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FEAR OF COMPLEXITY AND THE MENTAL ILLNESS MEMOIR

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ABSTRACT

I write this essay in response to a question that has captured my interest for some time: what do memoirs written by people who have experienced mental illness have to say about current attitudes towards behavioral and psychological dysfunction? To answer this question, I examine two memoirs published in the past two decades: Barbara Taylor's *The Last Asylum: A Memoir of Madness in Our Times* (2014) and Andrew Solomon's *The Noonday Demon: An Atlas of Depression* (2001). I chose these as much for their high-caliber writing and vivid narratives as for the authors' emphatic scrutiny and reasonable criticism of practices, establishments, and assumptions vis à vis their illnesses. These memoirs are more than extended ruminations on past events or vehicles for airing personal ideologies or grievances. Taylor and Solomon seek to paint a picture of mental illness that is as close to the truth as possible without resorting to caricatures or tired stereotypes. They respect its singularities and mysteries.

This ability of the authors to respect the complexity of the experience of mental illness in Western[1] countries today catalyzed the formation of my argument, which is that attitudes towards behavioral and psychological dysfunction (at least in the United States and in the United Kingdom) are characterized by a fear of complexity. The two main manifestations of this fear of complexity are simplified stories and reductive language, both of which are perpetuated in movies, books, and the media. I will examine how each memoir reacts to this fear of complexity first by choosing a specific example of a simplified story or instance of reductive language to which the author responds, and then by analyzing the narrative strategies the author uses to formulate their response. What effects might these narrative strategies or stylistic choices have on the reader, and by extension, the people living with mental illness? How does each author

[1] The adjective "Western" denotes a cultural, and not geographical, specification.

characterize their own memoir, and how does this characterization affect the author’s response to simplified stories and reductive language? Finally, how do Solomon and Taylor represent the complexity of mental illness? These are the questions that prompted me to consider these memoirs as more than bedtime reading, and to examine their role in a culture that in many ways shies away from accepting complexity.

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Chapter 1

Fear of Complexity

For the purposes of this essay, I have defined the phrase "fear of complexity" as an inability to tolerate coexisting and contradictory realities. In other words, people exhibit a fear of complexity when a situation or a problem requires them to understand that two seemingly opposing facts may be true at the same time. For example, in her memoir, *The Last Asylum*, Barbara Taylor responds to the assumption that the closure of psychiatric hospitals in the late 20th century signified the end of an oppressive, restrictive system of treatment and ushered in an era of enlightened community care models. This is a popular assumption, initially conceived by well-intentioned activists and perpetuated by frightening portrayals of asylum life in books and movies. More importantly, however, this aversion to mental hospitals stems from justifiable concerns about the realities of asylum life—care in many asylums in the US and the UK was custodial at best and abusive at worst. Taylor denies none of this. By depicting the role that her asylum—Friern Hospital—played in her recovery, however, she introduces an equally undeniable fact: for many people, the asylums provide shelter, sustenance, treatment, and social interaction. Although many felt liberated upon the closure of the asylums in the 80s and 90s, others lost their support networks and many became homeless. In Taylor's view "Conditions have to be at the extreme end of terrible [in the asylums] in order to become better than homelessness."[2] This observation nuances the assumption that psychiatric hospitals have no place in the treatment of mental illness and reveals the complexity of the subject of psychiatric hospitalization. One can wholly denounce asylums as medical prisons or endorse them as places that offer succor and shelter, but to recognize that they can represent these contradictory alternatives at once confounds those who would prefer to simplify.

[2] Taylor, discussion.

In a cultural landscape where people fear complexity, the world cleaves neatly into binaries: good and evil, normal and abnormal, healthy and sick, sane and insane. The possibility that one may inhabit multiple identities or oscillate between identities that oppose one another remains difficult to grasp. It is easier to sell a movie or a news story with a clear-cut antagonist. It might be for this reason that people attribute the prevalence of school shootings to the deteriorated mental state of the individual shooters instead of their unhindered access to semiautomatic weapons. People with mental illness are frequently the first to shoulder the blame and the last to receive compassion in regard to situations involving crimes, poverty, family dysfunction, and addiction. In fact, society has succeeded in "othering" people with mental illness so thoroughly that we conduct impressive mental gymnastics to avoid the slightest suggestion that our minds, characters, or personalities are defective. Note, for instance, the preponderance of the word "chemical" during discussions about depression or anxiety. Andrew Solomon, whose memoir I will examine in this thesis, dissects the allure of describing one's mental illness as simply the product of chemistry:

> The relief people express when a doctor says their depression is "chemical" is predicated on a belief that there is an integral self that exists across time, and on a fictional divide between the fully occasioned sorrow and the utterly random one….There is a pleasant freedom from guilt that has been attached to *chemical*. If your brain is predisposed to depression, you need not blame yourself for it. Well, blame yourself or evolution, but remember that…[c]hemistry and biology are not matters that impinge on the "real self;" depression cannot be separated from the person it affects. Treatment does not alleviate a disruption of identity, bringing you back to some kind of normality; it readjusts a

> multifarious identity, changing in some small degree who you are.[3]

In this passage Solomon describes the results of our fear of being given the value-laden label "mentally ill" as a marker of identity. Because of this fear, many people take comfort in the fallacious thought that their psychological troubles are "just chemical" and therefore they can be spared the shame thrust upon those whose troubles are not "just chemical." By that logic, they need not feel guilty; their brain chemistry, like blood sugar levels or genetic conditions, is out of their control. In a society that ignores, mischaracterizes, and alienates those whose behaviors or minds we do not understand, we resort to dualities like chemical vs. psychological to affirm our sense of normalcy and ensure social inclusion. The consequence of this is that we become blind to contradictions inherent to every human identity as well as to the inadequacy of a dichotomized model for understanding mental illness.

[3] Solomon, *Noonday Demon*, 20.

Simplified Stories

People also shy away from confronting the complexities of mental illness by relying on simplified stories, which I am defining as stories circulated by the media and the general public that are based on prevalent and/or persistent assumptions (that may or may not be accurate) and that make use of stereotyped characterizations and outcomes.[4] Film-makers resort to simplified stories when they position people with mental illness as violent antagonists, tragic or helpless characters, and misunderstood geniuses[5]. In the world of news reporting, a similarly pernicious characterization occurs after crimes or mass shootings when the media attempts to dissect the motives of the perpetrator by questioning his or her mental state. Moreover, shootings are one of the only causes that can prompt national conversations about mental illness, which leads people to associate the subject with violence, trauma, and fear. So not only do representations of mental illness occur sparingly, but because of these unfortunate associations with violence, eccentricity, and misery, the stories embedded within them tend to rely on dramatizations and stereotypes, which often lead to misperceptions.

Storytelling helps people make sense of troubling or inexplicable phenomena or behaviors. One easy way of constructing a memorable or easily reproducible story is by relying on stock characterizations. Stock characterizations simplify the job of the storyteller because ensure that the protagonists' motives and actions remain predictable, which makes the plot easier to construct and the stories message easier to transmit. These stock characterizations manifest themselves differently according to time period and cultural context, and can occur in books, film, and oral history. To use an example that illustrates the point about how some stories rely on stock characterizations to represent mental illness, take Charlotte Bronte's classic novel, *Jane*

[4] I use the terms "story" and "storytelling" throughout this thesis in an abstract sense, not in the literal sense of a tale that one would hear told or find in a book.
[5] See for example movies like *American Psycho*, *Silence of the Lambs*, *Black Swan*, *Shine.*

Eyre. A work of fiction written in 1847, *Jane Eyre* is not comparable to the memoirs analyzed in this thesis, but the characterization of Edward Rochester's wife, Bertha Mason, springs from the same kind of radical misperceptions that Andrew Solomon and Barbara Taylor still confront as people living with mental illness. In *Jane Eyre*, Bertha plays the role of the madwoman in the attic, a common Victorian-era literary trope. She is violent and irrational, and remains confined and concealed from society. Her existence is a painful burden to Rochester and an impediment to his union with Jane. Once her character accomplishes its symbolic function, the book concludes without any exploration of her motives, personality, or inner life. Obviously concessions must be made given the time period and the book's genre; there are also important connections to gender that help explain the extremeness of Bertha's characterization.[6] Nevertheless, *Jane Eyre*'s madwoman in the attic is one example of a stereotype of someone with mental illness. This characterization provides Bronte with a convenient and dramatic plot device (since Bertha is at once a shocking character and an expendable one), and it provides the audience with entertainment that does not require them to parse the complexities and the implications of Bertha's role in the story.

