Re/construction of Self: Discourse, and the myth of the return analyzing the narratives of seven women diagnosed with schizophrenia

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Jeffery J. Hill

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Declaration of Committee

Name:	**Jeffery J. Hill**
Degree:	**Doctor of Philosophy (Individualized Interdisciplinary Studies)**
Title:	**Re/construction of Self: Discourse, and the myth of the return analyzing the narratives of seven women diagnosed with schizophrenia**

Committee:

Chair: **Stephen Duguid**
Professor Emeritus, Humanities
& Graduate Liberal Studies

Gary McCarron
Supervisor
Associate Professor, Communication

Samir Gandesha
Committee Member
Professor, Humanities

Michael Kenny
Committee Member
Professor Emeritus, Anthropology

Charles Scott
Examiner
Adjunct Professor, Education

Charles Reeve
External Examiner
Associate Professor, Liberal Arts & Sciences,
Graduate Studies
OCAD University

Abstract

Psychiatry underwent a significant transformation from 1945 to 1965, particularly with respect to techniques and practices for patients with schizophrenia. My dissertation offers evidence of this transformation in autobiographical narratives written by women diagnosed with schizophrenia published during this time that references psychiatric language in the patients' narratives of becoming, stories of their renewed self or return to their former state of normalcy. By analyzing these autobiographical texts in the historical context of these two decades, which included the widespread adoption of psychoanalytic theory in the late 1940s, the rise of the anti-psychiatry movement, and the introduction of anti-psychotics into the asylums, overlapping and intersecting spheres of influence in the field of psychiatry can be seen to inform the autobiographers' efforts to re/build their sense of self.

The socio-political and theoretical works of Erving Goffman, Michel Foucault, and Sigmund Freud serve as a foundation for this work. Vladimir Propp's study of the folktale form and structure, and the mythological motif of "the return" in particular, complements the work of these three figures and can consistently be seen in the architecture of narratives written by schizophrenics. These autobiographical schizophrenic narratives construct the authors as a third persona generated in the act of writing a "fabricated self." The writing process is therefore not a cure, but a desire to return to their family, their community, and ultimately to a normal state they believe existed prior to diagnosis.

Keywords: Schizophrenic narratives, autobiographical tales, psychoanalytic theory, Erving Goffman, Michel Foucault, Sigmund Freud, Vladimir Propp, Writing the Self

Dedication

To all those students and clients, I have had the honour of working with over the years. Just know that I have had the privilege of learning more from you, than I could ever teach you.

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Dr. Jerry Zaslove, mentor and friend, patiently and tirelessly walked me through the labyrinth of thought and theory that surrounds the maligned but influential figure of Sigmund Freud. His valuable readings and recommendations revealed where psychoanalysis could be essential to my dissertation.

Finally, I would like to thank my wife, Amanda, for her support, patience and willingness to put up with the loss of the dining room table, kitchen counter, and bedroom floor to stacks of paper, books, articles, and notes. I am sure she will be happy to have her house return to normal.

To others too numerous to mention, thank you so much for your help with this work.

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Preface

> *"He who has once begun to open the fan of memory never comes to the end of its segments; no image satisfies him, for he has seen that it can be unfolded, and only in the folds does the truth reside." —Benjamin, 6*
>
> *"Autobiography has to do with time, with sequence and what makes up the continuous flow of life … for even if months and years appear here, it is in the form they have at the moment of recollection." —Benjamin, 28*

In *Anti-Oedipus: Capitalism and Schizophrenia* (1972), Gilles Deleuze and Felix Guattari recount the time they were asked "if we had ever seen a schizophrenic" to which they replied "No, no, we have never seen one" (380). This is a revealing question to pose to two great minds of the last century. Both Deleuze (1925–1995) and Guattari (1930–1992) were French philosophers and Guattari was also a psychotherapist. Their response is tongue-in-cheek given that Guattari worked as a practicing psychotherapist in the La Borde Clinic where he met many patients diagnosed with schizophrenia. Perhaps they meant to imply there was no single *defining* example of schizophrenia as diagnosing the disease was highly subjective and involved an assessment of a whole constellation of symptoms that could suggest any number of maladies along the full spectrum of mental disturbances.

I begin with this anecdote not to be flippant, but to suggest that schizophrenia presents a unique challenge for many with this diagnosis when narrating their story to others, such as employers, counsellors, and even new acquaintances. What I have noticed is that these individuals tend to identify themselves initially by saying "I am schizophrenic" before telling their tales of woe. For example, in the fall of 1992 at a small private recreation facility where I was working as a Recreational Attendant, a regular guest dropped by to say a friendly good morning. He turned to me and added, "I have something I need to tell you." I was distracted trying to get the facilities ready for activities. He whispered, "It is rather personal, and I don't know how to tell you this." He typically arrived with another man with whom he talked on the sunny patio. He must have noticed my body language change because he said, "You thought I was going to tell you I was gay, didn't you?" I denied this before he blurted out, "I am schizophrenic." I offered a nonchalant acknowledgement and he asked, "Doesn't that bother you?" I said,

“No” and went on to explain that being schizophrenic did not change how I perceived him.

We became friends while I was employed at the centre and he told me about his shrinking world following his diagnosis. He was prescribed medication to minimize auditory hallucinations and then additional drugs to reduce the side effects of the first. He was prescribed other meds to help him sleep and if he did find a medication that worked for him, he was often taken off it because of a reported increase in patient suicide and placed on another form of anti-psychotic instead. Despite this, his life was relatively stable, but he often described himself as “bored.” He was functioning, but he was not living. He was at a psycho-pharmaceutical and personal impasse. As long as he managed his meds and did not work, he could collect his disability pension. If he decided to get a job, or volunteer, or go back to school, he would lose his disability pension, cutting off his medical insurance, which covered the cost of his meds, which in turn kept him healthy and able to return to work, if permitted.

Introduction

Having worked with people with mental health disabilities for almost 25 years as an Instructional Associate, I have grown accustomed to hearing my clients reveal their diagnosis by way of identifying themselves. This anecdote reveals a scenario common to schizophrenics who often cite their diagnosis and then tell their tale, beginning not in early childhood, but from the moment they received that diagnosis. These stories are typically constructions of who they are as individuals, built from fragments of memories, familial tales of their formative years, reflections, comments from past caseworkers, and statements from doctors, psychiatrists, or other medical professionals.

In revisiting other similar examples from my own experience, I am struck by both the language schizophrenics use to tell their stories and the form the stories take. Typically, schizophrenics pepper their narratives with psychoanalytic terms and adopt medical language to construct and maintain their sense of self. Notably, if this expression of self is constructed using the language and expressions of a particular time period, the notion of self is, by this definition, a function of that finite context. As the language changes and new tools and vocabulary materialize, patients avail themselves of these terms to craft an ever-more precise self, reflective of this new moment. The language they use is drawn not only from what they have archived in their minds based on what they have heard or read, but also from what has been used to describe them by those in authority. As they age, they acquire more language, just as a child learns new words and concepts with maturity. This ongoing development of language acquisition is an essential foundational concept, not only during childhood but as I will demonstrate throughout one's life, and one Jean Piaget expanded upon when he delivered a lecture to the Alfred Binet Society in 1920 in which he discussed the shift children make from seeing themselves as a subject to becoming an object among many other objects in their world. This is the moment the individual's backstage persona takes center stage, or in Piaget's theory, the ego appears (qtd. in "Concept of Egocentrism" 2011). This egocentric self begins to identify itself both orally and in print. It is at this moment or these moments the individual becomes more than just the one. The individual becomes the many among others, the subjective objective, a self that both recognizes and realizes their place within the world. Plus, the undeveloped self of the child begins to

grasp the need to not only preserve their self-esteem but also hide their quirks and idiosyncrasies behind the mask of projected poise.

In order to understand these processes in greater detail, this thesis considers eight autobiographical texts composed by authors diagnosed with schizophrenia. These autobiographical narratives frame one's concept of self, and, of particular interest to me, are sites where schizophrenics might also use diagnostic language to establish their identity. It raises the question, once one crosses the threshold between sanity and insanity (a subjective threshold influenced by many socio-political factors), whether the mind retains this diagnostic language and interpolates it to construct identity. By examining the creative and intellectual expression of the schizophrenic experience through their autobiographical narratives through the use of Michel Foucault's concept of "discursive practices", we can analyze the use of language, symbols, and images to determine what the authors consider significant for their audience (*Archeology of Knowledge* 60). These "discursive practices" also provide the means or lens through which each author tells her story during the shifting psychiatric practices and rules of engagement being experienced over time. To that end, the eight narratives selected for analysis here are commercially published autobiographical texts and first-hand accounts by psychiatric survivors uncovered from the Psychiatric Survivors Archive located in Toronto, Ontario. These reveal how the schizophrenic, through his/her written material, re/constructs a sense of self from memories, reveries, or recollections and how these echoes of the past reflect cascading experiences set in particular times and places.

Furthermore, taken together these "narratives of self" adopt a consistent and revealing form, one common to myths in which a hero makes an audacious return to his/her "normal" life as it was prior to a significant deviation/crisis/adventure. This return to normalcy not only signifies for the schizophrenic "being cured," but also "coming home" to their family, friends, and community. I would go even further to suggest that schizophrenics, through the act of writing their own narratives, not only re/construct a normal self, but do so as a means of *responding* to their own psychiatric case history. The sample schizophrenic autobiographies thus will be examined for the presence of these two characteristic features: 1) the use of language, images, and expressions reflecting psychiatric theory at the time of writing and 2) mythological structures akin to those in folklore and fairy tales. I contend that it is the interplay between these two

approaches to the autobiographical narrative that best explains how the schizophrenic as autobiographer re/creates a sense of self.

To extend this logic further, if schizophrenia is a "splitting" of one's thoughts and emotions so that the disorder results in the perceived presence of more than one clear self, their autobiographical narratives might re/create a singular self by adopting psychiatric language that delineates the stages of a schizophrenic's evolution. In sharing the story of internalized experiences and emotions against the constraints of family, community, and institution, the schizophrenic is able to externalize these to a character for an audience. This process allows the schizophrenic to establish an alternative case history and articulate his/her/their own tale to supplement the psychiatric dossier.

This dissertation will further examine how vignettes presented in these autobiographical texts chart a course from madness to normalcy, as defined by each of the authors. In doing so, I will call upon the work of Erving Goffman and Michel Foucault to establish how this trajectory influences notions of the self. Early on, Goffman describes the self – or individual – as emerging from a process of "impression management [and] performance… defined as all the activity of a given participant on a given occasion, which serves to influence in any way any of the other participants" (*Presentation of Self* 15). Goffman includes activities such as "fantasies… anecdotes from the past – real, embroidered, or fictitious – [which] are told and retold" (14).

Michel Foucault, on the other hand, describes the "cultivation of self, wherein the relations of oneself to oneself were intensified and valorized" (*Care of the Self* 43). Foucault describes this process in considerable detail in the context of historical practices outlined in *The History of Sexuality* (1986). Foucault in particular highlights the act of "self-writing or the retreat within oneself" (51), the ideas surrounding the "return to oneself" (46), and the "discourse of self with others" (52). Although the works of both Goffman and Foucault are essential to understanding how continually developing one's self is ultimately a process of reconstruction, their theories do not fully address the issues this presents for the schizophrenic.

The autobiographical material analyzed herein suggests the self is much more complex for the schizophrenic, and in fact for all of us, than these theories allow. In fact, the self may consist of all that we know, but it is also comprised of a great deal of that

we have forgotten yet fabricate as a means of remembering. The self as recalled, and re/constructed, is drawn from our internal mental appreciation of it and from our social interactions. The self is present in a particular time and space, as well as vertically and horizontally over the course of a lifetime lived within the wider social experience. These selves can be fleeting and easily frayed, more so if diagnosed with schizophrenia. The schizophrenic authors of the autobiographical accounts examined here describe these acts of becoming not so much as a cure, but as a testament that outlines their "return to self."

To begin this undertaking, I will venture into the murky waters of that literary genre sometimes referred to as autobiography. In an overview of prevailing thoughts both current and those originating from the past, I will attempt to grapple with how to define autobiography, and what constitutes an autobiographical text. In addition, I will discuss the ever-evolving questions that swirl around not only the shifting nature of autobiography, but also the authenticity of the material revealed by the author. Then, starting in Chapter 2, I will provide some historical background regarding the psychiatric developments leading up to the diagnostic criteria necessary for an individual to be labeled schizophrenic. I will also offer a brief history of the prevailing forms of psychiatric theories and practices in the US, UK, Australia, and New Zealand (where these texts have been published) from 1945-65, two decades characterized by 1) allegiance to Freud and attesting to the long shadow he cast over the profession of psychoanalysis; 2) the refutation of his effectiveness in the anti-psychiatry movement that paralleled his influence; and 3) the increased prescription of psycho-pharmaceutical drugs as an alternative. What I hope to reveal is that despite variances in the female authors' geographical locale, their families' socio-economic status, and the age of their institutionalization, they each experience and express a common tale, so that their stories to a large extent can be said to overlap. This is particularly true of their use of psychiatric language, which frames much of the autobiographical content.

In the third chapter, I will concentrate on Sigmund Freud and what I refer to as his shadow, Freud's vast influence over the field of psychoanalysis and psychiatry, focusing predominantly on his theories about mental trauma originating from childhood, repression, and the unconscious. These concepts will be developed and adapted through an examination of *The Interpretation of Dreams* (1900), *The Psychopathology of Everyday Life* (1904), *The Ego and the Id* (1923), as well as several essays and articles

written over the course of Freud's lifetime. Furthermore, a great deal of the language surrounding both the potential cause of and the treatment of mental illness during the timeframe in question originates from Freudian psychoanalysis. Consequently, his influence is evident throughout the autobiographical material examined as these seven women document their lives in and out of a mental institution. Freud's influence can also be felt to some extent within the ever-widening social circles of society as psychoanalytic investigation was incorporated in literature, art, film, and television of the day. Although the advent of antipsychotics eventually trumped psychoanalysis, Freud's psychoanalytic language remained firmly entrenched in society at large. Freud's ideas, terminology, and theories were simply in the air, especially in the lexicon of those labeled insane, and even today many of these terms remain ingrained within psychiatry, even though such usage may be more understated and less visible than it was 60 years ago.

I will then use Vladimir Propp's (1895 – 1970) concept of a "textual morphology," in particular his theories of the "journey" and the "return", in Chapter 4 to continue building an understanding of how the schizophrenic begins to construct a sense of self. Propp's analysis of the folktale determined that "from the historical point of view… the fairy tale, amounts to a myth" (Propp 82). He adds that "the creator of the folktale rarely invents … he receives his material from his surroundings or from current realities and adopts the form of the folktale" (Propp 102). Propp suggests that the characters, setting, and plot can be interchanged without changing the outcome of the overall storyline as the myth follows a familiar narrative pattern and a set of "functions." He reminds us that "the folktale possesses one special characteristic: components of one tale can, without any alteration whatsoever, be transferred to another" (Propp 6). Fascinatingly, each autobiographical narrative examined here shares certain structural components that function in this same mythological manner. Parallel to Propp's extensive use of myth and the symbols involved in the myth making process, Susanna Egan, in her text, *Patterns of Experience in Autobiography*, outlines the four basic narrative patterns that tend to determine "how the autobiographer attempts to find and reveal his inner self" (Egan 11). These essential patterns are then broken down into the following four mythic components or metaphors; 1) paradise lost and found, 2) confession, 3) conversion, and 4) the journey. Egan uses "journey" to highlight the "process of coming of age" (104); she also describes how the autobiographer using the journey as metaphor "represents a rite of passage, a particular metamorphosis celebrated in archetypal myth" (104). This

process, as realised by the autobiographer, provides not only a narrative devise to allow the autobiographical life to unfold before the reader structurally; it also, provides the opportunity for the autobiographer to develop and rationalize the experiences and emotional content as a means for creating the form of self exposed within the text.

And, like Propp, Susanna Egan also suggests that autobiographies often use the "myth-as-metaphor … [as it] serves to condense experience into a narrative of tellable length" (Egan 20). Each author here describes her experience using the Homeric pattern of "the journey" in a particular sequence: admittance or "rites of passage;" a metaphorical decent into hell (as so aptly described by Doris Lessing in her book *Briefing for a Descent into Hell*) or the "mortification of self;" and the return, not only to home or family, but more importantly, a return to normal. This blurring of the line between fiction and non-fiction offers an opportunity to fabricate a new self. Egan suggests autobiographers use myth as a tried-and-true literary structure for the telling of their tale because it describes a secret and inner experience that is "an emotionally and generally accurate description of that experience and because it means much the same thing to him as it does to his reader" (Egan 5). I will be focusing much of my analysis on the concept of "journey" as a narrative metaphor describing the nature and sense of return garnered from those autobiographical texts as produced by the schizophrenic as author.

In Chapter 5, I employ Erving Goffman's "frame analysis" as well as his dramaturgical approach to highlight how the authors' performances/experiences, and their underlying expectations both create and inhibit a possible re/fabrication of self. I will be probing Goffman's short paper, "Insanity of Place" (1969) which is not as well-known as the previous texts, but is also relevant to my research as it provides an insiders look at living with the mentally ill. I will also be examining the following texts, *The Presentation of Self in Everyday Life*, *Asylums*, *Stigma*, and *Frame Analysis* to establish how psychiatric terminology began to invade the language practices of everyday usage and in particular those autobiographical texts to be discussed in greater detail further in my dissertation. At which time, I will begin to examine and explain the re/construction of self as it is reflected in what Goffman terms the psychiatrized-self as well as his use of Cooley's concept of the looking-glass self.

This “psychiatrized-self” does not follow the normal assembly in which “an individual’s life course is an image constructed of their past, present, and future” (*Asylums* 150). For the patient “one’s stories are constructed along psychiatric lines… [which included] more than the official sheet of paper [but also] the case record… and the dossier” (*Asylums* 153-155). As such, the self is “not a property of the person … but dwells rather in the pattern of social control” (*Asylums* 168). Goffman summarizes his thinking by stating, “No clear-cut line can be drawn between normal people and mental patients, rather there is a continuum with well-adjusted people at one end and the full-fledged psychotic at the other” (*Asylums* 303). However, he goes on to state “the self may not be full formed … and our sense of personal identity often resides in the cracks” (*Asylums* 320). It will be Goffman’s conceptualization of “self” that will greatly influence my own working definition of self.

Goffman’s interest in the construction of self began very early in his career and would gradually be refined over the course of his lifetime. In 1952, as he was writing his PhD proposal, Goffman recognized the importance of observing “face-to-face interaction” and the subsequent behaviours that arise out of such interactions. He wrote that from the interactions of others “a person’s conduct during social interaction could be placed in a wider context of general information about his role, his relationships, and his reputation” (“Draft of Thesis Statement” 4). In addition, Goffman wrote, “rules regarding the transmission about self, that is, rules regarding self-expression, ought to be considered in relation to the strategies and ruses that are practiced as a means of adjusting to these rules” (“Draft of Thesis Statement” 6). And beginning from these ideas, we can begin to see Goffman’s concept of self emerge, even though at this time it could be considered an evolving idea. As Goffman’s work matured so did his conceptualization of self. This concept of self evolved into a multi-dimensional construct which can be represented as containing three main components. These components are referred to as 1) the Situated Self, 2) Self as performer, and 3) as Selfhood. Goffman describes the situated self resulting from the role that the individual is expected to play within a specific situation. Explaining this idea, Goffman states, “Thus, for example, when customers enter a service establishment, they clearly appreciate that all employees are different from customers by virtue of this official role” (*Presentation of Self* 104). Second, each individual within a scene, such as retail store take on specific roles, and in so doing become performers who manage the impressions they make as

they interact with one another. As a performer, the self must then construct the image they want to portray and maintain this image in order to represent the person they want acknowledged. Goffman further explains that “this self itself does not derive from its possessor, but from the whole scene of his action, being generated by that attribute of local events which renders them interpretable by witnesses” (253). Lastly, selfhood or the self, as Goffman writes, “is a product of all of these arrangements, and in all of its parts bears the marks of this genesis” (253). Furthermore, Goffman says these selves contain both a back region and a front region; “a back region with its tools for shaping the body, and a front region with its fixed props” (253). Therefore, from the combined concepts of the constructed self and impression management I will develop a “Goffmanesque” like definition of self which will be further developed in my dissertation.

Near the end of Chapter 5, I will also interpolate the work of French philosopher Michel Foucault, particularly his *Archeology of Knowledge* (1972) and Discipline and Punish (1975), with respect to the importance of discursive practices, so that the autobiographical material can be understood as a socio-historical object. In addition, I will be looking closely at what Foucault outlines as a “corpus of knowledge” which is the accumulation of professional and paraprofessional notes, observations, personal histories, as well as other documents. These documents then provide for the construction of the patient’s dossier which will follow the patient from institution to institution, doctor to psychiatrist, and sometimes even back into the community through family support services. What will become evident is not only the diagnosis and forms of treatment which follows the patient, but also the language applied by psychiatry as a means to explain why the patient behaves the way they do.

Foucault’s understanding of language as a means of communicating power and knowledge is closely linked to this wider notion of control. For my purposes, Foucault’s *History of Madness* (1961) and *Birth of the Clinic* (1973) offer invaluable insight in this regard. They lay the groundwork for, and continue the interrogation of a discourse he calls an “archaeological method” to determine how relatively innocent words can establish the signs and symptoms of a schizophrenia diagnosis. As Foucault suggested in his seminal *Archaeology of Knowledge*, “Statements different in form, and dispersed in time, form a group if they refer to one and the same object… mental illness was constituted by all that was said in all the statements that named it, and traced its development” (*Archaeology of Knowledge* 32). Foucault’s adds, “discourse is not the

majestically unfolding manifestation of a thinking, knowing, speaking subject but, on the contrary, a totality in which the dispersion of the subject and his discontinuity with himself may be determined" (*Archaeology of Knowledge* 55).

In *Birth of the Clinic*, Foucault suggested that "medicine must no longer be confined to the abode of techniques for curing ills and of the knowledge that they require … it will also embrace a knowledge of the healthy man… non-sick man, and the model man… it assumes a normative posture" (*Birth of the Clinic* 34). Normative is understood here to be more than being healthy in both mind and body; it takes in every aspect of society. The individual is observed as an object under the gaze of family members, teachers, employers, doctors, and psychiatrists. Foucault said, "language is the primary and alternate structure of madness" (*History of Madness* 237) and furthermore "in madness, man is separated from his own truth [whereby] he loses himself" (*History of Madness* 380). In losing oneself, Foucault suggests "the science of mental illness, as it developed in the asylums, was only ever of the order of observation and classification. It was never a dialogue…" (*History of Madness* 487). The autobiographical accounts by these seven women provide the mad (schizophrenic) with a reply, the ability to enter into a dialogue that eventually went beyond the walls of the institution.

Lastly, in Chapter 6, I will discuss the sources and where I located the material that the research consists of. I will then venture into the realm of schizophrenia and summarize the autobiographical narratives written by seven women, all of whom were at one time or another diagnosed as schizophrenic. However, I will focus on three authors and their narratives, Joanne Greenberg, Janet Frame, and Marguerite Sèchehaye. It is during this discussion, that I will present the written material contained within these texts describing how the authors present a sense of self through the language of their narratives. The eight main texts to be analyzed and a brief outline of their position within my dissertation will be as follows:

First, I undertake a close reading of Marguerite Sèchehaye's *Autobiography of a Schizophrenic Girl: The True Story of "Renee* (1951), the tale of a young woman's journey from the initial onset of mental illness, through diagnosis and treatment, and ultimately to her recovery. *Autobiography of a Schizophrenic Girl* highlights the nature of psychiatric care in the late 1940s in cases of individuals diagnosed as schizophrenic. In reading Sèchehaye's book, the reader becomes aware of the way that psychiatric care

was modelled more on trial and error than a standardized course of treatment. Renée's story also reveals a patient teetering on the edge of a psychiatric precipice, where readers see the beginning of a shift away from the previous diagnosis of dementia praecox to that of schizophrenia. This autobiography also shows the shift in care from institutional disregard to the attempts made by psychotherapy, with its focus on the so-called talking cure, to re-establish a connection with the patient.

The second text discussed is Joanne Greenberg's *I Never Promised You a Rose Garden*, written in the late 1950's but published in 1964. Initially, Joanne used the pseudonym Hannah Green as a means of removing herself from the stigma attached to her mental health diagnosis. She would also change the main character's name to Deborah Blau to further distance herself from the schizophrenic label. Joanne's story takes the reader through the corridors and treatment regimen of the fabled Chestnut Lodge, located in Rockville, Maryland. This is not only the tale of Joanne Greenberg; it is also the tale of Dr. Frieda Fromm-Reichmann and her unwavering belief that psychotherapy could, if done correctly, assist in the cure of schizophrenia.

Next, I analyze Janet Frame's *Faces in the Water* written in 1961. Frame was a well-known author of considerable prominence known both in her home of New Zealand and around the world. Like Joanne Greenberg, Frame employs a pseudonym when telling the story of her experiences under the control of psychiatric care and treatment. She writes her story from the perspective of Istina Mavet; however, as I argue, Janet's experiences with the mental health system mirrors that of Istina's in almost every aspect. Janet's account of life within the asylum is like many of the others as she details the neglect, abuse, and the constant disregard of her fundamental human dignity as she experienced these during her treatment. And like the other authors that I discuss, Janet's tale is so familiar that it is worth reminding the reader that it took place halfway around the world.

Clare Marc Wallace provides texts four and five on my list of autobiographies written by someone diagnosed with schizophrenia. Wallace's *Portrait of a Schizophrenic Nurse* and *Thank You Mr. Freud*, published 1964 and 1965 respectively, offer the reader unique insights into life within the psychiatric hospital. Wallace not only worked as a trained psychiatric nurse, she also frequently found herself a patient at several mental institutions in and around the London area. Clare Marc Wallace's stories are particularly

important as they capture the overlapping shifts in the different psychiatric spheres of influence I discuss in the thesis. Her treatment coincided with the increasing use of psycho-pharmaceuticals as replacements for other practices, such as psychotherapy. What makes Wallace's account so fascinating is her recognition—as both nurse and patient—that many things were not right within the psychiatric wards, and that writing provided a means for her to better understand her own predicament.

The sixth text I analyze is Lara Jefferson's *These Are My Sisters* which was published in 1947. Jefferson's text was written by one of the older women in this collection of autobiographical accounts. As Lara explains, madness "did overtake [her] in the twenty-ninth year" (18). She details her time spent in the wards of a large mid-western American mental hospital, and her experiences provide the reader with a vivid account of life as a schizophrenic where she was subjected to a great deal of neglect and abuse at the hands of those ostensibly attempting a cure. To understand her situation, Lara recorded her life on scraps of paper using a pencil she managed to secret away. Her notes, later edited and published, bemoan the horrid conditions and lack of psychiatric care for many living within the walls of the mental institution's back wards. However, her tale also offers the reader a sense of hope in the accounts of the women she meets and befriends while living in the wards.

Barbara O'Brien's (also a pseudonym) account titled, *Operators and Things: The Inner Life of a Schizophrenic* published in 1958 was written as form of therapy at the suggestion of a psychotherapist. Barbara's description of her schizophrenic experience literally follows the trajectory of a hero's journey. At the outset of her schizophrenic break, Barbara would board a Greyhound Bus at the suggestion of one her hallucinations and travel across the USA. Her journey through madness is very different from the other women because she only spent a couple of days committed to the psychiatric ward of a general hospital before she walked out. O'Brien's experience with schizophrenia was also short lived, only lasting approximately 6 months before reality began its sudden return. What makes O'Brien's text important is the picture she presents of madness being related to the concept of a journey. And it is this idea surrounding the concept of a "journey" that would heavily influence RD Laing and others in the anti-psychiatry movement.

Finally, the last autobiographical text that I discuss is *The Lost Days of My Life*, written by Jane Simpson and published in 1958. Jane Simpson was the youngest of the authors I study. Diagnosed as schizophrenic and institutionalized at the age of thirteen, Simpson spent the next thirteen years of her life being transferred from institution to institution. In the end, Simpson completed her high school diploma and went on to live her life outside of the institution. Simpson's story is important for her description of the horrendous conditions she experienced while institutionalized and the various forms of treatment she endured throughout her incarceration. She describes insulin induced comas, electric shock treatment, being forcefully tube fed, left in straightjackets, and the use of numerous sedatives to quell the rage of her madness. Yet, in the end, Jane's improvement came about in part because of the interest demonstrated by one psychotherapist who took the time to stop and listen to her story.

Once again, it is from these autobiographical accounts that we see the multifaceted and multi-layered components of my argument starting to come together to formulate the processes involved in the re/construction of the self as portrayed in the autobiographical narratives of those authors diagnosed as schizophrenic. These components of my argument hinge on the complementary nature between the explanation and understanding of this "hermeneutic arc" and the structural analysis, as outlined by Paul Ricoeur. Granted, Ricoeur's concept of the "*hermeneutic arc*" as outlined in his essays "What is a text?" and "Appropriation" may be a multifaceted theoretical approach describing the individual's level of comprehension as it moves from a point of explanation towards a position of understanding, and ultimately becoming a means for appropriation (*Hermeneutics and the Human Sciences*). Consequently, the reader of autobiography needs to realize that Ricoeur's concepts, explanation and understanding may seem to be diametrically opposed, they are in fact not mutually exclusive. In fact, the two concepts form spheres of knowledge which can only be incorporated into Ricoeur's hermeneutic circle through the individual's appropriation of the discourse which is in this case the autobiographical text. Furthermore, a text "transcends its own psycho-sociological conditions of production and thereby opens its self to an unlimited series of readings, themselves situated in different socio-cultural conditions" (101). However, when it comes to the authors of these texts, we realize that what may first appear as written discourse is actually a manifestation of both an oral discourse originating from the psychoanalytic and the written discourse formulated within

the autobiographical. Whereby the author engages in Ricoeur's hermeneutic process in which the circle or arc is completed. Thus, explanation of illness takes on understanding of illness (perhaps not for all) through the hermeneutic process involved in writing. When applied to the autobiographical material of these seven women diagnosed with schizophrenia forms an important role in merging seemingly disparate theoretical modes into a whole. From which my hypothesis emerges that the schizophrenic as author of their own life experience incorporates the psychiatric language over time and place as a means of re/constructing a sense of self within the dynamics of what can only be described as that which constitutes normalcy. I use the term normalcy in a broad manner as what constitutes normal although relative is also as we shall see often prescribed by the psychiatric profession, particularly within their diagnostic set of tools. However, what I will demonstrate is that the schizophrenic as author of self will integrate the psychiatric language (so often used as a means of dehumanizing and decentering the self) into their autobiographical narratives. These same authors will use this terminology to understand and re/construct a sense of self and as well as a sense of normalcy through their own autobiographical works. From this re/construction, what will become apparent from my argument is that the concept of self as well as the seeking of normalcy is structured along the lines of a myth. And, as we shall see, these texts as artifacts must be viewed not only as an integral part of the psychiatric experience, but also as vital to our understanding of the shifting historical landscapes of this timeframe.

Chapter 1. Method: Morphology, Framing, and Archeology of the Schizophrenic Narrative

I have adopted an interdisciplinary approach to the autobiographical narratives in order to provide theoretical depth as well as historical and socio-cultural context for roughly the two decades following the Second World War that this study analyzes, a very active and controversial period in the field of psychiatry and psychoanalysis as the next chapter underscores. It was also a turbulent time socially, as these 20 years saw the rise of "second wave feminism," (particularly after the publishing of Simone de Beauvoir's *The Second Sex* in 1949), signalled by Betty Friedan's *The Feminine Mystique* (1963) and the civil rights movement in the US. What Louis Menand (1952 -), professor, critic, and essayist in his text *The Free World: Art and Thought in the Cold War* (2021), so succinctly referred to as "the three pieces to the regime of subordination" (570). The three pieces Menand sets out as patriarchy, sexism, and misogyny. These socio-cultural forces influenced the writing and reading of the autobiographies I am examining, so a structural hermeneutic approach - whereby the autobiographical material becomes an object of analysis in relation to the autobiographical experience of writing and reading of each text – seemed most appropriate.

By structural hermeneutic, I propose a methodology similar to that set out by French Philosopher, Paul Ricoeur (1913-2005) in his essay, "What is Text? Explanation and Understanding". In this essay, Ricoeur explains that "in hermeneutical reflection – or in reflective hermeneutics – the constitution of the *self* is contemporaneous with the constitution of meaning (italics in original) (120). In this case, the self that Ricoeur references has a double meaning because it stems from the interpretation of the text rendering the possibility for the presence of not only a "self" but "another" (114). These two terms represent what I understand to be the author and the reader/audience formulated from the hermeneutic process. However, Ricoeur did not stop there; he proceeded to demonstrate that "structural analysis and hermeneutics [are] complementary" (121), and that if "we regard structural analysis as a stage – and a necessary one – between a naïve and critical interpretation, between a surface and a depth interpretation, then it seems possible to situate explanation and interpretation along a unique *hermeneutical arc*" (Italics in the original) (123). What I understand this hermeneutic arc to mean, and how I intend to use this concept to consolidate the parts

of this dissertation into a working whole, is the concept of the arc represents the path the individual takes as they move from explanation towards understanding. It is important to note that this path is not one-directional nor is it frozen in its dialectical stance. Rather, the hermeneutic arc reflects what may be referred to as a fluid search for understanding. “To understand”, Ricoeur writes, “is to follow the dynamic of the work, its movement from what it says to that about what it speaks. Beyond my situation as reader, beyond the situation of the author.” (*Hermeneutics and the Human Sciences* 139)

Ricoeur would further develop what he refers to as a “sense of narrative” which consists “in the very arrangement of the elements, in the power of the whole to integrate the sub-units and conversely, the sense of an element is its capacity to enter in relation with other elements and with the whole of the work … [defining] the closure of the narrative” (“What is text?” 118). He would add that “The task of structural analysis will be to carry out the segmentation of the work (horizontal aspect), then to establish the various levels of integration of the parts in the whole (hierarchical aspect)” (118). However, I will consider the “horizontal aspect” of the schizophrenic narrative to be closely aligned with the theoretical works of Vladimir Propp, Erving Goffman, and Michel Foucault. Propp’s “morphology”, Goffman’s “frame analysis”, and Foucault’s “archeology of knowledge” will provide both the foundation and the super structure from which these autobiographies can be analyzed. The psychoanalytical and anti-psychiatric texts will provide the breadth of interpretation necessary to comprehend the language and meaning that produces the multiple layers that comprise the “hierarchical aspect” or vertical planes that provide the means to increase our depth of understanding.

Furthermore, as I apply the structural hermeneutic approach it will become evident that each theoretical construct and those analytical components applied to generate understanding of the schizophrenic situation are complementary. My dissertation will also demonstrate that not only does the language contained within the autobiographical narratives connect with the language of the psychiatric practices from which they originate. These autobiographical works also serve to influence and create links within the philosophical texts produced from the language and stories of the schizophrenic experience. Thus, the structural hermeneutic task as practiced in my dissertation will aim at interpreting the autobiographical narratives within the historical context that provided the means and constraints of the autobiographical re/construction.

1.1. Autobiography: Coming to Terms

The term autobiography can be broken down into its three components: “Auto” meaning self, “bios” meaning life, and “graphia” meaning to record or to write. Hence, the very broad definition provided by Encyclopedia Britannica “Autobiography, the biography of oneself narrated by oneself” (www.britannica.com/art/autobiography-literature). However, the act of writing one’s autobiography is more than simply providing a written record of one’s past; it takes on overlapping and entangled stories and themes. Therefore, autobiography is by definition an interdisciplinary pursuit given the author’s varied social, political, economic, and historical experiences that make this necessarily the case. Also, the autobiographer ultimately chooses their points of focus making the final text dependent on what the author determines to disclose to the reader and what is held back. The writer’s content is consciously and unconsciously divulged, and determines what remains private versus public. Sue Estroff suggests, “the levels or layers of a person are divided typically into at least two facets … a private subject and a public person … and these layers must overlap to some extent” (*Self, Identity and Subjective Experience* 190). The author may intend to be candid, transparent, or truthful, but through the process of revisions such truths become less likely and may at best offer the reader only partial historical accuracy. The autobiographer is presenting an image of a self under constant revision. Irving Horowitz (1929 – 2012) points out, “The self in any case is a vacuum, nothing until it is filled, the autobiography searches to fill that void for generalized others as well as for particularized selves” (“Autobiography as the Presentation of Self” 175). In this way, as Stephen Spender states in James Olney’s *Confessions and Autobiography*, “the subject is made object” (117). If the author wants to present herself in the best light, that object may be created with this intent and necessarily leave out less complimentary aspects of personality.

