounts with “some irritation and found himself moved to respond” (West, 1998, p. 451).

Drawing on and making known his own struggles with depression, Styron wrote an op-ed titled “Why Primo Levi Need Not Have Died” and argued that Levi’s suicide couldn’t be dissociated from the suffering of major depression. As Styron (1988) would observe,

A friend, rejecting the idea that the writer had planned to kill himself, saw the death as the result of a “sudden uncontrollable impulse” as if rational deliberation might have somehow colored the act with wrongdoing. In this and other statements, at least a tinge of disapproval, an unspoken feeling there was that through some puzzling failure of moral strength Mr. Levi had failed his staunchest admirers. (p. A17)

Thoughts of suicide and acts of suicide need not be publically stigmatized, Styron argued, because depression generates unspeakable pain, torment, and causes uncontrollable lapses in judgment. Styron claimed that, “Mr. Levi’s death could not be dissociated from the major depression with which he was afflicted, and that indeed his suicide proceeded directly from that illness” (Styron, 1988, p. A17). The sheer pain of depression that often precedes suicide must be grasped. As such, Styron (1988) shared his own experience of depression in this article writing:

What had begun that summer as an off-and-on malaise and a vague, spooky restlessness had gained gradual momentum until my nights were without sleep and my days are pervaded by a gray drizzle of unrelenting horror. This horror is virtually indescribable
since it bears no relation to normal experience…The sick brain plays evil tricks on its inhabiting spirit. Slowly overwhelmed by the struggle, the intellect blurs into stupidity. All capacity for pleasure disappears, and despair maintains a merciless daily drumming. The smallest commonplace of domestic life, so amiable to the healthy mind, lacerates like a blade…Even the soothing balm of sleep usually disappears. And so, because there is no respite at all, it is entirely natural that the victim begins to think ceaselessly of oblivion. (p. A17)

Styron’s essay sought to dramatize the sheer inescapable pain of depression as being so profound that suicide is seen as a viable solution to suffering. Styron ultimately concluded his essay by observing that “time is the real healer” of suffering. This response sets the stylistic tone and template for the kinds of appeals and demonstrations Styron will expand upon in his memoir. *Darkness Visible* narratives are grounded in the personal sphere of Styron’s own experiences and employ disordered accounts to help shift the grounds of debate, discourse, and open deliberation on public sentiment on mental illness.

Styron’s opinion piece on Levi’s death resonated with readers, as the *New York Times* reportedly received “numerous” letters (Styron, 1990, p. 34; West, 1988, p. 451). Three of them were published in the paper. Interestingly, all three letters were from psychiatrists who each applauded Styron’s description of depression, though two of these writers, Dr. Joseph Siegler and Dr. Max Fink, expressed some reservation about Styron’s suggestion that, “time is the real healer and with or without treatment the sufferer usually gets well” (Styron, 1988, p. A17). Dr. Fink (1988) pointed out that electroconvulsive therapies are well-known treatments for halting suicidal thoughts, and Dr. Siegler (1988) pointed out that antidepressants and hospitalization are useful treatments. But all three of the letter writers, including the third, Dr. Herskowitz (1988)
acknowledged the rhetorical function of Styron’s essay, that is, its ability to express the symptoms and experiences of depression for sufferers, non-sufferers, and those who may be suffering but do not know they are suffering depression. And most relevant for each writer is how Styron’s voice could be used to combat the stigma of depression that often leads to “hesitation of a person with mental illness to seek early psychiatric intervention” (Siegler, 1988, p. A20). It is thus no surprise following the interest generated in psychiatric circles by Styron’s very public essay about his own depression that he would be invited to give a talk at Johns Hopkins University School of Psychiatry. As one writer commented, it appears as if Styron took on the charge of demonstrating the pain of depression as something of an “avocation” (Iannone, 1990, p. 54).

Styron would explain in an interview for the *New York Times*, “I was chagrined to discover how many people had a total misapprehension of what this illness is… My need to communicate overrode the risks of self-exposure…” (Glendinning, 1990, p.BR1). Not only did the essay portray the pain of depression powerfully, but it also offers an explanation of its causes. Styron wrote, “In depression, a kind of biomedical breakdown, it is the brain as well as the mind that becomes ill – as ill as any other besieged organ” (1988, p. A17). He continued by referring to the cause of depression as “…a basic chemical disturbance in the brain” and ultimately concludes his essay with, “He [Levi] succumbed to a disease that proved to be malignant and not a shred of moral blame should be attached to the manner of his passing (Styron, 1988, p. A17).

Given the depression he suffered and his knowledge of biomedical discourses, Styron considered sharing his story. *Darkness Visible* enters into dialogue with a revolutionary moment in psychiatric and public history.
As the private experience of mental illness and its technical treatment became matters of public interest and discussion, *Darkness Visible* was instrumental in popularizing this new amoral biomedical view. In many ways, just as *The Bell Jar* served a role in support of anti-psychiatry movements through its narratives about psychiatric treatments, *Darkness Visible* likewise served a role in emerging public advocacy of biomedical views of mental illness. As Styron himself acknowledged, “Out of a great deal of luck and timing, I was able to be the voice for a lot of people” (Glendinning, 1990, p.BR1). For instance, the National Alliance for the Mentally Ill was founded in 1979, composed mostly of families of those with mental illness and ex-patients. Or consider the National Depressive and Manic-Depressive Association, founded in 1986, whose credo, prior to changing their name in the early 21\textsuperscript{th} century to Depression and Bipolar Support Alliance, was to “educate the public about the biomedical nature of depressive illness.” Both groups work to raise public awareness that mental illness is caused by a real, medical condition. To this emergent dialogue, we can add Styron’s (1990) *Darkness Visible* where he writes,

> The madness results from an aberrant biochemical process. It has been established with reasonable certainty…that such madness is chemically induced amid the neurotransmitters of the brain…which for unknown reasons causes a depletion of the chemicals norepinephrine and serotonin, and the increase of a hormone, cortisol. (p. 47)

The causes of “madness” for Styron are now known and in such great detail with “reasonable certainty” as biological conditions. And Styron (1990) goes further to put “flesh” on these abstract medical concepts by writing,

> The madness of depression is, generally speaking, the antithesis of violence…It is a storm indeed, but a storm of muck. Soon evident are the slowed-down responses, near
paralysis, psychic energy throttled back close to zero. Ultimately, the body is affected and feels sapped, drained. (p. 47)

In this passage, Styron crafts a tone of causality, the body feeling “drained” and “sapped” as a result of “biochemical processes.” Drawing upon biomedical discourses in *Darkness Visible* in conjunction with appeals to his personal sphere of lived-experience, Styron is able to frame mental illness amorally while cultivating understanding of depression’s suffering. In this sense, the book becomes a timely surrogate “voice” for sufferers and the burgeoning biomedical view.

Years after its publication, *Darkness Visible* continues to shape discourses on not only the experience of depression but also its causes and treatment. Perhaps most indicative of its canonical status is its common use in clinical and psychiatric training. In 2005, Georgetown University’s unit for family medicine offered its clinical residents opportunities for “interacting with the medical humanities.” In the introduction to their online instructional unit they write,

> Clinical medicine is about patients. Here you will meet all sorts of patients—patients telling their stories; patients expressing themselves through theater, dance and poetry; imaginary patients, dying patients, patients in pieces and patients seeking to become whole…Using the arts, you will learn about many aspects of patients' experiences… (see Appendix B)

Styron’s *Darkness Visible* occupies a spot on the unit on depression. Styron’s memoir is also listed on the “must reads” list of the American Psychological Association’s 2007 *A Resident’s Guide to Surviving Psychiatric Training* (see Appendix C). In 2007 excerpts from Styron’s book were published as one of “50 Psychology Classics” (Butler-Bowden, 2007). The only novelist to be included in this edited volume; Styron finds a place among seminal essays by “giants” of psychology such as Freud, Jung, Piaget, Kinsey, and Erikson. Even Kay Redfield Jamison
(2001) reports “frequently” using *Darkness Visible* in “teaching medical students and psychiatric residents…” (p. 2). The book has become something of a primer for helping clinicians understand the subjective suffering of depression (Downes, 2006).

It is not only medical students and professors but also people suffering bouts of sadness who turn to *Darkness Visible* as a rhetorical resource for making sense of the ambiguous nature of the experience of depression. Today one in 10 Americans report having a major depressive episode at some point in their lives, though over 80% of these people are not receiving treatment (Healthline.com infographic, 2013). One reason for this disparity is that often people may have symptoms of depression but fail to recognize them as a clinical condition. There is something very astute to sociologist David Karp’s (1996) observation that,

Part of what makes depression difficult to comprehend is its intrinsic ambiguity. Unlike most illness that we either do have or do not have, everyone feels depressed periodically. Most people who feel “blue” from time to time would not describe themselves as clinically depressed. Others can’t get out of bed in the morning and deny they are depressed. In contrast, the sports fan whose favorite team has just lost an important game might truly mean it when he or she declares that the loss has precipitated a major depression. (p. 28)

The ambiguous nature of the meaning of depression and in particular “what it is” makes popular accounts of depression like *Darkness Visible* into something of a rhetorical resource for those wanting to know if their sadness is normal or “depression.” Consider the “student self-help library” of Southern Methodist University’s Counseling and Psychiatric Services website. Under the heading: “Am I Depressed or Is It Something Else?” is a reading list including Styron’s book (see Appendix D). The book also appears on Ohio State University’s Counseling and
Consultation Services Website (see Appendix E) as a therapeutic and diagnostic resource. Thus it is no surprise that in 2002 Styron was invited back to Johns Hopkins to speak once more on his experience of being the “voice of depression.”

The hope behind these web resources is that people suffering sadness will use the book as a form of “self doctoring” (cf. Emmons, 2010) or as assisting in bringing “…increased attention to one’s own [mental] health” (p. 2). Indeed, Darkness Visible is often taken up by persons wanting to articulate the nature of inner feelings that they feel unable or uncertain about, such as Norman Bendroth (2007), a minister writing in Christian Century about his experience with depression. He writes, “I began reading William Styron’s Darkness Visible…I sat in my bed that night and read it cover to cover, then turned to my wife and said, ‘He’s telling my story’” (p. 9). Famed CBS anchor Mike Wallace in 2006 reported about his own bout with depression and how Styron assisted him in his recovery (Perry, 2006). The book’s rich narrative passages have also become something of a rhetorical commonplace in the form of epigraphs and quotes that are made reference to in clinical writing on depression (cf. Blazer, 2003) and when introducing the depression of famous people (cf. Rich, 1997). Following Styron’s death in 2006, Lawrence Downes (2006) wrote the book had become a “blessing for everyone who has battled this disorder without hope of capturing it in words…” and become an “invaluable document for people trying to understand an illness that has consumed them or someone they love” (p. A20). Styron’s work continues to shape both deliberation in private experiences of sadness as well as public discourse on the cause and meaning of depression.
An Unquiet Mind: Then & Now

Before publishing An Unquiet Mind: A Memoir of Moods and Madness in 1995, Dr.Kay
Redfield Jamison was already a well-published and recognized researcher with over 70
publications in professional journals and popular presses. Though trained in clinical psychology
at UCLA and licensed as a clinical psychologist complete with private practice, Dr. Jamison’s
official title is Professor of Psychiatry at Johns Hopkins University School of Medicine. She
collaborated with colleagues to publish the textbook Abnormal Psychology in 1980. With
Fredrick K. Goodwin she published, Manic-Depressive Illness: Bipolar Disorders and Recurrent
Depression (1990), the seminal textbook in the field on the subject. And her first solo book,
Touched by Fire: Manic-Depressive Illness and the Artistic Temperament, was published in
1993. She had won numerous awards, including “Most Outstanding Book” from The
Association of American Publishers (for her textbook co-authored with Goodwin). She was also
listed as one of the “Best Doctors in the United States” in 1986, and has been a recipient of the
“William Styron Award” from the National Mental Health Association. In sum, prior to the
publication of her memoir, Jamison was an established and well-known psychological authority
on depression, manic-depression, and other disorders of mood.

Jamison has been a lifelong sufferer of bi-polar disorder, what at the time of the
publication of her memoir was called manic-depressive disorder. Manic-depressive disorder is
characterized by oscillating moods of shifting highs (mania) and lows (depression). Manias
involve “heightened mood, more and faster speech, quick-thought, brisker physical and mental
activity levels, and more energy” (Goodwin & Jamison, 1990, p. 22). Incidentally, today
Jamison continues to prefer the “manic-depressive” classification as opposed to the “bi-polar”
classification of current clinical nomenclatures, commenting she feels “affronted” by such
classifications (Linklater, 2011). Jamison treats her disorder with psychopharmaceuticals and continues to be a productive researcher, scholar, and teacher. Her memoir spans the time period from her first manic episode at 16 years old through her collegiate and professional career. As such, the memoir is perhaps the most “autobiographical” of the three memoirs I am examining. The memoir offers rich descriptive accounts of not only the personal anxieties and lulls of the disorder but also professional anxieties about “coming out” as a manic-depressive psychologist.

Like Plath and Styron, it is difficult to understand the lasting influence of *An Unquiet Mind* without understanding something of the biographical context surrounding Jamison’s disorder and the rhetorical context at the time of publication of her memoir. Early on in her youth, Jamison (1995) felt her illness to be simply “an extension of herself” (p. 5). Given the hormonal shifting emotional tones of adolescence, it is perhaps understandable how she understood these manias not as disorder but as an exuberant sense of life. Jamison recalls those moments as ones of great productivity, ebullient thought, and “zipping around like crusader rabbit” (Fried, 1995). But, inevitably, Jamison’s moods would swing back to lower energy, to depressed states of being unable to function and wanting to die.

As this pattern of highs and lows continued through college, Jamison recognized something was wrong but resisted seeking help. Jamison recalls that when she was younger her father, an Air Force officer, suffered from similar symptoms of manic-depressive disorder and never sought help. Citing this military ethic as well as strong protestant upbringing she comments, “I knew I was really disturbed. But I was from a very WASP military family. You figure it out for yourself…you just go on” (Fried, 1995). Jamison did not seek help until age 27, once her manias began to develop into hallucinations and delusions.
She was placed on Lithium, a metallic salt compound used to treat bi-polar disorder. The drug helped. But in an odd response, Jamison would consciously fail to take the medication regularly because of its side effects, particularly a form of neurotoxicity that would make it difficult to focus and process words during reading. As a scholar whose early scholastic and academic works were fueled in part by the “fires” of mania, the trade off to “being normal” was difficult to accept for Jamison. She eventually attempted suicide during one of her lower depressive states, but was unsuccessful. After an adjustment to her dosage that aided in reducing side effects, Jamison was able to stabilize her moods. She continues to take Lithium to this day, though not without a sense of nostalgia for the emotional rollercoaster ride of her those earlier years.

*An Unquiet Mind* is a memoir of the experience of her “manic-depressive years,” as well as the professional and personal struggles, considerations, and experiences surrounding her decision to share her story. The book was well received and often characterized as “honest,” “risky,” and “truthful” (Self, 1996, p. 68). Others note the book’s humor and hopeful tone (cf. Keogh, 1997, p. A10). The book stayed on the *New York Times* bestseller list for five months. The book was named best in non-fiction by *The Boston Globe*, best book of 1995 by *Entertainment Weekly*, and chosen as “one of the most influential books of the past 40 years” by *Washingtonian Magazine*. In sum, the book, like Plath and Styron’s books, was influential at its time of publication.

Interestingly, unlike Plath and Styron whose narratives respond to public and technical discourses from within their own personal sphere, Jamison’s “personal sphere” is intertwined with professional knowledge and ethos. As a practicing clinical psychologist, Jamison’s decision to disclose her manic-depressive disorder posed obvious threats to her credibility. She had to
consider the potential stigmatizing views of her colleagues. Jamison reflects on her hesitations, “It’s an awful prospect, giving up one’s cloak of academic objectivity” (O’Brien, 1995). As one reviewer observed, she feared her earlier work and future work would be “biased” because of her personal experience with the disorder (O’Brien, 1995). After “coming out” as manic-depressive, Jamison (1995) recalled one colleague’s words, “Kay is a good scientist and a good clinician – she should’ve stayed that way” (p. 68). Jamison herself often worried if upon reading some bipolar patient excerpts in class or in a talk that the “level of intensity when reading something very personal would show through” (Fried, 1995). The exigencies of her disordered moods are channeled into a critical perspective, shedding light on stigmatizing practices by members of her profession that should know better.

*An Unquiet Mind* can thus be seen as responding to a rhetorical situation as both a story about the felt struggles of living with mental illness and more deeply as responsive to public and technical moral exigencies about the biological basis of mental illness and its pharmacological treatment. The book’s opening passages announce the key rhetorical exigencies and tensions present in her memoir. Jamison (1995) writes,

> The major clinical problem in treating manic-depressive illness is not that there are not effective medications – there are – but that patients so often refuse to take them. Worse yet, because of a lack of information, poor medical advice, stigma, or fear of personal or professional reprisals, they do not seek treatment. (p. 6)

One would think that after the biomedical revolution that framed mental illness as an amoral disease that the practice of holding those who suffer responsible for their suffering would have lessened, particularly in technical spheres of psychiatry. But, these opening statements foreshadow the personal, public, and technical discourses with which Jamison’s narrative enters
into dialogue. First, the memoir engages a rich rhetorical situation when professional and personal reprisals result when “coming out” as a mentally ill psychiatrist. Second, there is the subject of public stigma and personal hesitations of being “on medication.” In the late ’90s, the use of psychopharmaceuticals, particularly Prozac, became a something of a folk parable for cheating at life. This development led to public questions about biological reduction of selfhood to chemical processes. Jamison offers a memoir that keeps company with these rich discourses.

*An Unquiet Mind* can be seen as responding to a complex history with multiple discourse currents. But two stand out most clearly: discourses about advances in the brain research and ethical questions about the use of “cosmetic psychopharmacology.” Exploring the history of these moments and help provide a nuanced reading that helps to suggest some of the moral purposes at work in Jamison’s memoir. First, I explore briefly the public’s exposure to advances in brain research, particularly brain imagining technologies. Second, I explore the then rising public awareness of biological determinism, antidepressant use, and authentic living that emerge in Jamison’s time.

The 1990s were proclaimed to be “The Decade of the Brain” by President Bush (1990). New research initiatives into brain research were to follow. As early as 1983, however, the public sphere was aware of the advances in brain research, particularly as it related to mental illness. For instance, in 1983 the popular magazine *Vogue* ran an article titled “Seeing Eye Machines” with a picture of three brain scans (Hixson, 1983). Each brain scan depicted differing ratios of blues, yellows, and reds. Under each brain image were the labels, “schizo,” “depressed,” and “normal.” What brain scans offer rhetorically are persuasive images. The public saw static images of brains in process, which revealed what appear to be different brain
states of mental illness. Jamison (1995) remarks on the importance of such images to the biomedical view,

There is a beauty and an intuitive appeal to the brain-scanning methods, especially the high resolution MRI pictures and the gorgeous multicolored scans from the PET studies. With PET, for example, a depressed brain will show up in cold, brain-inactive deep blues, dark purples, and hunter greens. . . I was, in spite of myself, caught up by the science, wondering whether these hyperintensities were the cause or the effect of illness. The clinical side of my mind began to mull about the visual advantages of these and other imaging findings in convincing some of my more literary and skeptical patients that (a) there is a brain, (b) their moods are related to their brains, and (c) there may be specific brain-damaging effects of going off their medications. (p. 196)

The idea that mental disorders are traceable to brain function may present evidence against stigmatizing views of depression as a form of moral weakness. But, as one psychologist in a 1993 Newsday article Stigmabusters would observe, such scans have a reductionist effect on our understanding of the full humanity of sufferers. He noted how parents who emphasize the biological origins of mental disorders are likely to label their children as “defective” (Puzzanghera, 1993, p. 59). In fact, social psychologists at the time were observed that viewing the mentally ill as diseased persons encourages perceiving them as biologically distinct, “biochemical aberrations” (Mehta & Farina, 1997). Popular magazines also aided perceptions of this “broken biology” type view undergirding moral judgments of “aberration” or “defective” humanity. Laura Hirshbein (2009) offers a book length treatment of how depression was often portrayed as caused by “chemical imbalances” and disordered “neurotransmitters” (Hirshbein, 2009, p. 62) throughout the later part of the 20th century. As a case in point, consider articles
found in *Time* magazine that routinely informed the public about “faulty circuitry” in the brain or “faulty brain chemistry” (“Faulty Circuits,” 1992; Elmer-DeWitt & Purvis, 1992). In short, by making the physical causes of depression visually concrete for the public, brain images helped shape public comprehension of mental illness toward a reductive view of brain, of self, and ultimately humanity. Stigma had become something much more essential. These were broken humans.

*An Unquiet Mind* responds to such views by amplifying the “humanity” of living with a mood disorder. Not to get ahead of myself, but by utilizing the autobiographical form Jamison’s book narratively engages this emerging reductive biomedical view. And we can see these narrative tensions existing between technical views and her personal sphere in the reasons for writing her memoir. In the introduction Jamison (1995) writes,

> It has been difficult at times to weave together the scientific discipline of my intellectual field with the more compelling realities of my own emotional experiences. And yet it has been from this binding of raw emotion to the more distance eye of clinical science that I feel I have obtained the freedom to live the kind of life I want, and the human experience is necessary to try and make a difference in public awareness and clinical practice…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, there are bound to be better than continuing to be silent. I’m 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 a title, or any manner and collection of words, is still exactly that: dishonest. (p. 7)
Her narrative appeals to the personal, existential character of her disorder, of felt senses of “being true” to herself. This is an autobiographical narrative about life-long living with a disorder, not simply suffering one. She is a clinician reconciling her personal and professional experience through the very “personal” autobiographical act. This is a very personal exigency and is demonstrated as such even in how she describes manic-depression itself. She writes,

The Chinese believe that before you can conquer a beast you first must make it beautiful. In some strange way, I have tried to do that with manic-depressive illness. It has been a fascinating, albeit deadly, enemy and companion; I have found it to be seductively complicated, a distillation both of what is finest in our natures, and of what is most dangerous. In order to contend with it, I first had to know it in all of its mode and infinite guises, understand its real and imagined powers. (Jamison, 1995, p. 5)

Referring to manic-depression as “the beast,” Jamison animates folk wisdom by moving from personal pronouns to the plural “our natures,” all while emphasizing the juxtaposing emotional polarities of “enemy and companion,” “real and imagined,” “finest and dangerous.” The result is an invitation to sense the felt polar tensions characterizing the shifting moods of her disordered reality. *An Unquiet Mind* grounds the clinical perspective in a return to the roots of personal experience through the use of autobiographical form. Jamison wants to create opportunities for readers to identify with a lifetime of highs and lows so shed light upon reductionist stigmas.

You gain a sense of one reason Jamison turns filters her clinical gaze through the personal form of autobiography by examining an important moment in Jamison’s early career, that is, her position within debates about the “romanticizing” of mental illness. Prior to “coming out” as manic-depressive, she published *Touch With Fire: Manic Depressive Illness and the Artistic Temperament*. The book examined the lives of famous creative artists and innovators
and argued their creative genius derived from manic-depressive tendencies. The book came under scrutiny because of her methodological practice of posthumous diagnosis, and her argument linking creativity with manic-depressive psychosis was seen as “romanticizing” mental illness. E. Fuller Torrey, a prominent schizophrenia researcher observed of Jamison’s book, “The danger is the romanticizing of serious mental illness…our tendency is to romanticize Sylvia Plath or someone like that without asking whether, if they hadn’t had the disease they wouldn’t have produced better things over time” (Fried, 1995). Other scholars argued that her work was reductionist and biased toward genetic biological psychology (cf. Rosenwig, 1993). Bob Boorstin, President Clinton’s speechwriter in the ’90s and sufferer of bi-polar disorder, commented in the Washington Post that the work showed that those who are mentally ill are capable of productively contributing to society but that the book also distorts the illness. He continues:

There must have been hundreds of thousands of middle-class folks lived alongside Byron and van Gogh who had these illnesses, and we don’t know about them because they didn’t leave letters or diaries. There are millions of people in this country who are not celebrities who have these illnesses…In a way, Kay has glamorized this illness. And for people who deal with it on a day-to-day basis, who don’t have the money, who don’t have access to the best treatment, this is not a glamorous thing. This is something that ruins lives. (Fried, 1995)

Jamison responds to these criticisms by acknowledging the dangers of romanticizing the illness but also questions if these artists would even be “artists” if they lacked these abnormal ranges of emotional experience through which to observe human nature. Jamison’s credibility in this area is hallmarked as she crafts many a “blurb” for books about detailing the perspicacious potentials
of disordered moods. A 2005 book written by Joshua Wolf Shenk, *Lincoln’s Melancholy: How Depression Challenged a President and Fueled his Greatness*, has the following dust jacket blurb written by Jamison:

A profoundly human and psychologically important examination of the melancholy that so pervaded Lincoln's life. His suffering and his transformation of that suffering into an astonishing grace and strength are persuasively and beautifully described in this remarkable book.

For Jamison, disordered experiences illuminate essential aspects of lived-experience and imbue a sense of percipience to the ethos of sufferers. As such, there is something quite personal in Jamison’s position on the creativity and perspicacity of manic-depressive disorder.

In a 2013 interview for the *Baltimore Magazine*, Jamison’s current husband observed of his wife “…not only is she someone who wrote a memoir, but she’s also passionate about language and writing. These books come from a prodigious love of words and literature and serious, worked-over writing” (Marion, 2013). Perhaps Jamison sees herself filled with those same fires of creativity and yet knowing about the biological aspects of the disease, thus grounding her belief in the linkage between mental illness and creativity. Her belief that manic-depression can have some life-affirming aspects influences both her research and decision to share her story. *An Unquiet Mind* can be seen as responsive to a rhetorical milieu calling forth a challenge to dehumanizing technical and public discourses.

Having explored the development of brain research advances and the public discourse it inspired as it relates to *An Unquiet Mind*, I now explore another related discourse, namely the emerging questions about the facile use of psychopharmaceuticals. As the rising awareness of brain scans captured public imagination of the physical causes of mental illness, the notion that
there must be a physical solution was not a difficult sell. As such, popular media began informing the public about antidepressants, particularly Prozac. One popular example of this was psychiatrist Peter D. Kramer’s published *New York Times* best seller, *Listening to Prozac*. His book detailed his patients’ experiences with Prozac. He wrote,

> I was use to seeing patients’ personalities change slowly, through painfully acquired insight and hard practice in the world. But recently I had seen personalities altered almost instantly, by medication…with Prozac I had seen patient after patient become…

> “better than well.” Prozac seemed to give social confidence to the habitually timid, to make the sensitive brash, to lend the introvert the social skills of a salesman. (Kramer, 1993 p. xv)

Kramer’s book provoked public deliberation on Prozac use and introduced the public sphere to the notion of “cosmetic psychopharmacology.” Kramer noted how his Prozac patients “‘became better than well,’ patients who acquired extra energy and became socially attractive” (p. xvi).

Retelling a story of one patient who became more assertive and outgoing after taking Prozac, Kramer recounted how after five years he took the patient off the drug and she reported feeling “not like herself.” The book opened public discussion about the nature of the self and the authenticity of its personality, emotions, and inner life.

> By the mid-90s Prozac had entered the mainstream consciousness of the public sphere. For instance, an article in *Newsweek* tells the story of a 40-something-year-old woman who took Prozac to “gain an edge.” These authors referred to her experience as a controversial “parable” for a medicalized approach to the treatment of mental illness (Cowely & Holmes, 1994, p. 41).

In 1990, the drug appeared on the cover of *New York Magazine* as “person” of the year. Indeed, the name “Prozac” had become as familiar as Kleenex and as socially acceptable as bottled
spring water (Cowley & Holmes, 1994). A New York Times article referred to its widespread use as the beginning of a “legal drug culture,” given the drug was prescribed 6 million times by 1993 and developed a cult following (Rimer, 1993, p. A5).

Yet, Kramer and the drug were not without their critics. Many of the critical responses to his book appearing in popular presses included claims about how the drug took attention away from those “slower” more hard-won paths to recovery. For instance, a popular Time magazine article informed the public of a six-year research study that demonstrated that psychotherapy was just as effective as antidepressants (Leo, 1986, p. 60). Or as one writer in Newsweek observed, “Prozac…raises more radical questions. If a drug can change our personality, is what we call the self simply a matter of brain chemistry?” (Gates, 1993, p.71). Still others questioned Prozac’s widespread use and argued that it was attributed to the fact that many doctors (not psychiatrists) were prescribing it for more than just depression, like for the treatment of phobias, obsessions, and compulsions (Toufexis & Brown, 1993). These questions became more relevant in the wake of a number of violent acts committed by persons being treated with Prozac (Cowley & Springen, 1991). One highly publicized event occurred when a former printing services employee being treated with Prozac opened fire in his work place with an AK-47.