While portrayals of people with mental illness in the media may have evolved since Charlotte Bronte's time, the tendency to simplify their identities and experiences continues. With the advancement of medical science and the advent of psychiatry, new forms of simplification affect stories about mental illness. Many of these simplified stories target psychiatrists and psychiatric treatment, resulting in fear-inducing dramatizations of life in mental hospitals, of unpleasant and hubristic medical professionals, and barbaric treatments.[7] I will note that many

[6] See as a reference *The Madwoman in the Attic: The Woman Writer and the Nineteenth-Century Literary Imagination* by Sandra Gilbert and Susan Gubar. Basically, many female characters in Victorian literature can be categorized as either angels or monsters according to how rebellious/transgressive they were.
[7] See the films *One Flew Over the Cuckoo's Nest* or *A Beautiful Mind*, or Sylvia Plath's semi-

times these dramatizations are rooted in a troublesome reality. For instance, Mary Jane Ward's semi-autobiographical novel *The Snake Pit* (which inspired the award-winning move of the same name) was written in response to the inhumane conditions of mental hospitals in the United States in the 1940s, conditions that Ward experienced herself when she was hospitalized in a New York asylum. Ward's book sparked a wave of reforms and helped change public attitudes towards people with mental illness. In this case, the dramatizations in her novel (and in the film) served an important purpose by raising awareness and advocating for more enlightened psychiatric treatment. Nevertheless, this important purpose does not change the fact that Ward's storytelling relies on a set of stock characterizations (e.g. a likeable but troubled protagonist, abusive nurses, one sympathetic doctor, pitiful patients) in order to get its point across. The stock characterizations in works such as *The Snake Pit* highlight the idea that simplified stories do not always imply shoddiness or crass sensationalism. Even still, whatever the intentions of the author/artist or the reception of the work, simplified stories will influence public perceptions for better or for worse. While the representations of mental illness and its treatment in Ward's book helped encourage advancements, they also foreshadowed (and helped foment) a complicated collective reaction of fear and suspicion towards psychiatry and psychiatric professionals that lives on today.

So it is important to remember that simplified stories often contain elements of truth and that they can influence public attitudes in both helpful and detrimental ways. The marker of a simplified story is its one-dimensionality, which frequently stems from the author's or the audience's lack of knowledge on the subject or their inability to reconcile multiple (and sometimes opposing) realities. Sometimes an author or a movie director wishes to emphasize a point or fulfill an agenda, and so ends up shoehorning their characters into a particular mold or

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autobiographical novel *The Bell Jar* for examples of these dramatizations.

excluding certain perspectives from their narrative. Furthermore, because of the impenetrable nature of its origins and the unresolved hardship it tends to cause people, writers and artists gravitate towards stories about mental illness. Audiences remain fascinated by these stories for the same reasons. On a larger scale, we can think of these simplified stories as responses, or collective coping mechanisms, towards the intimidating complexities of mental illness. As Barbara Taylor puts it, "People are frightened, and they're always going to be frightened, because it's frightening. We all have within us places where the mind is reluctant to journey. The extremism, the unmasking of impulses and forms of being that the rest of us skirt around—every society has a way of negotiating that fear, whether it is through ridicule, or idealizations, celebrations of madness as some sort of deeper truth."[8] Consequently, besides being difficult and unprofitable, depicting a complete and accurate picture of mental illness does not provide the easy answers about it that people crave.

[8] Taylor, discussion.

Reductive Language

One manifestation of fear of complexity is reductive language, which I define as rhetoric that minimizes, distorts, or excessively simplifies the realities and intricacies of a particular subject, condition, or experience. Among the memoirs I analyzed, the authors respond to reductive language in two contexts: medical parlance and everyday vernacular speech. Reductive language in medical contexts takes the form of formulas, statistics, and clinical observations of behavior and mental state. When I was developing my argument and analysis of reductive language in medical contexts, I kept in mind that speaking, writing, and describing mental illness or those affected by it is difficult. Often times the only language available is the one that reduces the experience of mental illness to a single aspect or set of aspects. We use this language to classify, diagnose, and label—in other words, to make sense of an affliction that we do not understand. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM), for example, universalizes the diagnostic criteria for illnesses for which we have no cure, no biological test or marker, and limited etiological explanations. While the language used may not adequately encompass all facets of the experience of mental illness, it is still a *common* language that doctors across the world can enlist. The ability to give an affliction a name and organize our understanding of mental illness around symptoms and categories represents an advance, and has helped countless people.

Nevertheless, problems arise when we view psychiatric nomenclature as the only legitimate language, or insist that it should be the only language informing mainstream conceptions of mental illness. Recognizing the limitations of this language means acknowledging our imperfect understanding of mental disease. William Styron provides an example of one of the possible shortcomings of medical language when he chronicled his depression in his memoir,

Darkness Visible. He criticizes the shift from "melancholia" to "depression" in our lexicon of labels. "Melancholia," he writes in his memoir about his depression, is a "more apt and evocative word for the blacker forms of the disorder," while the term "depression" is a "wimp of a word," bland in tonality and "lacking any magisterial presence, used indifferently to describe economic decline or a rut in the ground."[9] Styron's complaint about the sterile label assigned to "such a dreadful and raging disease" highlights a factor that texts such as the DSM do not take into consideration when formulating its language: the nuances of words. While it may be obvious and reasonable that a doctor would choose standard, scientific terminology over colorful or evocative vocabulary, it bears mentioning that words can have connotations and meanings beyond those that were assigned to them. In Styron's view, "depression" cannot do justice to his experience of mental suffering; it misrepresents the gravity of the disease and levels out the irregularities that characterize his own experience of it. Understandably, rewriting the entire DSM for this reason is out of the question, but recognizing how medical language overlooks the individualities of mental illness helps us understand cases in which a person's experience of psychiatric treatment was unhelpful or unpleasant.

Medicalese, however, cannot be equated with ignorant or disparaging language, which represents the most problematic context for reductiveness. Sensitivity to slang terms and slurs differs from person to person, and some people with mental illness even adopt otherwise offensive terms as a form of identity consolidation and empowerment. Nevertheless, in most situations slurs, slang, and insults engender feelings of shame and aggravate social stigma when non-mentally ill individuals use them. This language includes vernacular usages "lunatic," "schizo," or "psycho;" jokes ridiculing symptoms or treatment; or potentially alienating terms and descriptions. Pertaining to this last instance, for example, using "patient" to denote a

[9] Styron, *Darkness Visible*, 36.

recipient of mental health care has come under fire[10], as has the term "compliant," used to refer to whether a patient appropriately abides by the treatment regimen. These terms carry connotations of passivity and imply a lack of agency, which can influence the way people with mental illness view themselves or are viewed by others, which in turn can undermine their recovery and obscure important aspects of their identity. Psychologist Cynthia Grossman writes, "As people interact with one another, the language they use to express themselves may help shape their beliefs and assumptions about other people and the world. This is the case for professional and client alike; both are susceptible to the constructive power of language."[11] Calling someone a lunatic, mocking their symptoms or treatment, and advising them to be compliant disregards the complexities of their identity, character, and illness.

In short, words matter. The way people speak and write about a topic shapes public perceptions of that topic, and nowhere is this more apparent than in conversations about mental illness. A British study conducted in 2007 analyzed the relationship between avoidance of treatment among 14-year old students in England and the language they used to refer to the mentally ill. The results showed that students most frequently used derogatory terms like “nuts” and “psycho” or emotionally charged descriptors such as “disturbed” and “confused.” As stated by the researchers, “these are powerful terms and appear to reflect anxiety on the part of respondents when thinking about mental health problems and the people affected by them.” The students' unease with the idea of mental illness shaped their perceptions and lead them to perpetuate a vicious cycle of euphemisms, misnomers, slurs, and labels. The solution, nevertheless, lies not in suppressing this language or avoiding conversations about mental illness, but in remaining aware of the effects of the words we use.

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[10] Wing, "Patient or client? If in doubt, ask."
[11] Grossman, "Labels and Language," 514.

With that in mind, in this thesis I have chosen to use the terms “mental illness” and “psychological dysfunction” interchangeably. Unless I am discussing their use in an example or an argument, I will avoid using “mental disorder,” “psychiatric disorder,” or “psychopathology,” due to the overt medical connotations they carry. Admittedly, the semantic difference between "illness" and "disorder" is slight, but I choose the former over the latter because I prefer the connotation of "ill-being" to that of breakdown or confusion. I will also avoid saying “mental patients,” opting for the clunkier but less alienating “consumers of mental health care” or “people with mental illness.” I make these specifications fully aware that no word is completely free from judgment values and connotations. I do not intend to promote an activist agenda or prescribe the "correct" word that one should use; I simply strive to use the most appropriate word in each particular context.

The Memoirs

I chose the memoirs based on how relevant and replete with information they were in relation to my argument about the public's fear of complexity. For my analysis, I considered how topics were approached, the order in which the chapters were placed, as well as the tone and diction of the writing. I also considered how each memoir structures and names its narrative. It is worth noting that when I use the term "narrative," I am referring to the strategic arrangement of topics in the memoir. The story, by contrast, is defined as the narration and the events of the author's life (and also should not be confused with the *simplified stories* to which I claim the memoirs respond). Andrew Solomon's *The Noonday Demon*, for example, is not organized around particular events in his life; he places minimal emphasis on his own experience with depression in favor of a loosely connected progression of topics related to the illness. In each chapter, Solomon explores a different aspect of the disease, occasionally drawing from someone else's experience. Thus *The Noonday Demon* does not have a story because it does not focus on Solomon's life. Barbara Taylor's *The Last Asylum* follows a more typical format in that it relies on the events of her life—from her childhood and then her admission into Friern Asylum up until her present-day state—to guide the trajectory and the implications of the memoir. My goal is to argue that by strategically choosing the manner in which they present their experiences of mental illness, *The Noonday Demon* and *The Last Asylum* counteract the misperceptions created by reductive language and simplified stories, and challenge readers' fear of complexity.

