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‘Pressured Speech’:
The Work of Narrative in Manic-Depressive Storytelling

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Doctor of Philosophy

Women’s Studies

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Abstract

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By Alyssa R. Levy

'*Pressured Speech'* investigates how, why, and to what effect narrative matters to people living with manic depression and other mental illnesses. It uses 'the work of narrative' as an analytical substrate in examining a subset of fiction, memoir, and performative personal narrative that exemplifies manic-depressive storytelling's distinctive verve and politico-therapeutic value. This collection of stories reveals that manic-depressive storytellers most often employ narrative to negotiate identity and selfhood, epistemic and embodied experience, and political subjectivity once transformed by the illness's attendant socio-medical processes. *'Pressured Speech'* registers these indices of narrative function in executing its textual analyses along three axes of critical inquiry that deliberate the following questions: What does storying manic-depressive illness *do,* materially and metaphysically, for people living with the illness? What *kinds* of storytelling best serve these ends and under what conditions? How might the work of narrative revealed in manic-depressive storytelling be extrapolated for use in contemporary mental health politics, policy, and praxis?

In mapping its selected texts' unique responses to these guiding questions, *'Pressured Speech'* sets some general parameters for all types of progressive narrative enterprise in mental health domains. It determines that storytelling modalities that are dynamic, didactic, and morally and politically self-aware best serve the work of narrative it explicates in its materials of study. Furthermore, *'Pressured Speech'* concludes that individual and institutional mental health storytellers' actualization of narrative's political and therapeutic potential rests in their recognition of 'the ethical, 'the political,' and 'the interdisciplinary' as imminent venues and values for twenty-first century narrative work.

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Chapter1

Introduction: The Work of Narrative in Manic-Depressive Storytelling

"Where would the memoir be without manic depressives?" quips novelist Ayelet Waldman while promoting her own memoir in a recent radio interview (Gross, 2009). Waldman's wisecrack snapped with equal parts comedic irony and ardent conviction, however, as a rhetorical qualification punctuating the uninterruptable barrage of personal disclosure with which she had just assailed her interviewer. This deluge of intimate revelation—unleashed, appropriately, through the rapid-fire heat of 'pressured speech'—showcased the very "oversharing" Waldman was seeking to propound as the source of manic-depressive storytelling's distinctive verve and literary value. Waldman's (2009) memoir, in fact, is just the latest dispatch from an eclectic and prolific bipolar literati whose personal narratives have inundated commercial bookshelves alongside swells of 'madness memoir' since the 1970s (Chesler, 2005, pp. 5-6; Jacobson, 2004). For some of these storytellers, including Waldman, life writing about or inclusive of manic-depressive illness has been avocation in a broader-reaching literary career; for others, such as ubiquitous BP, Kay Jamison, it has been the points of both embarkation and terminus for a literary oeuvre that may extend beyond memoir but *not* beyond manic depression.[1]

Whatever its valence for the modern memoir, contemporary manic-depressive life writing owes much of its own cultural cachet to Jamison (1995) and her now canonical

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[1] Jamison is a psychiatrist who lives with and researches manic-depressive illness. She has written extensively about the illness for both scientific and popular audiences. *Manic-Depressive Illness* (Jamison & Goodwin, 1990) is considered a definitive clinical text on the subject, and *An Unquiet Mind: A Memoir of Madness and Moods* (1995) and *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* (1993) are her best-known popular works. Other BP authors whose literary careers begin and end with manic-depressive life writing include Lizzie Simon (2002) and Andy Behrman (2005).

text, *An Unquiet Mind: A Memoir of Moods and Madness.* Jamison's unimpeachable authorial credibility as a Johns Hopkins-educated psychiatrist who lives with the same illness she treats clinically undoubtedly has buttressed her memoir's standing as the most decisive and authoritatively circulated account of manic-depressive illness published in the modern era (Mondimore, 1999, pp. 13-14; Salmon, 2009, pp. 26-30). Jamison's memoir, in consequence, has held a commanding presence in popular, clinical, and academic discourses surrounding manic-depressive illness since its publication in 1995. As high profile, commercially and critically successful texts are prone to do, however, Jamison's memoir has attracted somewhat dubious public attention over the years. In casting a bright, mainstreaming spotlight on the illness during the "popular psychology" boom of the 1990s (Cloud, 1998; Wilson, 2003), for example, *An Unquiet Mind* may have inadvertently hastened 'bipolar disorder's' appropriation into a popular psychotherapeutic lexicon that has threatened to diminish, distort, and commodify its meaning ever since (Cloud, 1998; Jamison, 1995; Wilson, 2003).[2]

The Work of Narrative

Despite the problems associated with its cultural appropriation, Jamison's (1995) memoir and other literary and scientific work have been pivotal in legitimizing manic-depressive illness culturally and scientifically (Mondimore, 1999; Salmon, 2009), as well as key in solidifying 'bipolar memoir' as a genre of interest within the late twentieth century explosion in autobiography (Chesler, 2005, pp. 5-6; Eakin, 1999). Jamison's memoir, to this extent, also led an important narrative charge within mental health care

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[2] Although this lexicon and the larger 'therapeutic' culture to which it belongs have proliferated in the post-World War II era, they hit a fever pitch during the late twentieth century. During this period, they were emboldened by and implicated in both the commercialization of mental distress and the concomitant privatization and individualization of mental health care services (Cloud 1998; Wilson 2003).

fields that has affirmed a role for personal narrative in mental health politics, practice, and outreach (Jacobon, 2004), as well as consolidated the influence of 'celebrity' storytellers in those domains. An *Unquiet Mind's* success bolstered the longstanding market appeal of celebrity BP memoir for mental health advocates, in effect, further incentivizing the literary franchising of 'celebrity' activism. In this sense, Jamison's memoir also helped create a new strata of mental health celebrities whose notoriety is predicated on their mental illness narratives and/or advocacy, rather than more conventional sources of fame (Jamison 1993, 1995; Mondimore, 1999).[3]

Whether famously-, infamously-, or obscurely-penned, manic-depressive personal narrative's popularity and extended sway underscores the salience of storytelling within contemporary mental health domains (Bracken & Thomas, 2005; DeSalvo, 1999; Jacobson, 2004). The enduring currency of first-person accounts of mental illness in mental health policy, politics, and treatment paradigms is also indicative of the more fundamental ways in which "the power of narrativity makes a crucial difference to our lives" (Kearney, 2002, p. 14). Jamison gestures to these broader dictates of narrative work in affirming her own life writing as a means of counteracting the stigma and shame that surround mental illness in contemporary culture, as well as a vehicle for working through illness-induced losses and reconfigurations of 'self' and 'identity' (Jamison, 1995; Salmon, 2009, pp. 26-30). Furthermore, Jamison (1993, 1995) indicates that she has relied on narrative work to productively sublimate manic-depressive illness itself,

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[3] Jamison is clearly the most prominent of these newly famous folks; however, Susanna Kaysen (1993), author of *Girl, Interrupted,* is a prime non-BP example of this pathway to fame.

arguing that it is a condition whose pathology is both deeply narrative[4] and intrinsically bound to artistic production and creative fervor—storytelling in all its forms.

Narrative Ethics

Narrative ethics scholarship offers further elaboration and contextualization of Jamison's foundational but cursory assessments of 'the work of narrative' in manic-depressive storytelling. It illuminates with the ramifying impress of critical inquiry the intricate webs of ethical and moral imperatives, socio-linguistic schemata, and cultural and political geographies that direct and (ultimately) freight narrative practice of *all* persuasions in mental health domains. Richard Kearney's (2002) text, *On Stories*, extols the virtues of storytelling and narrative practice in modern cultures and outlines the central suppositions of narrative ethics and theory, beginning with the core assertion that: "Telling stories is as basic to human beings as eating. More so, in fact, for while food makes us live, stories are what make our lives worth living. They are what make our condition *human*" (p. 3).

Kearney (2002) credits "the art of storytelling," which he describes as the dramatic imitating and plotting of human action," with making our world "shareable," as it is only when "haphazard happenings are transformed into story, and thus made *memorable* over time, that we become full agents of our history" (p. 3). He maintains that, "this becoming historical involves a transition from the flux of events into a meaningful social or political community," a process he notes as operating on the levels of both communal *and* individual history (p. 3). "When someone asks you *who* you are, you tell your story," Kearney writes, "That is, you recount your present condition in the light of past memories and future anticipation" (p. 4). He argues that interpreting present

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[4] 'Pressured speech' being axiomatic of the essential manic-depressive impulse to *tell*, to *iterate*.

'location' based on "where you have come from and where you are going to" gives you "a sense of yourself as a *narrative* identity that perdures and coheres over a lifetime." In this way, Kearney argues, storytelling humanizes time "by transforming it from an impersonal passing of fragmented moments into a pattern, a plot, a *mythos*" (p. 4). Invoking Alasdair MacIntyre's (1984) notion of the 'narrative unity of a life,' however, Kearney (2002) ultimately determines that narrative is, most importantly, "a stay against confusion." He argues that, "The storytelling impulse is, and always has been, a desire for a certain 'unity of life.'" His particular interest in *On Stories*, therefore, is to explicate how, "in this postmodern era of fracture and fragmentation, narrative provides us with one of our most viable forms of *identity*—individual and communal" (p. 4).

Paul John Eakin (2004) concurs with Kearney's foundational but sweeping attributions of narrative work in matters social, political, and metaphysical; however, he describes the particular functions of 'life writing' as a narrative subtype, assigning it an equally bold sociocultural and existential catalogue. In elucidating life writing's distinctive moral charge and disposition for addressing "important goods, both psychological and social" (p. 4), Eakin underscores what is at stake in telling stories about oneself. "When we tell or write about own lives," he argues, "our stories establish our identities both as content—I am the person who did these things—and as act—I am someone with a story to tell." By taking up such writing, however, we also do something even more fundamental—"we establish ourselves as persons: 'I am someone, someone who has lived a valuable life, a value affirmed precisely by any life story's implicit claim that it is worth telling and hearing'" (p. 5).

Eakin (2004) links the production of these ‘identity narratives,’ as well as their conveyance of what Charles Taylor (1989) terms our “life plans”[5] with the “expressive freedom” that both Taylor and Eakin (2004) believe so definitive of the modern individual. Eakin argues that “members of oppressed and silenced groups instinctively recognize this core attribute, making life writing a leading form of expression in postcolonial and minority literature today.” Furthermore, he maintains that life writing’s function as a “forum for the individual’s claim to freedom and dignity” is closely connected to its function as testimony. In its ‘testimonial’ capacities, Eakin indicates that life writing may act in response to “programmatic totalitarian assaults on [the values of freedom and dignity],” such as during the Holocaust, or to “more personal threats to the integrity of the person, such as illness and disability” (p. 5).

Importantly, Eakin (2004) also foregrounds the case of illness and disability to warn against the potential dangers that narrative poses despite or because of its great power as a ‘social good.’ “If life writing as both act and content has the power to confirm our status as persons,” he writes, “then it also casts a shadow: Do you have to have a story in order to be a person?” (p. 5). Eakin points to the predicaments of people who can no longer tell their stories, such as those living with Alzheimer’s Disease or other forms of dementia, in emphasizing that the narratability of one’s life figures as a prerequisite for the conferment of personhood and its entitlements. People living with those types of brain conditions expose the stakes of narrative work, therefore, by urging us “to reckon with the fact that the self-narrations in which we express our ‘life plans’ function as the mark not only of the free person but of the normal person as well” (pp. 5-6). Eakin contends that the systems of social intercourse we inhabit demand that we be

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[5] i.e. our sense of the direction and meaning of our lives, to which narrative understanding is crucial

able to articulate a narrative identity as confirmation that we possess "a working identity." When brain disorders undermine our ability to tell others who we are, therefore, "our claims to recognition as persons may suffer irreparable harm." This breakdown of narrative identity, "the collapse, as it were, of 'life writing' in any of its forms," has led Eakin to think of ethics as "the deep subject of autobiographical discourse" (p. 6).

Eakin and narrative theorists like Arthur Frank have been pivotal in establishing illness and disability as key foci of narrative study. They have drawn particular attention to the "illness narrative" as a provocative genre whose dialectical mobilization and refinement of narrative and disability theory alike has generated incisive scholarship on the nature of selfhood, narrative, and political subjectivity (Eakin, 1999, 2004; Frank, 1995, 2004). Frank's primary contributions to this scholarly milieu emanate from his explorations of illness narratives in and as moral inquiry—in particular, his explications of illness as a moral occasion and "the wounded storyteller" as a narrative archetype saddled with distinctive ideo-political projects and 'plights.' Frank (2004) places at the center of his theoretical and ideological claims about illness and disability the contention that both phenomena "call upon people to become morally engaged because [ill people] have everything to lose, but also to gain." As a result, Frank argues that "illness is inherently a moral experience, and life writing about illness is inherently moral, as it seeks to sort out what has been lost, gained, and preserved" in the aftermath of illness (p. 177). Like Eakin and Kearney, however, Frank also stresses the larger cultural and political imperatives that animate narrative work, noting that the 'moral occasion of illness' may transcend an individual's personal life and relationships and be parleyed into a *sociopolitical* occasion in which an ‘ill’ author may present his or her story as “testimony about a suffering that society too often ignores, compartmentalizes, and diminishes.” The writer of the illness narrative, therefore, “is primarily a witness, whose testimony speaks not only for himself or herself but also for a larger community of those who suffer.” As Frank concludes, “Being a witness is moral work” (p. 177).

Finally, Frank (2004) elaborates his claims about the essential connection between ‘the moral’ and ‘the political’ by enlisting Hilde Lindemann Nelson’s study of “counterstories,” which he deems the most significant form of narrative’s “remoralization work” (pp. 177-178). He notes that Nelson describes counterstories as a type of “narrative work of resistance” in which people who have been “systematically damaged by stories that categorize and denigrate the identities to which [they] are relegated” must engage in order to restore themselves to full respect and moral standing in their communities (p. 178). Frank, incorporating Nelson’s critique, posits that illness becomes a moral occasion when an ill person engages in writing or other ‘work’ that remoralizes his or her identity. He argues: “What is moral is also political: because demoralization is a political project to delegitimate the values, perspectives, and identities of some persons, remoralization affects the distribution of social resources currently known as power” (p. 178). In practical terms, then, “life writing about illness and disability upsets the conventional identities assigned to these groups,” as well as “breaks with the epistemology of an ill or disabled person as the object of knowledge—one who is observed and recorded by others—and asserts such persons’ claims to be knowing subjects” (pp. 178-179).

Although Frank (2004) contends that the very act of ill and disabled people speaking for themselves constitutes a kind of counterstory to hegemonic medical meta-narratives and epistemologies, he cautions that not any story will do in satisfying the dictates of 'remoralizing' narrative work (pp. 178-179). "Telling a counterstory that makes a moral claims is one thing," he writes, "making a *good* moral claim is another" (p. 179). The question becomes then, "What is a good story to tell about oneself?" (p. 179). He responds to this query by making a case for moral non-fiction about illness and disability as a "form and forum for personal reflection on questions of value" during a time in which "canonical, institutionalized standards of public and private morality have broken down" (p. 175). Frank argues that "illness and disability test the writer, who then tests which values are to be acted upon, when, in what ways," and in the process, offering us some direction in addressing the perennial question of "how we are to live— what ways of living are better than others, and how we become the sort of people we want to be" (pp. 175-176). Frank determines that 'moral perfectionism'—the idea of "morality as an ongoing story of possibilities, realized and as yet *unrealized*, with perfection always beyond the horizon" (p. 190)—provides an especially promising conceptual framework within which to make determinations about which stories and types of moral non-fiction serve 'good' moral claims better than others. He concludes that its promulgation of dialogical storytelling and refusal of narrative closure and finalization produce the most distinguishing features of 'good' narratives.

Narrative Ethics in Mental Health.

Kearney (2002), Eakin (1999, 2004), and Frank's (1995, 2004) explications of narrative ethics, illness, and disability in contemporary culture provide a critical context in which to consider storytelling that makes *mental* illness its principal subject. In mapping ‘the work of narrative’ across a range of intrapsychic, sociopolitical, and representational locations, however, these narrative scholars detail a theoretical terrain for storytelling and life writing about illness in which mental distress is salient but oftentimes incidental and, thus, topographically shortchanged. Nevertheless, their foundational claims about narrative’s importance to identity, selfhood, and political subjectivity are imperative to/in any study seeking to elucidate the distinctive character of manic-depressive storytelling and/or catalogue the ways in which narrative comes to matter in the lives of people living with and writing about manic-depressive illness.

Patrick Bracken and Philip Thomas (2005) embark on such a study in their text, *Postpsychiatry: Mental Health in a Postmodern World.* The two authors, both of whom are psychiatrists, position narrative ethics at the center of mental health politics and practice as they describe both the liberatory and repressive functions of narrative in mental health domains (p. 195). They maintain that their field has long been poised for the recent convergence of narrative and ethics in other academic and professional arenas; not only are medical knowledge and practice essentially narrative in nature (p. 199), but storytelling has served a longstanding, fundamentally ethical role in medicine by facilitating practitioners’ empathic identifications with patients’ suffering and ‘difference’ (p. 193). Although Bracken and Thomas assent to the basic conceits of narrative ethics scholarship reviewed here, they stipulate their application in mental health settings by illuminating the ways in which the experiential and politico-narrative contingencies of storytelling about mental distress uniquely animate its ethical dilemmas and ‘work.’

Importantly, Bracken and Thomas (2005) address narrative ethics as part of a larger program of critique they elaborate under the rubric “postpsychiatry,” which, as they indicate, calls for a fundamental reorientation of mental health work that deposes the modernist assumptions and positivism that currently predominate in mental health fields (p. 1). ‘Postpsychiatry’s’ primary project, then, is to challenge the “monologue of reason about madness” that Foucault (1965) describes as definitive of the post-Enlightenment period by advancing a dialogical, *post*modern approach to mental distress in which the ‘voices’ and stories of people who experience ‘madness’ figure prominently (Bracken & Thomas, 2005, pp. 1-2).

Bracken and Thomas (2005) argue that the contemporary modernist context makes narrative vulnerable to cooption by powerful people and institutions that enlist it to support processes of exclusion and control that subjugate and constrain ‘patient’-storytellers and their narrative work (p. 195). The authors cite narrative practices that shape ‘patient’ subjectivity, such as doctors’ assumption of an ‘editorial’ role and the objectification of patients via the psychiatric exam or interview, as illustrative of the ways in which the medical establishment and its personnel rely on narrative processes to exercise institutional and professional power (p.193). Bracken and Thomas identify the *power-shaping* activities of narrative in contemporary modernist psychiatry, therefore, as particularly troubling sites of ethical concern. They are not only pivotal in determining whose perspectives “matter” in mental health contexts, but also in determining whose interpretations of mental distress “count” in both mental health politics and practice (pp. 199-200).