The author furnishes her story with vignettes that regale the reader with life’s triumphs, missed opportunities, and make it all cohere in an historical construction of the past. Reminiscing, ruminating, and reflecting on the past rely on memories often tainted by the passage of time as well as coloured by the emotions of the present. Oliver Sachs (quoting Frederic Bartlett) says:

> Remembering is not the re-excitation of innumerable fixed, lifeless, and fragmentary traces. It is an imaginative reconstruction, or construction, built out of the relation of our attitude toward a whole active mass of organized

> past reactions or experiences… It is thus hardly ever really exact. (*Hallucinations* fn154)

These moments become Wordsworth's "spots of time" (Prelude) or Woolf's "cotton wool" (*Moments of Being*) and to reconstruct them and bring them to life for the reader, the writer often must re/create rather than merely reiterate. Georges Gusdorf (1912-2000), the French philosopher and autobiographical theorist, says, "Autobiography is not simply repetition of the past as it was, for recollection brings us not to the past itself only the present in spirit of the world forever gone… the recapitulation of a life lived" (qtd. in Olney *Autobiography, Essays Theoretical and Critical* 38). Autobiographies are fluid and dynamic in the sense that they are the ongoing story of a life as it is being lived. The author is in the process of writing about her life as she continues to live it. Her experiences, actions, emotions, and re/interpretations are in process. The autobiographer becomes the subject of their own work of fiction, a narrative structured along familiar themes. Louis A. Renza (1940 -) said "autobiography, in short, transforms empirical facts into artifacts: it is definable as a form of 'prose fiction'" (qtd in Olney *Autobiography: Essays* 269).

Paul L. Jay (1946-) states "The self can only exist conceptually as a representation… [and] the relationship between the self, writing, and the past is paradoxical… [because, quoting Roland Barthes] the "self" is shattered, scattered, decentered and –at least in a text– always a fiction" ("Being in the Text" 1056). Barthes in his essay "An Introduction to the Structural Analysis of Narrative" states, "Men may keep reinjecting into narrative what they have known, what they have lived, but if they do, it is through a form which has conquered repetition and instituted a model for a 'becoming'" (271). Liz Stanley, summarizing Barthes, states "[there is the need] to distinguish between the 'self who writes,' the 'self who was,' and the 'self who is'" (*On Auto/Biography in Sociology* 48). The self who was is the schizophrenic patient prior to being admitted to the hospital as mentally ill and "abnormal." The self who is, happens to be the patient when released from hospital and proven "normal." The self who writes admits she is mentally ill despite viewing her behaviour and thought processes as normal.

However, the concept becomes further convoluted when one begins to consider the various forms of autobiographical writing such as journals, memoirs, diaries, letters, and poetry. Furthermore, the notion that autobiography may be considered its own genre

only seems to muddy the waters surrounding its place in literary circles and the many attempts to place it in its own unique literary category.

In so doing, autobiography, or at least what constitutes that referenced as representing autobiographical material, has provided several examples of early autobiographical text. The most common early examples of autobiographical works include Saint Augustine's *Confessions* (397 – 400 CE), Jean-Jacques Rousseau's *Confessions* (1782), and even William Wordsworth's autobiographical poem *The Prelude* (1850). However, two of the earliest examples of autobiographies happened to be written by women, one being Julian of Norwich's *Revelations of Divine Love* (c. 1300, first published in 1670) and *The Book of Margery Kempe* (1432). What becomes apparent is that even these examples of early autobiographical works generate questions from the reader as one attempts to determine what constitutes an autobiography and what does not, as this literary domain expands because of the creativity exemplified by the authors of autobiography. For example, Saint Augustine's text, although written about himself, is clearly an ode to God. Wordsworth's autobiographical account about his life and his experiences is a long poem. Does that constitute an autobiography? And what about Margery Kempe's autobiography which was written for her by a scribe? Does this change how one views her autobiographical account? These are questions that not only continue to animate the field of autobiographical studies today but they are also questions that arise from the research conducted in this dissertation. My initial response to these questions is, "yes" these all constitute autobiographical works and furthermore provide invaluable insight not only into the lives of the authors but also the culture and environment from which they emanated.

Although it is important to understand the historical nature of autobiography and its attempted incursion into literature as a genre, how does it assist us in coming to terms with what autobiographical writing is and is not? Autobiographical studies, two decades ago, shifted its point of reference from autobiography to Life Writing, which has enlarged the focus of attention. Especially as this shift, according to David McCooey "from auto/biography studies to life-writing studies has therefore involved expanding the object of study from putatively literary texts to life narratives as they might be most broadly understood: testimony; autoethnography; digital life writing; and so on" (Limits of Life Writing 277). Therefore, the expansion of material under consideration as

autobiographical does little to solve the issues surrounding what one means by the term "autobiography". If anything, attempts to place autobiography into its own genre, and the expansion of autobiographical studies to life writing has made such attempts "founder in questions that are both pointless and unanswerable" (Autobiography as De-facement 919). However, McCooey sums up his argument stating:

> Life writing is, after all, key to understanding how the past reverberates in the present, how 'history' is always 'contemporary'. In addition, like history, life writing is a discourse that generates considerable insight, and sometimes anxiety, about its generic and literary status, about the limits between 'life' and 'writing'. (280)

If so, then where does this leave us, and how should we make a determination on what constitutes an authentic autobiographical account when we haven't been able to agree what we mean by autobiography?

Philippe Lejeune, in *On Autobiography* (1971) attempted to define the term autobiography as well as place it within its own genre, and in his initial attempt (he would rework and refine his work over the course of his lifetime) wrote the following:

> Definition: Retrospective prose narrative written by a real person concerning his own existence, where the focus is his individual life, in particular the story of his personality. (4)

In addition to this, Lejeune would add the following four categories:

1. Form of language
    a. narrative
    b. in prose
2. Subject treated: individual life, story of a personality
3. Situation of the author: the author (whose name refers to a real person) and the narrator are identical
4. Position of the narrator
    a. the narrator and the principal character are identical
    b. retrospective point of view of the narrative

> Any work that fulfills all the conditions indicated in each of the categories is an autobiography. (4)

Thus, Lejeune's classification scheme originates from the perspective of the reader, and installs the notion of an "autobiographical pact" which demands the "affirmation in the text of this identity [protagonist/narrator], referring back in the final analysis to the name of the author on the cover" (14). Although necessary for Lejeune, these same requirements (specific as they are) tend to exclude many narratives of self written under

a pseudonym or utilizing a main character who is not the author. I therefore, view Lejeune's standards surrounding autobiography as being rather strict, and he may even come across as heavy handed in his rejection of certain areas of self narrative that demand certain rules be broken as a means of protecting the identity of the author and their family.

Paul de Man, in his 1978 article "Autobiography as De-facement," grapples with the literary push from some scholars, such as Lejeune, to place autobiography within the confines of its own genre. He questions not only this move but also ponders the place of the author within the text. As de Man wrote,

> We assume that life produces the autobiography as an act produces its consequences, but can we not suggest, with equal justice the autobiographical project may itself produce and determine the life and that whatever the writer does is in fact governed by the technical demands of self-portraiture and thus determined, in all its aspects, by the resources of his medium? (920)

De Man asks that we consider the idea that writing an autobiography is also an act producing its own consequences. The author is thus compelled by "the technical demands of self-portraiture" to offer an account that meets the demands of the autobiographical medium. If this is so, then where do we envision the author in relation to the text? Moreover, do we then need to question the veracity of the story told? These questions then lead us to ponder whether or not the text happens to be a real account of a life lived or does the text represent a fictionalized account of life that may have under the right circumstance quite possibly have been lived. Paul de Man later asserts that:

> The interest of autobiography, then, is not that it reveals reliable self-knowledge —it does not— but that it demonstrates in a striking way the impossibility of closure and of totalization (that is the impossibility of coming into being) of all textual systems made up of tropological substitutions. (922)

Therefore, if as de Man suggests, autobiography does not provide the reader with "reliable self knowledge" and reflects the "impossibility of coming into being" of literary closure and totalization, we are left with fragments of a life however artfully composed. Therefore, what I will be arguing is that autobiographical writing provides the author with the opportunity to re/construct a sense of self through the use of language (in this case

psychiatrized language) and experience to create not a coming into being but a becoming.

For the schizophrenic, even if she, as author, does recognize she is mentally ill, how can she then categorically prove normalcy? Typically, no matter what the individual with schizophrenia says or does after diagnosis, she will always be viewed as mentally ill, for the common belief is that there is no cure for schizophrenia. The autobiographical materials, such as the texts I will be examining in this dissertation, required a little more discretion and at times the ability of the author to mask their identity behind not only the use of a pseudonym but also cloak themselves in the persona of a different character. Joanne Greenberg, for example, in her 2019 article "Chestnut Lodge 1948 – 1951" relates a similar concern regarding *I Never Promised You a Rose Garden*. She not only used the pseudonym, Hannah Green, she also made sure that the heroine of the novel had a different name from the author of the text. Greenberg did this purposely because she wanted to protect her young family from unwanted attention, comparing the stigma surrounding schizophrenia in the 1950's to the public reaction to Aids in the 1980's. These accounts while certainly autobiographical in nature as they reflect the telling of events and experiences of the author, have been termed "autopathography" or the less formal term "patient tales," by Jeffrey K. Aronson a medical researcher from the United Kingdom. In his article "Autopathography: the patient's tale" in which he discusses the importance for practicing doctors to read patient accounts of their illness and understand where the patient is coming from, Aronson states:

> I call these accounts patients' tales not merely to echo Chaucer, but because "tale" means both a true narrative and a lie. Fabrication is almost unavoidable in autobiography, but if it adds verisimilitude to the account, is that to be regretted? (1602)

It is from Aronson's collection of over 270 patient accounts that he comes to this conclusion. It is particularly important that he reflects on the overall veracity of these autobiographical accounts. What he determines is that some of these narratives are at times highly fictionalized, and as such, questionable according to their ability to relate the "truth". Overall, these autopathographical accounts, according to Aronson are "a good way of venting that vehemence" (1600) related to serious illness. Aronson also suggests that autopathographical accounts tend to be broken into two broad categories, the poetic and the prosaic (1602). Outlining the poetic nature of such accounts, Aronson

found that they “tend to be cast in more mythical terms, invoking such themes as rebirth, battles, and journeys” (1602). These mythical terms are similar to the themes that occur within the autobiographical texts that I will be examining in this dissertation, such as Jane Simpson who writes, “Was it possible that if I wrote my story, I might feel better? Was it even possible? … ‘But no,’ I thought to myself. ‘I have not the courage to do it…[But] I pick up a notebook and pencil …My pencil is moving rapidly backwards and forwards across the paper” (*Lost Days of my Life* 156). However, the writing of their autobiographies provided these women with one way to change their circumstances, at least on paper, with many shifting their stories toward the mythical. Yet, the importance should not be lost in the conundrums and connotations associated with the mythical. As Aronson, quoting Gilbert Ryle, reminds us myth is “the presentation of facts belonging to one category in the idioms appropriate to another. To explode a myth is accordingly not to deny the facts but to reallocate them (1602)”.

Another emerging line of inquiry concerning autobiography and self is the concept “autotheory”. The term autotheory was coined in 2008 by Paul B. Preciado in the text *Testo Junkie* and later picked up by Lauren Fournier. In *Autotheory as Feminist Practice in Art, Writing, and Criticism*, Fournier writes,

> In autotheory, writers and artists join lived experiences to intertextual references—to the history of art, literatures, philosophy, film, and pop culture—as part of the development of a theory. (2021 149)

Furthermore, Fournier states that autotheory provides a means where “self and life become material through which to explore questions, from theories, and “test” them against different forms of evidencing” (149). Originating from an interdisciplinary feminist perspective, autotheory certainly does provide a means to interrogate literature of an autobiographical nature. It also, provides an approach that includes rather than “exclude personal experience from the discourse of knowledge” (15), as Fournier suggests. I definitely can see how the schizophrenic experience (particularly the female perspective) has often been overlooked when attempting to “better” understand the societal oppression faced by those deemed mentally ill.

However, the female authors under analysis in this dissertation, while they may certainly be overlooked feminist precursors to an autotheoretical line of inquiry well off on the philosophical horizon. Some of the authors, like Joanne Greenberg, and Louisa

Düss, did wade into the murky waters of psychoanalytic theory. Even though, most of the authors, expressed their experiences couched in the language of psychiatry. They did so not necessarily as a means of working through philosophical questions, but as a means to understand and describe their plight. And, as we shall see, these authors used the psychiatric terminology after being labeled schizophrenic as a means of becoming, a return to what may be considered normal.

Chapter 2. Psychiatry's History of Control

"The word "schizophrenia" has a scientific sound that seems to give it inherent credibility and a charisma that seems to dazzle people… Schizophrenia is one of the great myths of our time." —Lawrence Stevens

"There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside – the asylums which our forefathers built with such immense solidity to express the notions of their day. Do not for a moment underestimate their powers of resistance to our assault." — Enoch Powell, 1961

2.1 Schizophrenia Diagnosed, Treated, and Survived

The cause and definition of mental illnesses and their possible cures have been sources of debate since "around 400 BC [when] Hippocrates (460–370 BC) attempted to separate superstition and religion from medicine by systematizing the belief that a deficiency in or especially an excess of one of the four essential bodily fluids (i.e., humors) — blood, yellow bile, black bile, and phlegm — was responsible for physical and mental illness" (nobaproject.com). The cause and definition of mental illness continues to be debated to this day, but was particularly so in the period in question, 1945-65. This history, with all its controversy and human tragedy, would require a book-length narrative to do the subject justice and, in any case, these have already been undertaken. Andrew Scull's *Madness in Civilization* (2015), Roy Porter's *Madness: A Brief History* (2002), Edward Shorter's *A History of Psychiatry* (1997), and Michel Foucault's *History of Madness* (1961), present interpretations of this history and although not in absolute agreement, often raising as many questions as answers, they all contribute valuable pieces of this puzzle.

For instance, Foucault (1926 -1984) in his ground-breaking text, *History of Madness*, argues that the development of psychiatry as a practice constituted a means for citizens deemed normal to control and confine those diagnosed as abnormal. By contrast, Shorter believes "psychiatric illness is real and that it can change in frequency depending on social circumstances that might affect mind and brain" (*History of Psychiatry* 48). Other psychiatric theorists and practitioners, such as Thomas Szasz (1920 – 2012), and David Scheff (1929 -), adopting a social constructionist perspective, view madness as merely a label and not a particularly useful one at that.

There are three issues [questions] that have been at the heart of the controversy about mental illness documented in these histories: 1) Are the contributors to mental illness biological or social? 2) What symptoms should be used to diagnose it? and 3) What are the most effective treatments – pharmaceutical, surgical, or psychoanalysis? Given the interwoven nature of these three questions, and the multiple overlapping layers of interpretation and understanding involved, I have therefore chosen the term "structural hermeneutics" to designate my analysis of the structure of psychiatry, and the theories, diagnoses, psychoanalysts, asylums, drugs, and surgeries that constitute an industry designed to control and contain the mad.

From a medical perspective, mental illness is a disease that requires a "cure," whether it be psychosurgery or administration of psycho-pharmaceuticals. The search for the biological roots of mental illness looks for signs of genetic, chemical, or neurological/structural damage and treats patients using surgery, insulin, or electric shock treatment and pharmaceuticals to fix "imbalances" within the brain. Doctors exert control surgically or by applying a chemical straitjacket, as attested to by patients cited later in this chapter. This medical model or gaze often tends to view the cause and symptoms of mental illness such as schizophrenia from a clinical or detached system of treatment based on the descriptions of symptoms by the patient. The reliance upon symptoms places the psychiatric patient within the realm of behavioural subjectivity. Diagnosis is then constructed from the concerns and complaints noted by the patient rather than signs such as high blood pressure, heart rate, and blood sugar levels for heart disease or diabetes. Therefore, as psychiatrist Dr. Huda explains, "Diagnosis is a system of classification based on the cause. It is the process of determining which disease or condition provides the proximal explanation for a person's symptoms and/or signs. This enables matching of specific treatments to address specific pathological processes" and furthermore diagnoses such as schizophrenia "cannot explain behaviours as there are only symptoms that are descriptions (not explanations) of behaviours or experiences" (2019). What begins to emerge from the clinical gaze is a focus on the brain or genetics as the root of the problem, all the while neglecting the possibility that perhaps mental illness originates from a variety of societal issues.

If, on the other hand, madness is viewed from a social constructionist perspective, then it is no more than a term applied to those who others want to remove from society – the illness is "constructed" by economic, social, and/or political forces.

Such an idea as the simple removal of individuals from society can be linked to the Cold War abuses of psychiatry especially as practiced by the Soviet Union and its satellite states. As Johannes Baks reports in his 2010 doctoral thesis:

> The practice is common to but not exclusive to countries governed by totalitarian regimes. In these regimes abuses of the human rights of those politically opposed to the state are often hidden under the guise of psychiatric treatment. In democratic societies “whistle blowers” on covertly illegal practices by major corporations have been subjected to the political misuse of psychiatry. (https://hdl.handle.net/20.500.12259/126052)

However, the authors under scrutiny in this dissertation don’t align with the political opponents of the Eastern bloc nor do they fit with the corporate scapegoats of the Western capitalist sector. These seven female authors having very little if any political or corporate sway, nonetheless may have something important to say regarding the socio-economic factors influencing their unique circumstances. Kenneth Gergen suggests from a social constructivist perspective, “all psychological theorizing and the full range of concepts that form the grounds for research become problematic as potential reflectors of an internal reality and become themselves matters of analytic interest. Professional agreements become suspect; normalized beliefs become targets of demystification; "the ‘truth’ about mental life is rendered curious” (271). The psychosocial or “romantic psychology” (*History of Psychiatry*), as Shorter calls it, involves studying the individual’s upbringing or social circumstances to account for triggers or causes of antisocial behaviour and mental illness. Romantic psychology is as dynamic as one’s personality and psychological profiles continue to develop over the course of a lifetime. This psychological progression from infancy to childhood and then into adulthood may involve traumatic situations that stimulate negative thought patterns, neuroses, and psychoses that manifest as mental illnesses like schizophrenia.

Referring to the mind in a mechanistic way as we would a clock, or a computer, is a gross oversimplification, as is separating the physical from the social, as constructionists attempt. Neither approach has fully benefited the mentally ill, though in combination they do explain much of the history of psychiatry over the last two centuries. This chapter will address definitions of mental illness (especially schizophrenia), and then move into the surgical and pharmaceutical “solutions” and reactions to them, particularly as articulated by patients in writing. The following chapter will take on psychoanalytical responses to schizophrenia, and Freud and his legacy for

psychoanalysis in particular, especially as they inform notions of the self as constructed in autobiography. Whether mental illness has a biological basis or a psycho-social basis, the means these two approaches have taken to address mental illnesses both have resulted in control over the patient.

In the asylum, the biological and social approaches of psychiatry often came together. As Shorter explains, “Most of the twentieth century has seen restless experimentation within psychiatry to find a cure for chronic psychosis …mainly schizophrenia” (*History of Psychiatry* 192). Just before the turn of that century, and more than 60 years before the period under review here, the phrase, “dementia praecox,” the precursor to the term schizophrenia, was coined in 1891 by Arnold Pick (1851 – 1924) and brought into common psychiatric parlance by Emil Kraepelin (1856 – 1926) with the publication of his textbook on psychiatry and psychiatric diseases. Kraepelin’s work combined case studies and observed symptoms of young people with what seemed to be early onset dementia, to create a classification system that correlated these to various mental illnesses.

Use of the term ‘schizophrenia’ can be traced to Eugen Bleuler (1857–1939), a Swiss psychiatrist, who in 1908, gave a lecture to the German Psychiatric Association. Bleuler explains the rationale for the new term by citing easier language and diagnosis:

> In Kraepelin’s dementia praecox it is neither a question of an essential dementia nor of a necessary precociousness. For this reason, and because from the expression dementia praecox one cannot form further adjectives nor substantives, I am taking the liberty of employing the word schizophrenia for revising the Kraepelinian concept. In my opinion the breaking up or splitting of psychic functioning is an excellent symptom of the whole group. (2004, 361-366)

Bleuler saw the splitting of the patient’s mental functioning as key to diagnosing what had been referred to as dementia praecox. Bleuler was not suggesting that schizophrenia was the splitting of personality, but rather the mind, as implied in the word’s origins: “from the Greek verb schizein, indicating a splitting. The second part of the word goes back to the Greek phren, originally denoting ‘diaphragm’ but later changing to ‘soul, spirit, mind’ (Kuhn, 362).

This definition is vague and could be used to refer to multiple conditions, so the term should more accurately be plural. If schizophrenia was a group of interwoven

mental illnesses, then perhaps the mind itself had multiple functions and vulnerabilities: affect/mood, reasoning, and behaviour. Distinguishing between these branches of schizophrenia and trying to accurately diagnose and "treat" the particulars of said mental illness was challenging and invited debate. Although Kraepelin recognized the schizophrenic condition by this definition, he "believed that schizophrenia constituted a unique disease entity with a single etiology and defined pathology" ("Schizophrenia, just the facts" 2). However, the etiology or cause of schizophrenia can not be and has not been linked to one single element common to all instances of schizophrenia, nor has the pathology of schizophrenia been determined to be related to a cause-and-effect component.

Kurt Schneider (1887 – 1967) also developed a means of recognizing psychiatric disease based on the range and forms of symptoms at the onset of illness with the publication of *The Psychopathic Personalities* in 1923. Then in 1939 with the publication of *First Rank Symptoms*, Schneider created a list of first rank or positive symptoms for schizophrenia. According to Schneider positive symptoms where those indicators such as hallucinations, delusions such as thought insertion, and distortions of reality. However, what mattered was not that a patient may have experienced hallucinations but that they incorporated these hallucinations into their sense of reality. Schneider, like Karl Jaspers (1883 – 1969), focused on diminished communication during the onset of schizophrenia and he "considered the un-understandability of the individual experience as its distinguishing feature" ("Schizophrenia, just the facts" 2). As we shall see, emerging theories, shifting diagnostic criteria and psychiatric practices, and overlapping forms of treatment made and continue to make the disease and its diagnosis contentious.

If we accept the fifth edition of the *Diagnostic and Statistical Manual* (DSM-5) the description of schizophrenia that describes the presence of a complex group of overlapping mental impairments (belief in alternative realities, hallucinations, and delusions), and the absence of affect, facial expression, interest, and social drive, that occur suddenly and dramatically, we are closer to a common understanding. Yet as Dr. E. Fuller Torrey (1937 -) eminent psychiatrist and schizophrenic researcher, carefully documents in his text *Surviving Schizophrenia* (1988), "In almost all diseases there is something which can be seen or measured, and this can be used to define the disease and separate it from non-disease states. Not so with schizophrenia!" (73).

Despite these debates, throughout the 1950s, Bleuler's description of schizophrenia was the most widely used in the United States, while Kraepelin's and Schneider's dominated the rest of the world. However, the difficulty in accurately diagnosing schizophrenia was universal, which led researchers to question whether cases with similar symptoms, but different diagnoses, on either side of the Atlantic were in fact the same disease. During the 50s, the US saw a spike in the number of patients diagnosed as schizophrenic, while Europe saw increasing numbers of patients with manic-depression or bipolar disorder. Was this a function of commitment to one definition over the other? As Tandon reports, "Although patients admitted to public mental hospitals in New York and London had similar symptoms, those in New York had twice the likelihood of receiving a diagnosis of schizophrenia" ("Schizophrenia, just the facts" 3). Most likely this variance in diagnoses between the US and Europe came down to the diagnostic tools and definitions adopted by psychiatrists in each territory when admitting patients into the psychiatric wards of the hospital. More recent studies seem to confirm this assessment, such as the Jansonn et al, 2002 article which compared 15 different diagnostic tools over the past 30 years and concluded that their "findings re-emphasize the need for a continuing debate and research on the boundaries of schizophrenia, [and that] the obvious arbitrariness of the contemporary diagnosis poses a serious problem for etiological research and early intervention studies". Furthermore, these same researchers found that "issues of validity and reliability of psychiatric diagnosis are frequently conflated in the literature, yet a demonstration of a high reliability of a given diagnostic system does not make that system valid" (Jansonn et al, 2002).

The female authors of the autobiographical narratives introduced in chapter 1 were all diagnosed schizophrenic, though these diagnoses may not have been correct; perhaps they were misdiagnosed or hadn't experienced any form of a mental break at all. For the most part, however, they were diagnosed using the prevailing diagnostic criteria available at the time as outlined in the *Diagnostic and Statistical Manual* (DSM), first published in 1952 and which described schizophrenia as a psychotic disorder:

> Psychotic Disorders are: (1) affective disorders, characterized by severe mood disturbance, with associated alterations in thought and behavior, in consonance with the affect; (2) schizophrenic reactions, characterized by fundamental disturbances in reality relationships and concept formations, with associated affective, behavioral, and intellectual disturbances, marked

> by a tendency to retreat from reality, by regressive trends, by bizarre behavior, by disturbances in stream of thought, and by formation of delusions and hallucinations... from this grouping, a psychotic reaction may be defined as one in which the personality, in its struggle for adjustment to internal and external stresses, utilizes severe affective disturbance, profound autism and withdrawal from reality, and/or formation of delusions or hallucinations. (12)

As the reader can tell, the original diagnostic conditions necessary for schizophrenia were quite broad, and could be used to describe a great deal of behavioural symptoms that may not necessarily mesh with the definitions today. However, the symptoms recounted by the authors of these autobiographies tended to match the standard definition of the time. These symptoms would commonly include bizarre behaviour, regressive trends, and a general retreat from reality – at least as reported by their family.

The DSM also refers to dementia praecox in a separate entry. The quotation above recognizes "a grouping of psychotic disorders" from which schizophrenia emerges as *one* strong possibility. The diagnosis is contingent on a disturbance in behaviour, affective phenomena, and thought processing. As Horacio Fabrega Jr. says in his essay "The Self and Schizophrenia: A Cultural Perspective":

> What is known about schizophrenia… reflects and deals with what is expected of and known about the self and human subjectivity. Schizophrenia is a disorder that by definition affects individual perception and cognition and compromises social identity and functioning… schizophrenia affect[s] the self in a broad context… [and] thus erodes and undermines the organization and functioning of the self. (277)

Tandon concludes "schizophrenia is probably neither a single disease entity nor is it a circumscribed syndrome – it is likely to be a conglomeration of phenotypically similar disease entities and syndromes. Given current knowledge, however, these entities cannot be distinguished or demarcated" ("Schizophrenia, just the facts" 15). What Tandon means by "conglomeration of phenotypically similar" is that for schizophrenia the symptoms and experiences of the patient while they may appear to be similar, are most likely possible features of several different overlapping mental health maladies. Therefore, to describe schizophrenia as a syndrome because of its grouping

of certain symptoms or as a specific disease entity may be misleading because these same experiences can be found in those diagnosed as bipolar or even autistic.

Though it is possible to chart the history of schizophrenia, it is considerably more difficult to pin down the origin of other terms associated with “madness” in general: the insane, the mentally ill, or the deranged. As Gomory, Cohen, and Kirk (2013) remind us in their historical review of “Madness or Mental Illness”:

> Expressions such as lunatic, lunacy, crazy, chronic mental illness, severe and persistent mental illness, mental illness, psychosis, insanity, the insane, psychotics, mental medicine, psychiatry, psychological medicine, mental disorder, disorder, mental disease, and disease are used frequently and interchangeably throughout [the] literature. The habit of comingling words that are prone to ambiguous interpretations, such as insane, crazy, or illness, with others that also have more formal medical definitions in contemporary medicine, such as disease or psychosis, has consequences. (124)

I make note of this to remind the reader that within the lexicon surrounding the mentally ill there is an abundance of terms that are not only ambiguous but also demeaning. These terms tend to confuse and paint those diagnosed as mentally ill as being less human all the while maintaining the stigma associated with mental illness.

Rather than take these words at face value, affirming their truthfulness and granting them power over those deemed mad, psychiatrists needed to better delineate what they jointly meant by these terms and agree upon a common and practical definition. If members of the public adopt these words and use them in more colloquial arenas, everyday usage will come to mask nuances and critical differences or falsehoods. Quickly gossip becomes damnation. A diagnosis of schizophrenia would have a profound effect on the individual and his/her family given that the patient would likely be ostracized due to a fearful community and the stigma attached to this form of mental illness. If schizophrenia is not a single mental illness that can be consistently distinguished from other mental illnesses, such as bipolar disorder, then the patients’ own descriptions of their experiences in mental institutions, using their own language, get us that much closer to identifying a common condition and definition.

As we have seen, the period in psychiatry during which the autobiographies I am studying were written was characterized by an emphasis on documenting and classifying mental illness according to the DSM. It was also a time of great upheaval for the mental patient because psychiatrists were strongly encouraged to diagnose and then institutionalize patients in order to control and segregate the mentally ill from society at large. Given the negative responses to this choice, from both those working in psychiatric care and those living with mental illness, it is no surprise that both demographics began to question the definition of mental illness as a disease at all. This gave rise to the anti-psychiatric movement, which ran parallel to these developments.

2.2 The Anti-psychiatry Movement Reclassifies Schizophrenia

In the early 1950s, Gregory Bateson (1904-1980) anthropologist, social scientist, and linguist began to examine the legitimacy of mental illness as a disease, psychiatry's legitimacy as a branch of medicine, and the ethics of incarcerating those diagnosed with it in asylums. Researchers and theorists Michel Foucault, Erving Goffman, RD Laing, Aaron Esterson, and Thomas Szasz also wrote works that contributed to growing doubts that psychiatry could diagnose and treat mental illness. In 1961, three ground-breaking and thought-provoking texts were published in quick succession: Erving Goffman's *Asylums*, Michel Foucault's *History of Madness* and Thomas Szasz's (1920-2012) *The Myth of Mental Illness*. Szasz's text created quite a furor when first published, particularly his stance on mental illnesses as "counterfeit or metaphorical" (34). Szasz said, "Soon physicians and psychiatrists were joined by philosophers and journalists, lawyers and laymen, in labeling as mental illness any and every kind of human experience or behaviour in which they could detect, or to which they could ascribe malfunctioning or suffering" (40). He argued there was no evidence to suggest a biological cause for this "disease."

Szasz questioned the power psychiatrists had over patients and their "use of the medical model—namely, the idea that psychiatric treatment must be based on psychiatric diagnosis—[which] has led … to a disastrous abuse of patients" (49). Szasz viewed "mental illness [as a] myth" (*The Myth of Mental Illness* 262) and suggested that "the aim of psychoanalytic therapy is, or should be, to maximize the patient's choices in the conduct of his life" (259). Szasz stressed that all psychiatric treatment should be

voluntary and supportive of the individual's attempt to rebuild his "knowledge of himself, others, and the world about him, and his skills in dealing with persons and things" (259). *The Myth of Mental Illness* would be re-released in 2010, fifty years after it first publication. Szasz continued to maintain mental illness was a myth in that edition:

> Diseases of the body have causes, such as infectious agents or nutritional deficiencies, and often can be prevented or cured by dealing with these causes … [while] persons said to have mental diseases, on the other hand, have reasons for their actions that must be understood; they cannot be treated or cured by drugs or other medical interventions, but may be helped to help themselves. (xviii)

His argument raised many questions about forms of psychiatric treatment and the field's ever-broadening definition of what constituted mental disease. Others in the anti-psychiatric movement were equally critical. Psychiatrists RD Laing (1927 – 1989), and Aaron Esterson (1923 -1999) were particularly critical of psychiatry's definition of schizophrenia: "There is no objective, reliable, quantifiable criteria —behavioural or neurophysiological or biochemical— to appeal to when psychiatrists differ … we do not accept 'schizophrenia' as being a biochemical, neurophysiological, psychological fact, and we regard it as palpable error, in the present state of the evidence, to take it to be fact" (*Sanity, Madness, and the Family* 12).

They would also question the signs and symptoms said to identify a schizophrenic. Laing and Esterson argued that the behaviours exhibited by an individual labelled schizophrenic were a function of their relationship to "the family nexus, that multiplicity of persons drawn from the kinship group, and from others who, though not linked by kinship ties, are regarded as members of the family" (*Sanity, Madness, and the Family* 21). The individual is part of a greater social whole and, as such, their behaviour must not be understood in isolation, but as a reaction to their total social experience. I will have more to say about how the women whose autobiographies I am analyzing react not only to their own situation but also how they chronicle their own reactions to those around them such as family, friends, and even their community. Importantly, they do report a sense of loss, and abandonment; but more significantly they tell the reader how such reactions deeply hurt their own concept of self along their schizophrenic journey.

Officially, the term “anti-psychiatry” was coined in 1967 by psychiatrist David Cooper (1931-1986) in his text *Psychiatry and Anti-psychiatry*. “Although,” as Petteri Pietikainen points out, “there never was anything like an ‘anti-psychiatric movement’, what united the radical critics of psychiatry was their assumption that psychiatry is a form of social control rather than a robust medical or psychological science” (314). Cooper’s “approach would be based on an understanding of schizophrenia not as a disease-entity, but as a certain more or less specifiable set of personal-interactional patterns … not as something happening in a person, but rather something between persons” (88). This idea affirms Laing and Esterson’s evidence that the upbringing and living arrangements of an individual diagnosed as schizophrenic were direct contributors to the patient’s state of mind. Cooper began to unravel the interconnected social ties that contributed to a “schizophrenic reaction,” linking them to unstable social dynamics. He suggested that to comprehend the behaviour of the patient, including his ‘schizophrenic’ presentation, one would need to investigate the “familial origins of his parents” and his interactions with them when they visited as well as with the patients and staff (*Psychiatry and Anti-psychiatry* 90). Cooper argued the schizophrenic took on the roles and expectations of those who surrounded him as well as environmental influences in a certain time and place. For instance, Lara Jefferson writes “Here I sit—mad as a hatter—with nothing to do but either become madder and madder—or else recover enough of my sanity to be allowed to go back to the life which drove me mad” (*These are my Sisters* 12). Clare Marc Wallace before her first schizophrenic break would describe how, when out in her neighbourhood she would “imagine that [people] were talking about [her], and being as critical of me as I was myself… I would hear thoughts telling me that my sandals were cheap, and that people were laughing at me, or criticizing me” (*Portrait of a Schizophrenic Nurse* 23). Both examples provide insight into how the self can be belittled by the individual as well as by others around them and that these others, be they friends or family or even strangers can impact and influence the concept of self, especially when these individuals may already find themselves in a fragile state of self doubt particularly for these young women on the verge of entering adulthood and playing the roles defined for women in society at this time. Furthermore, the self, as Goffman maintains, “is the product of all of these arrangements, and in all of its parts bears the marks of this genesis [and] the whole machinery of self-production is cumbersome, of course, and sometimes breaks down” (Presentation of Self, 253). And when this happens as it did for these women, what does the subject experience when their world

falls apart, and when what they refer to as “self” breaks down. Where does their identity start and finish?

Goffman described patients in an asylum as products of the “total institution,” the physical and social surroundings to which Cooper was referring. RD Laing, in *The Divided Self* would suggest that schizophrenic “identity is reached and retained two-dimensionally; it requires recognition of oneself by others as well as the simple recognition one accords to oneself” (*The Divided Self*, 138). Laing expands on this by saying:

> Interpersonal life is conducted in a nexus of persons, in which each person is guessing, assuming, inferring, believing, trusting, or suspecting, generally being happy or tormented by his phantasy of the others’ experience, motive, and intentions. (174)

Proponents of the anti-psychiatry movement argued that if the patient is provided the time and means to understand the self in interaction with these and more familial others in psychoanalysis then biological or chemical means of treatment would be unnecessary. However, as the following documentation attests, the vast majority of patients were treated by these means primarily and psychoanalysis was treated by many as a motion the patient went through, an afterthought to the central “cure” that came in a vial, cup, or current.

2.3 Anti-psychotic Pharmaceuticals

In 1952, while making the rounds of the psychiatric ward in Montreal, Dr. Heinz E. Lehmann (1911 – 1999) and a small group of interns stopped to “look at two young schizophrenic patients gesturing excitedly toward the ceiling from where they were hearing frightening voices. When one of the students asked afterwards, ‘Will we ever get a pill to help these people?’ [Dr. Lehmann] replied, ‘Unfortunately, it would never be as simple as just a pill’” (“Before they Called it Psychopharmacology” 298). Little did Dr. Lehmann know that a French doctor searching for an antihistamine to minimize “surgical shock” would stumble across a drug that would turn the world of psychiatric medicine on its head.