Kay Redfield Jamison (1993) herself intervened in the public discourses about Prozac. She argued for therapeutic alternatives and raised questions about the personal ethical issues surrounding the use of the drug. In her Washington Post review of Kramer’s book, she writes:

I find myself in disagreement with Kramer…Two of my own patients, for example, were placed on Prozac for depression. Both are highly successful, energetic men whose depression largely abated once on medication. Their sex drives, however, were greatly reduced. This is not an uncommon effect of Prozac, but one might expect that it would
be terribly distressing to these particular men, both of whom had histories of very pleasurable and meaningful sexual relationships with women. Somewhat to my amazement they both reported this side-effect with relatively little dismay, stating that it bothered them but that they could “live with it.” A certain quality of indifference had drifted into their otherwise impatient and demanding temperaments. They had become comfortable with a situation they would have found intolerable prior to taking Prozac and, once switched and effectively treated by a different antidepressant, they expressed utter disbelief that they had been willing to “write off” such a vital part of their lives.

What is to be made of such a balming and lulling drug? (Jamison, 1993, p.2)

Jamison’s sentiments expressing uncertainty surrounding the use of Prozac in some cases found support in yet another bestselling author’s published perspective on the use of the drug. A year before Jamison’s memoir Elizabeth Wurtzel published her bestselling autobiographical book, *Prozac Nation*, a story about Wurtzel’s experience with major depression. In one *Time* magazine interview, Wurtzel comments on the role Prozac use has in generating public uncertainty regarding blurred diagnostic criteria between life stresses and clinical depression. She comments,

Now I go to parties and everyone says, “I'm on Prozac too.” You can just walk into a doctor's office and say, “I think I'm depressed,” and he writes you a Prozac prescription. This should not be a drug for people who sort of feel bad. If they feel bad, they should figure out what's wrong with them. (Toufexis & Brown, 1993, p. 61)

In the epilogue to her book, Wurtzel (1993) goes on to say,

Still, I can’t ignore the compelling evidence presented…that maybe all this drug prescribing is not an overaggressive response, but actually a sane reaction on the part of
doctors to a whole slew of people from whom simple existence is fraught with intense misery. (p. 300)

Segments of the public, including those most familiar with Prozac, began to question if the psychotherapeutic value of “hard won” insight was being lost in a quick consumerist approach to alleviating the challenges of modern life. Within the public sphere, there was both praise and blame for the use of Prozac. The increased presence of Prozac offered the public sphere a space of deliberation regarding blurry distinctions between severe mental disorders like depression and the normal stresses, sadness, and struggles of life. In short, the widespread use of Prozac itself worked to create rhetorical conditions that gave rise to questions about who needs to have Prozac to function and who is just abusing it.

For some portions of the public, the uncertainty surrounding antidepressant use led to further stigma surrounding the use of medicines for psychological stresses. The implicit suggestion is that those who took “meds” were somehow “cheating” at life and cheating the growth of self. They were at best missing out on life-affirming struggles or at worst only capable of living genetically and biologically engineered lives. Like the mental asterisks publically held in the minds of professional baseball fans regarding the accomplishments of Jose Conseco, who was found to be taking performance-enhancing drugs in 1988, the lives of those taking psychological medications would be publically perceived as lives “with an asterisk.” That people were willing to take Prozac for the purpose of dealing with life stresses and bouts of normal sadness became a stigmatizing mark of one’s inability to cope with life. Public perception of mental illness, despite of (and in some cases because of) the biomedical revolution still trafficked in moral judgments about those from suffering mental illness, but now such stigmas were rooted in biological determinism.
Engaging public sentiments that fail to make meaningful distinctions between necessary medication and cosmetic psychopharmacology, Jamison’s memoir offers detailed accounts about her own concerns about living authenticity while on medication. For instance, when confronted for the first time about being placed on Lithium, Jamison (1995) writes:

I believe without a doubt that manic-depression is a medical illness; I also believe that, with rare exception, it is malpractice to treat it without medication. All of these beliefs aside, however, I still somehow thought that I ought to be able to carry on without drugs, that I ought to be able to continue to do things my way. (p. 102)

Responding to those discourses that would question the authenticity of a life on psychopharmaceuticals, Jamison’s narrative depicts the hesitation one might feel given these public stigmas. But more than this, Jamison’s narrative also gives account of what it feels like to really seriously contemplate what it means to be on psychiatric medications, personally. She writes,

I was actually secretly terrified that Lithium might not work; what if I took it, and I still got sick? If on the other hand, I didn’t take it, I wouldn’t have to see my worst fears realized. My psychiatrist very early on saw this terror in my soul, and there is one brief observation in his medical notes that captured this paralyzing fear completely: *Patient sees medication as a promise of a cure, and a means of suicide if it doesn’t work. She fears that by taking it she will risk her last resort.* (Jamison, 1995, p.103)

Unlike public perception of the facile use of psychiatric medicines as life-enhancers, Jamison’s personal appeal depicts a more measured and conscientious attitude to drugs.

And even more importantly, Jamison’s narrative presents richly descriptive depictions of why her cautiousness is warranted as an account that speaks directly to emerging personal
concerns about emotional authenticity and its relation to drugs that alter personality. Jamison
does eventually take Lithium. And as a result she feels a sense of longing for highs of her manic
episodes. She writes,

I compare myself with my former self…When I am my present “normal” self, I am far
removed from when I have been my liveliest, most productive, most intense, most
outgoing and effervescent. In short, for myself, I am a hard act to follow. (Jamison,
1995, p. 92)

Given a public sphere willing to stigmatize the use of psychiatric medicine as a sign of weak
character, this passage shifts the grounds of those positions that argue that taking drugs means
one’s life as a mentally ill person is in some way inauthentic. She writes, “When I complain of
being less lively,” people say, “‘Well, now you’re just like the rest of us’” (Jamison, 1995, p.
92). The message here resonates with Wurtzel’s commentary on the fad of cosmetic
psychopharmacology. Jamison’s narrative shifts the grounds of debate from the authenticity of
the mentally ill who use drugs to survive to those who, for cosmetic reasons, use drugs to simply
get through life’s “normal” stresses. In the late 20th century, the ubiquity of
psychopharmacological use and its “fashionable” status, stirred up existential questions about
what it means to be human fully, authentically.

An Unquiet Mind emerges in the context of a rich rhetorical milieu of 1990s discourses
against the reductionist tendencies in biomedical views that stigmatize scholarly and artistic
contributions of the mentally ill and cultural uncertainties about the use of psychopharmacology
as it relates to living a fully human life. The autobiographical form of her response shines an
existential light on these public questions. As its narratives of disordered moods dwell in a
semantic tension between cultural available means of expression and experiential knowledge
gained through illness itself, *An Unquiet Mind* works to shift the grounds of public discourses towards neither an argument for medicalization as a good nor “hard won” insight as a good. As a clinical psychologist, a lifelong sufferer of manic-depression, and a user of Lithium, Jamison’s narrative carves out a middle perspective. The result is that her text illuminates the disordered self and the moral weight of its cultural embeddedness, that is, those conditions of significance the awareness of which can encourage deeper modes of authenticity to take root. *An Unquiet Mind*’s rhetorical dimensions, that is, its use of narrative about disordered selfhood as lenses for critique, in part undergird the book’s enduring popularity.

Years after its publication, the text and Jamison continue to shape public debate and discussion on the meaning of mental illness. Jamison continues to publish books. Her latest works include a book on suicide (*Night Falls Fast*, 1999), a book about exalted states of happiness in famous people (*Exuberance*, 2004), and something of a sequel to *An Unquiet Mind* (*Nothing Was The Same: A Memoir*, 2009). *Nothing Was The Same* is a memoir about Jamison’s adjustment to the death of her husband, which offers an elucidation on the distinction between depression and grief. In 2011 when *An Unquiet Mind* was reprinted, one observer wrote, “The writing is clear and beautiful, the descriptions accurate, the interior world she evokes is furiously alive. In the 16 years since *An Unquiet Mind* was first published, no greater book about manic depression – or bipolar disorder – has appeared” (Linklater, 2011, p. 35). Writer Melody Moezzi in the “You Must Read This” section of the NPR website in 2011 wrote, “At once, *An Unquiet Mind* gives its readers a ride and an illustration like no other – one that seamlessly merges the ostensibly contradictory worlds of doctor and patient, lofty and low, crazy and sane” (“You Must,” 2011). The book continues to be a valued rhetorical resource for illuminating the personal
experience of bi-polar disorder. And, like Styron, excerpts from Jamison’s memoir are commonly found in psychology textbooks and clinical guides.

Jamison’s credibility has not waned since coming out as manic-depressive. In 1997, *Time* magazine named her “Hero of Medicine.” Thomas Styron, William Styron’s son and Professor of Psychiatry at the Yale School of Medicine, observes:

She is an absolute giant in the field of psychiatry as someone who has been able to combine top-notch academic work with this incredible personal story, which has been such a huge service to people who suffer from mental illness. (Quoted in Marion, 2013)

Jamison continues to give talks on bi-polar disorder and her personal experience with the disorder. She gave a talk, for instance, at Swathmore College in 2005 titled “Madness, Moods, and Creative Achievement,” which advocated for the “creativity manic-depression link” (cf. Stokes, 2005). Despite her fears of losing credibility, Jamison and the narratives of *An Unquiet Mind* are considered credible rhetorical resources that guide clinical and personal deliberations. Her memoir continues to be valued for offering something of a balanced clinical and personal perspective, a holistic view of the disorder from the outside and inside. In short, like Plath and Styron, her work has become widely used for public, private, and technical deliberation on the sheer experience of mental illness.
Conclusion: Review and Synthesis of the Rhetorical Responses of Plath, Styron, and Jamison

The narratives of Plath, Styron, and Jamison respond to the demands of their time. Because I am attempting to read these as rhetorical text, it seemed reasonable to attempt to identify some historical contexts that may have influenced each author’s reason for sharing their stories. Lloyd Bitzer’s (1968) classic idea of the rhetorical situation observes that “rhetorical discourse comes into existence as a response to a situation” that involves an “exigence,” or “an imperfection marked by urgency” (pp. 5-6). Later Bitzer (1980) would add that such exigencies are not objective but require the conjoining of factual conditions with human interest. What I have tried to show in this chapter is that when we consider each author’s work respective to their rhetorical contexts, it becomes possible to consider the moral purposes at work in these narratives. Each author brings critical, illuminating, and urgent appeals that discursively engage demands emanating beyond themselves, taking the exigencies of a disordered mood that calls for a story and channeling that story to discursively engaged specific rhetorical situations. In many ways, I want to suggest that these narratives might usefully be considered as deriving from felt calls to share personal stories, much as Charles Taylor would suggest many people feel called to live meaningful lives. In general, my hope was to encourage consideration about how autobiographical acts mobilize what is different about a life in order to offer new meanings about mental illness and selfhood.

I could not do justice to the many histories possible, but chose to focus on those most relevant to each author’s work. For Plath, The Bell Jar works to open a critical space for public deliberation about the norms of domesticity and the patriarchic values of psychiatry in the 1950s and ’60s. For Styron, Darkness Visible attempts to open a critical space for public deliberation
on moralistic views of depression as a moral failing of the 1980s. And for Jamison, *An Unquiet Mind* attempts to open a space of public deliberation on emerging biological stigmatization in the mid-1990s.

Returning to Charles Taylor’s notion of authenticity, we can see that each author’s narrative responds to particular rhetorical situations of their unique historical time. Each author in their own way embodies Taylor’s ideal of authenticity, for each brings their own unique personal experience into the public sphere as a way of advocating for a “good,” as they respond to the demands of their times. Read in the context of Taylor’s view of the 20th century ideals of authenticity, encourages us to consider how Plath, Styron, and Jamison works might be a kind of personal calling, yet not a simply narcissistic one but a more communal one. They write in the hopes of addressing and inspiring communities to question higher ideals of what it means to live fully. Plath desires to create a world where women are free to pursue roles beyond societal norms. Styron desires to create a world where the depressed are met with empathy and support. And Jamison desires a world were those with mental illness are valued as they are, even if they are on medications and genetically disposed to illness. These memoirs, as such, work to open up discussion about what it means to live fully more generally.

The communicating of a disordered mood like depression dwells in a tension between culturally available means of expression and experiential knowledge gained through illness itself. Read in the context of the historical moments reviewed in this chapter, *The Bell Jar, Darkness Visible, and An Unquiet Mind* appear to be deriving from a moral purpose, something like a felt calling that discursively engages over 50 years of public discourse affecting mental illness, from public domesticity norms and anti-psychiatry, to public stigma of depression and biomedical determinism. These books offer rhetorical resources for readers that provide opportunities for
reflection on taken for granted everyday moods, an awareness of which may encourage and speak to deeper modes of authenticity, and thus suggests at least one reason for their enduring popularity and cultural relevance.

In the next chapter I dive deeper into the rhetorical function of the affective exigencies deriving from disordered moods that disrupt easy, forgetful flights into daily concerns. The ecstatic character of their selfhood, that is, its tendency to lose itself in practical demands of life, is held in a kind of narrative relief. The current chapter has set the stage for this next chapter by exploring the rhetorical situations that surround each author’s personal exigencies of this “narrative relief.” Each author depicts their experiences of living with a disordered mood in the context of social and professional daily demands. An able minded reader of disordered realities is invited to encounter this narrative relief of normative involvements of mood. Readers encounter narratives about living with depression that offers a perspective on the social, embodied, symbolic, and temporal conditions of selfhood, perhaps appealing tacitly or explicitly to the 20th century reader’s inner pulls for living authenticity.
CHAPTER 3

WHAT DISORDERED MOODS COMMUNICATE: RHETORICAL DIMENSIONS OF INTERRUPTION AND IDENTIFICATION

In this chapter, I explore in greater depth how depictions of the disordered experiences of Plath, Styron, and Jamison work as grounds for critique of public and technical discourses and practices, as well as how such depictions function to create identification with readers despite two rhetorical barriers inherent in memoirs about mental illness. In plain terms, this chapter explores how disordered moods communicate. First, I will demonstrate how Plath, Styron, and Jamison successfully overcome “rhetorical disability” and “the inexpressibility thesis.” Second, this chapter explores the ways each author’s narrative makes use of a form of identification that functions as a “critical interruption” (Avrahami, 2007; Farrell, 1993; Hyde & Rufo, 2000) that foregrounds the ableism of moods functioning in the background of audiences’ normative engrossment in public and technical practices. Lastly, in a deep reading of representative passages from each author, this chapter demonstrates the rhetorical conditions that make Plath, Styron, and Jamison’s critiques possible, critical work I’ll explore in greater detail in Chapter 4.

Overcoming Rhetorical Disability and the Inexpressibility Thesis

In Chapter 2, I put forward the long-lasting appeal of these works for audiences as it relates to how each text recreates and describes the experience of a disordered reality. Given the status of these works as best-selling texts, in this chapter I explore how these authors successfully generated identification with audiences (and how such identification grounds their rhetorical critiques) in the face of rhetorical challenges that often cast those with mental impairments as “unreliable narrators.” There are two rhetorical challenges, “rhetorical disability” (Johnson, 2010; Owens, 2009), and what I am calling “the inexpressibility thesis.”
Wayne Booth (1983) coins the term “unreliable narrator” to designate a literary device in fiction. He believes a narrator is “reliable,” “when he speaks for or acts in accordance with the norms of the work (which is to say the implied author’s norms), unreliable when he does not” (pp.158‒159). The “reality” of the author is the balance sheet against which to judge fictional depictions that push against what is commonly expected in everyday general human experience. An example is the use of “the Madman” literary device found in first-person literature studied by William Riggan (1981). The madman is a plot turning device that misleads readers by concealing the fact that the narrator of the story is mentally disordered until some crucial moment of the story. The novel *Fight Club* (Palahniuk, 1996) is one example. Readers encounter a fantastic story of underground rogue fighting clubs only to discover toward the end of the novel that the whole story is a figment of the narrator’s psychotic breakdown. The narrator was proven to be an unreliable one.

There is a real world counterpart to Booth’s unreliable narrator. Audiences can sometimes encounter the words of persons who have suffered or are suffering mental illness with suspicion. Rhetorical scholar Cynthia Lewiecki-Wilson (2003) locates this dubiousness in the “received tradition of emphasis on the individual rhetor who produces speech/writing, which in turn confirms the existence of a fixed, core self, imagined to be located in the mind” (p. 157). If an audience senses or believes this fixed or core self is disturbed, disordered, or cognitively compromised, then to be disabled mentally is tantamount to being disabled rhetorically (Prendergast, 2001, p. 202). For instance, the voices of schizophrenics are rarely afforded the power of signification.

[The]…writing of schizophrenics can only be seen as a-rhetorical, simply data: the test, the record of symptoms…At best, it is seen as music, as poetry, as some personal
expression that has no bearing outside of itself, no transactional currency…If people
think you are crazy [or have been in the past], they don’t listen to you. (Prendergast,

The “they” who is not listening to the “crazy person” are audiences convinced that
communication “works” only because speaking is at its heart referential and signifying. When
such a suspicious audience characterizes a person’s words as “poetry” or “music,” this is
tantamount to a denial of that person’s rhetorical agency or the power of “signifying speech.” Kim Owens (2009) coins the term “rhetorical disability” to refer to when a person’s rhetoricity is
limited by audiences who perceive mental or affective conditions that may limit the rational
expression of a rhetor. She examines the case of women’s birthing plans. A birthing plan is a
document somewhat similar to a living-will that communicates the wishes of those facing
situations that may be life threatening or may impair one’s ability to communicate “reasonably.” Owens (2009) argues that birthing plans are women’s response to “their (perceived) inability to
communicate effectively due to pain, medication, an impaired mental state, or a power imbalance” during the pains of labor (p. 248). Rhetorical disability is the real-world counterpart of Booth’s unreliable narrator.

As a literary device, the unreliable narrator is an internal attribute of some fictional
character. Real-world rhetorical disability is not simply an internal attribute of a person. Jenell Johnson (2010) identifies the social, moral, and communicative conditions that give rise to
rhetorical disability in people who have suffered depression. She sees rhetorical disability “as a
social force enacted through language and rooted in culturally and historically contingent values”
and rooted in stigmatizing views of a person’s character (p. 462). Johnson traces the ancient
roots of stigma to the once punitive and disciplinary practice of placing a physical mark (e.g.,
branding, scarring, etc.) on the bodies of those with “bad character,” or those whose values were perceived to be a threat to communal values. This visible marking served a civic function of making “the invisible bad character visible” and thus rendered the “bad guy’s” body a form of embodied epideictic that reminds people of how not to act, functioning to reinstall the “nomos” in an act of public shaming (cf. Johnson, 2010, pp. 463–464). To be disabled mentally is to be disabled rhetorically, that is, it is to have one’s ethos marked with an epistemological asterisk.

*Be cautious dear reader or audience; do not accept this person or their words without due caution and suspicion!

Johnson (2010) and Pryal (2010) are two rhetorical scholars who demonstrate how rhetorical disability impacts a rhetor’s ethos. Johnson examined the failed vice-presidential campaign of Thomas Eagleton in 1972, reviewed earlier. Recall that upon disclosing that he had been admitted to psychiatric hospitalization for depression, Eagleton resigns from the race as George McGovern’s running mate amidst social and political pressures as public perception about the “soundness and stability” of someone with mental illness. While not a literal, visibly stigmatizing mark, the “epistemological visibility” of Eagleton’s past as someone who has been hospitalized for depression casts him in the public sphere as an unreliable narrator. Johnson (2010) argued that Eagleton “was forced to resign because his presence was perceived to ‘cripple’ the campaign an issue of ethos rather than competence or qualifications” (p. 467).

Katie Rose Guest Pryal (2010) also examined rhetorical disability of mental illness. She outlined the generic features of “mood memoirs,” a term she seems to have coined (p. 480). Using “shared conventions” of memoirs, such as apologia, “awakening,” criticism of doctors, and rhetorical amplification, Pryal (2010) argued that mood memoirs respond “to rhetorical exclusion” by reclaiming “reliable ethos for the mentally ill, at least in certain spheres” (p. 480).
Taken together, both Johnson and Pryal provide a deeper sense of the communicative challenge of rhetorical disability that faces those attempting to communicate to audiences about their disordered experiences.

There is an even deeper condition that gives rise to rhetorical disability, however, that I call “the inexpressibility thesis.” This is the idea that expressions of emotional suffering resist meaningful objectification in language because subjective emotions cannot be communicated with the same veridicality as propositional statements and thus should be met with suspicion. The inexpressibility thesis is a belief activated by a dialectics of certainty and doubt. This view is convinced that any real identification with another’s suffering is at best practical illusions and at worse deliberate deceptions or manipulations of reason because we can never “truly” experience another’s suffering. Here is an example of this prevailing belief.

![AMATEUR THERAPY](http://www.fowllanguagecomics.com)

Figure 1. This is cartoon illustrates rhetorical disability and the inexpressibility thesis as it caricatures the way people tend to respond when someone expresses feelings of depression. Brian Gordon is a web-based cartoonist (http://www.fowllanguagecomics.com).

The above comic depicts a “Chuck & Beans” comic strip. Chuck expresses his suffering: “I’m depressed.” Seemingly, with little hesitation, Beans shouts, “Cheer up!” If asked, Beans might claim he is acknowledging the suffering of Chuck. But, in effect, Bean denies the
expression of suffering and the suffering in the Chuck’s expression. That this is one possible 
interpretation of this comic strip is suggested when we read that Chuck continues in his down 
mood. “Nope. Still bummed out.” And in response to this, the Beans is now “stumped,” this 
perhaps being a more sincere impression of Chuck’s suffering all along.

The unstated warrant that allows a reader to “get” this comic is the widespread cultural 
belief that it is impossible to know other’s suffering because subjective suffering is beyond 
communication. But other reasons also nourish this lack of trust in emotional expressions, 
especially in cases of disordered sadness. For instance, there are deep cultural beliefs that 
happiness is a sign of national, civic, and personal health (cf. Elliot, 2003). As a culture, people 
seem “obsessed” with feeling happy (cf. Wilson, 2008). Is it any surprise that those suffering 
depression often have their feelings denied (e.g., “cheer up!”)? Or, if still undeniable to the 
sufferer (as in the case of the white rabbit above), then their suffering is disbelieved (e.g., “I’m 
stumped. Why can’t you just snap out of it?!). There is a tragic irony here. Feelings of 
loneliness are hallmark symptoms of depression (Karp, 1996; Rowe, 1978). So to feel unheard, 
disbelieved, or to have one’s emotional expressions not acknowledged creates double injury. As 
Joel P. Smith (1997) reflects on those moments in his life living with depression:

We depressed people suffer more than is necessary because so many others trivialize 
depression by assuming it is ordinary. After all, they say, we all have bad days; we all 
get the blues. But depression is worse than the blues by several orders of magnitude. 
This is why so many depressed people are put down when others try to cheer us up. At 
best, these cheerful words reveal a disconnect, a failure to understand the stuff of 
depression. At worst, the cheerful words are received by us as accusations that feed our 
self-contempt. (p. 497)
Such rhetorical imbroglios make it difficult to tease out if a person feels unable to express their suffering because the pain feels so deep as to be inexpressible or if their expression is limited because few others have the competence, willingness, or life experience to actually listen and comprehend deep feelings of sadness. In either case, the rhetorical phenomenon on display here is a longstanding one: the distrust of emotional expressions.

Since Aristotle, emotions and emotional appeals have been a recurring subject of rhetorical study and debate. There are centuries of thought on the rhetoricity of emotions. And yet, there is a remarkably consistent feature of thinking about emotional appeals throughout the millennia. A quick look at the way Aristotle and late 20th century and contemporary thinkers view emotional appeals in texts gives insight into this long-standing distrust of emotional expression.

Since Aristotle’s day, one view of emotional appeals is that such appeals “twist” the reason of an audience. We find this perspective in his Rhetoric commenting, “it is not right to twist the juryman into pandered anger, or envy, or pity; this would be the same as if someone intending to use a ruler would make it crooked” (Kennedy, 2007, pp. 31-32). The division between logos and pathos initiated here certainly hints at “an ethics of persuasion” (Walker, 2000, p. 74) that seems suspicious of the use of emotional appeals because of its apparent power to affect an audience’s judgment. Reason can be trusted in a way that emotions cannot. This view seems to privilege the use of logos appeals over pathos appeals. But this is not all that Aristotle had to say about emotional appeals. The second stance toward emotions is an appreciative one that views them as a condition of appeal. Aristotle devotes a whole chapter of the Rhetoric to what many scholars have called the first ever “systematic” treatment of the psychology of an audience’s emotional life (Fortenbaugh, 2002; Gross, 2006; Heidegger, 1962;
Smith & Hyde, 1991; Walker, 2000; Jasinski, 2001a). Aristotle, in short, clearly considers emotions in a larger sense as something to be fully appreciated as a valid mode of proof and that must be considered seriously as a speaker addresses the moods of an audience, for an audience’s emotions are considered a condition of appeal. This tension between emotional and logical appeals is a long-standing one.

In the early 80s, around the time William Styron was telling his highly emotional story, communication scholars where also directing their attention to emotional forms of expression and argumentation. Michael Hyde (1984) was noting the lack of disciplinary appreciation of emotional appeals. James Crosswhite (1989) was arguing that rhetorical scholars mistake conceptual distinctions between reason and emotion for being ontological distinctions because their critical and pedagogical focus tends to be directed to the predication and control of rhetorical behavior. Other scholars like Phyllis Lassner (1990) and Jim Corder (1985) were arguing that empathetically identifying with another’s emotions was not possible, nor advisable particularly for marginalized groups. Lassner (1990) argued that emotions are deeply subjective and that no one can “really know what another person is feeling” (p. 225), so why should women attempt to empathize with the experience of those they oppose when their experience had not been seriously appreciated and respected up to that point? Corder (1985) argued that attempting to subordinate one’s own emotional feelings for the sake of empathizing with other’s feelings is a fool’s errand in the middle of a passionate argument, and is like, “…storming Hell with a bucket of water…” (p. 22). While it may seem Lassner and Corder’s critiques embrace the role of emotion as a productive aspect of argument more generally, their suggestion, if read closely, is to embrace one’s own emotions because those are the only emotions we can know with certainty. As for the emotions, feelings, and experiences of others, well…we do well to remain cautious of
opening ourselves up to identifying with them. The supposed inexpressibility of other’s emotions warrants their distrust, especially as they might reinforce existing power structures.

Also during this time, a now widely cited work in contemporary critical theories exploring the expressivity of suffering was published, Elaine Scarry’s (1985) *The Body In Pain*. Interestingly, she seemed to move out of the inexpressibility thesis most explicitly by explaining that

When one speaks about “one’s own physical pain” and about “another person’s physical pain,” one might almost appear to be speaking about two wholly distinct orders of events…For the person in pain, so incontestably and unnegotiably present is it that “having pain” may come to be thought of as the most vibrant example of what it means to “have certainty,” while for the other person it is so elusive that “hearing about pain” may exist as the primary model of what it means “to have doubt”…Whatever pain achieves, it achieves in part through its unsharability, and it ensures this unsharability through its resistance to language…Physical pain does not simply resist language but actively destroys it, bringing about an immediate reversion to a state anterior to language, to sounds and cries a human being makes before language is learned…It [pain] resists objectification in language. (Scarry, 1985, p. 4)

Scarry explicitly casts the communication of another’s pain from within the dialectic of epistemological certainty and doubt. For her, a person simply cannot ever truly identify with other person’s expressions of pain. Suffering destroys language. Also consider the widely read perspective of Susan Sontag, likewise published during this time of questioning empathy and suffering. Susan Sontag (1978) wrote in her book, *Illness as Metaphor*, that “illness is *not* a metaphor, and the most truthful way of regarding illness…is one purified of, most resistant to,
metaphorical thinking” (p. 3). Sontag argued that an objective, emotionless language purified of metaphor and able to maximize certainty about the communicated suffering of others should be the only “proper” language for communicating suffering and illness. These views expressed distrust in emotional cries and language’s ability to capture such subjective suffering.

Today, critical scholarly inquiry is still undergoing what is known as the “affective turn” in the humanities (cf. Clough & Halley, 2007), a turn toward greater appreciation of emotions, embodied feelings, and affect. Though a widely cited warrant for this turn is that the history of western theorizing has privileged “intellectualist” or “deliberationist” models of human sense-making (Connolly, 2002. p. 10–44), contemporary affect theory continues to exhibit a commitment to the inexpressibility thesis, a distrust of affect. Brian Massumi, for instance, a widely recognized contemporary affect theorist and translator of philosophers of affect Deleuze and Guattari, treats emotions and affects as two different phenomena, one “affective” and the other “personal.”