“Scientific psychiatry” is an especially fraught genre of ‘exclusion’ and ‘control’ that ethically threatens manic-depressive storytellers by underwriting their ‘othering’ and concomitant clinical de-contextualization (Bracken & Thomas, 2005, p. 201). Bracken and Thomas argue that the ‘case history’ epitomizes medicine’s tendency to (borrowing from Bakhtin) ‘create a character not a person’ who has a life and ‘interests’ outside the clinic. Medical professionals, therefore, must task themselves with countering the case history’s objectifying gaze by approaching ‘patients’ and their lives with a sense of awe and wonder (p. 193). Bracken and Thomas contend that stories and storytelling expedite this reorientation by acting as ethical spaces in which to address mental illness and its ‘treatment’ openly and collaboratively. Stories, then, should be incorporated into doctors’ clinical encounters with patients and patients’ encounters with medical personnel and institutions (p. 193).

Despite their associated hazards, Bracken and Thomas (2005) maintain that narrative and storytelling contribute enormously—and indispensably—to the lives of people experiencing and/or treating mental distress (p. 197). Stories help doctors ‘connect’ with patients and focus on values, meaning, and ethics in their work, not simply “best practices” and clinical effectiveness. They also help medical professionals and patients discern a multiplicity of ‘truths’ about illness now simplified or obscured by large-scale cultural over-investments in a biomedical narrative of mental distress (p. 198). Bracken and Thomas argue, however, that the real value of narrative in clinical domains is its “contextualization of practice” (i.e. locating mental illness within the larger narratives of patients’ lives), as well as its promotion of holistic treatment approaches that enable patients, advocates, and practitioners alike to grapple with the "existential significance of mental illness" (p. 197).

Bracken and Thomas (2005) envision 'postpsychiatry' as an "emancipatory narrative," therefore, that foregrounds the personal narratives of people living with mental illness and "creates an ethical space in which [they] can safely explore their own understandings of their experiences" (p. 201). A 'postpsychiatry' approach, however, also requires that mental health communities confront problems of 'truth' and representation if they hope to engage seriously with the broader ethical implications of narrative praxis in mental health (p. 192). Bracken and Thomas note that 'authorship' presents a particularly complex set of ethical concerns for narrative advocates, as it is the narrative stage on which power differentials between "the represented" and "the representers" 'play out' in narrative work (p. 202). They argue that Narrative exponents must remediate these disparities between the "powerful, privileged professionals" now predominating as 'representers' of mental distress and the ordinary, often socially disenfranchised 'patients' now predominating as their representational objects (p. 207). Furthermore, Bracken and Thomas also exhort Narrative supporters to discontinue narrative practices that support the singular, monologic medicalizing narrative of mental distress now subsidizing these power differentials (pp. 207-208).

Bracken and Thomas's (2005) 'postpsychiatry' approach, in contrast, calls for writing about subjects *as* subjects and privileges firsthand accounts of mental distress above all other forms and sources of narrative produce (p. 207). They argue that this shift in paradigms is the best way to ensure ethical accountability in questions of 'authorship,' as well as vital to recognizing representation and epistemology as key foci of an ethical narrative praxis (pp. 207-208). ‘Postpsychiatry,’ to this extent, is concerned with uncovering “different ways of writing” about different ways of knowing and being—an excavational imperative of ethical narrative work that also helps specify the types of narrative that “open up or close down possibilities for truth and meaning” (p. 208).

Although their colleagues in Narrative Studies cite Bakhtinian “dialogism” as a central feature of progressive narrative practice (Frank, 2004; Kearney, 2002), Bracken and Thomas (2005) make it ‘postpsychiatry’s’ methodological and theoretical centerpiece. The two authors invoke Bakhtin’s study of language as infinitely varied, contextual, and definitive of the human condition itself, in clarifying the broader project of a postpsychiatry narrative ethics (pp. 209-210). Bakhtin’s *Dialogical Imagination* (1984) and explications of language and ‘alterity’ are particularly important to a ‘postpsychiatry’ model. Bracken and Thomas (2005) note the significant implications they present for “our understanding of consciousness and, particularly, our awareness of difference” (pp. 210-211). They posit this Bakhtinian ‘awareness of difference’ as compulsory in their formulation of an ethical narrative praxis in mental health domains and argue that it would allow patients, advocates, and practitioners to understand people living with mental distress as “truly dialogical, an ever unfolding set of infinite possibilities, unfixed, and dynamic, unpredictable and indeterminate” (p. 211).

Bracken and Thomas (2005) contend, therefore, that a ‘postpsychiatry’ narrative ethics demands that narrative practices honor both the dialogical nature of human experience and the humanity and ‘interests’ of all parties engaged in the storytelling exchange (pp. 212-213). Moreover, they must encourage said ‘parties’ to “engage with the Other’s reality, to imagine them and enter into those worlds without judgment or prejudice" (p. 213). The primary 'work' assigned mentally ill/distressed storytellers in Bracken and Thomas's formulation of narrative praxis is to discover and assert themselves as *subjects*. They must do so, however, while 'articulating' themselves and storying their 'difference' outside the repressive hegemonic discourses and representational models currently imperializing their subjectivity via objectifying, monologic narrative processes of exclusion and control (pp. 207-212).

Although Bracken and Thomas (2005) welcome the narrative turn in mental health, they worry that its proponents have not committed themselves seriously to addressing the ethical implications that this 'turn' inevitably entails (p. 192). The authors' fears are neither unwarranted nor unreasonable. Despite narrative's enduring importance and extensive catalogue of use in mental health domains, individual and institutional mental health storytellers often fail to approach narrative work with the critical consciousness, political acumen, and philosophical deliberation that narrative ethicists would demand. As Bracken and Thomas suggest, engagement with the *meaning*—not simply the utility—of narrative work is a precondition for developing an ethics-centered program of narrative work within mental health that is capable of promoting social change and improving the lives of people living with mental distress (pp. 211-213).

Narrative enterprise in mental health domains currently runs along three major rails: the therapeutic, the political, and the pedagogical. The *therapeutic* 'work' of narrative and storytelling in mental health is particularly celebrated and pronounced, as clinicians have long employed narrative-based therapies to alleviate suffering associated with mental illness and distress (DeSalvo, 1999; Pennebaker, 1997; Pennebaker & Beall, 1986). Although these practitioners have been diligent in their study and clinical deployment of narrative as a means of 'working through' illness-based destabilizations, they often do not incorporate narrative ethics into their evaluative or theoretical frameworks (Bracken & Thomas, 2005). Advocates working in *political* venues have enlisted mental illness narratives as supporting testimony for policy and legislative initiatives, as well as tools to publicize mental health issues and combat stigma and discrimination (Perlin, 2000; Stefan, 2001). Bracken and Thomas (2005) recognize this work as valuable but suggest that a narrative ethics-based critique would expose the dangers of conscripting mental illness stories into 'assimilationist' political programs that seek to secure the 'mentally distressed's' inclusion into social institutions whose hegemony necessarily depends on *ex*clusion and the homogenization of difference (pp. 79-81).

Lastly, advocacy groups and their institutional partners, such as the National Alliance on Mental Illness (NAMI) and the Carter Center Mental Health Program, often employ narrative for *pedagogical* purposes, such as informing mental health communities and/or the general public about the nature and sociopolitical exigencies of mental illness in contemporary culture. While NAMI promotes this work by supporting 'consumer' storytelling initiatives that give mental illness narratives a public, 'stigma-busting' stage, the Carter Center offers fellowship support to journalists who use their position *on* that stage to advance public discourse about mental illness. As Bracken and Thomas (2005) indicate, however, these types of 'mainstream' narrative-based programs will be unable to serve fully the liberatory' functions and ethical dictates of narrative work until they grapple more systematically with questions of truth and representation in soliciting and circulating mental illness stories (p. 192).

Storying Manic-Depressive Illness

If the aforementioned 'rails' account for the contexts in which mental illness is storied and made appreciable as narrative work, then the organic and social processes associated with mental illness itself account for its narrative 'becoming' as an eventual textual artifact in these domains. 'Mental illness,' however, is as varied as the people who experience and story it. The illness narratives produced and deployed along any of these 'rails,' therefore, are necessarily divergent in content, authorship, and (therapeutic, political, or pedagogical) effect. These stories describe different registers of mental distress as it emerges from individual experiences of the organic processes, symptomatology, and social meanings with which an illness is associated. Moreover, socio-demographic and intrapsychic variations further differentiate the course and character of mental illness and, therefore, also influence its attendant narrative crises and demands.

The *Diagnostic and Statistics Manual-IV* (1994) describes several different forms of 'bipolar disorder,' including two major subtypes—'Bipolar I' and 'Bipolar II'—and the less categorically established, 'secondary' forms, 'Cyclothymic Disorder' and 'Bipolar Disorder Not Otherwise Specified (NOS)' (Mondimore, 1999).[6] Mental health professionals may further elaborate these diagnostic designations with accompanying

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[6] See the 'Bipolar Disorder' information sheet preceding this chapter for detailed information about the signs and symptoms on which these diagnoses are based. Mondimore (1999) offers further elaboration of the two most important diagnostic categories for this dissertation. He describes 'Bipolar I' as "the designation for the classic variety of the illness" and notes that it is "characterized by full-blown manic attacks and deep, paralyzing depressions" (p. 31). In contrast, he notes that 'Bipolar II' is "characterized by fully developed depressive episodes and episodes of *hypo*mania" (p. 39). In comparing the two diagnoses, he writes that: "Bipolar II might be the more common and 'simpler' disorder, and Bipolar I its more complicated and more severe form" (p. 41).

“specifiers” (i.e. “rapid cycling”) or descriptive designations (i.e. ‘with psychotic features’) that indicate the nature, intensity, and duration of ‘manic’ and/or ‘depressive’ episodes. Although medical professionals recognize ‘unipolar’ states as part of the ‘manic-depressive’ continuum, most ‘bipolar’ classifications and diagnostic designations share both ‘manic’ and ‘depressive’ states in common; however, they may do so to greater or lesser degrees and in varying affective proportions (Goodwin & Jamison, 1990; Mondimore, 1999).

These different categorizations of ‘bipolar disorder’ share narrative interests to the extent that they (more often than not) share an affective palette, ‘neuroatypicism,’ and cultural ‘coding.’ Like all types of ‘mentally ill’ storytellers, people living with and writing about manic depressive-illness must negotiate its alteration of perception, sensation, reason, behavior, and emotion—the very building blocks of ‘being.’ They must also then adjust to the new ways of knowing, feeling, and being in the world that those internal transformations occasion. The epistemic and neuro-corporeal disruptions attendant with manic-depressive illness and its treatment often destabilize or reconfigure identity, selfhood, and sociopolitical subjectivity in ways that generate new and often competing notions of ‘self,’ such as an ‘ill,’ ‘well,’ or ‘medicated’ self (Jamison, 1995). These various sites and types of disruption often act as the focal points of manic-depressive storytelling and, therefore, play a central role in uncovering how and why narrative comes to matter in the lives of BP storytellers and their communities. As they embark on their narrative endeavors, therefore, manic-depressive storytellers are likely to seek similar narrative resources and rewards, as well as encounter similar narrative dilemmas in storying the material and metaphysical in BP experience.[7]

Overview of Project

This project seeks to demonstrate how narrative matters to people living with manic depression and other mental illnesses. It takes as its central task the elucidation of ‘the work of narrative’ in a subset of manic-depressive memoir, fiction, and performative personal narrative that exemplifies the promise of progressive narrative practice in contemporary mental health domains. My primary contention is that these texts reveal narrative and storytelling to be most essential in negotiating *selfhood and identity*,[8] *epistemic and embodied experience*,[9] and *political praxis and subjectivity*[10] as they have been transformed or re-configured by manic-depressive illness and its irascible phenomenological finger, invariably stuck in the high-voltage socket of affective experience at its most ulcerating extremes. These indices of narrative function and the phenomena they catalogue organize this project’s analytical architecture and, thus, its explication of the stories and storytellers foregrounded in the chapters that follow. These authors and texts were selected for study because they model narrative tools and ingenuity that promote ethically-, politically-, and experientially-sound manic-depressive

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[7] The bipolar storyteller’s narrative dilemmas (explored in future chapters) include: the limits of narrative structures and linguistic resources; the problem of “truth” and narrator reliability; the dangers of meta-narratives and narratives constructed for/as “closure;” stigma; and the risk that ‘telling’ illness stories poses for authors and readers/listeners.

[8] ‘Selfhood’ is meant here as Eakin (1999) describes: a ‘self’ characterized by multiple-registers that shape identity as it coalesces “in our lives in and as bodies,” including embodied and social sources of self, such as relational and narrative nodes of identity (xi). Brison (2002) also contributes to my analysis of selfhood as fundamentally unstable and fragmented.

[9] ‘Experience’ is meant here as one’s dialogic (and dialectical) engagement with the materialities of lived ‘selfhood,’ as well as the metaphysical and epistemological dilemmas posed there within. This broadly construed ‘experiential’ category of analysis is a heuristic for culturally, socially, and relationally-bound facets of BP identity, embodiment/physiology, and sociality.

[10] ‘Politics’ refers here to both the institutions through which power is acquired and exercised by some groups over others and the mesh of contests that surround negotiations of social power and resources. My treatment of ‘politics’ will be most informed by feminist political theory (Jagger, 1983).

storytelling. Although manic-depressive illness convenes them in this project, the condition finds divergent expression in their lives and pages. This dissertation, therefore, honors their resurgent heterogeneitical impulse as central to *any* compelling, constructive, and 'just' narrative enterprise.

My case for narrative proceeds iteratively, with each chapter taking 'the work of narrative' as an analytical substrate from which to specify the exemplary character and core competencies of the given author and text around which it develops. I imagine these chapters, therefore, as mapping distinct responses to the following guiding questions: What does storying manic-depressive illness *do,* materially and metaphysically, for people living with the illness? What *kinds* of storytelling (i.e. genres, methodologies, media) best serve these ends and under what experiential and sociopolitical conditions? Lastly, how might the work of narrative revealed in storytelling about manic-depressive illness be extrapolated or adapted for use within clinical and activist settings so as to promote both the individual (i.e. intrapsychic and therapeutic) and collective (i.e. political and social) interests of people living with mental illness? I have formulated these questions and the evaluative terms through which they are operationalized and assessed within an interdisciplinary theoretical matrix that privileges feminist, disability, performance, and narrative ethics-based critiques of illness, storytelling, and their many points of political and cultural intersection. This theoretical framework advances along an agile methodology forged from sociological inquiry and literary criticism to accommodate this project's divergent topics and materials without dropping its guiding theoretical and evaluative threads. Nevertheless, to the extent that my sociological-literary criticism gets lost—or *found*—in its own hyphen, this project's 'methodology' constitutes what Norman Denzin (2003) has described as a performative social science.

In formulating my project's guiding questions, I have kept its potential practical applications and non-academic audience in mind. I have recognized, however, that its prescriptive ambitions are necessarily hemmed at its thematic and methodological seams, as both determine the substantive and literal bounds of its study. As a result, this dissertation generates general guidelines for 'the revitalization of narrative practice in contemporary mental health' by stipulating the terms of such a program within the province of manic-depressive storytelling. It does not, however, lay a blueprint for comprehensive mental health policy reform with its outlined 'revitalized narrative practice' at the center. Nor does it propose resolutions to long-standing contests between the various constituencies and moneyed interests perpetually wrangling for a piece of the (meager) mental health care 'pie' based on its revelations about the political and therapeutic efficacies of storytelling. Its 'prescriptive' intent, rather, is to position narrative and storytelling as implements and orientations in re-envisioning what the composition and technical design of such 'blueprints' and 'reforms' might even be or be imagined as doing and why. In short, I contend that they are critical alloys in forging more durable and productive 'pans' in which to bake mental health 'pies' in the first place. This project, therefore, is interested in reinvigorating narrative practice in mental health by affirming the virtues—and *jouissance*—of writing and telling stories. It is also interested, however, in inciting discussion about an ideological and moral vision for contemporary mental health advocacy that aspires beyond, yet does not abandon, the exigencies of the present political moment.

Chapter Reviews

Chapter 2. Terri Cheney's (2008) *Manic* introduces the BP storyteller's primary material and metaphysical dilemmas, as well as enlivens manic-depressive experience at the intersections of illness, identity, and selfhood. My analysis of *Manic*'s narrative 'work,' therefore, centers on revealing the ways in which manic-depression's organic features, intra-psychic processes, and socio-relational aftershocks transform self–understanding and identification. I organize my study around three facilities of selfhood and identity that Cheney indicates are central in BP experience: *Being Bipolar* explores ontology, embodiment, and epistemology through the prism of manic-depressive illness; *Living Bipolar* considers 'being bipolar' *in practice*; and *Writing Bipolar* describes BP storytelling's unique narrative obstacles and rewards. I argue that Cheney's greatest source of narrative capital in seizing Narrative's stakes in both the identificatory and the 'interior' in BP experience is the extraordinary ferocity she displays in crafting her memoir's stunning visceral renderings of manic experience. These literary portraits not only describe, but *achieve* mood, and Cheney unfurls them agilely in a relentlessly clear narrative voice that steadies readers inside the polyphonic chaos of psychosis without sparing them the sharpest and most disorienting edges of its affective din.

Susan Brison's (2002) work on trauma narratives and articulation of an essentially fragmented but relational 'Self' direct much of this chapter's evaluative labor. I also enlist them in arguing that Cheney's (2008) greatest contribution to progressive mental health storytelling is demonstrating (literally) narrative's utility in easing illness-induced adjustments to self-understanding and –identification. Furthermore, I conclude that Cheney's memoir reveals that narrative typologies adept at facilitating those transformations work outside literary conventions to protect the experiential integrity of BP stories, complement and augment their power as political testimony, and bolster their therapeutic value as resources with which BP storytellers may incorporate illness-based 'traumas' into the larger narratives of their lives.