Since the mid-1940s, several French researchers had been studying chemicals used to dye clothing (Lopez-Munoz et al., 114) and chlorpromazine happened to be a derivative of these chemicals. By the early 1950s, French psychiatrists working at the Val de Grace military hospital in Paris, were administering chlorpromazine to severely agitated psychotic patients (Lehmann & Ban, 154). Prior to the introduction of chlorpromazine and its chemical derivatives into the psychiatric ward they were typically used as antiseptics and anthelminthics (a form of medication that assisted in driving parasites out of the body); however, their toxicity levels made such use problematic. (Lopez-Munoz et al, 114). Yet, within a few days of being administered to those institutionalized for schizophrenia, the patients became calm and communicative and could be released from hospital.

Psychiatric patients of all types had been introduced to a wide range of chemical and pharmacological agents – “opium, cocaine, hashish, codeine, digitalis, choral hydrate, and bromide” (Lopez-Munoz, 113) – in an attempt to quell the madness, but so far none had proven effective. These sedatives supplemented insulin and tuberculin administered as a means of shocking the body and the mind out of madness by inducing a coma, convulsions, or fever. Even though some of these efforts did show promise, they were extremely short lived. Chlorpromazine would prove to last and be the first of many antipsychotics to hit the market.

By 1955, chlorpromazine, under the name Thorazine (American brand name) would prove to be the single most effective long-term treatment plan for schizophrenic patients. It was also quickly tested in the UK, Canada, and Switzerland. It would be reluctantly introduced into the psychiatric treatment plan given the “strong psychoanalytic tradition, a direct influence of Freud on American Psychiatry” (Lopez-Munoz, 125), as discussed in the next chapter. Its “success” ushered in the race for other pharmaceutical drugs with similar properties and gave rise to reserpine and haloperidol. Patients who stopped taking their medication relapsed fairly quickly and schizophrenic symptoms returned, often with even more devastating effect.

Even though chlorpromazine resulted in a positive outcome for schizophrenics by lessening their hallucinations and delusions, it did nothing to “help with the so-called negative symptoms (lack of feeling, lack of motivation) or the problems with attention and judgment that may be major barriers to leading a productive, healthy life” (“Post by

Former NIMH Director," 2013). The long-term side effects of its use were also extremely troublesome and included everything from "lethargy, orthostatic hypotension, jaundice, and dryness of mouth [to] Parkinsonian syndrome" (Lopez-Munoz et al, 131). Fear of possible remission outweighed the tremors, stilted gait, and balance issues of Parkinson syndrome and tardive dyskinesia (random arm waving, lip smacking, sticking out of one's tongue, and other uncontrolled movements of the face). Drugs were administered, patients were monitored, and then were sent home to their families who had once thought them incurable. All of this was done, Dr. Lehmann states, without "informed consent by the patient for such drug trials" ("Before they called it Psychopharmacology" 301).

Lehmann described the use of antipsychotics as both a "chemical lobotomy and a chemical straitjacket" allowing the psychiatrist to communicate better with the patient. Interestingly, communication in the form of the patients' own notes while in the hospital, and after an eventual return to the world, did not result in a spike in published autobiographies by schizophrenic patients, perhaps due to their low motivation as a side effect, or due to less demand by the general public and thus publishers. Deinstitutionalization seemed to result in very little autobiographical material annotating the schizophrenic experience, but what was there occasionally made it into archives for public research and access.

2.4 Patients' Accounts of Psychiatric Treatments

I discovered poems that attest to this history of drug and shock treatment during one of my first forays into research about autobiographical narratives by schizophrenic authors at the Psychiatric Survivors Archive of Toronto (PSAT). I decided to conduct my research of the PSAT archives because prior to my request to access their records they had not been open to the public, and so I was provided the opportunity to be one of the first to examine these documents. During a brief email exchange with the volunteer archivist at PSAT asking permission to access the "schizophrenic archives," the archivist chastised me for my use of this term instead of "psychiatric survivor." He clarified that patients diagnosed as schizophrenic were more than their designated label; they were people who had stood against both the psychiatric establishment and pharmaceutical

industries. If I was granted access to this archival collection of newspaper clippings, narrative essays, psychiatric journals, letters, poems, survivor reports, and autobiographical materials, he said I would need to respect the psychiatric survivors and use the correct terminology. In the same exchange he explained that the material had been gathered and categorized by schizophrenic patients themselves, and therefore did not follow typical bibliographical protocols. Prior to my visit, the PSAT archives also had a change in their archive staff. From what I could gather, the previous individual working on organizing the documents had a falling out with PSAT and so a new person was brought in to finish what was started. As I understand it, the archival process of these documents, although initially organized under one system, was then completed under the arrangements of a second system that did not always coincide with the original plan. Therefore, accurately citing those articles and documents, was difficult. I should also mention that the archives were staffed by volunteers as well as psychiatric survivors rather than trained archivists, so the organizational system is not as rigorous as one might expect with archives. Nonetheless, the PSAT certainly assisted me in locating the documents I required for my research.

The PSAT materials cited below were published in this 20-year period, which mainly reference the psychiatric procedures and various treatments in the mental hospitals around Toronto. Hiding from the prying eyes of the institution staff and taking on “the role of the career inmate” (*Asylums*, 127), patients kept their heads down and wrote to survive, and in some cases, thrive. Pages amassed slowly given strict rules and regulations to limit the inmate’s free time. In the poems, the patients used language co-opted from psychiatric institutions to relate their plight during years of coercion. The poems below discuss these years and treatments using adjectives that suggest fear and prolonged dread. They tell of memory loss, break downs, and degradation. They suggest the patients had no control over either mind or body. They also imply medicalized murder. These documents fit the timeframe, but did not on their own provide enough material, however, they will supplement the eight edited volumes annotated in the last chapter and provide additional and valuable perspective.

In a poem titled, “The White Shirts,” an anonymous patient describes life in the institution:

Danger lies in the undefined

Hospital whiteness, purity

Covering iniquity

Double talk

Treatment (torture, brainwash, conditioning) (29)

Another anonymous patient writes:

Hospital Obsolete!

We are no longer citizens

We are “outpatients”

Overtly free

Covertly controlled

The next five-year plan, a wonder drug phase

To replace the Shockiatry (sic) phase (31)

The author foresees the shift from “shockiatry” and the heavy use of ECT to an increasing use of the psycho-pharmaceuticals as a means to control his inappropriate behaviour. “Terror is a handy device for controlling difficult people if it is properly labelled as treatment” (*History of Shock Treatment* 19). If a patient complained, he was considered non-compliant. If he resisted restraint, he was labelled difficult and assigned correction measures. If he fought back, he was subdued with tranquillizers, strapped into a straitjacket, or wrapped in the cold damp blankets of a wet pack. Many psychiatric survivors described being on a “human assembly-line [where] electric shock clubbed [one’s] good brain into needless unconsciousness” (*History of Shock Therapy* 29).

2.5 ICT, ECT, and Psycho-pharmaceuticals

The PSAT archived material offers a detailed description of the various modes of treatment unleashed upon those with mental illness just before and during this decade.

Though there are records of ancient tribes attempting to release the evil spirits from those who presented as mentally ill by trepanning or the drilling of a hole through the skull into the dura mater of the brain (*Madness: A Brief History* 10), was it any more brutal than the lobotomies and leucotomies that have followed? The documents referenced early accounts of electroshock therapy (ECT) beginning in 1952. ECT was administered over the course of weeks or months to "depattern" the mind. Dr. D. Ewen Cameron, President of the American Psychiatric Association from 1952–1953, describes its stages: "The patient passes into the first stage of depatterning about the fifth day of electroshock treatment and into the second state somewhere between the tenth and twentieth day of treatment" (*History of Shock Treatment* 28).

Many psychiatrists were also cavalier about the patients' memory loss after each successive treatment. "All patients who remain unimproved after ECT are inclined to complain bitterly of their memory difficulties" (*History of Shock Treatment* 22). Memory is vital not only for the development of the individual in recalling the lessons of the past, but in anchoring them to the present. Dr. Cameron states that "these periods of turbulence are necessary states of anxiety occasioned by the transition from a phase in which the patient feels no necessity to maintain a space-time image, to the stage where he feels a strong urge *to recreate* his space-time image but is not yet able to do so" (*History of Shock Treatment* 28 italics mine). The "periods of turbulence" are synonymous with Dr. Cameron's "period of reorganization" necessary for electroshock success. Reference to turbulence, reorganization, and depatterning all signal a belief that psychiatry of this nature can "fix" those deemed mentally ill by annihilating the patient's former self and creating a new one. Dr. Cameron in his address to the Royal Medico-Psychological Association states:

> Intelligence may be the pride – the towering distinction of man; emotion gives colour and force to his actions; but *memory is the bastion of his being*. Without memory, there is no personal identity, there is no continuity to the days of his life. Memory provides the raw material for designs both small and great. (Italics mine) (*History of Shock Therapy* 29)

These "designs both small and great" hint at Cameron's belief in the mind's ability to make itself over through the use of ECT. However, I could find no citation from him or any other psychiatrist that explained why this should be so, or even how long

such a process would take or last. Psychiatrists are on record affirming ECT did "something," but it was not quantified or qualified except to justify memory loss or permanent brain damage. Doctors didn't need consent for ECT; in fact, "as far as getting permission from the patient [was] concerned, this [was] not necessary" (*History of Shock Treatment* 30). They used it as a means to control patients considered difficult and unruly, but they were under no illusion that this was care.

Insulin Convulsive Therapy (ICT) was introduced between 1955 and 1958. It caused the patient's body to be racked with uncontrollable seizures, while presumably "improving" the mind in the process. After all, "the objection to ICT is the destruction of brain cells" (*History of Shock Therapy* 27) and memory. Yet ICT continued and was fine-tuned, the patient being made compliant under threat of more treatments. One patient after undergoing several days of ICT remarked to the head nurse that "people may destroy my mind, but they cannot pervert it! ... To the extent that they are trying to make me conform to another's normal, and not to my own normal, it is perversion" (*History of Shock Therapy* 23). ICT was slowly abandoned in favour of the cheaper and easier-to-administer electroshock treatment in the 1960s. A report from an anonymous psychiatrist tells of the patient's experience of "nausea after treatment … of the topographical schemata becom[ing] totally disorganized, and of the many gaps in memory" (*History of Shock Therapy* 35).

Fred [psychiatric survivor] writes this account of receiving ECT at only 19:

Eyeballs rolling; unhinged, loosened;

Attached only by optic strands.

They awaken me. Shock again today.

Drink the serum, swallow the pills.

Breakfast: toast and juice rasp

The gullet, hellfire-scorched.

Seconal adds a cotton blend.

To the gurney, into the straps,

The bit in the mouth; the ritual I know.

Submit or submit; the choices I own.

Yet relish I the rare seconds, the Pure Black

(*Poetry Thru the Ages* 33)

Fred references the sedative Seconal used to minimize the terror of ECT. Many patients who didn't receive the barbiturate would be fully cognizant of the treatment that awaited them as they lay strapped to the gurney. Electrodes were applied to their temples and when the knob turned, they blacked out. In his poem "A Day in the Death" he describes ECT:

… Light and sound slowly

Sift back into my awareness…

I know that it is done, for I am in my bed

I feel again my heart's beat.

Thoughts emerge from their opaque hibernation.

Then the sudden clarity dawns; the day is still the same:

Oh no, God no, Please no! PLEASE NO-OH-ohhh-ohh-oh-oh

Deeper than depth can go, my soul sobs audibly.

Pleading, to human, to Spirit, is no avail;

I've come to know.

Somehow, they again will kill me,

And provide no final death;

Their grim-faced torments, with renewed

Solemnity, expertly they will continue,

It's a cycle with true human demons;

Hell's treadmill without end.

(*Poetry Thru the Ages* 34)

Another former patient recalls the experience in her poem “I Can’t Close the Door, Yet…”:

I can’t close that door, yet…

Before I grieve for me.

I can’t close that door yet…

Before I remember

Standing in line,

Clasping hand with another,

In fear, always in fear.

I can’t close the door yet…

Before I remember

That small room, that smelled of death.

I can’t close that door yet…

Before I remember

That narrow table,

Those ‘reins’ holding me down.

(*Poetry Thru the Ages* 36)

These poems provide a glimpse of the fear patients felt prior to receiving ECT. Many patients came to view it as a form of torture. As an anonymous patient states in the short essay in the *History of Shock Treatment,* “Terror on Tuesdays and Thursdays”: “The truth is that electric shock is physical torture of the extreme type.” (6). Ellen Fields’ description of ECT in the same volume elaborates further:

> Tranquilizers are the transition stage to a hospitalless (sic) society. Terror has been removed from the foreground into the background. Electric shock and other terror devices can be administered as well outside, so don’t

> imagine with the passing of the big detention and torture places, the torture chambers are going too. There'll be a torture chamber as near as your Community Psychiatric Clinic or even your own home. (*History of Shock Treatment* 34)

By late 1960s, the costs of housing mental patients in the asylum were climbing out of control and the public's awareness of the terrible living conditions and brutal treatment regimes found in these institutions was putting pressure on staff. In actuality, this pressure had been building for over a century. Dorothea Dix's 1845 report to the US Senate on the horrendous conditions mentally ill individuals lived with inside the walls of the almshouses, prisons, and asylums along the US Eastern seaboard had first raised the alarm. Over 60 years later, Clifford Beers' 1908 autobiographical account, A *Mind that Found Itself* renewed concerns. Nearly 40 years after that, *Life Magazine's* 1946 photo essay "Bedlam" became the third pivotal event to heighten public awareness of life inside asylums. While these three reports may only gloss the surface of the call for institutional reform, they provide a glimpse at the ebb and flow of the public's growing awareness of the horrendous conditions that many mental patients endured within the walls of these imposing grand old buildings.

Something had to be done, so across North America and Western Europe beginning in the late 1950's, the doors of the institutions were flung open and the inmates set as free as they could be on heavy doses of anti-psychotics. Some managed to find refuge in group homes or other accommodations designated for mental patients, or were fortunate enough to return home to their families. Those without family that could offer them shelter joined homeless populations in cities coast to coast. This often meant a life on the streets in a doped-up stupor, subject to judgmental or fearful stares from neighbours. Many could not remain on their medications without the strict scheduling of the institution to keep them in check.

2.6 Psychiatric Survivors Movement

Even before this "emancipation," patients had started to band together to advocate for more control over their treatment and to seek support from fellow sufferers.

In 1943, eight mentally ill patients from Rockland State Hospital formed the We Are Not Alone (WANA) Society on the principles of Alcoholics Anonymous (AA) and its 12-step program with an emphasis on support from fellow patients. The society would go on to create Fountain House, a "clubhouse" model for former mental patients now living outside the asylum and referred to as members. WANA would also be the inspiration for *Phoenix Rising*, a newsletter first published in 1979 by former mental patients, dedicated to dispelling the myths surrounding psychiatry and psychiatric patients (*psychiatricsurvivorsarchives.com/artifacts*). This newsletter for mental patients inside and outside mental hospitals introduced the general public to the concept of a "psychiatric survivor."

The 135 years between Dorothea Dix's report and *Phoenix Rising* go well beyond the decade we are looking at, but magazines and texts such as *Phoenix Rising* and the autobiographies under examination signal early indications of a shift in the profile of the psychiatric patient, moving from a passive to a more active role in their own care to ultimately become a survivor. According to patients like Clare Marc Wallace and Barbara O'Brien, survivors took small steps toward directing their own treatment and advocating for themselves as individuals, not *just* as patients. In the decade under review and after, they began to recast the language so the public saw them not just as "cared for" but "cared about." This literally and figuratively moved the patient from psychiatric object isolated from the general public in asylums and hospitals to an individual reintroduced into his/her community.

However, within the "friendly" confines of the mental hospital, doctors restricted the patient's ability to make choices and control behaviour, unintentionally incentivizing their desire to do so. Patients began to reposition themselves as active agents seizing control over their own recovery. Perhaps one way they did this was by writing their own experiences, their own story, not just with drugs and ECT or ICT as in the poems above, but in longer diaries that captured their inner world as well as observations, notes that would eventually become autobiographies. These would also, no doubt, recount sessions in psychoanalysis, and perhaps be useful during these sessions, as they engaged in the Freudian process of recounting early experiences of distress. The following chapter will look at this non-pharmaceutical approach recommended by the social constructivists (with their interconnectedness to Freud) focused on recovery, and perhaps even the re/construction of the self.

Chapter 3. Freud and his Shadow

> *Lastly, there is the effect of the remarkable fact that people in general experience their present almost naively, unable to appreciate what it holds they must first put some distance between it and them – in other words, the present must first have become the past before it will furnish clues for assessing what is to come. (Mass Psychology & Other Writings 109)*

3.1 Freudian Psychoanalysis, Recovery of the Self, and the Role of Autobiography

Henri Ellenberger (1905 – 1993), psychiatrist and historian, in his monumental text *The Discovery of the Unconscious* suggests that Freud's *The Interpretation of Dreams* "could be called an autobiography in disguise" (451). According to him, it laid the groundwork for Freud's "discovery of the psychoanalytic method and of a new theory of the mind" (450). Freud's *Interpretation of Dreams* was drafted over the course of five years and published in 1900. During this period, Freud painstakingly explored his own memories and dreams in a detailed self-analysis. Freud's writing process was supplemented by several years of correspondence with Wilhelm Fliess (1858 – 1928) a German ear-nose-and-throat surgeon who was introduced to Freud in 1887. Although Freud did not undergo psychoanalysis directly, perhaps his correspondence with Fliess constituted a written form of "talk therapy" so that he could reflect on, and reconstruct, his thoughts using the interpretative process.

Didier Anzieu's 1959 title *Freud's Self-Analysis* suggested Freud's self-analysis and his writing of *The Interpretation of Dreams* paralleled the flow of letters between Freud and Fliess. Fliess listened and no doubt influenced Freud's thoughts and theories while offering a social and emotional connection during the isolation of writing the first draft. To some extent then Fliess could be viewed as an "analytic third" offering feedback and contributing to Freud's work. Thomas Ogden (1946 – present) refers to "thirdness," but the concept originated in Andre Green's description of the relationship between a mother and infant generating the notion of other from her fantasies of the father (2004). Ogden revisits this in the context of psychoanalysis as it relates to the re/construction of self for the schizophrenic. The analyst and the patient interpret her experience and both parties jointly propose possible meaning. Greenberg reminds us that much of what she

relates to her psychotherapist regarding actions, behaviours, and delusions are “dust” (private conversation). This “dust” is often an elaborate attempt to hide from the truth so that the real issues or traumas will not have to be faced. As Greenberg explains, “To hide one can forget, or pretend to another happening, or distort. These are all just good methods of getting away from the truth that might be bitter” (*Rose Garden* 83). The patient thus places the burden of truth on the psychoanalyst. Thirdness relies on the analysand to deliver repressed thoughts generated from the unconscious.

Writing about one’s own inner thoughts and turmoil, as Freud did while formulating his theories about dream analysis, parallel to some extent the process the schizophrenic authors underwent in writing their autobiographies while they were patients under analysis.

Although Freud died in 1939, his work cast a long shadow. In fact, Freud’s influence within the institutions for the mentally ill was at its peak from the late 1940s to the mid 1950s. Many of Freud’s followers went to the European battlefront and took up positions as psychotherapists and superintendents of large institutions. While there, they would have been influenced by, among other texts, Freud’s essay “On Narcissism” in which he says that “the patients of this kind, who I have proposed to term paraphrenics, display two fundamental characteristics: megalomania and diversion of their interest from the external world – from people and things. In consequence of the latter change, they become inaccessible to the influence of psychoanalysis and cannot be cured by our efforts” (546). However, towards the end of 1938, Freud does suggest:

> The future may teach us how to exercise a direct influence, by means of particular chemical substances, upon the amounts of energy and their distribution in the apparatus of the mind. It may be that there are other undreamt-of possibilities of therapy. But for the moment we have nothing better at our disposal than the technique of psycho-analysis, and for that reason, in spite of its limitations, it is not to be despised (*An Outline of Psycho-Analysis* 62).

The chemical substances that Freud would have been referring to at this time would be lithium derivatives, which were according to Edward Shorter, becoming used more frequently to assist in the management of both mania and depression. (“The History of Lithium Therapy” 2). And those limitations of psychoanalysis mentioned by Freud, would be directly related to the use of such therapy on those individuals experiencing psychosis.

What is of significant interest here is Freud's focus on psychoanalysis as a means for the patient to verbalize her inner turmoil and for the analyst to assist the patient to interpret her own thoughts and actions. He and others contended that the use of psychotherapy, combined with psycho-pharmaceuticals such as anti-psychotics listed in the last chapter, would impose a range of controls, that might produce enough awareness in the individual that she could learn to control her own thoughts and behaviour. Under Freud's classic psychoanalytic technique, the analysand (patient) would take to the couch, where the analyst, sitting out of view of the analysand, would listen carefully to the words spoken by the analysand during a one-hour session. The psychoanalyst would typically provide little in terms of interpretation, relying on the analysand to give her own interpretation when she was ready to do so. If the sessions became stagnant and the analysand's conversation slowed down, then the psychoanalyst used free association to reinvigorate the conversation. Through free association, the patient is expected to provide the analyst with those words, phrases, or thoughts that simply come to mind while under analysis. Free association is a fundamental part of the psychoanalytic technique because according to Freud "the whole theory of psychoanalysis is … built up on the perception of the resistance offered to us by the patient when we attempt to make his unconscious conscious to him" (*New Introductory Lectures* 85). But the patient had to be verbally present during psychoanalysis for there to be any chance of success, and unfortunately those patients diagnosed with schizophrenia presented the analyst with an increased level of difficulty.

However, psychoanalysts such as Harry Stack Sullivan (1882 – 1949), Frieda Fromm-Reichmann (1889 – 1957), and Harold Searles (1918 – 2015) [of the seven authors under review in my dissertation only Joanne Greenberg would be analysed by both Fromm-Reichmann and Searles] working with patients often modified the traditional Freudian approach. Sullivan would provide a seat for his patients, Fromm-Reichmann would usually meet her patients in her cottage at Chestnut Lodge or in their rooms, and Searles would meet his patients in his office, in their rooms, on a bench in the gardens of Chestnut Lodge, and even in his car as he drove. Their use of Freudian psychoanalysis to treat patients, to listen, and to hear what the patient was trying to communicate, did result in significant successes. At this stage, success could be defined minimally as return to some form of reality or more profoundly as the remission of all schizophrenic symptoms. Yet, these psychoanalytic skills were often otherwise absent among family

members and partners in the lives of the women whose autobiographies I will later examine more closely.

While the "boundary between the normal," as Scull reminds us, "and the pathological remains extraordinarily vague and indeterminate" (387), it was Freud, Foucault tells us, who "took up madness at the level of its language … restoring the possibility of dialogue with unreason" (*History of Madness* 339). Freudian discourse in psychiatry, and specifically the theoretical terminology that permeates the wider social sphere including use of such terms as the unconscious, ego, repression, transference, regression, condensation, dream analysis, and interpretation in everyday language is noteworthy. These terms also rise from the pages of the autobiographical texts under examination in this paper. His impact upon the authors of the schizophrenic narratives is evident in the language they relied on to describe their psychotic experiences, rationalize behaviour, and tell their stories.

For the most part, the schizophrenic narratives are filled with indirect reference to Freud. Barbara O'Brien's account of her initial break from reality presents us with an all too familiar story, whereby she "awoke one morning, during a time of great personal tension and self-conflict, to find three grey and somewhat wispy figures standing at [her] beside… they were not Men from Mars, but the Operators" (*Operators and Things* 28). O'Brien also punctuated her narrative with Freudian images and ideas. For example, her notion of repression is described as "many parts of yourself… you bury in the process of maturing, adjusting to society" (181). In addition, these three figures as described by O'Brien can be viewed as her mind's physical manifestation (albeit detailed hallucinations) of Freud's tripartite characters representing the ego, superego, and the id.

Interestingly, Clare Wallace references Freud directly. Wallace even went so far as to suggest that as a psychiatric nurse she "was in a superior position" and "felt that Freud and I would have had much in common" (*Thank You Mr. Freud* 8). She maintains she "knew all about the dynamics of group psychotherapy, regression, suppression, repression, introjection, [and] projection" (8). Other authors, such as Joanne Greenberg, claimed to have never read Freud nor been influenced by him, during the writing. Nonetheless, many of Greenberg's delusions and hallucinations seemed to have been heavily influenced by Freudian theoretical concepts. For instance, Greenberg's account

of her inner fantasy world, called Yr, suggest her memories of childhood are guarded by the Censor, and are where the gods Lactamaeon, the guide Anterrabea voice of reason, and Upuru the punisher all acted upon her and pulled her from reality. Greenberg's inner world seems to be populated by three figures that may represent Freud's ego, id, and superego.

3.2 Freudian Terminology

The terms ego, id, and superego, which Freud used throughout most of his theoretical work on the unconscious, are understood by many laypeople at the level of paraphrase and appreciation of these terms tends to be somewhat superficial and often inaccurate. Freud's *An Outline of Psycho-Analysis*, states:

> the ego is no longer able to fulfill the task set it by the external world (including human society). Not all of its experiences are at its disposal, a large proportion of its store of memories have escaped it. Its activity is inhibited by strict prohibitions from the super-ego, its energy is consumed in vain attempts at fending off the demands of the id … as a result of continuous irruptions by the id, its organization is impaired, it is no longer capable of any proper synthesis, it is torn by mutually opposed urges, by unsettled conflicts and by unsolved doubts. To start with, we get the patient's thus weakened ego to take part in the purely intellectual work of interpretation, which aims at provisionally filling the gaps in his mental assets, and to transfer to us the authority of his super-ego; we encourage it to take up the struggle over each individual demand made by the id and to conquer the resistances which arise in connection with it (60).

Freud defines these three terms by comparing them to Plato's charioteer. A reference to this much earlier but seminal thinker reminds us the notion of self has been discussed and dissected for almost three thousand years. Plato first began discussing the idea of the tripartite soul using an image of a chariot pulled by two conflicted horses. The soul is driven by a black horse, representing a human's appetites and desires, and a white horse representing a human's spiritedness or virtuous nature (*Phaedrus* 34-35). Freud introduced his own tripartite psyche consisting of the conscious, pre-conscious, and the unconscious.

Barbara O'Brien in her autobiography referenced this by using Freud's terminology when she said that "Behind the units of the unconscious there appeared to

be a wholeness, a Manager of sorts, selecting for its job of curing insanity, its choice of machine parts" (182). The Manager was "an individual without adequate courage who learns to separate himself so that he is acceptable to himself and his environment" (*Operators and Things*, 191).

Freud would later rename the conscious, pre-conscious, and the unconscious to align with ego, id, and super-ego:

> The functional importance of the ego is manifested in the fact that normally control over the approaches to motility devolves upon it. Thus, in its relation to the id it is like a man on horseback who has to hold in check the superior strength of the horse, with this difference, that the rider tries to do so with his own strength while the ego uses borrowed forces. The analogy may be carried a little further. Often a rider, if he is not to be parted from his horse, is obliged to guide it where it wants to go, so in the same way the ego is in the habit of transforming the id's will into action as if it were its own. (*Ego and the Id* 19)

The ego is not the self, for the self is the result of the interaction of all three of these structural components working in concert (though not necessarily in harmony). Interestingly, Harry Stack Sullivan (1892 – 1949) also postulated that the human character could be broken down into three components: "one the affective which refers to the emotions, two the cognitive referring to sentience, and the third conative referring to impulse" (*Schizophrenia as a Human Process* fn28). Freud makes clear, that as Sullivan contends, all three components are constantly present and reminds us early on that, "Where id was, there ego shall be" (*New Introductory Lectures* 100).

Freud suggests that "the ego can take itself as an object, can treat itself like other objects, can observe itself, criticize itself, and do heaven knows what with itself …. So the ego can be split" (*New Introductory Lectures* 73). The id, by contrast, represents our inner desires that provide us with both pleasure and pain. "The id knows no judgements of value: no good and evil, no morality… [It] is intimately linked to the pleasure principle" (*New Introductory Lectures*, 93). Finally, the superego is "allotted the functions of self-observation, of conscience and of maintaining the ideal… [It] is the representative for us of every moral restriction" (83). The superego functions as moral inhibitor, attempting to steer us onto the path of righteousness and what is socially acceptable. This conscience is our moral compass learned in early social development from our parents or other family members, teachers, etc.

The human psyche under Freud's complex structure consists of these interacting, and overlapping conceptual players, which when functioning well, provide us with the means of fabricating a relatively normal sense of self. The ego, as Freud explains, "serves three masters and does what it can to bring their claims and demands into harmony with one another. These claims are always divergent and often seem incompatible… Its three tyrannical masters are the external world, the superego and the id" (*New Introductory Lectures* 97). Jefferson refers to her awareness of being self-centered and the problems this creates in her autobiography: "I am I, an odd piece of Egotism who could not make the riffle of living according to the precepts and standard society demands of itself, I find myself locked up with the others of my kind in a hospital for the insane" (*These are my Sisters* 11). She adds, "They have got us all analyzed and psychoanalyzed down to the insignificant blobs of protoplasm and personally, my Ego is not flattered by the things they found out about me" (27). These young women filled their texts with the language of the day, providing the reader with a narrative account of life under the influence of Freud.

To continue our itemization of Freud's terminology, we turn now to the concept of "condensation" (*Interpretation of Dreams*), which is of particular relevance for the schizophrenic given that hallucinations, while not dreams per say, have many similarities to the dream state even though patients are disconnected from reality while fully awake. His theory of condensation suggests that "The dream which we remember on waking would thus appear to be merely a remnant of the total dream-work… and that the recollection of it [the dream] becomes more and more defective as the day goes on" (*Interpretation of Dreams* 171). Greenberg recalls attempting to throw her baby sister from the window to her death. Dr. Fried [who was in reality Dr. Frieda Fromm-Reichmann], Greenberg's psychotherapist, reassures her a five-year-old couldn't lift a baby from a bassinette while opening the window (*Rose Garden* 204). The "memory" is demonstrative of the hate she believes she felt for her sister. Dr. Fried explains, "You may remember hating, but the facts are against you..." (205). Greenberg re/created the circumstances as a childhood memory to justify her feelings. Over the passage of time, and through the continuous process of reshaping and retelling the story, she condensed the "facts" of the story and reduced the hatred toward her sister to hatred toward herself for having such feelings. The delusion emotionally blackmails Greenberg to the extent that she creates a hallucinatory memory played over and over again until it becomes

reality for her. In analysis, Greenberg began to forgive herself for her feelings, and in writing about that process she begins to fully understand their power.

Freud's 1889 essay "Screen Memories" explains how an individual's memories from childhood can be so vivid they are reflected in adult dreams and comprised of details pulled from episodes in their past. These "screen memories" are yet another attempt to construct a whole from fragments of earlier selves. Screen memories are "impressions and thoughts of a later date whose content is connected with its own by symbolic or similar links" (*The Freud Reader* 123). Freud reminds us that "There is in general no guarantee of the data produced by our memory" (*The Freud Reader* 123). As we have seen from the schizophrenic autobiographies under review, the memories from the past which stand out to these women as emotionally significant have often been revisited over a long period of time. At some point in the process of recollection, these memories which appeared to be genuine have become entangled in other events, thoughts, and actions. In the Greenberg example she "remembers" throwing her baby sister out the window, but Fromm-Reichmann convinces her it was more likely she looked through the bars of the crib at her baby sister while thinking about how the arrival of her sister meant Joanne was no longer the centre of attention and favoured – a distasteful realization. Her feelings of dislike turned to hate and she may have daydreamed about throwing her sister from the window. This terrible fleeting thought would fill her with guilt.

Freud states, "I hope, [I] have to some extent clarified the concept of 'screen memories' as one that owes its value as a memory not to its own content, but to the relation existing between that content and some other that has been suppressed" (*The Freud Reader* 126). He would add "Our childhood memories show us our earliest years not as they were, but as they appeared at the later periods when the memories were aroused" (*The Freud Reader* 126). These are a shield to protect us from past traumas – physical or sexual assaults or deep-seated feelings of guilt and embarrassment. Freud reminds us that memories are rarely absolutely accurate, but are nonetheless indicative of the dynamic between ourselves and others.

Freud's notion of repression is also an important one for those schizophrenic writers under analysis in this dissertation. The astute reader of these autobiographies notes instances when ideas, thoughts, and memories were too psychologically difficult to

discuss so were pushed back as the mind's "defense mechanism." In Freudian terms, the patient is moving from resistance to repression. "The same forces which, in form of resistance, were now offering opposition to the forgotten material being made conscious, must formerly have brought about the forgetting and must have pushed the pathogenic [causal] experiences in question out consciousness… [to which he] gave the name repression" (*Five Lectures* 21). These repressed experiences are pushed from the conscious to the unconscious mind. For the schizophrenic, repressed events buried in their unconscious psyches present in dreams and auditory or visual hallucinations and delusional states. The repressed material then plays over and over again (like sampling multiple audio tracks) in an effort to make them cohere. Greenberg, Jefferson, and Simpson detail their childhood memories, some of which reside within, as with Greenberg's complex creation of the world of Yr. Their minds are working to pull these together into a story that is both rational and reasonable.

Repression and regression are closely related in Freud's pantheon of psychoanalytic terminology. Reverting to a former stage of development from maturity, often early childhood, occurs frequently under analysis as a means to revisit foundational emotional moments. Regressive behaviour is documented in many of the autobiographies. Greenberg regresses from a teenager to the attention-seeking behaviour and tantrums associated with a much younger child. Regressive techniques used as mode of therapy can invite lapses into an animalistic state (raving like wild beasts, urinating and defecating on the floors, and overt displays of sexuality). The physical toll on those undergoing regression is significant. Simpson describes "the mortification of being treated like a beast" (*Lost Days of My Life* 71). She would look in a mirror and see an "unrecognizable self" (62), or "just an animal… a skeleton- like figure" (95-96). Frame says, "I did not know my own identity… I was burgled of body and hung in the sky like a woman of straw" (*Faces in the Water*, 65). Jefferson laments "All that was my former self has crumbled and fallen together and a creature has emerged whom I know nothing… she is a stranger to me" (*These are My Sisters* 14). This dramatic change in their physical bodies from vibrant young women into less-than-human creatures represents a devolution. Simpson recounts the horror of that moment: "Never had I seen anything so inhuman before—the wide staring eyes without expression, the yellow-white cheeks, the bruised mouth, the rough short hair tumbled over the head" (*Lost Days of My Life* 62-63). The longer these young women lived within the institution,

the more their outward appearance altered; they regressed into child-like state mentally under analysis, but also transformed physically as one of the consequences of long-term institutionalization, the lack of personal care, and the abusive nature of many forms of treatment levied by hospital personnel.

Transference is also a psychoanalytic practice discussed in Freud's chapter on the "Psychotherapy of Hysteria" in *Studies on Hysteria* (1957) written with Josef Breuer. "In every psycho-analytic treatment of a neurotic patient the strange phenomenon that is known as "transference" makes its appearance. The patient, that is to say, directs towards the physician a degree of affectionate feeling (mingled, often enough, with hostility) which is based on no real relation between them" (*Five Lectures* 56). Freud is describing the relationship that arises from the intimate nature of psychoanalysis that allows the patient to finally be heard. Frame begins to have affectionate feelings toward Dr. Steward who pays attention to her as an individual, and not just as another patient. He asks her if "[she] would like to make morning and afternoon tea for the doctors" adding, "I've given you full parole …" (*Faces in the Water*, 232). From this moment on, Frame trusts in the care she is being provided, and the one person who helps her get out of the institution. She begins to anticipate Dr. Steward's arrival on the ward with hope and relate to him more fondly.

Simpson offers an even more detailed example of transference with Dr. Grant who gives her an opportunity to tell him about how "she hates her mother" and instead of berating her for such thoughts he says, "There is no need for you to feel mean and guilty because you don't love your mother; you have tried, but things have gone wrong" (138). In giving Dr. Grant her trust, she admits to warmer feelings for him, and begins the process of healing (though these two actions are not necessarily or always aligned). As these women started to put their faith in the hands of authority figures, they foresee a possible future outside of the institution. The provision of some form of occupational therapy – Frame worked in the doctors' lounge making coffee and tea, Simpson wove scarves – often followed from this progress and drew the patients closer to release from institutional care.