2 Affect and emotion, writes Massumi (1995), “follow different logics…orders” (p. 88). Affect is a felt intensity, “that margin of maneuverability, the ‘where we might be able to go and what we might be able to do’ in every present situation” and is “something other than personal feeling” (Massumi, 2015, p. 3). Affect is a nonsignifying, deeply visceral, and a preconscious and fluid movement of the body’s relationship with its surrounding world. Affect is its own kind of quality of experience that cannot be captured fully by representation because it’s like “being right where you are – more intensely” (Massumi, 2015, p. 3). On the other hand, an emotion is “a subjective content, the socio-linguistic fixing of the quality of an experience which is from that point onward defined as personal” (Massumi, 1995, p. 88). There are two different logical orders: one affective and the other personal, cultural, and biographical.
Ruth Leys (2011) reveals the scientific history of a certain kind of neuro-affective research to which Massumi’s affect theories are highly indebted, namely the influential work of Silvan Tomkins (1962) and Antonio Damasio (1995). These researchers view emotions as distinct from thinking, judgment, language, or cultural meaning by positing that human beings have universal, genetically hard-wired basic emotions. These views understand affect and emotions as “inhuman” forces that warrant suspicion about their influence on human reason.

What the new affect theorists and the neuroscientists share is a commitment to the idea that there is a gap between the subject’s affects and its cognition or appraisal of the affective situation or object, such that cognition or thinking comes “too late” for reasons, beliefs, intentions, and meanings to play the role in action and behavior usually accorded to them. The result is that action and behavior are held to be determined by affective dispositions that are independent of consciousness and the mind’s control. (Leys, 2011 p. 443)

For Leys, even today after the “affective turn,” affect is entangled within the inexpressibility thesis because emotions are taken to be personally and socially constructed, whereas affect is taken to be a pre-cognitive, extra-verbal forces that nonetheless shapes human reason. Cultural critics continue to caution that the “importance of affect rests upon the fact that in many cases the message consciously received may be of less import to the receiver of that message than his or her non-conscious affective resonances with the source of the message” (Shouse, 2005). Thus a scholar like Massumi practices a suspicion of affect because such “affective resonances” can produce “ideological effects by non-ideological means” (Massumi, 1995, p. 102). After all, how else explain the overwhelming cultural popularity of President Ronald Reagan except by theorizing that his means were “brainless” or “affective” (Massumi, 1995, p. 101)? Reagan
twisted the juryman. Other scholars working with affect and emotion, like Sara Ahmed (2004), warn us how affective messages can hide a “cultural politics of emotion” that can reinforce existing power structures (a critique echoing Phyllis Lassner’s over 20-year-old observation!). And here, once again, a desire for “prediction and control” of human behaviors for a certain kind of political agency and action continues to activate distrust of emotion (and now affect). 

Both rhetorical disability and the inexpressibility thesis are obstacles to the generation of identification between highly affective or emotional expressions of mood memoirs and a non-disordered audience. Identification is contemporarily associated with the work of Kenneth Burke (1969b), though Burke’s idea was inspired by a passage in Book 1 of Aristotle’s *Rhetoric* (cf. Burke, 1969b, pp. 55‒57; Kennedy, 2007, p. 83). For Burke identification is at once both a deliberate rhetorical device through which a rhetor attempts to demonstrate similarity with an audience and a non-deliberate function of the dispositional *ends* of an audience’s desires for cooperation, specifically “as when people earnestly yearn to identify themselves with some group or other” (Burke, 1951, p. 203). Identification is thus a necessary condition for the possibility of persuasion. But more than a strategy for persuasion, arguments work by inducing cooperation by leading readers or listeners to identify deeply with a rhetor’s position—position here meaning literally “that person’s perspective on things...‘where they are coming from’” (cf. Anton & Peterson, 2003, p. 407). “You persuade a man [sic],” writes Burke (1969b), “only insofar as you can talk his language by speech, gesture, tonality, order, image, attitude, idea, identifying your ways with his (p. 55).” Particularly in autobiographical acts, this established “pact” of shared experiences between audiences and the author’s works to cultivate narrative fidelity and coherence (cf. Fisher, 1987).
In her book, *Lives of Their Own: Rhetorical Dimensions in Autobiographies of Women Activists*, Martha Watson (1999) provides a useful framework for viewing autobiographical acts as public arguments rooted in identification. Specifically, her analysis reveals how women activist autobiographies function as rhetorical texts when they “articulate a model of selfhood for others to emulate” (Watson, 1999, p. 2). Watson offers a close reading of 19th century women activists’ autobiographies, such as the anarchist Emma Goldman or the abolitionist Elizabeth Stanton. As these women defied many social conventions of “womanliness” in their time, Watson (1999) argues that their autobiographies provided a way of asserting themselves into public discourse as well as articulating a model of selfhood for other women to emulate. The success of their political agendas depends on garnering support of more than just those who were the initiate or sympathizers. As such, the autobiographical genre allows women activists to share their everyday lives as women, thus appealing to a women readership less inclined to challenge social conventions. Watson (1999) insightfully concludes that these 19th century women activist’s autobiographies successfully met an important rhetorical challenge to identification, namely to “affirm their womanliness [for audiences] in the face of charges that they had rejected traditional feminine roles” (p. 3). These activists’ autobiographies offered compelling models of selfhood that more traditional women could identify with, not just on ideological grounds but on more shared personal grounds of everyday experiences of being women.

Analogous to activist’s autobiographies, Plath, Styron, and Jamison aim to use an autobiographical act to assert their narratives into public discourse, generate identification with more than depressed audiences, and provide a model of selfhood for others to imaginatively inhabit. Like the activist who uses autobiography to advocate for changes to the status quo of communal values, Plath, Styron, and Jamison must reach both supporters and potential followers
in order to advocate for changes in public and technical exigencies of their time. However, unlike the unpopular or unconventional lives of 19th century women activists, whose rhetorical challenges to identification are imposed by ideological or conventional differences between author and audience, Plath, Styron and Jamison have to work within rhetorical disability and through the inexpressibility thesis to generate identification with audiences. Their rhetorical challenges are not ideological or only a matter of convention, but epistemological, ontological, and, ultimately, existential.

**Communicating the Disorder of a Mood Disorder: Figuring the Inability to React**

Plath, Styron, and Jamison have successfully crafted compelling narratives that were able to connect with audiences albeit through the use of stories about breakdowns in the cohesiveness of their world-experience. They present a model not of selfhood similarity but of a “broken self and world” through figurative and metaphorical passages as ways of communicating about these extra-verbal sensations and relations of being in the world. Esteemed scholar in the medical humanities Arthur W. Frank (2011) argues that the metaphors used in memoirs that convey the extra-verbal pain of illness function, “…no longer a[s] trope, in the sense of a twisting of language. Instead, reality is what is twisted, and language is a straightening out process” (p. 193). In like measure, Perelman and Tytecas’ (1969) notion of presence characterizes the process as when a rhetor makes present by verbal magic something that is absent to an audience (p. 117; also Karon, 1976). The use of figurative images, phrases, analogies, and metaphors are one well studied way of transforming something “absent” into something “present” for an audience (Jasinski, 2001a, p. 456; Murphy, 1994; Perelman & Tyteca, 1969, p. 160). Plath, Styron, and Jamison craft rich accounts of drifting shifts in their sense of responsiveness to life and their general sense of being in a meaningful world by making use of figurative and
metaphorical expressions to convey an extra-verbal experience of disordered reality.

To gain a sense of how these disordered moods are communicated by these authors, I begin with Jamison’s narrative account because she suffers from manic-depression. Manias are highly energetic and vivid experiences of being “up” while depressions are energy lacking, deadening world-experiences of being “down.” Given these extreme mood swings, Jamison’s depictions of her disordered experience offers something of a “skeleton key” for understanding what the “disorder” of a mood disorder is like because she sheds light on the sheer high-to-low shifts in her world-experiences. Jamison’s unique position illuminates the portrayals of depressions by Plath and Styron.

Jamison (1995) writes about her first “attack” of mania as feeling like a “crazed weasel” racing about life, “bubbling with plans and enthusiasms…” (p. 36). She continues:

…everything seemed so easy…reading everything that wasn’t nailed down…The world was filled with pleasure and promise; I felt great. Not just great, I felt really great. I felt I could do anything, that no task was too difficult. My mind seemed clear, fabulously focused, and able to make intuitive mathematical leaps…not only did everything make perfect sense, but it all began to fit into a marvelous kind of cosmic relatedness. (pp. 36–37)

These manias are extremely high flights of mood. She uses the metaphor of a crazed weasel as a way of depicting the way her world lights up with enticements and compulsions that draw her into sporadic and frenetic pursuits. Jamison is also quick to mention the effect her moods have on those around her as she would often “button hole” friends to tell them about the “fizzy” feelings that accompanied her enchantment with the natural world. Whilst “fizzy” may not be a standard category of emotion, say as “happy” or “sad” or “excited,” it nonetheless through
configuration captures a visceral quality of her body during a mania, the effervescent quality of an alert and vibrant mind and ecstatic body. Her friends would grow exhausted by her enthusiasm and energy. “You’re talking too fast, Kay. Slow down, Kay,” her friends would say in fatigue (p. 37).

Jamison would eventually slow down as her moods shifted toward depression. She writes that the “bottom began to fall out my life and mind” (Jamison, 1995, p. 37). Again through the use of metaphorical expressions like “bottom falling out,” she generates the visceral sensations of the receding energy of the body and mind’s active engagement with the world. She continues,

My thinking, far from being clearer than crystal, was tortuous. I would read the same passage over and over again only to realize that I had no memory at all for what I had just read. Each book or poem I picked up was the same way. Incomprehensible. Nothing made sense…My mind mocked me for my vapid enthusiasms; it laughed at all of my foolish plans; it no longer found anything interesting or enjoyable or worthwhile…I was totally exhausted…I dreaded having to talk to people…with a dead heart and a brain as cold as clay. (p. 38)

Jamison’s depression is portrayed here in contrast to her manias by amplifying her shifting sense of inability to respond to the world and others around her. When she is “high,” everything feels easy, the mind thinks fluidly, the reading insatiable, and conversation effortless to a fault. She can respond and act in a meaningful world that demands for actions and projects to be accomplished. When she is “down,” thinking is slow, reading difficult, and conversation a dreaded chore. The viscerally clear mind, depicted in the figure of clear crystal, darkens. She continues by noting that every morning she would awake “deeply tired” and feeling “bored” and
“indifferent to life.” Darkness of mind and the sluggish quality of an exhausted body, feeling unable or willing to physically act and do the things of life with vitality, become ultimately organized around a metaphor of death. She recalls her thoughts being preoccupied with “death, dying, decaying, that everything was born but to die…” (Jamison, 1995, p. 38). No longer able to respond, to react, to hear the calls of action and projects to be accomplished in a meaningful world, Jamison’s world is depicted as “deadening” of her world-experience. Death becomes an organizing metaphor for a lived-experience of depression.

Jamison’s account of her manias and depressions depict how she lives in a liminal space. She is in the world, but not of the world, not at home in her world. This inability to respond to the world during her depressions is remarkably similar to the ways Plath and Styron depict the deadening of their world-experience. For instance, consider Plath. *The Bell Jar* follows Esther’s progressing decaying and deadening lived experience into depression and, eventually, a suicide attempt. This is depicted in figurative and metaphorical passages that express shifts in both inside senses of losses in personal efficacy, self-mastery, motivation, and Esther’s observations of a normative world that becomes increasingly meaningless, foreign, and deathly.

*The Bell Jar* opens with Esther obsessively preoccupied by thoughts about the electrical execution of the Rosenbergs. Despite being “stupid about executions,” she “couldn’t help wondering what it would be like to be burned alive all along your nerves…” (Plath, 1996, p. 1). That’s when she “knew something was wrong,” as that summer she had also developed a “fascination with death” (p. 14). The book opens already with the figure of death and dying. More still, having just won a college summer internship with a prominent magazine in New York, she doesn’t feel excited, “the way most of the other girls were” (p. 2). She writes, “I wasn’t steering anything, not even myself. (I felt very still and very empty, the way the eye of a
tornado must feel, moving dully along in the middle of the surrounding hullabaloo)” (pp. 2‒3). The figure of a tornado stands for the visceral qualities of feeling at once both stirred by outside compulsions and happenings but an odd and unsettled empty calmness about it all. Instead, the significance of this summer internship recedes into the background, as Esther laments, “I just couldn’t get myself to react” (Plath, 1996, p. 2). Once again, as with Jamison, we find the inability to react as a recurring theme that depicts the visceral and embodied qualities of losing touch with normative desires, that is, to just do the things of everyday life. The progressing loss in the significance of her world-experience and the loss in senses of her internal ability to respond in normative ways continues throughout the story, eventually culminating in the ultimate deathly figure of her suicide attempt.

As with Jamison, Plath also portrays the way her mood affects her ability to relate to others, and, once again, provides a figure of “death” as an organizing metaphor. As her disordered mood grows, Esther is alone in her hotel room after deciding not to go with the other girls who were heading out for an evening of socializing. Feeling visceral tugs of isolation, she writes, “The China white bedside telephone could’ve connected me up with things, but there it sat, dumb as death’s head” (Plath, 1996, p. 19). The ominous juxtaposition of a telephone with the figure of a severed head reveals the depth and degree of just how out of touch she feels in that moment. Also like Jamison, Plath gives a figurative sense of the loss of mental sharpness and clarity. Esther continues to tell how, “Every time I tried to concentrate, my mind glided off, like a skater, and to a large empty space, and pirouetted there, absently” (Plath, 1996, p. 145). Through the use of the figure of a skater gliding off into its own kind of activity, Plath portrays the general loss of mental focus. Her mind is portrayed in ways that parallel Jamison’s experience of her lows, the mind loses its attachment to senses of vitality and activity. Figures of
absence and death become ways of metaphorically organizing the lived-experience of depression.

We find a similar theme of “inability to react” expressed in figurative and metaphorical ways in William Styron’s account of his depression. Styron (1990) recalls visiting Martha’s Vineyard, a place he has “spent a part of each year since the 1960s.” It is there that he discovers that he’s “in the grip of the beginning of a mood disorder” (p. 42). He writes,

It was alarming at first, since the change was subtle…that my surroundings took on a different tone…the shadows of nightfall seemed somber…mornings less buoyant…walks in the woods less zestful, and there was a moment during my working hours in the late afternoon when a kind of panic and anxiety overtook me…accompanied by a visceral queasiness…I realized that it should be plain to me that I was already in the grip of…a mood disorder. (p. 42)

Transforming depression into an ontological thing through the use of personification metaphors that allow “it” to “grip” its victim undergirds Styron’s depiction of an increasingly deadening personal horizon. He continues to refer to this experience figuratively as being “engulfed by a toxic and unnamable tide that obliterated any enjoyable response to the living world” (Styron, 1990, p. 16). Unlike Plath or Jamison, Styron is very clear in his writing that this is a “visceral” sensation, a deeply embodied sense of shifting degrees of being in the world. The world that is “living” is the world that calls forth a visceral and incarnate, wholly embodied response. What was “normal” is becoming less than normal. Styron (1990) continues to depict this shift writing,

But I had begun to respond indifferently to the island’s pleasures. I felt a kind of numbness, an enervation, but more particularly an odd fragility – as if my body had
actually become frail, hypersensitive and somehow disjointed and clumsy, lacking normal coordination. (p.43)

Styron here explicitly refers to bodily sensations to describe what it felt like for him to not be able to react to his world, but also like Jamison and Plath, “death” became a “daily presence” blowing over him “like cold gusts.” (p. 50). He continues:

…during one of those insomniac trances that there come over me the knowledge …that this condition would cost me my life…Death…was now a daily presence, blowing over me in cold gusts…plainly the possibility was around the corner, and I would soon meet it face to face. (p. 50)

Again, “death” in the figure of an entity becomes a way for depicting what are internal senses of a loss of the ability to respond in embodied ways. Also implied is the figure of a person in a trance, a spell. The narrative structure itself literally brings presence to the word death by building upon an experience that is already framed as trance-like. The power of the “trance” is broken only by still colder gusts of obsessive thoughts of death. Styron’s narrative generates intensity around his experience of death as a daily presence.

For each author, the “disorder” of a mood disorder is depicted as losing the ability to respond to a world that would “normally” have a “living” character to it, or in plain words, a normative, ableist world. This is depicted by reference to non-normative, disabled embodied, and visceral sensations that accompany their moods. Interestingly, the common sense idea that mental illness is, well, something “mental” is challenged in these canonical memoirs about “mental illness.” These richly detailed disordered experiences reveal how the experience of depression is lively with bodies and always connected with embodied experience, and Plath, Styron, and Jamison make use of “death” as an organizing metaphor for this experience. The
larger implication here is that Plath, Styron, and Jamison viscerally and cardinally experience themselves as living in the world but not quite as active participants of the world. Their inability to respond to a “living world” gives these authors an existential and radical ground from which to critique normative reality because they are literally living at a distance from everydayness.

**How Living-at-Distance Functions Rhetorically: Critical Interruption and Existential Grounds of Critique**

As seen in Chapter 2, Plath, Styron, and Jamison’s works have been characterized as perceptive, critical, and illuminating. That these texts offer a “perspective by incongruity” is what is “rhetorical” about these texts, namely that they illuminate alternative meanings of certain cultural practices. Consider the rhetorical exigencies identified by Plath, Styron, and Jamison, specifically domesticity norms and anti-psychiatry, the blaming of mental illness as moral failing, and stigmatizing views of mental illness. Each exigency is a normative feature of a rhetorical environment, a customary or “normal” practice toward which these author’s memoirs are directed. As such, *The Bell Jar*, *Darkness Visible*, and *An Unquiet Mind* enter into these rhetorical environments as “anti-environmental” forces. As anti-environmental forces, the figurative and metaphorical nature of these memoirs becomes an indispensable means of illuminating background practices that are often imperceptible (cf. McLuhan, 2011). Their memoirs about living in a disordered world generate rhetorical presence to taken-for-granted practices.

Living in the world but not being of the world creates a critical distance that allows Plath, Styron, and Jamison to expose ableist, normative practices of everyday life. For Plath, *The Bell Jar* works to open a critical space for public deliberation about the norms of domesticity and the patriarchic values of psychiatry in the 1950s and ’60s. For Styron, *Darkness Visible* attempts to
open a critical space for public deliberation on moralistic views of depression as a moral failing of the 1980s. And for Jamison, *An Unquiet Mind* attempts to open a space of public deliberation on emerging biological stigmatization in the mid-1990s.

Working at the intersection of when culturally available rhetorical resources meet against extra-verbal realities allows the metaphorical and figurative nature of Plath, Styron, and Jamison’s memoirs to function as acts of critical interruption,

where the taken-for-granted practices of a culture are concerned…the phenomenon of rhetorical interruption juxtaposes the assumptions, norms, and practices of a people so as to prompt a reappraisal of where they are culturally, what they are doing, and where they are going (Farrell, 1993 p. 259).

Each author has chosen to engage discourses through the use of the autobiographical form, or a personal grounding in a return to the roots of personal experience. Self-disclosing narratives about illness have been argued to have disruptive power for readers. As Thomas Couser (1997) writes, reading such narratives heighten “one’s awareness of one’s mortality, threatening one’s sense of identity, and disrupting the apparent plot of one’s life (p. 5). Avrahami (2007) characterizes how reading such narratives can invade normative lived-experience of readers. He writes,

…[R]eading self-disclosures of the lived-experience of illness at once implicates the reader in her own mortality and aims to obliterate the distance between the writer, the text, and the reader. Illness narratives, thus, insert themselves between the referential, “extratextual” reality of the sick writers and the ideological and linguistic constructs of their illness. They do so not because they manage to establish a simple and direct link between text and the experience of suffering “out there” but because they create a sense
of imaginative identification so powerful that its effect is to point the reader outside the
text. (Avrahami, 2007, p. 7)

Given the disruptive nature of disordered moods for those experiencing them, mental illness
memoirs are primarily about the experience of a soul dwelling acutely aware of these dialectical
tensions between “extra-verbal” realities and culturally available rhetorical resources. In
presenting their disordered accounts, these narratives often articulate the personal sphere through
technical and public discourses, and hail readers into deliberative space where what is sensed as
normal is now strange and open to question. As Goodnight (2012) observes:

An arguer can accept the sanctioned, widely used bundle of rules, claims, procedures and
evidence to wage a dispute. Or, the arguer can inveigh against any or all of these
“customs” in order to bring forth a new variety of understanding. In the first case, the
common grounds for arguing are accepted, and argument is used to establish knowledge
about a previously undetermined phenomenon. In the second, argument is employed as a
way of reshaping its own grounds. (p. 200)

As Plath, Styron, and Jamison bring presence to broken relations between self and world, they
bring presence to unexamined grounds of technical and public discourses and practices. An
audience is thus offered a deliberative perspective through which they then might reshape the
grounds of their own understanding and practices of how they relate those with mental illness, as
well as how they relate to their own being in the world more generally.

Plath desires to create a world where women are free to pursue roles beyond societal
norms. Her inability to react puts her at a distance from social expectations that she then
conveys in figurative passages about losses of ambition and purpose. This helps generate a
radicalizing interruption and presence to societal norms and pressures she feels as a woman
growing up in the 1950s. For instance, Esther, having been called into the office of her employer, is asked if her work still interests her.

Doesn’t your work interest you, Esther? Oh it does, it does, I said. It interests me very much. I felt like yelling the words, as if that might make them more convincing, but I controlled myself… I’m very interested in everything. The words fell with a hollow flatness onto Jay Cee’s desk, like so many wooden nickels. (Plath, 1996, p. 31)

In this passage, Esther feels the need to convince herself that her work is available as a possibility and something relevant to her life. But her work no longer calls forth her normative emotional and volitional responses; she “should” feel the normative societal moods of wanting to care about her life. In a later moment, Esther likewise imagines all the future possibilities she desires as large over ripening figs hanging from a tree. She imagines, travel, lovers, writing and begin “to wrinkle and go black, and, one by one, they plopped to the ground at my feet” (Plath, 1996, p. 77). Plath here uses the figure of overly ripened figs to convey inner senses of detachment to future aspirations.

Indeed, Plath conveys how Esther, now in the throes of a depressed mood, is found lying in bed unwilling to get up.

I crawled back into bed and pulled the sheet over my head. But even that didn’t shut out the light, so I buried my head under the darkness of the pillow and pretended it was a night. I couldn’t see the point of getting up. I had nothing to look forward to. (p. 117)

---

3 In the existential-phenomenological philosophies of embodiment, as the body feels down or low, so to does the world appear to lack meaningful lines of action. The body has nascent powers for making things available and relevant according to its phenomenal structure through a manifold of ways for making contact with the world, including embodied senses, sociality, symbolicity and temporality. If these are disordered in their functioning, then the world itself appears disordered. For more on availability and relevance as existential-phenomenological concepts, see Anton (2001).
Esther conveys her loss of volitional and visceral desires by portraying her body as listless and uncooperative. The shine of the day here implies that action and activity are normal and expected, but this is too bright for her eyes. As Esther has nothing to look forward to, no futural sense of time for her to accomplish her life’s projects, the significance of her work and life are conveyed as no longer available for and relevant to creating the life she wants. Embodied losses in visceral connections to one’s actions are figuratively portrayed as speech that drops as wooden nickels, dead fruits, and blinding light, which generates a tension in the narrative between normative and disordered realities.

There is more here in Plath, however. Plath’s account also reveals that Esther’s sense of reality portrayed not a total loss of availability and relevance, but rather, a disordered, non-normative sense of availability and relevance. For instance, consider the way that normal everyday objects take on a more ominous purpose than their customary and socially acceptable and appropriate purposes. While in her home, Esther makes a visual scan of the room she is in. Feeling in a particularly suicidal mood, she recalls:

That morning I had tried to hang myself. I had taken the silk cord of my mother's yellow bathrobe as soon as she left for work, and, in the amber shade of the bedroom, fashioned it into a knot that slipped up and down on itself. It took me a long time to do this, because I was poor at knots and had no idea how to make a proper one. Then I hunted around for a place to attach the rope. The trouble was, our house had the wrong kind of ceilings. The ceilings were low, white and smoothly plastered, without a light fixture or a wood beam in sight… My grandmother's house was built in the fine, nineteenth-century style, with lofty rooms and sturdy chandelier brackets and high closets with stout rails
across them, and an attic where nobody ever went, full of trunks and parrot cages and
dressmakers' dummies and overhead beams thick as a ship's timbers. (Plath, 1996, p. 158)
Normal things like knots, ceilings, empty rooms, and light fixtures take on more than their
mundane meaning. The sheer thickness of overhead beams is present in a way that is usually
absent. In reading such experiences, a reader is offered possibilities for reconsidering how the
things of everyday life are never simply as they “are” but as they might be, especially given the
possibilities of a depressed mood. Passages like this bring presence for audiences to how moods
affect the very sense of reality.

A non-depressed audience reading such passages is offered a deliberative moment
wherein they might imagine their own moments of feeling uninterested in playing the game of
socially acceptable and appropriate behavior as a way of bridging the gap between the two
experiences of being in the world. In the real time moment of reading, Plath’s figurative
passages generate a radicalizing presence to the sheer pressures of societal pressures. In Chapter
4, I explore how she makes use of such radicalizing light to illuminate societal pressures upon
women growing up in 1950s American culture.

Like Plath, William Styron’s account also brings presence to how moods affect
normative senses of reality through the use of figure and metaphor. Styron desires to create a
world where depressed people are met with empathy and support rather than with incredulity and
moral judgments. His inability to react puts him at a distance from his normal (healthy) self,
which is then portrayed in figurative passages conveying lapses in rational control. These
passages generate a radicalizing presence and interruption to everyday assumptions of a self who
acts purely through deliberate, rational control.
I particularly remember the lamentable near disappearance of my voice. It underwent a strange transformation, becoming at times quite faint, wheezy and spasmodic… the libido also made an early exit…. many people lose all appetite… but I found myself eating only for subsistence: food, like everything else within the scope of sensation, with utterly without savor. (Styron, 1990, p. 48)

Whilst speaking may seem a mundane facet of everyday life, requiring very little of our attention to simply get along in everydayness, Styron’s account of the struggle of speech brings presence to speech as something that is effort-filled. Indeed, Styron’s lapses in communicative function nearly cause him to breach social proprieties, as he forgets a dinner request of the benefactor of the Prix Mondial Cino del Duca award at his own award ceremony.

Simone del Duca…was understandably incredulous at first, and then enraged, when after the presentation ceremony I told her that I could not join her for lunch upstairs in the great mansion…My refusal was both emphatic and simpleminded…Of course this decision on my part was outrageous. I was suddenly flabbergasted, stunned with horror at what I had done. (Stryon, 1990, pp.14–15)

Social propriety absently operating in the background of normal ableist moods of mundane and routine bodily possibility has, for Styron (and for a reader), become all too present in its dysfunction. The ease of socially acceptable and appropriate speech is figuratively conveyed as “wheezy” and “spasmodic.” Speech is no longer available for or relevant to rationally controlled expression. Furthermore, the uncooperative body is figuratively portrayed through the analogizing of food and sex, which brings presence for audiences to the loss of control over one’s own hardwired senses of hunger and sexual desire. Embodied losses in visceral connections to one’s actions are figuratively portrayed as stilted speech, loss desire, and social
incompetence, which illuminate tensions between normative, rational control and disordered losses of rational control.

Much like Plath’s suicidal passage above, as Styron’s mood continues its deathly turn, everyday objects take on a lethal tone. When asked by his therapist if he felt suicidal, Styron refuses to share how everyday objects and things have taken on a singular purpose and meaning. He recalls,

I did not tell him that in truth many of the artifacts of my house had become potential devices for my own destruction: the attic rafters (and an outside maple or two) a means to hang myself, the garage a place to inhale carbon monoxide, the bathtub of vessel to receive the flow from my opened arteries. The kitchen knives in their drawers had but one purpose for me. (Styron, 1990, p. 52)

The everyday and mundane is figuratively foregrounded as Styron brings presence to non-normative senses of things and objects as available for and relevant to self-destruction. Notice the way metaphorical and figurative expressions “harden” into visceral realities; “the flow of open arteries” and the bathtub as a “vessel” become ways of adjusting language to a twisted reality. A reader is thus thrust into that intersection where extra-verbal realities meet against culturally available rhetorical resources, and presence is brought for audiences about the ways their moods regulate their own sense of speech and reality.

A non-depressed audience reading such passages is offered a deliberative moment wherein they might imagine their own moments of feeling—losses in appetites and desire as a way of bridging the gap between two experiences of being in the world. In the real-time moment of reading, Styron’s figurative passages generate a radical presence to the ways depression is experienced as a loss of rational and bodily control. In Chapter 4, I explore how Styron makes
use of such radicalizing light to illuminate stigmatizing views of depression that blame the victim for their disorder (with much help from biomedical discourses).