Chapter 3. This chapter explores the convergence of storytelling and activism in Bebe Moore Campbell's *72 Hour Hold* (2005) and deliberates fiction's mettle as a narrative vehicle through which to advance the sociopolitical work of narrative in mental health domains. I proceed with my analysis by distilling *72 Hour Hold's* narrative work into three categories of study that describe the narrative enterprise to which Campbell sets her novel: Campbell's novel acts as *sociological instrumentation* in generating a multifaceted sociology of mental illness; it acts as *progressive political and pedgagoical practice* in functioning as a treatise and primer on contemporary mental health politics; and it acts as *philosophical dramaturgy* in illuminating mental illness's moral economy, as well as the political implications of the narrative imagination.

I maintain that *72 Hour Hold's* (Campbell, 2005) most outstanding narrative achievement, however, is its incisive explication of contemporary mental health politics delivered through and *as* Campbell's ambitious but ingenious literary adaptation of the modern mental health care crisis. I conclude that this feat is demonstrative of *Campbell's* greatest contribution to mental health advocacy: modeling an industrious merger of storyteller, storytelling, and activism. I argue that Campbell has contributed significantly to securing a role for well-crafted, socially sophisticated fiction in mental health storytelling that tells a 'harder truth' than would be possible outside its elasticity, capaciousness, and dramatic scope. In a community recognized for its literati, I contend that few mental health writer-activists have risen to the ‘civic-storytelling’ occasion with Campbell’s grace, authenticity, and fervor.

Chapter 4. This chapter uses Carrie Fisher’s *Wishful Drinking* (2008) as an engaging and iconoclastic point of departure in assessing performative storytelling’s rewards in mental health domains. It enlists Fisher’s memoir to illuminate the particular narrative promise and contingencies of employing performative writing methodologies and personal narrative genres in storying manic-depressive illness. My primary contention is that these modalities are most valuable to BP narrators for their ability to ‘show’ rather than simply ‘tell’ an illness story. I argue that this narrative facility is vital to accommodating the experiential and literary exigencies that inhere in BP storytelling and is attended by a performative ethic that, in privileging didactic, self-reflexive, and embodied narrative work, is better suited than less representationally and communicatively dynamic narrative forms to meet BP narration’s social, political, and intra-psychic demands.

My inquiry in this chapter is divided into two major evaluative sections. The first takes Fisher’s (2008) storying of manic-depressive illness as its organizing subject and the explication of her memoir as exemplary performative writing and personal narrative in style, mission, and method as its guiding objective. The second uses Fisher herself as a case study in appraising celebrity storytelling’s value as a staple of activist narrative practice that reveals both the currency and hierarchization of storytelling in mental health. Furthermore, Fisher’s ‘case’ also serves as a point of departure in discussing the ethics of life writing about manic-depressive illness in a “decadent culture of disclosure” in which the “merchandizing of personal pain” and a rapacious public appetite for confession threaten privacy rights and the social and moral integrity of American culture (Eakin, 1999). Despite its perils and potential dangers as a form of BP meta-narrative, I conclude by endorsing the responsible and targeted use of celebrity storytelling and activism in mental health domains, positing the burgeoning field of media-based mental health activism as a promising arena for celebrity work.

Chapter 5. After raking through disembodied selections of BP stories throughout most of this project, this chapter cedes the evaluative floor to a personal narrative about manic-depressive illness called "Mad People Without Instruments." I wanted to include a BP story whose intended rhythms, structure, and *esprit* were left undisturbed by the impositions and interruptions of critical commentary, excerption, and abridgement. I chose to include a story drawn from my own narrative archive because it is the one I am most authorized to tell and reproduce here in its entirety. This decision, however, also signals an explicit disruption of the illusion that scholarship can or does elude autobiography. It acknowledges, instead, that authorial accountability and self-reflexivity about this subjective mediation are not antithetical to academic rigor but, in fact, its cornerstone (Denzin, 1997). Finally, I also selected this particular story for its exemplification of performative autoethnography as another performative genre that manic-depressive storytellers may stock in their narrative arsenals.

Chapter 6. The final chapter of this project requisitions "thinking *with* stories" (Frank, 1995, p. 158) as a methodological instrument in drawing concluding materiel from its primary texts and drafting final responses to its guiding questions about how Narrative comes to matter most in manic-depressive storytellers' lives. It begins by synthesizing this project's major findings about the genres, media, and methodologies that best perform ‘the work of narrative’ in BP storytelling. In delineating terms for producing and deploying ‘good’ BP narratives, this chapter then broadens its analytical lens to consider the future of ‘good’ mental health storytelling more generally. It posits feminist mental health clinicians and the “New Writing” (Denzin, 1997) as key coordinates directing the course of this work and identifies the ‘the political’ and ‘the interdisciplinary’ as its imminent venues and values. Finally, this chapter concludes by staking a place for *bp Magazine* in this twenty-first century narrative milieu, pinpointing this next-generation text’s location via political vetting against *Ms. Magazine,* a seasoned feminist counterpart.

Notes for Reading

A Note on Politics and Policy

In making the case for Narrative as an *essential* component of progressive mental health work, I am mindful of this ‘work’s’ vast and daunting scope. In the chapters that follow, therefore, I consider the most pressing challenges contemporary mental health communities face, including: staying mentally and physically healthy; thriving outside the custodial purview of the criminal justice system and protecting access to the resources and support on which such ‘thriving’ depends; and investing in scholarship that exposes and addresses the systemic and cultural dimensions of mental distress. Furthermore, these difficulties also include making scientific study of mental illness’s underlying causes more cost-effective and transparent; attenuating the influence of the pharmaceutical and health insurance industries in mental health research; and expanding integrative, patient-centered treatment practices.[11] Finally, contemporary communities must also confront the recovery paradigm’s primacy in mental health domains and

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[11] Treatment practices appropriate for acute, long-term, and preventative care.

experiment with more clinically and narratively pliable approaches that challenge stigma and promote resiliency while affirming difference, identity, and political consciousness based on mental illness. Such approaches would not only better accommodate the clinical and therapeutic particularities of persistent and severe conditions, they would also be less vulnerable to cooptation and commercialization.[12]

The vibrancy and political viability of contemporary mental health communities ultimately hinges on their access to affordable, high-quality mental health care services. Although these services have been scarce and blighted by fragmented, inefficient systems of delivery in the modern era, they face even graver threat in the present historical moment (Grob, 2006; Institute of Medicine, 2001). A worsening economic downturn, as well as persistent cultural failures to recognize health care (of *any* kind) as ethically and morally imperative (Caplan, 2008), has heightened mental health care's vulnerability to budget cuts and disenfranchisement within a general health care system that has long stigmatized and marginalized its services and service providers (Grob, 2001, 2006). Mental health's fate, therefore, is bound up inextricably with the general health care system's own structural and under-capitalization woes. Bioethicist Arthur Caplan (2008) underscores the extent of these problems in a post-Bush Administration era by characterizing the general health system itself as "a wheezing, uncoordinated, under-funded isore that needs to be rebuilt to face the challenges that 21st century living pose" (para. 6).

As President Obama trudges through his first year in office and juggles a host of new and inherited political and economic problems, he has vowed to make health care

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[12] Jacobson (2004) provides a useful history of 'recovery' in mental health policy and practice. 'Recovery' scholarship has much greater ground to cover, however, as 'recovery' threatens to become an assimilationist trope of 'normalcy' in contemporary mental health work (Cloud, 1998).

reform a top legislative priority. His decision to do so, however, reflects less the rise of a critical political mass concerned with asserting health care's ethical import than the contemporary moment's economic imperatives (Caplan, 2008). Health care comprises nearly one-sixth of the American economy and has proved one of its only solvent sectors amidst a blanketing global recession (Caplan, 2008). In this context, *no one* can afford to ignore health care any longer. Although not an ideal impetus for formulating virtuous and sustainable programs of reform, the current climate does provide mental health advocates an excellent opportunity to refine their policy agendas and galvanize their base. These advocates have reason to believe that President Obama's election, at the very least, will suspend the institutional and fiscal free-fall of recent years, however, reprieve and 'not hurling to one's death' does not a politics make.

As we sit on a possible precipice of substantive changes to American health care policies and structures, therefore, we must confront the fragmentation, stigmatization, and economic under-investment that continues to burden mental health care systems (Institute of Medicine, 2001). Individual states must also evaluate their own programs and address the human costs of their chronic shortfalls in providing and delivering mental health care services.[13] Mental health advocates, therefore, must seize this historical moment's democratic and 'reformist' effervescence and determine what their constituencies require to do more than simply survive their lives. Moreover, they must develop any subsequent programs or projects with feasibility and ethics in mind. Finally, as mental health advocates seize this moment, they must understand it as cultural and political opportunity effected by the 'moral occasion of illness' (Frank, 1995) that we now face as a country.

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[13] The National Alliance on Mental Illness (2009) recently gave the states a 'D' average in managing mental health care services. The group has issued the same 'grade' for nearly a decade.

A Note on Bipolar Disorder

Duckworth (2006) describes bipolar disorder as “a medical illness that causes extreme shifts in mood, energy, and functioning that may be subtle or dramatic and vary greatly over the course of a person’s life, as well as among individuals” (para. 1). The illness is a chronic condition marked by recurring episodes of mania and depression that can last from days to months[14] and is treated with medication (e.g. lithium, mood stabilizers, antidepressants, and/or antipsychotics), psychotherapy, and patient education (para. 1). Although research has revealed a genetic basis for bipolar disorder, it has also illuminated the ways in which external triggers, such as stressful environments or negative life events, interact with underlying genetic or biological vulnerabilities to produce the disorder (Duckworth, 2006, para. 6).

‘Mania’ is the bipolar disorder’s activated phase and includes symptoms, such as: increased physical and mental activity/energy; an elated or irritable mood; decreased sleep without experiencing fatigue; racing thoughts and flight of ideas; increased and/or more rapid talking (i.e. ‘pressured speech’); grandiosity and risk taking; and impulsive activities, such as spending sprees, sexual indiscretion, and alcohol abuse (Duckworth, 2006, para 2). The illness’s other phase, ‘depression,’ presents contrasting symptoms, such as: loss of energy and prolonged sadness; increased feelings of worry, anxiety, or guilt; restlessness and irritability; less interest or participation in activities normally enjoyed; hopelessness and thoughts of suicide; and changes in appetite or sleep patterns (Duckworth, 2006, para. 3). The terms ‘mixed state’ and ‘rapid cycling’ further describe

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[14] Duckworth (2006) indicates that bipolar disorder affects over ten million Americans (men and women in equal proportions). Bipolar-related episodes usually begin in adolescence or early adulthood and vary by the type, i.e. bipolar I, bipolar II, cyclothalmic, or bipolar NOS. See this chapter’s previous review of these different bipolar categories.

bipolar disorder and its associated episodes. A mixed state refers to the co-occurrence of manic and depressive symptoms (i.e. a depressed mood accompanied by manic activation), and rapid cycling refers to the increased frequency of episodes that some people with the illness may experience (Duckworth, 2006, para. 5).

A Note on Language

Kay Redfield Jamison (1995) makes important clinical and political distinctions between 'bipolar disorder' and 'manic-depressive illness.' Whereas the former is rooted in and legitimized by the scientific nomenclature of the *Diagnostic and Statistics Manual (DSM)*, the latter is "historical" and, in Jamison's view, clinically and politically preferable (pp. 180-181). Jamison has and medically treats this condition and indicates that, on both accounts, she finds the word 'bipolar' "strangely and powerfully offensive" for its obfuscation and minimization of "the illness that it is supposed to represent" (p. 181). She contends that "manic-depressive," in contrast, captures "both the nature and the seriousness of the disease…rather than attempting to paper over the reality of the condition" (pp. 181-182).

Jamison (1995) concedes 'bipolar disorder's' predominance in contemporary culture and clinical work and attributes its primacy, in part, to patients' and clinicians' belief that it is the less stigmatizing term (p. 182). Although she encourages people living with the illness to adopt the terminology that best suits their experiences, she questions 'bipolar disorder's' medical accuracy in arguing that "the polarization of these two clinical states flies in the face of everything we know about the cauldronous, fluctuating nature of manic-depressive illness" (p. 182). Jamison also believes that re-branding manic-depressive illness is less effective in addressing its associated stigma than adopting comprehensive advocacy programs that emphasize public education about the illness, expand its scientific study, and invest greater resources in political work that improves the lives of people of living with the illness (pp. 183-184).

I concur with Jamison's designation of 'manic-depressive illness' as the more clinically and politically efficacious term, however, I am less hesitant about and conditional in my support of lexicons that privilege 'bipolar disorder' instead. I use 'manic-depressive illness' and 'bipolar disorder' interchangeably in the chapters that follow in order to accommodate the linguistic preferences of the authors whose narratives I examine. In addition to 'bipolar disorder' and 'manic depressive-illness,' I also employ the abbreviation 'BP' with some frequency. I use it as an abbreviation proper (i.e. a shorthand for 'bipolar disorder' meant to ease linguistic redundancy) and as an identificatory term that people living with manic-depressive illness often employ (formally and informally) in contemporary culture. 'BP,' therefore, signifies both an act and practice of individual and communal self-naming, as well as references a collectivity and subjectivity bound, but not entirely beholden to, 'bipolar disorder's' clinical meaning and administration.

Chapter 2

Selfhood, Identity, and The Bipolar Storyteller:
Terri Cheney's *Manic*

Terri Cheney's *Manic* (2008) opens full stride: Cheney, gripped by a mixed-state apocalypse and mourning the death of her father, has absconded to New Mexico on a suicide quest that soon goes horribly awry. "I didn't tell anyone that I was going to Santa Fe to kill myself," she writes. "People always mean well, but they don't understand that when you're seriously depressed, suicidal ideation can be the only thing that keeps you alive. Just knowing there's an out—even if it's bloody, even if it's permanent—makes the pain almost bearable for one more day" (p. 5). Cheney's 'out' proves far bloodier (and less permanent) than she could have imagined, however, when on the eve of fruition, her plan is derailed by a troubled young locksmith dispatched to her rented cottage after she loses her key and locks herself out of her "most desperate dream" (p. 9). By the time he gives up on opening the door and busts through a window instead to let Cheney inside, the locksmith has not only been ensnared by Cheney's frenetic desperation, he has raised its stakes with a churning volatility of his own. When Cheney offers him a 'celebratory' drink, the two become locked in a dizzying collision of human suffering and despair unfolding amidst brash manic intimacies and the perilous collusions of two strangers' self-loathing and misery.

Despite the chaos that subsumes them, Cheney's (2008) refusal of the locksmith's advances is resounding and absolute, her *'NO!'* reverberating hauntingly across the page as he overpowers then rapes her with a broken bottle, finally choking her unconscious before fleeing the scene. When she regains consciousness, Cheney is badly injured but momentarily uncertain about how and even *if* the attack should "matter," given that she would be "leaving this body for good" (p. 14) as soon as she could muster the strength to overdose as planned. As she surveys her wounds, however, she concedes that it *did* matter. "It mattered a lot," Cheney writes, "I wanted a clean death…no loose ends or good-byes, not even to my innocence" (p. 14). This inspection, then, only sharpens Cheney's resolve to die and reinvigorates the grief that drove her here: her father is gone, and she is "utterly and completely alone" for the first time in her life. It doesn't matter that her father would not have protected her from this attack, or even acknowledged the dangerous mania that made her vulnerable to it. "'It's all in your head,'" he would tell her about manic-depression, "without the slightest tinge of irony" (p. 15). Shortly before his death, Cheney's father even disinherited her after 'catching' her in the act of taking psychotropic medication. She had forgiven him for that transgression, but reeling and brutalized in New Mexico, she could not forgive him for leaving her alone. Struggling through injury on the cottage bathroom floor, Cheney begins swallowing fistfuls of pills and contemplating her fate in the afterlife.

When she regains consciousness this time, Cheney is strapped to a hospital gurney. "I knew it wasn't Heaven," she writes, "because they kept asking for my insurance" (2008, p. 19). After a doctor informs her that she is still alive, she speculates that she might actually be in Hell. "I didn't make it," she writes somberly, "desperation had failed me" (p. 19). Indifferent or oblivious to her devastation, however, the doctor continues to reassure her of her good fortune: "We found you just in time…It seems a young man, a locksmith I think, came by to replace a broken pane of glass at your house, and he found you unconscious. He saved your life" (p. 19). Cheney is silent, stunned. She has no idea what motivated the locksmith to return—let alone try to revive her and call for help when his own efforts failed. Nevertheless, she *was* certain that, however much she did not want her life back, *he* had given it to her. When the police arrived at the hospital later in the day, therefore, Cheney turned them away. She vowed to keep her memories of that night to herself—for now.

Reading *Manic*

Cheney (2008) warns readers from the outset that manic-depressive illness is not a safe ride: "It doesn't go from Point A to Point B in a familiar, friendly pattern. It is chaotic, unpredictable. You never know where you're heading next" (p. 1). By choosing to join her on this 'journey' into bipolar experience, then, they are assuming its risks—most notably, the looming threat of affective ambush that her memoir carries from narrative start to finish. After all, Cheney's wrenching account of events in Santa Fe comprises only the first of her memoir's eighteen equally grueling chapters. By hurling the reader into manic-depressive illness at its most perilous extremes, however, this opening vignette serves a number of important narrative functions: it introduces readers to her text's jarring pace and lush narrativity; samples manic-depression's elementary corporeal and epistemic disruptions; introduces the material and ethical exigencies that inhere in BP experience; and, proffers an embodied account of manic-depressive illness that enlivens its uni-dimensional clinical description, as well as challenges popular representations of the illness that efface its human costs.

Importantly, Cheney also leads with this story of grave personal reckoning in order to register manic-depressive illness's central material and metaphysical dilemmas, as well as survey her memoir's basic moral landscaping. Cheney (2008) closes her recollections about events in Santa Fe with the assertion that "the world itself is bipolar—driven to extremes but defined by flux" (p. 20). This determination suggests both the structure of her memoir's 'moral landscape' and the nature of the 'dilemmas' that define and are defined by its contours, textures, and shapes. Cheney confesses that her life often has been derailed by the rigidity and naivety that attend the polarities of 'black and white' and 'either/or' thinking. Although she condemns 'manic depression' as a *mind-set* that epitomizes these polarizing extremes of thinking, she maintains that manic-depressive experience itself has uniquely prepared her for a 'real world' of contradiction—a place where nothing is absolute, where rapists can be saviors and beloved fathers perpetrators of harm. As she writes: "It was impossible not to know that my dad loved me and that his love had conditions, and it was still love. The trick was remembering that enormous word *and*" (p. 20).