Chapter 2

The Noonday Demon: An Atlas of Depression

"This book strives to capture the extent of depression's temporal and geographical reach."[12]

Andrew Solomon's 2001 memoir garnered immense critical praise and popular attention upon its release, making it one of the most renowned books written about mental illness. The difference between Solomon's book and most works in the same genre,[13] however, is that instead of following the following the events of Solomon's life, it derives its narrative from the order of its chapters and the unifying infrastructure of themes that recur throughout Solomon's profiling of depression.[14] He devotes the second chapter, "Breakdowns," to his personal experience with the illness, starting it off with a revelation: "I did not experience depression until after I had pretty much solved all my problems." He reveals that his childhood and family life was comfortable and stable—his parents loved one another; he had a solid circle of friends throughout his school years; and he always did well academically. As he continued his education at university, he remembers that being alone sometimes unsettled him: "...I would suddenly feel isolated, and the feeling was not simply sorrow at being alone, but fear….This was an occasional and not crippling problem."[15] He obtained his MA in London, and began his career as a writer shortly thereafter with no major trouble. He writes, "I have had a good life so far, and I'm grateful for it."

Nevertheless, he relates memories that indicate undercurrents of anxiety, and remembers a small breakdown he had during a trip through Europe the summer after his final year of college. He did not know what was happening at the time and had to cut his trip short to come

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[12] Solomon, *Noonday Demon*, 13.
[13] Kay Redfield Jamison's *An Unquiet Mind* and Elizabeth Wurtzel's *Prozac Nation* are comparable examples. While I do not analyze them in this thesis, both typify the mental illness memoir genre.
[14] See Figure 1 on page 22 for an outline of the chapters.
[15] Solomon, *Noonday Demon*, 40.

home. The event did not trouble him for long afterwards, and throughout his twenties he continued to live life fully and unabashedly. In August of 1989, however, his mother was diagnosed with cancer, a life event that Solomon believes might have transformed his depressive tendencies into full-blown illness. His mother died in 1991, which left Solomon "paralytically sad," but not "crazy." He began psychoanalysis the summer of that year, and comes to rely on the support of his analyst to mitigate his grief. Two years later, the week before his thirtieth birthday, he broke off a tumultuous relationship with someone he dearly loved, which prompted his mental state to slip "another ratchet down." The following year his analyst announced that she would soon retire, which prompted Solomon to cry for an hour even though he had been contemplating terminating the sessions. An emotional numbness took over his life: "I didn't care about love; about my work; about family; about friends. My writing slowed, then stopped."[16] He describes feeling bored, even though his first novel had been published to favorable reviews, and soon social events began to feel burdensome. In August of 1994, Solomon experienced a bout of kidney stones and had a painful stay at a hospital, after which he states that either the pain he felt or the painkillers he received had "completely undermined [his] mind."[17] He grew irrationally angry at his father for not staying with him in the hospital, and after returning from a friend's wedding in Vermont, began to feel "that no one could love [him] and that [he] would never be in a relationship again."[18] Then, before his thirty-first birthday, Solomon snapped, collapsing into bed after an unpleasant trip to the grocery store, with no life in him left to cancel his birthday plans or call his father. He decided to start taking medication and to move in with his father. He struggled to accomplish basic tasks like showering and cutting up his food, and for most of the day could not stand to speak to anyone. Despite everything, he managed to drag himself through

[16] Ibid, 45.
[17] Solomon, *Noonday Demon*, 47.
[18] Ibid, 48.

a book tour with the help of his friends and medication, and he felt his symptoms begin to lift slightly. Three weeks into the tour however, he developed a reaction to the medication he was prescribed, and the intense anxiety returned: "I felt as if my head had been encaged in Lucite, like one of those butterflies trapped forever in the thick transparency of a paperweight."[19] He leaned on his friends and on his father to get him through the tour, and then by the end of the year, the "terror" lifted. Solomon remained in a "half-recovery" state for some time, suffering a few anxiety attacks but mostly coping. He desperately wanted to stop taking medication, and so goes off them quickly, against the advice of his psychopharmacologist. As a result, he went through a self-destructive period in which he attempts to contract HIV so that he could "end [life] with the least possible damage to the people around me." He went through the typical symptoms of agitated anxiety, sleeping badly, irritably lashing out at people, and unable to concentrate on his tasks. He stopped having unsafe sex when he realized that he could have infected his partners, but remained convinced that his HIV test would come back positive and that his thirty-second birthday would be his last. In the time between his last sexual encounter and the test, however, he recovers, his depression leaving "gradually, quietly."[20]

By the time the second breakdown in his life hits him, he more or less anticipates the damage and recognizes the signs. He began taking medication again and he warns his father and his friends that the depression had returned. Even though his HIV test came back negative, he continued to feel terrible for two months and continuously struggled with suicidal feelings. Fortunately, by the following year he had recovered and enjoyed a genuinely happy thirty-third birthday celebration. Then, Solomon suffered an accident in his home, resulting in a badly dislocated shoulder. Anticipating the effects of the pain on his mental state, he went to the

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[19] Ibid, 66.
[20] Solomon, *Noonday Demon*, 73.

hospital and tried to get the staff to help relieve his pain, noting that he had a history of severe depression exacerbated by extreme pain, only to be rebuffed and told to pull himself together. The trauma of the hospitalization sent him reeling and he relates that "within three days of [the] emergency room ordeal, I had acute suicidal feelings of a kind I had not experienced since my first severe episode...."[21] He became overwhelmed by tearfulness, lack of motivation, and paranoia. After this third breakdown, Solomon realized that he would have to be on medication permanently. His psychopharmacologist adjusted his medications in response. Although Solomon struggled to function amid the cognitive dimming and confusion that his pills caused him, he slowly began to emerge from the fog. He writes that he currently has a set of procedures to go through in case future episodes strike, and that he still suffers moments of frailty and panic, particularly if he spends too much time thinking of past pleasures and sadnesses. Solomon then concludes this chapter on his breakdowns with the statement: "The worst of depression lies in a present moment that cannot escape the past it idealizes or deplores."[22]

Each subsequent chapter after "Breakdowns" contains only passing references to Solomon's experience, although sometimes Solomon will include a personal anecdote if it has relevance to the topic at hand, such as in chapter VII, "Suicide," when he narrates his mother's decision to kill herself once it became clear that she would not survive her cancer. Even though these are moments most memoir authors would put under the microscope, Solomon keeps them in the periphery, and he is cautious not to use his experience as the basis of his conclusions. By loosening his personal ties to the book's titular subject, Solomon subverts the expectation that the central subject of *The Noonday Demon* is his life and his struggle. Instead, the focus is on depression itself—its mechanisms, treatments, history, and status in a society that fears

[21] Ibid, 85.
[22] Solomon, *Noonday Demon*, 100.

psychological dysfunction.

This choice to foreground the disease instead of the individual should not come as a surprise after a cursory examination of the book's title, which emphasizes the depression: *The Noonday Demon: An Atlas of Depression*. Compare this to the title of the other memoir I will examine in this thesis: *The Last Asylum: A Memoir of Madness in our Times*, by Barbara Taylor. While both titles are to some degree influenced by commercial sensationalism and demands for catchiness, Solomon's title characterizes the book as a compendium of knowledge and information on the subject of depression. Taylor's title, on the other hand, focuses on the asylum and signals to the reader that her narrative will give an account of Taylor's childhood neuroses, her eventual encounter with "madness" in her adult years, followed by the process of her recovery. Thus, *The Last Asylum*'s narrative is linear and more author-focused; whereas the topic-focused narrative of *The Noonday Demon* almost moves the book away from the memoir genre.

So assuming the term "atlas" is not just a more colorful placeholder for "journey," "story," or "memoir," what is the difference between an atlas and a memoir? I believe the difference between the two derives from a topic-driven narrative that resembles a manual, a guide, or a similar compilation of knowledge and information.[23] This narrative configuration also has slightly different effects on the reading experience and on Solomon's ability to broach controversial matters. Structuring his book like an atlas allows him to consolidate vast amounts of knowledge, scholarship, and anecdotes under different subject headings. By doing this, he can separate his own experience with depression from the "universal " experience of depression, which allows the topic of depression (as opposed to the topic of his own life) to take center stage.

[23] Because *The Noonday Demon* is inspired and informed by Solomon's depression, however, I still nominally categorize it as a memoir.

The atlas-like structure also enables him to embed different stories (both of his life and of other people) within each chapter as he sees fit. And finally, because *The Noonday Demon* has no need to adhere to a particular storyline with one specific implication or set of implications, Solomon can allow multiple versions and viewpoints to flourish. In other words, he can participate in the telling of multiple stories. A narrative structure that favors multiple stories directly prevents readers from settling into one understanding of depression or another, which means that at its core, *The Noonday Demon* is constructed to respect the complexity of the human experience of the disease.