Like Plath and Styron, Jamison brings presence to how moods affect the sense of reality through the use of figure and metaphor. Jamison desires a world where those with mental illness are valued as they are, even if they are on medications or genetically predisposed to illness. Her inability (and manic-abilities) puts her at a distance from routine or mundane ways of living in a very different way than Plath or Styron. Whereas Plath and Styron’s accounts use figurative language to capture down moods, Jamison conveys her experience through figurative accounts of extremely visceral and ecstatic ways of being in the world. Jamison generates a critical interruption of mundane, taken-for-granted moods that brings presence to the routine and numbed nature of everydayness.

Jamison, like Plath and Styron, brings presence to the ways moods affect the sense of reality through the use of figure and metaphor. However, unlike Plath or Styron, Jamison’s manias, in contradistinction to her depressions, give her an “immediacy” and “appreciation” of the sensuous nature of life that would “not otherwise exist” for her (Jamison, 1995, p. 214). Milder manias are portrayed as ecstatic and vitalizing. Once her moods are regulated by Lithium, however, she recalls,

There are still occasional sirens to this past, and there remains a seductive, if increasingly rare, desire to recreate the furor and fever of earlier times. I look back over my shoulder and feel the presence of an intense young girl and then a volatile and disturbed young woman, both with high dreams and restless, romantic aspirations: How could one, should one, recapture that intensity or re-experience the glorious moods of dancing all night and into the morning, the gliding through starfields and dancing along the rings of Saturn, the
zany manic enthusiasms? How can one ever bring back the long summer days of passion, the remembrance of lilacs, ecstasy, and gin fizzes that spilled down over a garden wall, and the peals of riotous laughter that lasted until the sun came up or the police arrived? (Jamison, 1995, p. 211)

Jamison’s visceral readiness for creativity and inspiration experienced during her manias is foregrounded utilizing an image of a siren. Jamison further foregrounds the sensual and embodied senses of freedom and lightness through metaphorical images of flying among the stars and the rings of Saturn. But in writing as longing for these ecstatic moments, Jamison’s figurative passages work also to foreground and bring presence to the numbing character of “regulated” moods. Whereas Plath felt the pressures of being unable to feel the normative societal moods of wanting to care about her life, Jamison feels losses of deep volitional and sensual engrossment of life, as now she is “normal like everyone else.” Being normal like everyone else is not a value for Jamison. She builds the case that her disordered moods are an asset rather than a biological defect. Indeed, it is those who have never experienced breakdowns in moods that are missing out on deeply meaningful experiences of selfhood.

Jamison’s figurative framing of her disordered reality brings presence to the ways moods operate absently in the background of an audience’s reality. Jamison (1995) writes,

Yet however genuinely dreadful these moods and memories have been, they have always been offset by the elation and vitality of others; and whenever a mild and gentlish wave of brilliant and bubbling manic enthusiasm comes over me, I am transported by its exuberance— as surely as one is transported by a pungent scent into a world of profound recollection— to earlier, more intense and passionate times. The vividness that mania infuses into one’s experiences of life creates strong, keenly recollected states, much as
war must, and love and early memories surely do. Because of this, there is now, for me, a rather bittersweet exchange of a comfortable and settled present existence for a troubled but intensely lived past. (p. 211)

Her moods are portrayed as vessels for travel that take her into deep and strong experiences help to foreground the normative reality of mundane engrossment. Making sense of her twisted reality through these metaphorical devices, Jamison brings presence to the relative certainty and stability of normative moods that can slide into numb and bored everydayness. Her moods are portrayed as available for and relevant to understanding reality and her selfhood in more than mundane ways. Jamison, writing of her first moments of recognizing that she had, in fact, a disordered mind, compares her experiences to the figurative passage of a poem. She writes:

The Millay poem, “Renascence,” was one I had read as a young girl, and, as my mood became more and more ecstatic, and my mind started racing ever and ever faster, I somehow remembered it with utter clarity and straightaway looked it up. Although I was just beginning my journey into madness, the poem described the entire cycle I was about to go through: it started with normal perceptions of the world (“All I could see from where I stood / Was three long mountains and a wood”) and then continued through ecstatic and visionary states to unremitting despair and, finally, reemergence into the normal world, but with heightened awareness. (Jamison, 1995, p. 72–73)

Disordered moods for Jamison are portrayed as ways of gaining access to unseen aspects of everyday reality, unseen because the “normal” mood conceals from itself the relationship between one’s moods and one’s sense of reality. The everyday and mundane is figuratively foregrounded as Jamison brings presence to non-normative senses of things and objects as available for and relevant to self-awareness. Like Plath and Styron, a reader is thrust into that
intersection where extra-verbal realities meet against culturally available rhetorical resources. One possible affect of this is a rich presence is generated on the taken for granted ways moods regulate an audience’s own sense of speech and reality.

A non-depressed audience reading such passages is offered a deliberative moment wherein they might imagine their own moments of feeling bored and mundane as a way of bridging the gap between two experiences of being in the world. Unlike Plath or Styron, whose passages bring presence to a disordered reality as a way of bringing presence to problematic normative ways of being in the world, Jamison’s passages bring presence to disordered experiences as a way of suggesting how normative ways of being in the world are themselves problematic. In the real-time moment of reading, Jamison’s figurative passages generate a radical presence to the ways manic-depression is experienced as a meaningful part of her selfhood, while also inviting non-depressed audiences to reconsider the mundane nature of their own routine moods. In Chapter 4, I explore how Jamison makes use of such radicalizing light to illuminate stigmatizing views that treat those who suffer mental illness as less than human.

**Conclusion: A Different Moment of Identification and Its Use**

In Chapter 2, I reviewed how these works connect with those who suffer depression. But it was equally clear that these works appeal to many more audiences than just those suffering depression and, indeed, are written in large measure as a response to those audiences. Here in Chapter 3, we see how these texts bring presence to background normative moods of non-depressed audiences. Whereas autobiographies such as those reviewed by Watson (1999) may offer “models of selfhood to emulate” (p. 2), the figurative accounts of breakdowns of selfhood offer something different: not opportunities for similarity, but for *radical relation*. As Thomas Farrell (1993) observes, the “excitation of emotions” involves the generation of a relation
between rhetor and audience in a “doubly reflexive move” as an audience’s awareness of their own emotional life is juxtaposed with those of another’s emotional life (p. 71). Given the reading of radicalizing passages above, the contemporary Burkean notion of identification is here re-figured somewhat. When reading accounts of breakdown of self and world, a normative reality is interrupted by the disordered reality expressed in figurative terms. This generates a rhetorical function more akin to Burke’s notion of “pure persuasion” than just identification. As Bryan Crable (2005) explains Burke’s idea, “Pure persuasion describes a condition of anguish, one where a sacrifice of unity precedes (and is a prerequisite for) any rhetorical act” (p. 237). These author’s memoirs work at the intersection of extra-verbal reality and culturally available resources and thus continually interpose a distance between the normative audiences and disordered experiences through the use of radical figures of disorder in their text. In the moment of reading, a vivid division is produced between normative and disordered that an audience interpretatively bridges. In the process, these autobiographical acts generate identification as two separate radical experiences are encountered. These works not only open up a space for reflection on the discourses of their specific times but also open up a space wherein a reader’s taken-for-granted reality is laid bare as it encounters the disordered realities of others. Readers are just as much offered opportunities to encounter the conditions of their own selfhood as they are to identify with the affective appeals offered by Plath, Styron, and Jamison. In the next chapter I demonstrate how these author make use of these figurative and metaphorical work to engage public and technical discourses about mental illness.

*The Bell Jar*, in general, makes use of its figurative and metaphorical pages that function to generate a kind of *catachresis*, or the argumentative use of radical metaphorical expressions (Jasinski, 2001a, p. 434). A non-depressed audience encounters the deathly depictions of
Esther’s world and provides a radical presence to her critique of 1950s American Dream of
domesticity as a kind of “death” and psychiatric treatment as both a masculine punishment and a
personal hell. The ominous character of the novel’s episodes harkens death, deadening, and
disintegration by the use of highly figurative language, style, and form. Making sense of an
ineffable disordered experience, Esther’s personal sphere becomes the “bud” from whence “form
unfolds like a blossom” (Bakhtin, 1990, p. 24).

Styron’s *Darkness Visible* as a whole makes use of its figurative and metaphorical
passages to generate a dissociative style and tone. Styron is responding to those who would
blame depression on personal, moral failing. Writing in early moments of the biomedical
revolution, he finds in biomedical discourses the view that depression is a biological disease, like
cancer, and thus any moral judgment or culpability assigned to its sufferers is to be challenged. A
non-depressed audience is invited to encounter what “depression is really like” (Styron, 1990, p.
32) through a dissociative style and tone demarcating two senses of selfhood: the healthy (i.e.,
“real”) Styron and the depressed (i.e., apparent) Styron.

*An Unquiet Mind*, in a broad sense, makes use of its figurative and metaphorical passages
to generate a humanizing tone through a recurring use of *meiosis*, or a rhetorical style of
understatement through comedic framing and strategic juxtaposition. Drawing on her own
experience of living with a mood disorder, Jamison’s comedic style responds to the public
stigma of biomedical essentialism by arguing for empathy in clinical practice while also
questioning the value of “being normal” to living a meaningful life. Non-depressed audiences
encounter foibles and episodes of living with unstable manias and depressions. And with a sense
of comedic (and tragic) awareness, her narrative is wrought with comic correctives that
demonstrate a “maximum consciousness” that “transforms her foibles [her malfunctioning biology] into assets” (Burke, 1984b, p. 171).
CHAPTER 4

THE RHETORICITY OF MOOD MEMOIRS: BIOMEDICAL DISCOURSE AND…

Cynthia Lewiecki-Wilson (2003) argues that rethinking rhetorical theory by “thinking through mental disabilities” can offer revised understandings of rhetoricity and the public sphere (p. 164). In the spirit of such “rethinking,” I apply the “spheres of argument” model to the very personal genre of mood memoirs as a way of counter balancing the public-centric spirit that informs much use of Goodnight’s model. Few rhetorical analyses fully explore the utility of the spheres of argument model for disclosing the rhetorical dimensions of personal, autobiographical aspects of mental illness. As I am also interested in exploring the ways the biomedical revolution in psychiatry shapes the rhetorical actions and choices of the autobiographical acts of Plath, Styron, and Jamison, this chapter uses the spheres of argument model to help disclose those rhetorical dimensions in *The Bell Jar*, *Darkness Visible*, and *An Unquiet Mind*.

What follows is an examination of how these autobiographical acts work as rhetorical texts. Each author is presenting a case, an argument about a difference they want to see in the world. Their personal experience as sufferers of mental illness has imbued their words with a kind of prescience, if not, certainly a felt charge to speak out on some perceived ill. I examine key passages of these autobiographical acts that suggest how each author’s personal sphere is positioned against, with, and alongside technical and public discourses to meet rhetorical exigencies of their time.

The Spheres of Argument Model

I will be using the concepts public, technical, and personal when referring to spheres of discourse and grounds of appeal. A brief review of the specific way I will employ these terms,
as well as an understanding of their interactive nature, would be useful before moving on, for the sake of clarity and to allow the richness of these works to show itself.

In 1982, in the *Journal of American Forensics* (today known as *Argument and Advocacy*), Thomas Goodnight offered a standout essay about “spheres” of argument. This award-winning account distinguishing the norms and expectations that ground rhetorical behavior in the personal, technical, and public spheres would recontextualize the notion of argument fields and generate over “30 years of influence” (Rowland, 2012). Spheres of argument are ways of talking about the conditions of appeal that undergird rhetorical behavior, evaluation, and proclivities. Goodnight (2012) explains,

> Differences among the three spheres are plausibly illustrated if we consider the differences between the standards for arguments among friends [i.e., personal sphere] versus those for judgments of academic arguments [i.e., technical sphere] versus those for judging political disputes [i.e., public sphere]. (p. 200)

Arguments in the personal sphere affect those involved in the interaction. They are also the ones most eligible to participate in deliberations. The expertise required in the give and take of evidence is really their familiarity with one another and maybe the history of their relationship and even emergent resources in the moment that can be used with “strategic guile” (Goodnight, 2012, p. 201). The evaluation of arguments in the personal sphere are often just as “ephemeral” and dynamic as the evidence presented and may even never have a definitive conclusion so much as being open to further discussion. Arguments in the technical sphere, however, affect persons who are familiar with specialized knowledge, issues, and have specialized training. Those “in the know” or with specialized training are most eligible to participate in deliberations. The expertise required is familiarity with recent research and things like knowing the norms of formal
appeal found in any particular technical field. The evaluation of arguments in technical spheres is often left to recognized “referees” (Goodnight, 2012, p. 202). And unlike either the personal or technical spheres, the demands of proof in the public sphere are open and generalized as appeals are grounded in matters of the common interest. Anyone affected by public policy or the debate can be active participants, as arguments are evaluated largely through socially shared knowledge.

Goodnight’s early essay was not simply useful for its taxonomy but also rightly recognized as a “warning” (Zarefsky, 2012, p. 214). Goodnight (2012) felt that civic participation and the public sphere were “being steadily eroded by the elevation of the personal and technical groundings of argument” (p. 205). Writing in the Cold War 1980s, Goodnight (2012) was concerned about “unanticipated missile launchings, ozone depletion and atomic power incidents,” and new media technologies that transformed the public sphere “…into fragmented groups” (p. 206). This led to political rhetorical strategies arguing more from “groundless” ideographs and personality rather than offering substantive debatable options and discourse. The art of public deliberation as civic discourse practiced by common citizenry about “issues of significant public consequence” was being weakened as “important matters of policy or value were wrongly treated as narrow technical questions” (Zarefsky, 2012, p. 214).

Instrumental reason and increased specialization gave way to a political technocratic rhetoric milieu and a public more apt to evaluate personalities rather than substantive, grounded arguments.

Goodnight’s article would be commemorated in yet another special issue of *Argument and Advocacy* in 2012. The authors in the 2012 commemorative article celebrating Goodnight’s theory share concerns about an eroding public sphere, as each examines how the public sphere is
affected by the elevation of, or interaction with, technical or personal grounds of argument. In short, there is a public-centrism characterizing each article.

Edward Schiappa’s (2012) essay analyzes California’s Proposition 8 legislation defining marriage as between a man and a woman. His analysis looks at how “the norms and practices of constitutional argument in the technical sphere filter out specific arguments…that are prevalent in the public sphere over Proposition 8” (Schiappa, 2012, p. 216). As such, he wants to take this opportunity to argue that the role of the rhetorical critic is to work for the enhancement of “audience competence in the public sphere.” Speaking of enhancing the competence of the public sphere, Nicolas Paliewicz (2012) analyzes the global warming debate to offer the public sphere standards for evaluating the authenticity and worth of technical claims. His essay argues that the public sphere can often usurp technical claims and thus “threatens sensible decision making in the public sphere” (p. 232). Rachel Avon Whidden’s (2012) essay gives the most attention to the personal sphere. Her essay examines how pharmaceutical companies manufacturing HPV vaccines use personal appeals to support technical claims. This “colonization” of the personal by the technical is a problem for her just as much as the encroachment of the personal sphere into evaluating claims in technical and public spheres. For her, the “encroachment of one sphere on another” affects how people evaluate decisions and arguments about public health (Whidden, 2012, p. 243). Whidden, like the others, frames the importance of her study in terms of its implications for the public sphere. Each article pays homage to the spirit of Goodnight’s original concerns about the influence of technical and personal spheres as contributing to a decline of public discourse and deliberation.

What I have wanted to show in this brief review is the public-centric and technical-centric focus characterizing the use of the spheres of argument model. The personal sphere gets
short swift or subordinated attention as scholars are focused on teasing out possible reasons for a
decline in the quality of public discourse. It’s as if the personal sphere is treated as a
contaminant of public discourse or as contaminated by technical discourses. Though research
using the spheres of argument model has been fruitful for the past 25 years, what is lacking is in-
depth attention to the personal sphere itself. Again, in the spirit of “rethinking rhetorical theory
by thinking through mental illness,” I turn to the personal case of mood memoirs to demonstrate
one way the personal sphere might serve as an asset for enabling public discourse rather than one
of its contaminants. In particular, this chapter seeks to demonstrate how technological discourse
surrounding mental illness enters into public discourse through personal means as well as how
personal voices engage technical and public discourses. In due course of narrating their personal
experience of mental illness each author makes use of available technical and public discourses
of their time, both as invention resources and as dialogical interlocutors.

By adopting this approach to these works, a rhetorical perspective is opened on an
important technological innovation that has fundamentally shaped the way the public and
individuals relate to their moods and/or mental illness. As of right now in 2015 U.S. culture,
biomedical understandings of mental illness are a normative feature of public and technical
discourses on mental illness. This chapter thus offers important perspective on how gifted
communicators strategically channel extra-verbal aspects of their experience of depression
through technical and public discourses at three key moments in the biomedical revolution: prior
to the arrival of biomedical understandings of mental illness within public discourse (1960s),
directly in the early stages of its introduction to public awareness (1980s), and some five years
after biomedical discourses had become a regular feature of public and technical talk about
mental illness (1995). Said very simply, what follows is an analysis of the rhetorical influence of biomedical discourses on these author’s personal expression, sense making, and critical aims.

First, I present how these texts offer differing perspectives on the source and cause of their suffering. Second, I demonstrate the critiques of public and technical spheres offered by each author, given the causes they identify as sources of their suffering, as well as how their place and moment in the biomedical revolution shape their critical perspectives. Third, I present how these texts argue for increased technical and public “empathy” for individuals suffering breakdowns in mood. Finally, I demonstrate how each author relates to their mood disorder, owning their disorder in differing degrees.

**Biomedical and the Source of Suffering: Attributions of Differing Degrees of Suffering**

As seen in Chapter 3, Plath, Styron, and Jamison each offer an account of the “disorder” of their disorder as a loss in the ability to respond to their world in normative ways. This inability to respond is organized around “death” as a metaphor and other figurative passages. Furthermore, this inability to respond to everydayness becomes an existential and radical ground for critique. Before demonstrating the critical work made possible by this moody alienation from normative everydayness, I first explore how each author attributes their suffering to differing causes and, indeed, even offer differing senses of what is being suffered in their “suffering.” This is an important step because it demonstrates the influence of biomedical discourses on how each author makes sense of the causes of their suffering, and, therefore, influences the solutions they identify for alleviating the public and technical ills they perceive.

Considerable differences exist in how Plath, Styron, and Jamison identify and portray the cause of their suffering. To get a sense of just how differently these authors frame the cause of their suffering, it is wise to begin with Plath. Recall from Chapter 2 that Plath writes before
biomedical explanations of mental illness were commonplace. In one sense, then, Plath’s book acts similar to a “control group,” that is, a sample unmanipulated by biomedical discourses about mental illness. As such what follows is an analysis of representative passages from *The Bell Jar* that will be, at times, read against Styron and Jamison, who write from within the biomedical discourse era. Nonetheless, at other times, I read *The Bell Jar* alongside and with Styron and Jamison. In short, I begin demonstrating the nuanced differences of how Plath, Styron, and Jamison attribute the cause of their suffering by giving an account how the literary gifted Plath gives expression to her experience of being “depressed” in a pre-biomedically depressed world.

Plath channels the “disorder” of her disorder through a rhetorical style that was fitting for her time and the public and technical discourses surrounding rhetorical situation. You can gain a sense of *The Bell Jar’s* rhetorical dimensions by starting at the end of the book. Esther, having survived depression, suicide, electroconvulsive therapy, and psychiatric hospitalization and treatment is reflecting on key events from her life, now with the insight born of hard-won suffering.

Dr. Nolan had said, quite bluntly, that a lot of people would treat me gingerly, or even avoid me, like a leper with a warning bell. My mother’s face floated to mind, a pale, reproachful moon… A daughter in an asylum!... “We’ll take up where we left off, Esther,” she had said… “We’ll act as if this were a bad dream.” A bad dream. To the person in the bell jar, blank and stopped as a dead baby, the world itself is the bad dream. A bad dream. I remembered everything. I remembered the cadavers and Doreen and the story of the fig tree and Marco’s diamond and the sailor on the Common and Doctor Gordon’s wall-eyed nurse and the broken thermometers and the Negro with his two kinds of beans and the twenty pounds I gained on insulin and the rock that bulged between sky
and sea like a gray skull…they were a part of me. They were my landscape. (Plath, 1996, p. 237)

This passage contains “cases of argument” when viewed as a piece of rhetoric engaging both public expectations of female domesticity in the 1950s and anti-psychiatric undercurrents of the 1960s. The first case of argument responds to public stigma, concerns for societal propriety, and the pressures of meeting a feminine domestic ideal, here represented by her mother’s concerns about being judged by others for having a daughter in an asylum. The second case highlights her experience of dehumanizing forms of psychiatric treatment, here represented by the recounting of horrific treat in the figure of a “bad dream.” The overall message of both cases seems to be: “society makes me crazy.” So, the pathway Plath takes to bring presence to this view is to memorialize moments from her personal experience of depression to work as affective rhetorical backgrounds that assist in foregrounding a critical augmentative case about public and technical worlds. But there is one more case being made at a very deep and implicit level within the text, though not so obvious from this passage. The Bell Jar also makes a case for the adoption of a biomedical discourse on mental illness. This case is remarkable considering that it comes 50 years before public and technical views of mental illness as an amoral, disease condition become commonplace.

The growing loss of agency (i.e., inability to respond) and world-significance are attributed to the felt pressures Esther encounters as her own internal desires for careerism and freedom clash with the normative expectations of female domesticity in the 1950s. Esther’s ever growing detachment from what is “normal” creates a rhetorical dimension to the narrative as Plath (through Esther) builds an affective case that expectations of being a woman are a
significant cause of her distress. One way she builds her case narratively is her portrayal of the
other girls participating in her summer internship.

This hotel – the Amazon – was for women only, and they were mostly girls my age with
wealthy parents who wanted to be sure their daughters would be living where men
couldn’t get at them and deceive them; and they were all going to posh secretarial schools
like Katy Gibbs, where they had to wear hats and stockings and gloves to class, or they
had just graduated from places like Katy Gibbs…these girls looked awfully bored to me.
I saw them on the sunroof, yawning and painting their nails and trying to keep up their
Bermuda tans, and they seemed bored as hell…simply hanging around New York waiting
to get married to some career man…Girls like that make me sick. I’m so jealous I can’t
speak. Nineteen years, and I hadn’t been out of New England except for this trip to New
York. It was my first big chance, but here I was, sitting back letting it run through my
fingers like so much water. (Plath, 1996, p. 4)

Esther cannot grasp the opportunity she is living through and allows it to metaphorically run
through her fingers. The theme again of Esther’s detached participation in normative, work-a-
day living imbues narrative authority to her critical view of career and life choice norms
expected of women in the 1950s. The ungraspable nature of her experience allows the gradual
losses of internal senses of efficacy, desire, and want-to to always haunt the content of Esther’s
personal judgments and views throughout the book. Esther expresses having no desire for the
typical jobs designated to women in the 1950s, like stenography, typing, or secretarial work, and
least of all to “serve a man.” Indeed, consider the “deathly” way she depicts such a life in the
above passages. Dead babies, bad dreams, and suffocating bell jars become radical metaphorical
expressions of what, in her time, were normative expectations of nationalistic goods:
domesticity, motherhood, and the American dream. So why does she express jealousy of these girls in this passage? Esther is jealous less of the charmed lives of these girls (though certainly this is the case), but more so that, while these girls are also missing out on their own opportunities for self-actualization (rather than living out gendered expectations norms), they do not seem to care very much about this, indeed, they seem all too comfortable to live out their gendered expectations. Esther is jealous that other girls are, to her, living without the felt senses of ambition that complicate her world. Indeed, throughout the text, Esther wishes she could be “normal,” that she could just comfortably live out those gendered expectations. Esther wants to fly easily into worldly concerns, but just can’t.

As Esther experiences deteriorating senses of the ability to respond to her world and losses of motivation and action, she attributes the cause of her distress to these felt pressures to live up to gendered domesticity norms 1950s. She uses descriptive, figurative, and metaphorical styles that function as catachresis (as one might expect from a poet). Plath provides a perspective by incongruity as she aligns these inner senses of loss with depictions of how “deathly” it feels to be an ambitious woman in 1950s America. Writing not only in pre-biomedical times but also “pre-women studies” (before the publication of The Second Sex), Plath’s novel argues, again, seems to give the impression that society makes her crazy.

The suffering of Plath can be seen as a kind of socio-politically grounded suffering. Lacking a biomedical discourse for making sense of encroaching depressive symptoms, her sense-making turns to the world around her and her own choices and decisions. It is through the use of radical metaphors that her narrative portrays how it feels to be in her world. Without a biomedical discourse, her world retracts into her immediate, concretely lived-experience. In short, her suffering is ontological in the sense that it has to do with her being in the world. Her
depression is attributed to her desires to live in a way that is counter to public norms of female domesticity. Society is portrayed as both the source of her depression and the exacerbation of its pain. Unlike Styron, who writes at a time when depression is a biomedical disease, a medical condition, for Plath there is not her depression (as a clinical category) and society’s impact upon it. Her depression and her feelings of blocked desires for careerism are one and the same. What we will see soon is, having so identified the source of her suffering in a social-political realm, Plath’s narrative thus conducts a critique of public domesticity norms and psychiatric care on the basis of socio-political considerations.

By reading Styron in light of Plath, we gain further insight on how biomedical discourses shape rhetorical invention because by reading Styron is writing at the beginnings of the biomedical revolution. In Styron’s case, the growing loss of the ability to respond to his world is attributed to brain chemicals, not inner, ontological desires. Styron (1990) writes,

But never let it be doubted that depression...is madness. The madness results from an aberrant biochemical process....with all this upheaval in the brain tissues...it is no wonder the mind begins to feel aggrieved, stricken, and muddied thought processes register the distress of an organ in convulsion....a disturbed mind will turn to violent thoughts...with their minds agonizingly inward, people with depression are dangerous only to themselves. (p. 47)

Throughout the text are Styron’s observations about depression such as this one above. It represents the way his narrative relies on a biomedical model for his understanding of depression’s cause and operation. Within this passage is a confused melding of brain (a biological organ) and mind (a social process) as Styron employs a dissociative style to explain how depression works directly upon the brain to disturb what would otherwise be a rational
mind. This dissociative style works to turn depression into an entity that is foreign to the natural body. Styron portrays depression as not natural, a distinction that would seem to not be readily available for Plath. In fact, Styron writes that, given enough time, “depression” itself will “sap” and “drain” the body of its “juices.” Both body and mind are affectively brought out of their normative reality and practical relation to the work-a-day world as the entity “depression” disrupts their chemical foundation. Styron has recourse to a biomedical explanation for his suffering. Plath’s only recourse to understand her suffering is to understand it as a socio-political suffering. There is no rhetorical recourse to a biochemical narrative that might account for her suffering. If given enough time of such suffering suicide seems a viable palliative.

Whereas Plath is left to understand her suffering as an amalgam of blocked inner desires that are in opposition to her time, Styron is well invested in using emerging biomedical discourses to understand his inner personal sphere. Take, for instance, how he explains the disordered shifts in his experiences. He writes:

…Unwilling to accept its own gathering deterioration, the mind announces to its indwelling consciousness that it is the body with its perhaps correctable defects –not the precious and irreplaceable mind –that is going haywire…such madness is chemically induced amid the neurotransmitters of the brain, probably as the result of systemic stress, which for unknown reasons causes a depletion of the chemicals norepinephrine and serotonin, and the increase of a hormone, cortisol. (Styron, 1990, pp. 44–47)

Styron’s turn to the body is wholly consistent with his dissociative emphasis on claiming primary reality for biomedical explanatory frames. The sine qua non of the biomedical model is the body of a very lifeless type and not of the actively social, embodied, desiring, or “real life” type. As Frank (2002) writes, when a person becomes a patient, physicians take over her body, and their
understanding of the body separates it from the rest of life (p. 52, cited in Marcum, 2008). The tone of Styron’s unique, actual personal sphere of disordered experience is subordinated as he depicts the body as an assemblage of technical hydraulic systems of chemical flows. As Alastair MacIntyre (1979) observes, to view the human body as “an assemblage of bodily parts and processes is to deprive the patient…of every moral as well as every social dimension (p. 90). Styron “the biomedical patient” is portrayed as a passive object in an environment.