As Cheney sets readers afloat in the chaotic wash of her memoir, she offers the 'and' as a narrative lifeboat—even as she positions manic-depressive illness itself as a call to and embodiment of the '*and.*' Furthermore, Cheney also emphasizes that narrative in general and *Manic* (2008), in particular, have played essential roles in making her experiences of 'illness-as-*and'* both meaningful and bearable. Although she refuses to cast mental distress as 'virtuous suffering,' Cheney's prioritization of Narrative's lifesaving and life-staking work in the face of this suffering not only preoccupies and defines her memoir, it gives it a pulse. "Telling my story is what's kept me alive," Cheney tells readers in *Manic's* introduction, "even when death was at its most seductive. That's why I've chosen to share my personal history" (pp. 2-3).

Manic's (Cheney, 2008) complex treatment of manic-depressive experience makes it an excellent model of BP personal narrative that strives to work outside the conventions of traditional storytelling to realize and re-imagine narrative's ideopolitical and therapeutic potential in mental health storytelling. This chapter explores *Manic's* success in a particular realm of BP narrative work—selfhood and identity—and specifies the substantive rewards and mechanisms of these achievements as they advance this project's larger goal of elaborating progressive storytelling models in mental health. This chapter's analytical work pivots, in large part, on Terri Cheney's exceptional skill as a wordsmith—in particular, her gift for manic 'grit.' I maintain that Cheney's true value as a *bipolar* storyteller rests in the extraordinary narrative ferocity and agility she displays, first, in crafting stunning visceral renderings of manic-depressive experience that not only describe—but *achieve*— mood, and, second, in delivering these affective portraits in a relentlessly clear, eloquent 'voice' that steadies readers inside the polyphonic chaos of mania and psychosis it unleashes around them while refusing to blunt the sharpest and most disorienting edges of its din. I argue that these portraits of manic experience act not only as feats of storytelling in their own right, but constitute Cheney's greatest source of narrative capital in demonstrating narrative's utility in navigating selfhood and identity as they are transformed by manic-depressive illness. Furthermore, I contend that they are also Cheney's most distinctive assets in tackling the bipolar storyteller's narrative dilemmas and, therefore, key in *Manic's* actualization of Narrative's political and therapeutic worth.

I organize my discussion of 'the work of narrative' in Cheney's *Manic* (2008) around three major facilities of BP identity and selfhood: *Being Bipolar* examines

Manic's elucidation of BP ontology, embodiment, and epistemology; *Living Bipolar* explores BP 'being,' identity, and selfhood *in practice*; and *Writing Bipolar* evaluates Cheney's navigation of the bipolar storyteller's narrative dilemmas while also considering *Manic's* political and therapeutic utility. Before developing these spheres of inquiry, however, I briefly review the theoretical framework that will inform my close reading and analysis of Cheney's text, especially in this chapter's latter half. Susan Brison's (2002) work on trauma narratives and the remaking of 'self' in the aftermath of violence organizes much of this framework and, therefore, guides this chapter's overall explication of the models of BP identity and selfhood that emerge from Cheney's memoir. Although I draw from Brison's general theorizations about narrative's sociopolitical imperatives and import in managing traumatic experience, I give particular attention to her elucidation of the 'self' as essentially fragmented and relational, as well as to her critiques of the recovery paradigm, in making a case for narrative as a *necessary* resource in tending to one's 'self' amid upheaval and disruption.

Finally, I conclude this chapter by considering the ways in which Cheney's memoir contributes to progressive mental health storytelling. I suggest that it is most instructive in illuminating narrative's promise as a practical tool for bipolar storytellers in easing their adjustments to identity and self-understanding, which persistent and severe mental illness both occasions and demands. As Cheney's text suggests, however, not any story/narrative will do in facilitating these transformations; in fact, it demonstrates (by example) that people living with mental illnesses are best served by narrative work that protects the experiential integrity of their stories, augments their power as testimony, and actualizes their worth as therapeutic practices and devices.

Manic's 'Narrative Work': BP Selfhood and Identity

In *Aftermath: Violence and the Remaking of Self*, Susan Brison (2002) uses her own experiences of sexual violence as a point of departure in exploring the performative aspect of speech in testimonies of trauma. In short, she investigates "how *saying* something about the memory [of trauma] *does* something to it" (xi). Brison posits narrative as an essential component of working through traumatic experience that enables a survivor to 'go on' by "opening up possibilities for the future through retelling the stories of the past." She argues that narrative does this "not by reestablishing the illusions of coherence of the past, control over the present, and predictability of the future, but by making it possible to carry on without these illusions" (p. 104). As Brison indicates, however, narrative's value in surviving trauma is contingent upon the trauma survivor's access to empathic listeners. In consequence, she contends that "it is not sufficient for mastering the trauma to construct a narrative of it; one must (physically, publicly) say or write (or paint or film) the narrative and others must see or hear it in order for one's survival as an autonomous self to be complete." She argues that this dependence on others reveals the "self" as fundamentally relational in nature and shows the "extent to which the self is created and sustained by others and, thus, is able to be destroyed by them" (p. 62).

Trauma Narratives, Selfhood, and Identity

Brison's (2002) work on trauma narratives provides a critical context in which to evaluate the dynamic interplay of narrative, identity, and selfhood in manic-depressive experience. Cheney characterizes BP selfhood and identity as fundamentally fragmented, steeped in traumatic disruption, and deeply troubled by relational deficits that (per

Brison's model) imperil bipolar storytellers' ability to employ narrative as a resource in moving forward with their lives as they are transformed or reconfigured by mental distress. Brison's theorizations of narrative's restorative properties, as well as her reformulations of self and selfhood, dictate a different intra-psychic project for those people, like Cheney, who have taken up narrative work as a means of 'recovering' from traumatic experience. Brison's conceptionalization of 'moving on with one's life,' for example, is rooted less in a sense of 'recovering' one's pre-trauma self and life pursuits than in promoting a survivor's ability to incorporate traumatic experience into the larger narrative of her life in order to seize the possibilities of a future unburdened by illusions about the past and previous notions of self.

BP and trauma narratives' points of convergence. *Manic* (Cheney, 2008) tests Brison's basic claims about trauma, selfhood, and identity in narrative work and, in the process, underscores the indispensable role narrative plays in managing the emotional, corporeal, and existential 'traumas' wrought by manic-depressive illness. The memoir both documents and enacts Cheney's struggle to realize a personal identity and 'self' that incorporates, without succumbing to, the upheavals of bipolar disorder—an illness-informed sense of herself that recognizes the inescapably fragmented nature of (especially bipolar) selfhood and, yet, does not preclude the possibility of her 'wellness' or inclusion among a community of empathic others. Furthermore, Cheney's pursuit of a distinctly BP selfhood is also marked by her explicit use of storytelling as a means of culling this new sense of her'self' while repairing the wounds incurred by the excision or 'roughing up' of the 'self' it deposes or subsumes. In extracting therapeutic and existential reward from storytelling and acting as a form of 'testimony,' therefore, *Manic* is precisely the type of trauma narrative project Brison imagines as conducive to ‘remaking the self’ amidst violent disruption.

In many ways, *Aftermath* (Brison, 2002) and *Manic* (Cheney, 2008) are complementary texts—the latter embodying and enacting the former’s ‘theory.’ As such, they interlock at several key points of narrative convergence: they make similar use of personal narrative in working through significant disturbances to ‘self;’ they are both charged with representing and making meaningful experience at the extremes of human existence; they work to contextualize their trauma stories within the larger sociopolitical milieus in which they occurred and will be received and interpreted once told; and they reject the recovery paradigm (in its ‘purest’ form) in favor of alternative therapeutic models that, in positing the self as essentially fragmented, direct therapeutic work toward more pragmatic, philosophically and clinically plausible goals, such as “resiliency” (Brison, 2002) and “stability, for now” (Cheney, 2008).

BP and trauma narratives’ points of departure. Despite these literary and ideological affinities, Cheney’s (2008) text indicates that manic-depressive experience tests, as much as affirms, the theoretical and practical applicability of Brison’s work on trauma narratives. As suggested in the previous chapter, the nature of manic-depressive illness itself makes people living with the illness vulnerable to neurochemical, cognitive, and behavioral destabilizations (to greater or less degrees) that, as *Manic* animates, uniquely burden selfhood and identity. As indicated, the illness’s impact on how one thinks, reasons, senses, remembers, and ‘acts’ often wreaks havoc on self-understanding, relationships, and social ‘place’—in effect, mediating one’s ‘being’ in the world and, thus, (re)setting the ontological, epistemological, and relational terms of how, why, and to what consequence one lives his or her life. Furthermore, the repeated disruptions of 'identity' and 'self' to which manic-depressives (especially those with a Bipolar I diagnosis) are subject often erupt along the bio-physiological fissures of the BP body in ways that dramatically—and dangerously—alter behavior.

Cheney's (2008) recollections about Santa Fe illuminate how these changes may catalyze a host of traumatic events that both exacerbate and exponentially amplify the underlying organic and intra-psychic processes at work in any given individual and/or bout of mental suffering. Her memoir suggests that these internal and external forces often make BP women (especially those of color and/or who are poor), in particular, vulnerable to physical and sexual violence, social subjugation and criminalization, and any number of acts of self-harm. In contrast to Brison's (2002) treatment of trauma as emanating, more or less, from a single event or distressing 'epicenter' (e.g. a sexual assault), Cheney's memoir (2008) indicates that trauma is not simply a risk or isolated outcome of (especially untreated) manic-depressive experience—it is a veritable industry motored and sustained by the symptomatology, pathophysiology and materiality of the illness itself.

The torrent of corporeal, ontological, and epistemic uncertainty that afflicts BP identity and selfhood leaves people living with the illness to negotiate significant internal fracture—most pressingly, to distinguish between 'real,' 'ill' or 'medicated' states of being and subsequently manage their competing interests as distinct but often overlapping ways of knowing and 'doing' (Jamison, 1995). This internal division and discord inevitably informs, if not determines, the nature of BP embodiment—'being' in the most literal sense. The BP body is subject to both the illness's organic processes and the neurochemical and psychological re-inscriptions of the therapeutic modalities used to treat them, such as psychotropic medications (Jamison, 1995; Mondimore, 1999). BP identity and selfhood are also troubled by external processes, however, as the illness takes a major toll on one's relationships and social roles. People living with the illness, for example, often incur significant relational deficits as a result of its destabilization of their interpersonal connections and social roles (Jamison, 1995). Furthermore, widespread social stigma and discrimination against people living with manic-depression and other mental illnesses only compound (and/or precipitate) these losses, often working in conjunction with other forms of marginalization in disenfranchising BP storytellers and potentially jeopardizing their narrative work (Perlin, 2000; Stefan, 2001).

The 'burdens' with which BP selfhood is saddled force BP *identity* to carry a heavy intra-psychic and social load, obliging it to serve a broad catalogue of functions for both BP people and communities. Cheney's *Manic* (2008) suggests that personal and communal investments in BP identity are essential to one's acceptance of the illness as a persistent condition requiring a long-term commitment to often unpleasant and expensive treatment. Cheney's text also indicates that these investments support a BP person's day-to-day management of the illness, as well as fosters political solidarity among a larger BP community. Importantly, this 'collectivization' helps combat the external and internalized stigma associated with all mental illnesses in contemporary culture (Cheney, 2008; Fisher, 2008; Jamison, 1995).

'*Being' Bipolar*

People living with manic-depression frequently 'tell' their diagnosis as an origins story, as 'being' bipolar often begins with *becoming* bipolar via nosological designation or christening. Importantly, many people who have mental illnesses—including Cheney—draw great relief and validation from this process of clinical pathologization; a diagnosis makes ‘sense’ of them and gives them something ‘to be’ after psychiatric illness has rendered what ‘used to be’ unrecognizable, provisional, or irrelevant. Cheney (2008) notes that her diagnosis followed on the heels of a stint defending Michael Jackson in a case that presaged the end of her legal career and landed her in electroconvulsive therapy (ECT) for what her doctors had determined was treatment-resistant depression. ECT triggered a severe manic psychosis that indicated manic depression as a more accurate diagnosis, however, and from the ruin of that episode, Cheney emerged “a different person, with a different identity…no longer depressed but bipolar” (p. 161). Cheney emphasizes that “the label mattered,” as it “made sense of [her] erratic life” (pp. 161-162). In consequence, she embraced it swiftly and absolutely as an essential and certain orientation in the world. “I believe in this diagnosis,” she writes, “It’s as true to me as being a redhead. Despite the constant shifting of the earth beneath my feet, I feel grounded at last” (p. 162).

Cheney’s diagnosis may have bestowed her a ‘bipolar identity,’ but only a BP community could bequeath a ‘*B*ipolar identity.’ A powerful troika of shame, denial, and ambition limited her identification with manic-depressive illness, which remained mostly private and individualized for many years after her initial diagnosis. Cheney (2008) indicates that this combination of forces thus hindered her self-recognition as being ‘one of them’—one of the *real* mentally ill people and “walking diagnoses” she met and feared in hospitals as potential mirrors of her own disease (p. 128). Cheney was a formerly-elected ‘Most Likely to Succeed’ Vassar graduate who represented major moguls and movie stars in the theater of courtrooms. She imagined herself, therefore, as fundamentally different—and better (or, perhaps, less sick)—than those people (pp. 83-84). Consequently, Cheney's encounters with other BPs became crucial dialectal engines driving her B/bipolar evolution. Each one advanced her identification with the illness and the mental health community a little more than the last. In the process, each encounter strengthened Cheney's epistemic and material hold on the illness, as well as deepened her engagement with 'being bipolar' as a social and collective endeavor, *not* simply a biopsychosocial experience she endured in isolation.

Manic (2008) begins its tracking of this maturation with Cheney's initial refusal to identify explicitly with manic-depressive illness. Cheney recounts an incident in which she failed to defend a bipolar associate against the derision of her colleagues after they discovered he took Lithium. In truth, Cheney was not only silently complicit in their ridicule—she 'joined their chortling.' "Manic depression was not my identity back then," she explains, "It was simply something I had, like a nasty flu or poor credit. I wasn't even convinced it was real most of the time" (p. 28). Importantly, 'it' was also something Cheney still believed "might magically go away any morning now" (p. 28). She admits, therefore, that the fairy tale of waking up "one fine sunny morning to discover that the spell is broken, the curse is lifted, and [she was] not bipolar anymore" (p. 27) ultimately made her unwilling to risk her professional future by acting in solidarity with her business associate and the illness by which they were bound. This incident gave Cheney a disturbing preview of her own fate at this firm and, ultimately, inspired her to call a headhunter and disclose immediately: "There's something you should know about me…I'm bipolar" (p. 29).

Cheney's BP elitism was unseated only by her interactions with other patients during psychiatric hospitalizations. Cheney (2008) notes that two encounters were particularly transformative in recognizing herself as 'one of them.' The first one occurred during her first hospitalization, which, incidentally, her psychiatrist goaded her into by comparing her brain to a 'Ferrari' that required a "tune up" by the "experts" at a "Ferrari shop" (p. 80)—not, presumably by the drop-outs at a Jiffy Lube. Once at the plush oceanside facility, Cheney was paired with a roommate whom she describes as "certifiable" and badly disfigured by burns (p. 87). Despite Cheney's fear and initial misgivings about her roommate, the two women quickly developed a relationship in which Cheney experienced empathy exchanged through a "shared language of suffering" for the first time (p. 87). Cheney marks this time as a turning point at which she became cognizant of *already being* 'one of them' (p. 88). With her roommate's support, Cheney began to "welcome the monster" of her illness and "give it a home." She reveals the extent of her gratitude for this shift in BP identity and self-awareness in disclosing that every year on the anniversary of that hospitalization, she sends her old roommate a card, saying only 'thank you.' She sends it anonymously, she says, "because I don't know how to explain. I only know that my greatest victories have always been surrenders" (p. 88).

The second in-patient encounter Cheney (2008) cites as central to the evolution of her BP identity represents the triumph of that first experience of empathy and connection. It occurred after a fellow patient attacked Cheney while she was on a fourteen day hold. Cheney had to choose between using the incident as leverage in securing an early release and hiding the attack in order to spare her attacker an indefinite stint in 'isolation' (pp. 134-135). Cheney herself had been held and humiliated by an attendant in 'isolation' just days before. In an act of humanitarianism and solidarity, therefore, she ultimately decided not to report her assailant. Importantly, she made her choice only after the patient who came to her rescue during the assault made a startling appeal, imploring her to remember that: “He [her attacker] is just like you. He’s sick” (p. 135). Cheney reflexively resisted (and resented) this comparison, but eventually conceded that there was little evidence left to suggest that she belonged anywhere *but* among her present company: the paranoid schizophrenic who had held her at ‘fork-point’ in the hospital cafeteria and the delusional man, (predictably self-named) ‘Jesus,’ who had successfully brokered their peace deal (pp. 134-135). After all, paramedics had wheeled Cheney into that hospital only days before when her exterminator (in a bit of irony she appreciates) found her barely alive following yet another suicide attempt (p. 120).

As road-marks on Cheney’s path to recognizing herself as, in fact, already being ‘one of them,’ these in-patient encounters helped precipitate her development of B/bipolar identity. Her exercise of empathy toward the patient who attacked her, however, was particularly important in expanding and politicizing her BP identification. It ultimately allowed her to access the support and political perspective of a larger community of people living with mental illnesses with whom she felt bound by common experiences of marginalization. These resources, in turn, fostered a ‘Bipolar’ identity with which the seeds of her now deeply entrenched sense of BP consciousness were sown. [15] Cheney (2008) describes these dynamics at work within her patient support group: “We shared the instant intimacy of the oppressed, finding endless topics of discussion in the apathy of the nurses, the incompetence of doctors, the shocking injustice

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[15] Cheney’s (2008) BP identification today includes serving on the Community Advisory Board of the UCLA Mood Disorders Research Program and running a community support group at UCLA’s Neuropsychiatric Institute (*Manic’s* dust jacket).

of the health care system. Mostly, however, we talked about what it was like to be mentally ill" (p. 136).