A Note on Method

I. Depression

II. Breakdowns

III. Treatment

IV. Alternatives

V. Populations

VI. Addiction

VII. Suicide

VIII. History

IX. Poverty

X. Politics

XI. Evolution

XII. Hope

XIII. Since

Figure 1. Table of Contents of *The Noonday Demon*

Chemical Imbalances

As I stated before, *The Noonday Demon* does not organize itself around the story of its author's life (or the story of any one person's life), but it does possess an identifiable narrative through which Solomon can endorse and critique certain viewpoints and assumptions. Throughout the span of chapters and topics, he confronts various misconceptions and blind spots in the public's understanding of depression—from the continuous expectation that taking medication for a mental illness is shameful to the frequently overlooked impact of poverty on mental health. Many of these misconceptions can easily be characterized as or transformed into simplified stories. In this analysis of his memoir, I intend to examine how Solomon responds to the chemical imbalance theory, which has been used since the 90s to explain the origins and mechanisms of mental illness such as depression and bipolar disorder. The theory became prominent with the advent of antidepressants like Prozac, and was one of the first biological explanations for why some people became disabled by dysfunctional moods:

> The first attempts at defining depression as a biologically-based illness hinged on a theory of 'a chemical imbalance in the brain.' It was thought that too much or too little of essential signal-transmitting chemicals—neurotransmitters—were present in the brain. Treatments were developed to keep neurotransmitters (such as serotonin) within the tiny gaps called synapses between adjacent nerve cells, where signals are exchanged. By preventing specific neurotransmitters from being reabsorbed into nerve cells, the theory went, the signals between cells would be boosted and mood would be lifted. The most popular antidepressant medications, such as Paxil® and Prozac®, were developed to function in this manner.[24]

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[24] Schwartz and Tarr, "Interview with Robert C. Malenka."

Even though most medical professionals and researchers now believe the theory to be outdated, simplistic, and inadequate, it remains widely propagated by the media and the general public. The pharmaceutical industry stands to profit from the understanding that different mental illnesses can be managed by tweaking brain chemicals, and people who suffer depression themselves also find it easier to make sense of the condition and to "justify" treatment when they tell themselves the symptoms are due to a chemical imbalance. As of now, few plausible theories have emerged to replace it. As a result, people have grown accustomed to imagining a certain neurochemical action whenever they hear the words "chemical imbalance;" to expect a compassionate reaction from others if they describe their illness in such terms; and to believe that the sole act of taking antidepressants (in particularly SSRIs[25]) will counteract this chemical imbalance. These expectations and outcomes have now assumed stereotypical proportions. For these reasons, the chemical imbalance theory can be considered a simplified story, particularly when people propagate it without any mention of the immeasurable scope and complexity of the neurological events that lead to depression, or without recognition of the fact that the origins and mechanisms of most mental illnesses still remain unknown.

Solomon recognizes the ubiquity of this theory and its impact on the public's understanding of depression. He cites "oversimplification" among the four biggest factors influencing public perception of the illness, "in particular, the popular supposition that depression is the result of low serotonin the same way that diabetes is the result of low insulin—an idea that has been substantially reinforced by both the pharmaceutical industry and the FDA."[26] He adamantly disavows the theory, drawing from his own research and from professional opinions, yet he also recognizes that the theory's wide public acceptance may have

[25] SSRI stands for Selective Serotonin Reuptake Inhibitors, one of the most frequently prescribed classes of antidepressants. Prozac and Paxil are examples of SSRIs.

[26] Solomon, *Noonday Demon*, 362.

some inadvertently helpful effects. The atlas-like configuration of the narrative helps Solomon qualify his responses to this simplified story. For example, in the first chapter, "Depression," Solomon details how the theory is inadequate, but in Chapter Ten, "Politics," he recognizes that reframing depression as a flaw in brain chemistry can be helpful for those campaigning for legislation to cover mental health expenses. By writing an atlas instead of a story, Solomon can make room for differences in individual experience of depression and for the interplay of different variables that affect popular perceptions of the illness.

Solomon's response to the chemical imbalance theory begins as a critique early on in the book's first chapter. He crafts an impassioned counterargument against the notion that depression is a single-effect illness like diabetes:

> Indeed, it is strikingly dissimilar to diabetes. Diabetics produce insufficient insulin, and diabetes is treated by increasing and stabilizing insulin in the bloodstream. Depression is *not* the consequence of a reduced level of anything we can now measure. Raising levels of serotonin in the brain triggers a process that eventually helps many depressed people to feel better, but that is *not* because they have abnormally low levels of serotonin. Furthermore, serotonin does *not* have immediate salutary effects. You could pump a gallon of serotonin into the brain of a depressed person and it would not in the instant make him feel one iota better, though a long-term sustained raise in serotonin level has some effects that ameliorate depressive symptoms. "I'm depressed but it's just chemical" is a sentence equivalent to "I'm murderous but it's just chemical" or "I'm intelligent but it's just chemical." Everything about a person is just chemical if one wants to think in those terms.[27]

The tendency to ascribe "chemical" qualities or origins to one's moods and mental states seems

[27] Solomon, *Noonday Demon*, 22. Italics are his.

to validate the pain and trouble of addressing the problems that these moods cause. And yet, as Solomon points out, the chemical imbalance explanation is fallacious—it offers no helpful insight that could allow someone to differentiate between the neurochemical processes that result in a depressive episode and those that lead to moments of joy or states of anxiety. It is a story told to simplify the frightening complexities of depression and to make the task of getting treatment and support easier to accomplish.

Because the chemical imbalance theory has the effect of facilitating access to treatment, the prevalence of the theory does not have entirely harmful consequences. The theory also raises some important questions about what we consider to be a physical ailment and what we consider to be a mental or psychological ailment. If mental illness is the result of malfunctioning brain chemicals, then it is as biologically based as cancer or heart disease. By this standard, it can be argued that depression is a physical disease. These considerations matter because they dictate whether people can receive coverage for a psychiatric condition, or whether employers or insurance companies can discriminate between mental and physical illnesses. Solomon grants that the chemical imbalance theory encourages the understanding that the boundary between the physical and the mental is tenuous: "While parity legislation is pending, the notion that there is a separation between physical and mental diseases is breaking down, and it is politically expedient, perhaps even necessary, to cleave to the biological view, to let chemistry alleviate personal responsibility, giving mental illness symmetry with major physical illness."[28] He raises this point about political expediency in Chapter Ten, "Politics," as part of an extended meditation on the effects of public perceptions of depression on policy and legislation. When the public's association of violence and mental illness escalates, for example, politicians will react in kind with legislation that anticipates potential violence from the mentally ill and defends the public

[28] Solomon, *Noonday Demon*, 371.

from it, often through involuntary confinement or increased policing. The same process occurs when the public adopts the view that mental illness is due to an imbalance of neurotransmitters: politicians can pass parity laws; doctors can provide insurance companies with a somewhat measurable indication of "physical" illness; and patients can justify the need for treatment of their symptoms.

Solomon's response the chemical imbalance theory nonetheless remains marked by ambivalence. Even though the explanation may help more people get access to medication, a simplified and incomplete understanding of depression undermines education efforts and inhibits the development of treatment strategies and advocacy efforts. Furthermore, the prevalence of the theory casts the psychiatric profession as well as mental health care providers in an unseemly light. Many "antimedication crusaders," as Solomon dubs them, frequently criticize the chemical imbalance theory, even though the medical establishment has mostly renounced it. More broadly speaking as well, the theory seems to encapsulate a challenge that the field of psychiatry has struggled to overcome since the mid-20th century: how to transition from a "discipline that understood itself in dimensional terms to one that concerned itself with categorical ones."[29] Ever since psychiatry embraced the medical model, it has been plagued by its inability to diagnose mental illness through biological tests, and continuously seeks to portray itself as a discipline that relies on scientifically measurable and observable symptoms instead of arbitrary classifications, with little success. Solomon laments how psychiatry clings to categories and classifications in the attempt to legitimize its status as a medical discipline, and worries about the message that this sends to the public:

Indeed, this is perhaps the most alarming thing about current wisdom on depression: it

[29] Solomon, *Noonday Demon*, 398. Solomon quotes the words of David Healey, former secretary of the British Association for Psychopharmacology.

> dismisses the idea of a continuum and posits that a patient either has or doesn't have depression, is or is not depressed, as though to be a little bit depressed were the same as being a little bit pregnant. The categorical models are appealing. In an era in which we are increasingly alienated from our feelings, we might be comforted by the idea that a doctor could take a blood test or a brain scan and tell us whether we had depression and what kind we had. But depression is an emotion that exists in all people, fluctuating in and out of control; depression the illness is an excess of something common, not the introduction of something exotic.[30]

The above quotation provides an opportunity to understand how Solomon's self-described "atlas" gives him the ideal platform to explore the subject of depression, a platform where he can present content normally reserved for academic and scholarly texts and at the same time write about this content with the voice and lyricism of a literary prose writer. Therein lies the point at which the atlas and the memoir meet: the marriage of factual and creative methods of presenting the truth about a topic, and the combination of concrete and abstract. This combination allows Solomon to punctuate his narrative with both anecdotes and statistics; to demonstrate a point with metaphors as well as quotes from experts; to pragmatically mention an idea about mental health being on a continuum (currently a prominent theory among mental health professionals) and then conclude the point with an eloquent generalization stating that depression is an emotion that exists in all people (a generalization that Solomon earns the right to make because he has spent the entire chapter illustrating this exact abstract concept in clear and concrete terms). In other words, Solomon has a greater range of stylistic and literary techniques at his disposal by opting for an atlas instead of a typical memoir or a purely informational guide to understanding depression. He has the freedom to use both wry, humorous tones and serious ones; everyday

[30] Solomon, *Noonday Demon*, 398.

slang and professional jargon; figurative language and unembellished narration. This freedom to diversify the language of his memoir matters, because as I intend to demonstrate in the following section, language plays a huge role in how stories, assumptions, and ideas are disseminated.