These passages from Styron’s narrative reveal how depression as “an entity that effects brain chemical flows” becomes a way for him to understand his disordered moods, given newly available rhetorical resources funded by emerging biomedical discourses. Read in light of Plath’s lack of such rhetorical resources, Styron’s narrative demonstrates how biomedical discourses fund a dissociative style for narrating one’s suffering. Indeed, as we will soon see, Styron will use this amoral discourse to support his critique of moralistic views on depression. It is first instructive to continue noting the differences in how Plath and Styron attribute causes to their suffering.

Whereas Plath’s narrative identifies an ontological suffering of depression attributed to socio-political conditions, the dissociative style of Styron’s narrative allows him to portray an additional kind of suffering and its cause. Styron’s narrative identifies a suffering of suffering attributed to public moralistic views of depression that blame the sufferer for their suffering. The cause of this suffering is attributed to a lack of words that can accurately communicate the suffering of depression to other people. Consider how Styron amplifies the way “depression” eludes words that communicate its suffering accurately.

This leads me to touch again on the elusive nature of such distress. The that word “indescribable” should present itself is not fortuitous, since it has to be emphasized that if
the pain were readily describable most of the countless sufferers from this ancient affliction would have been able to confidently depict for their friends and loved ones (even their physicians) some of the actual dimensions of their torment, and perhaps elicit a comprehension that has been lacking…due not a failure of sympathy but to the basic inability of healthy people to imagine a form of torment so alien to everyday experience.

(Styron, 1990, p. 16–17)

Throughout the book, Styron’s refers to the “elusive,” “indescribable,” and “mysterious” nature of depression, and in this account he links it directly to an implied philosophy of communication and everydayness. The timeless nature of the disorder amplified by the alliterated “ancient affliction” provides a sense of its long history of incomprehensibility. Dissociation is used to highlight the cause of this incomprehensibility, namely that those suffering depression experience a world that is unimaginable to everyday, normal experience. This suffering is an “ontical” suffering, or what we might refer to when public and technical discourses exacerbate the ontological pain of depression.4

The above passage also betrays Styron’s understanding of communication. Communication is a linear process that he assumes is made possible by linguistic transparency. But because the suffering of depression eludes words, the “blues which people go through occasionally” (Styron, 1990, p. 7) can only give a “hint” of depression’s suffering and thus cannot offer sympathetic grounds for communication. So just as the ontological pain of feeling alone in the world and disconnected from other people settles in during depression, Styron

4 The ontic-ontological difference is a philosophical theme that emerges in Martin Heidegger’s Being and Time (1966). I use the terms here in a related way, but not in a philosophically rigorous way. Ontical refers those to any concrete, discernable external factors, things, or others that contribute to suffering. Ontological refers to the extra-verbal inner senses of suffering characterizing one’s inner sense of being in the world.
identifies an additional ontical suffering of his suffering in being unable to express his pain fully to people and physicians.

Styron does not attribute this ontical suffering to socio-political conditions, as Plath does. He attributes his suffering to a lack in the English language to accurately communicate the pain of depression, especially to those who have never experienced its suffering. Once more in a dissociative style, Styron subordinates the experience of depression for its sufferers as mere “appearance” and as such privileges the reality of normative moods of everyday living as a primary value. This works to generate an “insider vs. outsider” narrative (cf. Styron, 1990, p. 25). There are those who have experienced depression and those who have not. Styron blames the word “depression” itself as contributing to this lack of social sympathy and understanding. For instance, consider how Styron shares the first time he felt he lacked linguistic resources for communicating his suffering. He writes that the first time he was “laid low by the disease” he instantly “felt the need” to “register a strong protest against the word depression” (Styron, 1990, p. 36). Styron refers to depression as a true “wimp of a word,” especially when compared to the actualities of the lived-experience of depression. He prefers the more ancient “melancholia.” But melancholia, Styron (1990) writes, was

…usurped by a noun with a bland tonality and lacking any magisterial presence, used indifferently to describe an economic decline or a rut in the ground…the word has slithered innocuously through the language like a slug, leaving little trace of its intrinsic malevolence and preventing, by its very insipidity, a general awareness of the horrible intensity of the disease… (p. 37)

The cause of his ontical suffering is that “the uninformed layman” often is unable to display sympathy to his suffering. Instead his suffering is met with “the standard reaction that
‘depression’ evokes, something akin to ‘So what?’… ‘We all have bad days’” (Styron, 1990, p. 38).

Unlike Plath, Styron’s biomedically funded dissociative style can enact a rhetorical process similar to a process of scapegoating, wherein his depression is rhetorically “perfected” into an entity to blame and sacrifice. Styron’s narrative portrays “depression” itself as some “thing” accountable for ontological suffering, choices, and disordered thoughts and actions of a depressed person. Plath is left to blame society and her own desires for her suffering. Society makes her crazy. Society does not make Styron crazy, brain chemicals do. In this sense, Plath’s narrative lacks a comparable dissociative way of making sense of her depression. Brain chemicals are the source of Styron’s ontological suffering. Styron stands rhetorically with technical grounds of appeal and not simply public, socio-political grounds. Having a biomedical discourse for an invention resource means attributing the cause of his ontological suffering to socio-political conditions is not the first thing he considers. More still, whereas for Plath society is the source of both her ontological and ontical suffering (indeed, there is no distinction), a biomedical discourse allows Styron a dissociative style of sense-making to bifurcate his suffering into biological kinds (ontological) and social kinds (ontical). Chemicals make him crazy, but society’s lack of sympathy, due to a lack of clear communication and language, makes him suffer.

Given the purposes Styron has for writing his memoir of depression and his reliance on newly emerging biomedical discourses, his lack of attention to the socio-political compared to Plath is understandable. We will see, however, that Styron nonetheless does offer critiques of public and technical discourse in the course of sharing his experience of living through depression. But until then, it is first necessary to gain further insight into how biomedical
discourses shape rhetorical invention by reading Jamison, who writes after the biomedical revolution had become a normative feature of public and technical discourse.

Jamison’s narrative is something of a skeleton key for deepening our understanding of Plath and Styron. But Plath and Styron are also heuristic when reading Jamison. Plath attributes her suffering to her personal desires and societal conditions that block her. For Plath, it is key for her narrative case that she portrays how it feels to be blocked by domesticity norms. Styron attributes his ontological suffering to chemicals, and his ontical suffering to a lack in language to cultivate sympathetic responses from others. For Styron, it is key for his narrative case that he portrays the upheavals of rational thought as symptoms of a biomedical condition. Jamison, writing as a technician, attributes her ontological suffering to chemicals and her ontical suffering to technical discourses that fund rhetorics of dehumanizing biological determinism. For Jamison (1995), it is key to her case that she portrays how manic-depressive disorder is “…an illness that is biological in its origins, yet one that feels psychological in the experience of it” (p. 6). Jamison’s narrative contains elements of Plath’s focus on feeling and Styron’s focus on the biomedical-based dissociation, but adds her own unique style as she responds to a different moment in the biomedical revolution.

Jamison’s loss of active agency in her world, as well as her disordered ecstatic senses of agency in her world, are attributed to brain chemicals. She is aligned with Styron’s view on this point. But unlike Styron, Jamison’s ontical suffering is attributed to episodes of dehumanizing judgments by other technicians and a public who too earnestly adhere to biomedical understandings of her personhood. Rather than attribute this lack of empathy to a lack of linguistic resources for communicating depression’s pain as Styron does, Jamison challenges Styron’s view that a lack in language is a source of stigmatizing suffering.
But the question also arises whether, ultimately, the destigmatization of mental illness comes about from merely a change in the language or, instead, from aggressive public education efforts; from successful treatments…from discovery of the underlying genetic or other biological causes of mental illness; from brain-imaging techniques, such as PET and MRI (magnetic resonance imaging) scans…from the development of blood tests that will ultimately give medical credibility to psychiatric diseases; or from legislative actions, such as the Americans with Disabilities Act, and the obtainment of parity with other medical conditions under whatever health-reform system is put into place.

Attitudes about mental illness are changing, however glacially, and it is in large measure due to a combination of these things… (Jamison, 1995, p. 183)

In addition to this, she explains that “there is a need for freedom, diversity, wit, and directness of language,” and that the issue is one of “context and emphasis” as too often the highly precise language needs of science get mixed together with the fears and misunderstandings of the public to generate a “divine confusion” (p. 181). Writing five years after the biomedical revolution had begun to make its presence felt in public discourse and technical practices, the problem for Jamison is not that language is unable to communicate the suffering of a mood disorder, but that a biomedical discourse often dominates how the expressions of disordered moods and persons are understood. For Jamison, when biomedical understandings become too totalizing of a personhood this leads to “ignoring the positive role of wit and irony as positive agents of self-notion and social change” (Jamison, 1995, p. 180). Whereas Styron would want to emphasize biomedical language as an agent of “self-notion” and “social change,” Jamison attributes her ontical suffering to a lack of a comedic corrective to the totalizing attitudes of biomedical discourses. Comic correctives are rhetorical attitudes that demonstrate a “maximum
consciousness” of self and world that transforms “foibles” into “assets” (Burke, 1984b, p. 171). One of their functions rhetorically is to break through monological discourses to allow more novel and dialogical discourses to be opened. Her ontical suffering is attributed to biomedical discourses that block ironic and non-totalizing ways of talking about disordered moods not only in public and technical spheres, but also, most importantly, in one’s own “self-notion.” To this end, Jamison’s narrative employs a comedic style of strategic juxtaposition of humanizing allusions, themes, and images.

The “wit,” “freedom,” and “irony” needed for speaking about abnormal states and behavior is reflected in both form and content in Jamison’s narrative. Her ontical suffering is portrayed as “foibles” that her narrative stylistically transforms into “assets” along her life’s way. Jamison (1995) shares that she has been a lifelong student of moods because, “It has been the only way I know to understand, indeed accept, the illness I have…” (p. 5). Unlike Plath or Styron, Jamison’s case is built on portraying how she has cultivated acceptance of her suffering. For instance, she observes that

Manic-depression is a disease that both kills and gives life. Fire, by its nature, both creates and destroys…Mania is a strange driving force, a destroyer, a fire in the blood. Fortunately, having fire in the blood is not without its benefits in the world of academic medicine, especially in the pursuit of tenure. (Jamison, 1995, p. 123)

The comedic allusion of mania juxtaposed with the academic pursuit of tenure and the analogizing of manic moods to the nature of fire is used to acknowledge the seriousness of her disorder while also comedically amplifying other possible interpretations of her disorder. Jamison (1995) also observes, “The disease that has, on several occasions, nearly killed me does kill tens of thousands of people every year: most are young, most die unnecessarily, and many
are among the most imaginative and gifted we as a society have” (p. 5). Accepting that she has manic-depressive disorder begins with transforming her suffering into an asset and is performed rhetorically in this passage through the juxtaposition of the facticity of death with the transcendent value of imagination. Her strategic use of juxtaposition continues,

The Chinese believe that before you can conquer a beast you first must make it beautiful…I have tried to do that with manic-depressive illness. It has been a fascinating, albeit deadly, enemy and companion…a distillation both of what is finest in our natures, and of what is most dangerous. (Jamison, 1995, p. 5)

Alluding to Eastern, dialogical perspectives, Jamison’s style of juxtaposition works to amplify two aspects of her disorder, namely its facticity as an illness and its transcendence as an enhancement of her selfhood. Unlike Styron’s dissociative style that sets up an either/or binary between appearance and reality, these passages are representative of Jamison’s comedic approach that in essence allows for a both/and perspective. The result of this comedic “maximum consciousness” is that it allows Jamison to push against totalizing biomedical attitudes. Thus, unlike Styron, Jamison’s narrative portrays how she has learned to accept that she is her mental illness, but also that she is not just her mental illness. Writing directly at the start of the biomedical revolutions, Styron’s narrative argues that he is not his illness. And Plath, lacking a biomedical discourse, just suffers her disorder as felt pressure and blocked desires in the world.

Jamison’s ontological suffering is attributed to biochemical processes, but her ontic suffering is attributed to a lack of comedic correctives for public, technical, and personal attitudes that rely only on the letter of biomedical discourses. Her comedic style funds her rhetorical choice of highlighting the role of wit, irony, and freedom as ways she has learned to
accept her disorder as a part of her life. Unlike Styron or Plath, it is not simply that society makes her suffer but that her well-humored perspective manages her suffering. Without denying the biomedical status of mental illness, Jamison’s comedic style plays with the distinction between technical knowledge and personal experience. This is highly significant. As a trained psychologist, this juxtaposition offers a means for her to express the felt difficulties of weaving “together the scientific discipline of my intellectual field with the more compelling realities of my own emotional experiences” (Jamison, 1995, p. 7). Unlike Styron, but very much like Plath, Jamison’s narrative tends to emphasize her personal feelings and experience of the disorder alongside her technical understanding of the disorder. As both a clinician who treats and studies mental illness as well as a sufferer of mental illness, the personal and the technical are in tension in Jamison’s narrative in a way that it is not in Plath or Styron.

**On Being Normal: Critiques of Public Practices**

Having covered the ways each author portrays the nature of their suffering and the causes of their suffering, another rhetorical dimension of the autobiographical acts of Plath, Styron, and Jamison is how their narratives function as critiques of technical and public discourses and practices. Beginning with their critiques of public norms and values, each author identifies a tension when their disordered moods clash with normative public expectations. Each author’s critique is rhetorically shaped in ways that reflect the influence of the evolution of biomedical discourses, or lack thereof in the case of Plath. The specific style of their critique also sheds light on how biomedical discourses guide rhetorical invention in responding to the exigencies of their time. It is instructive to start with Styron, move to Jamison, and finish with Plath.

Earlier, I noted that, unlike Plath, Styron’s ontical suffering is not attributed to socio-political conditions but to a lack in public understanding of biomedical discourses that reveal
depression to be a biological illness, as well as a lack of language for communicating the depth of its suffering. Implied in Styron’s critiques of public views is thus the idea that if people could just be educated about depression’s biomedical status and its pain, then people might no longer blame the victim of mental illness for their suffering, their choices, and their decisions. He does not critique social-political conditions. Relying on biomedical discourses, Styron instead portrays depression as an entity that corrupts rational control. Portraying depression in a dissociative style not only allows him to scapegoat depression for the “irrational” actions and choices he makes but also generates implied critiques of public norms of propriety and empathy.

What specifically “acting rationally” means for Styron is revealed in narrative passages describing the consequences of some of his irrational choices. This is a key rhetorical move if Styron is going to be successful in shifting the burden of responsibility away from his actions and choices and onto depression itself. Thus, we read of Styron’s trip to France to accept an award for his literary accomplishments.

I wasn’t cheered by the festive occasion that had brought me to France…I had suffered more and more from a general feeling of worthlessness as the malady had progressed. My dank joylessness was therefore all the more ironic because I had flown on a rush four-day trip to Paris in order to accept an award which should have sparkingly restored my ego. (Styron, 1990, p. 5)

In the example above, Styron’s narrative makes use of the hallmark dissociative move, the appearance-reality pair. He notes the “irony” that he could not be cheered by an occasion that “in reality” is festive. Styron, aware of the normative rhetorical significance of the occasion, could not bring himself to react, to use the award as something available or useful for ego-gratification or simply for celebration. Styron continues to tell about how Simone De Luca, the
award’s namesake, became “incredulous and eventually enraged” when he said that he would not be joining her and the award-granting academy for a luncheon in his honor.

My refusal was both emphatic and simpleminded; I told her point-blank…of course this decision was outrageous…but my behavior was really the result of the illness, which had progressed far enough to produce some of its most famous and sinister hallmarks: confusion, failure of mental focus and lapse of memory. (Styron, 1990, p. 14)

The emotional shifts in the rhetorical tone of an immediate, actual, and unfolding personal sphere is subordinated by an implied dissociative style that frames lived-experience as mere appearance and not reality. But what is reality is what is being hidden by the illness, namely rational thought and control over actions and choices. More still, the inclusion of how “point-blank” and “emphatic” was his refusal, Styron amplifies the way depression deceives the rational mind into thinking appearance is “reality.”

For Styron, being “rational” means being able to participate in the impression management of everyday life, to be mindfully aware of performing up to the expectations of others and occasions. Rationality is being able to consciously manipulate impressions found in what Erving Goffman (1982) calls “rituals of interaction” that exist between self, others, and occasions. However, akin to Plath, as Styron’s world begins to lose its meaningfulness, deadening and deathly imagery begins to fill the void when normal, mindless everyday coping with others and occasions begin to lose value. He begins to feel himself in the world but not of the world—able to feel emotional-volitional connections to normative meanings.

In Chapter 3, we reviewed how each author portrays the disorder of their disorder in terms of deadening loss of the ability to react in their worlds. Styron’s narrative portrays this growing lack of agency as a loss in “rational control.” Hence, he describes some of his
experiences of being depressed as living in a “trance” (Styron, 1990, p. 17), a prototypical image of a person not in control of his or her own choices and actions. Indeed, the metaphor of “trance” is used to shape how Styron describes his own growing thoughts of suicide.

…during one of those insomniac trances that there come over me the knowledge …that this condition would cost me my life…Death…was now a daily presence, blowing over me in cold gusts…plainly the possibly was around the corner, and I would soon meet it face to face. (Styron, 1990, p. 50)

Styron offers a justification for this mental event again in the dissociative form.

…in ways that are totally remote from normal experience, the gray drizzle of horror induced by depression takes on the quality of physical pain. But it is not an immediate identifiable pain, like that of a broken limb. It may be more accurate to say that despair, owing to some evil trick played upon the sick brain by the inhabiting psyche, comes to resemble the diabolical discomfort of being imprisoned in a fiercely over heated room. And because no breeze stirs this cauldron, because there is no escape from this smothering confinement, it is entirely natural that the victim begins to think ceaselessly of oblivion. (p. 50)

The motive for thinking of suicide is to end the suffocating pain of depression. Echoing Sylvia Plath’s experience of being under a bell jar, Styron’s narrative grounds depression’s suffering in senses of remoteness from a colorful reality of normal experience with the beautifully syncopated expression: “gray drizzle of horror.” Biomedical “reality” understands the brain as literally sick. But the “apparent” psyche plays “tricks” on its normal rational functioning. Imagery of stuffiness and suffocation of a heated room works to analogize Styron’s experience of the constant, persistent, and uncontrolled pain that, for him, “naturally” leads to obsessive
thoughts of death. Suicide, for Styron, seems a “sane” choice in an irrational world, a choice of escape from the pain of being in a depressed world. Given that Styron’s notion of rationality is intertwined with impression management, there is an implicit critique of public pressures in his privileging of “rational” over “irrational.” To be normal is to be “rational,” and to be rational means being able to go on in impression games of polite society. For a pain rooted in a lack of being so abled, Styron’s thoughts turn to suicide.

Having to “put on airs,” to “be on,” to have a “good show” are part and parcel of what is foregrounded when Styron writes of his foibles, faux pas, and trances. It is highly instructive then that what does finally relieve Styron of his depression is hospitalization and time. He writes how his recovery is attributed to the environment of a hospital that allows for

…sequestration, of safety, of being removed to a world in which the urge to pick up a knife and plunge it into one’s own breast disappears…But the hospital also offers the mildly, odd gratifying trauma of sudden stabilization –a transfer out of the too familiar surroundings of home, where all is anxiety and discord, into an orderly and benign detention where one’s only duty is to try to get well. For me the real healers were seclusion and time. (Styron, 1990, p. 69)

This passage functions as a critique of public pressures and public culture. A hospital is seen as a more beneficial alternative than to the anxiety-producing world he must live in. The world, for Styron (1990), is depicted in the following passage:

The hospital should be shorn of its menacing reputation…the hospital is hardly a vacation spot…the one in which I was lodged (I was privileged to be in one of the nation’s best) possessed every hospital’s stupefying dreariness…This was not ameliorated for me by the subairline food or by a peek I had into the outside world: Dynasty and Knots Landing
and *CBS Evening News* unspooling nightly in the bare recreation room, sometimes making me at least aware that the place where I had found refuge was a kinder, gentler madhouse than the one I’d left. (p. 72–73)

Given how Styron has narratively built himself into the position as a sufferer of real madness, his comments help bring presence to the “madness” of everydayness, or, at the very least, of popular culture and current events of an ongoing Cold War. Indeed, Styron (1990) refers to depression as a “simulacrum” of “all the evils of our world, of our everyday discord and chaos, our irrationality, warfare and crime, torture and violence, our impulse toward death…” (pp. 83–84). Irrationality is at the core of the evils of the world. The world as an anxious place of an assortment of chaotic pressures grounds his view of the stability of a hospital as a sanctuary for recovery. Social propriety pressures and global strife are madness inducing.

For Styron, being “normal” means being able to “play” the impression games of social propriety. His suffering is not normal. His thoughts of death are not normal. He is being attacked by his depression and is not in any way responsible for his suffering. Normal means feeling good and able to be an appropriate player in everyday life. The new biomedical discourse promises an amoral perspective on the cause of mental illness and thus requires that one is “sick,” which in practice means unable to unproblematically participate in normal life. Corrective measures are thus directed toward getting better, which for Styron means sequestration and time away from everyday life. He is not, while depressed, normal.

Whereas Styron is willing to be considered a passive sufferer of a disease, by mid-decade a new deterministic attitude toward such biomedical discourses began covering over more humanizing views of those suffering mental disorders. Jamison understands being normal very differently, however. Attributing her ontic suffering to a lack of comedic correctives to
totalizing biomedical discourses, Jamison utilizes a comedic style to critique public sentiments that view the mentally ill as essentially flawed in their humanity by appealing to her ethos as a psychologist living with a mood disorder. In due course of portraying moments where her disordered moods clash with normative expectations, Jamison’s narratives imply critiques of what it means to be “normal” and what it means to living meaningfully at all.

Throughout Jamison’s narrative, the question of “being normal” arises as her moods clash with the ableist expectations of everyday living. Jamison’s narrative is building a case for the importance of acknowledging that mental illness is biomedical in its origins while reconciling that this is not the complete story about the humanity of its sufferers. There is a psychological feeling of “being in the world” of its sufferers that is both important and, in some cases, valuable. Jamison uses this comedic awareness to juxtapose normative reality and disordered reality in a way the foregrounds the “moody” dimensions of everydayness. Such passages generate uncertainty about what “being normal” means in the context of living meaningfully.

Being manic-depressive, Jamison is uniquely positioned to have moods that disclose vivid and extreme experiences that “normal” persons take for granted in everyday life. For instance, she reflects on how remarkable it was that she had passed for so long as “normal.”

I have no idea how I managed to pass as normal in school, except that other people are generally caught up in their own lives and seldom noticed despair in others if those despairing make an effort to disguise the pain. (Jamison, 1995, p. 39)

The imagery of the phrase, “caught up in their own lives,” harkens to what are everyday engrossments and preoccupations that characterize routine moods of work-a-day realities, a sense of being truly pushed and pulled by events, responsibilities, people, and things that matter. At its
core, Jamison passes as “normal” not because people lack empathy, but because people are, in
general and for the most part, fully present in attending to the choices and decisions that make up
the projects of their own lives.

Jamison’s narrative juxtaposes normative reality against her own experiences in a way
that sets up a critique of taken-for-granted, everyday moods undergirding everyday public life.
This moody critique is displayed in passages where Jamison struggles with taking drugs that
would make her “normal.” She recalls her reluctance to taking Lithium because it would mean
giving up the euphorias of her manic episodes and depths of her depressions.

The intensity, glory, and absolute assuredness of my mind’s flight made it very difficult
for me to believe, once I was better, that the illness was one I should willingly give up.
Even though I was a clinician and a scientist, and even though I could read research
literature and see the inevitable, bleak consequences of not taking lithium…It was
difficult to give up the high flights of mind and mood, even though the depressions that
inevitably followed nearly cost me my life…when I am my present “normal” self [after
medication], I am far removed from when I have been my liveliest, most productive,
most intense, most outgoing and effervescent. In short, for myself, I am a hard act to
follow. (Jamison, 1995, p. 91–92)

This passage can be read in the context of public discourses of her time that question the facile
use of psychopharmaceuticals to deal with life’s pressures. Her mood-based critique portrays the
decision to use drugs as not an easy one. The maximum consciousness of Jamison’s comedic
stance to her own disorder, that she is a “hard act to follow,” works to understate the “bleak
consequences” of her disorder while juxtaposing the difference between routine normal moods of
public life against the extraordinary moods of her own personal sphere. Taking Lithium to “be
normal” is not necessarily something that she sees as enhancing her life. Jamison (1995) continues her mood-based critique,

My family and friends expected that I would welcome being “normal,” be appreciative of Lithium, and take in stride having normal energy and sleep. But if you had stars at your feet and the rings of planets through your hands, are used to sleeping only for five hours a night and now sleep eight, are you sustaining up all night for days and weeks in a row and now cannot, it is a very real adjustment to blend into a three-piece suit schedule, which, while comfortable to many, is new, restrictive, seemingly less productive, and maddeningly less intoxicating. People say, when I complained of being less lively, less energetic, less high-spirited, “Well, now you’re just like the rest of us,” meaning among other things, to be reassuring. (p. 91)

Jamison’s extreme highs and lows become the affective context upon which she frames everyday moods. Manias with interstellar hallucinations and real sensations of flights of mind, the liveliness and productivity, and the depth of her personal sphere makes it possible for Jamison’s narrative to foreground everydayness as “less than” her disordered experience of life.

The use of metonymy, “three-piece suit schedule,” harkens the clash of disordered moods with everyday moods and foregrounds the way the “reality” of everydayness is built on ableist assumptions of “…steadiness and consistency in moods and performance…” (Jamison, 1995, p. 48). Being “normal” means performing consistently. This case is amplified further by the following episode in Jamison’s life. Upon traveling outside of the U.S. on a research internship in Scotland, Jamison offers a narrative that foregrounds further the public and normative assumptions of consistent moods in everydayness. Referring to the year she spent in Scotland as the “Indian summer” of her life, Jamison returns to UCLA.
It was an abrupt shift in mood and surroundings, and an even more abrupt disruption to the pace of my life. I tried to settle back into my old world and routines but found it difficult to do so. For a year I had been free of having to work twenty or thirty hours a week in order to support myself, but now I once again had to juggle my work, classes, social life, and disruptive moods. (Jamison, 1995, pp. 52–53)

The consistent moods needed to perform routine everydayness are portrayed metaphorically as an inability to “keep pace” with “three-piece suit scheduled.” Given Jamison’s sensitivity to the way moods affect how she finds herself in the world, this passage generates uncertainty about the value of everyday routines of schedules, work, and social life for living meaningfully. In sum, these passages build the case that being normal is not necessarily to live meaningfully.

Drawing attention to the ableist assumptions of stable and ordered moods provides Jamison a way of building a case that her disorder is not only not an impediment to living a full life, but also is, itself, an extraordinary way of meaningful living. Jamison does eventually decide to take Lithium and continues to regulate her moods with its help. But in the Epilogue of her memoir, she reflects even more on the meaningful aspects of having lived with a manic-depressive disorder. The passage that ends her book captures the comedic maximal awareness that is utilized throughout the text to affirm the biomedical status of the disorder but also to affirm the way the disorder has enhanced the meaningfulness of her life. She writes,

I have often asked myself whether, given the choice, I would choose to have manic-depressive illness. If lithium were not available to me, or didn’t work for me, the answer would be a simple no – and it would be an answer laced with terror. But lithium does work for me, and therefore I suppose I can afford to pose the question. Strangely enough I think I would choose to have it. (Jamison, 1995, p. 217)
Here her ability to comment on all the aspects of her disorder is made possible by the use of Lithium. With her moods regulated, she can hazard to “choose” manic-depression. The question then remains: why would anyone want such a disorder?

So why would I want anything to do with this illness? Because I honestly believe that as a result of that I have felt more things, more deeply; had more experiences, more intensely; loved more, and been more loved; laughed more often for having cried more often; appreciated more the springs, for all the winters; mourn “death as close as dungarees,” appreciated it – and life – more… (Jamison, 1995, p. 218)

This richly beautiful passage utilizes its anaphora and repetition of “more” to amplify the distance between routine moods of public life that can, all too often, fall into pallid and flat moods. The tone of these passages build the case that too often people can become “caught up in themselves” and take for granted the spring, the love, the laughter, the pain, and the depth of feeling of life’s experiences. Jamison’s narrative seems to suggest that nothing less than a fullness of human experience characterizes the spoils of her mood disorder.

Unlike Styron’s narrative that affirms that he is not his depression and hence not feeling normal, Jamison both affirms that she is not her manic-depression and that she is also not not it either. Being normal becomes a question she must wrestle with in a way that Styron did not. Jamison’s narrative seeks to reconcile her technical knowledge that she is in fact sick with what it feels like to actually experience her disorder, especially her manias, which she seems to hold as a positive feature of her life. Being normal, for Jamison, means accepting her disorder, including its suffering, while managing it with medicine and good humor. She critiques the emerging attitudes that take amoral perspectives on mental illness too literally to suggest that one is
genetically flawed, which in practice, means one’s humanity is understood as a difference in kind rather than mere degree. Being normal means being who she is, disordered moods and all.