Freud's lexicon – ego, id, superego, condensation, screen memories, repression, regression, transference – constitute the language of the asylum, and would have been overheard in the psychiatric offices and hallways of these institutions so it is not

surprising the language of psychoanalysis permeates these autobiographical narratives as it did their conversations and environment. In these ways, Freudian analysis influenced psychiatric notions of the construction of self, especially as it worked to help the patient define her position within the community of "normal" others and with other "abnormal" patients in asylums.

Many psychoanalysts saw patients in their offices as noted above, but many also worked in the mental institutions that symbolized "the practical consciousness that separated the mad from the rest of society, condemning them and making them disappear, [and which was] necessarily mixed with a certain political, legal and economic conception of the individual in society" (*History of Madness* 172). However, the British historian Roy Porter (1946 – 2002) claims in his book *Madness: A Brief History* that the push towards the "Great Confinement" in asylums is "… simplistic and over-generalized. With the exception of France … [as] different nations and jurisdictions acted dissimilarly" (93-94). The historian of medicine, Edward Shorter (1941 -), seems to agree with Porter stating, "In England, it would be nonsense to speak, as … Foucault does, of any kind of "grand confinement" (*History of Psychiatry* 5). However, Shorter does concede that "on both sides of the Atlantic, the history of psychiatry began as the history of the custodial asylum" (*History of Psychiatry* 7).

Yet before the advent of the large public mental institutions of the 19th and 20th century, where did the "mad" reside? How were they cared for and what forms of treatment, if any, were provided?" Most likely, the "mad" simply lived among us as those who may have lost their sense of reason or had become unhinged living a lifestyle that did not correspond to the morality acceptable to their community. They were often in the care of their immediate family or of their parish. However, when they could no longer work, according to Foucault, "confinement was demanded quite independent of any desire to cure. What made it necessary was a work imperative" (*History of Madness* 62). Although it has been reported that as early as 1377, the Royal Bethlem Hospital in London, England did house a handful of insane individuals (Allderidge 1979; Andrews 1997; Porter 2006), it really wasn't until the 1600s that Bethlem became focused on the housing of the insane. I use the term "housing" purposefully because mental asylums at this time provided shelter, food when available, and a means to control the unwanted behaviour of those interned. The asylum would take on the role of social segregation and its purpose was not to cure but to separate those individuals no longer fit for life in

the community. Bethlem would be rebuilt three times over the 750 years of its existence and would move from London to Croydon. Life in the asylum was mainly focused on warehousing and feeding those individuals removed from the general population, without promises of treatment or therapy.

What is important to note is that from the 1300's to the time period I am focusing on is that although new forms of treatment and therapy for the mentally ill have emerged, those confined to the asylum are often housed within the same architectural design of confinement as those patients a hundred years prior. The grand castles of moral and mental control, particularly those built in the United States during the mid-1800's followed the Kirkbride plan. These institutions such as St. Elizabeths Federal Hospital for the Criminally Insane in Washington DC, Danville State Hospital in Pennsylvania, and Trenton State Hospital in New Jersey housed thousands of patients. In the US alone, 73 mental institutions would be built following the Kirkbride design (Murphy 35), all of which were based on the principles of environmental determinism and the philosophy of moral treatment. Proponents of environmental determinism propose the notion that one's environment plays a role in the well being of the individual. Dr. Kirkbride's design followed this thought process suggesting that "The design of the asylum can be described as having a cheerful and comfortable appearance with ornamented grounds including trees, shrubs, and flowering plants. The attractiveness of the asylum is meant to impress upon the patient a desire to reside in the building" (Harvilla). These institutions were also built on large estates, many of which were landscaped with trees, shrubs, and flower gardens to instill a sense of nature and well being. Inside the asylum, the patients were subjected to what has been described as the moral treatment which focused on re-establishing the routines of acceptable social behaviour. Or as Foucault proposes, "the nineteenth century, through the invention of its notorious 'moral methods', had brought madness and its cure into the domain of guilt" (*History of Madness* 325). Emerging from this context of guilt is Freud's psychoanalytic method and the shift towards understanding mental illness at "the level of language" (*History of Madness* 339).

Physically, the structural components of the asylum, as we have seen was very important in segregating patients, and for controlling patient behaviour however, language in its own right can be just as constraining as any physical constraint and perhaps even more so. Shifting from Goffman's more structural model, and overlaying

Freud's topographical model upon the architecture of the mental institution we can also discern features of control generated from diagnostic labels and the use of language on these patients. Freud began to outline his "topographical model" in his text *The Interpretation of Dreams* and continued its development until shifting his attention to his "structural model" which would incorporate aspects of the first. The topographical model, Freud suggests that psychoanalysis, "by reason of its *dynamic* view of mental processes; now in addition it seems to take account of psychical *topography* as well, and to indicate in respect of any given mental act within what system or between what systems it takes place. On account of this attempt, too, it has been given the name of 'depth-psychology'" (*Complete Psychological Works* 2997). And furthermore, "Our psychical topography has *for the present* nothing to do with anatomy; it has reference not to anatomical localities, but to regions in the mental apparatus, wherever they may be situated in the body" (2998). These regions according to Freud were represented by the unconscious, the conscious, and the pre-conscious.

However, if the mental act or idea under the topographical model is not to be considered taking place anatomically, then what is Freud suggesting and how does it apply to the structure of the mental institution? I suggest that Freud's topography actually complements Goffman's model of the total institution as it weaves together the architectural aspects of the asylum with the psychological elements experienced by the patients. From Goffman's perspective we saw how the patient may move both vertically within the mental hospital as they become more or less compliant. At the same time these same patients also move horizontally (from front stage to back stage) depending on their willingness to follow direction and their treatment plan. The topographical model highlights a similar patient trajectory through the asylum but rather than being behaviour focused it is language/idea focused. What I am suggesting is that as the patient is moved from an unlocked ward to a locked ward, we need not only center our attention on the willingness of the patient to comport themselves in conformity with the rules and expectations of each ward. Rather, what I am suggesting is that the shift between wards must also take into consideration Freud's concept of regression. For as the patient regresses, they demonstrate a tendency to shift from an unlocked ward to that of a locked ward. And for those patients that have regressed to the point beyond the locked ward they frequently found themselves in the "rubber room" which is solitary confinement.

What may have changed is the patient's concept of themselves as they begin to regress to a more infantile like nature as well as a shift from a conscious to an unconscious awareness of self. Frieda Fromm-Reichmann in a lecture on the "Psychotherapy of Schizophrenia" states, "All schizophrenic patients live in a state of partial regression to early phases of their personal development, the disturbed ones more severely regressed than the conformative ones" (410). Furthermore, "Patients" according to Fromm-Reichmann, "have to learn to integrate the early loss and to understand their own part in their interpersonal difficulties with the significant people of their childhood" (416). Accomplishing this acceptance and integration of loss within the patient required, as explained by Fromm-Reichmann, an attempt "to reach the regressed portion of their personalities by addressing the adult portion, rudimentary as this may appear" (411). Thus, topographical model allows for further insight into how the physical layout of the mental institution can be used to not only confine patients but also how this same layout can reaffirm the language applied to those patients.

However, the key to the application of the Freud's topographical model is "regression" and the shift of understanding the process of regression by the patient and the institution's personnel. As Freud laid out in "The Unconscious":

> If we communicate to a patient some idea which he has at one time repressed but which we have discovered in him, our telling him makes at first no change in his mental condition. Above all, it does not remove the repression nor undo its effects … But now the patient has in actual fact the same idea in two forms in different places in his mental apparatus: first, he has the conscious memory of the auditory trace of the idea … and secondly, he also has – as we know for certain – the unconscious memory of his experience as it was in its earlier form. (579-580)

It is from this overlaying of physical structures of the mental institution with Freud's topographical model of the psyche that provides insight into the schizophrenic experience. As Freud summed up, "In schizophrenia *words* are subjected to the same process as that which makes the dream images out of latent dream-thoughts - to what we have called the primary psychical process. They undergo condensation, and by means of displacement transfer their cathexes to one another in their entirety" (*Complete Works* 3021). Yet words, at least for the schizophrenic require considerable patience and time for the psychotherapist attempting to provide treatment which can be in short supply, especially when results and budgetary constraints factor in patient outcomes.

As just discussed, psychoanalysts plumbed the mind through its own expression in language, revealing various levels of consciousness. These levels often mirrored the classical architecture of the asylums that housed these minds. The mental institutions had tiers, multiple floors signifying patients' levels of sickness and controllability, and welcoming visitors waiting areas and therapeutic rooms obscuring from view the back wards where the severely disturbed and "incurables" were hidden from the eyes of the public. As explained in his text *The Ego and the Id* (1923), Freud's structural model (which supplemented the topographical model) suggested an architecture of the conscious and unconscious mind that reflected a similar desire to present one aspect, but hide another, some memories and experiences expressed upfront with little to no filter, while others only came to light when revisiting extreme circumstances or trauma. Furthermore, both the architectural elements of asylum are dynamic like that of mind. For the patients not only move horizontally (up front to hidden in the back) through the mental institutions, they also move vertically through the ward system. Those patients who happen to demonstrate more behavioural issues or who are not responding to treatment as well as hoped are transferred to higher floors. While those patients who follow orders and willingly complete the steps involved in their treatment regiment tend to be transferred to the unlocked wards which are usually found on the lower levels of the asylum. If the asylum's very structure mirrored the structure of the mind, so too did the books that housed its outpourings – the cover that invites one in, the opening friendly pages, and the darker interior. As this self within took shape on the page, it can be said to transform into an autobiography that for the schizophrenic constructs as much as records.

3.3 The Psychiatric Self and the Autobiographical Self

For the female authors of the autobiographies under review, the combination of analysis and writing their life story helped them deal with the stigma, shame, isolation, or denial of a schizophrenia diagnosis. Writing the stories of their lives may also have been a vehicle to re-write their own case histories and seize some control from the hands of the psychiatrist. The continuous reworking and reinterpretation of thoughts, memories, and dreams on the page allowed their notebooks to act like a confidant, a listening but silent companion/analyst in whom they could confide. Unlike Freud, they did not have a stable home, friends and family, or a neutral setting conducive to writing that could

perform this function for them until they got into therapy, and even there they may not have felt safe enough to fully divulge their thoughts.

Authoring these autobiographies within the confines of an insane asylum, procuring paper and pencil by whatever means possible, and writing in secret or openly defying the rules of the institution, presented significant obstacles the women had to overcome. Most patients were never provided with a pen and paper as authorities believed they could be used to inflict violence on themselves or others, so a patient's written documentation of their experiences is all the more remarkable. Lara Jefferson told ward attendants and nurses she was "Shakespeare, the reincarnation of Shakespeare… re-writing Hamlet" (*These are my Sisters* 126). Others wrote to silence the voices within or the noise around them as they struggled to survive. As they wove the textual fabric of their lives, they recognized the power of the written word, not just the labels and diagnoses that told one story, but the truer stories they told themselves. Re/creating this self, using the language of Freud's psychiatry offers not only an alternative history of mid-century psychiatric practice, it offers an alternative life in a place where that was not sanctioned.

Psychiatry functions within a framework of its own official discourse, both verbal as in talk therapy and the spoken terms defined above, or written as in case studies and notes or official forms. The patient is exposed to, and confronted by, the institution's discursive techniques on a daily basis and likely begins to take notes to record her experience within the mental institution. The act of doing so will likely invite attention and questions as well as additional psychiatric labels, such as "hypergraphia" or "graphomania," the obsessive-compulsive desire to indiscriminately write down thoughts, feelings, and observations about those experiences. This was often met with derision and mistrust despite the fact that psychiatrists and other individuals working within the mental institution could use these observations to assist them (*Asylums* 1961). This overabundance of officially and unofficially documented material, be that a psychiatrist's notes, the transcripts of patient or group sessions, notes compiled by nurses or messages about certain patients, and the journalistic case study produced were just as subjective and suspicious as the patient's attempt to relate her own plight.

Chapter 4. Morphology of the Narrative Self

"We must inescapably understand our lives in narrative form, as a 'quest'." –Taylor 52

"We "journey" as we've read books, watch films, look back at our past, imagine the future, even mindfully try to live in the always and only present moment while thoughts of what was, and is still to come, crowd our minds… That's the price of living in time." –Diski 146

4.1 Toward a Morphology of Self – Vladimir Propp

In 1928, Russian scholar Vladimir Propp (1895 – 1970) wrote *Morphology of the Folktale* (1958/2015), a text that would be translated into English in 1958. Propp used "the study of forms" (1), or morphology, to break down folktales into their component parts so each could be studied in the context of the whole. Propp suggested that "a study of the logical structure peculiar to the folktale would lay the groundwork for the study of the folktale as myth" (2). To prove this, Propp set about categorizing, cataloguing, and codifying several hundred Russian folktales and fairy tales to implement a system of classification that assessed character, setting, actions, intentions, and functions. Propp determined the folktale could be broken down into 31 functions, actions or situations that the main characters experience within the narrative units (narratemes), that could then be used to analyze any text within the folktale genre.

Propp defines a function as "an act of the dramatis personae, which is defined from the point of view of its significance for the course of action of the tale as a whole" (*Morphology of the Russian Folktale* 20). Functions have several roles: "they serve as stable, constant elements in folktales, the number of functions is limited, and the sequence of functions is identical" (20). Propp explains that although "the number of functions is highly limited… all tales included in our material develops within the limits of these functions… [and] one function develops out of another with logical and artistic necessity… they all revolve around on a single pivot" (58).

Controversially, Propp suggested that "motif" would be more important than plot. In narrative, a motif is any recurring element that has symbolic significance in the story. Through its repetition, a motif contributes to the work's theme or mood; it is a distinctive feature or dominant idea in the artistic or literary composition. Propp disagreed with

Veselovskij who thought that “motif… was an indivisible narrative unit…the simplest narrative unit [and] incapable of being divided further” (11) and that motif must be considered in connection to the “significance of the functions as part of the course of action for the tale as a whole” (20). Propp’s disagreement with Veselovskij was subtle in its nuance; what Propp proposed was that if Veselovskij’s notion of singular motifs were espoused, then these motifs, as suggested by Veselovskij, could potentially be even further reduced, and consequently be viewed as divisible which would unfortunately lead research of the folktale down the wrong path (12). Propp wanted to separate himself and his theoretical ideas from other Russian theorists. His focus on the structure of the text as it pertained to role played by the 31 functions and the interchangeability of characters and their actions within the folktale wound up being a more beneficial means of analysis.

According to Propp, “this explains the two-fold quality of the folktale: it is amazingly multiform, picturesque, and colorful, and to no lesser degree, remarkably uniform and recurrent” (19). Propp dissected multiple Russian folktales and demonstrated that one could interchange the various dramatis persona in different settings and assign each character a wide range of actions yet still conclude all the folktales were “constructed according to identical functions” (80), and that each re/constructed a myth. What’s particularly important to this work is Propp’s statement that “the creator of [the] folktale rarely invents… he receives his material from his surroundings or from current realities and adopts them for the folktale” (102). Close readings of the autobiographies studied here benefit from Propp’s morphological approach insofar as the authors adopt elements from their surroundings and current reality to fashion the story of their lives, with mythical elements and motifs that repeat not only within their own stories but across all seven authors’ works. Each vignette is a function that can be coded to count occurrences and compare across authors.

4.1.1 Dramatis Personae

Propp identifies seven distinct character classifications: 1) the Hero, 2) the Villain, 3) the Donor, 4) the Helper, 5) the Princess, 6) the Dispatcher, and 7) the False Hero. I will begin with the introduction of the hero, typically a young man whose future act of bravery and courage will gain him the hand of a princess or fair maiden. In the autobiographies, the “hero” is female and the writer herself, who undertakes a set of courageous tasks that demonstrate strength and fortitude in order to survive treatment

and win release from the institution. The author is typically unwillingly forced on a journey into the world of the mad, running this gauntlet to eventually prove her reason or mental competence. The women enter this battlefield to demonstrate their sanity, to explain their actions and behaviours, and to get back the life they left behind.

Greenberg, had her first schizophrenic break and was admitted into the mental hospital at 16. O'Brien, whose schizophrenic break occurred in her early twenties, was briefly hospitalized before she released herself from care. Jefferson, at 29, wrote that "it [madness] did over take her… [and] has whirled and left a stranger unknown to me" (*These Are My Sisters* 18). We don't know what became of Jefferson, but presumably she likely spent most of her remaining days as a patient in a mid-western mental hospital. This assumption of Lara's continued confinement was drawn from the original Introduction written by Jack Vickers, who described the original source of Lara's autobiographical account as well as stating that the "authoress is unavailable to prepare" (7) a preface or a prologue. Plus, Lara herself tells the reader that she had to stop writing for she could not continue writing as she was about to be transferred to "the semicivilized purgatory upstairs" (236) which signaled her move to a more secured lockdown ward. Frame's first mental break occurred in her early twenties, during which time she was committed to several institutions around New Zealand. Simpson, who was committed at 13, would spend the next 27 years being shuffled between six different British institutions for the mentally insane. Wallace, who was 16 when she started to show symptoms of schizophrenia, spent time in and out of various mental hospitals in the London area, but uniquely also worked as a schizophrenic nurse between episodes.

The villain in folktales is typically a single figure who commits an act of villainy shortly after being introduced, but in the autobiographies this character is often plural and represented by several individuals who emerge as such during the hero's journey into madness and treatment within the institution. Villains tend to be the absent-minded and busy superintendents, uncaring and overworked psychiatrists, underappreciated and nasty nurses who prowl the wards maintaining order via threat of punishment disguised as treatment, unfriendly and heartless care attendants, or a cold and distant parent, often a domineering mother. The villain could also be schizophrenia itself, as identified using diagnostic criteria, and the stigma that surrounds those labeled with the disease. The author as hero eventually outsmarts these villains, but often only after much damage is done. As readers, we supplement the authors' descriptions by bringing

to the page other images pulled from the headlines, novels, and movies about life within the asylum. These villainous characters take on familiar roles in the fight between good and evil, light and darkness, reason and unreason, sanity and insanity.

Each autobiographical text under review provides many examples of said villainous characters. Jefferson poetically describes the institution's superintendent: "His trip is such a whirl of motion his coattails stream out behind him… [b]ut his eyes project shifting penetrating beams of observation… If anything were not as it should be, he would see it instantly" (*These Are My Sisters* 108). Ward doctors also were surveilling patients, overprescribing medication, too freely performing lobotomies or subjecting patients to insulin or electric shock treatments. These doctors were presented as villains who didn't take the time to speak with the patients or to listen to them, particularly those in the back wards.

Frame writes, "It was well known that Lawn Lodge patients were 'so far gone' that it was not much use the doctor devoting his valuable time to them, that it was wiser for him to be attending the others, the Ward Seven and the convalescent people who could be 'saved'" (*Faces in the Water* 101). Yet, even though she understood all too well the "new attitude towards mental patients" (43) which was implemented as a means to prevent patient abuses and to remind the institutional personnel that "mental patients are like you and me" (72), the head nurse used EST as form of retribution, saying to another staff person that "she is down for shock, it will put her in her place ... she needs to be taught a lesson" (99).

Simpson describes Dr Walters as "wizened, impersonal, she was quite incapable of looking on any patient as a person, only as something that had to be given treatment, or told not to be stupid" (118). Walters, the consummate villain, says, "We will give her insulin and ECT tomorrow and see if it does anything for her." When Jane responds negatively to this course of treatment, she is told, "Be quiet! You will have what you are given" (*The Lost Days of my Life* 116).

Nurses also issued medicalized punishment for uncooperative behaviour, exerting their power over patients as gatekeepers for day programming like occupational or group therapy. Frame describes a nurse-initiated game called a "lolly scramble" in which the nurse would "fetch a bag of sweets from the tin … [and] the paper lollies would

be showered into the middle of the dayroom floor and it would be first come first served with fights developing, people being put into strait jackets, whistles blowing" (*Faces in the Water* 98). Villains use any means possible to wield control. The patient undergoing the treatment regimen learned that to survive, "you must pretend to conform and accept imprisonment" (*Portrait of a Schizophrenic* 92). Villains like these rendered patients docile and those that fought for dignity either became psychiatric survivors or broken souls of the back wards.

Each autobiographical text also refers to a mother figure. In 1948, Frieda Fromm-Reichmann introduced the concept of the "schizophrenic mother" to the field of psychiatry. In her paper titled, "Notes on the Development of Treatment of Schizophrenics by Psychoanalytic Psychotherapy," she suggested that "the schizophrenic is painfully distrustful and resentful of other people, due to the severe early warp and rejection he encountered in important people of his infancy and childhood, as a rule, mainly in the schizophrenic mother" (265). Although Fromm-Reichmann became known for blaming the mother and her interactions with the child for the development of schizophrenia, later in her career she recognized "early childhood experiences… and their repetition in [one's] adult life either in reality or by virtue of repetition" (*Some Aspects of Psychoanalytic Psychotherapy* 92-93) created the potential for schizophrenic behaviour.

Jefferson's "mother had been an attendant at an asylum… [Whose] suckling children were brought to her at intervals for nursing by a patient who had only to walk across the grounds" (*These Are My Sisters* 16). She also had to read, memorize, and quote from the Bible so "that her mind was crammed with knowledge no child should be forced to absorb" (*These Are My Sisters* 16). Jefferson never felt she lived up to her mother's expectations; she become an evangelist and thus "debased her before God [and] failed in [her] Destiny" (17). Simpson tells a similar tale of her upbringing, remembering her mother's "voice rising to an almost impossible crescendo, … screamed yet again: 'You all of you are nothing but a burden and a worry. God, how I hate you all! Blast you!'" (16). The childhood trauma of verbal abuse at the hands of her mother is triggered by similar abusive experiences from the nurses and nuns during her years in the institution. Her past overlaps continuously with the present and neither are syncing up with the reality of her situation in the now. Her waking nightmares and delusions reinforce times she was to be a "good girl" and to do as she was told or face

punishment. In the asylum the punishment is electric shock treatment or liquid cascara to induce spontaneous seizures. The presence of the mother is often related to the moral of the fairy tale, i.e., that bad parenting / mothering can result in schizophrenic tendencies.

Other autobiographies hint at the actions of shadowy figures or the remembrances of long past conversations that may or may not have been directed at them during their childhood, yet still gnaw at their consciences. O'Brien's autobiography suggests the unconscious is a storehouse for villainous thoughts and selves: "how many parts of yourself do you bury in the process of maturing, adjusting to society … [because] to be different was to be suspect [especially] where the lines of thought and behavior were rigid." (*Operators and Things* 163 – 184).

It should be noted that all of these women may have been more vulnerable to villains because they worked in fields dominated by men and pursued careers rather than followed paths toward marriage and family. This created conflict given their willingness to fly in the face of cultural and societal norms for women at this time. Trapped between a conservative post-war era and the emergence of second wave feminism (Rudnick, Smith and Rubin 2006) that saw more women entering the workforce, these women were victims of the mental hospital instead of an unhappy marriage.

4.1.2 Setting

According to Propp, the setting of folktales is often universally "colorful and picturesque" (*Morphology of the Russian Folktale* 19), but like many other components of the folktale this too is interchangeable. In the schizophrenic narratives, the setting is almost identical: an asylum that was positioned as a refuge from the stress of life that offered a "rest cure" at a well-manicured estate on idyllic parkland with wide expanses of greenery. Only later did they find out that the cure may not be so restful and the grounds off limits unless strictly supervised by nurses and attendants. However, the author heroes spent the majority of their time in the carefully controlled confines of large, overcrowded public institutions, or like Frame, Simpson, and Wallace, were shuffled between them. Jefferson was housed in one large mid-western institution, while Greenberg was admitted to Chestnut Lodge, a private hospital for schizophrenics in

Rockville, Maryland. The only author not to be institutionalized was O'Brien, who was briefly brought to the psychiatric ward of a hospital only after passing out in a bus station. She describes her first impressions: the "attendant appeared, took away my possessions, gave me a cotton robe and a pair of carpet slippers, and led me to the ward" (*Operators and Things* 61). She counted "the number of beds in the ward, the number of bodies in the beds, the number and texture of the attendants, the location of the windows … [And] the hypodermic needle in the hands of the attendant who came towards her" (61-62).

4.1.3 Functions/Plot

Interestingly, most authors begin their tale with their first schizophrenic break. The next development is their admittance to the mental hospital, and their experiences when separated from the outside world (normalcy) and confinement to the inside world of the institution (insanity). The author or "hero" is then delivered to the ward, where she undergoes further transformation from patient to schizophrenic, and is given sedatives, convulsive chemicals, or anti-psychotics and subject to electric shock treatment, lobotomy, and the wet pack. While Propp outlined 31 functions in his analysis of the Russian folktale, my analysis of the schizophrenic narratives focuses on five main functions present in the autobiographies that revolve around a single pivot point, and are recognized as having artistic value. The following table outlines the five narrative units I believe comprise the published autobiographical stories of their lives:

Table 1
Narrative Units

Function/Narrative Unit	**Autobiographical Relevance**
The Schizophrenic Break	The author recounts her initial break from reality.
Admission to a Mental Hospital	The author is removed from family and community.
The Journey	The author undertakes a journey into the world of the mentally ill and back to reality.

Treatment	The author is given pharmaceuticals, undergoes surgery and bodily suffering, and endures these through acts of strength and perseverance.
The Return	The author attempts a return to normal life, to her family and community.

Each of these five functions appear in the schizophrenic autobiographies, though they may not each carry equal weight. A review confirms Propp's assertion that one can substitute one female author for another, change the setting/place of the action, and the timeframe with little affect to the story and its outcome. Hence, Paul Ricoeur's "series of nows" can be joined to make a complete narrative of these linked scenes that reflect a journey from a normal state to mental breakdown/ insanity to a return to normality using the autobiographical accounts as means to do so. This third and final stage could mean being cured, returning to who they were before diagnosis, or living in community with family and friends in a state of becoming. Yet for many of these women there was no place to return to and notions of an idyllic setting were frequently figments of a fractured mind longing for a sense of normalcy and a healthy self. This fictive place may have even provided the impetus to emerge from their schizophrenic journeys.

Each author's experience is nuanced and their respective goal unique to their individual circumstances. Propp reminds us that "it is not the quantity of the material [under investigation] but, rather the quality of the analysis" (22), that a "return is generally accomplished by the means of the same form as the arrival" (50), and that "one character in a folktale may easily be substituted by another" (79). Constructing the morphology of the schizophrenic narrative both accepts these statements and proves them. Their schematic structure when broken down into functions or smaller narrative units reinforces the similarities between the narratives without erasing their distinct variations.

According to Susanna Egan, the writing of most autobiographies tends to follow four main narrative time periods: childhood, youth, adulthood, and old age. It also pursues three familiar motifs: "the journey, conversion, and confession with all three

recurring metaphors following an overarching schema of birth, life and death" (*Patterns of Experience* 4). Egan goes on to say "that the scheme any autobiographer chooses provides a shape for his narrative. It also provides a meaning. The formula of anticipation, recognition, and fulfillment is matched by the formula for separation, initiation, and return borrowed from the rites of passage and described by Vladimir Propp as part of the total action of every folktale" (21).

4.1.4 The Journey

When the author hero realizes that in order to escape the mental institution, she must demonstrate she is better/normal, the journey commences. Propp defines the journey as the course of action "on which various adventures await the hero" (39). The journey often begins with a "decent into hell" as Greenberg describes: "For the people on the edge of Hell were most afraid of the devil: for those already in Hell the devil was only another and no one in particular" (*Rose Garden* 72). The phrase a "Descent into Hell" as noted earlier is a reference to Doris Lessing's novel published in 1971, *Briefing for a Descent into Hell*. In this text Lessing documents the struggles of a professor from Cambridge University to explain to doctors what happened to him before arriving in hospital. He is admitted into the psychiatric wing of the hospital and treated as a psychiatric patient. Odysseus's "descent into hell" during his voyage home and Dante's *Divine Comedy, Inferno* in which he is escorted through Hell by the poet Virgil, and Ezra Pound's epic poem Cantos are also invoked here. Pound actually experiences hell while incarcerated in St. Elizabeths Mental Hospital for the Criminally Insane.

The women shuffled laterally between buildings and wards and horizontally between floors, according to their behaviour and manageability. Patients who were disruptive and violent were moved upstairs to the wards with locked doors and barred windows, straitjackets, and padded cells. Those who played by the rules, listened to the staff, and behaved amicably were given more freedom on the wards on the lower floors. The less disruptive, the more privileges and the more individual rights and freedoms were offered. This included their access to vocational and recreational therapy, and social activities. This multilayered labyrinth forced the women to navigate a physical and psychological journey with many obstacles.

O'Brien describes her 6-month ordeal as a time when she "hadn't been in control [of herself] but … had been controlled" (35) by "Operators," voices in her head that told her what to do and where to go. They ensured she was protected from the "Flies" that would attempt to take over other Operator's Things, and take them under their control.

Simpson sums up her loss of self when she becomes an object to be scrutinized and "looked over for bruises and scars" while enduring the "mortification of standing within nothing on" (*The Lost Days of My Life* 53). She feels the injustice of having the same emotions as others, however more intensely and less predictably, yet she is punished and captive while others are free: "I feel, I suffer like others [but] why should I be locked up" (64). Many of the women saw this journey as a game that they couldn't win unless they took on the role of cooperative patient and willing participant in their own care.

Although many of the women described their journey through mental illness as a perpetual shuffle from one institution to the next or from one ward to the next. Their adventures also consisted of multi-layered interactions between staff and inmates alike. These daily interactions moved their stories beyond the initial shock endured upon entrance into the institution, and subsequent treatment regimens. Simpson being only a child describes this scene almost clinically, "the sisters quickly seized me by the arms on either side and led me off. The great front door, which had stood open up till now, swung to with a clang, and never before had I suffered such a terrible feeling of desolation" (*Lost Days of My Life* 35). However, their narratives come to life because of these interactions, as the reader is transfixed by the commonalities of their lives within the confines of the mental institution. For instance, several authors describe their initial observations of life on the ward, their room, and the other patients that filter in and out of their solidifying daily routine. "There were about forty people in the room", according to Simpson's account, "all either standing or sitting on benches which ran round the walls and which were the only furniture" (35). As for the patients, "some of the people were mumbling senselessly, some stood with dribble running down their chins, and others just either stood or sat staring endlessly at nothing … I was too petrified to move…" (35). Not until Simpson had time to reflect would she realize that these "people… were in fact women" (35), and once again she knew that she "had been betrayed" (35). Jane Simpson was then escorted up stairs to her room by Sister Andrew who pushed Simpson "into a small room with a heavily barred window high up in the wall in the door

a little peep-hole… I found the room so dark after coming in from the open air that it took me a moment or two to get accustomed to it, and when I did, I saw an old woman with a closely shaved head standing looking at me with staring eyes" (37). It is at this point, the old woman told Jane that she had been there for twenty years, and that she would never get out. Terrified, Jane "swung round and groped wildly for the door handle, only then did I realise that there wasn't one; I was locked in with this crazy old woman" (37). This was Jane Simpson's welcome to life within the institution, and her realization that she was considered "mad".

And like Simpson, a majority of the autobiographical narratives reviewed here tell similar stories of the author's initial foray into the world of the insane. Yet, this was just the beginning of their fear and pain. Janet Frame succinctly described life in the institution stating that "There is no past present or future. Using tenses to divide time is like making chalk marks on water" (*Faces in the Water* 37). However, to pass time in a world devoid of time the patients find their own means. In Frames case, she would "play the time game" (31) which she defined as assisting others on the ward with getting the bread for Mrs. Pilling, or helping Mrs. Everett empty a milk jug both of whom were patients within the ward (32). These were "the prospect of two journeys at the same time beyond the locked doors was so full of delight that I dallied to savor the pleasure," (32) activities that Frame used a way to break up the monotony.

Such activities, although trivial seemed to provide the authors with an opportunity for a semblance of normality, even though these activities happened to be short lived and often closely monitored. Joanne Greenberg, in *I Never Promised You a Rose Garden,* was fortunate enough to be provided with an opportunity to attend school and even managed to complete her high school equivalency (251). Yet even Joanne recalled all the individuals, important or minor players in her life at Chestnut Lodge that assisted her along her journey towards recovery. Even at the end of account, Joanne is terrified by her own opportunity of succeeding at leaving Chestnut Lodge and its wards, returns. She is provided with a place to sleep and a warm meal before she once again must venture into the outside world. It is during breakfast Joanne realizes her success, for as she is eating breakfast, "She looked again at the faces on the ward. Her presence was making them struggle with Maybes. [When] suddenly she realized she was a Doris Rivera (a former patient that made the transition outside the hospital), a living symbol of hope" (254). Joanne like the other authors who walked out of the mental hospital had

somehow managed to find the path towards recovery, a journey that had begun with confinement and would begin again with the return.

4.1.5 The Return

The most prominent element common to all texts is the author hero's desire to return to the normal person she was before the schizophrenic break. According to Propp, the return or "returning … implies a surmounting of space … whereas a return takes place immediately and, for the most part, in the same forms as an arrival" (*Morphology of the Folktale* 56). Therefore, Propp's use of the term "returning" encapsulates the processes involved and the entirety of the journey undertaken by the hero. While the "return" involves a more immediate sense of becoming one with their intended outcome, which typically means being cured or normal. However, the author being schizophrenic wants to be worthy of functioning in civilized society, and of going home to family. The final obstacle is overcoming the stigma attached to being mentally ill (especially as a schizophrenic). The decisive act of recording their experiences in writing is a means of reconstructing a normal self, rehearsing it, rereading it like a myth that is both true and invented. Each woman re/produced a narrative identity to counter their own case files, and began to grapple with what it would mean to direct their own health and well-being.

Of the autobiographies under examination, Jefferson's *These are My Sisters* provides the best example of the search for the elusive normal self: "She is not real – she is not I – I never saw her before I dreamed her. I am dreaming now… there is only a shadow remaining of the person I used to be" (19). Jefferson goes on to write, "If the person whom I used to be could not prevent the birth of the person I have become, there is not much chance that the latter more powerful creature will be controlled by the ghost of the person whom she succeeded" (19). Jefferson first writes as a means of controlling her fits, then later as a means of understanding herself and connecting memories from childhood with the present:

> Once the great Madness in me found a voice, there was no stopping it. It rolled out in such a tumult I was amazed at it myself… It seemed obscene and terrible that I should answer in adult language, things said to me in my childhood. Things I had forgotten, until they again began to pour about me in a flood of bitter memories. Even incidents I remembered clearly came back so warped and twisted they seemed like evil changelings. (214)

Despite all the abuse and the attempted destruction of her will, Simpson managed to make it through the psychiatric system explaining to the reader that "you cannot travel to Hell and back without being burned and the scars heal slowly" (154). Simpson said she rose from hell in part by writing herself sane and finding a way out: "Was it possible that if I wrote my own story I might feel better?" (156).

Frame would also take to writing her own story as a means of solidifying her sense of self and personhood. Frame, using the pseudonym Istina Mavet, relates moments of uncertainty as she emerges from ECT-induced unconsciousness: "I rise disembodied" writes Frame, "from the dark to grasp and attach myself like a homeless parasite to the shape of my identity and its position in space… I cannot find myself" (*Faces in the Water* 26). She reiterates this later after successive rounds of the therapy: "I did not know my own identity. I was burgled of body and hung in the sky like a woman of straw" (65).

Greenburg describes Deborah, her alter ego, as "dry and barren … the smell of her burnt-up self was always in her nostrils" (118). Caught between three competing worlds (reality, the institution, and "Yr") she wore many masks. As Deborah she contemplated suicide and wrote "of the misery which was apparently leaking through the mask [and] out of the eyeholes" (102). Her guilt-laden memories of childhood and the self-doubt inflicted by antagonists living within her delusional world of Yr made her "self" one of the most complicated to singularize and reconstruct.