A Riven Discourse

Throughout *The Noonday Demon*, Solomon assumes no persona other than that of someone who experienced severe depression. Nowhere does he position himself as a medical professional, scholar, or activist, and although biases are to be expected, for the most part he remains impartial toward the viewpoints that each of those audiences would embrace. This neutral stance is important to recognize because it lends credibility to Solomon's reflections, in particular his critiques. One prominent critique that recurs throughout *Demon* involves diagnostic language in psychiatry. In an effort to reify intangible concepts such as mood or feelings such as sadness, this diagnostic language ends up minimizing or disregarding the interplay of circumstantial or environmental factors. It can also sometimes be incompatible with qualitative descriptions or forms of measurement, such as patient interviews or case studies. To illustrate this, Solomon points out the absurdity of a formula printed in a psychiatry textbook from 1989 used to calculate the extent of a patient's depression:

> [A] depression score is equivalent to the level of 3-methoxy-4-hydroxyphenylglycol (a compound found in the urine of all people and not apparently affected by depression); minus the level of 3-methoxy-4-hydroxymandelic acid; plus the level of norepinephrine; minus the level of normetanephrine plus the level of metanepherine [sic], the sum of those divided by the level of 3-methoxy-4-hydroxymandelic acid; plus an unspecified conversion variable…. The score should come out between one for unipolar patients and zero for bipolar patients, so if you come up with something else—you're doing it wrong. How much insight can such formulae offer? How can they *possibly* apply to something as nebulous as mood?[31]

Solomon's reaction towards diagnostic language in these particular examples is marked by

[31] Solomon, *Noonday Demon*, 21.

disbelief. "The language of science," he writes, " used in training doctors and, increasingly, in nonacademic writing and conversation, is strangely perverse."[32] Even though it would be nearly impossible to create a standardized system of diagnosis that accommodated the hundreds of factors that influence a person's behavior, personality, and mood, the classifications of the DSM and the rhetoric used by doctors constitute one of the most prominent cases of reductive language. Solomon crafts his response to this kind of reductive language not by targeting the doctors or researchers who use it, but by criticizing the rigid, black-or-white attitude that informs it.

This black-or-white attitude is similar and related to the concept of fear of complexity. Black-or-white thinking occurs when someone can only conceive of two possible conditions or situations, which generally oppose each other. A fear of complexity operates with the same disregard for nuance and context. Therefore, imagining that other possibilities exist counteracts this dichotomous thinking, and recognizing that some of these coexisting possibilities may stand in opposition to one another entails an understanding of and respect for complexity. In the field of psychiatry and mental health care, a competent professional will have this understanding, even when the diagnostic language proves limiting or arbitrary. Solomon provides an example of how this language can sometimes seem nonsensical:

> Psychiatry's bible—the Diagnostic and Statistical Manual, fourth edition (DSM-IV)—ineptly defines depression as the presence of five or more on a list of nine symptoms. The problem with the definition is that it's entirely arbitrary. There's no particular reason to qualify five symptoms as constituting depression; four symptoms are more or less depression; and five symptoms are less severe than six. Even one symptom is

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[32] Ibid.

unpleasant.[33]

According to these classifications, the presence of depression can be ascertained through the number of symptoms someone reports to have. As Solomon points out, this system—while useful as a shorthand measurement of the degree of someone's depression—operates based on an understanding of depression as a condition that exists only after particular criteria are met. Less than five symptoms indicates one state of mind; five or more indicates another, and there is no in-between. An alternate, less black-or-white way of viewing the illness posits that depression is present regardless of the number of symptoms—what changes is the degree of intensity of the illness. Instead of a set of opposing states (depressed vs. not depressed), we see a spectrum.

As of yet, however, the fluid nature of human moods and emotions does not easily lend itself to measurements and quantification. In fact, without biological tests, few psychiatric or psychological conditions can be studied, treated, or debated without some degree of reductive language. This tendency to split into opposing camps or to use rhetoric that simplifies or misrepresents the complex reality of a mental illness goes beyond just the DSM, pervading various other contexts and conversations. One good example of this can be found in the final chapter, "Since," when Solomon addresses the controversies surrounding medication. Ever since the antidepressant craze in the 90s, psychotropic medications have triggered passionate denunciations in measures that belie the massive amounts of people reported to be taking them. Antidepressants have been accused of driving people to suicide, and many who oppose them do so on the basis that psychiatrists do not yet understand how mental illness works, let alone how the drugs interfere with the brain. As a result, anti-medication campaigns have emerged. At the same time, those who promote medications often exaggerate their effectiveness or disavow their

[33] Solomon, *Noonday Demon*, 19.

risks. Solomon writes of this rift: "The debate is only one manifestation of what has become a painfully riven discourse, in which many public figures have found it expedient either to gainsay the risk of medication or to blame it for everything that has gone wrong in modern life."[34] These all-or-nothing reactions are easy to defend, promote, and conceptualize, hence their popularity. Solomon's response is to suggest a reconciliation of the two extremes, a "weighing [of] conflicting liabilities" instead of trying to prove that the drugs are either "consistently safe or consistently treacherous."[35] In this way, the inherent complexity of treating mental illnesses—not to mention identifying and diagnosing them—will at the very least be reflected in the language we use to talk about them.

As I stated earlier, the diagnostic tools that we currently have available to identify and treat mental illness will remain inherently reductive, at least until biological tests can be developed. As helpful as the DSM can be, it is important to remember that there exist other ways of representing and describing mental illnesses. In *The Noonday Demon*, Solomon does not explicitly present or endorse any examples of these alternative portrayals, but in describing his disease and presenting his own understanding of depression, he ends up writing what I consider to be the antithesis of reductive medical language:

> Major depression is a birth and a death: it is both the new presence of something and the total disappearance of something. Birth and death are gradual, though official documents may try to pinion natural law by creating categories such as "legally dead" and "time born." Despite nature's vagaries, there is definitely a point at which a baby who has not been in the world is in it, and a point at which a pensioner who has been in the world is no longer in it. It's true that at one stage the baby's head is here and his body is not; that

[34] Solomon, *Noonday Demon*, 481.
[35] Ibid.

> until the umbilical cord is severed the child is physically connected to the mother. It's true that the pensioner may close his eyes for the last time some hours before he dies, and that there is a gap between when he stops breathing and when he is declared "brain-dead." Depression exists in time. A patient may say that he has spent certain months suffering major depression, but this is a way of imposing a measurement on the immeasurable. All that one can really say for certain is that one has known major depression, and that one does or does not happen to be experiencing it at any given present moment.[36]

Solomon's comparison of depression to binary concepts like birth and death reflect the question that doctors and patients face when trying to determine where health ends and dysfunction begins: how can we accommodate and account for the grey areas? The idea of depression existing in time is too abstract for medical or even practical purposes, but it reminds readers of the futility of clinging to exact measurements and durations. In addition, this passage illustrates yet again how the atlas configuration of *The Noonday Demon* respects the fluidity of human mental states. Any respectable atlas will acknowledge the arbitrary borders that separate one land from another, but will not prevent these borders from influencing the depiction of terrain or geography. Solomon's memoir does the same with its overview of depression. Not only does it show readers what the boundaries that we use to organize our understanding of depression are, it shows us that these boundaries need not be all that we rely upon.

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[36] Solomon, *Noonday Demon*, 17.

Chapter 3

The Last Asylum: A Memoir of Madness in Our Times

"To offer up to people a sense of the experience [of living with mental illness] that is truthful—to the degree that that is possible—seems to me to be the best thing."[37]

The entire premise of Barbara Taylor's memoir, *The Last Asylum*, hinges upon her experience as one of the last "true" mental patients of the 20th century, before the hospital in which she stayed closed down in 1993. Drawing from her time as one of the last people to have known institutionalization before the era of community care, Taylor provides an account of hospital life for contemporary readers whose knowledge of psychiatric wards may have been shaped by books such as Sylvia Plath's *The Bell Jar*, Ken Kesey's *One Flew Over the Cuckoo's Nest*, or Susanna Kaysen's *Girl, Interrupted*. In this sense, *The Last Asylum* takes its place alongside those works as a self-described modern "bin memoir."[38] Taylor recognizes the variety of perspectives that influence the portrayal of mental hospitals in these so-called bin memoirs:

> [They] are a peculiar genre. Some are modern gothics: lurid tales of decent, healthy-minded people consigned to asylums by evil or stupid doctors. Others recount the sufferings of individuals who, while they were certainly unwell at the point when they were hospitalized, experienced asylum life as cruel and degrading. And a minority are very positive, depicting the asylum as a place of healing, a sanctuary from the madness of 'normal' life. The portrayals are generally black or white, mimicking the emotional extremes of mental illness.[39]

Taylor's characterization of the book as a bin memoir signals to the reader that by constructing a

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[37] Taylor, discussion.
[38] Taylor, *Last Asylum*, 129. This is Taylor's term.
[39] Taylor, *Last Asylum*, 129.

narrative out of her personal experiences, she too will interact with and respond to these assumptions and biases that confront people with mental illness. Many of these assumptions and biases—such as, for example, the misconception that people with mental illnesses are violent—form the basis of prominent and damaging simplified stories. With this in mind, I will focus on how the memoir responds to simplified stories about mental hospitals, and also how it responds to reductive language used by proponents of the community care movement. Because Taylor emphasizes the ways in which Friern Hospital helped her recover, I argue that *The Last Asylum* functions as a defense of ongoing, open-ended care that sometimes needs to happen in a hospital environment.[40] Furthermore, because Taylor actively deplores the rhetoric used by community care centres, the memoir also functions as an exhortation to its readers to demand better infrastructure and more compassionate, intelligent services.