Like Styron and Jamison, Plath also offers nuanced critiques of public life. The catachresis structure of Plath’s critique, however, is not funded by a biomedical discourse. So she turns to the emotional and evocative episodes of her life as ways of critiquing public values of domesticity. As a career-minded woman with desires to be free, her critiques focus on amplifying the figure of death in a way that foregrounds public norms of domesticity as death in and of itself.

Esther expresses her desires very clearly to “never get married” and to “shoot off in all directions at once,” (Plath, 1996, p. 83) to be independent and “never serve a man” (p. 77). Consider Esther’s grim reflection on the prospects of marriage:

And I knew that in spite of all the roses and kisses and restaurant dinners a man showered on a woman before he married her, what he secretly wanted when the wedding service ended was for her to flatten out underneath his feet like Ms. Willard’s kitchen mat. (p. 85)

Here Esther equates being married with a loss of self-mastery, with becoming a thing. One’s horizon becomes a mere object in an environment, subsumed “flatten out underneath his feet” like a “kitchen mat.” To be married is to become like a physical thing. This is significant because we learn earlier of just what becoming a thing means for Esther as she attends her first physics course in college. She recounts,

The day I went into physics class it was death. A short dark man with a high, lisping voice, named Mr. Monsey, stood in front of the class in a tight blue suit holding a little wooden ball. He put the ball on a steep grooved slide and let it run down to the bottom.
Then he started talking about let $a$ equal acceleration and let $t$ equal time and suddenly he was scribbling letters and numbers and equal signs all over the blackboard and my mind went dead. (Plath, 1996, p. 34)

Physics is the domain of the abstract, silent, and emotionless world of things in mere motion. Its objects are “dead.” Abdicating one’s personal, unfolding horizon to become a static facet in an environment of physics is a kind of death for Esther. The association here made between death and the motion of a ball rolling down according to the laws to which is it, in a sense, a slave. The ball must obey. Esther associates social mores of domesticity with this kind of numbed, lifeless obedience, for she muses, “when you are married and had children it was like being brainwashed, and afterward you went about numb as a slave” (Plath, 1996, p. 85). Esther offers a counter response to physics quipping,

What I couldn’t stand was this shrinking everything into letters and numbers. Instead of leaf shapes and enlarged diagrams of the holes the leaves breathe through and fascinating words like carotene and xantrhophyll on the blackboard, there were these hideous, cramped, scorpion lettered formulas and Mr. Monsey’s special red chalk. (Plath, 1996, p. 35)

Esther here responds to the letters and numbers of physics in advocating the imagery of “breath” and “language”—elements of a field of action, of being able to react—only to find at the end of the passage a signifier of death, a scorpion, and the imagery of blood in the “red” of Mr. Monsey’s chalk. Esther “cannot stand” that it should be possible to trade one’s freedom for the lifeless, routine motion of domesticity.

For Esther it is deathly to abdicate her desires of freedom to become as if a thing in motion in an environment, that is, to become a mere representative of the routines and social role
prevalent in 1950s American domesticity. Esther, imagining what it would be like to be married, writes,

It would mean getting up at seven and cooking him eggs and bacon and toast and coffee
and dawdling about in my nightgown and curlers after he left for work to wash up the
dirty plates and make the bed, and then when he came home after a lively, fascinating day
he’d expect a big dinner, and I’d spend the evening washing up even more dirty plates till
I fell into bed, utterly exhausted. (Plath, 1996, p. 84)

The routine does not bring lively and fascinating experiences; it deadens experience by bringing
a kind of security for Esther. Contrary to the public “good” of domesticity as the American
dream in the 1950s, “the good” for Esther does not include security, for “the last thing I wanted
was infinite security…I wanted change and excitement and to shoot off in all directions myself,
like the colored arrows from a Fourth of July rocket” (Plath, 1996, p. 83). Esther wants to be
free to be the master of her own life and the “Fourth of July Rocket” signifies that it is from the
American dream of domesticity and the “role” it assumes for women that her personal sphere
responds against.

Throughout the text are moments when Esther encounters babies. In every case, the
episodes are accompanied with a deathly and painful hue. When visiting Buddy Willard, her
boyfriend and medical student in training, Esther observes a woman giving birth. Buddy informs
Esther that the woman has been given medicines that will make her forget the pain of childbirth.
She writes:

I thought it sounded just like the sort of drug a man would invent. Here is a woman in
terrible pain, obviously feeling every bit of it or she wouldn’t groan like that, and she
would go straight home and start another baby, because the drug would make her forget how bad the pain had been… (Plath, 1996, p. 66)

The imagery of a woman being given a drug by a man so she does not feel the reality of pain, for Plath, offers a critique of the patriarchal assumptions that women should want to have babies. The public expectation is that women would be married and have babies. Another moment in her story regales readers with her encounter of dead babies in “big glass bottles” as specimens at the medical school lab. The babies are in the same room as “un-human looking cadavers.”

Esther is proud “of the calm way I stared at all these gruesome things” (Plath, 1996, p. 63). The disturbing images crafted in her narrative bring an incongruous perspective that implies a critique of normatively valued “goods,” namely motherhood, babies, and by extension, domesticity.

Esther does not feel normal because she does not desire the things society says she should. But, she also has no issues with being out of step with public expectations. For instance, Esther tells her boyfriend that she never plans on being married. And Buddy responds, “You’re crazy” (Plath, 1996, p. 93). Esther responds by “owning” this label and proudly refers to herself as “neurotic as hell” (p. 93). This sentiment is given more radical presence when followed by an episode when Esther is taken skiing for the first time. Perched atop a high ski slope, the thought that she might kill herself “formed coolly as a tree or a flower” (p. 97). As she races down the mountain recklessly, she crashes. “She was doing great,” an observer tells her, that is, “until that man stepped in front of you” (p. 98). Being labeled neurotic, a designation popularized by Freud, misses what matters most to Esther when it comes to living with societal pressures namely, “how a girl felt” (p. 81, italics added). Being normal for Plath means allowing a man to step in front of her deeply felt desires for freedom. Feelings in the context of societal pressures
and expectations are brushed aside as “the man” steps in front of her to halt and manage her forward momentum. Her critique is amplified as Esther, unaware that she has broken her leg in the skiing crash, wants to go back up and try again. But Esther is told by Buddy, with a “queer, satisfied expression” and with a “final smile,” “No you are not…your leg’s broken…” (Plath, 1996, p. 98). Her desires to be a truly free and liberated woman may be “out of step” of the norm for her time, but it is this tension between her desires of freedom and agency and societal norms that make the question of “being normal” an important one for her.

Unlike Styron or Jamison, whose understanding of “being normal” is cast against either affirming or disconfirming that they suffer a clinical disease, Plath, writing in a pre-biomedical rhetorical milieu, neither affirms nor denies her disordered experience. Her disorder is not something exclusively separable from her socio-political felt pressures, her being in the world. She is, in many ways, “normal” in a rhetorical sense (certainly not in a clinical sense). Her narrative portrays her desires as out of step with the norms of her time. So the question of being normal (or in her case neurotic) is something that appears in her narrative only in relation with socio-political pressures. So, even though Jamison and Styron also wrestle with what it means to “be normal,” for them the fight is between their disordered moods, per se, and moods of everydayness. But for Plath, wrestling with what it means to “be normal” means the fight between her felt internal desires for freedom and patriarchal domesticity norms.

Critique of the Technical

Each author offers critiques of technical practices through their narratives. The influence of biomedical discourse is again on display in how they narrate their experiences with the technical sphere. Beginning with Plath is useful because she writes prior to the biomedical frame and, as such, her critique demonstrates how problematic technical practices are filtered through
the same socio-political pressures she feels throughout the narrative. Another reason reviewing Plath first is useful is because, though she writes prior to the biomedical, her narrative nonetheless presages the warrant for biomedical understandings of mental illness, namely empathy.

After prolonged bouts of depression, Esther sees a psychiatrist, “Dr. Gordon.” He is depicted as “conceited,” patronizing, and lacking empathy. For instance, Dr. Gordon asks Esther, “Suppose you try and tell me what you think is wrong” (Plath, 1996, p. 129). Esther responds,

I turned the words over suspiciously, like round, polished pebbles that might suddenly put out a claw and change into something else. What did I think was wrong? That made it sound as if nothing was really wrong, I only thought it was wrong. (p. 131)

Dr. Gordon performs a double rhetorical function as both a representation of routine, custodial-type care in psychiatry and as a representative of how the status quo seeks to “place” women. Plath is able to make this case by portraying Dr. Gordon as uncaring of her as a person suffering. When with a “dull, flat voice” Esther opens up about her struggles with not eating, not sleeping, not reading, Dr. Gordon responds by telling a story about himself and laughing self-amused.

The whole time I was talking, Doctor Gordon bent his head as if he were praying, and the only noise apart from the dull, flat voice was the tap, tap, tap, of Doctor Gordon’s pencil…When I finished, Doctor Gordon lifted his head. “Where did you say you went to college?” Baffled, I told him. I didn’t see where college fitted in. “Ah!” Doctor Gordon leaned back in his chair…“I remember your college well. I was up there, during the war. They had a WAC station, didn’t they?…Yes, a WAC station, I remember now…My they were a pretty bunch of girls.” (Plath, 1996, p. 131)
Later in the story, Dr. Gordon asks these same questions to Esther as if he never had this conversation with her before. Needless to say, Esther is suspicious and distrusting of Dr. Gordon. Dr. Gordon is depicted as wanting to place Esther as just any other “pretty girl,” as well as depicted as a figure of the dehumanizing psychiatric care. This critique is amplified with even more radical presence when Dr. Gordon prescribes ECT for Esther. And in the seconds following her first harrowing, painful shock, Esther is depicted as wondering, “what terrible thing it was that I had done” (Plath, 1996, p. 143). For a 1960s audience, Plath’s account of this episode (based on her own real-life personal experience) builds the affective background that foregrounds and presages a feminist critiques of psychiatry.

The experience with Dr. Gordon is contrasted by Esther’s experience with Dr. Nolan, a female psychiatrist. Dr. Nolan’s first interaction with Esther is to ask if she “liked” Dr. Gordon. Allowing Esther to vent about her experience, Dr. Nolan assures Esther that it would be different with her. When Dr. Nolan conducts ECT treatments for Esther, she hugs Esther “like a mother” and is with her the entire time and when it was over. Unlike her first ECT treatments, this was much more like simply falling asleep. Esther trusts Dr. Nolan, who never spoke in “abstract” qualities or of “egos and Ids” (Plath, 1996, p. 224). She just seems to listen as Esther would talk. Under her care, Esther recovers from her depression. By including this contrast of treatment, Plath is able to place a personal affective element to what was often still a fringe topic of psychiatric care in the 1960s. Mental illness had not yet appeared on the public docket of topics affecting the common well. Recall that mental illness at this time was still more often than not attributed to moral failing or weakness of character. But passages like this help amplify Plath’s views on the potential dehumanizing and oppressive aspects of psychiatric treatment.
Esther’s experience in the mental hospital and the way her recovery is depicted illuminates the pervasive presence of normative, public expectations, even in the extra-normative realities of the mental hospitals. While in the hospital, Esther visits the common room where other patients are gathered. They stand around lifeless, motionless. Peering across the room to a large window, Esther is reminded of a department store window and imagines the mostly motionless patients standing around to be shop dummies, “painted to resemble people and propped up in attitudes counterfeiting life” (Plath, 1996, pp. 141–142). Unlike the start of the book where what is “normal reality” becomes something dead and meaningless for Esther, now, in the throes of a disordered reality where people are themselves standing “lifeless,” Esther drapes an active narrative over them that gives them some kind of dimension of normative meaning, even if only as shop dummies. Her awareness of the deadening of normative reality in the first part of the book also works in the second part of the book to help her frame the extra-normal realities of psychiatric hospitals. Rhetorically this passage supports Plath’s sense of the inescapable horizons of public expectations that are the cause of her suffering.

Outside of the walls of a mental ward, Esther is an outsider to public norms. She is not a Katy Gibbs girl. But inside the disordered reality of a public, psychiatric hospital, Esther is now treated as if she was one of those Katy Gibbs girls—spoiled and demanding. For instance, lying in bed recovering from her suicide attempt, Esther wants to see a mirror. But the nurse at first refuses to give her a mirror because, “you don’t look very pretty” (Plath, 1996, p. 174). When Esther does see herself in the mirror, she is startled by the “supernatural conglomeration of bright colors” of the wounds on her face (p. 174). She drops the mirror and it breaks. The nurses berate her, “Didn’t I tell you!” They raise their voices to Esther and threaten her, “At you-know-where they’ll take care of her!” (p. 175). This episode gives a radical presence to the
dehumanizing effects of custodial, routine care of the mentally ill. Not only is Plath able to push forward anti-psychiatry discourses, but she also depicts the pervasive quality of public norms and expectation, as they can be found even in the abnormal contexts of psychiatric hospitals.

Esther’s confrontation with custodial dehumanizing care also generates a reversal of roles for her. Whereas outside the hospital Esther is new to a world of propriety where shows of good upbringing are of paramount importance to being seen as “normal,” inside the crazy situation of the public mental ward she now becomes an authority of propriety. Esther is served food by a “grinning and chuckling” nurse assistant who “bangs down” tureens of “stone-cold, gluey” food (Plath, 1996, p. 180). As he returns to collect the dishes, Esther tells him “we are not done. You can just wait” (p. 181). The nurse’s eyes widen in “mock wonder,” makes an “insolent bow,” and under his breath, calls Esther, “miss Mucky-Muck” (p. 181). Esther could only reassert her justification for her actions by critiquing the meal. “Now I knew perfectly well you didn’t serve two kinds of beans together at a meal,” she assures herself (p. 181). This passage is all the more relevant as a reversal of roles for Esther, especially given that earlier in the book she tells of an embarrassing faux pas of drinking a finger bowl thinking it was soup. Her awareness of social propriety, which stands out vividly as part of what causes her depression, also funds the way they makes sense of her experiences within the psychiatric hospital ward. That is, note how the pressures of the social never cease to haunt her narrative. Within the overall structure of the story Plath depicts Esther’s reversal of position in a way that allows her to suggest, as other anti-psychiatry proponents had, that mental hospitals make you just as crazy as society does.

Whereas Plath’s critiques of the technical follow socio-political lines, the dissociative style of Styron’s critique is funded by biomedical discourses that allow him to critique moralistic public sentiments that charge depression as a “moral failure” by offering a very rational appeal.
His is a critique that argues that rationality is what is corrupted by a mood disorder, and his appeal involves logically arguing that he is not his illness and thus should not be blamed for his actions and choices. But his critique is not only directed at public sentiment, it is also directed toward psychiatric practices and medicine.

In due course of rhetorically framing depression as a “worthy” scapegoat for disordered actions and choices and as an experience that is “mysterious,” Styron’s narrative portrays the way his suffering beguiles not only the public sphere but also the technical sphere, that “even physicians” cannot truly understand the suffering of those suffering disordered sadness. Styron tells a story of the time he “broached” the topic of “hospitalization” with his physician, “Dr. Gold.” Dr. Gold advises Styron to not seek hospitalization because of the stigma he might suffer as a result. There is something of critique of the technical sphere in naming his physician Dr. Gold. Not only does his physician not listen to his request for hospitalization, but he also does not listen to Styron’s suffering. Styron (1990) tells of the time Dr. Gold prescribes the antidepressant, Nardil.

Dr. Gold said with a straight face, the pill at optimum dosage could have the side effect of impotence…I had not thought him totally lacking in perspicacity; now I was not at all sure. Putting myself in Dr. Gold’s shoes, I wondered if he seriously thought that this juiceless and ravaged semi-invalid with the shuffle and ancient wheeze woke up each morning from his Halcion sleep eager for carnal fun. (p. 60)

As Styron’s body suffers the throes of its breakdown to the degree of a loss of speech, motility, and libido, Dr. Gold’s “straight faced” comments about impotence become amplified as a hallmark case of unsympathetic care. This passage further represents Styron’s felt sense that depression suffering cannot be fully communicated because here is a psychiatrist, a person
trained to recognize psychic pain, being portrayed as unsympathetic to the very real suffering of Styron. The problem of stigmatization is not only found in public’s inability to understand the suffering of the disorder, but also in the technical sphere.

Styron’s depression does not respond to psychopharmaceuticals. He observes that the drugs that were prescribed to him—Ativan, Nardil, and Halcion—are scientifically known as a “causative factor in producing suicidal obsession and other aberrations of thought…” (Styron, 1990, p. 71). Though Styron makes hefty use of biomedical etiologies of depression, drugs are not the answer to his recovery. In fact, he critiques psychiatrists like Dr. Gold, …who simply do not seem to be able to comprehend the nature and depth of the anguish their patients are undergoing, maintaining their stubborn allegiance to pharmaceuticals in the belief that eventually the pills will kick in. (p. 68)

Styron appeals to his own experience to warrant his cynical view of the use of drugs in treatment. Feeling alone in his experience of suffering and frustrated at being unable to “find the right words” to express his suffering, the “solution” of a pill is amplified as wholly off the mark for his treatment. For Styron (1990), a “quick fix” is a “fraudulent” thing (p. 10). Styron describes his experience as “atypical,” which lends a radical ground to his framing of the mysteriousness of the disease. “One’s faith in a pharmaceutical cure for major depression must remain provisional,” writes Styron (p. 55). Continuing, he writes, “The failure of these pills to act positively and quickly – a defect which is now the general case – is somewhat analogous to the failure of nearly all drugs to stem massive bacterial infections in the years before antibiotics…” (p. 55) Styron portrays psychiatric science as lacking a full understanding of depression, that “it has yielded its secrets to science far more reluctantly than many of the other major ills besetting us” (p. 11). Styron’s personal experience with psychopharmaceuticals strategically generates
uncertainty regarding the technical sphere’s ability to truly control this disease with medicines
while also generating certainty about depression’s mysterious nature.

By first highlighting the mysteriousness and lack of effective pharmacological treatment,
Styron’s narrative now hints that anyone can suffer the disorder and not even know it. Upon his
recovery, Styron reflects on the characters of his novels.

But after I had returned to health and was able to reflect on the past in the light of my
ordeal, I began to see clearly how depression had clung close to the outer edges of my life
for many years. Suicide has been a persistent theme in my books –three of my characters
killed themselves. In re-reading, for the first time in years, sequences from my novels –
passages where my heroines have lurched down pathways toward doom – I was stunned
to perceive how accurately I had created the landscape of depression in the minds of
these young women…thus depression…was in fact no stranger…it had been tapping at
my door for decades. (Styron, 1990, p. 79)

By framing depression as always present but only arriving at his door in later life, Styron’s
narrative works to make depression not only an issue of personal responsibility but also
something of a shared public concern. In the above passage, his pre-depression life is amplified
by his use of an implied dissociative style to portray depression’s sneaky omnipresence. Styron
further aligns the personal experience of depression with public concerns about substance abuse
by memorializing his own sense of what caused his depression. For years, Styron relied on
alcohol to help him write.

I used alcohol as the magical conduit to fantasy and euphoria, and to other enhancements
of the imagination….I did use it – often in conjunction with music –as a means to let my
mind conceive visions that the unaltered, sober brain has no access to…Alcohol was an
invaluable senior partner of my intellect…sought also, I now see, as a means to calm the
anxiety and incipient dread that I had hidden away for so long somewhere in the
dungeons of my spirit. (Styron, 1990, p. 40)

When Styron becomes suddenly unable to drink because doing so irritated his urinary tract, this
“great ally” that keeps his “demons at bay” was no longer there to protect him from the
depression that hovered over him “waiting to swoop down” (p. 43). We all have our ways of
coping with life’s stressors. These “shields of anxiety” can give way. Depression as an entity
just waiting for a moment of weakness, of having one’s guard down, generates a disruptive and
ominous imagery in Styron’s passage. Given the natural recalcitrance of living, passages like
these allow the narrative to direct attention to the very real probability that depression can affect
anyone at any time. Depression, for Styron, is truly an ill as any other disease and must, itself,
be the sacrificial target of public judgment whenever a person suffers openly or takes their life as
a tragic remedy. As Styron crafts depression in these terms, this generates implied critiques of a
lack of empathy in psychiatric practice and the efficacy of psychopharmacology.

Styron’s critique of the public is that there is a lack of public understanding of the
suffering of depression. The public cannot understand how suicide can be seen as a solution for
someone suffering a pain that is a mystery but nonetheless really is a physical illness. Jamison,
on the other hand, is writing a few years after the biomedical revolution had taken hold in
psychiatric and public practices and discourses. A new kind of biological deterministic attitude
began to develop in public and technical spheres toward those suffering mental illness.
Jamison’s critiques are thus particularly quite damning of other psychiatrists and psychiatric
practices. Attributing her ontic suffering to this lack of comedic correctives, Jamison’s comedic
style allows her to critique deterministic biomedical discourses and public sentiments that view
the mentally ill as lacking flawed humanity by appealing to her ethos as a psychologist living with a mood disorder.

Jamison writes of encounters with stigmatizing views that directly reflect the shifting rhetorical climate surrounding biomedical accounts of mental illness. Her narrative highlights the personal suffering that comes when the biomedical view becomes a monological discourse on the personhood of the mentally ill. Jamison recalls visiting a physician. After finding out that she had been taking lithium for manic-depression, he then tells her, “…as though it were the God’s truth, which he no doubt felt that it was – you shouldn’t have children. You have manic-depressive illness” (Jamison, 1995, p. 191). Jamison continues,

I felt sick, unbelievably and utterly sick, and deeply humiliated. Determined to resist being provoked into what would, without question, be interpreted as irrational behavior, I asked him if his concerns about my having children stemmed from the fact that, because of my illness, he thought I would be an inadequate mother or simply that he thought it was best to avoid bringing another manic-depressive into the world. Ignoring or missing my sarcasm, he replied, “Both.” (p. 191)

This passage gives both a point and counter point of the emerging stigmatizing discourses on biomedically understood mental illness. First, it is noteworthy that the stigmatizing view comes from a trained physician. The biomedical view advocated by Styron was adopted as the “official” nomenclature of mental illness largely to lighten moralistic discourses on mental illness. Yet, here is a doctor overlaying moralistic view based in the biomedical origins of mental illness. Second, as a counter point, Jamison draws upon her own training as a psychologist and her experience as a “good lithium responder” to literally stand up against this view. Her overall comedic and juxtaposing form narratively shapes Jamison’s counter point in
the form of sarcastic questions that direct attention to the absurdity this doctor moralizing view. But there is more, she continues,

…it had never occurred to me not to have children simply because I had manic-depressive illness. Even in my darkest depressions, I never regretted being born. It is true that I had wanted to die, but that is peculiarly different from regretting having been born. (Jamison, 1995, p. 191)

Jamison uses her own lived-experience of “wanting to die” as an affective context to amplify the “peculiarity” of the important difference between wanting to die and regretting being born. It is because of her disorder that Jamison is “grateful” about her life. She hints that such experiences give gravity to the choices she makes, a gravity rooted in a deeper perspicacious and resoluteness born of living with a disorder.

Consider another moment when Jamison discloses her illness for the first time to a fellow psychiatrist. She tells him about her manias and depressions, and “fixed an eye on a distant pile of rocks out in the ocean and waited for his response” (Jamison, 1995, p. 200). Jamison then recalls,

Finally I saw tears running down his face…I remember thinking that it was an extreme response – particularly since I had tried to present my manias in as lighthearted a way, and my depression with dispassion…his pain at hearing that I had manic-depressive illness was, it would seem, far worse than mine at actually having it…he told me he was “deeply disappointed”…I felt betrayed, deeply embarrassed, and utterly exposed…I told him he ought not worry, that manic-depressive illness wasn’t contagious…He squirmed in his seat and averted his eyes. (p. 200–201)
Jamison, recalling this moment, refers to those words “deeply disappointed” as “the most killing of words” because of their candor in getting to the heart of the matter: “he was normal and I am not” (p. 201). It is, once again, significant that this is a psychiatrist directing stigmatizing responses toward her, a representative of the technical sphere. Training in biomedically based understandings of mental illness have led to the view that those with mental illness are genetically not normal. Jamison’s recourse to a comedic stance when presenting her manias in a “lighthearted way” to her friend, interestingly, parallels the comedic approach utilized throughout the text to understate pathology while also amplifying more positive aspects of her disorder. The clause, “far worse than mine at actually having it,” is highly insightful because with it Jamison highlights the communicative conditions of stigma, namely that the “pain” of stigma is not rooted in her disorder but rather in the suffering that comes when that pain is viewed as inhuman and shameful, something lacking humanity. Through this comedic style, Jamison’s narrative affirms her disorder while also opening up other possibilities of understanding and valuing her disorder.

With Jamison’s critique in tow, it is possible to see the influence of how a biomedical discourse guides rhetorical invention in each author’s critiques. Jamison’s critiques of technical practices have something Plath-like about them. Unlike Styron, whose narrative structure is one of dissociation, the “maximum awareness” that Jamison brings to her narrative foregrounds the way it feels to live with a disorder. But unlike Plath, these “feelings,” though certainly “psychologically” real to Jamison, are understood as the result of a chemical, biological condition. Jamison’s critique, like Styron’s, thus foregrounds once more the suffering of stigmatization and not socio-political conditions, per se, as the source of suffering. If Plath, Styron, and Jamison were to meet in a café to share their experiences with one another, Plath
would hear Styron and Jamison making due with a biomedical discourse, feel sympathetic to it, but alas, given she wrote and lived in a pre-biomedical rhetorical milieu, she would (and I suspect with a sense of exasperation) remind them of the socio-political conditions that generate suffering.

Biomedical and Empathy: Styron’s Indifference, Plath’s Tolerance, and Jamison’s Models of Love

It is thus, perhaps, no surprise that writing and living in a biomedical rhetorical milieu also is reflected on how each author imagines solutions to their suffering. At the core of their narratives, Plath, Styron, and Jamison each portray some kind of practice of “empathy” as a palliative response to their suffering. To gain a perspective on this aspect of the invention of biomedical discourses, it’s instructive to look at what Plath, Styron, and Jamison describe as the more positive experiences of how others and technicians treated them. This empathy emerges as a rhetorical theme in each narrative in slightly differing ways, however. These differences reveal the influence of biomedical discourses (or lack thereof) in each author’s demonstration of what “empathy” as a solution looks like and how each author grounds their appeals.

Lacking a biomedical discourse, Plath’s desires for empathetic responses are to have others accept her hopes and dreams, in short, to accept who she is. Her narrative offers rich, radicalizing metaphors that work to portray what it “feels” like to be a career-minded and ambitious woman in a society where such desires for personal freedom for women were not the norm. As we have already seen above, Dr. Nolan represents one empathetic and caring approach to her ECT and recovery. Dr. Nolan accepts Esther as a woman who is suffering. But Plath also
offers a powerful passage that portrays the lack of empathy from others through an appeal to a concept of Christian tolerance.

Esther is asked to have her picture taken for the magazine. But Esther did not want to have her picture taken that day. She does not know why, but she feels like crying. She just knows she will cry recounting, “if anybody spoke to me or looked at me too closely the tears would fly out of my eyes and the sobs would fly out of my throat and I’d cry for a week” (Plath, 1996, p. 100). And true to her feeling, she does cry in front of her boss and the photographer, “an immense relief” of tears and “miserable noises” that “had been prowling around” in her all morning (p. 102). She buries her face in a nearby loveseat. When she was “free of the animal,” she raises her head to find that she has been left alone, the photographer and her boss gone. She felt “limp and betrayed” and craved “Christian tolerance” (p. 102). The use of personification metaphors assists Plath in shaping what it felt like to be in the throes of uncontrollable inner forces. The animal body is foregrounded in the context of how others respond to a person suffering. Plath is making a case about the way people respond to those whose bodies may push against social norms. They run away. They hide. They pretend it is not happening. Her boss and the photographer leave because they have no idea how to respond and, therefore, leave Esther to feel it is her fault. This is a commentary by Plath on the values of normative realities in the work-a-day world that operate on the assumption of controlled, collected, and calm emotions. The uncontrollable, animal, forces of extreme displays of emotion are seen as a breach of that order and, in Plath’s pre-biomedical day, were not popularly understood as a medical symptom.