O'Brien says that after sitting "placidly enough in my box seat during insanity relaxed, and in a way enjoying the play…[that] seemed to have a purpose and after a fashion [she] had finally gotten the point" (28). She was as a bystander caught in conversations inside her head, she listened to advice to find a way out of the world of insanity:

> When schizophrenia had struck, my unconscious had taken over. It guided me while my mind had been shattered… it had sensed an approaching recovery and had steered me quickly to a doctor's office where, when my voices left me, I would discover that insanity, not Operators, had overwhelmed me, and the repair work was finished… my unconscious was a friend, a real friend. (127)

She describes how the voices helped her rebuild the "latticework" of her mind, those "habit patterns which had been scalloped out and they had to grow back again"

(32). She would seek answers to her questions from textbooks, and from various doctors. She asks, “How many parts of yourself do you bury in the process of maturing, adjusting to society. Half bury? Quarter bury? Departmentalize?” (181). She explains that, “The great latticework of electronic wire that connect the conscious and the unconscious are closed down hurriedly and the unconscious surveys the wreckage” (181). She speaks to the chemical and electrical components within the mind and both separates and reunites the biological and the psychological elements that explain her illness and provide opportunities for support and treatment.

In the end, she determines that “Where no man knows the answer, anyone has the privilege of making a guess. [Her] guess is that the individual who is to become schizophrenic is as I have described him—an individual without adequate courage who learns to separate himself so that he is acceptable to himself and his environment” (191). She also states that “losing wholeness to gain acceptance for a part is… the tragedy of the schizophrenic” and “regardless of his method of making adjustment, he is guilty of self-murder and must, as a consequence, live with a lively corpse … He has learned only to divide, separate” (190).

Wallace, too, is split, living the life of a young professional woman both as a nurse in London’s mental institutions and as a writer, and as a schizophrenic mental patient. In her first autobiography, *Portrait of a Schizophrenic Nurse*, Wallace made an effort to write her story “both as a patient and a nurse” (17) to produce “an honest account: no melodrama, and no little fictional sketches” (18). Her story developed a dialogue between her two selves: “I am not a typical schizophrenic; probably if I were, I should not be able to write this book” (12). She then proceeds to explain to the reader that “as I write … I am aware that my illness is running more true to form. I have deteriorated in several ways. I don’t notice this myself, but the nurse in me does” (13). She reported to her psychotherapist that she was “hearing my thoughts repeated … I told her [psychotherapist] about this critical self who gave me no peace and whom I’ve regarded as being an outside agency rather than part of me … being an observer of myself: I’ve seen everything I did, as though I was someone else” (34). By 1964, Wallace reports nine psychiatrists had labelled her schizophrenic, and “the schizophrenic was often the scapegoat of the sick family … [which] could have been true” (137). Her view of mental illness is that “the reason only some people have a mental illness is because the so-called ‘norms’ have not met the specific type of stress

which would trigger a breakdown in them … that the 'normals' have not met their own stressful breaking point" (167). What seems to keep Wallace going, like others, is her writing.

4.2 Autobiographical Truth: Stranger Than Folktale?

In paying close attention to their stories and the way they are being told, recognizing patterns and repeated occurrences of language, symbolic associations, etc., the author comes more clearly into view, and their authentic self is revealed. RD Laing said, "To be authentic is to be true to oneself, to be genuine" (*Self and Others* 127). In this way true is a flexible term; there may be multiple truths. This in no way diminishes their experiences, nor dismisses their claims, however elusive truth has been to them and to the professionals treating them. For the women writing, their truth was what was on the page and their stories began at the beginning.

The authors critiqued here describe the onset of their illnesses, the effects of their illness, and their recovery from schizophrenia. The authors' attempts to solidify memories into the written word reveals tensions between the inner/outer voice, the concealed/ revealed self, and the truth/fiction of the text. Their stories are being altered by the passage of time so the autobiographer faces what Paul Ricoeur refers to as the "*problem of refiguration*," which "lies in the way history and fiction, taken together, offer the reply of a poetics of narrative to the aporias [contradiction] of time" (*Time and Narrative* 99). Interweaving the past and the present, remembering and recreating memories, producing a truth from often fictional events can pose significant challenges for writers diagnosed with schizophrenia or not.

Gusdorf's essay "Conditions and Limits of Autobiography," published in 1956 and announcing this new genre just as our period of analysis begins, states:

> In the final analysis, then, the prerogative of autobiography consists in this: that it shows us not the objective stages of a career—to discern these is the task of the historian—but that it reveals instead the effort of a creator to give the meaning of his own mythic tale. Every man is the first witness of himself; yet the testimony that he thus produces constitutes no ultimate, conclusive authority—not only because objective scrutiny will always discover inaccuracies but much more because there is never an end to this dialogue of the life with itself in search of its own absolute. (*Autobiography: Essays* 48)

If the stories contained within an autobiography are not to be fully trusted then they must be seen instead as "a second reading of experience, and it is truer than the first because it adds to experience itself consciousness of it" (*Autobiography: Essays* 38). Stephen Spender concurs when he says:

> That the problem of an autobiographer, when he considers the material of his own past, is that he is confronted not by one life—which he sees from the outside—but by two. One of these lives is himself as others see him—his social or historic personality—the sum of his achievements, his appearances, his personal relationships. All these are real to him as, say, his own image in the mirror. But there is also himself known only to himself, himself seen from the inside of his own existence. (*Autobiography: Essays* 116)

All autobiographies are a reworking of these two selves, and for a schizophrenic, possibly more. Richard Sorabji, in his text *Self: Ancient and Modern Insights* (2006) "approaches the question of self indirectly by arguing that there is a need to see the world in terms of me and me again … and that we tend to develop an autobiographical picture or pictures of ourselves … thus build[ing] up a particular persona or identity, and this is often considered part of the self" (22). To bring them together, the autobiographer, intentionally or unintentionally, rewrites her own history while preserving the appearance of continuity. The opportunity to adjust her story, restructure the narrative, represent it in the best possible light is tempting and weaving, braiding, or stitching memories, if not always their own, is therefore always going to be, at least in part, an act of creation.

Throughout this act of creation and its product— the autobiography, Paula Heimann's (1950) intriguing question "Who is speaking?" is relevant when examining the texts. Heimann says, "it had always been assumed that the speaker was the patient who had formed a therapeutic alliance with the analyst… but at any one moment in a session a patient could be speaking with the voice of the mother, or the mood of the father, or some fragmented voice of a child self either levied or withheld from life (qtd in *Shadow of the Object* 1). The author needs freedom from the selves that populate the tale(s) under construction.

Usually, the written work of schizophrenics is disorganized, and as psychiatrist and researcher Albert Rothenberg (1930) so matter-of-factly states, "Schizophrenic communication is often highly distorted" (*Creativity and Madness* 63). Yet, as

Rothenberg states, “good psychotherapy should both alleviate any illness and enhance …. creativity. The healing effect of psychotherapy consists of facilitating emotional growth, prompting independence, and developing psychological freedom” (180). Rothenberg refers to this as the “Janusian process” in which “multiple opposites or antitheses are conceived simultaneously, either as existing side by side or as equally operative, valid, or true …. The creative person [then] consciously formulates the simultaneous operation of antithetical elements or factors and develops these formulations into integrated entities and creations” (15). It is possible, for these seven creative young women, that the psychotherapeutic method was interpolated into the autobiographical process, thereby organizing the narrative on the page and in their minds to create a more cohesive self.

Renowned psychoanalyst and writer Erich Fromm’s (1900 – 1980) theories would seem to confirm this desire to build something new: “Mental health is characterized by the ability to love and to create…” (*Sane Society* 69). As Fromm suggested, “the real problem of mental life is not why some people become insane, but rather why most avoid insanity” (*Sane Society* 29). Part of that creative impulse, says Fromm, is a theatrical desire to “play many roles and subjectively be convinced that he is “he” in each role. Actually, he is in all of these roles what he believes he is expected to be… [However] the original self is completely suffocated by the pseudo-self” (*Escape from Freedom* 202). When faced with the potential loss of original self, the individual “is obsessed by doubt since, being essentially a reflex of other people's expectation of him, he has in a measure lost his identity. In order to overcome the panic resulting from such loss of identity, he is compelled to conform, to seek his identity by continuous approval and recognition by others” (203). Perhaps the autobiography allows for an exorcism of sort of these pseudo roles and a return to the original self, more easily recognized on paper. These roles, too, may be distinct and time-bound, fleeting and a function more of a particular environment or space than a lasting identity.

Finally, just as time frames expectations of the self, so does space. Reinhart Koselleck (1923-2006) developed the terms the “space of experience” and the “horizon of expectations.” Koselleck says these “two conceptual couples, experience and expectation…are indicative of a general human condition… without which history is neither possible nor conceivable” (*Futures Past* 257). As Koselleck suggests, “experiences overlap and mutually impregnate one another; [this] penetration of the

horizon of expectation, therefore, is creative of new experience" (*Futures Past* 262). As such self, identity, and time are bound up together and comingle in the creative space of the story.

4.3 Construction of the Self in Time: Narrative and the Near Now

Mark Freeman in his *Rewriting of the Self: History, Memory, Narrative* reminds us that:

> Even if we do not live narratives of the same nature and scope as those we tell when we pause to reflect comprehensively on the past, the very act of existing meaningfully in time, I will argue, the very act of making sense of ourselves and others, is only possible in and through the fabric of narrative itself. (21)

He goes on to add, "That the histories we tell are inextricably intertwined with both our own understanding and our own narrative choices" (173). Our memories are threads overlaid, one on top of the other, and are continuously twisted to fuse together a notion of self. These allow us to construct the story we tell to define ourselves to others and to ourselves. These memories are then the echoes of experience and emotions and reverberate within the confines of our own mind. Autobiography tells the stories of several selves that comprise the individual, in context and often at a particular time and place. These stories are built from memories generated over a lifetime, as well as the memories, stories, fables, myths, and experiences told by others. They are influenced by photograph albums, movies, family stories, and current events. These are the artifacts that mark the passage of time, a concept not as clear for the schizophrenic as for others.

If the schizophrenic mistrusts her own memories, stories, and beliefs can a self still be created? Corcoran and Firth in their 2003 research paper, "Autobiographical memory and theory of mind: evidence of a relationship in schizophrenia," determined that "poor autobiographical memory [was] a feature of people with schizophrenia" (902). They also found that "people with schizophrenia have a tendency to retrieve more markedly odd events when asked to recollect events from their past lives than do normal participants" (902). McLeod, Wood, and Brewin in their 2006 study, "Autobiographical memory deficits in schizophrenia," concluded that "schizophrenia is associated with impaired memory for autobiographical facts and events" (543) and such "anomalies in

perceptual processes lead to the destabilization of the working self" (544). Can one conclude then that when friends, family, and psychiatrists relate events that do not coincide with the schizophrenic's memory of these events, her sense of self is necessarily destabilized?

When this sense of self is missing, we tend to say, "I am not myself" or "I am beside myself." Philosopher John Searle describes the self as being formulated from a continuity of memory and personality ("Is Your Self Just an Illusion" – Interview with Robert Lawrence Kuhn), while philosopher Daniel Dennett in the same interview suggests the self is the "center of narrative gravity." In this view, autobiography can be seen as a means to cohere many selves into a possible whole. The act of telling stories and writing them down leads to what Kenneth Gergen describes as a world in which, "we become the stories that we tell, which are based on the fleeting images of memories … the historical narratives our verbal fictions, the contents of which are as much invented as found" (*Saturated Self* 109). He adds that "the self is therefore created and recreated depending on the frame of reference that one finds oneself in and this frame can itself be reframed over and over again" (*Saturated Self* 109). This frame often involves a particular timeframe that delineates past and present, and future, a place where Gergen's notion of "self" can formulate plans, make choices, and exert will.

Foucault, during his 1983 lecture at UC Berkley, proposed that "the self has to be considered as the correlate of technologies built and developed through our history" ("The Culture of the Self" (Part 5 of 5)). Here he means not only the socio-political environment, but also the social-scientific practices of a particular timeframe that serve to reproduce and maintain a certain level of social control. The schizophrenic draws upon her past to make sense of her present, but must also perceive a future when these memories and recollections can be trusted and shared with a psychiatrist. This provides her with frame of reference from which to act or withdraw. British psychoanalyst and writer Christopher Bollas (1943 – present) relates reference and presence to describe the role time plays in sedimenting the self when he states, "by self we mean a set of intersubjective relations that recur in a person's life and provide him with a sense of presence over time" (*Shadow of the Object* fn 285).

German philosopher Martin Heidegger (1889 -1976) suggests in *Being and Time*, our concept of time revolves around a "series of nows" that in turn provide us with the

ability to contemplate and recognize our self in time. Institutionalized patients in care experience time at a standstill, an endless “series of nows,” a reality in which the self is either constructed or fragmented. The routine of daily treatments and care include waking, bathing, and eating, group therapy, work therapy, and art therapy. These experiences affirm existence is a continuous series of events constantly being re/written, and re/constructed. As Gergen writes, “the fact people believe they possess identities fundamentally depends on their capacity to relate fragmentary occurrences across temporal boundaries” (*Studies in Social Identity* 255).

This capacity to formulate and unite such occurrences over time is blunted for the schizophrenic, especially those institutionalized for any length of time. Asylum life is built on carefully scheduled routines that create familiarity. The patient is awokened [awakened] at the same time every day. They are dressed, washed, and fed according to a set schedule, and then they are led from one activity to another before they are fed, washed, and undressed so that they can go back to bed. Jefferson describes her experience of life in the institution as living “in a state of existence that is neither death nor living… we are the living dead; who have ascended, or descended (according to one’s point of view) into a strange limbo of irresponsibility” (*These are my Sisters* 108-109). However, the most damning statement about lost time within the institution comes from Jane Simpson, who was shuttled from hospital to hospital from age thirteen onward. When asked how long she had been institutionalized she said “Ten years, I think” (*The Lost Days of My Life* 126). She had no idea the extent of her stay until the superintendent working with her told her she had been institutionalized for over thirteen years in six different institutions. She spent nearly a year in the “pads” (padded cells).

As we have seen in this chapter, the schizophrenic’s re/construction of self counterpoints experience, expression, and emotional response and draws upon memories, reveries, and recollections that are held in a disunified tension in her mind. These images of the past become muddled with reactions to them, and confusingly also often mirror aspects of her contemporary life in the institution. Though these internal notions of the past are out of sync temporally, they loop in such a way as to smoothly process the external world and maintain herself within it. These sequences tether her to the now and perpetuate the experience of being present, while also projecting future actions that allude to the possibility of becoming. Trapped within the world of mental illness, they resort to the act of writing to reframe their experiences and take control of

their thought process. Their autobiographical narratives thus provide a momentary toehold in the foundation of a re/constructed self. Though they are constrained and contained they are nonetheless writing their way out of it.

The notion that we contain a “real self” or a “true self” is a remnant from our childhood based on moral ideals passed on to us in stories told to us in our formative years. Fairy tales, fables, and myths teach us how to sequence our own story so that the “self” is both the audience and subject of this ongoing narrative. Understanding the mythological nature of the narrative according to Propp reminds us that both psychiatry and autobiography rely heavily on the chronological nature of story based on historical experiences. In order to construct story, both the psychiatrist and the patient move from beginning, to middle, to end. The authors starting with the initial break with reality and the reasons for it, move to the experience that preceded being committed, and then talk and write their way to a cure. The mythological elements of their tale include the descent into hell (the making of the mad), life in hell (institutionalization), and the return (the desire to live normally at home). We conceive of life as comprising a “sequence of nows” that takes us from childhood through adulthood to old age, or from the vantage of these women in their 20s, more simply past, present, and future. Our memories, reveries, and dreams construct the self just as the sociological conditions of our present do, a present framed in various ways by the forces at work in the very real environment of our everyday.

Chapter 5. Frames, Discourse and the Self

> *"It is probably no mere historical accident that the word person, in its first meaning, is a mask. It is rather a recognition of the fact that everyone is always and everywhere, more or less consciously, playing a role…"* – Robert Ezra Park 249

5.1 Goffman & Foucault: Frames, Discourse, and Counterpoints of Mind

Erving Goffman, the Canadian sociologist considered by some to be the most influential of the twentieth century, is the author of the landmark texts *The Presentation of Self in Everyday Life* (1959), *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961), and *Stigma: Notes on the Management of Spoiled Identity* (1963), all written during the decade under examination here. These works are widely cited in the social sciences and humanities in the company of Foucault, Bourdieu, Giddens and Habermas. Goffman was the 73rd president of the American Sociological Association and primarily studied the sociology of everyday life, social interaction, the social construction of self, the framing of experience, total institutions, and stigmas, all subjects that are relevant to this study.

These texts, along with his magnum opus, *Frame Analysis: An Essay on the Organization of Experience* (1974), provide methodological and theoretical tools useful in examining the autobiographical texts under scrutiny and build on Propp's discussion of the structure of narrative as it relates to our life stories. Goffman's dramaturgical approach, his understanding of frames, and his notion of the "total institution" authoritatively speak to the social construction of mental illness.

A lecture Goffman gave at the Group Processes Conference (1956) for the Josiah Macy Jr. Foundation outlined his method and provided preliminary findings from his fieldwork at St. Elizabeth's Mental Hospital for the Criminally Insane, where he spent a year [1955-1956] as a participant observer, acting as the Assistant to the Athletic Director. Here, Goffman begins to play with the language that will become the foundation for all his later work. He says there is "a kind of babel of tongues; there are two tongues really… the language of psychiatry which says, "You are sick," [and] there is the language of privilege and of punishment" (*Group Processes* 167). Goffman also begins

to address the idea of the "psychiatric self" (*Group Processes* 177) and how this concept of self develops within the framework of the institution under the guise of a medical model of care. Much of Goffman's early work viewed "mental illness" as a socially constructed concept. Later, in his essay "The Insanity of Place" (1969), Goffman considers the possibility that mental illness is biologically determined, a change attributed to the death of his first wife, diagnosed as bi-polar. This shift in language is also found in the schizophrenic autobiographies under review.

A close reading of *The Presentation of Self*, *Asylums*, *Stigma*, and *Frame Analysis*, reveals how the shifting language of psychiatry framed the socio-cultural events of this period. Goffman suggests our experience and recollections are a performance with some moments punctuating the story more emphatically than others, either because they are traumatic, or induce guilt and shame – a theory borne out in the accounts already reviewed here. These may also translate to audible and visual hallucinations in the case of the schizophrenic.

Goffman's "interaction order" and the need to sequence performances in daily interactions with others is likewise evident in the autobiographical accounts that follow a tripartite construction relating to the period before schizophrenia presented and was diagnosed (the break), the time in the institution when the patient was a schizophrenic by psychologists' definition, and the period after release when she was "cured" and lived a normal existence. This tripartite construction is also evident in therapy in which the patient undergoes coercive treatment, analysis, and then seizes control over her own life. Goffman's focus on face-to-face interactions and the inner monologue thereafter, in which the individual reviews how well she performed, is a means of playing out "fantasies… in which devastating exposures occur. Anecdotes from the past – real, embroidered, or fictitious – are told and retold, detailing disruptions which occurred, almost occurred, or occurred and were admirably resolved" (*Presentation of Self* 14). The public self is "front stage" in Goffman's terms and the private self is "back stage" (the unconscious) where grief, embarrassment, and shame manifest as regret and trauma.

Goffman's *Presentation of Self*, published shortly after leaving St. Elizabeth's, explains that the self is an impression managed and controlled while in the presence of others. According to Goffman, "This impression of reality is fostered by each

[individual's] performance" (*Presentation of Self* 56). In other words, "life is a dramatically enacted thing" (*Presentation of Self* 72), and the performance of self is "an intricate manoeuvre of self-delusion" (*Presentation of Self* 81). The self "can be seen in terms of how we arrange for such performances… [for] the self, then is a performed character" (*Presentation of Self* 252-253). This performance varies depending on if and how the individual is constrained by social expectations, or conversely if provided the opportunity to act more openly (such as within the analyst's office).

In *Asylums*, Goffman analyzes the idea of the "total institution." Goffman says, "A basic social arrangement in modern society is that the individual tends to sleep, play, and work in different places, with different co-participants, under different authorities, and without an over-all plan. The central feature of the total institution can be described as a breakdown of the barriers ordinarily separating these three spheres of life" (*Asylums* 6). As we have seen in the autobiographical narratives, the female authors are frequently viewed as children or as Goffman observed, "the inmates at times are not defined as fully adult" (*Asylums* 115). Through treatment, the "person is gradually transformed into a patient… and the concept of self becomes questioned" (*Asylums* 42, 48).

5.1.1 Frame Analysis

The world of the mental institution and of psychiatric care provides a frame through which the author's experiences must be seen, as it informs the authors' language and expression. In a "Reply to Denzin and Keller" (1981), [Norman Denzin and Charles Keller were Sociology and Anthropology professors from the University of Illinois, Urbana] Goffman says, "I will be using the term 'frame' in roughly the sense in which [Gregory Bateson] meant it. If I didn't so state, I would be open to accusations of rip-off" (64). Bateson's definition of the psychological frame is "an indication that mental processes resemble logic in *needing* an outer frame to delimit the ground against which the figures are to be perceived" (Bateson, 1968, 188-189, italics in original). Goffman expands upon this when he writes in *Frame Analysis* (1974), "Everyday life, real enough in itself, often seems to be a laminated adumbration of a pattern or model that is itself a typification" (562), a point he reaffirms in his rebuttal to Denzin and Keller who said "Goffman's actors are monads, with single frames looking out at the world. There is no interaction in *Frame Analysis*. Selves are relegated to the sidelines. They are not

necessary…" (59). However, I put forward the contrary interpretation, pointing out that Goffman's sense of frame is not flattened but rather a multilayered endeavour in which the individual must enter with some previous knowledge or background understanding.

Goffman examined a wide array of situations in which individuals might have found themselves in the course of their daily routine. Goffman looked at "principles of organization which govern events—at least social ones—and our subjective involvement" (*Frame Analysis* 10). These frameworks "are not merely a matter of mind, but correspond in some sense to the way in which an aspect of the activity itself is organized—especially activity directly involving social agents" (247). For those observing social actions, frames, framing, and frameworks are simply a means of taking into consideration the social context(s) of each setting or stage.

In the case of these autobiographical narratives, the frame is a lens through which the writer and reader can understand the content and the particular psychiatric paradigm operating at the time of writing. As we have seen, the authors' works reference psychiatric language heard during treatment. These paradigms of psychiatric care then represent frames through which the authors understood their experience of the mental institution. Their movements, thoughts, beliefs, and actions were seen to meet or disappoint the expectations of those in charge of the mental hospital and as such they had to re/construct a sense of self within this frame to survive.

These selves were performed in the backstage areas of the institutions where visitors and other public guests were not to tread - hydrotherapy rooms, and shock shops where control and constraint was heavy. By contrast, the front stage areas were waiting rooms, visitor areas, and the grounds, all of which were much less controlled. The patients also had to navigate various forms of therapy, psycho-surgical remedies, and psycho-pharmaceuticals that required managing these performances of the good patient, daughter, and wife (Simpson 1958; Frame 1961; Jefferson; 1975; Wallace; 1965). Though they wanted to be writers, to have careers, and to direct their own lives, these choices were not "normal" for the typical woman when seen through the frame of societal expectations of women.

Goffman understood that, even if chaffing against the literal and figurative constraints of the institution and society, the individual was an active agent with her own

set of expectations and experiences, which in turn either interrupted or augmented her performances. Frame analysis, as Goffman explained, “Allows the user to locate, perceive, identify, and label a seemingly infinite number of occurrences” (*Frame Analysis* 21). As social agents, “we can hardly glance at anything without applying a primary framework, thereby forming conjectures as to what occurred before and expectations of what is likely to happen” (38).

Hospital staff, doctors, and other institutional personnel saw the schizophrenic patient through either the frame of medicalized or therapeutic care or through the frame of criminal incarceration. The patients’ performances are thus guided by learned actions and behaviour and determine how to respond to certain nurses or how not to behave in front of certain attendants or fellow patients. Patient behaviours, actions, and non-actions (such as sleeping too long or looking out the windows too often) are recorded in daily activity logs and patient notebooks. This establishes the authority and legitimacy of these personnel in the institutional setting or “bounded space.” Living with the institution’s agents of control under these conditions, patients soon came to appreciate the power of the recorded word. These acts of “passive surveillance” and “soft coercion” establish appropriate or normal behaviour. The mental hospital as a total institution thereby uses these means of control to operate under the guise of therapeutic care.

Goffman’s concepts surrounding “frames” and the language he uses, may be particularly useful in examining the schizophrenic’s account of past events, memories, and recollections when applied to the dynamic nature of memories. Psychologist Frederic Bartlett (1886 – 1969) suggests that memory “is a dynamic process… remembering is not the re-excitation of innumerable fixed, lifeless, and fragmentary traces. It is an imaginative reconstruction, built out of the relation of our attitude towards a whole active mass of organized past reactions or experiences … It is thus hardly ever really exact. (qtd. In Sacks, p. 154). Oliver Sacks qualifies this by saying, “And yet, some memories do, seemingly, remain vivid, minutely detailed, and relatively fixed throughout life. This is especially so with traumatic memories or memories carrying an intense emotional charge and significance” (*Hallucinations* 155).

Neuroscientist Antonio Damasio (1944 -) explains how we can pull material from memory and use it to construct a past experience: “What we do have is a remarkable consistency in our construction of reality that our brains make and share” (*Descartes’*

Error 235). He says, “The neural basis for the self, as I see it, resides with the continuous reactivation of at least two sets of representations. One set concerns representations of key events in an individual’s autobiography, on the basis of which a notion of identity can be reconstructed repeatedly … The second set concerns representations underlying the neural self of an individual’s body (239). The “self” then becomes just another part of this “dynamic process” of re/collection, a process not fully understood.

This is even less clear if the self (that we remember) differs dramatically from the self we knew yesterday and or that we will know tomorrow, as is sometimes the case for schizophrenics. This uncertainty is a troubling aspect of this disease that ravages thought processes and emotional connections to the world around them. In order to make sense of this shifting world, the schizophrenic sometimes constructs elaborate background stories, such as Joanne Greenberg’s alternate universe, the Kingdom of Yr., or Lara Jefferson’s belief she was the reincarnation of Shakespeare. Even with such elaborate schemes, they still managed to adjust their own reactions to, and interactions with, others according to hospital and societal expectations. In other words, they learned to play the game.

5.1.2 Setting and Scene

For the most part, the seven authors resided within a similar setting: a mental hospital that guaranteed they were housed, fed, and controlled. Goffman says these “total institutions” “capture something of the time and interest of its members and provides something of a world for them, in brief, every institution has encompassing tendencies … symbolized by the barrier to social intercourse with the outside and to departure that is often built right in to the physical plant, such as locked doors, high walls” … (*Asylums* 4).

Within this setting are separate scenes that comprise it. Each scene has its own set of rules, expectations, and constraints determined by time, space, and volume. For the authors, scenes might be set in the day room, the dormitory, the shock-room, or the back ward. The shock-room where ECT was administered was usually overseen by one doctor and a nurse or an attendant and admitted one patient at a time. However, some of the institutions permitted a patient to assist with the removal of those who had already

undergone shock therapy so that the assembly line could be maintained with utmost efficiency. The description of the shock-room is almost identical among the seven authors, as is their emotional turmoil in relating the experience. Shock treatment was described as barbaric particularly when sedatives were not used before the procedure. It was frequently prescribed as a means of punishment for bad or inappropriate behaviour. As one anonymous patient said, “The truth is that electric shock is physical torture of the extreme type” (“Terror on Tuesdays and Thursdays” 6). This same patient continues to describe the scene as the practice of electric shock unfolds before her:

> The loading in the corridor near the open door was supervised by attendants. (Patients assisted the Dr. in giving treatment, i.e., hold down the convulsing body. This takes about six people.) Loading, they stood you on a stool, so that when the gurney girls arrive with an empty gurney, you can mount it quickly. The thing is timed down to split seconds. This is another factor which seems to reduce you to utter insignificance. You are just a part on an assembly line, and not an important part. (7)

Another unnamed patient declares, “Accept torture called treatment? Become a number? God help me, no” (28). This poem by a young woman institutionalized for three years writes after undergoing more than 40 insulin coma and shock treatments:

> *The Killing of Susan Kelly*
>
> The black-suited man slithered,
>
> Black box in hand, to our bedside. four girls, innocent. naked,
>
> Waiting…. waiting…. waiting,
>
> Sticky-headed,
>
> One by one.
>
> Zapping currents through us,
>
> Young bones racked, brains bruised
>
> By his cold-fingered electrified touch.
>
> Crime completed,
>
> In collusion with white-skirted nurses,

The limb holders,

He slinked back into the early morning frost,

Hot morning coffee in hand,

Leaving us quieted, flat as pancakes.

And Susan,

The soft white sheet covering her,

Did not move at all.

His shocks had stolen her, skin and bone,

That beautiful flaxen-haired child,

At seventeen.

Silencing her questioning stream.

(Dorothy Washburn Dundas)

These commentaries from former mental patients describe the terror, humiliation, and lack of respect and compassion as bodies and minds were shocked into submission.

Other scenes in the day rooms and the back wards played out repeatedly in the seven autobiographies despite differences in the authors' countries of origin. The scenes are the same, the actors are similar, and the patients are all reduced to a number and a diagnosis. The introduction of anti-psychotic medication meant the patients could be medically subdued with less cost and less manpower, and this too was a familiar scene in each storyline. Each patient, doctor, nurse, and attendant views each scene they enter through their own frame and these scenes then overlap and interact. Everyone plays a role in the social scene and aligns their actions and behaviours with other agents. The actors, upon entering the action of the scene, bring with them expectations and experiences that operate in an environment that either enables or curtails interaction.

This perception of the social self as active agent is closely related to Charles H. Cooley's (1864 – 1929) concept of the "reflected or looking-glass self" (152). Goffman

borrows from Cooley in his text *The Presentation of Self in Everyday Life* (1959). Cooley described the looking-glass self as:

> A self-idea of this sort seems to have three principal elements the imagination of our appearance to the other person; the imagination of his judgment of that appearance, and some sort of self-feeling, such as pride or mortification. (*Human Nature and the Social Order* 152)

While Goffman focused on mortification or embarrassment, the drama and emotion of the social scenes that individuals enter and then participate in of course involve other reactions. As Thomas J. Scheff suggests in his short essay titled "Looking Glass Selves: The Cooley/Goffman Conjecture" (2003), both men failed to fully take into account the emotions of shame and guilt, although they may be indirectly connected to embarrassment. As an individual enters a scene, she has a preconceived frame of mind or reference/experience depending on her memory of similar circumstances or expectation of what should or could happen. The individual is thus constructed by these forces at the moment she steps into the social scene. The shifting dynamics of the scene play out for all parties as a function of the goals of each participant and the end game other social agents wish to achieve. Internal dialogue occurs simultaneous to external communication with other actors in the scene. If rapport and trust is generated during their interaction, the dialogue will advance a self that is performed authentically.

Other materials can augment the patient's ability to remember in these scenes, including photographs and stories retold over and over again and in endless circulation in the mind. Some of these storylines construct interior scenes that play out the "What if…?" scenarios as a means of getting at the source of a patient's illness. This endless repetition of past events is often a symptom of schizophrenia referred to as rumination or "thoughts that go around and round [in one's] head but get you nowhere" (Schizophrenia.com/earlysigns). These thoughts tend to focus on past disappointments, missed opportunities, or failed relationships. Halari et al. researched schizophrenic behaviour and concluded:

> Among the different types of coping strategies used by people with schizophrenia rumination, which is the tendency to passively and repeatedly focus on negative emotions and the possible consequence of those negative emotions, is a generally unhelpful method of coping with negative mood. It is characterized by self-reflection as well as repetitive and passive focus on one's negative thoughts. ("Rumination and negative symptoms in schizophrenia" 704)

Jefferson writes of a recurrent comment by her mother: “I heard the voice, filled with cruelty, sneering ‘You poor ungodly thing.’ Then I saw her eyes and I knew they were at that moment filled with unspeakable anguish at the thing which had overtaken her daughter … I had not fulfilled all the beautiful things she had planned for me” (*These are my Sisters* 213-214). Greenberg described to Dr. Fromm-Reichmann a scene in which she, at five, “reached into the bassinet for the little darling [her new born sister] whose ugliness was so apparent to her and so invisible to everyone else; about the window out of which she had held the little creature, the arrival of Mother, and the shame of hating and being caught at it…” (*Rose Garden* 204).

Rather than deal with their shame and discomfort, they created an elaborate backstory to alter and repress the truth of these memories and feelings. As Freud explained in *Introductory Lectures on Psychoanalysis* (1915) “We come across a principle which will later on reveal its enormous importance for the causation of neurotic symptoms: the memory’s disclination to remembering anything which is connected with feelings of unpleasure and the reproduction of which would renew the unpleasure” (*Freud’s Complete Works* 3080). Rather than capture images, sounds, smells, and emotions from the past accurately, the schizophrenic’s unconscious played these out in the form of hallucinations, delusions, and lack of distinction between present and past. These formed the framework for each scene, often creating even greater misunderstanding and confusion for the patient and those around her. Marshall Gregory, quoting Robert Schank, explains, “human memory is story-based and that story creation is a process … because the process of creating the story also creates the memory structure that will contain the gist of the story for the rest of our lives” (“The Sound of Story: Narrative, Memory, and Selfhood” 47).

5.2 Foucault’s Theory of Discourse

Although both Goffman and the French philosopher Michel Foucault were writing about mental institutions at the same time, their work did not intersect. Despite this, Ian Hacking, has proposed that their “two perspectives are complementary, and both are necessary” (278). In the article, Hacking argues these two eminent figures were critical to an historical understanding of the individual within the asylum/mental institution. According to Hacking, “Goffman’s work is essential for coming to understand how people are made up day by day, within an existing institutional and cultural structure” (299).

Foucault's work, meanwhile, "gave us ways in which to understand what is said, can be said, what is possible, what is meaningful – as well as how it lies apart from the unthinkable and indecipherable" (300). Foucault claimed "discourse is not the majestically unfolding manifestation of a thinking, knowing, speaking subject but, on the contrary, a totality in which the dispersion of the subject and his discontinuity with himself may be determined" (*Archaeology of Knowledge* 55).

For example, Foucault's theory of panopticism reflects a conceptualization of power and control that cannot necessarily be seen or felt by the inmate, and although he theorizes panopticons mainly in the context of prisons, it is also relevant to the mental institutions where the doctors, nurses, and various attendants were all guards of sorts. The monitoring resulted in a constant surveillance. As Foucault puts it:

> Hence the major effect of the Panopticon: to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power. So to arrange things that the surveillance is permanent in its effects, even if it is discontinuous in its action; that the perfection of power should tend to render its actual exercise unnecessary; that this architectural apparatus should be a machine for creating and sustaining a power relation independent of the person who exercises it; in short, that the inmates should be caught up in a power situation of which they are themselves the bearers. To achieve this, it is at once too much and too little that the prisoner should be constantly observed by an inspector: too little, for what matters is that he knows himself to be observed. (*Discipline & Punish* 195).

In this same text, Foucault describes what he calls a "corpus of knowledge" generated from the accumulation of notes, observations, personal histories, and other documents written not only by psychiatrists, but also by nurses, care aides, and even other patients. He suggests these documents produce the "emergence of the individual 'case' [whereby the patient] becomes described, judged, measured, compared with others ... [and in return] the individual needs to be trained, corrected, classified – normalized" (*Discipline and Punish* 191). Each of these documents, be they "professional" observations or otherwise, speaks to the discursive practices that prevailed during the patient's stay within the institution. They may even have extended to the period after they left the institution and fell under the scrutinizing gaze of their family and the community at large. These documents also constitute a form of surveillance, albeit more passive, as the individual conforms to what is considered normal behaviour.

This soft coercion ensured the patient behaved appropriately and in accordance with the expectations of both the institution and proper society.

In his *Archeology of Knowledge* (1972), he articulates the nature and effect of these discursive practices by demonstrating how language is a means of communicating power and knowledge closely linked to this wider notion of control. For this research, Foucault's earlier work, *History of Madness* (1961), and his *Birth of the Clinic* (1973) also lay the groundwork for and continue the interrogation undertaken in his "archaeological method." In this latter text, he uses the method to demonstrate how relatively innocent words can establish the signs and symptoms of a schizophrenia diagnosis. Taken together, these works show how "statements different in form, and dispersed in time, form a group if they refer to one and the same object… mental illness was constituted by all that was said in all the statements that named it, and traced its development" (*Archaeology of Knowledge* 32). Foucault states that "Whenever one can describe, between a number of statements, such a system of dispersion, whenever, between objects, types of statement, concepts or thematic choices, one can define a regularity… we will say, for the sake of convenience, that we are dealing with a *discursive formation*" (italics from original, 38).