To challenge these simplified stories, Taylor opts for a narrative strategy that is frequently employed by writers of mental illness memoirs: a comprehensive account arranged in chronological order about the author's life and how they encountered, treated, and recovered from his or her illness. *The Last Asylum* tells a single story—that of Barbara Taylor's titular "madness"—through a linear narrative. This story is then sandwiched between a prologue and an epilogue in which the author provides commentary on his/her life since the recovery, together with an analysis of the problems afflicting the mental health care system and a call to action. Unlike *The Noonday Demon*, *The Last Asylum* offers no forays into other people's stories, nor does it provide a platform for topics and attitudes that Taylor does not embrace. It is not a memoir functioning as an atlas; it is a memoir functioning as a critique of certain mental health services and attitudes that are currently prevalent.

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[40] Taylor seems to use the term "open-ended care" to refer to mental health care that does not rely on time-limited, formulaic structures.

It is worth noting that Taylor does not specify any kind of psychiatric diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) that might have described her condition. This is most likely because the kind of psychoanalytic treatment she opted for operates outside of medical psychiatry's diagnostic classification system.[41] The absence of a psychiatric diagnosis puts her memoir in a category almost by itself—practically every other comparable autobiographical book about mental illness (and especially every other bin memoir) derives its central conflict not just from the author's illness, but from his or her official diagnosis. The conflict in *The Last Asylum*, however, stems from the hypothetical question of whether Taylor would have been able to survive her psychological crisis with the mental health system in its current state. Taylor's decision not to specify a diagnosis could be considered a response in itself to simplified stories and reductive language. The diagnoses of the DSM function as labels which, once attached to a person, tend to develop lives of their own. The misinformation surrounding different mental illnesses such as depression, anxiety, and addiction (all of which could be used to describe Taylor's condition) makes it difficult to write about them without simplifying their contradictions and incongruences in some shape or form. The reductive nature of both medical and colloquial language used to describe these illnesses poses a similar problem, since it challenges the author's ability to portray them in all their complexity. Thus, writing the memoir without reference to a diagnosis has a liberating effect, allowing Taylor to depict her experience unhampered by external classifications or stereotypes.

A brief overview of the organization of the chapters and of Taylor's story is in order before we progress. The chapters (excluding the prologue and epilogue) are titled and arranged

[41] Another plausible reason for why she does not engage with formal diagnoses from the DSM is because Taylor is skeptical of the biomedical leanings of modern day psychiatry, as evidenced by her statement in the prologue of her memoir that "there is no compelling evidence" for the theory that mental illness is due to glitches in brain chemistry.

as follows:

Part One

1- Beginning

2- History

3- Spain

4- Genius

5- Dead Babies

6- God

7- Sex

8- Hunger

9- Filth

10- Crisis

11- Women

12- Bad Dreaming

13- Inferno

Part Two

14- The Asylum

15- First Day

16- In the Bin

17- Psychoanalysis and Psychiatry

18- Friendship

19- Mad Women

20- Day Patient

21- The Hostel

Part Three

22- Change

23- Separation

24- Cure

25- Stories

26- Endings

Figure 2. Table of Contents of *The Last Asylum*

Part One of *The Last Asylum* concerns itself with beginnings: the beginning of Taylor's life, the beginning of Taylor's anxieties, and the beginning of her treatment with her psychoanalyst, who she calls V. The year is 1977, and Taylor is in the midst of writing her doctoral thesis when an idea that would later become the basis of her first scholarly book strikes her. Her excitement devolves into nervous energy:

> Excited, I tested [the new idea]: would it hold up? I was sure that it would...and my excitement became overwhelming. I lay awake all night, breathing fast, heart lurching. The sleepless night segued into a day of exhaustion and anxiety, followed by an endless stream of nights and days. I had been an easy sleeper; now insomnia was my bedfellow, and my anxiety levels climbed steadily. A lightless misery engulfed me. The world drained of warmth and color; a cold blankness was everywhere. This went on and on as—

armed now with many good ideas—I continued to labour away on my thesis.[42]

Taylor continues to suffer sleepless nights long after she completes her thesis. She self-medicates with sleeping pills and alcohol, until she decides to try psychoanalysis in 1981. Taylor chooses psychoanalysis, she says, "as much for its prestige value, I suspected at the time, as from any optimism about its curative potential."[43] She begins seeing V twice-weekly, and by 1984 she has become fully entrenched in her psychoanalysis, having a session with V every weekday. Taylor's relationship with him is marked by emotional extremes, from manic sexual attraction to rancorous hate, and her attitude towards him alternates between a desperate desire to please and a haughty confidence that he will never be able to successfully analyse her. Nevertheless, they develop trust for each other and V remains her analyst for the next twenty one and half years.

For the first few years after beginning her analysis, however, Taylor's ravenous nervous energy leads her to frustrating affairs with multiple men who, according to V, seem to be dysfunctional versions of her father. After breaking up with one of her lovers, Taylor's loneliness engulfs her: "Over the following months, I twist and turn inside my loneliness. I drink heavily, take fistfuls of pills, rail at V, whose stolidity in the face of my suffering makes me nauseous with rage."[44] She begins to have violent dreams, and is consumed by rage and hunger, "...not physical appetite, but a craving for something to be put into to me that will still my anguished voracity."[45] Taylor's rage is compounded by loneliness and self-hate, and by Chapter 9, "Filth," Taylor introduces the Laughing Woman, a noxious alternate version of herself who she describes as a "ruthless harridan who wells up inside me whenever my suffering is acute, poking me,

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[42] Taylor, *Last Asylum*, 3.
[43] Ibid, 4
[44] Taylor, *Last Asylum*, 57.
[45] Ibid, 61

prodding me, delighting in my pain."[46] Eventually Taylor's misery exacerbates itself, and her alcoholism and pill-popping begin to worry her friends. Her GP refers her to a psychiatrist, who she calls Dr. D throughout the book. After another painful break-up Taylor loses control, and relies exclusively on friends to take care of her and keep her from drinking. She characterizes herself at this stage as a "baby-emperor, ruthlessly dictating to my friends," someone whose "need for support was real enough but it was also an alibi, a way of reassuring [herself] of [her] omnipotence."[47] Despite her overbearing dependence on her friends' support and goodwill, Taylor feels alone and begins to lose her sense of self (she quotes a line from her journal in Chapter 12, "Bad Dreaming:" "I have no idea who writes here. I cannot understand why I have not died, except that the fact of being alive is a hard fact to change").[48] Finally, in 1988, the friends with whom she shares a house no longer want to live with her, and as she tries to look for a new place to stay, Taylor realizes she cannot bear to be alone with herself. She drinks for several days straight until Dr. D arranges for her to be hospitalized at Friern.

Part Two sees Taylor remembering her time at Friern, as well as her stays at the Whittington Day Hospital and the Pine Street Day Center, both places where, according to Taylor, genuine "community care" could be found for people with mental illness. By March 1983, after a slew of reports about abuse and neglect in its wards, it had been announced that Friern was set to close, so Taylor's stay occurs during its final years. For her, "life at Friern was hard but never unbearable."[49] The difficulties of this life included the ever-present threat of violence from other patients as well as staff members; the exacerbation of social vulnerabilities related to gender and class; the dinginess of the surroundings; the constant degradations; and the

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[46] Ibid, 71.
[47] Ibid, 84.
[48] Taylor, *Last Asylum*, 91.
[49] Ibid, 131.

infantilization of patients on the ward. At the same time, asylum life allowed Taylor to identify and develop her personal strengths; combat her self-hate; interact with people of different backgrounds to whom she otherwise would never have spoken; appreciate the silent companionship and friendship of these fellow patients; and realize the ways in which she was privileged financially and socially. In the summer of 1988, after her hospitalization at Friern, Taylor goes to the Whittington Day Hospital, a facility that she describes as a "psychodynamic unit based on small-group therapy."[50] She alternates her time between Friern and the day hospital depending on her mental state, and sleeps in a friend's spare bedroom at night. Eventually she gets a room at a psychiatric hostel, and soon gets accustomed to the routine of going to her session with V, going to the day hospital, and then returning to the hostel at night. She does this for two months, until Dr. D decides she should stop going to the day hospital and start attending the Pine Street Day Centre. There, she meets the three psychotherapists who organize the group therapy sessions, as well as the other patients. She gets along well with the other patients and draws strength and gratitude from the kindness of her support worker, a trainee psychotherapist named Florence.