Her boss leaving, the photographer leaving, all work to depict how her emotional outburst was judged as a breach of normative order, an impious act. They leave her to feel
shame and betrayal. She feels alone, an outcast. Penance. So while Esther is already in pain, she now suffers shame in addition. Esther desires “Christian tolerance.” Christian tolerance is the space of empathy. Plath is aware of a way toward cultivating more sympathetic responses. Confused about what is happening to her, Esther wishes that it can be traced to a physical sickness. Esther says, “…if only something were wrong with my body it would be fine…” (Plath, 1996, p. 188) and “if only I could persuade my mother to get me out of the hospital I could work on her sympathies, like the boy with a brain disease in the play…” (p. 179). Within these passages, Plath proves to be prescient of the warrant that will undergird much of the public and technical support for the adoption of a biomedical model of mental illness. Rather than have to suffer the confusion of “what a terrible thing I had done” simply because her desires are out of step with norms, she would be able to work on the sympathies of others because she is sick. Her moods are disordered. We do not hold the sick accountable for their sufferings. We sympathize with the ill. Such will be the argument of William Styron, writing some 40 years after Plath’s first pangs of sadness.

Styron’s narrative was motivated by unsympathetic views on suicide and depression. It is difficult to find positive accounts of how others and technicians treated him. The reason why this is so perhaps has to do with his dissociative style. He writes specifically to demonstrate that he is not his depression and thus cannot be held accountable for his suffering or his actions and choices. He wants others who accuse the victim of “moral failing” to likewise utilize dissociative reasoning as a way of practicing empathy. Though he does acknowledge his wife for her patience and care, there are few positive experiences Styron recounts during his treatment. To be fair, Styron (1990) does argue that recovery may “require on the part of friends, lovers, family, admirers, and almost religious devotion to persuade the sufferer of life’s worth”
Yet, mostly absent from his memoir are stories of others being empathetic to his suffering.

Styron’s narrative seems written so those who would read it would practice empathy through dissociative reasoning, but lacking in the memoir itself are specific portrayal of actual practices of empathy. The palliative care Styron identifies is mostly within his control, namely his decision to seek sequestration and time off. As his suffering lessens, he attributes this to the “pacifying effect that the hospital can create, its immediate value is a sanctuary where peace can return to the mind” (Styron, 1990, p. 70). There is, however, one moment, seemingly reluctantly portrayed, of positive sympathetic treatment during Styron’s hospitalization. He attends “art therapy” in the hospital, which he portrays as “organized infantilism.” He writes,

> Our class is run by a delirious young woman with a fixed, indefatigable smile, who was plainly trained at a school offering courses in teaching art to the mentally ill; not even a teacher of very young retarded children could have been compelled to bestow, without deliberate instruction, such orchestrated chuckles and coos. (p. 74)

Styron’s feelings of humiliation are given form by his allusions to elementary school, of childhood, and the alliterative “chuckles and coos.” Styron portrays an annoyed mood in this practice, which also helps portray the affective tones of agitation compensatory to his depression. One day Styron draws a picture of his house. This therapist showers him with praise, only serving to amplify this sense of humiliation. But, as Styron’s health improved so did his “sense of comedy” (Styron, 1990, p. 74). So as Styron’s suffering lessened over time, he began to “dabble happily” with clay modeling. He recounts,

> Coinciding as it did with the time of my release, this creation truly overjoyed my instructions (whom I’d become fond of in spite of myself), since, as she told me, it was
emblematic of my recovery and therefore but one more example of the triumph over
disease by art therapy. (p. 74–75)

Though it appears as if Styron frames his recovery as something that he initiated, that he enacted
and activated somewhat despite of art therapy, it is important to note that Styron’s sense of the
empathy of others is portrayed as a sense that comes only after he had recovered a sense of
comedy. It was only then that Styron was able “in spite of himself” to acknowledge the
empathetic intentions of his therapist. Styron portrays his encounter of others, prior to this
moment, as ripe with indifference.

A comedic perspective appears to be at the root of Jamison’s portrayals of empathetic
responses in her life. Indeed, Jamison (1995) goes even further to comment that she originally
sought to write a “book about moods, and an illness of moods, in the context of an individual
life,” and what she ended with was a book about “love as a sustainer, as a renewer, and as
protector” (p. 215). In short, Jamison’s empathy is portrayed in her narrative in actual accounts
of loving responses of others who accept who she is (…somewhere Plath is saying “yes!”).

Jamison’s narrative portrays the loving responses of her mentors, colleagues, and lovers
(themselves all psychiatrists or doctors) who, when read in the context of the earlier stigmatizing
passages reviewed, generate their own comedic “maximum awareness” that works to emphasize
personhood over pathology. In so doing, her passages generate a comedic corrective to
monological biomedical discourses that underemphasize the humanity of those with mental
illness while also portraying empathy as ameliorative. The first of these portrays Jamison as a
student in her first psychology course. The professor asks Jamison to his office to discuss her
written interpretation of inkblots. Jamison has written a manic and fantastical account as part of
a class assignment. She recalls,
He said that in all of his years of teaching he had never encountered such “imaginative” responses to the Rorschach. He was kind enough to call creative that which some, no doubt, would have called psychotic. It was my first lesson in appreciating the complicated, permeable boundaries between bizarre and original thought, and I remain indebted to him for the intellectual tolerance that cast a positive rather than pathological hue over what I had written. (Jamison, 1995, p. 47)

The strategic juxtaposition of terms such as “creative” against “psychotic,” “bizarre” against “original,” and “positive” against “pathological” generates a sense of her own very clear awareness of the broad ranges of her moods and how they can be interpreted by others. Her professor’s response to be tolerant and “positive” is thus narratively framed as a very active and meaningful choice. Another professor during her graduate school years is portrayed as “exceptionally kind in understanding my own fluctuating moods and attentiveness” (Jamison, 1995, p. 53). When Jamison would neglect her research assistant duties and sneak away into her office and sleep, exhausted by her manias, she would awake with her coat draped upon her and a supportive note from her professor on her computer expressing, “you’ll feel better soon” (p. 54). As each of these professors represent the technical sphere, these moments generate comedic correctives that narratively build a case that more empathetic responses begin not with knocking down the biomedical nature of the disease but by actively viewing the humanity of persons, by choosing other ways of seeing the lives of its sufferers.

This case of actively choosing to view the humanity of the person is amplified further by passages Jamison includes detailing moments when she discloses to her lovers that she has manic-depressive. For instance, when she comes clean about her disorder to one of her lovers, Jamison recalls feeling regret for disclosing her disorder. She wrote, “I wished I had never told
him; I wished I was normal, wished I was anywhere but where I was...I had just resigned myself
to a subtle round of polite farewells” (Jamison, 1995, p. 144). Jamison’s use of anaphora
portrays the tension she feels as she waits for his response, which felt like an “eternity.” Jamison
(1995) recalls that he was “silent for a very long time, and I could see that he was sorting through
all the implications, medical and personal, of what I had just said” (p. 144). Finally he responds:
“I say. Rotten luck” (p. 144).

I was overcome with relief; I was also struck by the absolute truth of what he just said. It
was rotten luck, and somebody finally understood. All the while, in the midst of my
relief, the small shredded island of humor that remained in my mind, recorded, on a
totally different brain track, that David’s phrasing sounded like something straight out of
a P.G. Wodenhouse novel. I told him this...We both laughed for a long time... (p. 144)

Jamison continues to recount how kind and accepting David was and how he asked question
after question about her personal experience of living with the disorder. This made her feel “for
the first time” that she was “not alone” (p. 145). Note once more the way Jamison embodies a
comedic style not only in the form but in the content of her own lived responses. This maximal
awareness contributes a very radical and personal critique of monological biomedical stances.

Jamison’s personal sphere, itself, is a critique the technical. The more empathetic model
of psychiatric care Jamison presents offers a comedic corrective to a biomedical view and is
narratively embodied in the loving responses of Jamison’s lovers, mentors, and colleagues.
Consider in addition that in one very moving passage, after Jamison (1995) discloses her
disorder to yet another lover he responds: “I thought it was impossible for me to love you more
than I do” (p. 160). Concluding her chapter on these memories of acceptance and understanding
from her lovers, mentors, and colleagues, Jamison (1995) writes, “But if love is not the cure, it
can certainly act as very strong medicine” (pp. 175–176). By offering a narrative of how others have seen her disorder with understanding and empathy, Jamison supports an implied case for how more empathetic psychiatric practices can serve as correctives to the tendency to become too clinical in assessing the mental ill.

**Biomedical and Self-Relation: On Stars and Rituals**

What Jamison’s maximum awareness suggests is that as these authors’ write their memoirs, each author is offered opportunities to “own” their illness in differing ways. In short each author is “doubled” as they each offer reflections on what their suffering has meant to them. Thus by “doubled” I mean we can read how each author, as they write their memoirs, betray how they relate to their disordered experiences with varying degrees of acceptance. The influence of the biomedical rhetorical resources is also present in how each author narrates an experience of being “doubled” by their disordered moods. That is, each author takes ownership for their disordered experiences that are influenced by biomedical discourses. This ownership is not an ownership for their suffering, per se, but an owning of the fact that they have suffered and that their suffering has yielded insight into their being in the world. By reading deeply into how this self-relation is portrayed, insight is gained into the existential consequences biomedical discourses may have upon each author’s sense of self. Moreover, this is important because these passages are built around each author’s reflection on what their suffering means to them. This in turn influences what each author considers to be a “good” for how to treat those suffering a breakdown of mood.

Styron perhaps stands out as the most obvious doubling. His entire narrative employs a dissociative style that pits the apparent man, depressed Styron, against the real man, healthy Styron who is being attacked. Recall how the biomedical rhetorical milieu makes possible this
dissociative move in a way that was not present for the pre-biomedical Plath. Here is one way this dissociative doubling impacts Styron’s view of his recovery. Upon recovery, Styron, now with insight grounded in living through disordered experiences of self and world, relies upon the poetry of Dante. He reflects,

The vast metaphor which most faithfully represents this fathomless ordeal, however, is that of Dante…

“In the middle of the journey of our life
I found myself in a dark wood
For I had lost the right path...”

For those who have dwelt in depressions dark wood, and known its inexplicable agony, their return from the abyss is not unlike the ascent of the poet, trudging upward and upward out of hell’s black depths and at last emerging into what he saw as the “shining world.”…

“And so we came forth, and once again beheld the stars.” (Styron, 1990, pp. 83–84)

Continuing with his dissociative approach, is it any wonder that this passage from Dante most resembles Plato’s allegory of the cave wherein those beholden to false shadows take them as real? Styron’s analogizing depression as a “dark wood” harkens images of his own trek upward out of his low moods. It is surprising that he does not recall Milton’s Paradise Lost, with its allusions to the furnaces of hell as “darkness visible.” Like Styron, Plato, and this passage from Dante, contains allusions to a fall from innocence into a new kind of knowledge. The world is seen now through the hindsight of disordered experiences, and for Styron, his recovery is framed as clearing the brush and darkness to look up at the stars. It is not altogether insignificant that he
chose to end his book with allusions to looking up at the stars, for Styron’s dissociative style frames him as one for whom reason, the realm of eidetic higher-order thinking, has been corrupted by a force that makes lower-order appearance seem like reality.

Lacking such a biomedical resource for a dissociative understanding of her disordered moods, Plath, as we have seen, views her experience in more concrete, socio-political, and ontological terms. Thus, unlike the abstract reasoning that underlies Styron’s approach, Plath’s approach is grounded in what it feels like to be in her world, and this is reflected in how she relates to her recovery. As Esther attempts suicide by swimming out into the ocean as far as possible, she recalls the sound of her heart in her ears: “I am, I am, I am” (Plath, 1996, p.158). Though Esther was unsuccessful, the repetitive and rhythmic use of “I am” as onomatopoeia for her heart’s hard pounding is both a physical description of her body and an affirmative statement of her deep awareness that she is alive. Esther does attempt suicide once more with pills but is unsuccessful.

As Esther attends the funeral of a friend who has successfully committed suicide, a friend she identifies as “my double,” her heart once more beats: “I am, I am, I am.” The return to this onomatopoeia comes toward the end of her book as she is recovering from her depression. Now, given her recovery, the message is an affirmation of her survival and a renewed commitment to live toward her dreams. Plath crafts this experience through a moving passage about arriving before a board of doctors who were conferring about her dismissal from treatment.

There ought to be, I thought, a ritual for being born twice—patched, retreaded and approved for the road, I was trying to think of an appropriate one when Doctor Nolan appeared from nowhere and touched me on the shoulder…Pausing, for a breath, on the
threshold…The eyes and the faces all turned themselves towards me, and guiding myself by them, as by magical thread, I stepped into the room. (Plath, 1996, p. 244)

Her pain and suffering is portrayed as a transformative ritualistic passage. Rituals are ceremonial enactments of transitions and transformations. Having now recovered from this particular episode of disordered sadness, Esther feels as if reborn, her allusions to the tread on tires referring to her own renewed psychological protections and inner senses of ability. Unlike Styron who is content to stop and look up at the stars, Plath is ready to hit the road toward her desires, to be “perfectly free.” Her first steps are not out from the dark wood, but toward her unfolding future existence.

Unlike Styron or Plath, Jamison’s manic-depressive disorder renders her self-relation as neither a breaking through nor a renewing, rather hers is a self-acceptance. Again, writing within a biomedical world, she acknowledges her disorder as a biological condition but also accepts its “effects” in a way that Styron does not and Plath is unable. Interestingly, like Styron, Jamison likewise alludes to stars. Recall she writes:

My family and friends expected that I would welcome being “normal,” be appreciative of Lithium, and take in stride having normal energy and sleep. But if you had stars at your feet and the rings of planets through your hands, are used to sleeping only for five hours a night and now sleep eight, are you sustaining up all night for days and weeks in a row and now cannot, it is a very real adjustment to blend into a three-piece suit schedule, which, while comfortable to many, is new, restrictive, seemingly less productive, and maddeningly less intoxicating. (Jamison, 1995, p. 91)
For Jamison, she has had no recovery. She can only manage her disorder with Lithium. But even in this, she relates to her disorder by owning it fully. She ends her book with the following passage:

The countless hypomanias, and mania itself, all brought into my life a different level of sensing and feeling and thinking. Even when I have been most psychotic – delusional, hallucinating, frenzied – I have been aware of finding new corners of my mind and heart…when feeling my normal self, beholden for that self to medicine and love – I cannot imagine becoming jaded to life, because I know of those limitless corners, with their limitless views. (p. 219)

Whereas Styron looks up at the stars, Jamison has flown amongst them, and it is such flights among the stars that give her insight into her existence. She feels herself to be a privileged keeper of emotions and feelings to which most “normal” people will never have access. Given the biomedical discourse that makes possible a dissociative understanding of depression, Jamison’s comedic perspective owns her illness in a way that Plath is unable to and Styron is unwilling to. In either case, the biomedical discourses seem to have helped shape the ways each author related to their disorder and the existential consequences of such rhetorical possibilities.

Conclusion: The Tensions Between Personal Sphere, the Public Sphere & Biomedical Discourses

In this chapter, I reviewed the ways that Plath, Styron, and Jamison make use of their disordered experience in service of critiquing public and technical discourses. In good measure, this chapter offered an analysis of the rhetorical influence of biomedical discourses on personal expression, sense making, and critique.
First, I presented how these texts offer differing perspectives on the source and cause of their suffering. Plath attributed her suffering to 1950’s society’s expectations that women seek domesticity as their norm. Styron attributed his suffering to chemical imbalances and moralistic views of mental illness. Jamison attributed her suffering to a biomedical discourse that had become too totalizing of the humanity of those suffering mental illness.

Second, I demonstrated the critiques of public and technical spheres offered by each author, given the causes they identify as sources of their suffering, as well as how their place and moment in the biomedical revolution shape their critical perspectives. Plath, writing prior to biomedical understanding of mental illness and having identified domesticity norms as the cause of her suffering, critiques the facile ways that such expectations are perpetuated by a lack of personal mindfulness of those expectations both by women and men. Perhaps most telling of this call for mindfulness is her critique of psychiatric care as she associates the electroconvulsive therapy with masculine punishment and her recovery with feminine care. Predating feminist critiques, Plath’s work sets an existential groundwork for understanding how patriarchal values can go unnoticed in everyday and technical practices.

Styron, writing at the beginning of the biomedical turn in psychiatry and having identified faulty brain chemistry as the cause of his suffering, critiques the moralistic public views of depression and suicide. Styron critiques how empathy is denied to those who have never suffered the pain of depression because they have never experienced it themselves. He raises awareness of the lack of knowledge in the public sphere of the biomedical status of mental illness. Unlike Plath, Styron can ground his critique in a biomedical understanding of depression that transforms the disease and his suffering as something passively endured that should garner the same sympathy and understanding as the suffering of cancer.
Jamison, writing after the biomedical turn and having identified dehumanizing biomedical views of mental illness as the cause of her suffering, critiques her own technical sphere for being too earnestly adherent to biological determinism. Jamison, somewhat like Plath, also critiques a lack of mindfulness of the whole person, a lack of comedic perspectives. But unlike Plath, Jamison not only argues for mindfulness of social conditions that give rise to deterministic views but also for personal mindfulness of the ways that all moods affect the very sense of life. In her emphasis on the personal mindfulness she departs from Styron’s framing of mental illness as something simply passively endured. Jamison advocates for both a personal, technical, and public comedic perspective on mental illness that will remind others of the humanity of those suffering mental illness.

This chapter has also presented one way these texts argue for increased technical and public “empathy” for individuals suffering breakdowns in mood. Plath, very interestingly, writes of wishing she were simply biologically ill so she can play upon the sympathies of those in her life. Writing prior to the biomedical turn in psychiatry, Plath nonetheless writes of wanting something like the sympathy Styron will call for in the name of biomedical views of depression. For Styron, such sympathy will only be possible given public education of the biomedical model of mental illness and the nature of the suffering of depression. Jamison, on the other hand, calls for the cultivation of mindfulness of the humanity of those with mental illness over and against their biomedical diagnosis. What is perhaps most interesting is that unlike Styron and Jamison, Plath’s appeal for more empathy is situated in cultivating a mindfulness of social-cultural conditions in a way that Styron and Jamison do not. One potential take away from this is how biomedical discourses seem to limit public discourse about the causes of mental illness to the
theater of personal and technical spheres while subordinating questions of how the public sphere contributes to mental illness suffering.

Finally this chapter demonstrated how each author relates to their mood disorder, owning their disorder in differing degrees. Once again, the influence of the biomedical model in shaping rhetorical invention and personal sense making is on display. Styron has an antagonistic relationship with his disorder. He is not his disorder. It is an alien force that had invaded him. Writing with a biomedical knowledge, he cannot help but feel attacked and as a passive victim. Jamison, on the other hand, having now made peace with her biology, moves towards deeper acceptance and appreciation of her suffering humanity. Plath, neither fully accepts nor fully denies her mood disorder because she, writing in a pre-biomedically depressed world, does not relate to “it” as a thing with whom she can relate. Rather, Plath relates to herself and the felt tensions she feels of her being in the world with all the manifold tensions and desires for freedom burning within her in the context of 1950’s domesticity norms.

This chapter began with a discussion of Goodnight’s spheres of argument, and it’s instructive to return to him as a final remark on this chapter. Goodnight (2005) felt that an examination of spheres of argument would help can insight into the nature of controversy, especially those rooted in scientific innovation. He observes,

The production, performance, and reception of science and technology from positions of provider and user form the hub of modern communication controversy…this process may be difficult when a gap emerges between the quick pace of scientific development and the longer time it takes to reach normative consensus in times of innovation or change. (p. 29, italics added)
In this chapter I have taken an approach that I believe helps to gain insight into how scientific innovations in psychiatry enter into public discourse, namely through the personal accounting of a mood disorder. As Thomas Goodnight’s spheres of argument model has led many scholars to follow his concerns about waning public discourse at the hands of personal and technical grounds of appeal, this chapter has offered one way to “close the gap” between the quick pace of scientific innovation and normative consensus by offering a deep reading of the personal sphere as an existential site for examining the interanimation of the public, technical, and personal spheres.
CHAPTER 5

CONCLUSION: MOOD MEMOIRS, AUTHENTICITY, AND THE RECOVERY OF PUBLIC
DISCOURSE IN THE WILLINGNESS TO BE PERSUADED

Any nation is in trouble if its citizens are not trained
for critical response to the flood of misinformation
poured over them daily. A citizenry not habituated
to thoughtful argument about public affairs, but
rather trained to “believe everything supporting my
side” and “disbelieve everything supporting the bad
side,” is no longer a citizenry but a house of
gullibles.

(Booth, 2004 p. 89)

In this concluding chapter, I review what I’ve learned from exploring depression
memos as rhetorical texts. First I offer a review of the ground covered in each chapter. Then
based on the work covered, I bring attention to the ethical importance of cultivating more
“appreciative” rhetorical critical stances as a way of rounding out cynical tendencies of
contemporary critical rhetorical studies. Lastly, I return to issues first raised in earlier chapters,
namely authenticity and the “decline” in public discourse. Drawing on Wayne Booth’s critique
of the roots of “modern dogma and assent” as a springboard for culminating thoughts, I think
through a key aspect of Booth’s argument for rejuvenating public and civic discourse. Booth’s
emphasis on cultivating a willingness to be persuaded as a way of rejuvenating public and civic
engagement is vividly “brought home” in my reading and analysis of depression memoirs.
The Ground Covered in This Study

Chapter 2 was an account of the historical context of these works. I identified three distinct rhetorical exigencies for each author. Plath writes in response to 1950 domesticity norms and psychiatric practices. Styron writes in response to moralistic views of mental illness. Jamison writes in response to overly biologically deterministic views of mental illness. In Chapter 2 I posed a larger question about what makes such texts so enduring. First I reviewed their critical reception during their publication and then their continued relevance to contemporary times. Couching my history in the perspective of Charles Taylor’s view of the 20th century as an “Age of Authenticity,” I suggested that what in part makes these texts continually relevant is their form as autobiographical expressions of disordered experiences. These author’s experience a disruption in their normative ways of being and by writing about those, readers are invited to experience those disruptive shifts in world experience themselves. In so doing, a reader can become mindful of the everyday moods of selfhood, allowing for mode of self-reflection that Taylor argues is vital for the pursuit of deeper forms of personal authenticity. I’ll be returning shortly to Taylor in this conclusion.

In Chapter 3 I dove deeper into the disruptive form of these texts. In this chapter, I posed the question of how disordered moods communicate. Each author faces the rhetorical challenge of giving expression to extraverbal realities that meet against socially constructed rhetorical resources. I reviewed how each author figured the disorder of their disorder in the face of “rhetorical disability” and the “inexpressibility thesis” by identifying the figurative and metaphorical forms each author uses to narrate these extra-verbal rhetorical challenges. I also suggested that such being “at-a-distance” from cultural rhetorical resources and normative moods functions as existential grounds for critique as each author finds themselves acutely aware
of the meanings of cultural practices precisely in the mode of their breakdown.

I then discussed how such figurative and metaphorical framing communicates with readers. Specifically, my reading of these memoirs led me to consider refiguring somewhat the contemporary understanding of Kenneth Burke’s idea of identification. The figurative accounts of breakdowns of selfhood do not communicate simply by identification because there is no stable model of selfhood that an “able minded” reader can identify with. Instead there is a very different self with whom a reader might meet in *radical relation*. Narrative depictions of disordered experiences communicate more akin to a process of “pure persuasion” than mere identification. The figurative narrative passages about disordered realities continually interpose a distance between normative understandings and disordered experiences. This generates a symbolic division that catalyze non-depressed audiences to interpretatively bridge the gap through juxtaposition of their own normative reality along with the disordered experiences of Plath, Styron, and Jamison.

In Chapter 4 I demonstrated how such figurative framing of disordered experiences functions rhetorically by reading *The Bell Jar, Darkness Visible*, and *An Unquiet Mind* as autobiographical responses to exigencies of their time whilst also noting how biomedical discursive forms dialogically influence rhetorical invention and modes of expression. *The Bell Jar*, in general, makes use of its figurative and metaphorical pages to generate a kind of *catachresis*, or the argumentative use of radicalizing metaphorical expressions (Jasinski, 2001 p.434; Solomon, 1988) that refigure norms in incongruent ways. Plath generates a radical presence to her critique of 1950’s American Dream of domesticity portraying it as a kind of “death” and psychiatric treatment as both a masculine punishment and a personal hell.
Darkness Visible as a whole makes use of its figurative forms to generate a dissociative style and tone that invites readers to encounter what “depression is really like” (Styron, 1990 p.32) through a dissociative style and tone demarcating two senses of selfhood: the healthy (i.e., “real”) Styron and the depressed (i.e., apparent) Styron, all while making use of biomedical disease models of mental illness to scapegoat depression itself as the cause of lapses in rational control. An Unquiet Mind makes use of its figurative passages to generate a humanizing tone through a recurring use of meiosis, or a rhetorical style of understatement through comedic framing and strategic juxtaposition that critiques the public stigma of biomedical determinism and questions the value of “being normal” to living a meaningful life.

Chapter 4 also noted the influence of biomedical discursive forms in how each author identified the causes of their suffering, the solutions to their suffering, and the way they understood the meanings of their suffering. I used Plath as a kind of “control group,” or rhetorical representative anecdote for writing about depression in a “pre-biomedical world.” I then read all three memoirs with a keen eye towards how biomedical discourses interact with personal and public grounds of appeal. To begin, Plath attributed her suffering to 1950’s society’s expectations that women seek domesticity as their norm. Plath, in many ways, cannot help but relate to her suffering as hers, as consequences of how her desires and choices conflict with her times. Lacking a biomedical model through which to frame here sufferings, there is little doubt for Plath that her suffering is rooted in the conflict with social-cultural conditions. Plath’s autobiographical act attempts to shed a light upon the personal consequences and sufferings of a “society that has made her crazy.”

On the other hand, Styron, writing as the biomedical model of mental illness was first shifting psychiatric diagnostic practices, attributes his suffering to chemical imbalances and
moralistic views of mental illness. Styron cannot help but related to his suffering agonistically. He is not his depression. Unlike Plath who had little recourse to biomedical understandings of mental illness, Styron is complicit in rising suspicions about the social cultural conditions that may give rise to mental illness. There is little doubt for Styron that his depression is a medical disease, biomedical models having received widespread assent in the technical sphere. Interestingly, Plath does have doubts of her own about the social-cultural causes of her disorder and wishes for a biomedical cause in the course of her story. So even before the biomedical model emerges as a rhetorical form, the stage is already set for Styron’s appeal in Plath’s call for Christian Tolerance for her suffering. Styron’s autobiographical act attempts to educate his audience about the medical condition of depression and how its suffering corrupts reasonable choices and actions.

Nonetheless, this turn to a biomedical model did not remove considerations of social-cultural conditions altogether. Thus, Jamison attributes her suffering to a biomedical discourse that has become too totalizing of the humanity of those suffering mental illness. While not denying she suffers from a biomedical condition, Jamison at times echoes Plath’s own felt tensions of being trapped in a social system that judges and limits her professional and personal desires, as the social-cultural norms of the technical sphere’s adherence to a biomedical model come under scrutiny in Jamison’s memoir. Jamison’s autobiographical act attempts to portray to audiences the life-affirming aspects of manic-depression in an effort to remind audiences that her humanity is not just her biomedical diagnosis.

In many ways, Chapter 4 offered a deep reading of the personal sphere as an existential site for exploring the way the biomedical model influences rhetorical invention about the self and its lived-experiences of disordered reality. Heeding Thomas Goodnight calls for exploring public
controversies involving scientific innovation, this chapter offered one way to “close the gap” between the quick pace of scientific innovation and normative consensus. I offered a mode of reading sensitive to the interanimation of the public, technical, and personal spheres at work as Plath, Styron, and Jamison narrate concretely lived-experiences. This chapter demonstrated how each author enters into dialogue with biomedical discourses, often unwittingly, as they respond to exigencies of their time.

Suspicion and Appreciation: Rhetorical Criticism and Mental Illness Memoirs

We saw in Chapter 3 a tendency to be suspicious of emotional arguments because of fears of hidden ideological and political content. This long standing distrust of emotional appeals as well as the dialects of the certainty and doubt embodied in the inexpressibility thesis, means that the suffering found in mood memoirs are vulnerable to facile and cynical critiques, readings, and responses. These texts can be easily characterized as explicitly seeking to arouse a reader’s sympathy at best and at worse can be viewed has obscuring some facet of cultural politics that reinforces existing power structures.

About the time Kay Redfield Jamison was publishing An Unquiet Mind, dance critic Arlene Croce (1995) refused to review a dance performance, “Still/Here.” The performance integrated video and audio of the suffering of “real” AIDS and cancer patients. She cited that it was beyond criticism because it was victim art and ultimately played upon sympathy that “has a deadly power over the human conscience” (p.18). The article was said to provoke “a near cataclysmic response” to the New Yorker and became a “common reference point” for “drawing battle lines” of the stakes involved in how we approach rhetorical performances of suffering (Berger, 1998 p. 2; Jurecic, 2012 p.13). Those lines seemingly follow to opposing critical stances identified by Paul Ricoeur’s (1970) hermeneutics of suspicion and hermeneutics of appreciation
Echoing the ancient tension identified by Aristotle between pathos and logos, there are those critical stances that are suspicious of affect, distrust the idea that a text can provide access to experience, denying the rhetoricity of personal suffering because it is considered an illusion, usurpation of reason, or subjected to oppressing forces of power. On the other hand, a hermeneutics of appreciation tries to “…let speak what once, what each time, was said, when meaning appeared anew, when meaning was at its fullest” (Ricoeur, 1970 p.27).