Cheney's commiseration with people 'like her' was essential to her negotiation of another major facet of 'being' bipolar: inhabiting the BP body, mastering its terrifying corporeal contingencies, and recalibrating her epistemic bearings accordingly. Cheney (2008) frequently declares some experiences as belonging solely in and to the province of BP people (p. 41). As a result, she considers other BPs indispensable to her management of the material and intrapsychic demands of 'being bipolar.' She indicates that this service is particularly crucial when even the most ordinary and prized of emotions, such as happiness, can feel treacherous to the BP mind and brain. As Cheney describes: "How could I ever hope to tell a normal personal about the terrors of being happy? Unless there was a damned good reason for it, something objective and verifiable like a winning bingo card or a negative biopsy, happiness wasn't a safe harbor for me. It was just another checkpoint on the road to mania" (p. 33).

Cheney (2008) indicates that, like many people living with manic-depressive illness (especially those who are doing and feeling well), she is forced to subject every moment of joy to critical scrutiny, leaving each dispirited with exhaustive, heartbreaking suspicion (p. 33). As she indicates, it *is* possible for a BP person to enjoy life 'inordinately,' as "what felt like happy now might well be *too* happy in a minute" (p. 33). In consequence, she writes: "When the little hairs on my neck tickled, or the midwinter sun shone more brightly than usual, or I heard myself actually laughing out loud…I stopped, if I still could. I stopped just to see if I *could* stop. Then I ruthlessly pinpointed the moment on the mood scale, skewered it like a dead butterfly" (p. 34). She concedes that “happiness management was a cruel science”—it may have kept her “safe from unexpected butterflies, but it also killed all the flutter and delight” (p. 34). As she suggests, therefore, “only another manic-depressive could understand that putting on the brakes is sometimes far more exhilarating than winning the race” (p. 40). Another ‘manic-depressive’ would know what lurks around a manic corner and, therefore, could understand why happiness, for Cheney, “no longer lived in excess.” To the contrary, “It lived in the absence of: the absence of pain, the absence of depression, the absence of consequences I never intended to incur” (p. 41).

‘Being’ bipolar, therefore, requires adjustments to different ways of feeling, knowing, and being in the world, all of which are mediated through a unique type of embodiment informed by the internal fracture and flux characteristic of BP symptomatology and experience (Jamison, 1995). Cheney (2008) underscores the great existential uncertainty attendant to this fracture, as a manic-depressive person struggles to discern if the ‘real me,’ ‘ill me,’ ‘well me,’ or ‘medicated me’ is calling the shots in his or her life. She reports feeling perpetually tasked with teasing out and accounting for her various ways of knowing, being, and behaving; in particular, she indicates that she must constantly reconcile the often grand behavioral and cognitive divide between the ‘ill me’ and the ‘well me.’ This disjuncture has been especially sharp and consequential in the context of Cheney’s intimate relationships. As her BP identity evolved and her sense of ‘self’ consolidated over time, however, she was able to be more consistent and principled in her handling her relationships.

Cheney (2008) contends that one of her biggest relational frustrations during the early years of ‘being bipolar’ was coping with the “monumentally unfair” process of having to atone for the transgressions of a manic 'other' she felt she barely knew (p. 215). She writes: "Sure, I'd met that manic redhead before…We frequented the same mirror, I'd seen her in passing. But it's not like we were actually related. As far as I was concerned, she'd hijacked my flesh, and I shouldn't be held responsible for anything my body had done while she was in control of it" (p. 215). Prolonged periods of good health and medication compliance helped crystallize Cheney's BP 'being,' however, and she slowly began to accept responsibility for her manic other's misdeeds. She figured out that, "regardless of who was ruling [her] brain chemistry that day," the perpetrator was still someone the world knew as Terri Cheney (p. 215). Importantly, Cheney notes that she was astonished to find that taking responsibility for her manic misconduct did not feel like an admission of guilt; rather, it felt like an acceptance of her illness, in all its many facets. "It felt like surrender," she writes, "This is who I am: sometimes manic, sometimes depressed, but always and inescapably manic-depressive" (pp. 215-216).

Finally, 'being' bipolar means having to let go of *not* being bipolar. In this sense, Cheney's *Manic* (2008) often reads like a lamentation for the 'self' she understood herself as having and being before the onset of her illness, as well as for the future self she imagined she would become. Cheney's grief for this aspirational version of who she is or could be exists alongside her quest to establish new bearings and purpose in the midst of illness. *Manic's* frequent eschewal of chronology often casts this dynamic as an existential haunting that looms over Cheney without ever truly making its peace. Cheney, in fact, actively resists any neat resolution of these intra-psychic dislocations and existential deaths. She offers instead only the untidy calculus of grief that transacts so much of BP 'being' and 'living' as people who have the illness struggle to account for an old life’s losses and expectations in light of a new one’s demands. For Cheney, this means having to let go of a long-held desire to simply be ‘somebody’s girl next door.’ She writes: “The girl next day isn’t crazy. She may have her quirks, but at heart she’s innocent, simple, and pure. Life touches her lightly; it doesn’t leave scars” (p. 75). Cheney concedes that, “instability like [hers] needs considerable distance to pass as quirkiness” (p. 75-76), and thus she knows ‘*living bipolar*’ means surrendering unviable ‘self’ fictions and embracing the practical demands of a newfound reality.

Living Bipolar

Cheney (2008) reveals that one of manic-depressive illness’s primary mechanisms of disruption in BP people’s lives is its obliteration of the relational economies that normally regulate identity and selfhood and, by extension, that infuse one’s life with meaning and direction (Brison, 2002; Eakin, 1999). As Cheney’s memoir demonstrates, however, narrative can act as a key resource in reconfiguring identity and selfhood in the wake of illness-induced destabilizations of interpersonal connections and social roles. As previously suggested, BP experience may complicate or refuse models of relational selfhood, such as the one Brison (2002) propose. The illness’s impact on behavior, in particular, can lead to the alienation of potential pools of empathic listeners by exhausting (literally) existing ‘audiences’ of partners, family members, and friends who must often bear the brunt of their loved one’s illness and, therefore, may be unwilling or unable to hear their stories. These relational deficits make people living with mental illness all the more indispensable to *each other* as listeners and sources of support; however, these losses still necessitate the reconfiguration of one’s ‘being’ *and* ‘living.’

Cheney (2008) portrays ‘living bipolar’ as an athletic social and interpersonal enterprise. Her memoir demonstrates how manic-depression’s decimation of relationships and social roles adversely impacts a BP person’s life and upsets the relational dimensions of his or her ‘selfhood.’ It also painfully catalogues the illness’s methodical slaughter of all things relational in Cheney’s life, describing how illness episodes claims her friendships and intimate relationships, one by one, while precluding the creation of new ones. Although BP symptomatology and ‘manic misconduct’ are prime culprits in this destruction, Cheney also admits that she is often in a constant state of terror about being ‘found out’ and, therefore, makes every effort to ‘hide away’ when not feeling or doing well. Cheney also indicates that her friendships with women were disproportionately vulnerable to ruination as her illness developed and was inconsistently treated over time. “I can hardly blame them,” Cheney writes about her women friends, “when I was depressed, I never returned phone calls. And when I was manic, I simply had no use for women.” (p. 164).

Cheney (2008) illuminates how the destructiveness of a bipolar episode can spill into the lives of others, frequently hijacking the innocent (and often much beloved) bystanders in one’s life. She ruminates on the tragedy of BP intent in such situations in trudging through the agonizing details of betraying her best friend, “Linda,”[16] whom she cites as evidence of how her “sins were greatest against those [she] never wished to harm” (p. 163). These ‘sins,’ she argues, always leave their mark: “Look closely enough in the mirror, and you’ll see a whole new spate of crow’s feet, or a crinkle in your forehead where it once lay smooth. To this day, I see the furrows etched around my mouth, and all I can think is: Linda” (p.163). “Manic-induced lust and ECT-induced

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[16] Cheney uses pseudonyms to protect the identities of her main ‘characters.’

amnesia" prompted Cheney to have an affair with Linda's boyfriend, "Jeff." Cheney concedes that, after "a year of bone-crushing, soul-starving depression," she chose to believe "in the law of the moment" instead of the laws of friendship (p. 169). As Cheney's health improved, however, she began to reckon with the full implications of her betrayal. She became increasingly consumed by guilt and remorse, and, soon, the transgression had taken on a life of its own: "I didn't realize that after that first delicious plunge into temptation, you just keep falling and falling forever. Gravity not only exists, it seems. It is a moral imperative. And it was going to keep me bound to [Jeff], locked in an endless free-fall together, for as long as he would have me, for as long as I could convince him to stay" (p. 175). Cheney maintains that she and Jeff "will always be friends, or lovers, or something else inextricably entwined. It's not about love, it's about retribution. When God wants to punish us, He grants us our sins" (p. 175).

Cheney's (2008) manic-induced conquests are strewn about her memoir's seething pages; however, "Rick," whom Cheney describes as 'the love of her life' (p. 92), emerges from the relational carnage as a recurring presence in her text that comes to emblematize manic-depression's catastrophic impact on her relationships and relationality. When Rick materializes in Cheney's memoir, he is almost always suspended in Waiting: when Cheney is well, he is waiting to see if her good health is 'real' and sustainable; when she is not well, he is waiting for the tide to turn. Mostly, it seems, he is waiting for the other shoe to fall—or be hurled at him in a manic rage—and, always, he is waiting for something to justify his belief that Cheney's illness *will* resolve and that he will not always feel bullied and shortchanged by loving her. Cheney confesses that she was sympathetic to Rick's position but simply could not reciprocate his care and attention throughout most of their on-again/off-again love affair. Importantly, even when Rick's love was available to her, Cheney describes it as always feeling "just out of reach" when she was ill and needed it the most: "The memory of sustenance is a terrible thing," she writes, "far worse, I think, than actual starving. Starving just kills you. Longing can gnaw away at you forever" (p. 90).

Cheney's relationship with 'Rick' eventually imploded under the pressure of this irreconcilable longing and affectively-intercepted hope. Cheney (2008) indicates that their break-up was precipitated by Rick's attempts to convince her that a particularly brutal bout of (mixed state) depression was "just exhaustion" (p. 186). Frustrated by his dismissiveness and insistence that a weekend retreat of rest and fine dining would "cure" her, Cheney fired back: "Sometimes, it just can't be fixed, Rick. It's a disease. For once, stop trying to make it better and just let it be. Just ask me where it hurts!" (p. 186). Cheney became increasingly agitated as their argument intensified. As it reached a violent crescendo, she punched Rick in the face. She writes: "I reached back into years of pent-up anger and resentment, years of pretending to be all better because better was what Rick had bought and paid for, because he was the fixer and I was the fixee, and better was part of the bargain" (p.187). Cheney was overcome with remorse immediately and begged Rick to forgive her. As he packed up his things, however, he only replied: "You know, sometimes it just can't be fixed" (p. 188). Rick never spoke to Cheney again. "Few things are strong enough to survive that deadly clash of mania and depression," Cheney writes, "Certainly not love" (p. 188).

Cheney (2008) later found herself at a similar relational crossroads with another long-time love, "Alan," who attempted to coax her out of a depressive episode by confessing that he would marry her "in a heartbeat—if it wasn't for [her] manic depression" (p. 216). Needless to say, Cheney took no comfort or 'psychic' motivation from his admission, however, armed with the diplomatic advantage of *any* state that is not manic, as well as fortified by a slightly more refined sense of BP 'self,' Cheney only fired back a verbal assault that both affirmed and defended her BP 'being' and identity. She writes: "If it wasn't for my manic depression, there would be no me to marry, period. I'd be some other person entirely…I wouldn't have those flashes of brilliance that [Alan] so admired, that made him want me in the first place. I wouldn't have the volatility that maddened but intrigued him. Alan hated ordinary. That's just what I would be" (p. 217).

Cheney (2008) notes that 'Alan's' wildly inappropriate, ill-timed admission ultimately proved valuable in nudging her out of the lingering depression in which she had been stuck: "I cared again," she writes, "[Alan's] words ignited such a rage in me that I vowed to stay alive, just to prove him wrong" (p. 217). Cheney considered this deliberative response to Alan's offensive remark an important measure of her evolving BP identity and burgeoning sanity. Importantly, this response also marks a key turning point at which 'being' and 'living' BP converge in Cheney's life, becoming discernable as affirmative, integral components of her 'Self' that informed her entire self-concept in its entirety. This incorporated sense of herself allowed Cheney to conceptualize manic-depressive illness as more than a facet of her being for which she had to be apologetic and accountable; it encouraged her to embrace the illness as a dimension of her 'self' that uniquely colors her humanity and, thus, that should be regarded as a source of pride.

Cheney (2008) discovered a final and somewhat unanticipated adjustment that 'living bipolar' entails: adapting to 'normal' life and the tyranny of quotidian tasks.

Much to her chagrin, she found that stability and sanity present their own problems, ranging from the mundane task of wresting her wardrobe from the proclivities of its former mistresses—the ‘manic vixen’ and the ‘graveyard ghoul’ (p. 220)—to the more onerous work of piloting a strange, newly sane bipolar ‘being’ about an equally peculiar sane world. Cheney poignantly describes her body at and *as* the crossroads of ‘being’ and ‘living’ bipolar when, inspecting it one day, she recognizes it bearing witness to itself as ‘ground zero’ in the collision between ‘Normal’ and ‘Madness’:

> I looked down at my wrists. Three long white raised scars traversed the veins, relics of a dull, desperate razor. It seemed my body remembered my extravagant moods, no matter how hard my mind tried to forget them. But normal lived on inside my eyes. They shone with the remnants of a few stray tears, but they didn’t blaze or snap like wildfire, nor were they as dull as sodden coals. They were simply eyes, looking back at me, wondering what next. As if I knew. (p. 221)

For all her qualms and uncertainty about ‘normal,’ however, Cheney (2008) relishes the stability it affords her. “I liked waking up in the morning knowing that more likely than not, I would probably meet all my commitments that day,” she writes, “I wouldn’t have to cancel, to come up with excuses, to weather disapproval and sidestep shame. I would remember everything I would have done the night before, and it would probably be boring and a trifle routine. After so many years of not knowing what fresh hell was next, how I adored boring and a trifle routine” (p. 226). In consequence, Cheney comes to guard her hard won stability ferociously and wages a campaign against external triggers, including bad relationships, alcohol and drugs, and eventually, the ‘fast track’ of her legal career, with its “relentless pressure of the billable hour,” the “endless jockeying for favor" it required, and, most of all, "the scrutiny" it entailed (p. 154).

Cheney (2008) concedes that abandoning her legal career was as much "an act of desperation" as it was "an act of courage" (p. 154). Although her professional pursuits exacerbated her illness, they had grounded her self-understanding and defined her place in the world across temporal categories. "Being an attorney had made me very unhappy," she confesses, "But not being an attorney made me invisible" (p. 235). She continues: "My whole adult identity had vanished, along with the money and the trappings that had so clearly defined my prior existence. In their place was a formless, shapeless, terrifying blob: the nonbillable hour. How was I supposed to fill it? " (p. 235). Cheney's memoir reveals that her professional collapse was one of the most significant adjustments she had to make in 'living bipolar.' Her career had been one of her illness's most grievous casualties *and* most dangerous triggers. Although this occupational void upset Cheney's life and self-concept tremendously, she contends that she knew she could never practice law again—she knew it "absolutely"—even when and if material need becomes dire (p. 234). Whatever the short-term rewards of taking on such work would be, Cheney emphasizes that it would invariably trigger a terrible and dangerous reaction: "Sometimes manic, sometimes depressed, frequently suicidal" (p. 234). She notes that "not even a pitcher of martinis," could destabilize her so completely (p. 234).

Cheney 's *Manic* (2008) concludes by documenting her first public rehearsal of 'living bipolar,' as well as revealing her eventual turn to narrative work as a means of coping with her occupational dislocation. Cheney debuted her freshly-minted BP identity and the 'self' renovations it had required at a Hollywood party teeming with the old players and temptations of her former life. Bringing her full circle, this soiree acted as an appropriate stage for Cheney's BP 'coming out.' When she first arrived at this party, however, Cheney felt so out of place and vulnerable without a high-powered business card behind which to hide that she locked herself into the bathroom and practiced fielding responses to her fellow partygoers' inevitable (and dreaded) questions about what she did for a living: "I'm sick for a living' didn't quite sound right. 'I live on federal disability' was true enough but no better. I could always just say I'm a lawyer. That was true, too, but highly misleading" (p. 233). As Cheney fumbled through an array of possible responses, however, she realized that she did not miss her old life. "I was sick to death of lies," she writes, "I was stable, the medication was working—what was wrong with reality?" (p. 236).

Cheney (2008) resolved to rejoin the party and simply tell the truth about who she was and what she did. Cheney's 'truth'—"I'm manic depressive, and I'm writing a memoir about my experiences" (p. 237)—was warmly received by the other guests, who promptly bombarded her with questions and personal anecdotes about their own experiences of mental illness. Cheney, shocked and relieved by their enthusiastic responses, had to brace herself against the urge to 'open the floodgates' of truth after so many years of hiding and feeling ashamed of her illness. "Telling the truth is a dance like any other," she writes, "It had taken me a lifetime to learn how to lie. I would have to devote a little more time to studying the art of disclosure" (p. 237). This display of restraint in the face of such long yearned for joy exhilarated Cheney almost as much as the validation and support of strangers did.

Later that evening, Cheney retreated to the bathroom again to absorb the evening's extraordinary events. She describes this triumphant scene in her memoir's final lines, closing the text with one of its few portraits of her at peace:

> I closed my eyes and simply listened: to my breath, to my blood, to the light patter of the last remaining raindrops on the roof, to the faint snatches of Ella Fitzgerald seeping through the walls. I listened for answers. When none were forthcoming, I realized that listening itself was the answer for now. I was ready. I stood up, stretched, and walked out of the bathroom without even a sideways glance in the mirror. I'd had enough of my own reflection for one evening. Besides, I very much wanted to dance. (pp. 237-238)

This 'coming out' experience, especially in such a symbolic venue, reveals the extent to which Cheney ultimately incorporated manic-depressive illness into the fabric of her 'being.' By that point in her life, illness had begun to inform the everyday practice of her selfhood, as well as her 'self's' broader existential imperatives. Importantly, Cheney's experience at this party also revealed that 'being' and 'living' bipolar now provided her a livelihood: writing professionally about her experiences with her illness.

Writing Bipolar

In charting Cheney's exceptional negotiation of the bipolar storyteller's narrative dilemmas, *Manic* (2008) models the very narrative ingenuity their 'resolution' requires. As her memoir demonstrates, Cheney's ability to parlay formidable literary talent into narrative achievements borne of these dilemmas, not forged in spite of them, underwrites this success. The dilemmas with which Cheney and other bipolar storytellers must most often contend include: the limits/powerlessness of traditional narrative structures and linguistic resources in storying manic-depressive illness; the problem of "truth" and narrator reliability; the dangers of meta-narratives and narratives constructed for/as closure; stigma as a narrative obstruction; and the risk of retraumatization that telling illness stories may pose to BP storytellers and their audiences.