Part Three details Taylor's recovery and her transition into a new life. In the spring of 1990, Taylor feels a change occurring in her, although it was preceded by months of panic attacks and confusion. Nevertheless, "sparks of optimism begin to flare"[51] and her symptoms shift. She learns to use the help she receives and feels safe at Pine Street. Taylor still cannot live on her own without a caretaker, so she stays with her friend Anna, and then with a retired nurse named Shirley who she finds through an "adult adoption" service. She stops drinking, and begins a shaky transition to normal life—finding a flat, celebrating her fortieth birthday, and visiting

[50] Taylor, *Last Asylum*, 180.
[51] Ibid, 205.

friends in Toronto. She continues her sessions with V, occasionally suffering from panic attacks and resurgences of the Laughing Woman. In Chapter 24, "Cure," Taylor announces that the panic attacks suddenly stop and she stops self-medicating with pills. After a session with V in which he angrily tells her he doesn't know how to help her, Taylor has a sudden realization of how she should approach her psychoanalysis. She has a breakthrough, and when V and Taylor resume their sessions after the summer break, "it was on new footing."[52] She settles into her routine, eventually realizing she doesn't need a caretaker anymore and moving out of Shirley's house. Taylor decides to find some work, and decides to teach creative writing to the patients at Pine Street and other day centres in London. The classes progress well with a few challenges along the way, and by 1992 she starts receiving payment. As she recovers, however, her ability to relate to the patients decreases, and she reaches a point where she can no longer teach. In October of 1992, she is informed by her GP that Dr. D had discharged her. By May of the following year, Taylor has landed a new job as a lecturer at the University of East London. Though she is growing in confidence, she still feels lonely and is "plagued by self-dislike."[53] Friern shuts down on April 1, 1993. Taylor falls in love with a friend in 1996, and this friend becomes her civil partner. In 2003, she publishes her book about Mary Wollstonecraft and has successfully established her career and reputation in academia. She has her final session with V on July 27, 2003.

[52] Taylor, *Last Asylum*, 225.
[53] Ibid, 237.

Stone Mothers

The term "stone mother" descriptively and concisely encapsulates Taylor's attitude towards Friern and its role in her recovery. It personifies the asylum and turns it into a character in her own story. For her, Friern straddled the line between prison and restorative retreat, but even when it was at its most unpleasant, she "never lost [her] sense of the hospital as a refuge from unmanageable suffering (a 'stone mother', as some describe it), however bleak the physical environment and attenuated the caregiving." Even the word "asylum," which Taylor uses in the title of her memoir, for example, carries within its etymology the idea of refuge and shelter. The harshness of asylum life notwithstanding, Friern remained a haven, somewhere for her to stay and receive care when she could not function alone or when she found herself without a support network. The term "stone mother" acknowledges the restrictive and authoritarian aspects of asylum life that prompt many critiques of institutionalization, but it also suggests that the hospitals provided personalized care that can be difficult to replicate in less structured environments. By representing asylums in this measured, humanized, manner Taylor offers readers a more complete understanding of hospitalization and how it affects patients.

In response to the simplified story that the community care model liberated people with mental illness and provided them with a more empowering system of support and treatment, Taylor highlights the crucial role that Friern Mental Hospital played in her recovery. As mentioned earlier, mental hospitals are easily dramatized. The variety of terms used to refer to them over the centuries—asylum, sanatorium, institution, madhouse, loony bin, etc—testify to the lurid and unsavory associations that people have attached to them. Even in contemporary society, seeking treatment in a psychiatric facility remains a matter of shame and secrecy, and is looked upon as a step backwards, or as the very last resort in an emergency. Taylor's defense of

mental hospitals does not attempt to mitigate or soften this unpleasant reputation; on the contrary, she candidly expresses the fear and the confusion she felt during her stay at Friern. Taylor does not challenge the idea that patients are often mistreated at hospitals, but she does emphasize—through her narrative—the beneficial effects of her stay at Friern, the day hospitals, and the psychiatric hostel. Later in the epilogue, she laments how the contemporary mental health care system discredits the kind of structured, long-term care she received at these residential facilities.

The modern distaste for mental hospitals has its roots in the 20th century deinstitutionalization movement. Impelled by the justifiable observation that mental hospitals were harming the patients they confined, activists and politicians in the US and the UK during the 60s and 70s exposed numerous cases of abuse and neglect. They campaigned to shut down mental hospitals across the country, a cause that was widely embraced. In 1963, for example, President Kennedy implemented the Community Mental Health Act, which aimed to provide grants to build community mental health centers with the goal of replacing the old asylums. In the UK in 1948, the National Health Service began to integrate mental hospitals into the system, an event that, according to Taylor, helped expedite the fall of the asylums: "How could places that locked people up, subjected them to involuntary treatments, frequently neglected or even abused them, be part of a modern health system? No reform minded government could tolerate it."[54] As a result, both in the US and the UK, the community mental health care model began to replace the old-fashioned asylum-based system. Well-intentioned activists welcomed the humane and enlightened approaches of the community care philosophy, and government agencies eagerly promoted them, but in reality there was little actual investment into such facilities and services.[55]

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[54] Taylor, *Last Asylum*, 115-116.
[55] Sedgwick, *PsychoPolitics*, 192-193. The rate of reduction in mental hospital populations was achieved

After the asylums closed, patients who needed structured or long-term care now found themselves on the streets.

Despite this tragic reality, the narrative of psych wards as dehumanizing places that ignorantly confine the sane and apathetically shepherd the insane proves difficult to dispel. Such abject circumstances, after all, justly sparked the ire of mental health reform proponents and inspired the creation of the anti-psychiatry and service user movements. Taylor acknowledges and respects the role that these activists played in humanizing mental health care, and recognizes that the conditions in the asylums were lamentable, and that the “scope for mistreatment was enormous.”[56] She states: “Institutional vulnerability of the sort imposed on mental patients in the late twentieth century was invariably shadowed by potential injury—and there were many places, like Friern, where injury was inflicted.”[57] By recognizing the risks of institutionalization, she avoids positioning herself against the currents of progressive thought that sought to prioritize patient welfare. This kind of careful argumentation demonstrates that Taylor does not shy away from complexity; she knows that the story of psychiatric hospitalization is fraught with contradictory accounts that may both be true at the same time.

Another prime example of Taylor's respect for complexity in *The Last Asylum* occurs in Chapter 19, "Mad Women," when Taylor recounts how childish and immature she felt in the ward. The infantilization of patients in asylums is significant enough to warrant a potent argument against hospitalization. This simplified story contends that hospitals and long-term psychiatric facilities (like the day hospitals and the psychiatric hostel that Taylor lived in) encourage dependency and undermine the agency and maturity of the people they treat. Friern

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"through the creation of a rhetoric of "community care facilities" whose influence over policy in hospital admission and discharge has been particularly remarkable when one considers that they do not, in the actual world, exist."

[56] Taylor, *Last Asylum*, 254.

[57] Ibid.

was no exception to this, as Taylor describes: "Individuals reliant on these 'total institutions' for all their basic needs—food, housing, medical care, even clothing (I wore my own clothes in Friern but many patients did not)—were said to regress into childish dependency. The claim has force. Ward 16 often felt like a lunatic nursery with naughty—that is, uncooperative or disruptive—patients punished with scoldings or temporary banishments."[58] Taylor then remembers a moment in which a nurse calls her to the front of the lunch line and gives her extra lamb chops, ostensibly as a reward for being a "good—that is, compliant" patient. Taylor's "infantile glee' at being the object of the nurse's favoritism remains "one of [her] saddest memories of Friern.,"[59] and is a testament to the pernicious power dynamics that establish themselves in institutions like mental hospitals.

Nevertheless, Taylor argues that there is another, equally undeniable facet to this reality when she claims that to "blame the old asylums for such babyishness is too simple." "Madness," she says, "is a childish thing; its roots lie deep in infantile sufferings and confusions. I was a baby in adult guise long before I came to Friern. My 'inner child', that much-romanticized self of therapy-talk, was a frantic, furious infant."[60] In other words, many people who are affected by mental illness sometimes need the kind of around-the-clock care that hospitals provide, which leads to a cycle of infantilization. Taylor's argument that "madness is a childish thing" is provocative, and runs counter to accepted lines of rhetoric when talking about mental illness. While some readers may disagree with it and view her defense of the hospital as a justification for the mistreatment of patients by staff, the claim is a credible reminder of the range of factors and variables that determine whether or not hospitalization will be helpful or harmful to someone. By using her statement that "madness is a childish thing" to qualify her recognition

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[58] Taylor, *Last Asylum*, 170.
[59] Ibid, 171.
[60] Ibid.

that asylum life can infantilize patients, Taylor addresses two arguments that feature prominently in the hospitalization polemic. Not only does she address them, but she treats both as equally possible (albeit uncomfortable) realities that merit attention.