Foucault goes on to describe how discursive practices "systematically form the objects of which they speak… [that] these rules define not the dumb existence of a reality, nor the canonical use of a vocabulary, but the ordering of objects" (49). In this sense, the autobiographical narratives can be perceived as discursive objects that speak not just to the thoughts of the author, but to the larger psychiatric practice of the period, and the socio-political assumptions that governed life in the institution. The psychoanalytic language conveys, or in some cases obfuscates, the patient's present, past, and future in these narratives, or in the terms of Freudian therapy, the "reality of being" – actions and behaviour – and the "echoes of past-being" – memories and reveries of previous actions and behaviour for which patients tried to account – and the "person in becoming" – actions and behaviour they want to undertake. Within this triangle the self, or selves, existed, and need to consolidate to a singular stable entity. The female patients under review thus needed to grasp the reality of their disease and circumstances, for during this decade schizophrenia was thought to be a disease of the mind that disordered thought processes, and therefore the patient would only be cured

when she could consistently reorder thoughts to construct a stable self that recognized reality as non-ill individuals would.

RD Laing and others in the anti-psychiatry movement saw schizophrenia as a journey that began in health, travelled through this sickness of a disorganized state, and emerged again into health in a state of renewal. Laing wrote, “Can we not see that this voyage is not what we need to be cured of, but that it is itself a natural way of healing our own appalling state of alienation called normality” (*The Politics of Experience* 167). This notion of a journey aligns with Propp’s morphological analyses that the patient is a traveler of the mind who must return like the mythological protagonist to his home, unburdened by the weight of obstacles encountered along the way. Laing contends the schizophrenic’s journey towards a healthy and stable self “is experienced as going further ‘in,’ as going back through one’s personal life, in and back and through and beyond into the experience of all mankind…” (*The Politics of Experience* 126). The “self” in his view consists of a vertical plane reliant on the layering of past’s “thick description,” as well as a horizontal plane requiring “thin description” because the passage of time in the present is linear. Both concepts related to this memory work are continuously corrupted by emotions and the collecting and categorizing of experiences as either positive or negative.

These experiences on both planes then provide the patient with a level of expectation as they step into their role in Goffman’s sense of frame for that particular moment. The “self” is re/constructed from these processes and related as the story, or myth, we tell ourselves and others. For that self to be deemed healthy, psychiatrists must see a correlation between her understanding of reality and their own. This means they cannot see evidence of the madness, ‘waking dream,’ or hallucinations evident at the time of the patient’s psychotic break. As we recall from the second chapter, early in the history of madness, even before schizophrenia gained its diagnostic label, madness was sometimes referred to as a waking dream. In the 1860 autobiographical text, *The Philosophy of Insanity*, the unnamed author emerged from a psychotic episode and wrote, “The first thing I remember was awakening as out of a horrible dream” (23). While in Freudian terms dreams are similar to hallucinations in that they condense and superimpose images, the schizophrenic does not wake up. As Oliver Sacks stresses in *Hallucinations* (2012), individuals considered normal can recognize hallucinatory perceptions (whether auditory, visual, or other) are not based in reality.

The psychiatrist uses terms like ‘normal’ and ‘abnormal’ and ‘pathological’ in a discourse that Foucault would contend reflects the medical establishment’s hold on the balance of power. French philosopher Georges Canguilhem’s (1904 – 1985) influential text, *The Normal and the Pathological* (1966), states that “there is no fact which is normal or pathological in itself” (144). Later in the text he writes, “The normal is then at once the extension and the exhibition of the norm. It increases the rule at the same time that it points it out…. A norm draws its meaning, function and value from the fact of the existence, outside itself, of what does not meet the requirement it serves… the normal is not a static or peaceful, but a dynamic” (239). Does the individual, pre-diagnosis, realize she is not normal or does she assume she is just out of sorts, a little odd or peculiar, eccentric? Does she suspect she is mentally ill immediately, or, as the autobiographies attest, does it take time to comprehend that her mental state is significantly different from those of her peers? Wallace was diagnosed as schizophrenic by nine different doctors and yet she lived in denial of her diagnosis even as a trained psychiatric nurse who wrote articles and functioned as a productive citizen – all signs of normalcy.

Foucault suggested the power relations between the state, the community, and the individual also existed in the mental institution to ensure moral treatment and a recognized state of normalcy. Goffman likewise discussed the notion of moral career of the mental patient which describes the process in which “the psychiatric view of a person becomes significant only in so far as this view itself alters his social fate—an alteration which seems to become fundamental in our society when, and only when, the person is put through the process of hospitalization” (*Asylums*, 128). If normalcy is located on a spectrum that places abnormal at the opposite end, what happens if these two ends are brought together to form a circle so that the line between them bleeds together, as in the notion of the mad genius. Where does that leave the schizophrenic? Whose concept of self seems to depend so much on the shifting sands of the diagnostic tools used to determine who is schizophrenic and who is not.

During a four-day conference at Columbia University in 1975 titled “Schizo Culture,” several thinkers and advocates met to discuss mental illness and the concept of normalcy, including Foucault, Laing, Judith Clark, and Howie Harp. Harp, the leader of the Insane Liberation Front, said, “If there is such a thing as mental illness, I believe that it is a reaction to present social and economic conditions, a normal reaction to abnormal

conditions." Foucault agreed when he said, "In order to be considered normal, you have to go to work, to school, you have to become some sort of machine or robot" (*Foucault Live* 169). Both Harp and Foucault thus linked a desire for normalcy to social expectations, a desire later met by therapeutic treatments such as work therapy, music therapy, drama therapy, and further education.

Within the institution, psychiatrists defined normalcy and made clear to the patient whether this was considered attainable, just as the patient's parents had prior to having their son or daughter committed. Likewise, the family members take on the role of controlling and refining the individual into a functioning community member once the patient is released. Laing stated, "The 'committed' person labelled as patient, and specifically as 'schizophrenic,' is degraded from full existential and legal status as human agent and responsible person to someone no longer in possession of his own definition" (*The Politics of Experience* 122). The subtleties between normal and abnormal for these seven women constituted a diagnosis, yet Laing argues "There is no such 'condition' as 'schizophrenia,' but the label is a social fact and the social fact a *political event*" (*The Politics of Experience* 121 italics original). And yet, the desire for normal persisted for these seven women. It persisted within their autobiographical narratives, it lingered in their use of language, within their actions, and lastly in their behavioural outbursts during incarceration. Their desire for a return to what they believed to be a state of normal seemed to drive them onwards, towards a conclusion, as will become evident with the upcoming close readings of the eight autobiographies and their interconnections which correspond to the previous materials.

Chapter 6: Foray into Schizophrenia

"To read women's autobiographical texts is to attend to the historically and culturally specific discourses of identity through which women become speaking subjects." —Smith & Watson 22

"We must inescapably understand our lives in narrative form, as a 'quest'." —Taylor 52

6.1 Identification of Sources

In the course of working on my Master's degree at Simon Fraser University on Ezra Pound, I learned of the poet's chance meeting with Erving Goffman in Washington DC during Goffman's fieldwork for his text, *Asylums* (1961). In reading about this encounter, I was struck by the fact that much of Goffman's work centered on the institution's role in shaping the lives of its inmates. However, Goffman offered little or no information about those lives before and after their admittance. Most of the patients he researched were diagnosed as schizophrenic. The stories of their lives would presumably provide important insights into the schizophrenic's experience while institutionalized, so I decided to pick up where Goffman left off and focus on the same era in which Goffman was researching and writing *Asylums.*

In my initial forays into this research, I discovered a reference to Gail Hornstein, author of the *Life of Frieda Fromm-Reichmann* (2000), and her Online Bibliography of First-Person Narratives of Madness in English. This indispensable listing allowed me to search specifically for narratives written or published between 1945 and 1965 by individuals diagnosed as schizophrenic. While Hornstein uses the term 'first-person narrative,' this is similar in nature to the term autobiographical narrative, which I consider to be a more focused term than that used by Hornstein, moving away from first-person accounts such as journals, and memoirs. Autobiographical narratives are then a personal account, relating to a period or place written by an individual who experienced the events as documented by his or her self. My work is therefore similar to Stephen Shapiro's summary of what makes an autobiography, which he defines as "a review of a life from a particular viewpoint in time—a review in which attention is focused on the self as it interacts with the world … it is not a portrait of self but an interpretation of an evolution of self that is a shaping of the past through selection and emphasis" (425).

Furthermore, as Helga Schwalm states, “Autobiography … constructs an individual life course as a coherent, meaningful whole … turning past events into a meaningful plot” (“The Living Handbook of Narratology” Paragraph 12). However, if the author chooses to use a pseudonym, or employs a fictious character (to protect themselves from the stigma attached to the term “schizophrenic”) to relate life events, these are also eligible by my terms of reference.

Surprisingly, although “the prevalence [of] schizophrenia [is] the same for both men and women” (Schizophrenia.com), the autobiographies I could source to meet the criteria were exclusively written by women between the ages of 13 and 29 who were diagnosed with schizophrenia, all of whom managed to survive the horrors of incarceration in mental institutions across the US, Canada, Switzerland, the UK, and New Zealand. Goffman’s year of fieldwork in St. Elizabeth’s Mental Hospital for the Criminally Insane in Washington DC as participant observer was spent mainly in the wing dedicated to its male population. Rather than this somehow disqualifying the autobiographies, it seemed all the more vital that the voices of *women* be heard through narratives in their own words to expand and nuance the body of knowledge on these patients at large.

Despite suffering at the hands of psychiatrics during or after their confinement, they all wrote coherent autobiographical accounts of their experiences. These accounts were published between 1947 and 1966, though in some cases the authors entered institutions in the late 30s but remained in care until sometime between 1945-65. Thus, these accounts are speaking to the middle years of the last century, a time when the psychiatric profession, both theoretically and practically, was facing a crisis of identity, especially concerning the care and treatment of the schizophrenic. The very nature of mental illness was contested territory, as were theories to support it and the treatments used in psychiatric practice. Three overlapping phenomena in psychiatric practice during the period—Freudian psychoanalysis, the anti-psychiatry movement, and big pharma’s implementation of first-generation anti-psychotics—as described in Chapter 2 provided historical context for these narratives.

The material to be analyzed, as mentioned above, includes eight autobiographical accounts, written by seven authors. Although the quantity of works to be investigated may not be great in number, their content speaks volumes and the

voices of these young women need to be heard, perhaps especially in concert. This collection of titles supplements Goffman's research, and adds to a limited scope of case studies, but it also addresses how gender affected the schizophrenic experience and as such offers new insights I pursue in the final chapter. Though I will focus considerable attention on the act and product of writing itself, a factor in these selections, I am by no means suggesting that the act of writing an autobiography is in itself a "cure," nor do I believe that this act facilitated remissions, but I *will* argue that by creating an autobiographical account of their experiences, each of these young women does manage to re/construct a sense of self that aligns with their pre-diagnosis definition of "normal" and thus allows them to return to an earlier home.

The eight published autobiographical texts to be analyzed, in chronological order of publication date, are:

Jefferson, Lara. *These Are My Sisters: An "Insandectomy."* London: Victor Gollanez Ltd., [1947] 1975. (238 pages)

Sèchehaye, Marguerite. *Autobiography of a Schizophrenic Girl: The True Story of "Renée."* New York: Meridian, 1951. (136 pages)

O'Brien, Barbara. *Operators and Things: The Inner Life of a Schizophrenic.* Los Angeles: Arlington Books, 1958. (202 pages)

Simpson, Jane. *The Lost Days of My Life.* Sidney: Allen & Unwin, 1958. (156 pages)

Frame, Janet. *Faces in the Water*. New York: George Braziller, 1961. (254 pages)

Greenberg, Joanne. *I Never Promised You a Rose Garden.* New York: Holt, 1964. (256 pages)

Wallace, Clare Marc. *Portrait of a Schizophrenic Nurse.* Grimsby*:* Hammond, 1965. (207 pages)

Wallace, Clare Marc. *Thank You, Mr. Freud.* Grimsby*:* Hammond, 1966. (142 pages)

Admittedly, while these materials may not represent a wealth of information on their own, when analyzed through the work of Freud, Goffman, Foucault and Propp, they provide significant context and texture for the schizophrenic patients' perspective during this decade. Moreover, given that they were the only such autobiographies listed in the time period in English, they will constitute the primary documents for my own original research.

6.2 Summary of Eight Autobiographical Narratives

What follows is an overview of each autobiographical text, clarifying the circumstances that brought these young women to the attention of the psychiatric profession and ultimately confined them to a mental hospital. Although I will be discussing all eight autobiographical accounts, I will be conducting a close reading of the following four authors and their corresponding texts; Joanne Greenberg's *I Never Promised You a Rose Garden*, Janet Frame's *Faces in the Water*, Marguerite Sèchehaye's *Autobiography of a Schizophrenic Girl: The True Story of Renée*, and Clare Marc Wallace's two autobiographies *Portrait of a Schizophrenic Nurse,* and *Thank You Mr. Freud*. In my effort to generate a close reading of these materials, I have attempted to uncover as much background information as possible. However, what I discovered was that despite searching online databases such as the London Review of Books, and the Book Review Digest Retrospective as well as Google Scholar much of my efforts were thwarted by the date of publication and for some the minimal number of copies sold. I even tried emailing publishers directly as a means of gaining information about book sales but to no avail. In the end, I had to work with the materials that I could find and try to cross reference to ensure a continuity of factual information.

The writing coming out of these mental institutions reflects the psychiatric nomenclature used within its walls, and often this language seems employed in part to bolster the author's arguments and authority. By laying claim to these terms, these psychiatric survivors transcended their roles as passive *recipients* of care, to become critics of, and active participants in, their own care. The texts serve as indicators of this shift, and augment and subtly support the larger argument that the schizophrenic, as patient and author here, comes to greater awareness of her power and position within the institutional framework. This in turn makes them covetous of greater control over their minds and bodies and to direct their own treatments, especially as they become

better versed in the language of psychiatry and the expectations or rules of the institution.

The awareness of their own positioning, through the act of writing and reading about and discussing their experiences in sessions with psychiatrists over the long term, forges a new sense of self that arises from the pages of the narrative. The autobiographical work provides a vehicle to re-establish or create anew the individual's sense of self using a divested version of the language of psychiatry. When the authors emerge from the institutions, they refer to themselves as "survivors" rather than victims of psychiatric institutions, and this too is an indication that they have undergone a significant transformation, not *as a result of* their physical treatments, but *in response to* them.

6.2.1 Marguerite S chehaye: *Autobiography of a Schizophrenic Girl: The True Story of "Renée" with an Analytic Interpretation* (1951)

This autobiographical account of Renée takes place in Geneva Switzerland in the 1930s. Renée's psychotherapeutic treatment with Dr. Sèchehaye began July 1930, when Renée was 18 years old and would end in June 1938 at which time, she regained her sense of reality. She was almost 26 years old at this time however Renée would continue to see Dr. Sèchehaye well into 1940. Renée's memoir according to Darian Leader "was once considered a classic in the field of mental health literature, an example of how a serious case of schizophrenia could stabilize through long and attentive psychotherapeutic work'' (Leader, 2011: 213). Renée is a pseudonym for Louisa Düss, a patient of Dr. Marguerite Sèchehaye (1887 – 1964) a Swiss psychotherapist. Throughout the text, it is Dr. Sèchehaye's interjections that assist the reader in understanding Renée's recollections and experiences after being diagnosed with schizophrenia. For instance, Dr. Sèchehaye describes the significance of Renée's renewed interest in the doll Riquette, explaining "Renée, who had never cared for dolls, suddenly, at the age of seventeen or eighteen, began to play with them like a little girl … this obviously indicates a regression" (39). Renée's state of regression would reduce her to a little girl, at which time Dr. Sèchehaye would take on a motherly role during their psychoanalytic sessions and would be referred to a "Mama" by Renée.

In fact, Louisa Düss would later be adopted by Dr. Sèchehaye. Louisa would even go on to complete her psychoanalytic training and work with children developing her own theories and style. It is during this time, Düss wrote 10 fairy tales which she would use to assist in her work with children. It seems that these fairy tales would be read to children of varying ages but the ending of the tale would be left out. The children were then to supply the ending, describe the characters, and explain the outcome of the tale. Louisa Düss's 1946 article "The Psychological Function of The Proper Name in the Reconstruction of the Personality of a Schizophrenic" is of particular importance as it provides the reader with some possible insight into the name Düss chose for the heroine of the text. For Renée, a French name, means reborn, which also is an accurate description of her own regression and eventual recovery or return to a state of normality. According to Düss, "for the individual, the name precedes the sense of his personal self, as being a more concrete reality" (647). She even goes so far as to suggest that as a psychotherapist she "has had occasion to observe that small children establish a bond between their names and their personalities" (646). Louisa's / Renée's life is mentioned very little in the text providing the reader with a sparse background; however, many details can be found in Sèchehaye's 1951 detailed case account *Symbolic Realization. A New Method of Psychotherapy Applied to a Case of Schizophrenia*. Yet anther account of Renée's life can be found in the 1968 film adaptation *Diary of a Schizophrenic Girl*, directed by the Italian poet, movie director, and screenwriter Nelo Risi (1920 – 2015).

Renée's account of her life documents the binary experience of reality and unreality, toggling between the two in a fashion that is both dynamic and fluid. According to Renée, this sense of unreality began "when she was five years old" (21). Renée was born in Switzerland. She was the first born and as such it was expected that she would assume the responsibilities of the oldest sister to care for her siblings. Her mother was "descended from an old aristocratic family of Southern-French extraction. Pretty and cultivated, with artistic tastes, she married a healthy, intelligent, Swedish gentleman, younger than herself. He was an industrialist who, in spite of his absorbing business, studied Russian, Chinese and the violin for the pleasure of it (*Symbolic Realization* 21). Renée's childhood was not a happy one. She was rejected by her mother, who frequently told her she was not wanted. She was raised by her grandmother for the first year of her life because Renée's mother seemed incapable of raising a daughter she viewed as "ugly" and who wouldn't eat the diluted milk she was given. Unfortunately for

Renée, her grandmother would unexpectedly leave the family household. Later, Renée's father would also abandon the family. Soon after, Renée's world would collapse into a binary state of the "real" and the "unreal" in which those people in the street "seemed alive, gay and real… while all that was within the confines of the yard was limitless, unreal, mechanical and without meaning" (*Autobiography of a Schizophrenic Girl* 25). Renée's sense of reality was slipping, and she knew it, as she recounts how "desperately I wanted to break the circle of unreality" (31). Frequently she would almost slip into a catatonic state. Seemingly "froze[n] in the midst of this electric immobility" (31), Renée would attempt to re-enter reality.

In the translator's preface, Renée is said to have "experienced a particularly early and severe form of dementia praecox" [meaning premature dementia, a mental diagnosis predating the term schizophrenia] (*Autobiography of a Schizophrenic Girl* 8). This diagnosis was *not* schizophrenia though Sèchehaye asserts that schizophrenia can be *caused by* this regression into childhood experiences. Renée's visual and auditory hallucinations paint a clear picture of the emotional upheaval experienced during events from the age of five to her recovery when she was in her mid-20s. Each schizophrenic break is described as "the Enlightenment," which "looked artificial, mechanical, electric" (31). Renée had a difficult time differentiating objects and sometimes believed objects had agency and that she could command their movements. Renée recognized that this was not logical and she was cognizant that she was experiencing the "tragedy of madness."

Renée was committed to several psychiatric institutions over the course of her illness. Originally, she was placed in a private hospital, but because of her tendency to self-harm, usually by attempting to burn herself (*Autobiography of a Schizophrenic Girl* 66), she was put in the locked wards. She describes "the great bars on the windows, the screaming women, complaining or transfixed in odd poses, motionless as statues… [I] remained alone in the midst of this fantastic setting, crushed by terror and paralyzing despair" (68). Renée's initiation into a new ward usually meant "A nurse led [her] to the bathroom, helped [her] undress, slipped a big gown of rough material over [her] and made [her] get into a nearby cold bath." (68) Known as hydrotherapy this was the practice of immersing the patient for a set length of time in a bathtub filled with cold water. Her inner voices tormented her in a place she called the System, directed her to

self-harm, and demanded strict “obedience to [its] orders [which] involved severe damage to the integrity of [her] personality” (65).

Despite this, Renée was still able to work as a secretary, assist around the house with minor chores, and even to write. This productivity, and what could be referred to as a sense of normal, occurred in the midst of Renée’s continued psychotic breaks which she referenced as horrific images such as “people whom I had entombed in milk bottles, putrefying, and I was consuming their rotting cadavers” (59). In the process, Renée began to associate her psychiatrist with her mother, and she referred to Dr. Sèchehaye as “Mama” throughout her two years of psychoanalytic analysis, including regression under Dr. Sèchehaye’s guidance.

The reader is provided an excellent interpretation of Renée’s analysis by Dr. Sèchehaye in the second half of the text, which is given over to an explanation of what took place and how Renée’s thoughts influenced her recovery. She goes through a process of “ego reconstruction” whereby Dr. Sèchehaye attempts to “trace step-by-step the ego’s route toward psychotic disintegration” (*Autobiography of a Schizophrenic Girl* 156). Dr. Sèchehaye explains that “The primary objective at this point was the achievement of an image of [Renée], a new “image” (161). Through a long process of transference and projection, Renée began to model the need for motherly love and attention using dolls, redeveloping a connection not only to things outside of herself, but also as a means for reinvigorating her own needs. This “pre-symbolic magical participation, presuppose[es] a complete unconscious self” (161). According to Dr. Sèchehaye, “the lack of maternal love had prevented the development of normal narcissism” (181), which in turn stifled Renée’s ability for “ego-synthesis,” necessary for creating an unconscious concept of self (182). Sèchehaye, summarizing Louis Lavelle, (1883-1951) a French philosopher, explains that for the process of ego reconstruction and ego-synthesis to occur “we must differentiate ourselves from the world and consequently realize our body limitations … [and] for this reason the ego is nothing without its own body and without an awareness of the universe which would be impossible except for the body” (181). It is only when the individual becomes conscious of their body as object within the world as subject that they can then begin to re/construct their ego within both the constraints and freedoms accessible to them, even if these lie deep within their unconscious self. Unfortunately for Renée, it would be her inability to reconcile these unconscious thoughts and images which ruptured her sense

of reality creating the opportunity for her to experience not only a loss of ego but also her subsequent psychotic breaks.

Ultimately, the language of Renée's narrative needed to be deciphered symbolically by Dr. Sèchehaye through psychoanalysis, an accomplishment that intrigued RD Laing so much that *Autobiography of a Schizophrenic Girl* was referenced in his own work. Suddenly, the schizophrenic utterances, mutterings, and ramblings signified something more powerful and profound, if not almost confessional. Dr. Sèchehaye sums up her work with Renée this way:

> It is hoped that this brief examination of the disintegration and reconstruction of a schizophrenic ego may serve to indicate the importance of recognizing the formative ego mechanisms in the psychotherapy of a schizophrenic. For if one aspect of the psychosis is characterized by the eruption of unconscious drive into the conscious life, the disintegration of the ego seems to be one of the principal causes of this usurpation by the unconscious. (187).

Again, it can be said, that Renée's schizophrenic experiences lie in her inability or at least in her lack of ego preparedness to withstand the unconscious attack on her ego, resulting in a rupture from reality, thus opening the possibility for a series of psychotic breaks. Dr. Sèchehaye's account detailed a similar pattern of thought processes and behaviours which will occur in other autobiographical narratives. For instance, Renée seemed to suffer from extreme bouts of anxiety and guilt. In order to deal with these sensations Renée "imagined herself to be the Queen of Thibet, a place inaccessible to the younger siblings where one finds warmth and needs nothing (*Symbolic Realizations 135*). This imaginary land was also home to the "system" which Renée feared as she associated "with the punishment of an unknown persecutor (39). In addition, we begin to learn about Renée's "violent hostility against the mother and the siblings [which] found its expression in the conception of the System, just as the guilt feelings (135). Through Sèchehaye's intense psychoanalytic treatment, Renée was not only provided insight into her own unconscious thought patterns but also provided the tools to assess and overcome this inner attack on her ego and in so doing, re/create a sense of self.

6.2.2 Joanne Greenberg: *I Never Promised You a Rose Garden* (1964)

Joanne Greenberg was born in 1932. Growing up in Brooklyn, New York Greenberg knew from a young age that she was different. “I had tried all my life”, recalls Greenberg, “since the age of five to fit in, to be real, to be “normal,” and it hadn’t worked” (“Chestnut Lodge: 1948 to 1951” 64). By the time she was a teenager, Greenberg was committed to a mental hospital. There, Greenberg would shuffle between the second floor, which was a much more open ward and the fourth floor. The fourth floor was the ward for disturbed, housing usually 10 patients. She reports that “I was happy that there was no special segregation for adolescents. We were all together—young, middle-aged, divorced, widowed. We saw illness and strength in every age and situation” (64). Greenberg would write about her experiences during her committal at Chestnut Lodge in her best-selling novel *I Never Promised You a Rose Garden*, written in 1960 and published in 1964 under the pseudonym Hannah Green. Greenberg’s novel would go on to sell almost 4 million copies in its first 10 years, and remains perhaps one of the most significant texts of its kind (“Metaphors of Madness”). Joanne used the pseudonym as a means to protect her children from the stigma attached to those diagnosed as schizophrenic and incarcerated in a mental hospital. Throughout the text, Greenberg refers to herself as Deborah, suggesting it is only semi-autobiographical, despite what appears an accurate re/construction of her experience with schizophrenia. It is arguably the best-known and most widely read of the autobiographical accounts analyzed here. *I Never Promised You a Rose Garden* was made into a Hollywood motion picture in 1977, and in 2004 adapted into a play. It is also one of the few fully documented personal stories to be found as a case file in psychiatric articles, which supports its accuracy as a case history.

I Never Promised You a Rose Garden happened to be Greenberg’s second novel. Her first, titled *The King’s Person* published in 1963, won her the National Jewish Book award for fiction. Joanne would go on to write 21 novels, as well as several articles speaking to her recovery from mental illness and to her concerns regarding the use of medication to cure mental illness. At times, Greenberg speaks to the benefits of cold packs, which were frequently used to calm agitated patients explaining that “fighting against the cold, the body begins to heat the pack. All the fight goes out of the once-tense muscles. The patient is surrounded in a close cocoon of warmth, secured” (66). Yet, “unlike the drugs we now use” writes Greenberg, “there’s no danger to brain or

body" (66). Chestnut Lodge was a place of psychoanalytic therapy "sessions were the main focus of [their] days and sessions were never missed" (65). It would be these sessions and the hospital experience that Joanne Greenberg would ultimately discuss in *I Never Promised You a Rose Garden*.

The publication of *I Never Promised You a Rose Garden* brought Joanne Greenberg even more success as well as some positive reviews. "Best Sellers" 1964 review stated "this is a rare and fine novel" (49). "Book Week" review wrote:

> In a quiet way [*Rose Garden*] creates vivid tableaux of life in a mental institution, and of the characters who come and go, some helplessly sliding toward destruction, a few recovering. Mainly, though, the book focuses on one girl and her agonizing fight to re-enter the actual world. The novel is written under a pseudonym and the reader suspects that the author knows first-hand whereof she speaks. If this speculation is wrong, she has one of the most powerful imaginations now going. Though the book deals with infinite sorrows and terrors, the total effect is heartening. (14)

This reviewer, recognizes that the author is using a pseudonym to relate what is most likely a true story, or one based on events and experiences accumulated first hand by the author. Many years later, Greenberg once again addressed this doubt during a radio interview where she said, "people don't understand or don't realize that their idea of the mentally ill are a tiny minority of us …most of us get up off the floor, spit out the carpet and get on with it" (*Appearances* 2006). The New York Times in May of 1964 also reviewed Greenberg's novel stating:

> Hannah Green ... has done a marvelous job of dramatizing the internal warfare in a young psychotic. She has anatomized, in full detail, the relationship between a whole, sick human being and the clinical situation – including doctors, other patients and the abstract forces of institutional life. ... Yet, convincing and emotionally gripping as this novel is, it falls a little short of being fictionally convincing. Our attention is fixed on the roles played by the characters rather than on their essential humanity. We are made to care whether the doctor will succeed as doctor, whether the patient will successfully overcome her illness, while the real fictional question of the cost and value of such successes is ultimately slighted. (36)

Again, the reviewer questions the authenticity of Greenberg's portrayal of insanity and recovery suggesting that author may have created a "specialized, nonfictional discipline … dressed in the garments and mask of fiction" (36), leaving the reader "not cheated by this imposition – nor … truly satisfied" (36). And once again, questions of authenticity

and veracity arise, which seem to plague most autobiographical accounts, even though the author is providing accounts of their own experiences.

In 1948, when Greenberg was only 16 years old, she was diagnosed as schizophrenic and confined to Chestnut Lodge. Through the heroine of *I Never Promised You a Rose Garden*, Deborah Blau, we are told that "a difficult financial situation made [the] family move in with [the] grandparents in suburbs" and because Deborah had made a "poor adjustment and was taunted by [her] schoolmates… [and] at age 16 attempted suicide" (Greenberg, 19), they chose to admit her. For Deborah and her parents, Chestnut Lodge was a frightening place despite its boarding school appearance and well-manicured lawns. Her parents described, "the high, hard scream that they had heard from one of the barred windows as they left … [that] made them shiver and grit their teeth" (Greenberg, 17). It would make them question the decision to leave their oldest daughter behind, a difficult emotional and financial choice for Deborah's accountant father and stay-at-home mother.

Inside, Deborah lived in a fantasy world built around a place she referred to as the "Kingdom of Yr" where the "Great Collect" of gods and demons lived and a "Censor" punished the unworthy by threatening to throw them into the pit. She portrayed herself as a very troubled child that did not hesitate to self-harm by cutting and burning. She created a complex inner world consisting of levels and realms that sheltered her from reality, a place she termed Now, "where the ghosts and shadows lived" (Greenberg 12). Joanne Greenberg would also describe her life between the age 5 to 18 as being "flat and desolate" (*Appearances* 2006). She was caught between the fantasy world of "Yr" and a reality too difficult to manage. Deborah questions whether her memories and recollections are her own, as when recalling her grandfather reading Milton's *Paradise Lost*: "The nine-year-old had caught some of the ponderous thunder of the lines she did not know she had read, and the artist in her had studied the etched angels and fine engraved lines that had blessed them with dimension." (Greenberg, 252). These images provided the basis for her fallen angels, gods, and demons.

These were not so different than the wards, personnel, and patients of Chestnut Lodge, a place that also consisted of levels where individuals moved up or down depending on their behaviour. Those demonstrating good behaviour were moved to the better wards on the lower floors where less control and supervision was necessary. The

least desirable ward, the lockdown ward or D Ward, was on the top floor of the hospital. Although for Deborah the disturbed ward was not the “worst ward at all, only the most honest” (Greenberg, 72), she went on to say, only “the people on the edge of Hell were most afraid of the devil; for those already in hell, the devil was only another and not one in particular” (Greenberg 72). The separation of patients into categories was not an unusual arrangement as many mental hospitals operated under a ward system with the most challenging patients assigned to the lockdown areas typically on the top floor of the institution and furthest from the public gaze.

During the three years of her stay at Chestnut, Deborah, like Greenberg, frequently moved from ward to ward, sometimes as a form of punishment for poor behaviour and sometimes as a reward for working hard on her treatment plan. Chestnut Lodge was intentionally designed around family structure in which patients were provided care and support without violence or retribution. Patients were given the time and space to “regress”; a process involving the psychological return of the patient to a childlike state and then the rebuilding of the individual back to their adult self so that they could function as well-adapted and functioning individuals. Each patient was ostensibly given freedom, but he/she was always under surveillance either by the staff or by the other patients.

Deborah was fortunate to be under the care of Dr. Frieda Fromm-Reichmann who saw in her the potential for a successful outcome and recovery and was her psychiatrist for the three years of her therapy. Joanne Greenberg reports that “she would not have got past her mental state without Dr. Fromm-Reichmann’s support” (*Appearances* 2006). Deborah initially refers to herself as a mental patient as if she is a “stranger, someone else’s daughter to whom they [Joanne’s parents] had only now been introduced” (Greenberg 10). When she hears her mother talking to Dr. Fromm-Reichmann about her history before she speaks for herself, she is struck by “the quality of and the difference between these versions of reality [which] would help to give depth to each of their interpretations of it” (Greenberg 43). “It” refers to Deborah’s mental illness, a story that has different versions depending on the narrator. In fact, it was Dr. Fromm-Reichmann who suggested Greenberg write her own story after leaving Chestnut Lodge. Initially it was to be one of three versions/books, the other two by Dr. Fromm-Reichmann and Deborah’s mother. Only Greenberg’s version would ever be fully developed into what might be interpreted as semi-autobiographical because of

Greenberg's intentional fictionalization of certain aspects of her story such as changing the name of the main character. However, Greenberg's writing of *I Never Promised You a Rose Garden* supports and documents many of the experiences she endured and witnessed while a patient at Chestnut Lodge. For example, in Greenberg's 2019 article in which she recollects on her time at Chestnut Lodge, she tells the reader:

> The Lodge was about four blocks from the center of town, on the main street, but set well back from the street. The main building was "Addams Family" in style, a model madhouse. There were four stories and all its windows were fortified with heavy mesh and bars. The top floor housed the Women's Disturbed Ward and, now and then, the nuthouse feeling would be enhanced by screams from the dormer window. (62)

This is the same as Mrs. Blau's description of her experience when dropping Deborah off at Chestnut Lodge, where Deborah was to begin treatment for her schizophrenia. Greenberg also describes Dr. Fromm-Reichmann's house on the grounds of Chestnut Lodge, stating:

> Frieda Fromm-Reichmann, my therapist, had a house 30 yards or so from the back of the main building, catty corner to the other buildings. It was an ordinary house, white and comfortable looking, well-kept, with a patio in back. (63)

Life at Chestnut Lodge was, for Greenberg, predictable which seemed to allow her to recuperate on her own terms. As she writes:

> I am separating what the Lodge was all about: therapy with a skilled doctor and the experience of meeting and interacting with relaxed and accepting people—professional and nonprofessional. (68)

This would be Greenberg's memories of Chestnut Lodge 68 years after being released. Yet, Greenberg's memories and recollections continue to mirror her telling of the original tale even though the events detailed in *I Never Promised You a Rose Garden* happened to be told from the perspective of Deborah Blau, a story that needed telling and retelling.

Dr. Fromm-Reichmann would use Greenberg as her most successful example of schizophrenic remission after psychotherapy and cited her case history frequently in medical articles she authored. *I Never Promised You a Rose Garden* provides tremendous insight into the world of the mentally ill within the institution and offers a prolonged sojourn in the mind of an individual undergoing psychoanalysis.

6.2.3 Janet Frame: *Faces in The Water* (1961)

Janet Frame was born in 1924. She lived most of her life in New Zealand, except for seven years when she moved to Europe in 1956, where she spent time in London, Ibiza, and Andorra before returning to New Zealand in 1963. Over the course of her writing career, Janet Frame would write 13 novels, three collections of short stories, a children's book, compose and publish several poems, plus a three-volume autobiography. Frame was nominated for many literary awards and has been the subject of both a movie, *An Angel at My Table* (1990) and a play titled *Gifted* (2103), about her life and writing while staying with fellow New Zealand author Frank Sargeson.

It was during her time in Europe that she wrote *Faces in the Water* as well as several other novels. Frame's first publication *The Lagoon and Other Stories,* (1951) was a collection of short stories. It was this publication, and Frame's winning of the Hubert Church Award that put a stop to the leucotomy scheduled for her while confined at Seacliff Hospital for the mentally insane. Janet Frame describes the conversation that occurred:

> Dr. Blake Palmer, made an unusual visit to the ward. He spoke to me—to the amazement of everyone. Dr. Blake Palmer what do you think?
>
> He pointed to the newspaper in his hand.
>
> "About the prize?"
>
> I was bewildered. "What prize?" "No," I said, "about the leucotomy."
>
> He looked stern, "I've decided that you should stay as you are. I don't want you changed." (An Angel at My Table, 297)

A similar conversation takes place *Faces in the Water*, a scene in which Istina (the main character/narrator) writes about her own scheduled lobotomy:

> I suddenly ran up to him and pulled on his sleeve, and in defiance of Matron's horrified gaze, I spoke to him.
>
> "What is your opinion?" I asked.
>
> "What is my opinion?" he asked fiercely, adding in a more gentle tone, "What do you mean, Istina?"
>
> "What do you mean, Istina?" Dr. Protman repeated.