The limits of traditional narrative structures and linguistic resources. Susan Brison (2002) notes that writing about traumatic events "challenges accepted views of the limits of language and logic" (xi). Since there is "no language that is true to traumatic experience and the paradoxes of traumatic memory seem to defy analysis," our "ordinary concepts of time and identity cease to apply" (xi). Cheney (2008) indicates that manic-depressive experience, as a trauma and progenitor of other traumas, is similarly elusive and averse to traditional storytelling's (linear) structures, as well as frustrating to the vocabularies and discourses through which it is currently mediated. In consequence, Cheney must coerce new narrative resources from existing ones or innovate fresh ones entirely in order to achieve a textual interpretation—not merely a translation—of embodied BP experience that renders it simultaneously intelligible *and* ineffable. The task of all bipolar storytellers, in this sense, is to confuse their readers to a point of clarity about that the nature and effects of manic-depressive illness—especially at its most unknown and extreme.

Cheney (2008) meets this creative challenge and preserves the experiential integrity of her story by constructing her memoir so as to "mirror the disease [and] give the reader a visceral experience" of manic-depressive illness. She writes that, for her, "life is defined not by time, but by mood"—events are recalled "more by emotional state than date or sequence" (p. 1). As a result, Cheney tells her story episodically instead of chronologically. Her concomitant use of the illness itself as a storytelling structure and 'motif' allows her to capture the arrhythmic swells of bipolar mood, variously blurting, embellishing, or scoring each episode in time across her memoir's pages according to its own meter, grammar, and aesthetic. *Manic* (2008)*,* as a text, is the slow stewing of these episodes. Cheney deftly constructs then threads them together in a brilliant bid to specify the complexities of BP experience without tempering the violence and intensity that attends their collective din.

The problem of "truth" and the reliable narrator. Cheney (2008) maintains that, "Memory is the first casualty of manic depression. When I'm manic, all I remember is the moment. When I'm depressed, all I remember is the pain" (p. 2). She cites the organic processes associated with the illness, as well as the side effects of measures used to treat them (e.g. psychotropic medication and electroconvulsive therapy) as prime culprits in damaging the cognitive and neurological machinery of BP memory. Moreover, Cheney adds to this list of the BP narrator's potential narrative liabilities, manic-depression's generation of competing realities and lapses in memory that may worsen over time as a result of the illness's progression and/or the side effects of its long-term treatment (p. 2). By disclosing these narrative vulnerabilities in questions of truth and memory with self-reflexivity and transparency, however, Cheney works toward bolstering her own authority as a storyteller—asserting it succinctly in closing *Manic's* (2008) preface with the declaration: "This book represents what I remember. This book is my truth" (p. 3). This is *Cheney's* story, and its currency and resonance derive directly from its ability to make readers recognize themselves as witnesses to *Cheney's* fight for survival as a person living with manic-depressive illness. In other words, it matters that this is *her* story—the one that is true to her experience, the one she tells to stay alive.

Meta-narratives and the problem of speaking for others. Terri Cheney is not just any manic-depressive person. After all, the road to ECT is necessarily treacherous and desperate, but for most people, it will not include Michael Jackson as a source of personal derailment. Cheney *is* a powerful proxy for the bipolar "anyperson," however, in that her story is a portrait of the American Dream refracted through the funhouse mirror of mental illness in its contemporary context of sociocultural subjugation. Needless to say, when Cheney's fate is the fate of a group's privileged elite, then that group is in trouble. Despite her willingness to concede race- and class-based privilege, Cheney is often ambivalent about the advantages it affords her in the context of bipolar experience. Although her access to material resources (while it lasted) conferred advantages that most people with mental illnesses may never enjoy, Cheney indicates that they did not necessarily ensure her health and sanity, protect her against incompetent doctors and avaricious insurance companies, or spare her discriminatory treatment at work and in the world. Ultimately, then, Cheney argues that her Ivy League education and high-powered legal career may have landed her a Supreme Court case at one point in her life, but, at another, could not spare her a jail cell after she was arrested for driving in a MAOI-stupor. Moreover, they could not protect her from being beaten by a guard while in custody when pleading for access to her medication (confiscated during her arrest), she made the mistake of desperately grabbing for his arm. As Cheney explains: "It's religion with me, taking my pills on time. I don't want to mess with the gods, or my brain chemistry. Just because I'm mentally ill, doesn't mean I'm crazy" (p. 51).

Cheney (2008) contends that nothing has been or ever will be the same after that beating: “I know that I am touchable, that I am not immune,” she writes (p. 56). “You grow up separated from the people on the bus, or the people on the street, by a glass wall of money, education, a profession. You never think it could be you when you watch that poor black guy being beaten up by the cops. It’s just TV ” (pp. 56-57). In the end, however, Cheney’s resources and the reality that she is not, in fact, ‘that poor black guy on TV’ helped her secure a reduced sentence for her charge. It ‘cost a bundle’ but did not really “inconvenience” her life (p. 57). Nevertheless, she notes that she still hesitates to undress in front of a new lover and reveal her scars from the beating. “I hesitate to bear myself at all,” she writes (p. 57).

Stigma as narrative obstruction. Stigma is a pervasive force that reflects and reinstates discriminatory cultural beliefs and practices surrounding mental illness (Goffman, 1997; Stefan 2001). In narrative and storytelling contexts, therefore, stigma may influence the content, logistical fates, and impact of stories about mental illness and pose material risks for their authors. Manic-depressive storytellers’ disclosures about their illnesses may come with significant personal, professional, and social costs, including job loss, disruption of health insurance, ostracization, and curtailment of parental rights (Perlin, 2000; Stefan, 2001). In consequence, stigma jeopardizes bipolar storytellers’ socioeconomic standing, access to public storytelling venues, and ability to forge relationships with the empathic listeners Brison (2002) cites as preconditions for the remaking of self in the wake of serious disruption.

Temptations of closure: ‘recovery.’ Brison’s (2002) beliefs about the nature and therapeutic utility of “recovery” shifted as she ‘recovered’ from her own sexual assault.

She initially considered the trauma survivor's most central task to be "regaining a sense of control, coming up with a coherent trauma narrative and integrating it into one's life story" (p. 115). As time passed, however, she began to view 'recovery' instead as the ability to "learn how to relinquish control, to learn by going where we need to go, to replace the clenched, repetitive acting out with the generativity of working through" (p. 115). While the former conceptualization was "obsessed with control, with the soothing, numbing safety of the familiar," that latter was "inventive, open to surprise, alive to improvisation…[providing] the foundation of trust on which new life can be built…" (p. 115). Furthermore, Brison maintains that re-establishing control and coherence may be crucial to 'living to tell' one's trauma narrative, but it can also tether the survivor to one rigid version of the past and, therefore, work against 'telling to live,' which she now imagines as "a kind of letting go, playing with the past in order not to be held back as one springs away from it" (p. 103).

Brison (2002) indicts conceptions of 'recovery' that make false assumptions about the wholeness and coherence of the 'self' and, thus, that promote narrative and clinical practices that attempt to suture together fractured selves and lives by culturally, politically, and narratively normalizing experiences of trauma and psychosis (pp. 115-117). Her alternate 'recovery' model, in contrast, views the 'self' as fundamentally fragmented. She argues that, because we are socially constructed largely through group-based narratives, "the self is not a single, unified, coherent entity—its structure is more chaotic, with harmonious and contradictory aspects, like the particles of an atom, attracting and repelling each other, hanging together in a whirling, ever-changing dance that any attempt at observation—or narration—alters" (p. 95). In her estimation then, "Recovery no longer seems to consist of picking up the pieces of a shattered self (or fractured narrative). It's facing the fact that there never was a coherent self (or story) there to begin with" (p. 116).

Brison (2002) experienced her own recovery not as a return to who she was before her attack, but as the ability to "incorporate this awful knowledge into" her life story (p. 21). She subscribes to the notion that (borrowing from the leader of her survivor support group): "You'll never be the same [after trauma]…but you can be better" (p. 115). She clarifies, "Not 'better' in the sense of having a life that's more coherent, in control, predictable. But 'better' in the sense that comes from acknowledging that life is a story in the telling, in the retelling, and that one can have some control over *that*" (p. 115). No matter how mythical 'recovery' might be and no matter how wounded and displaced a trauma survivor might feel, Brison maintains that the shattered self may still aspire to/hope for a bearable future; in fact, she indicates that this hope emerges from the destructive processes of trauma itself: "[S]ince inferences from the past can no longer be relied upon to predict the future, there's no more reason to think that tomorrow will bring agony than to think that it won't" (p. 66). She contends that, "nothing is certain and the odds change daily," therefore, one must "set about willing to believe that life, for all its unfathomable horror, may still hold some undiscovered pleasures." (p. 66). Moreover, she writes: "And one remakes oneself by finding meaning in a life of caring for and being sustained by others" (p. 66).

Brison (2002) and Cheney (2008) both reject 'recovery' as narratively and ideologically ill-suited for the materialities of mental distress and mentally ill/traumatized narrators. As noted, Brison's (2002) critique centers on recovery's misguided reification of the self as ‘whole’ and ‘coherent,’ while Cheney (2008) takes greater issue with recovery’s dubious therapeutic value given manic-depressive illness’s chronicity, unpredictability, and destabilizations of identity and ‘self.’ Brison (2002) and Cheney (2008) develop alternatives to the recovery paradigm based on parallel constructions of “resiliency” and “provisional stability.” These alternative stands are poignantly demonstrated by each author’s decision to conclude her text in meditative ‘breath’ (i.e. *breathe in, breath out)*, as well as with a mantra: *all you have is this day.* For Cheney (2008), ‘this day’ means that she is alive and writing and both are truly glorious developments (p. 242). For Brison (2002), ‘this day’ means ‘I am not lucky or unlucky. I’m just alive, breathing in and out’ (p. 117).

Cheney’s *Manic* (2008) breaks from its contemporaries in mental health storytelling by foregoing ‘recovery’ rhetorics and discourses in favor of more somber but pragmatic themes, such as wellness and provisional stability. These tenets reflect a more complex and functional understanding of the BP self as fundamentally fractured and, therefore, ill-served by models that presume its wholeness as a natural state or desired end to which therapeutic narrative practices should be directed. Cheney, like Brison, indicates that conceptualizing the self as “fractured” provides a more philosophically and psychologically profitable framework in which to understand and story psychosis or trauma. This understanding of ‘self’ requires narrative to assume different ‘work’ as a therapeutic and moral project tasked with managing the ill effects of mental distress. First and foremost, it demands that a ‘suffering’ narrator enlist narrative to process and incorporate traumatic experience into his or her larger life story as a means of opening up possibilities for the future by releasing the narrator from preconceived ‘selves’ and undesirable recuperations of his or her past. This shift in narrative purpose and 'charge' better prepares BP storytellers, in particular, to integrate their illnesses into their present understandings of selfhood. This well-integrated BP identity, in turn, bears a number of practical benefits for BP 'being' and 'living.' These benefits include bolstering BPs' commitments to treatment, as well as solidifying their investments in the mental health/BP community from which they may not only garner emotional support but also a political consciousness that affirms the 'difference' their illness's confer.[17]

The trauma of re-telling. Cheney's impressive navigation of the bipolar storyteller's narrative dilemmas falters slightly in its consideration of the potential harm re-telling an illness story may do to BP narrators and audiences alike. Her failure to consider whether 'telling,' *in every instance*, is cathartic may leave Cheney and her BP readers vulnerable to relapse by triggering or aggravating existing illness states. Cheney imagines herself, however, as 'taking one for the bipolar team' in trudging through the painful details of her illness experiences. She believes that telling her story and re-living its traumas is far less dangerous to any party involved in the storytelling exchange than *not* telling her story would be. In her estimation, 'telling' serves a larger public and Bipolar 'good,' at the very least, by countering the silence and shame that attend mental illness. Cheney's carelessness does not go wholly unredeemed, however, as she does manage to extend the reader one pivotal narrative resource: humor. Cheney's quick wit and crass 'gallows humor' allow the reader to engage with her memoir without succumbing to its chaos. 'Humor,' therefore, acts as an effective temporal guardian keeping readers tethered to the present moment even as they are swallowed up by

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[17] The disability community has excelled in setting a bar for this 'difference' based identificatory and political work (Garland-Thomson, 1999; Wendell, 1996).

Cheney's text and immersed in the potential torment of a past or future illness episode. All things considered, however, readers currently under active manic-depressive fire should probably avoid this text at all costs.

Narrative Therapy, Political Testimony

Beyond 'Recovery'

As Susan Brison (2002) has suggested, narrative work facilitates a trauma survivor's ability to move forward with her life not by "re-establishing the illusions of the past,' but by 'making it possible to carry on without these illusions" (p. 104). Since telling the story is an essential component of working through the trauma, "it is not a question, then, of whether to tell, but whom, how, when, where, and—we must be especially aware of this—why" (p. 97). As long as recovery ideologies and narrative models dominate therapeutic practice—in effect, substantively governing the 'why' of Brison's assertion—the therapeutic value of manic-depressive storytelling may be circumscribed. As previously argued, narrative is better employed to support a reformulated notion of 'recovery' that is not bound to a mythical return to a 'whole' pre-illness onset self or a 'whole again' future self unburdened by the intra-psychic adjustments that living with a chronic and severe mental illness entails (p. 116). The recovery narrative's predominance as a narrative structure through which BP narrators may story and survive their illness experiences is understandable, however, as the quest for a unified sense of oneself is undoubtedly irresistible to people whose internal order is in chaos and, thus, cannot comport with normative standards of 'being.'

Cheney (2008) demonstrates that the recovery narrative is not the only mental illness story structure in the narrative sea. Her memoir models a type of therapeutic narrative practice that affirms a role for storytelling in making and maintaining the major adjustments to identity and selfhood that manic-depressive experience requires, as well as positions writing about the illness as its own reward. Furthermore, it also models narrative's potential therapeutic benefits for BP *readers*, especially those struggling with illness in isolation. These readers may draw comfort and validation from simply encountering themselves in print as recognizable and 'known.' People living with manic-depressive illness may often feel trapped in and marginalized by the ineffability of their experiences and, therefore, may find great relief in Cheney's narrative excavation of the illness's complex corporeal, cognitive, and sensory processes. Her narrative grasp of the bewildering forces that occasionally or relentlessly commandeer BP readers' lives makes intelligible elusive dimension of their 'beings' while upsetting the silence and shame by which they are frequently attended.

Politicizing Manic

In demonstrating narrative's power to clarify and convene, *Manic* (Cheney, 2008) affirms storytelling as a moral project amenable to progressive ideopolitical and therapeutic work, as well as beholden to certain ethical, political, and pedagogical imperatives. For example, in familiarizing non-bipolar people with manic-depressive experience, it makes BP identity and difference comprehensible and palatable to others. This revelatory/interpretive process is vital to 'others' understanding BP people as fully human and, thus, as having lives worth living and cultural value worth protecting (Eakin, 2004). Brison (2002) ties the individualized therapeutic processes with which narrative is associated to these larger cultural and political imperatives in positing storytelling as a mechanism for advancing progressive social change. As she writes: "It is only by remembering and narrating the past—telling our stories and listening to others'—that we can participate in an ongoing, active construction of a narrative of liberation, not one that confines us to a limiting past, but one that forms a background from which a feely imagined—and desired—future can emerge" (p. 99).

Cheney's *Manic* (2008) is subtle, but certain in its ideological and political ambitions. She shrewdly avoids dogmatic political rhetorics that may distract readers from recognizing lived experience of mental illness as the most compelling and appropriate locus of a BP politics. *Manic* does, however, directly serve the political dictates of narrative work by offering more than a de-contextualized and depoliticized testimonial about mental distress. Cheney proffers a textured, self-reflexive account of manic-depressive illness that enlivens BP experience at the intersections of gender, race, and class in contemporary culture. Although Cheney often comments incisively and explicitly on the latter two social variables, her 'gendering' of manic experience is particularly noteworthy. Cheney's exposition of gender-based experiences of BP symptomatology and 'trauma' uniquely contributes to manic-depressive memoir. It inserts a compelling account of how women might differentially experience 'manic sexuality,' in particular, into prevailing (largely 'androcentric') clinical discourses surrounding the illness and its processes (Chesler, 2005; Jamison, 1995).

Conclusion

Although Cheney's *Manic* (2008) offers a model for overcoming and even profiting from the BP storyteller's narrative dilemmas so as to advance the work of narrative in mental health communities, Cheney's *methods* are not entirely replicable. One simply cannot duplicate writerly prowess or manufacture creative will in storying BP experience. In short, one simply cannot copy or appropriate Cheney's most important narrative assets in combating the BP storyteller's narrative dilemmas and extracting the intrapsychic resources narrative affords BP writers in matters of selfhood and identity. Nevertheless, Cheney's memoir does suggest some general criteria to which therapeutically and politically productive manic-depressive storytelling should be held. First and foremost, it indicates that BP storytellers can and should benefit from mining their illnesses for indigenous narrative tools—making BP experience not only the subject of their storytelling, but also its structural and/or aesthetic muse. Cheney indicates that this narrative approach helps preserve the experiential integrity of BP stories and, thus, is central in supporting the narrative processes of clarification, extraction, and incorporation on which the therapeutic value of manic-depressive storytelling depends. Finally, as *Manic* catalogues Cheney's experience of writing herself out of personal wreckage, it emphatically underlines the importance of narrative work in re-configuring and transacting identity and selfhood as they have been transformed by manic-depressive illness and its generation of new ways of knowing, being, living, and *writing*.

Chapter 3.

'Hallelujah Anyhow':

Bebe Moore Campbell's *72 Hour Hold*

Novelist Bebe Moore Campbell is known for epic storylines and incisive sociocultural critique about race and gender in modern America. Her eclectic and acclaimed body of work includes three best-selling novels, a memoir, and a children's book.[18] In the years preceding her death, however, Campbell became better known for her artistic and activist turn toward mental health issues. This shift in literary gears produced three additional publications: a play, *Even with the Madness* (2003), a children's book, *Sometimes My Mommy Gets Angry* (2003), and the novel, *72 Hour Hold* (2005). Each of these texts took bipolar disorder as an explicit subject, and, collectively, they made Campbell a formidable force in mental health advocacy. In May 2008, the United States House of Representatives even posthumously honored Campbell's activism in communities of color by designating July "Bebe Moore Campbell National Minority Mental Health Awareness Month" (H. Con. Res. 134, 2008).