Taylor's claim about the childishness of mental illness also epitomizes the kind of argumentation for which a memoir can provide a platform. The claim is abstract, informal, and anecdotal; it is accountable to no one but Taylor herself and does not pretend to be a scholarly or evidence-based statement. Authors of memoirs make these claims based on the weight of their life experiences and the credibility of their stories—for a reader to challenge such a claim would be equivalent to doubting the author's narrative of their own life. Since it is difficult to prove that someone drew the wrong conclusions about their own life experiences, and because most readers are happy to give memoirists the benefit of the doubt, memoirs can be ideal outlets for controversial views or statements. This is not to say that a reader cannot question the veracity of a memoir—it is certainly possible to do so. However, in a memoir like *The Last Asylum*, which seeks to "offer up to people a sense of the experience [of living with mental illness] that is truthful, to the degree that that is possible," controversial statements have the potential to expose readers to the complexities of certain topics. In a poetic sense, it is fitting that the "stone mother" asylums would infantilize their patients, hence the appropriateness of the personification: it allows for multiple contradicting perspectives to coexist. Asylums can be places of abuse, oppression, custodialism, and infantilization; yet they can also provide safety, acceptance, company, and expedient, reliable care. The narrative structure of the storytelling chapters of *The Last Asylum* (chapters 1-26, excluding the prologue and epilogue) allows all of these aspects of asylum life to shine through.

Taylor then uses the Epilogue to sift through the simplified stories she has encountered

and comment on their accuracy (or lack thereof). In response to the current approach that stipulates that mental health care services should encourage personal independence and self-reliance, for example, Taylor offers the following anecdote:

> One day I asked a group of my creative-writing students to write down their responses to the sentence 'I want to be treated with respect'. As a literary exercise it didn't work well, but it triggered a lively discussion in which most people spoke passionately about their wish to be treated 'just like anyone else'. But one student, the gentle Andy, demurred. People who are 'really sick' are different from other people, he said. 'Sometimes it's right to treat such people like children, because that's what they're like!' I understood what he meant but Andy himself, who had been in psychiatric institutions since late boyhood, was walking testimony to the infantilizing effects of long-term institutionalization, the self-disrespect and lack of confidence bred by the system.[61]

Taylor's commentary on Andy's opinion ("I understood what he meant but...") reveals an important distinction in Taylor's argument: she opposes not the asylums, but the "system" that used to run them. This is a nuanced perspective that allows her to lament the damage wrought upon people like Andy, yet also deplore the way the system limits the number of treatment facilities (ostensibly to avoid fostering dependency). Furthermore, the subtlety of her argument does not prevent her from taking a clear stance on the topic: "True independence—for everyone, well or ill—is rooted in social connection; without this, it is mere isolation and loneliness. This deep need for connectedness is insufficiently acknowledged throughout the whole of our society, not just in the case of people with mental disorders. But the lack of it hits the mentally ill especially hard since it is so often failures of social connection...that cause such disorders in the

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[61] Taylor, *Last Asylum*, 252.

first place."[62] As I will demonstrate in the following section, Taylor argues that the system that ran abusive and poorly managed asylums in the 20th century is the same system running today's expensive, ineffective, and uncoordinated community care network. It is a system that views shutting down the asylums as the answer to the excessive dependency that results from long-term institutionalization. And while it was certainly an answer that garnered many devoted proponents, the stories that aligned with its interests were simplified along the way.

[62] Taylor, *Last Asylum*, 257.

Buzzwords

Stories and language go hand in hand; it is not surprising that as stories underwent simplification, so did the language used to relay them. One of the most prominent instances in which Taylor responds to reductive language about mental illness occurs in the Epilogue of *The Last Asylum*. Though this Epilogue was added in a later edition of the memoir and contains comparatively less moments of storytelling, I am still considering it a relevant and important part of the memoir. Not only does it give readers an overview of what became of Friern after its closure, it provides Taylor with an occasion for expressing her final views on a number of topics that we encounter throughout her narrative. The commentary, critiques, and exhortations that Taylor writes in the Epilogue are particularly useful because she directly identifies the simplified stories and instances of reductive language that she finds problematic, and then responds to them. To do this, she separates the Epilogue into sections based on specific words that she claims the mental health care system today uses disingenuously: recovery, choice, risk, and brain chemistry. I will focus on the first two, analyzing how Taylor scrutinizes the current usage of these words and the assumptions behind this usage.

In the section titled "Recovery," Taylor parses the numerous meanings of the titular word, which has populated mental health policies and brochures since the closure of the asylums. To "recover," in the world of mental health care, does not mean to get better or to be cured of one's illness, but to live as though one didn't have it (also known as to "be well" or to "flourish"). This sense of the word is particularly deceptive because this specific definition does not seem objectionable at first glance; to thrive despite a chronic illness seems like a desirable goal. The problem is that "recovery" is an easy word to appropriate. Its attractive connotations make it ideal for public-facing documents, but its vagueness and abstractness mean that it is difficult to

hold those who use it accountable for its meaning. Taylor claims, for example, that the word has been "hijacked for a policy of service cutbacks."[63] She argues:

> Mental health care today is a fast-track system geared to getting people back on to their feet, and back into work, as quickly as possible (one critic describes this as the 'garage repair' model of mental health care). People are hustled through a series of time-limited 'interventions'; getting stuck along the way (in hospital, in rehab, in therapy) is anti-recovery. Also anti-recovery are any services that provide open-ended care: thus, all across Britain, day centres have been closed, rehabilitation programmes run down, outpatient services sharply curtailed.[64]

In this quotation we see that Taylor differentiates between "open-ended care" based on ongoing, inward-looking treatment and "time-limited," independently-led community care. The definition of "recovery" splits according to these two approaches, with the latter approach co-opting the word so that lengthier and more intensive treatments, therapies, or hospital stays indicate a difficulty to recover. Because these kinds of open-ended care methods also consume more money and resources (both of which are scarce in mental health care systems around the world) and because the idea of going to a mental hospital seems antithetical to improvement, it becomes convenient to justify the downsizing of treatment centers and the shortening of hospital stays in the name of recovery. In the introductory section of this thesis, I defined reductive language as language that distorts or crudely simplifies the intricacies of a subject or a personal experience. In this sense, the use of the word "recovery" to describe a state in which a person no longer needs urgent hospitalization or therapy is both deceptive and reductive. Recovery from any kind of psychological suffering is messy, time-consuming, and above all, highly subjective. It is possible

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[63] Taylor, *Last Asylum*, 256.
[64] Ibid.

to not need hospitalization and still require immediate and consistent care; Taylor herself is an example of this. While recovery may be easier to quantify when it is defined as a patient's departure from a ward, this usage of the word disregards the existence (or absence) of other factors that determine a person's well-being: support networks, financial situation, personal resilience, and the effectiveness of treatment.

"Choice" is another word that occurs frequently in brochures and pamphlets but remains difficult to measure or define, and is therefore subject to manipulation. Like "recovery" and "independence" (another frequent buzzword), "choice" is an attractive word because of the contrast between its optimistic meaning and the public's impression of the mental health care system as restrictive and oppressive. This contrast raises an interesting point: many people nowadays believe the mental health care system today is better than it was in previous centuries, and that people with mental illness are viewed and treated more favorably. While the science may certainly have advanced in the past fifty years, the assumption that the mental health care system is better simply because asylums no longer exist and treatment seems more humane is specious. Taylor's criticism of the preponderance of the word "choice" speaks directly to that assumption. She quotes a statement from a spokesperson of the UK Department of Health upon the launch of their website in 2006: "[P]atients should know that they now have the powers to choose their own path through services and keep control of their lives. They have the preference to choose how, when, where or what treatments they receive."[65] She then cites statistics concerning the 2007 implementation of Community Treatment Orders (CTOs) which can be used to involuntarily hospitalize people if they do not agree to take medication. Although it was said they would be used sparingly, by 2009 14,295 people were under CTOs and over 70% of those CTOs were still active. As the statistics suggest, there is a discrepancy between the kind of

[65] Taylor, *Last Asylum*, 258.

choice that the community care system advertises and the power of choice that patients actually have. The use of the word "choice" that Taylor criticizes encourages the assumption that the mental health care system is functional and more humane than it used to be. This assumption—while accurate in some aspects—overlooks some crucial realities. Because the current community care network shies away from open-ended or long-term care, people with severe mental illnesses often end up on the streets or in prisons, which is counterproductive to say the least. Furthermore, fear and misunderstanding of people with mental illness drive the creation of legislation that curtails the actual choice they have when in treatment. Finally, in many places, quality of treatment depends on how much you can pay, which means that understaffed, underfunded, and frightening wards that recall the worst of 20th century asylums still very much continue to exist. Consequently, the notion that the current mental health care system is better than it was in the past and the assumption that it makes accommodations for patients' choices and desires are, at best, simplified stories, both of which are furthered by the indiscriminate use of words like "choice" and "recovery."

Taylor's choice to associate these problems with specific buzzwords allows her to dissect the language used in mental health policy instead of particular institutions, people, or facilities. This decision also makes sense because language reveals assumptions, which means that Taylor can uncover implicit meanings contained within the buzzwords as well as compare the idealized meaning of the word with its de facto meaning. In short, Taylor's critique of the rhetoric of the community mental health care system constitutes a response to a form of reductive language born of idealism and aggravated by the system's failure to provide care.

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