> "The lobotomy," I said, and felt dismay as the word escaped from me, for I was afraid of it…
>
> Dr. Portman spoke instantly. "I say no," he said. "I don't want you changed. I want you to stay as you are." (*Faces in the Water*, 218-219)

The similarities in the conversation, not only the content but timing, is striking. And, yet, Frame insists that from the outset of *Faces in the Water* that "It is a work of fiction [and] none of the characters, including Istina Mavet, portrays a living person," (Frame 6). Still, many of Istina Mavet's experiences parallel Frame's. In her three-volume autobiography, Frame offers an important insight regarding the way she plays with her memories and the matter of truth in her work:

> From the first place of liquid darkness, within the second place of air and light, I set down the following record with its mixture of fact and truths and memories of truths and its direction always toward the Third Place, where the starting point is myth. (5)

Frame's description of myth as the "Third Place" suggests that *Faces in the Water* is more autobiographical than she lets on or may have intended.

What I can document is that Frame spent a great deal of time proving that she was not mentally ill and that she was misdiagnosed as being schizophrenic. This seemed to be almost a quest for Janet Frame from the moment she was first committed to the mental hospital until she received the report from the Maudsley Institute of Psychiatry in London 1957-58. In a meeting, chaired by Sir Aubrey Lewis (Chair of Psychiatry), Dr. Miller informed her that "You've never suffered from schizophrenia" and that her "brain waves were more normal than normal" (*Angel at My Table* 497). According to Frame, Sir Audrey Lewis would further explain that she "had never suffered from schizophrenia… [and] I should never have been admitted to a mental hospital. Any problem[s] I now experienced were mostly a direct result of my stay in hospital" (498). Although, this may well have been the case, I want to reiterate that I am not attempting to prove or disprove Frame's diagnosis; rather I am attempting to demonstrate that through her writing Janet Frame began to re/construct a renewed sense of self. Even after Frame was provided with this news, she seemed to struggle with her identity, even asking in her autobiography, "Oh why had they robbed me of my schizophrenia, which had been the answer to all my misgivings about myself? Like King Lear had gone in search of "the truth" and I now had nothing" (506). Yet, she did have something. Frame

had gained the proof of sanity that she was searching for, but was it enough to overcome the stain of being institutionalized.

Faces in the Water was originally published in 1961, but Janet's actual institutionalization occurred in1945. Janet would be in and out of institutions for the next eight years, after initially being committed to the psychiatric ward of Seacliff Lunatic Asylum which was located 20 miles from Dunedin, New Zealand (King 71). Shortly before her introduction to life in and out of the asylum, Janet had begun to refer to her difficulty understanding the "primer of adult living" (*Angel at my Table* 242). She goes on to say, "I felt that I could see the feelings of people, beneath their faces, in their eyes, their imposed or swift ungraded expressions, and in the words they spoke" (242). And then, just as she is to be committed at the age of 21, Frame once again describes how she felt isolated and alone but was aware that she had to portray outwardly at least the demeanor of the good student, the girl who was no trouble at all, did what she was told and what was expected of her. As Frame describes her predicament: "Temporary masks, I knew, had their place; everyone was wearing them, they were the human rage; but not masks cemented in place until the wearer could not breathe and was eventually suffocated" (250). Then before she could reconcile her situation which meant continuing on as a teacher or pursuing other interests, she was admitted to Dunedin hospital's psychiatric ward for what was to be "a few days rest" (252). The parallels to Janet's real-life introduction to the world of psychiatry and that presented within the text *Faces in the Water* is similar. The narrator, of *Faces in the Water*, Istina, who also happens to be a teacher, describes the beginning of her ordeal describing how "the headmaster followed [her] home, divided his face and body into three in order to threaten me with triple peril, so that three headmasters followed me, one on each side and one at my heels" (11). Istina was then whisked away to Cliffhaven mental hospital. Like Istina, Janet was also taken to the psychiatric hospital by the Head Master of the Department and two other teachers at the teacher's college where she was studying. Frame and her main character Istina were both on their way to being diagnosed as mentally ill.

When *Faces in the Water* was published, Janet Frame was already a well-known author to those living in New Zealand. The initial book reviews, included several that were positive such as David Hayman's from the University of Texas, who wrote, "*Faces in the Water* marks the coming of age of an outstanding New Zealand novelist" (Books Abroad 322) while Robert Healy from the New York Herald Tribune wrote, "Highly

impressionistic and of limited appeal, but an impressive performance" (1961). Others noted that Frame's "skill at penetrating the feelings of the staff unites patients and staff in such a way as to make them all, however whirling, the members of the same tragic microcosm" (1962). Furthermore, *Kirkus Reviews* in 1961 suggest that the author, "has based much of this on what was presumably her own experience, added a poet's sensitivity to the flickering drift of thoughts, fears, memories" (557).

What I am suggesting is that Janet Frame, as author used the persona of her character, Istina Mavet, as the mask to veil her own experiences within the mental health system. For as Frame explains, it was Dr. Crawley's (Psychiatrist at the Maudsley Institute) view that "I should write my story of that time to give me a clearer view of my future" (*Angel at My Table* 510). This is exactly what Frame set out to do:

> I began to write the story of my experiences in hospitals in New Zealand, recording faithfully every happening and the patients and the staff I had known, but borrowing from what I had observed among the patients to build a more credibly "mad" central character, Istina Mavet, the narrator. (515)

Therefore, to minimize the stigma on the author, Frame fictionalized the work to hide her own potentially embarrassing past. As Carolyn Heilbrun states in her work on women's autobiographical contribution to the field of narrative studies:

> There are four ways to write a woman's life: the woman herself may tell it, in what she chooses to call an autobiography; she may tell it in what she chooses to call fiction; a biographer, woman or man, may write the woman's life in what is called a biography; or the woman may write her own life in advance of living it, unconsciously and without recognizing or naming the process. (*Writing a Woman's Life* 11)

It is therefore considered, for the purposes of this dissertation, to be an autobiographical text, however for continuity, I will maintain Istina Mavet as the narrator/main character. Even though, I do perceive Janet Frame and Istina Mavet as being one in the same person.

Under Frame's guidance as author, Istina reveals details about her life in the institution and her encounters with psychiatric treatment, but she does not speak about her family except to mention her mother and father who lived some distance from the hospital. Her mother "regarded [Istina's] illness as a reflection on herself" (*Faces in the Water* 56) and so did not visit. Istina's Aunt Rose came most frequently, bringing her food and news from home. Home had an almost magical allure for Istina: "How could I

help a little self-dramatization around one of the themes of living that is so consistently involved with man's mythology and religion—*The Return*?" (italics my own) (128). Yet, when she had an opportunity to go back to her family after five years and stay in her own room, she quickly realized the room was the same, but she had changed. Her memory was damaged by the treatment she had undergone, and she lasted only six weeks outside the mental institution before she returned to Cliffhaven under a new label: "Chronic."

Istina was also institutionalized at Treecroft and housed in multiple wards, suffering at the hands of nurses, attendants, and psychiatrists alike. Her story, like most of these autobiographical accounts, involves doses of the sedative paraldehyde, frequent bouts in a straitjacket, and being locked away in solitary confinement. When the sedatives wore off, and the straitjacket no longer served as an effective means of control, she was given rounds of ECT and insulin shock. Finally, (as mentioned earlier) she was threatened with a lobotomy, which fortunately was cancelled due to Dr. Portman's change of mind. Istina describes what a post-lobotomy patient looks like and says that, during their recovery, psychiatrists were hopeful for a cure, but patients were banished to the back wards when it became clear the surgery had been an abject failure (217).

According to Istina's account, the lobotomy was used as a last-ditch effort to "change the personality… to be retrained, rehabilitated, fitted, my mind cut and tailored to the ways of the world" (217). Patients who had the operation became "more docile, less inclined to fly into a rage, however this initial outcome didn't always last, as Frame accurately documents that often these patients would "again [become] just one of the hopping, screaming people in the dayroom" (110-111). The lobotomy, like so many other new and "promising" forms of psychiatric treatment during this time, was used to threaten and punish unruly patients who were too much trouble for institutional personnel.

Istina describes her subtle loss of self and a loneliness that inspired an immersion in childhood reminiscences: "I experienced not a surge of recollected incidents and delights, but a vast invasion of loneliness" (128). ECT and insulin shock treatments hindered her ability to string together memories or formulate stories from her past that would generate a sense of self. She "did not know [her] own identity, [for she

was] burgled of body and hung in the sky like a woman of straw" (65). She realized "treatment snatches these things from you and leaves you alone and blind in a nothingness of being" (24). *Faces in the Water* underscores several of the themes common to all the narratives under analysis and as such speaks to the consistency of these practices across the globe. Frame, while completing the last volume of her autobiography, described the process of creating a self through writing. She states:

> [A]lthough I have used, invented, mixed, remodeled, changed, added, subtracted from all experiences I have never written directly of my own life and feelings. Undoubtedly, I have mixed myself with other characters who themselves are a product of known and unknown, real and imagined; I have created "selves" but I have never written about me. (539)

Hence, my assertion that authors I am discussing re/construct themselves not only during the writing process but also during the reading/editing process. The author becomes both the creator and the interpreter of experiences; those experiences lived, and those experiences observed by the author. It is self which emerges from the reimagined, reinterpreted, and reworked amalgamation of experiences, memories, and missed opportunities.

6.2.4 Clare Marc Wallace: *Portrait of A Schizophrenic Nurse* (1965) and *Thank You Mr. Freud* (1966)

Clare Marc Wallace was a trained psychiatric nurse, as well as a diagnosed schizophrenic, when *Portrait of a Schizophrenic Nurse* was first published in 1965, and then one year later her follow-up text *Thank You, Mr. Freud* was published. Wallace also published two more novels *Nothing to Lose* and *Mink on my Apron* both long out of print. She also wrote several articles about the practice of nursing and what it means to be a nurse that happens to be mentally ill. Wallace later collaborated with Joyce Emerson in 1969 to publish a medical booklet aimed at informing doctors as well as patients and their families about mental illness titled, *Schizophrenia: The Divided Mind* which seems to be her last piece of writing, as I could not find any more information about her after 1969.

Portrait of a Schizophrenic Nurse documents her coming to terms with the label schizophrenic and is written as if she is in a dialogue with herself. Her inner self asks questions of her "true self," providing the reader with a unique means of engaging with

the schizophrenic mind. As Clare Marc Wallace explains in a follow-up article “Personal Viewpoint”, “I tried to show how it felt to be schizophrenic. This was not an easy task, and eventually I decided to write the book as a dialogue between myself and my hallucinations” (288). Wallace always kept to herself. In 1955, Wallace was 22 years old and living in the UK when she was diagnosed as schizophrenic, however, she claims to have had schizoid tendencies since she was 16 years old. At 16, she remembers “her thoughts telling [her] that [her] sandals were cheap, and that people were laughing at [her]” (23). Her father was “obsessional and [had] schizoid traits” (20). Her mother came from a very poor family and was “suspicious and paranoid about the neighbours, always keeping the kitchen curtains drawn… [she had] inferiority feelings” (20). Despite this, she still sees her upbringing as fairly normal “apart from the lack of affection from [her] mother” (21). While Wallace at times seems to fully recognize that she is schizophrenic, she continues to view herself as different from others diagnosed with schizophrenia. She writes, “I know something of the patient's problems, as well as those of the staff. I would not say that my case is typical, because I feel that I have not deteriorated to the extent that many schizophrenics would have done after so many acute episodes” (“Personal Viewpoint” 288). Wallace then takes her personal experiences and formulates them into her autobiographical novels. These books received mixed reviews. For instance, Una V Budge’s 1964 review states, “Miss Wallace was a very 'bad' patient; in spite of advice, she persisted in taking professional employment which wrought havoc in her own mind; and her book is egocentric to an alarming degree” (44). Furthermore, Budge writes, “She is fortunate that her illness uncovered an undoubted talent for writing, less fortunate, perhaps, that it shows with pathetic clarity how often the mentally ill person is his own worst enemy” (44).

In the first few chapters of *Portrait of a Schizophrenic Nurse* Wallace offers her case history, as if speaking to a psychiatrist or family doctor. She details her first love, which ended because the man she loved had been previously married and her faith would not allow her to marry someone with this history. When this man moved to Canada, she had feelings of “persistent hopelessness and despair” (29). A friend suggested she speak to a psychiatrist, so she began her first round of psychotherapy with Dr. Kinver who administered the tranquilizer serpasil. The psychotherapy came to an abrupt end when Wallace told Dr. Kinver she was “hearing [her own] thoughts repeated … and of her critical self who gave [her] no peace and whom I regarded as an

outside agency" (35). Her diagnosis was quickly changed from depression to schizophrenia. (137). After a couple of sessions, she was admitted into Tilsbridge Psychiatric Unit under the care of the ward psychiatrist Dr. Irvine, which occurred sometime between 1955 and 1957. Once again, she conveyed her full case history to the psychiatrist, who determined she was depressed and immediately arranged for six rounds of ECT. She was also expected to write down her dreams and with Dr. Irvine interpret their meanings. Wallace suggests it was like "the depths of the iceberg being plumbed… and what depth! It was like seeing oneself in a mirror for the first time, and not being particularly enamored with what one sees" (33). Dr. Irvine scheduled rounds of ECT. She was then transferred to Portstone Hospital where she started insulin shock treatment. After waiting five days for Dr. Irvine to arrive Wallace checked herself out.

Wallace's autobiography details frequent departures from institutions, believing she is well enough to restart her nursing career. Sadly, she inevitably returned to endure the all too familiar merry-go-round of more failed treatments followed by stronger medication and a desire to return to a life before the onset of mental illness. She recalls "weighing everything up – the conditions on the ward, and the fact that if [she] left she would be forfeiting [her] job at the clinic" (37). It seems that Wallace was able to return to work as a nurse in between her psychotic episodes. She also became adept at covering up not only her mental illness [by moving from job to job] but also covering up the symptoms associated with each oncoming break. Wallace's narrative account follows this pattern of in-patient and out-patient care while attempting to protect herself and her nursing career from the stigma of "ex-mental patient." Whenever there was a hint of impropriety on the job, she would lose her position or quit before she could be fired.

When Wallace checked into Cransburgh Manor at the suggestion of Dr. Kinver, [a psychiatrist referred to Wallace by her friend, and fellow nurse Ann] she had insulin shock treatment designed to induce a coma. While on the ward at Cransburgh, one of five women in insulin comas died when her coma could not be reversed. She also had more ECT to assist with her ongoing depressive feelings. Wallace did eventually have 18 months of remission, enough time to reinvigorate her nursing career, while on more medication to keep her stable. She was prescribed 90 mg of stelazine, a first-generation anti-psychotic medication with side effects like tardive dyskinesia (involuntary body movements). Later, she was put on haloperidol, and beginning in 1963 largactil, another anti-psychotic medication.

It is difficult to have any sense of stability when switching from medication to medication, job to job, and wellness to despair. When feeling well, Wallace would write, not only autobiography, but also articles for nursing journals about the trials and tribulations of being a nurse, which were published. However, her writing routine, in combination with her work as a nurse almost consumed her. She would stop eating, she began to see "double meanings in things that people said to [her] and felt that she was being closely watched" (88). She started to think her food was being poisoned. She would stop taking her medication because it dulled her creativity. Her paranoia initiated a spiral that put both her physical and mental health in peril.

Wallace tries to identify where her "true" self begins and where her "schizoid" self takes over – amazingly while continuing to work as a nurse – in her follow-up book *Thank you, Mr. Freud*. Wallace's work within the mental institutions while employed as a psychiatric nurse augment her re/construction of "self". *Thank you, Mr. Freud* was written only a year after *Portrait of a Schizophrenic Nurse*, but focuses more deliberately on her experiences as a nurse. *Thank you, Mr. Freud* would also be reviewed, and this time the reviewer Sid Chaplin would not mince words writing,

> At first sight the prospect is full of promise: trained psychiatric nurse and ex-schizophrenic gets a job in a small, Home Counties psychiatric unit … But the (writing) manner and a determined resolution to squeeze the last bit of humour out of every situation (including a good many that just don't have it) gets all too effectively in the way of the matter. (38)

Chaplin further says that

> The genre began with *The Ego and* /; it is at its deadly, machine-tooled worst in the monotony of Reader's Digest; it has been done to death in the 'Carry on' films. (38)

An intriguing set of comments, as Wallace is referred to as an "ex-schizophrenic" yet never once does Wallace actually state that she is recovered, and what genre is the reviewer referring to? I would suggest that perhaps the reviewer doesn't recognize Wallace's text as authentic or even autobiographical. And in the end, all Sid Chaplin can do is say, "I sincerely recommend Mr. Freud, the writer, to Miss Wallace. He describes funny people as well. But he respects them" (38). Yet, does he fully respect Wallace's account?

The text of *Thank you, Mr. Freud* is a linear progression of vignettes crafted with psychoanalytic language and references to Freud. Wallace states that "Freud and I have

much in common" (8) in that they both practiced self-analyses in the written form. Wallace documented her experiences, and conversations with herself, to relive these moments, attempting to sort out their historical and emotional significance. She understood the terms regression, suppression, projection, and sublimation, yet she had been exposed to the practice of psychoanalysis and psychotherapy, both professionally and personally, long enough to have grave doubts as to their effectiveness. She had the same doubts when it came to the use of occupational therapy, ECT, and the early use of largactil (also known as thorazine or chlorpromazine), a first-generation anti-psychotic.

Wallace also describes her attempts to maintain her career while struggling with the recurring schizophrenic breaks that occurred increasingly close together. When on the job, Wallace is able to "put on a fairly convincing act [of normalcy] … she can keep the well part of [her] mind away from the so-called ill part" (110). She refers to her "auditory hallucinations as 'the talking' while most people describe them as 'voices'" (160). Wallace goes so far as to assert that "the reason so many people have a mental illness is because the so-called 'norms' have not met the specific type of stress, which would trigger a breakdown" (167). Furthermore, "these patients have a point of view … however outwardly mad they may seem. It is all a question of trying to understand their behaviour instead of trying to change it to one of conformity" (171). If Wallace lost her job and the reason was identified, she would have to look for something outside traditional posts: "with a history of mental illness blotting [her] career, it became increasingly hard to get a hospital job, and after [her] twelfth breakdown" (97), it was only more difficult. For "what matron would risk having a schizophrenic on staff?" (7). Simply put, Wallace says, "Once a schiz, always a schiz" (136).

Thank you, Mr. Freud is significant for offering the perspective of an individual living both as a schizophrenic and as a nurse within the psychiatric institution, attempting to both control and cure mental illness. Taken together, Wallace's autobiographical works provide an invaluable documentation of the history of psychiatric care in the UK. She provides first-hand descriptions of psychoanalysis, the anti-psychiatry movement, and the introduction of psycho-pharmaceuticals, all three trying to find acceptance in the medical and scientific fields and strike a chord with the public during this period of her own analysis and employment. As such, Wallace's text demonstrates the difficulty someone diagnosed with schizophrenia has functioning within the community, an institution, and in a workplace. Incredibly, for almost 20 years, Wallace was able to mask

both her diagnosis and her symptoms to play the role of a psychiatric nurse. Was she an imposter or was this a function of her double mental life as well?

6.2.5 Lara Jefferson: *These Are My Sisters* (1947)

These are my Sisters: A Journal from the Inside of Insanity, alternatively titled *These are my Sisters: An Insandectomy,* was last republished by Victor Gollancz Ltd. in London in 1975, but had gone through many adaptations and title changes in the interim 28 years. This title was mentioned in Bert Kaplan's anthology *The Inner World of Mental Illness: A Series of First-Person Accounts of What it was Like*, published in 1964 and, according to Jack Vickers, the original editor and publisher of the American edition of *These are my Sisters*, Jefferson wrote this autobiographical account while a patient "in the violent ward of a state mental hospital" (Kaplan 8). Jefferson apparently "penciled on an odd assortment of scrap paper [so], it was almost impossible to interpret" (Kaplan 8). However, Vickers may have exerted significant editorial license to transform these scraps and fragments into a coherent document. Although the text may fall outside of my scope of research it was Kaplan's reprinting of Lara's account in 1964 that brought greater attention to her story as his text would become essential reading material for university students studying psychology. In addition, her book was cited by authors such as RD Laing, the eminent psychiatrist often linked to the anti-psychiatry movement. It also provides an important jumping off point in my research as Lara's autobiography details the mental patient's realization of self and brings to the forefront of our attention the awakening of the individual to their plight both within their own consciousness and to those outside of the institution, society at large.

Jefferson was 29 years old when she was diagnosed as schizophrenic and committed to a large mid-western American mental hospital which is never identified. She describes the abuses suffered by those patients in care, and her own desire to retain some semblance of normalcy. She is acutely aware that the label "insane" applied to her is just a means of controlling her. Jefferson is quite insightful about her psychiatrists' diagnosis: "They have a list of long Greek and Latin words and when they observe such and such symptoms in one of us, they paste the label for our phobia on us—and that is the end of the matter" (Jefferson 14). She is an imaginative free thinker who just could not "live up to the demands of civilization" (Jefferson 12). She states, "because I am an odd piece of egotism who could not make the riffle of living according

to the precepts and standards society demands of itself, I find myself locked up with others of my kind in a 'hospital' for the insane" (Jefferson 11). Yet, she willingly accepts her fate: "Madness. It has always been waiting before—behind—pursing" (Jefferson 15).

Jefferson first became aware of her potential for "madness" at a very young age. She writes, "I was only a child when I first felt its hot breath upon me" (Jefferson 15). No matter what she tried, she could not overcome what she considered her "destiny." Her mother was 46 when she gave birth to Lara and her father was 76; she was the youngest of six children. Mrs. Jefferson worked as an attendant at an asylum, so Lara grew up within the confines of a mental hospital and was raised by its patients even before she was "legitimately" committed. For children of the staff, growing up within the walls of the institution was not unheard of at this time, as staff often lived on the grounds of the asylum or on adjacent property. Often, the mental hospital was the major employer in these areas and as such provided opportunities for childcare which was the case for Lara's mother being a single parent raising six children. Her mother was determined to train her to be a "mesmeric speaker" or an "evangelical musician," but she didn't have the aptitude (Jefferson, 17). Feeling she had disappointed both her mother and God, Jefferson took "refuge in deliberate forgetfulness, in fanciful dreams, in delusions which include no music, no leading the world into light—life became easier" (Jefferson 17). She also briefly attended a convent to learn the ways of God, but she was sent back to the institution to live with her mother because "I, too, was sinful, I was worldly … I wanted to be a girl not a saint" (Jefferson 17). Later, Lara would be committed by the state as insane (Jefferson 18).

Once she is committed, Jefferson chronicles the institution's daily routines, the coming and goings of the nursing staff, the fleeting presence of psychiatrists, and interactions with other patients. She begins to analyze and investigate her place in this world of the insane. She writes, "there is only a shadow remaining of the person I used to be… she is not real— she is not I— I never saw her before I dreamed her" (Jefferson 19). She is "still divided" and "cannot truly forsake all the old ideas as long as their memory stays within" (Jefferson 22). Jefferson's scribbling is in secret, for if she is caught her papers will be taken away and she will be punished for her insolence. Her state of mind is calmer when she can capture her thoughts: "the slow rhythm of writing things out in longhand—the practice might tame her somewhat… because she is I—and because I still have myself on my hands, even if I am a maniac, I must deal with me

somehow" (Jefferson 25). She bounces between "I" and "me" and "she," so it is unclear where Lara the pre-institutionalized individual self ceases to exist and where Lara the psychiatric patient begins. It appears the former can only exist when she puts her memories to paper as a way of extending this moment.

Jefferson's record objectifies her separate selves through the nature and value of the written word, establishing a permanence, but also providing a means of challenging the psychiatric labels in her case file. She writes, "they [doctors] have got us all analyzed and psychoanalyzed down to insignificant daubs of protoplasm—and personally my ego is not a bit flattered by the things they found out about it" (Jefferson 27). After all this poking, prodding, labelling, and psychoanalysis she is given "sick" hypos (medication that causes her to vomit), introduced to the wet "pack" (being wrapped in cold wet blankets, with cold water added at regular intervals as a means of calming the mind) (Jefferson 32-33). She is given sodium-amytal, luminal, and paraldehyde, better known by the patients as "skunkoil." In the event the patient refused to drink the paraldehyde, "it was administered by the drenching method [and] once you start to swallow—you do it in a hurry, or be asphyxiated on the spot" (Jefferson 34). The patients referred to this technique of enforced administration as "giving the camel" (Jefferson 34). The drugs were used to sedate and disorient her, to make her more compliant and easier to control. If the drugs didn't work, she was placed in the straitjacket, an "implement of torture designed in the Dark Ages…to break your will" (Jefferson 35).

These forms of treatment are familiar to institutionalized patients and are well-documented, as is the ward system, adopted not only in the US, but also the UK and New Zealand for both state-run and privately-funded hospitals. Patients are assigned according to their level of difficulty as noted in their case file and charts, or what Jefferson calls "books of doom" (Jefferson 38). Nurses write down their observations, recording "depressed and suicidal… or the top of a list of unsavory suggestions… untidy" (Jefferson 39). These words reward or punish patients with a move to a better or worse ward respectively. Forsaking hope of escape from the institution, she begins to write not just as a distraction or record, but as an act of self-preservation and prevention: "Once you have felt it, and seen the force of yourself flow out in a stream of insanity, you get a pencil and sit down and write; anything to try and forestall a repetition of your experience" (Jefferson 45).

Writing an autobiographical narrative allowed Jefferson reprieve and a means to cope with life inside the institution, though this was, like so many other treatments not a "cure." She realized that she "was a fool to have thought [she] might build a ladder of words strong enough and long enough to reach out of this" (Jefferson 112). This is not to say that re/constructing a self in her notebooks that made sense of her situation, calmed her, returned her to fonder memories, or offered relief from others around her was insignificant, far from it, but her own "sanity" articulated within its pages was not enough to convince anyone but herself. She was, and would always be, seen as insane as long as she remained a patient in the mental institution.

6.2.6 Barbara O'Brien: *Operators and Things: The Inner Life of a Schizophrenic* (1958)

Barbara O'Brien is a pseudonym and her work a short exploration of her schizophrenic break, her experience with the psychiatric profession, and her own struggle to come to terms with the loss of self over a six-month period. O'Brien was in her mid-twenties when she experienced her first schizophrenic break. She worked in the office of a large, highly profitable business venture (which is never named nor does she ever disclose what it was she did while working in the office) mainly with men attempting to get ahead and move up the corporate ladder. This made O'Brien uncomfortable given all the office politics, back-stabbing, and lying and signaled the beginning of internal strife.

O'Brien's ordeal begins when she wakes up to find three male figures standing at the foot of her bed. These three "fuzzy ghosts" were called Operators who could "penetrate the minds of Things at any level… minds [that] can be read and whose thoughts can be initiated and whose actions can be motivated" (O'Brien 56-57). The Operators act as O'Brien's guides and explain what they do, the world they inhabit, and how, if she wants to return to the realm of sanity, she needs to follow their instructions. The first thing O'Brien is told to do is to quit her job and jump on a Greyhound bus. At the bus depot, O'Brien faints and ends up in the psychiatric ward where she spends one night and then gets back on a bus to travel across the country.

O’Brien weaves together her inner conversations with her three Operators and constructs her own psychological language in which she refers to the Operators as her unconscious mind and the Thing as her conscious mind. She is “forced to live in a double world” (O’Brien 97) where her sense of reality relies on her interpretation of insanity. She obeys her Operators’ suggestion and visits a psychoanalyst. After three visits, the voices disappear and never return. Although this may seem highly unlikely and somewhat unbelievable, this is the story that O’Brien tells and this is the story we must work with. It is at this point the psychoanalyst suggested she should write her story, which provided this autobiographical account.

While the text is critical of both psychiatry and psychoanalysis as a means to assist those with schizophrenia, O’Brien’s depiction led Michael Maccoby, PhD (who wrote the original introduction) to hypothesize that the hallucinations and delusions of the schizophrenic may be a means to overcome deeply troubling life experiences and social expectations. Dr. Maccoby, 50 years after the original publication of *Operators and Things*, said that RD Laing was also influenced by O’Brien’s story and this helped to forge Laing’s “idea about the positive functions of the visions and other symptoms in schizophrenia” (O’Brien 209). O’Brien concludes by saying, “The schizophrenic split was a physical split of a weird kind, horrible to think about, but intriguing in a way – that in schizophrenia, splinters of the conscious mind split off and hang down in the unconscious” (O’Brien 164).

6.2.7 Jane Simpson: *The Lost Days of My Life* (1958)

The Lost Days of my Life chronicles the 13 years Jane Simpson spent being shuffled from mental institution to mental institution in London, UK. Simpson was only 13 years old when she was first committed to a mental hospital by her mother in 1939, just before the outbreak of the Second World War. Simpson was the youngest of four children with two brothers and a sister. Her father died seven weeks before she was born and she was raised by her mother and her grandfather, who would also pass away when Simpson was very young. Shortly after, Jane’s eldest brother and sister would leave the household and Simpson contracted a series of illnesses that meant time in and out of the doctor’s office and hospitalization for an appendectomy. Simpson’s mother was relentlessly verbally abusive and Jane received the lion’s share of her mother’s anger. Early in the text, Simpson recalls her mother telling the doctor that her daughter is

“defective… and how backward [she] was, how [she] would only stare at people and had to be made to talk to them” (Simpson 11). Even at a young age, Simpson was keenly aware that her “mother was not as fond of us as most other mothers were of their children” (Simpson 16).

Her first stop was a “nursing home” where she was monitored by the nurses before being transferred to her first of many mental hospitals. Simpson was initially sent to the nursing home after speaking with a doctor about her feelings towards her mother after she became ill at the boarding school where she was studying. During this conversation with Dr. Green, she suggested that she wanted to kill her mother by “pushing her off the edge of the pier” and explained that her “mind seems full of other things and how they all try to make me feel I am mad, but I am not, I know I am not” (Simpson 31). With each transfer to a new institution in response to behavioural issues, Simpson’s concept of self was weakened. She was deemed defiant, difficult, and disruptive. Simpson said she wanted someone to listen and pay enough attention to her so that they heard and felt the emotional impact of her story. Unfortunately, it would take over 10 years before the psychiatrist, Dr. Grant, took enough interest in her case to allow this to happen.

As with most of the young women who found themselves in psychiatric care, treatment was doled out as punishment in the form of chemical tranquilizers. She was administered hyoscine, which would cause her to sleep, and the sedatives bromide, chloral, and paraldehyde. Simpson was also put in a padded cell, a straitjacket, given insulin shock treatment, and electroconvulsive therapy (ECT). These were a means to terrorize her and control her outbursts. Dr. Grant introduced her to “talk therapy” (Simpson 181) and intervened to prevent her from undergoing a leucotomy, the surgical cutting of white nerve fibers within the brain, especially prefrontal lobotomy, which her mother requested to control her outbursts (Simpson 128).

Simpson was a child in an environment entirely focused on the care and control of adults, some of whom were seniors with dementia. She struggled to fit in with these women, and was expected to follow instructions, daily routines, and to talk only when spoken to. She was to behave like a “good girl” and when she did not, sedatives and physical restraints were applied. Consequently, Simpson began to question her own sanity and her humanity. She yelled: “You can’t go on doing this to me! You can’t. You

are making a hideous animal of me. Have mercy on me! Have mercy!" (Simpson 106). She had transformed from a young girl into someone she no longer recognized. She entered into her own world of "make believe" where "everything went right, where one was loved and fussed over each day, and not just once in a while… [but] as far as [her] experience of life went at the age of twenty [she] could, in fact, only return in imagination to the age of twelve" (Simpson 107). Her sense of self returned briefly during the hourly psychotherapeutic sessions six days a week with Dr. Grant. Yet, even in the process of writing her autobiography, she is "afraid that [she] still live[s] in a world of fantasy, since [she is] not brave enough to face reality all the time" (Simpson 154).

6.3 Female Vs Male Autobiographies: A Comparison

Given that the autobiographies being discussed here are all written by young women, feminist theories about autobiography may be more applicable. In *Women, Autobiography, Theory: A Reader* (1998), Sidonie Smith suggests that the female autobiography proposes a different "relationship between subjectivity and autobiographical practice" especially those written by women "excluded from official discourse, [who] use autobiography to "talk back," to embody subjectivity, and inhabit and inflect a range of subjective 'I's" (16). Jill Conway states that often women's accounts "come from a culture of inferiority … [and that] our culture gives us an inner script …" (*Women, Autobiography, Theory* 4-6). The autobiographical accounts of the women being discussed here may be examples of a shift in cultural awareness or norms as they pertain to the increasing roles women begin to play within that culture. Additionally, critical race theorist Richard Delgado (1939 -) presents what I see as a supplemental argument with his concept of counter storytelling. Delgado asserts "Every well-told story is virtually an archetype - it rings true in light of the hearer's stock of pre-existing stories" ("Storytelling for oppositionist and others" 70). Furthermore,

> Stories, parables, chronicles, and narratives are powerful means for destroying mindset - the bundle of presuppositions, received wisdoms, and shared understandings against a background of which legal and political (and educational) discourse takes place.... Ideology - the received wisdom - makes current social arrangements seem fair and natural… [and] Stories build consensus, a common culture of shared understandings, and deeper, more vital ethics. But stories and counter-stories can serve an equally

> important destructive function. They can show what we believe is ridiculous, self-serving, or cruel. They can show us the way out of the trap of unjustified exclusion. They can help us understand when it is time to reallocate power. They are the other half - the destructive half - of the creative dialectic. (p. 61)

These autobiographical narratives, when viewed as counter stories, provide a cohesive argument for the growing sentiment emerging against the asylum, psychiatry, and the tyranny of the case file to take control of their story and definition of self for the reader.

For these women, as Susan Stanford Friedman states, “writing the self shatters the cultural hall of mirrors and breaks the silence imposed by the male speech” (*Women’s Autobiographical Selves* 79). As most of the doctors in control of their treatment and release were men their voice was louder and more respected than their female patients. If their voices were silenced, except in therapy, they were found again on the page, where the women could speak themselves back to existence and assert a self that could be read, heard, and lived both in enacting normalcy to the gatekeepers and in practicing it in advance of leaving the institution.

The female autobiography as represented by the seven women presented here tends to reflect a unique situation. Typically, those autobiographies written by women are generated by women of distinction and renown such as famous literary figures such as Virginia Woolf (1882 – 1941) and Mary McCarthy (1912 – 1989) or by women of some historical significance verging on the divine such as *The Life of Saint Teresa of Avila* or Julian of Norwich’s *Revelations of Divine Love* (1343 – 1416). However, the women and their autobiographical texts being discussed here revolve around women that for the most part (besides Joanne Greenberg) reflect women of their time and the expectations of their historical situation. These young women seem to be not only caught within the expected roles of the female during this timeframe but are essentially trapped within their historical moment as evidenced by their involuntary committal to the mental hospital. Although these autobiographies originated from women confined within the institution, their importance within the socio-cultural realm signifies larger societal fissures beginning to take shape in the relations between men and women as well as between the expectations of what it means to be a “good girl” or a “bad girl”. It was Carol Gilligan in her text *Joining the Resistance*, who suggested that “caring is what good women do, and the people who care are doing women’s work” (19) and during adolescent development efforts are made to ensure that “girls become “good girls”,

those who do not are shamed, beaten, excluded, mocked, shunned and condemned – not surprising that these times in development are marked by signs of psychological distress" (27). What Gilligan described is similar to the experiences of the authors under scrutiny before they entered the institution, during their convalescence, and even after they exited the confines of the mental hospital. Furthermore, Gilligan states "adolescence [is] the time when the division between good and bad girls sets in, and reinforced by often vicious practices of inclusion and exclusion" (27). All practices of social and interpersonal manipulation spoken to and experienced by the authors discussed here as they reflected upon their own experiences. And as Jerome Bruner (1915 – 2016), American psychologist states "everyday life can be understood as an ongoing narrative negotiation … articulated in collaborative everyday projects, such as family stories and interactions" (qtd in *Women, Autobiography, Theory* 32). Evidence of such adolescent angst and trauma can be found in the pages of these authors, especially as they reflect back onto their childhood. For instance, Renée in *Autobiography of a Schizophrenic Girl* recounts her growing fear and the growing sense of her mother's disappointment: "a girl, hardworking and full of responsibility (I managed a household of six persons on a pitiful budget, educated my brothers and sisters, and was an excellent student), I felt more and more bewildered" (35). Similarly, Joanne Greenberg relates the overpowering memory of watching her younger sister asleep in her crib all the while wishing that her sister was dead and how these "ghosts of the past clutch at the present" (*Rose Garden* 98). Yet, for these young women such memories, though seemingly banal, build themselves up from mere thoughts and innocent day dreams to the point that these memories take on an aspect of unshakeable reality, at which time they construct their inner defenses. For both Renée and Joanne these defenses consisted of alternative realms of reality. Renée's world was what she referred to as the Enlightenment which was her "perception of Unreality… the 'Land of Light' because of the brilliant illumination, dazzling, astral, cold, and the state of extreme tension" (45). Joanne's refuge from reality was the "Kingdom of Yr" where she experienced "no emotion to endure, no past or future to grind against" (11). These were the spaces of madness and unreality that many of these women retreated to during times of turmoil both inner and external. They also reflect a growing struggle between the wider societal expectations being heaped upon them as well as expectations from their families.