Campbell has been sorely missed in the mental health world following her death from brain cancer in 2006. Although she was universally revered, she was especially beloved at the National Alliance for Mental Illness (NAMI). Campbell worked closely with this mental health consumer organization as a spokeswoman, public educator, and rank-and-file member. She was hardly an ordinary mental health foot solider, however; she was a celebrated literary figure and consummate storyteller who recognized her craft

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[18] Campbell's three novels: *Brothers and Sisters* (1994), *Singing in the Comeback Choir* (1999), and *What You Owe Me* (2001); her memoir, *Sweet Summer: Growing Up with and without My Dad* (1989); a non-fiction text, *Successful Women, Angry Men* (2000); and a children's book, *I Get So Hungry* (2008).

and the notoriety it afforded her as a vehicle for social change that could—and *should*—be employed to advance progressive political work on behalf of a heavily stigmatized subset of the population.[19] Although Campbell used her public platform most notably to open a dialogue about mental illness in the African American community, she also reached out to families across *all* communities as they searched for support in coping with a loved one's illness. This was Campbell's own route to activism.

In this chapter, I explore the extraordinary convergence of storytelling and activism in Bebe Moore Campbell's *72 Hour Hold* (2005) and argue for fiction as an indispensable narrative vehicle through which to advance the sociopolitical work of narrative in mental health domains. I proceed with my analysis by distilling *72 Hour Hold's* narrative work into three interrelated categories of study that reflect the narrative enterprise to which Campbell sets her novel: *72 Hour Hold* as sociological instrumentation, progressive political and pedgagoical practice, and philosophical dramaturgy.

I begin by reviewing Campbell's *sociological instrumentation* of fiction as a means of elucidating the macro-level sociocultural forces at work in determining the character and course of mental illness in contemporary culture. I argue that Campbell's 'sociology of mental illness' specifies mental distress at the intersections of social conditions and identities that inflect (and are inflected by) its social meaning, as well as mediate (and are mediated by) its social effects. Next, I examine how Campbell's 'sociology' exposes the family at/as the institutional frontline of mental health care. Campbell's novel reveals the ways in which family members often bear the brunt of

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[19] Campbell's official website, www.bebemoorecampbell.com, still bears her mission statement about, among other things, the importance of literary work in social change.

mental illness's human and material costs amid widespread systemic failures in the provision and administration of mental health care services. Finally, I contend that Campbell's sociological inquiry establishes the modern mental health consumer movement as a social movement operating in the ideopolitical traditions of abolition, civil rights, and other liberation-based sociopolitical struggles.

My cursory review of the mental health consumer movement as a 'liberation' struggle introduces the next analytical domain of interest: Campbell's *72 Hour Hold* (2005) as *political and pedagogical practice*. This section, in turn, introduces her novel's most distinctive narrative achievement: an astute and instructive explication of contemporary mental health politics delivered through Campbell's ambitious but ingenious literary adaptation of the modern mental health care crisis. I argue that *72 Hour Hold,* thus, functions as a political treatise. It reveals that mental health services in contemporary culture continue to be too inaccessible, unaffordable, and ineffective. Furthermore, it suggests that the mental health care system responsible for their administration is not only deeply fragmented, arcane, and under-funded, it is *destined* to be so. Campbell implicates ongoing cultural failures to recognize health care (of any kind) as morally and ethically imperative, as well as the unabated codification of bigotry into national public health policy and jurisprudence, as the prime culprits in this predestination.

My objective in this section is to develop a broader sociopolitical context in which to evaluate the substantive terms of Campbell's transmutation of a progressive mental health agenda into her novel's internal critique of 'The System.' As Campbell details, the 'seventy-two hour hold' is often the arbitrary currency of action and inaction in this system. Consequently, she uses it as the narrative fault line along which her novel's dramatic action and central moral dilemmas unfold. In the process, she spotlights this ineffectual System's domination of the mental health care market. Importantly, Campbell issues her critique while grappling with the lack of viable alternatives and acknowledging mental health's long-running marginalization within existing efforts to reform health care in American culture.[20]

Finally, my last analytical section explores *72 Hour Hold* (Campbell, 2005) as *philosophical dramaturgy* that affirms mental illness as the "moral occasion" Arthur Frank (1995) describes. Campbell's (2008) characters experience illness as such in that it: unites more than divide their families and communities; calls them to re-examine the meaning and direction of their lives; fortifies their personal relationships and civic commitments by demanding their re-evaluation and reformulation; and, ultimately, prompts both introspection and social action based on what illness has taught them about 'what is good' (existentially and politically) and who is worthy of social care and accommodation.[21] Furthermore, I also elaborate how Campbell's novel, as philosophical dramaturgy, affirms storytelling about mental illness as an ethically consequential, politically significant narrative enterprise capable of inspiring the empathy and awe on which sustainable social change depends (Kearney, 2002)

I conclude this chapter with a review of Campbell's contributions to progressive storytelling in mental health domains. Drawing on Dorothy Allison's (1995) commentary on the role of fiction in truth-telling, I present Campbell's (2005) novel as

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[20] Although these claims will be reviewed in greater depth in the sections that follow, they are substantiated by the literature. The Institute of Medicine (2001) published a comprehensive study of mental health care services in America that confirms Campbell's literary findings.

[21] Frank's (1995) work supports Campbell's approach to literary moralization and is explored later in this chapter.

an important demonstration of how storytellers can use well-crafted, socially sophisticated fiction to tell a ‘harder truth’ than might be possible to convey outside its narrative elasticity, capaciousness, and dramatic scope. Furthermore, I contend that Campbell’s ‘truth’—an engaging, multi-perspective, didactic portrait of a complex social issue—authorizes her novel’s pedagogical utility and reach. I determine, therefore, that Campbell’s novel demonstrates fiction’s unique potential to educate popular audiences whose access to mental health information may be limited or whose interest in mental health issues might not otherwise have been piqued. I conclude, however, that Campbell and her novel are most remarkable for modeling a productive merging of storyteller, storytelling, and activism in mental health. In a community known for its literati, few other writer-activists have risen to the ‘civic-storytelling’ occasion and served its duties and responsibilities with Campbell’s grace, authenticity, and fervor.

Book Preview

72 Hour Hold (Campbell, 2005) tells the story of Keri and Trina, a mother-daughter duo whose lives are besieged by Trina’s bipolar illness on the cusp of her eighteenth birthday—a milestone marking both her legal emancipation from her mother and the psychiatric treatment that, thus far, she has been obliged to receive. Equal parts love story, family drama, and mental health polemic, *72 Hour Hold* chronicles Keri’s desperate efforts to negotiate a labyrinthine mental health care system saddled with inefficiency and perpetual disrepair to secure the care her daughter needs—but can now legally refuse—before the next manic episode strikes and lands her in jail (again) or, worse yet, dead. As Trina’s condition deteriorates and Keri’s attempts to intervene are thwarted by system obstructions at every turn, Keri partners with Bethany, a rabblerouser from her support group facing similarly dire circumstances with her own daughter. The two women solicit help from ‘the program’—an underground group of mental health workers who offer a radical treatment alternative that intervenes immediately, and forcibly, with care instead of waiting for someone with a mental illness to “hit bottom,” as the system does. This group, however, achieves its ends through extreme and illegal means: kidnapping and imposing treatment on adults who have legally refused it.

Desperate and facing interminable futures of unbidden psychiatric chaos, however, Bethany and Keri sign on with the group and begin their journey in its underground networks after intercepting their daughters’ release from a nearby mental hospital. The program’s leader, Brad, shepherds the troupe through the California countryside, shuttling the two families clandestinely from house to house en route to the program’s remotely- and confidentially-located treatment center where the girls will receive care. Before they can reach their final destination, however, their ‘underground’ travels are derailed by a series of misadventures that test their relationships and resolve to stand by ‘the program’ even as its methods and mission begin to falter. Keri, ultimately deciding that its potential benefits no longer outweigh its mounting risks, breaks from the program and returns home to Los Angeles, back to a system that proves as broken and maddening as ever. This time around, however, *Keri* has changed. Seasoned by her travels and newly-emboldened by the support of family and friends who have rallied at her side—appropriately sensing ‘kidnapping’ as a compelling metric for her desperation—Keri joins with other parents determined to organize within the system in order to keep their loved ones safe, healthy, and in the running for decent and meaningful lives.

72 Hour Hold as Sociological Instrumentation

The Sociology of Mental Illness

Campbell (2005) pitches her trenchant critique of the social systems and conditions that mediate mental illness in contemporary culture against the backdrop of her novel's vibrant, socially textured literary landscapes. In mapping mental illness across multiple axes of social life and identity, her text takes on the narrative project of enlivening scholarship in the sociology of mental health and illness. This academic sub-discipline examines the influence of macro-level social processes on experiences and outcomes of psychiatric illness, as well as studies the psychosocial variables that impact social life and psychological health and functioning (Kendell, 2002; Sternberg, 2004).

Although *72 Hour Hold* (Campbell, 2005) presents the etiology of mental illness in decidedly biomedical terms, it generates a complex *socio*medical account of organic brain-based phenomena unfolding in conjunction with social variables that differentially shape their outcomes and effects. Campbell subjects her characters to the provisions of race, gender, class, geography, and mental disability and, in casting this expansive intersectional net, generates the raw sociological material she needs to elucidate mental illness at the interstices of its interlocking and mediating materialities. Furthermore, this 'sociology' underwrites two of Campbell's most striking narrative feats in constructing her novel: commanding fiction's dramaturgical dexterity to craft a story that is both experientially specific *and* pluralistic and instantiating mental illness into sociological and political study as a distinct axis of analysis. Campbell does more than simply insert it alongside more traditional axes, however, she shows that its valence extends beyond the lives of people directly affected by mental distress as an 'axis' that fortifies *all* systems of inequality and processes of social stratification.[22]

Intersectionality. Campbell's (2005) eclectic cast of characters allow more than an academic understanding of 'mental illness at the intersections;' they act as literary case studies charged with enlivening the human costs and political stakes of the issues they dramatize. As the novel's protagonist and narrator, Keri is the most comprehensively developed of these studies. She functions as the narrative porthole through which the novel's supporting cast comes to life and, with divergent personalities and life circumstances, animates and extrapolates the universal and particular effects of mental illness on American families. Campbell's novel, as socioethnographic fiction, focuses heavily on the experiences of its African-American 'leads.' In this way, it serves as an activist narrative practice that honors and extends Campbell's own personal and political investments in the African American community. Campbell was dedicated, in literature and in life, to provoking discussion about mental health issues in communities of color. As she indicates in her memoir, these communities' histories of subjugation have been authorized, in part, by the pathologization of people of color as essentially 'dangerous' and 'violent' and, therefore, justifiably subject to margnialization, criminalization and institutionalization.[23] Campbell contends that this brutal, ongoing legacy has foreclosed open conversation about mental illness in communities of color, as well as intensified its associated stigma within them. In consequence, her outreach was both a call to dialogue *and* action: she urged people of color to confront the realities of mental illness in their

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[22] Chesler (2005) provides a rigorous scholarly survey of intersectionality in mental health that nicely compliments Campbell's literary review.

[23] Caplan and Cosgrove (2004), Ballou and Brown (2002), and Chesler (2005) all provide useful analyses of racism and sexism in mental health.

communities and challenged them to stand against discriminatory practices in mental health, such as race-based disparities in care, a dearth of culturally competent practitioners, and disproportionate criminalization.[24]

Campbell's (2005) lead character, Keri, delineates the terms and effects of racism in contemporary mental health contexts. She assumes this 'informant' role from *72 Hour Hold's* outset as she begrudgingly travels all the way across town just to attend a mental health support group. She reports that mental illness "had a low priority" on her side of the city, "along with the color caste and the spread of HIV" (p. 49). She concedes that, "Some things [communities of color] just didn't talk about, even if it was killing us" (p. 49). As a result, she had to "come to the white people, who, although just as traumatized, were a lot less stigmatized by whatever went wrong in their communities" (p. 49). Keri's discovery of the other African American parents in her group, therefore, was "like falling in love." After first meeting, she reports that this coterie joked that they were "the only black people in America willing to admit having mental illness in [their] families" (p. 50). Pointing to the compounding effects of racism and 'sanism' in her mental health experiences, Keri indicates that these parents understood that "being black is hard enough" without 'adding in crazy'" (p. 50).

Keri catalogues the collusion of these two marginalizing forces in detailing the racism she encounters within mental health contexts. She does so with particular force while interacting with white counterparts for whom she must routinely establish race as a decisive factor differentiating their sociostructural experiences of mental illness. Keri must be vigilant in anticipating the adverse effects of racism in her negotiation of clinical,

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[24] Again, Campbell's official website, www.bebemoorecampbell.com, offers further information about her life and work.

institutional, and social settings. "If Trina were a "little blonde girl," she asks herself, would her doctors "have presumed compliance and passivity, been less on guard, treated her more kindly?" (Campbell, 2005, p. 188). Keri is especially concerned about the possibility that the police will be more likely to shoot Trina while she is in the throes of manic defiance. Her fears are well founded and validated in her daily life. In consequence, Keri is reluctant to call the police even when Trina's manic behavior becomes violent and dangerous. When she finally does dial 9-1-1, Keri decides not to tell the dispatcher that Trina was destroying their house with a hammer. After considering the image of "a black girl going crazy with a hammer in front of the cops" (p. 31), she decided that it was too reminiscent of a recent news story about a mentally ill black woman being killed by the police after brandishing a knife mid-psychotic episode.

Importantly, Keri also worries about her own vulnerability to police 'attention' while navigating the mental health world, especially in 'the program's' elicit underground. As she obligingly reminds her white comrades-in-arms: "When radical white people get tired of being radical they get to be state senators, or they write books, or if push comes to shove they can move to Oregon and hang out for thirty years before the FBI finds them. Radical black people get killed" (Campbell, 2005, p. 147). When their journey on the underground does go awry and they attract the notice of local police, Keri refuses to be placated by her white traveling companions' reassurances that 'no one is going to jail.' "Black people go to jail in this country for bullshit every day," she reminds them, " So, don't tell me nobody's going to jail. The way it works in America is I'd be the one to go" (p. 235).

Campbell (2005) complicates her treatment of race by accounting for the influence of social class in mediating mental illness. Keri and Celestine, another ‘mental health mother,’ draw out this contrast while commiserating about their troubled daughters after Keri comes to Celestine’s working class, largely African American neighborhood searching for Trina, who is ‘on-the-lam’ again. Celestine notes how much Keri’s affluence differentiates their options in addressing their daughters’ problems. She tells her: “You probably got the money and the insurance to go along with every little crazy thing your child do. Me, I ain’t got it like that. I can’t be bailing nobody out time after time. No. I told Melody: You don’t stay on your program, you on your own, and all Mama want to know is do you want to be cremated or buried” (p. 136). Echoing Keri’s fears about Trina’s vulnerability to police violence, Celestine adds: “I’m serious. When somebody black get to acting a fool out in these here streets, the cops gonna shoot ‘em and go on about they business” (pp. 136-137).

Keri and Bethany’s slightly charged but affectionate relationship further textures Campbell’s (2005) depiction of mental illness at the intersections of race and social class. Importantly, in Campbell’s estimation, ‘class’ denotes not only financial wealth or resources, but also the sensibilities, expectations, and values those means encourage or allow. Bethany, one of Keri’s most trusted if contentious allies, is her sociological contrast: a white, working class woman whose daughter’s struggles with a much more formidable set of mental health problems. This grim constellation of psychiatric issues, including schizoaffective disorder, borderline personality disorder, and methamphetamine addiction, comes to generate significant tension between the two mothers that illuminates the confluence of class and illness type in differentially texturing mental health-based experiences. Importantly, Campbell acknowledges that mental illnesses indeed are arranged into hierarchies based on an unsavory calculus of its associated stigmatization and prospects for normalization in which some conditions (usually those with the ‘schizo’ prefix) are marginalized more than others.

Keri’s obsession with the ‘crazy game’ best exemplifies this collusion of classism and illness-based bias. While traveling through the ‘underground,’ Keri becomes intensely preoccupied with drawing sharp contrasts between her National Merit Scholar daughter and Bethany’s meth-addicted, schizoaffective, borderline personality disorder train wreck. In short, she needs and wants to establish Bethany’s daughter, Angelica, as ‘crazier’ (i.e. more hopeless) than Trina. “At least Trina was still beautiful,” she tells herself, “At least she looked normal and clean…If she walked into a store, no one would alert security” (Campbell, 2005, p. 219). Although Keri knows it is wrong to compare the two girls, she confesses: “I couldn’t help myself. I needed to feel superior” (p. 219). Although clearly struggling to deal with Trina’s illness, Keri’s disdain for Bethany and Angelica has deeper roots. Her middle class scorn for their lack of refinement and educational attainment plays a significant role in fueling this ‘game,’ leading her to issue a series of offensive judgments about what the two women do and ‘are.’ When Keri apologizes for yet another inappropriate remark about her daughter, Bethany finally fires back: “My feelings? Fuck my feelings,” she screams, “Don’t you dare write off my kid! I’m not here because I want her to get a degree from Brown and meet the perfect man. I want to keep her alive. That may not be enough for you, but it’s enough for me” (p. 242).

The family. The family grounds Campbell’s (2005) ‘sociology of mental illness.’ It is her elected narrative perspective and analytical point of entry into the dendritic networks of institutions and systems that administrate mental health care. By sampling mental illness ‘at the intersections,’ Campbell’s novel creates a bank of parental perspectives across family configurations and cultural circumstances that suggests that the despair and social isolation that attend mental suffering holds steady across all stations and interfaces of social life. Campbell’s families, therefore, find common cause in their struggles to care for ill loved ones while protecting themselves against the ravages of mental illness. The novel indicates that this solidarity is imperative in a culture in which mental illness is construed as a private burden, not a public health issue; a culture in which incarcerated populations remain the only group who, in effect, is extended a constitutionally protected right to health care (an arguable ‘good’ given that jails and prisons serve as primary dumping grounds for America’s mentally ill citizenry) (Fee, 2000; Stefan, 2001). Campbell’s (2005) characters dramatize the family’s consequent overburdening on the frontlines of mental health management, as they work to procure or provide care without direction or subsidy and incur significant costs to their own lives in the process. In illuminating mental illness’s disruption of family members’ relationships, careers, and physical and emotional health, Campbell’s novel also reveals the breadth and perniciousness of mental illness’s effects on extended networks of family, friends, neighbors, and co-workers. This ‘second string’ often must be enlisted to offset illness’s immediate collateral damage, taking up any emotional or material voids left by indisposed loved ones and caretakers.