A more appreciative stance moves in faith and trust to willingly listen to the rhetorical force of suffering human beings and believes that meaningful communication is possible.

Also around this time, rhetorical scholar John Murphy (1995) drew attention to similar spurious distinctions emerging between rhetorical criticism and critical rhetoric. Briefly tracing the spirit of rhetorical criticism, or “the descendants of Whichelns” (p.2), and critical rhetoricians, represented by Raymie McKerrow (1989), Murphy identifies how arguments for a critical rhetoric as a practice of “never-ending skepticism” employ a dissociative rhetorical appeal that fail to appreciate the ever-present possibility of genuine public deliberation and the importance of performative traditions. While still supportive of critical projects in rhetorical studies, Murphy (1995) draws on Mikhail Bakhtin to argue,

…the "critical spirit" that we invoke has lived before; and the work that we do can benefit from those who have come before. Faith, not skepticism, is the hard work in an era of Gingrich and Foucault. I suspect, however, that a restoration of faith in the possibility of public deliberation will be neither as arduous nor as impossible as some suggest if we can learn from, rather than dismiss, the wisdom of living communities.

(p. 19)
This “suspiciousness” is also the subject of attention in Ann Jurecic’s (2012) book, *Illness as Narrative*. She identifies and evaluates a deficient mode in literary criticism of illness narratives. I quote at length Jurecic’s (2012) keen observation of contemporary critical practice because I feel it well captures the spirit of suspicion not only in literary criticism but also in the criticism in general. She writes:

…the hermeneutics of suspicion has displaced…listening and become ‘nearly synonymous with criticism itself’…Distrust of texts’ errors, lies, and manipulations has become prescriptive…for scholars trained in such habits of reading, the idea of trusting a narrative to provide access to the experience of another person indicates a naïve understanding of how texts function. Before a contemporary critic begins to read an autobiography about cancer or pain, she knows that it has been constructed by medical discourse and political, economic, and cultural forces. She also knows that common readers are likely to misread it because they will assume they can try on the experience of the author and that they will therefore succumb to the myriad of powers of dominant discourse. She is also likely to assume that the narrative itself is not as sophisticated or knowing as the theory she uses to interpret it…contemporary critics have become alienated from ordinary motives for reading and writing. (p. 3).

That “criticism has become synonymous with suspicion” is no less the case in rhetorical criticism, especially in the mode identified by Murphy (1995) above in the rise of “critical rhetoric,” as well as in the sense that “the ‘critical spirit’ invoked has ‘lived before’” (p. 19). Rhetorical studies has primarily and for the most part approached their objects of study suspiciously to greater and lesser degrees, insofar as the history of rhetorical studies has been to make some claim about what some message is, how it works, what was accomplished (cf.
The tension between appreciation and suspicion is perhaps as long-standing as is the tension between appeals based in logos or pathos. Consider Philip Wander & Steven Jenkins (1972) who observe:

Criticism means coming to terms with an object in light of one’s values. One discovers that a particular object holds interest over against any number of other potential objects; one tries to understand both the object and one’s interest in it; and one decides what to say about it… “What are my values; where do they come from; what sort of being they imply?” These questions lie at the heart of criticism as we conceive of it, but the practice of academic criticism tends to divert us from this kind of questioning… academic criticism is primarily interested in the demarcation of objects it looks at things out there, wasting little time on how they are apprehended by the critic…it does mask the personal quality of the critical act. This masking…offers a substitute for personal experience. (pp. 441)

Criticism in a suspicious stance towards personal experience of others and oneself remains blind and deaf to what it means that, in the critical move of analysis, we have betrayed our personal sense of what matters simply by choosing to focus criticism as an elucidation of rhetorical elements of any symbolic act. Rhetorical criticism has at times utilized historical and critical orientations as approaches for uncovering what any rhetorical act does what it does (cf. Lucas, 1981). In addition, Jasinski (2001b) suggests that even that distinction is problematic and may now be considered a distinction between historical and theoretical orientations. In fact, consider Celeste Condit’s (2013) observation that over the later half of the twentieth century,
From the primarily historical study of public address, rhetoricians spread out to study the tropes, genres, fantasy themes, narratives, ideographs, and multiple implied personas of virtually any type of human-generated text, from television programs to country music, to mainstream movies, to public parks and monuments, to scientific reports. Scholars worked to come to terms with an account of ‘ideas’ grounded in the materiality of symbols and their social circulation… (p. 2)

In either case, when the process of criticism involves turning a deaf ear or blind eye to the evocative aspects of a text – the mood, the feel, the suffering – and instead attend to a critical analysis and presentation of “an account of ideas,” then suspicion reifies alienating modes of encounter with others,’ and even our own modes of everyday address and appeal (Cf. Also Latour, 2004).

In Chapter 3 I presented both rhetorical disability and the inexpressibility thesis, and given the preceding discussion, we can now see these as two ways that suspicion plays out in public discourse and rhetorical criticism. In reading memoirs about mental illness and suffering the critic faces an ethical tension between practicing appreciation of another suffering, being willing to hear the cries and suffering, and taking a more detached and suspicious stance. If the critical act involves looking through or past such expressions in an effort to give an account of ideas at work in the text, then the critic becomes complicit in denying the rhetoricity of their suffering and the suffering in their rhetorical performance. The extreme position of critical rhetoricians who operate in a mode of continuous skepticism of rhetorical texts, particularly of that operation that seeks to uncover ideological content and power dynamics, are particularly prone to just such alienating and damaging stances.
What is needed is a neo-critical supplement rooted in appreciation of manifold phenomenological aspects of lived-experience (i.e., embodiment, sociality, symbolicity, and temporality) (cf. Anton, 2001). I believe continued rhetorical study of the extreme case of memoirs about illness and suffering offer just such opportunities for developing methodological orientations that can round out critical stances with an equally rigorous, mindful appreciation. Mood memoirs, and other illness narratives, offer ethical opportunities to study the rhetorical possibilities and dynamics at work when someone attempts to communicate experiences of disordered breakdowns to someone for some purpose, thus laying bare the workings of ideological and socially constructed meanings.

In this dissertation I have aimed to offer something different than the critical practice of suspicion. Though I have perhaps failed to remain completely appreciative at times. Indeed, it is simply not possible to remain wholly and completely open in appreciation, as I have had to offer an account of ideas about these texts to meet the whole bevy of requirements of the genre of a dissertation. Nonetheless, I have attempted to resist reading these texts with a particular kind of suspicion, the kind that seeks to uncover implicitly hidden ideological content. Thus my suggestion for future studies of mood memoirs is to remain mindful of the descriptive and appreciative approach because scholarly work on depression memoirs is just beginning and what is needed is to trace of their contours, feelings, and tones and offer what Jamison suggests: to conquer the beast by making it “beautiful.” This involves not a complete jettisoning of suspicion (which is not possible) but a commitment to mindfulness of appreciation, that is, a willingness to listen to the suffering in the text even if and when suspicion tugs.
Being Willing to Listen: Radical Encounter, Authenticity, and the Public Sphere

In Chapter 4 I briefly reviewed how rhetoric scholars have used the spheres of argument model to analyze public argument, noting in particular its use in “warning” about the dangers declining public discourse at the hands of technical and personal influences. This dissertation has been motivated by the question of how realities that on their surface appear radically different than what is considered normal are capable of connecting with audiences and effectively accomplish rhetorical goals. Just as the scholars following the legacy of Thomas Goodnight’s original essay on spheres of argument and his warning of the decline in meaningful public discourse, I too am invested in wanting to uplift the public sphere. But I do not share with Goodnight and other scholars in viewing the rise of personal or technical spheres as the cause of the decline in public discourse. Rather, the decline of public discourse sits squarely with those for whom the problem and the solution can take any meaningful and lasting form: the personal. What is needed is the cultivation of personal competencies of deepening and mindful personal engagement with self, world, and others.

If suspicion “lives” on in the spirit of criticism, then so too does the “willingness to listen” live on in the appreciative spirit of encounter in the public sphere. This process of being “willing to listen” is a key aspect of a popular view on how public discourse can be invigorated. In the introduction of Wayne Booth’s (1974) *Modern Dogma and the Rhetoric of Assent* he shares frustrations about the state of civic discourse. At the time, Booth had in mind the 1969 civil unrest on the University of Chicago campus over the firing of Marlene Dixon, a professor known to be a Marxist sociologist. Booth marvels at the lack of genuine communication between students and administration, and sees this failure rooted in lack of appreciation for rhetoric as a “whole philosophy of how men succeed or fail in discovering together, in discourse,
new levels of truth (or at least agreement) that neither side suspected before” (p.11). Both the administration and the student-body suffer from what Booth views as a “radically mistaken conception of the nature and possibilities of argument,” specifically the tendency towards a particular kind of “modernist” dogmatism that relies on the hard distinctions between facts and values.

If the word dogma is applicable to any general notion that cannot, for the believer, be brought into question, the belief that you cannot and indeed should not allow your values to intrude upon your cognitive life – that thought and knowledge and fact are on one side and affirmations of value on the other – has been until recently a dogma for all right-thinking moderns. (Booth, 1974 p.13)

For Booth, the discovery of a “truth” is neither “mere feeling” nor “mere fact-based deduction” but a process of mutual inquiry wherein people holding positions on an issue learn something more than how their opposition fails to fit into a preconceived view. In short, it is a process of willingly submitting oneself to radical relation and encounter, a willingness to be persuaded.

As seen in Chapter 2, the depression memoirs of Plath, Styron, and Jamison are a part of American popular culture and continue to have a lasting impact on public discourses on mental illness and personal, public, and technical understandings of feeling and moods more generally. I couched the historical context of these texts within the philosophical observations of Charles Taylor, who identified two forms of the pursuit of authenticity take shape in the 20th century, both limited in their approach to meaningful living. Taylor identifies these two forms as “knockers and boosters” and argues that both fail to meet one another in dialogue about authenticity because of a pervasive individualism and relativism at their root. To Taylor’s own meaning of these terms I highlight how his characterization of “knockers and boosters” functions
anecdotally to represent any moment in a public controversy wherein people’s attitudes, beliefs, and values feel like deeply irreconcilable positions, not unlike the rhetorical situation Booth was addressing in his time.

Taylor first identifies the “knockers.” These are people who feel the modern pursuit of authenticity is simply a brand of narcissism lacking any substantive or redeeming moral basis. Second, there are “boosters.” These are people who feel the modern pursuit of authenticity is an expression of individual freedom to self-fashion lives of their own. In either case, Taylor argues the atomistic individualism at the core of both positions makes it difficult for either position to articulate satisfactory reasons for pursuing a meaningful life. He writes,

The relativism was itself an offshoot of a form of individualism, whose principle is something like this: Everyone has a right to develop their own life, grounded on their own sense of what is really important of value. People are called upon to be true to themselves and to seek their own self-fulfillment. What this consists of, each must, in the last instance, determine for him or herself. No one else can or should try to dictate its content. (Taylor, 1992 p.14)

Both boosters and knockers are not discrete factions or interest groups or even easily categorized or explicitly known subcultures. Knockers and boosters refer to a general sense of being, a way people existentially relate to the pushes and pulls of life’s demands characterizing the 20th century.

For Taylor, these generalized senses of life bubble to the surface of public discourse whenever and wherever someone tries to persuade another person about the best way to live their life. He argues there is a pervasive inarticulacy surrounding a very important public ideal: “how best to live well.” As reviewed in Chapter 2, neither boosters nor knockers can thoughtfully
engage the question of meaningful living because of a pervasive atomistic individualism
constituting an ethos of “mutual respect” for the differences between people. The logic goes like
this: You shouldn’t tell people how to live their lives and you should not listen to others who
attempt to tell you how to do so. This is for you to figure out on your own. Respect others and,
“just do you.” Boosters argue that meaningful living is a personal matter that one should feel
through alone and cannot be reasoned with others through factual propositions. So no one can
talk about authenticity because it is a personal matter. Knockers argue that the idea of
meaningful living is really just a way for people to practice feel-good moral laxity and self-
serving narcissism at the expense of factual realities. So there is no reason to talk about
authenticity because it is nothing more than morally depravity. Both sides are unwilling (or
perhaps simply incapable) of being persuaded by, or earnestly listening to the opposing view to
find some common ground.

For Booth (1974), the acceptance of the fact-value dichotomy motivates an unwillingness
to listen to opposing positions on an issue because any single person can ground their rhetorical
behavior in the evaluation and/or demonstration of the “facts” or their “feelings” about any
matter of concern. Booth (1974) argues that, “whether by men of reason or men of faith…” the
fact-value dichotomy “…is often taken as the key test of modernity…” (p.14). He continues,

Each of these two main sects [men of reason or men of faith]…can easily show the
absurdities of the other, but the polemical displays of either side are so far from engaging
the real issues that they often seem to confirm, in their demonstration that meaningful
argument about such matters is impossible, the very distinction on which their war is
based. (p. 14)
It is tempting to cast knockers as “men of reason” and boosters as “men of faith,” but that would be a hasty generalization. What is, however, more useful to note is how Booth has identified a common way public discourse unravels on matters of importance, namely how generalized senses of being in the world coalesce into “sides of a debate” and fail to see opposing views as opportunities for dialogue and mutual inquiry. Instead, a debate emerges that is evaluated on persuasive strategies that conform to people’s proclivities for what counts as good reasons, be those “facts” or “feelings.” Neither side seems interested or driven towards mutual inquiry to discover new realities together.

Taylor attempts to find a middle position between knockers and boosters. To combat against the inarticulate relativism of respecting individual differences, Taylor (1992) calls for mutual inquiry on authenticity between boosters and knockers, namely that the arguments for authenticity “ought not be over authenticity, for or against, but about it, defining its proper meaning. We ought to be trying to lift the culture back up, closer to its motivating ideal” (p.73). Taylor suggest we do not tell people how to live their lives but that we should be willing to at least have a conversation with each other about what it means to live meaningfully. We should find deeper and more fulfilling ways of cultivating personally meaningful lives, ones that include a mindful awareness of the communally shared conditions of selfhood. In short, we should find new realities together through mutual inquiry.

Booth offers Taylor’s project “good medicine” in the palliative practice of “listening rhetoric.” Where ever opposing viewpoints have settled into hard defensible realities, listening rhetoric nicely points the way to how very different tones of life might attune to the each other, starting with the advice that “whatever imposes belief without personal engagement becomes inferior to whatever makes mutual exchange more likely” (Booth, 1974 p.137). The practice of
listening rhetoric is a very personal matter. It is the personal effort of using all of one’s communicative competence to reduce misunderstanding by paying full attention to opposing views, “listening to the other side, and then listening even harder to one’s own responses” (Booth, 2004 p.21). It is not strategies of persuasion that are needed when faced with an opposing view. In fact, Booth sees a sole focus on technical proficient persuasive strategies as subtle forms of coercion. Instead, Booth argues for meaningful engagement with the other view with trust and empathy.

Booth’s view subtly undercuts arguments reviewed in Chapter 3, namely those that argue that empathy is not only not really possible but also potentially politically dangerous. Booth’s argument does not suggest one finds oneself “in the other” but that two distinct people “find themselves” anew in finding new realities together. The purpose of listening rhetoric in its ideal form is to have both sides “pursue the truth behind their differences,” requiring one or both people to move beyond their original positions to find a new reality created through their mutual assessment of arguments, character, and emotional demonstrations. Listening rhetoric is a fully engaged, risk-fraught, and meaningful encounter with what is radically other for the purpose of discovering, together, a socially created truth.

In writing about their disordered experiences, Plath, Styron, and Jamison offer the moods of boosters and knackers a narrative world wherein attention is brought to conditions of selfhood as each author weaves narrative moments about the breakdown of those conditions. In a sense then these depression memoirs function as attunement devices, that is, these texts can color the tone of booster and knocker everyday moods. This attunement can assist in pushing against the inarticulacy of relativism that silences talk about how best to live the good life because each narrative subversively directs attention away from any one particular way of pursuing
authenticity and towards an encounter with selfhood’s fragile conditions. To read these works is already to be engaged in listening rhetoric.

In Chapter 3 I suggested that these texts communicate to non-depressed audiences through “radical relation.” Rather than suggest that two very different senses of reality can meet in some kind of unifying identification, I pointed to the process whereby encounter is sensed as the narratives about disordered realities continually interpose a division between disordered and readers’ normative experiences. Like the rhetorical process of Kenneth Burke’s “pure persuasion,” readers are then involved in a process of juxtaposition that takes them out of their own immediacy in the world and towards more deliberative consideration about their own everyday moods. In this sense, reading narratives about disordered realities become something of attunement devices that tune the mood of audiences, not unlike the classic concept of the exordium, or prefatory remarks that readies an audience’s ear for a persuasive appeal. In that moment reader and text are offered a radical encounter between two different senses of reality, one of which (the reader), discovering their own taken for granted senses of self through reading the breakdown in another’s sense of self.

Martha Nussbaum (1997) has perhaps famously offered her idea of “narrative imagination” as

an essential preparation for moral interaction. Habits of empathy and conjecture conduce to a certain type of citizenship and a certain form of community: one that cultivates a sympathetic responsiveness to another’s needs, and understands the way circumstances shape those needs, while respecting separateness and privacy. (p. 90)

Reading mood memoirs can offer just such a cultivation of the empathy required as a morally acting public. But, here there must be some caution. It’s worth noting that Nussbaum’s
characterization of the power of reading narratives as preparation for “ethical” practice has been critiqued as lacking in force because the empathy of reading a book in the private, quiet conditions of your home is not at all like the kind of empathy demanded when one encounters another person in the fleshy social situation (Keen, 2007). It is also worth noting that whilst it may seem that Booth’s ideas of willingness to listen as a mode of empathy would seem resonant with Nussbaum, Booth adds something very important: a self-reflectivity not just to listening to the other side, but to listening even harder to one’s own responses.

Booth is calling for personal mindfulness as a crucial, “even harder,” aspect of rhetorical situations if a willingness to listen and empathy for radical others is to be developed. Whilst we cannot ever identify completely with another’s experience of the world we can nonetheless become ever more mindful of our own inner responses to the suffering of others, the feelings of others, the moods of others, the attitudes, beliefs, and values of others. For it is this competence of mindfulness that grounds the real work of empathy, of being willing to listen. This involves a process of learning how to accept others as they are, rather than desiring to fit them into a preconceived view of how they should be, what they should think, how they should live. It is a mode of appreciating others through and through, but also appreciating more vividly one’s own being in the world exposed by such encounters of openness. Reading mood memoirs’ breakdowns of self and world offer opportunities for cultivation of personal inner rhetorical responsibilities.

In Chapter 2, I reviewed how the narrative accounts of Plath, Styron, and Jamison offer narrative depictions of radically different personal realities that have been characterized as perceptive, critical, and illuminating. Given a focus on radical relation as a moment of identification, the depression memoirs of Plath, Styron, and Jamison function dialogically to
achieve a sense of “existential wholeness” that, in the last analysis, is “never for oneself alone but for oneself with another” (Frank, 2000 p.153). To lay bare the nuance of the existential wholeness that readers might participate in when reading such disordered accounts, consider Bakhtin who observes,

What do I gain by having the other fuse with me? He will know and see but what I know and see, he will but repeat within himself the tragic dimensions of my life. Let him rather stay outside because from there he can know and see what I cannot see or know from my vantage point, and he can thus enrich essentially the event of my life. (cited in Todorov, 1984 p.108).

The “wholeness” of self-disclosing narratives of mental illness is their ability to generate a sense of identification with readers, but one that directs readers outside of the text to the substance of their own lived-experiences. It is not a pure identification with the author, but a plea to engage in a conversation between two persons, the suffering author and the normal reader moved to engage in the suffering of the author. In so doing, these works open a rhetorical dimension that shifts the grounds of debate to a radical, existential dimension and thus towards a deliberative call to dialogue.

As some final remarks, the history of these texts paints the image of each writer as an artist working with their experiences of disordered moods and the autobiographical form as their communicative palette for addressing what they see as problematic norms. Consider the rhetorical exigencies identified by Plath, Styron, and Jamison, specifically domesticity norms and anti-psychiatry, the blaming of mental illness on moral failing, and stigmatizing views on psychopharmaceutical use. Each exigency is a normative feature of a rhetorical environment, or customary and “normal” practices to which these author’s works of art were directed. Now,
imagine also that such environments are often imperceptible to their inhabitants, or at least certainly seemed so pervasive to Plath, Styron, and Jamison that a response was warranted. As such the finished literary artworks of The Bell Jar, Darkness Visible, and An Unquiet Mind enter into these rhetorical environments as “anti-environmental” forces. One function these works play in such a situation Marshall McLuhan (1966) observes,

Art as an anti-environment is an indispensable means of perception, for environments, as such, are imperceptible. Their power to impose their ground rules on our perceptual life is so complete that there is no scope for dialogue or interface. Hence the need for art or anti-environments. (pp. 91-92)

Depression is characterized clinically as an “anti-social” disorder, that is, disorders whose realities are foreign to normative, socially customary reality. This anti-environmental mood imbues the depression memoirs of Plath, Styron, and Jamison with a critical power. Again, I turn to McLuhan who writes:

The poet, the artist, the sleuth — whoever sharpens our perception tends to be antisocial; rarely “well-adjusted,” he cannot go along with currents and trends. A strange bond often exists among anti-social types in their power to see environments as they really are. This need to interface, to confront environments with a certain antisocial power, is manifest in the famous story, “The Emperor's New Clothes.” “Well-adjusted” courtiers, having vested interests, saw the Emperor as beautifully appointed. The “antisocial” brat, unaccustomed to the old environment, clearly saw that the Emperor “ain't got nothin' on.” The new environment was clearly visible to him. (McLuhan & Fiore, 1967 p. 88) Plath, Styron, and Jamison offer narratives about when they are not “well adjusted,” or attuned to social norms at a deep level. In inviting readers into narratives of those disordered experiences
they offer opportunities for readers to encounter the unused possibilities of the present. These works not only open up a space for reflection on the discourses of their specific times but also open up a space wherein the phenomenological conditions undergirding the sense of reality are laid bare. Readers are just as much offered opportunities to encounter the conditions of their own selfhood as they are to follow the affective appeals of Plath, Styron, and Jamison.
REFERENCES


Butler-Bowdon, T. (2007). *50 psychology classics: Who we are, how we think, what we do: Insight and inspiration from 50 key books*. Boston, MA: Nicholas Brealey.


doi:10.1353/lm.2011.0316


Lacy, W., & Zaroubin, G. N. (1958). Union of soviet socialist republics agreement to cultural, technological, and educational exchanges (*TIAS 3975*).


Leo, J. (1986, May 26). Talk is as good as a pill: NIMH study shows psychotherapy lifts depression. *Time, 127*(21), 60.


Retrieved from EBSCOHost. (Accession No. 9301032624).


Retrieved from EBSCO Host. (Accession No. 9310057689).


US Treaties and Other National Agreements, 1958 #3975, p. 13


Clinical correlate #3 Diagnosing depression in primary care

Read the following segments from William Styron's description of depression, and answer the study questions.

William Styron, *Darkness Visible* (excerpts)

Depression is a disorder of mood, so mysteriously painful and elusive in the way it becomes known to the self—to the mediating intellect—as too verge close to being beyond description, it thus remains nearly incomprehensible to those who have not experienced it in its extreme mode, although the gloom, "the blues" which people go through occasionally and associate with the general hassle of everyday existence are of such prevalence that they do give many individuals a hint of the illness in its catastrophic form. But at the time of which I write I had descended far past those familiar, manageable doldrums.

I had come to a point where I was carefully monitoring each phase of my deteriorating condition. My acceptance of the illness followed several months of denial during which, at first, I had ascribed the malaise and restlessness and sudden fits of anxiety to withdrawal from alcohol; I had abruptly abandoned whiskey and all other intoxicants that June.

pp.16-18

I was feeling in my mind a sensation close to, but indescribably different from, actual pain. This leads me to touch again on the elusive nature of such distress. That the word "indescribable" should present itself is no fortuitous, since it has to be emphasized that if the pain were readily describable most of the countless sufferers from this ancient affliction would have been able to confidently depict for their friends and loved ones (even their physicians) some of the actual dimensions of their torment, and perhaps elicit a comprehension that has been generally lacking; such incomprehension has usually been due not to a failure of
APPENDIX C

A Resident’s Guide
To Surviving
Psychiatric Training
2nd Edition

Edited by:
Tonya Foreman, M.D.
Leah J. Dickstein, M.D., M.A.
Amir Garakani, M.D.

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, Virginia 22209
www.psych.org

**Memoirs/Personal Accounts**


**Novels**

AM I DEPRESSED - OR IS IT SOMETHING ELSE?

Our mood naturally varies with time and from day to day and everyone gets down at times. We may say that we are "down", "fed up", or "feeling blue", or attribute it to "feeling under the weather"; we may get disheartened about something that happens or doesn't go the way we would have liked. Although people often say "I'm depressed" to mean these things, this experience would likely not be diagnosed as depression as it is simply part of the normal ups and downs of life. Some people naturally experience frequent mood changes, while others have a relatively stable equilibrium.

Similarly, if we suffer a major loss, we readily understand that it is normal to grieve. Although some of the emotions we feel when we are bereaved appear similar to depression, grieving is a natural and ultimately healing process. Sometimes, though, past losses which were not fully mourned at the time may appear as depression much later.

SO, WHAT IS DEPRESSION?

Put simply, the distinction between feeling "down" and being depressed is one of both degree and duration. Depression certainly includes a persistent low mood and loss of interest or pleasure in life; it also commonly involves symptoms from the following list:

- a change in eating, weight and/or sleep patterns
- lowered energy levels and a reduced level of physical activity
- difficulty with concentration
- feelings of worthlessness
- loss of interest, enthusiasm and enjoyment
- feeling irritable and short-tempered, or tearful
- being unable to continue as usual with work and interests, possibly as a result of feeling listless, (e.g., "I cannot be bothered" or "things feel pointless")
- sometimes people feel hopeless; s/he may feel like life is not worth living and may even have thoughts of suicide.

Please note that one may feel some of the above for reasons other than...
own battles with depression

- *Darkness Made Visible* by William Styron (Nonfiction) The novelist who wrote *Sophie's Choice*, Styron also wrote this brief but eloquent book about his depression.
Counseling and Consultation Service

Depression

What is depression?

Anyone can experience depression. However, the term is often misused. Everyone feels sad or down sometimes, but when it lasts for several days or even weeks it may be depression. Depression is a real illness that affects real people for a variety of reasons. Often times depression is linked to other physical or mental illnesses. If you are experiencing any of the symptoms below, please call CCS at 614.292.5766 and talk to the counselor on urgent duty or better yet, set up a phone screening /about-us-and-our-services/making-an-appointment/ to talk with someone further.

Physical

Managing Distress: Self-Management Skills Workshop

April’s Book of the Month: I Don’t Want to Talk About It: Overcoming the Legacy of Male Depression

Local Suicide Prevention Hotline. Call here first!


Online Resources:

- www.halffused.com
- Depression http://www.psychologydegree.net/
- Depression and Bipolar Support Alliance http://www.dbassalliance.org/bookstore/brochures.html
- Understanding and Treating Depression http://www.couns.ohio-state.edu/brochures/depression.htm

National Support Groups

- Depression and Related Affective Disorders Association http://www.drada.org/
- Emotional Health Anonymous http://www.flash.net/~spreyca
- Emotions Anonymous http://www.emotionsanonymous.org/
- National Alliance for the Mentally Ill http://www.nami.org/
- National Depressive and Manic Depressive Association http://www.ndmada.org/
- Prozac Survivors Support Group http://www.pssg.org/
- Postpartum Support International http://postpartum.net/
- Recovery http://www.recovery-inc.org/

The Ohio State University http://osu.edu

© 2014 The Ohio State University – Counseling and Consultation Service
Youkin Success Center (4th Floor), 1640 Neil Avenue, Columbus, OH 43210
Phone: 614-292-5756 | Fax: 614-688-3440 | Email Counseling and Consultation Service
mal浚ces@studentlife.osu.edu
If you have trouble accessing this page and need to request an alternate format, contact
accessibility@studentlife.osu.edu mailto:accessibility@studentlife.osu.edu?subject=CCS_Web_Site.