These autobiographies as stated earlier are unique in their nature not only because they are written from the perspective of an individual with schizophrenia but even more so because they are a reflection of the experiences of several young women coming into adulthood during a time of socio-historical upheaval. While this dissertation focuses on autobiographical accounts of women diagnosed with schizophrenia, male narratives were also published during this time period, such as J.A. Howard Ogdon's *The Kingdom of the Lost* (1947). And as this period was drawing to an end Gregory Stefan's *In Search of Sanity: The Journal of a Schizophrenic* appeared in 1965. Both were preoccupied with fixing the mental health system —from diagnosis and psychiatric therapy to asylums and surgery or pharmaceuticals— and thus were more prescriptive than reflective, looking outward to solutions rather than inward to rebuild the self.

Ogdon was a graduate of London University where he studied academic psychology and Eastern philosophy. Ogdon declared his account set him apart in that it was: "My own facts… the first time that schizophrenia has been written-up from the inside" (25) and that he was "the only person who has been cured at this stage, who has been snatched out of the tragedy before the tragic end was reached: I am certain that I am the only man who has cured himself" (10). Ogdon voluntarily checked himself into a mental institution for two weeks the first time and his recollection of the hospital matches those of the female authors shared here. He states:

> I remember the dank, chilly corridors, the reek of paraldehyde, the shouts and screams of patients, the bleakness of the wards, with rows of awkward-looking beds, the uniforms of the male nurses (they look just like warders), the acrid and sour stench of cooking, the blasts whistles (patients on the courts—or exercise grounds—are controlled by whistle), the grotesqueness and utter blankness of the patients (103-104).

Ogdon's second stay lasted two years when he was "a certified lunatic" committed to the institution by the town magistrate who issued him a Certificate of Lunacy (103). As in the female autobiographies, he describes in detail the process whereby he became an inmate. He was stripped of his clothes and placed in hospital clothing "M for males, F for females" (127) with their corresponding ward numbers stamped onto them. He was "(without limit in time or degree) incapable, irresponsible, and constrained" to the point that "you go to the lavatory under escort, you pass water under observation [and] if you are not washed you do the job for yourself under the

vigilant eye of the ward-nurse" (126). The individual is lost within the ward system, first patient, then inmate.

Ogdon carefully observed the interaction between patient and hospital personnel reporting that "the mental institution is a refuse dump for the unwanted and the aged… that there is no time limit to treatment—and there is no treatment… the numbers of the patients, and the conditions, make it impossible for the doctor to know more than the outlines of the selected cases" (160-161). Ogdon described the futile efforts of the mental hospital staff to "cure" the insane under conditions that severely limit opportunities for success. Ogdon concludes "institutional life lends itself to tyranny" (164) and that "mental institutions… are probably what they were originally intended to be: places where the mentally infirm are kept alive and kept out of mischief" (237). Though both male and female mental patients experienced similar conditions, I suggest that Ogdon's account is more critical in tone and seems intended to be a vehicle for instigating potential institutional reform.

Ogdon's first-hand commentary on his two years (May 24, 1939 to August 2, 1941) as a patient speak to the total institution, forms of treatment, and life on the ward and is littered with references to Jung and Freud. He quotes Freud's thoughts on schizophrenia when he states, "The 'ego impulses' are directly in conflict with the real world; the 'super-ego' is not much infracted, but the ego suffers most, in the regression (or withdrawal) of instinctive aims the 'ego' builds the phantasy-wall to keep reality out, and the 'libido', or motive power, is fixed exclusively on the ego—on one's intimate self" (21). Ogdon is familiar with Freud and seeks answers to his own inner turmoil through self-analysis.

Ogdon also practices yoga and credits it and other aspects of Eastern philosophy for his recovery from schizophrenia. Yet even with these resources he considers himself "very lucky in being able to piece things together again in the later years… [putting] in many hours of work on old diaries, using a principle of dates, tracing back sequences of wild ideas and chaotic impulses, checking the reason I offered myself for doing certain things, and trying to find real psychological meanings" (45). Though Ogdon's autobiographical narrative makes casual reference to self-analysis, it doesn't go so far as to conclude the act of writing provided him a means of reconstructing his self.

By contrast, Stefan's *In Search of Sanity: The Journal of a Schizophrenic* (1965) largely eschews the development of the self to focus almost exclusively on a critique of psychiatry. Stefan was 29 when he entered a private sanitarium. He was a college graduate who majored in Journalism and was working full-time as a "financial writer with a public relations agency" (16) in addition to part-time writing positions. Stefan was busy, newly married, and supporting his family when he felt the "illness began to take hold… very subtly at first… [and] noticed it first in [his] writing" (14). His first mental break was marked by fatigue, insomnia and physical aches and pains. Stefan reported he "seemed tired all the time [as well as] a terrible kind of desexualisation (sic), a loss of masculine identity" (19). Stefan went to a psychoanalyst at the recommendation of his family doctor, though he acknowledges his mistrust of them: "Psychoanalysts have an annoying habit of ignoring all the facts about a patient except those that conveniently fit into their theory about him" (13). This suspicion only deepens as Stefan reads study after study attempting to better understand his own disease. Stefan quotes British psychiatrist William Sargant when he says, "One has only to go today into the mental hospitals of the United States to see the total failure of Freudian methods" (230). Stefan becomes convinced that schizophrenia is "both a spiritual and a biological crisis" (209) he felt must be tackled by chemical means as it was "all metabolic after all" (186).

Stefan's two years within the institution cost him a great deal. As he explains, "When I was at last discarded from the sanitarium, it was like jumping out of the hell of unreality into the hell of reality. The illness had destroyed my marriage; it had cost me my wife, my home, and my job" (180). Yet he was still experiencing many of the same anxieties he'd felt before he entered treatment. He had lost confidence and the prospect of looking for work was terrifying. Stefan's suicidal thoughts resulted in seeing a psychiatrist who prescribed him tranquilizers and anti-depressants while undergoing psychotherapy, though this too failed to provide any lasting effect. Stefan like many of the female authors was incapacitated by his disease and by the treatments prescribed.

A year after leaving the sanitarium, Stefan found Canadian doctor H.P. Jones who believed "schizophrenia was caused by an error in metabolism, probably genetic, that results in the production of a brain poison [which] creates disturbances in perception, changes in mood, thinking, feeling and behaviour… no one was to blame" (214). Stefan describes his coming to terms with schizophrenia and his recovery as the result of getting "away from myself… to stop thinking about myself and the past and all

my symptoms" (221). Nonetheless, he "would lie on the bed studying the walls and the photographs of former selves that [his] mother prized. Greg Stefan as a child… Greg Stefan on a pony… Greg Stefan in his high school cap and gown…" (199).

Both male autobiographies discussed above share similarities with each other, as well as to the much earlier autobiographical accounts of Clifford Beers, *A Mind That Found Itself*, (1908) and Daniel Paul Schreber's *Memoires of My Nervous Illness* (1902), which were written well before Stefan's and Ogdon's. All four male autobiographers were university trained and all but Schreber had their initial mental breaks in their mid-twenties, whereas Schreber was 42. All were proactive in attempts to direct their care and claim to have recovered even though evidence suggests this is unlikely. By contrast, the women hadn't attended college or university (due to youth and social convention) and entered mental institutions when 13-25. They also had very little ability to direct their own care and considered treatment punishment and only a couple of the women "recovered" or more likely went in remission.

However, all of these authors did experience the terror of living within a mental institution with no effective treatment or cure. They all also speak to and about the concept of the unconscious as a repository of childhood memory triggered by events in the present.

Ogdon references the spilt mind as a division between the conscious and unconscious mind: "the mind (considered as a practical mechanism) is shattered inwardly and 'goes to pieces'" (*Kingdom of the Lost* 18) and gives "rise to dominance of the total Unconscious" (29). Ogdon was "convinced that [his] Unconscious mind was behaving like a living entity, to make the real world so nasty a place that [he] should be glad to live in the confines of [his] own delusions" (67). Here their conscious mind is a link to reality, while the unconscious mind is a link to reminiscences of the past. This to-and-fro between the present and the past created a fluid self where the former self seemed to overtake reality as described in Stefan's descent into madness: "My mind is clear; there's only one self—myself, my former self" (*In Search of Sanity* 44). Stefan seems to be addressing relatives whose impressions of him have changed despite the fact he remains convinced he is unchanged.

As noted in the earlier discussion of Freud, O'Brien speaks of the unconscious mind as an "operator" that controlled her thoughts for her own good: "What was important was that my unconscious even if it went about its business in seemingly strange ways, was aiding me, a health manifestation" (*Operators and Things* 125). Jefferson writes of the unconscious as a female entity: "She mocks the shadow of my former person… and I still am divided. I cannot truly forsake all the old ideas as long as their memory stays with me" (*These are my Sisters* 22). She adds, "It seemed obscene and terrible that I should answer in adult language, things said to me in my childhood… things I had forgotten, until they again began to pour about me in a flood of bitter memories. Even incidents I remembered clearly came back so warped and twisted they seemed like evil changelings" (214). These split minds largely remain so, toggling between past and present until the dividing line becomes more fixed and reality itself more stable.

Both male and female autobiographies explore this split and are critical of the psychiatric treatment that attempts to treat it, though the women tended to apply the analysis to heal the divided self, whereas the male writers focused on correcting the whole practice of psychiatry, especially as it pertained to psychoanalysis. Stefan lists the competing theories as a means of discrediting the profession:

> Before I was hospitalized I had read numerous psychiatric theories about the cause of neuroses and psychosis. The primary cause is lack of love in childhood, said one analyst. No, said another analyst, it's caused by a weak ego. You're wrong, said a third, it's an impairment of the superego. Bosh, it's really an impairment of the id. You're all wrong and you're all right, said still another, it's an impairment of all three psychic levels. The collective subconscious of the race has something to do with it, said another. It's conflict between love and hate, intoned still another. Conflict between husband and wife. Conflict between father and child. Conflict between mother and child. Conflict between subconscious and conscious. Conflict between homosexual and heterosexual drives. Conflicts between the individual and society. And, of courses, these conflicts had to be "resolved" before a cure was affected. (*In Search of Sanity* 156-157)

Stefan suggests the dubious focus on past interpersonal conflict and previous social behaviour is better replaced with a focus on alleviating mental illness through drugs. Stefan states, "The chlorpromazine quieted and stabilized me substantially and allowed me to function…" (157). He suggests that all of us operate along a sliding scale from sanity to madness with shifts that can be both subtle and dramatic. This is a theory

long acknowledged, going back nearly a century to 1860 in which an “unnamed inmate” from the Glasgow Royal Asylum for Lunatics at Gartnavel suggested that “the line which separates sanity from insanity is invisible, and there are as many kinds and degrees of the disease as there are sufferers” (*The Philosophy of Insanity* 16). Insanity may present as hallucinations, delusions, and lack of emotional affect as well as a constellation of other symptoms.

However, Stefan’s point remains. If “conflict” presents itself as such a predominant theme towards our understanding of schizophrenia or mental illness in general, then how do the female autobiographers incorporate the concept of conflict within their own narratives, and how does conflict integrate into the construction of self? Once again, the answer is both multi-faceted and multi-layered as it plays into Goffman’s conceptualization of self as being much more than just the masks we wear. The self, at any given time is also the product of the situation in which one finds oneself, especially if we begin to take into consideration the trauma and other conflicting memories that may percolate to the surface, even when most unanticipated by the individual. Situations of conflict, as described by Stefan, are important to recognize, and provide us with the means to formulate pathways of understanding which these women autobiographers attempted to demonstrate.

Conflict, as a concept, I believe is of utmost importance throughout their individual narrative accounts. It is reflected within the micro-nuances of the author as generated through their recollections of trauma both from childhood memories, and the more recent accounts of those traumas inflicted upon them by institutionalization and their subsequent treatment. Such individualized conflict is not only internalized, it is also externalized in various forms of behaviour which then become recognized by the field of psychiatry as symptoms of schizophrenia.

However, the affects of conflict are not just linked to the individual as patient within the mental institution. Conflict also raged between the numerous psychiatric modes, and factions present at this time. Not only was there discord between various groups of psychoanalysts. Disagreement persisted and was exacerbated amongst the psychiatric community as some psychiatrist pushed for surgical interventions such as the continued use of the lobotomy. Others in the psychiatric community foresaw the emergence and use of psychopharmaceuticals as the pathway to a possible cure. The

anti-psychiatry movement meanwhile developed from the general mistrust of psychiatry and its power over the mental patient, focusing specifically on psychiatry's ability to involuntarily commit individuals to the institution and then implement a treatment regimen. We saw this portrayed in the accounts from both Greenberg and Simpson whose committals came at the behest of the family.

The role of the family and other societal influences are crucial factors in the struggles highlighted by the autobiographical material presented by these women all of whom faced changing societal expectations in this particular timeframe. Each of them had difficulty finding and fitting into the roles they may have been expected to play. They also had trouble understanding the intricacies involved in successfully navigating different life scenarios such as changing schools, working in a male dominated office, or becoming an older sister. Often, as these women found out, life may happen within the scene, yet it is what goes on behind the scenes that is frequently of more importance, and these scenarios change as individuals get older.

According to Susanna Egan, the writing of most autobiographies tends to follow four main narrative time periods: childhood, youth, adulthood, and old age. It also pursues three familiar motifs: "the journey, conversion, and confession with all three recurring metaphors following an overarching schema of birth, life and death" (*Patterns of Experience* 4). Egan goes on to say "that the scheme any autobiographer chooses provides a shape for his narrative. It also provides a meaning. The formula of anticipation, recognition, and fulfillment is matched by the formula for separation, initiation, and return borrowed from the rites of passage and described by Vladimir Propp as part of the total action of every folktale" (21). Renza provides a similar textual breakdown by separating autobiographies into types: "memoir, confessional, and narcissistic" (*Autobiography: Essays* 280). First, the memoir depicts situations and experiences as representing important stages in the development of the author's overall life as they pertain to the present. The autobiographer "uses language to declassify information about his life; he uses langue (the socio-cultural construct which grounds speech activity) to apprehend his own life as an intersubjective phenomenon" (280). The confessional mode is described as a drawing from the past in order to explain why the author is the person they are in the now. As Renza suggests, "the autobiographical writer no longer fully entrusts his life to the present, organizing thrust of narrative or ideological conventions; rather, he intuits how his writing is a sketchy, arbitrary rendering

of his life (281). Lastly, the narcissistic mode can be outlined as the author's attempt to recreate from a life lived its own self determined character. In this mode "the writing self tries to transform the self-privacy yielded by the autobiographical act into a sui generis principle of self-identity" (289). Even though these autobiographical modes seem to be neatly organized into their own separate categories, the autobiographer often combines modes weaving the threads of experience into a presentable whole.

Given that the autobiographies being discussed here are all written by young women constrained by psychiatrists and subjugated in the mental institution, other more feminist examples are worth a brief mention. Sidonie Smith as quoted in *Women, Autobiography, Theory: A Reader* (1998) suggests that the female autobiography proposes a different "relationship between subjectivity and autobiographical practice" especially those written by women "excluded from official discourse, [who] use autobiography to "talk back," to embody subjectivity, and inhabit and inflect a range of subjective 'I's" (16). Jill Conway states that often women's accounts "come from a culture of inferiority … [and that] our culture gives us an inner script …" (*Women, Autobiography, Theory* 4-6). The autobiographical accounts of the women being discussed here may be examples of "cultural rebellions" against the asylum, psychiatry, and the tyranny of the case file to take control of their story and definition of self for the reader. These women also reflect not only a rebellion against the mental institutions in which their bodies are caged; they also represent a stance against the psychiatric system that has constrained and manipulated their minds. Each of these autobiographers has to some extent been harmed emotionally and physically by the institution and its representatives in the attempt to control those actions and behaviours that may have seemed out of sync with the times. To be incarcerated within the walls of a mental institution at this time was not uncommon for women whose husbands, fathers, or mothers found them too difficult to handle. They were not necessarily troubled; rather these women were viewed as trouble makers, and the mental institution became a method for controlling such behaviour.

Assessing the accuracy of the author's lives before institutionalization, and even during their confinement as given in the autobiographies is even more difficult. The reader is expected to trust the account as written because of its autobiographical nature however, all of these women have been diagnosed as schizophrenic and been confined within a mental institution for some duration. This alone might create some form of

hesitancy in the reader's mind, as schizophrenia is often portrayed in the media and in newsprint as an extremely disruptive form of mental illness, a disease that insinuates that the individual is not only out of their mind but unable to function. This in no way diminishes their experiences, nor dismisses the truth of their claims no matter how elusive that has been for them and the professionals treating them. RD Laing said, "To be authentic is to be true to oneself, to be genuine" (*Self and Others* 127). Yet, for the autobiographer, being authentic culminates in their ability to tell their tales of a life lived while maintaining not only a thread of truth but also a storyline that potentially engages the reader so that they will read on. Such threads of truth as presented by the author are established through the framing and presentation of those vignettes of life deemed important enough for relating to the reader. At the same time, the author needs to ensure that these vignettes are woven together in a format that is familiar enough that it draws the reader into the text. Vladimir Propp provided the potential for understanding just how this can be accomplished with maintaining an air of leaden authenticity.

Chapter 7. Conclusion

> *"Yes, I am ill. But there are dozens, hundreds of madmen walking around at liberty, simply because you, in your ignorance are incapable of distinguishing them from the sane." —Anton Chekhov 29*
>
> *"Is the self – not to mention the world – merely what we imagine it to be, a fictional extrapolation from the flux of experience, a name devised to stem the tide of the irreducible heterogeneity of things?" —Freeman 70*

At the start of my research, as my thoughts and ideas began to take shape, I considered the key concepts of self, autobiography, and even schizophrenia to be relatively simple, or even common, with little need of further explanation in the belief that most people would understand what is meant by their usage. However, as I worked my way towards understanding the central question the thesis dealt with – "How the autobiographer diagnosed with schizophrenia implements the language, theories, and practices contained within a shifting period of time to re/construct a sense of self?" – I soon realized that these three concepts are not simple terms at all. I also grasped the underlying thread that was interwoven throughout these autobiographical accounts was the almost mythical like journey towards recovery along with its overlapping and intersecting concepts of self, the diagnosis and treatment of schizophrenia, and what can only be termed the desire for normality.

In order to develop an explanation of the schizophrenic re/construction of self built from the autobiographical processes involved in the narrative nature of being I had significant work ahead of me. I needed to undertake a multi-pronged attack not only on the concept of self but also the ideas swirling around the literary notions of autobiographical narrative. To do so, I began in Chapter 1 with an overview of the theoretical landscape surrounding the literary term autobiography and what constitutes a "real" or authentic autobiographical account. Thus, I determined that the autobiography provides the author with the means to re/construct a sense of self through the use of language thereby providing the individual with a means of becoming. Moreover, this process of becoming is often reflected in the psychiatrized language that these authors implement as a means to grapple with their horrific experiences.

Then in Chapter 2, I proceeded to sketch an overview of psychiatry's historical features related to its diagnostic attempt at defining and labeling abnormal behaviour and the subsequent forms of treatment applied to those diagnosed as mentally ill. Specifically, I presented an account of the ever-shifting nature of the diagnostic criteria as it applied to schizophrenia. I then focused on the treatment of those deemed mentally ill and the specter of the institutions used to incarcerate the mentally ill. Lastly, I outlined the three competing theoretical and interwoven spheres of psychiatric theory that influenced the drafting of these autobiographies. These three spheres were 1) the realm of psychoanalysis – expressly Sigmond Freud's psychoanalytic theories, 2) the anti-psychiatry movement and the shifting dynamics related to the conceptualization of the patient needing to be cared for within the walls of the institution to that of the psychiatric survivor wanting more control over their own "illness", and 3) the increasingly dominant use of anti-psychotics as a means to "cure" the mentally ill. While these three spheres of influence were certainly not neatly separate in their influence over the mentally ill, they did, as I have demonstrated, greatly influence the language contained within both the autobiographical narratives and the very concept of self as it emerges from these works.

Chapter 3 is dedicated to Sigmund Freud and the large shadow his work cast on the field of psychiatry both in its theoretical influence over the cause of mental strife but also its influence over the treatment applied as means of a cure. The areas of Freud's impactful importance I focused on were the language and terms derived from his work as these appeared in the autobiographies I reviewed, and the psychoanalytic application of his "talk therapy" as a crucial mode of treatment widely used in the period of time I studied. I demonstrated that although Freud may have focused much of his theoretical work on assisting those individuals diagnosed as neurotic, the foundation of his ideas could and were also applied to the psychoses by such analysts as Frieda Fromm-Reichmann, Herold Searles, and Harry Stack Sullivan. These three analysts had success treating schizophrenia through intensive, long-term analytic sessions. One such success was presented by Joanne Greenberg in her book, *I Never Promised You a Rose Garden*, where Joanne discusses how her treatment sessions with Frieda Fromm-Reichmann helped her to work through her inner demons. It was also Fromm-Reichmann who suggested to Joanne that she should write out her struggles during those analytic sessions and produce an autobiographical account of her own success.

This chapter also initiated the shift towards understanding the concept of the "self" and how psychoanalysis provides a means for re/constructing a sense of self.

Vladimir Propp's contribution takes up Chapter 4, which offered me the opportunity to understand and apply the overarching notion of myth as it pertains to the construction and writing of the autobiographical narrative, specifically as it applies to the re/construction of the narrative self. Propp's morphology of the folktale supplied me with the single most important piece of the puzzle needed for not only connecting the autobiographical material together but also for generating an understanding of the possible motive behind why these seven women undertook the writing of their autobiographies – the notion of return and the myth of such a return. But what was it a return to? I determined that this desire for a return was a response to a multilayered overwhelming loss of self. For these seven women this desired return included: a return home, a return to their family, and friends, a return to work and their community, but most of all it seemed to signal a return to normal. And, if this idea of the return hinged on the larger ideal of normalcy, then I realized that the myth of such a return formed an even greater role in the entirety of the narrative process.

In Chapters 5, I focus on the two major thinkers I employed to ground my dissertation, Erving Goffman, and Michel Foucault. Erving Goffman supplied me with the theoretical references connected to his work on frame analysis, the presentation of self, and how those roles played out within the total institution. According to Goffman, "the self is the code that makes sense out of almost all the individual's activities and provides a basis for organizing them" ("Insanity of Place" 374) and in so doing allows the individual a "means of retaining a constancy of image" ("Insanity of Place" 374). Goffman also states that it is these activities and behaviours that are anchored within the individual's situational experience or the framing of that experience such that, both the "temporal and spatial brackets… like the wooden frame of a picture, are presumably neither part of the content of activity proper nor part of the world outside the activity but rather both inside and outside," offering us a rather "paradoxical condition" (*Frame Analysis* 252). Thus, the self is continuously being re/constructed both from within [prior experience] and from the outside [current experience]. The individual must either assume or reject these redefinitions of selfhood according to the social norms and expectations acting upon the individual at that time.

While Goffman's theoretical stance supplied a vision of the individual on a more micro level – often face to face interaction, Michel Foucault provided the heavy lifting necessary to understand those macro socio-historical perspectives as related to the discursive practices, those power imbalances as contained within the roles and language of the institution, as well as the surveillance experienced by the mental patient. Foucault's concept of self is built around the notion of power, specifically the idea of social technologies related to the institutional manufacturing of knowledge and control as it acts upon the individual. During his lecture at UC Berkley (1983) on the "Culture of Self," Foucault sets out his concept of self as complementary to Goffman's ideas. Foucault points out that:

> the self has been integrated in our world of educational and pedagogical, medical, and psychological techniques. The techniques of the self have been embedded either in some authoritarian and disciplinarian structure or substituted for and transformed by public opinion, mass media polytechniques which play a formative role in our attitude towards the others and towards our self so that the culture of the self is now imposed on people by the other and the culture of the self has lost its needed partners. (www.openculture.com/2014/08/michel-foucaults-lecture-the-culture-of-the-self.html)

Therefore, Foucault like Goffman views the individual as a self, operating within the framing constraints of larger societal expectations. However, Foucault's constraints branch out beyond Goffman's seemingly tighter boundaries of family and community towards the ever-expanding frontiers of knowledge controls such as science, medicine and government. This offered me the opportunity to utilize both perspectives as a means for understanding exactly how the schizophrenic as autobiographer can re/construct and re/build a concept of self, even though they may be constrained by the dynamics of the larger institution of control acting upon them by the prevailing psychiatric sphere. They are also liberated by this technology of control through the appropriation of the psychiatric discourse. Although intended to diagnose and label them, it also offers a means of rewriting the self so that their constructed image reflects that sense of normal being sought by the very institution incarcerating them.

Finally, in Chapter 6, I undertake an excursion into the world of schizophrenia as expressed and experienced by the seven women whose autobiographies take up the bulk of my analysis. Through a close reading of these self narratives, I demonstrated an overarching connection related to the language, images, and themes used as a means

to re/tell their stories. Specifically, I revealed that the autobiographical material laid bare the notion of connection between the psychiatric mode operating at the time of incarceration and the influence of the language of psychiatry which these women applied throughout the telling of their stories. For example, those women writing during the psychoanalytic dominated sphere of institutionalization frequently referenced such terms as the unconscious, regression, and transference (*Autobiography of Schizophrenic Girl*, *Lost Days of My Life*, and *These are my Sisters*). In addition, the imagery and delusional recollection contained within their narratives was interlaced with a pattern of three which could be specifically linked to the concept of one's ego, id, and superego (*Rose Garden*, and *Operators and Things*). Although, one could suggest that these connections may merely be the result of the author picking up the language that pervades their existence while housed in the mental hospital, I reckon that the insertion of such language underscores the myth making processes operating in the production of these narratives of self.

As storytellers, these women relied upon a formula to tell their story not only to the reader but also to themselves. They then adopted, perhaps unconsciously, the stylistic formula of myth because it provided all the elements necessary to tell and retell one's story. I also began to realize that if our internal dialogues are built on multiple layers of memories extracted from previous experiences, and the emotional carnage attached then perhaps these layers require a foundation from which they can be collected and recalled. The mythic structure of story telling formed such a foundation.

Myth and its structural components form the gesso layer from which the narrative layers of self can be assembled. For the autobiographer, each memory and every experience attached to this memory forms a layer which when laid down on top of each other in succession form the sediment of self. However, this sediment happens to be in a constant state of upheaval as it is disturbed by the emotional and physical attacks on the mind and body. This emotional upheaval then provides the dynamic nature associated with memory especially as the individual attempts to rewrite the self through the stories told and retold to oneself as inner dialogue and eventually for those undertaking the writing of self, the autobiographer.

As I stated, these philosophers provided the superstructure necessary for the assemblage of understanding the autobiographical material and the role each narrative

played in the construction of self. However, it would be the work of Sigmund Freud and his vast assortment of psychoanalytic terms which allowed for the interconnections required to formulate a cohesive understanding and explanation. The language of Freud overflowed from the autobiographical material I analyzed which then formed the thick descriptions of these autobiographical narratives, even though these autobiographies were often based on the thinly veiled layers of truth brought back into reality by the author's memories and recollections.

These memories and recollections would then form the source material from which these seven women would retell their experiences not only in autobiographical form but throughout their time within the mental hospital to doctors, psychiatrists, nurses, care attendants, and even other patients. And, from these tales of anguish these women would re/construct a sense of self based upon the many layers of memories manufactured from the experiences of childhood loss, and adolescent wrongs as committed against them by the myriad of people that came and went during their upbringing. In the end, they all wanted and sought a return to normal.

It is the myth of normal and the idea of such a return that I determined comprised the nature of these women's autobiographical accounts and their attempts to reconstruct a sense of self through the narrative format of writing. However, the success of this reconstruction of self was severely compromised by the application of the label 'mentally ill,' particularly as that label was exacerbated by the term schizophrenia.

The politics of diagnosis for these seven schizophrenic women was especially turbulent during this ten-year period, contributing to the rise and fall of psychiatric practices that favoured, pre-1960, first Freud's understanding of ego, the unconscious, and oedipal overtures that blamed mental illness on poor parenting by the patient's mother. Those autobiographies written in the mid-1960s spoke of increasing psycho-pharmaceutical dependence to counteract biological imbalances in the brain. Finally, the autobiographies that came after 1960 reflected the rise of the anti-psychiatric movement and the view that mental illness was a reaction to societal expectations.

Though the autobiographies appear linear in their progression, this structure may be the author's attempt to meet the expectations of the intended reader rather than to relate the story as they experienced it. As we have seen, the dynamic nature of the

schizophrenic mind might be better represented by a cyclical or spiral structure that reveals how the looping or spiraling nature of becoming incorporates memories into the perpetually changing present.

This present self is then in a constant state of flux, and the syncopation, melody, and mood of the mind maintain a sense of harmony. When this harmony is disrupted by a polyphony of discordant voices, images, and thoughts, the distortion of these memories has profound effect. As in Plato's discussion of memory, it is clear that our minds are selective:

> …whenever we wish to remember anything we see or hear or think of in our own minds, we hold this wax under the perceptions and thoughts and imprint them upon it, just as we make impressions from seal rings and whatever is imprinted we remember and know as long as its image lasts, but whatever is rubbed out or cannot be imprinted we forget (*Theaetetus* 191).

As seen in the autobiographies, the schizophrenic patient attempts to reconstruct the person they were prior to their initial break from this imprinted memory, a distinct yet distant person of their "normal" past. Yet this self as they remember her is often out of sync with the self others in their family remember and so becomes an amalgam of both her own memories and those of others as well as the heroines of the myths, fairy tales, folktales, and other stories familiar to them as children. If the women adopted this framework subliminally, it is not surprising that they would stage the story of their illness through Propp's sequence of descent, passage, and return. This return is to normalcy and to the home and family that recognizes them as reasonable reproduction of that former person.

Through the act of writing, these overlapping social, cultural, and political frames combine with memory to allow the author to reproduce a self they want to portray both to themselves and to the reader. This reconstituted self is a rehearsal, a way of maintaining the well-being she must project to those around her to manage the illness.

In reading the autobiographies I have attempted to focus not only on how their experiences are expressed, but also be keenly attentive to what is being expressed by these authors. This includes intuiting emotion and reading the language of psychiatric discourse woven throughout. The analysis of the narratives written by these female authors during the 20-year time span 1945 to 1965 reflect the influences of the socio-

cultural dynamics of that era. Though these seven may not have the same historical significance or readership as those written by more famous authors, they make a compelling case for the return home, not only in the sense of Homer's *Odyssey*, but the more profound and complicated return to normal. Though the psychiatric establishment maintains schizophrenia is incurable, and even remission is optimistic and fleeting, this normal seems more possible after reading these works. Rather than obsess over the distinctions between sanity and insanity, it seems more likely that normalcy resides at their intersection.

The autobiographical truth is that the author-as-subject, the author-as-narrator, and the author-as-audience are united in the patients here, making their act of writing serve multiple purposes and outcomes. As she writes "I was," "I am," and "I will be" she offers an alternative to her case history, and the psychiatric documents that make up her file. The overlapping of memories and carefully selected vignettes come to constitute a new truth, a new self fashioned from the old and from the influential world around her.

Our memories are highly adaptive and can be made to serve our purpose in times of need, and modified to suit our own stories when required. Feelings of guilt and shame can be re-written to put ourselves in a better light, to make ourselves feel better. Memories can also be corrupted by time, as emotional attachments lessen or as we incorporate the tales of others into our own recollections. Our stories, our narratives, our autobiographies are all tenuous tales of fiction at best, draped in the veils of truth. Are we to mistrust our own musings, or merely invest in continuously interpreting and reinterpreting our thoughts and actions? Though the authors here have constructed narratives that have faltered with misinterpretations, confused thoughts, and regrets shaped by traumatic events both real and unreal, they nonetheless have also held truths strong enough to establish a saner self.

Antonio Damasio in his TED Talk "The Quest to Understand Consciousness" declares, "The autobiographical self is built on the basis of past memories and memories of the plans that we have made; it's the lived past and the anticipated future. And the autobiographical self has prompted extended memory, reasoning, imagination, creativity and language" (March 2011). What Damasio makes clear is that though the search for self is elusive it is no less valuable. As we puzzle through a discourse in our minds, we are active agents of our own destiny, and we have only the tool of language, written or

thought, to do so. As Ricoeur reminds us, “Language is the great institution of the institutions, that has preceded each and every one of us [along with] the interpreted past and the interpreted present” (221). Language allows us to recollect and ruminate, to ponder and plan, to formulate a future beyond the constraints of the now. Thus, those self narratives in their mythical structure and form are then actualized as discourse which “takes hold in structures” according to Ricoeur, “calling for a description and an explanation that mediate understanding … to the point where structural analysis discloses the depth semantics of text, before one can claim to understand the text in terms of the matter which speaks therefrom” (*Hermeneutics and the Human Sciences* 53). It is this amalgamation of the autobiographical aligned with the foundational aspects of Propp’s morphology, the structural components of Goffman’s frame analysis, and Foucault’s claims surrounding those discursive practices that comprise psychiatry which allow for the deeper understanding of the re/construction of self. A re/construction of self, that I put forth is carefully woven together within the autobiographical by the integration of the language and concepts generated from the shifting psychiatric spheres of influence.

The fact that these women created a published legacy written within the restrictive world of Goffman’s “total institution” and overcame the stigma of schizophrenia is no small feat. In so doing, they exposed countless acts of violence in the name of psychoanalysis and psycho-pharmaceutical treatment. By carefully considering the discourse in these narratives, it became clear how each author drew upon the psychiatric language of the time in order to construct an identity, both within the institution and outside its walls. Through their own audacious writing they reclaimed the language of the psychiatric field to take control of their lives. And thus, as the narrator of their own stories, they drew upon complex dynamics of writing about oneself in order to re/create a sense of becoming that what they ultimately viewed as normal.

Epilogue

> *"… the typical schizophrenic lives in a world of twilight imagining. Marginal to his society, incapable of holding a regular job, these people live on the fringes content to drift in their own self-created value system. I said, that's it! That's it! Now I understand!" – Terence McKenna*

I can recall the exact moment I realized Stella, a former client, desperately wanted to be normal. She was volunteering in her community, for the first time outside the regular routine of her sheltered workshop, where she assisted a not-for-profit agency with a mass mailout. Each day we would take the bus to and from the site. One day we had this brief conversation.

Stella: I don't understand why I have to be this way?

JJ: What do you mean by "this way"?

Stella: To be so different.

JJ: Different in what way? I don't understand what you are trying to say.

Stella: (with tears in her eyes) To be handicapped.

I went on to explain that she was not her disability. She was more than the label applied to describe it. I enumerated the many wonderful characteristics that made up the person I knew as Stella: her humour, care, friendship, volunteerism. I talked about her various skills and abilities. We continued to talk.

Stella: (listening carefully) But why me? Why do I have to be handicapped?

JJ: It is simply what makes you unique. It is what makes you the Stella that I know.

Stella: But I don't want to be handicapped any more. I just want to be normal.

Stella returned to her seat at the table in the sheltered workshop that she had attended for the past 20 years. Her insatiable desire to be normal, to be like everyone

else, was heartbreakingly palpable. This conversation still haunts me because I was unable to provide her with what she wanted. Upon reflection, I realized I had unintentionally equated Stella's desire to be normal with having the skills and abilities to be a competent employee, to contribute on economic terms. What I didn't want to see was her yearning to be anything but "handicapped." She was unhappy with who she was and saw herself as the diagnosis used to describe her rather than the sum of the story of her life still unfolding… still in a process of becoming.

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