Campbell’s (2005) exposition of the family centers heavily on the experiences of mothers caring for their adult children with little support from their fathers—“as if this were women’s work,” one mother remarks (p. 251). Her novel shows women disproportionately tasked with family caretaking duties, including tending to their mentally infirm dependents in a variety of (gendered) auxiliary roles, such as social worker, personal attendant, advocate, and housekeeper. The gendered onus of this labor is only one facet of Campbell's broader characterization of mental illness in a child as a distinctly *maternal* calamity infused with unique burdens, guilt, and grief, as well as marked by a particular type of dashed expectations and helplessness that accompany an adult child's decision to forgo treatment. Campbell, not coincidentally, is exceptionally skilled at articulating this maternal agony, as well as in illuminating how a woman's identity and perceived social value are inextricably bound up with her children's personal and social fortunes. As Keri observes, "Your pedophile uncle and your alkie mama aren't your fault, of course. Your child, however, is always your fault" (p. 28). She also expounds on the endless array of maternal shortcomings that imperil a woman's children—all of which, she suggests, are leveled with particular venom against mothers whose children develop mental health problems:

> Mom didn't do this, she didn't do that. She nursed too long; she bottle-fed. She slapped the shit out of the kid; she raised a spoiled brat. She was too dumb and lazy to get a job; she worked full-time and never paid attention…She stayed with a husband who beat her and set a poor example; she left the fool and broke up the family or, worse yet, she kicked his ass and started running things. She let her boyfriends spend the night; she didn't provide a male role model. Too trifling to help sell Girl Scout cookies. She let her children run wild and had herself a good ol' time. Her child was drowning, and she didn't save her. (p. 30)

Importantly, Campbell's (2005) mothers punish *themselves* with this internalized litany of accusations and 'should haves,' 'could haves,' and 'what ifs' as they negotiate the guilt—"ancient, primordial, but so maternal" (p. 89)—they feel over their children's conditions. As Keri discovers, this guilt is particularly resilient and resistant to reason and re-orientation. Even after "months of reading books about mental illness, months of support groups, of psychotherapy, of assiduously learning that Trina's problem was not of my making (all together now: 'I didn't cause it, and I can't cure it!)," Keri concedes that "the jazz of [her] present existence scatted only one refrain: *whatdididowrong whatdididowrongwhatdid ididowrong whatdididowrong"* (p. 90).

The commiseration of guilt-ridden, overwhelmed mothers in support groups, county jails, and living rooms drives *72 Hour Hold's* (Campbell, 2005) central themes—exasperation, devotion, and love. One mother, Jean, captures their plight in telling Keri that, although they endure different 'parts of the hell' of mental illness, parents have it worse than their ill children. As she explains, "At least when the kids are spinning out of control, they're in their own little world, imagining they're okay. But we have to stand there and watch them and love them and know we're helpless" (p. 188). Keri's 'hell' is undoubtedly anchored by grief and motored by the inability to surrender her expectations for the life she had imagined for herself and her daughter before the onset of her illness. Keri's running internal dialogue, in fact, reads like a steady stream of lamentation about 'life now,' as mental illness has transformed it irrevocably: "*So this is how the kid turned out…my sweet, sweet baby. Ballerina princess at 11, cheerleader at 14, nutcase at 18. So this is how my life turned out*" (p. 117).

Campbell (2005) tracks Keri's interlocution between the stages of grief popularly touted in psychological literature—denial, anger, bargaining, depression, and acceptance (Sternberg, 2004). Campbell (2005) indicates that Keri's (or *any* parent's) first task will also be the most enduring project of her grieving: dislodging her denial about the severity and long-term ramifications of Trina's illness and accepting that she must retire her previously held 'life plans.' Keri clings desperately and stubbornly to the conviction that Trina can and will still 'catch up:' "She'll go on to college, go on to graduate school, get a great job, and meet a nice guy, an understanding go-getter. Everything will work out fine" (p. 21). She simply cannot help herself—she looks at Trina and sees the daughter she has always had, expectations intact. She is consumed with envy, therefore, when receiving the graduation notices of her friend's children, knowing that Trina—a National Merit Scholar with a 1535 SAT score (as Keri reports, compulsively, to anyone who will listen)—will *not* be similarly 'growing up' and 'moving on' as planned (p. 90).

Keri's mental health peers are quick to pluck her from this jealousy and resentment, as well as to impress that everything will not, in fact, work out 'fine.' They urge her to abandon the quixotic hope that Trina's life and health will resolve to their pre-onset states, leaving her poised to resume her march toward Keri's imagined future for her. Sage-mother, Jean, once again offers Keri insightful commentary on the subject in plaintively urging her to let go of a past in which Trina's perfect report cards sufficed as the pinnacle of her motherhood and accept the new reality they both face: "Those days are gone, sweetheart…Move forward. Appreciate what [Trina] has got going for her right now, right in this moment. She's a tremendous survivor, dear. They all are. She has battled hard to be here. Respect that. Straight A's? That was then" (Campbell, 2005, p. 201). Importantly, Jean also exhorts Keri to cherish Trina's life as it is now and recognize that it has value "just as it is," the same value it had "when she was making straight A's and got into Brown" (p. 201). For much of the novel, however, Keri can only stew as she hears her peers laud their ill children 'achievements:' part-time jobs, medication compliance, and quasi-independent living. She admits that she would 'slit her wrists' if that were Trina's future (p. 201).

Bethany's experiences with her daughter, Angelica, illuminates a different permutation of maternal anguish that is marked by further advancement in the grieving process but steeped in the terror, despair, and exhaustion that attend more severe or complex mental health conditions. Bethany describes this turmoil to Keri in articulating the different stakes they bring to 'the program.' She confesses that if the program did not work for her, she would have to 'walk away' from Angelica: "And then what will happen? [Angelica will] become homeless. I'll have to accept that, right? I'll have to accept the fact that I gave birth to the crazy lady and people will laugh at her and exploit her and be afraid of her and not want to be around her. Because if I don't walk away, she'll end up killing me. So the program has to work, because this is my last go-round. After this, I give up" (p. 252). Bethany's despair and depletion is universal to her literary cohort of caretakers. They earnestly preach the gospel of self-care to newcomers like Keri and warn them about stress-induced ailments, such as high blood pressure and depression. One man (a doctor), who attributes his wife's stroke to her near-suicidal devotion to their schizophrenic daughter's care, issues this warning to Keri: "When you love someone who has a mental illness, there comes a point at which you must detach in order to preserve your own life" (p. 225). Articulating one of the novel's most poignant take-away lessons for caretakers, he adds, "You can't always beat what is difficult in your life. Sometimes you have to let it win and say hallelujah anyhow" (p. 226).

Mental health social movement. Campbell (2005) often employs the idiom of slavery in writing about mental illness, describing it as an oppressive force that 'owns' her characters or to which they are 'shackled.' Moreover, she also invokes the sociopolitical movements and activists slavery subsequently inspired to underscore the subjugated status of people living with mental illness and establish the political pedigree of the mental health movement and activists now charged with their political bidding. Campbell's novel portrays this movement along a limited but appreciable political continuum as its characters labor within and/or outside the systems at their disposal. They often engage in radical acts explicitly motivated by the ideo-political traditions of slave rebellion, abolition, and twentieth century social movements, like Civil Rights, The Black Panthers, and The Weatherman. As Bethany describes then, "groups that recognized that radical problems called for radical solutions and that did not wait for the system to give them what they needed" (p. 147).

Keri envisions her own turn to 'program' radicalism, as well as the desperation and moral outrage that fuelled it, in these radical, liberationist terms. For its part, 'the program' conceptualizes its work as 'liberation'-based political struggle, as evidenced in its appropriation of Harriet Tubman's 'Underground Railroad' as an organizational and ideological model. Interestingly, Tubman maintains a spectral presence throughout the novel via 'program' undertakings. She also plays a central role in Keri's internal monologues about the stakes and moral and political imperatives underlying her alliance with an extremist group whose radicalism, she tells herself appeasingly, is analogous to Tubman's or Denmark Vasey's or Nat Turner's (Campbell, 2005, p. 165).

'Program' leader, Brad, reinforces this notion in pitching his group to Keri. He tells her that Tubman's 'Railroad' was a suitable model for what they do given that "mental illness is a form of slavery" and their group, too, was about "freeing people"—in this case, from the subjugation of psychiatric illness and being "written off or warehoused" in the mental health system (Campbell, 2005, p. 174). The program provides them instead a literal and metaphorical route to freedom via a treatment center and philosophy based on and operating with the central conviction that "recovery is possible…when the right conditions are present" (p. 166). He assures her that they, not the system, can facilitate those conditions. 'Program' care is directed by a group of psychologists and psychiatrists "who believe that the mental health system…is a sad joke" (p. 166). As its former lackeys, therefore, they have all experienced firsthand the wasted opportunities for people to recover within the system. As a result, they forgo its usual channels—"the 9-1-1, [community outreach teams], the conservatorships" (p. 166)—and take people in need of an intervention but "are too sick to accept help" to their secret center where they are educated about their illnesses, placed in psychotherapy, and taught medication compliance as the "key to leading a productive life" (p. 167).

Brad recognizes that the program's ethically dubious practices are 'not for the faint of heart;' however, he assures Keri that they, at least, will not wait for Trina to 'hit bottom' before intervening with care (Campbell, 2005, p. 146). Keri has already learned the unfortunate truth about the system: the worse off a person was, the sooner she would 'qualify' for help (p. 162). She has also learned, therefore, that it is in a parent's best interests to encourage the deterioration of a loved one's condition once he or she has legally refused help. When Trina was at her self-annihilating worst, Keri finally reached the end of her parental rope and baited Trina into relapse with a bottle of scotch. She was hoping to provoke a physical altercation or anything else that, at last, would elicit a response from a system custodian or authority (medical, legal, or law enforcement) (p. 162). Keri describes this demoralizing, merry-go-round of system ineptitude as it precipitated her turn to 'the program' and that, should she decide against the program as a primary option, would remain her only recourse in handling Trina's increasingly destructive behavior. If 'Option One' is the program, then "Option Two" means having to:

> Start again. Go back to support group. Call the SMART [community response team] people. Wait. Call them again. Hope that she meets the criteria, that she is swallowing the bottle of pills or punching me as they come through the door. Hope that she gets put on a seventy-two-hour hold. Hope that the hospital has a psych bed available. And that the meds don't work so fast that she's totally lucid after three days, too lucid to stay longer. Pray that the hospital decides to extend her hold and that the patient's rights advocate is lazy. Pray that Dr. Bellows will do all the paperwork, come to court, and testify on my behalf. Pray that the judge will see things my way. Wait. Hope. Pray. Trust the system. (p. 171)

Sensing both her desperation and reservations, Brad quells Keri's concerns about the program by offering up a cavalcade of parental alumni who have assembled in the wings of their secret meeting to testify about the group's value as an alternative to the mental health establishment. Keri finds that their stories are similar to her own: "Sick loved ones, a system that had failed them, nowhere to turn. And then suddenly a light" (Campbell, 2005, p. 169). As they disarm her suspicions of 'the light' as a potential cult out to brainwash and swindle her, stealing her daughter in the process, Keri begins to consider their endorsements alongside the alarming tales of 'system breakdown' that sparked their entrance into with the program. She comes to the sobering realization that her pre-'program' plan—waiting for or orchestrating Trina's relapse in order to expedite her conservator petition—would not bring the "complete deliverance" she had supposed (p. 168). By the end of the procession, Keri can no longer fight the inevitable conclusion that "came from feeling [her] back against the wall" (p. 169). In the words of her final program 'witness' of the night: "What other choice do they give us?" (p. 169). If she returns to the system, Trina will not be safe or well—she will simply be 'lost' (p. 170). At least with the program, Keri thought, they will no longer have to be at the mercy of people "who didn't give a damn" (p. 165).

72 Hour Hold as Pedagogical and Political Practice

Campbell's *72 Hour Hold* (2005) is an outstanding model of politically progressive, didactic mental health storytelling, and, in fact, its most distinctive narrative achievement emerges from this realm of narrative service: an astute and instructive explication of mental health politics delivered through/as Campbell's ingenious literary adaptation of the modern mental health crisis. The previous section elaborated the central terms and dilemmas of that crisis in its discussion of the systemic and cultural exigencies that motivate mental health movements. Campbell's treatment of mental health politics must be understood, however, within the broader context of her affiliations with the consumer movement and that National Alliance on Mental Illness (NAMI). NAMI, the most influential consumer group in mental health advocacy today, acted as the primary organizational vehicle through which Campbell rose to prominence as an activist. She not only delivered the group's political message, she helped fashion and refine it. *72 Hour Hold*, in effect, is a practical extension of this political collaboration and the activism it inspired. It advances NAMI's consumer-based political platform and affirms its neoliberal values and objectives. As such, Campbell's novel assumes both the sociopolitical rewards and liabilities of this partnership and the program of work it propagated, which although predominate in mainstream mental health work, is not without contest or controversy (Chesler, 2005, p. 28).

Contemporary mental health politics. Mental health politics and advocacy are, in fact, notoriously contentious political terrains, marked by long histories of internal strife promulgated by diverse constituencies vying for limited resources to subsidize competing and/or divergent programs of interest (Jacobson, 2004; Tomes, 2006). This fractiousness is further encouraged by the mental health care system's unique political and structural challenges, such as long-standing afflictions with fragmentation, marginalization from general health care, social stigma, and a faltering quality management infrastructure (IOM, 2001). The resulting ideo-political factions coalesce roughly around the liberal and radical divisions typical of many modern social movements, with a similarly rich spectrum of political affiliation/identification/ascription strung between them (Bracken & Thomas, 2005; Tomes, 2006).

'Consumer'-directed work, as the name suggests, is politically predicated on the belief that the mental health community's purchasing power provides its most advantageous route to exercising political agency and bargaining potential in a consumer driven mental health marketplace (Tomes, 2006). Furthermore, these groups, like NAMI, espouse largely biomedical models of mental illness whose political expedience in post-'Decade of the Brain' social and scientific venues they exploit in advancing neo-liberal political work formulated in the discourses of rights and inclusion (Fee, 2000). These approaches are alluring not only for their resonance with traditional American political values but also for outperforming, politically and materially, their more radical rivals who have consistently faltered in proffering viable alternatives to the prevailing systems and paradigms their proponents criticize (Tomes, 2006). NAMI and its neoliberalist ilk, on the other hand, have made significant headway for the mental health community in expanding its political capital, improving its access to services and resources, raising the public profile of mental health issues, and even transforming clinical practice and policy by helping to re-shape the criteria for "effective treatment" in championing integrated models of care that push health and social services to support programs for recovery and rehabilitation (Tomes, 2006).

Members of more radical camps, such as MadPride, charge that these consumerist-neoliberalist 'achievements' ultimately undermine the long-term interests of people living with mental distress. They maintain that 'consumer'-based political programs obstruct more progressive prescriptions for political action by diverting resources and attention away from fundamental reformulations of contemporary social systems and institutions (Bracken & Thomas, 2005). They claim that the hegemony of the sociopolitical and economic infrastructure currently in place not only produces but requires *ex*clusivity, social stratification, and the homogenization of difference (Bracken & Thomas, 2005; Cloud, 1998; Fee, 2000). A consumer orientation and rights- and inclusion-based politics are more than just misguided political strategies and philosophies to these radical critics they underwrite the consumer movement's complicity with the institutional and systemic machinery of its own constituents' marginalization (Chesler, 2005, pp. 28-29).

These radical groups, in contrast, adopt social constructionist views of mental illness that position psychiatry as an oppressive instrument wielded by a privileged elite that stands to profit (materially and politically) from the normalization of transgressive corporealities and neurologies and the eradication of natural variations on human psychological experience (Bracken & Thomas, 2005; Chesler, 2005; Fee, 2000). Instead of an assimilationist 'politics of inclusion,' then, these groups advocate for political empowerment based on the affirmation of mental/neurological 'difference' as a facet of human experience and cultural resource worthy of celebration (Chesler, 2005; Fee, 2000; Wendell, 1996). These ideological ascriptions, therefore, direct a divergent program of political work that is geared mostly toward the politicization of mental distress through consciousness-raising and organized protest enacted outside the purview of the systems that propagate mental health-based oppression.

Campbell's (2005) novel gives limited attention to radical ideologies in their purest political sense. Its 'radicals' are hardly archetypical "anti-psychiatry" dissenters set on dismantling 'the system' because of social or political opposition; rather, they are system defectors abandoning a sinking ship to build a better, more buoyant and humane one of their own. Although their 'ship' is still *a* ship subject to the nautical pitfalls attendant to all 'ships' sailing in contemporary mental health waters, their objectives and methods are radical to the extent that they operate far enough outside those of mainstream mental health advocacy, as well as the ethical and legal dictates of society at large, as to warrant criminalization. The bulk of *72 Hour Hold's* political engagement, therefore, sits squarely with NAMI and the consumer movement. Although Campbell never explicitly identifies it by name, NAMI clearly organizes the political and narrative architecture of her text. She directly appropriates their 'consumer'-based nomenclature and ideo-political agenda, as well as models her novel's network of support groups (major characters and sets themselves) on the design and modus operandi of NAMI's peer support and family-to-family programs. Importantly, NAMI was founded by family members of people living with mental illness and, therefore, shares the "ally" perspective Campbell assumes in writing about and advocating for mental health issues. This perspective directs the substantive terms and priorities of NAMI's—and, thus, *72 Hour Hold's*—political agenda. In focusing on 'ally' concerns and interests, both foreground debates about patients' rights, conservatorship, the procurement of mental health services, involuntary commitment, and the protocols and procedures that precede the aforementioned's award and implementation (Campbell, 2005).

Politics and pedagogy in 72 Hour Hold. Like their 'real life' corollaries, Campbell's (2005) support groups are charged with connecting and educating families coping with mental illness. Keri's regular attendance at their meetings reveals their work in action, therefore, they become the primary literary devices through which Campbell elaborates a progressive mental health political agenda that privileges parental interests and concerns. The group members themselves hash out the planks of this agenda as they brainstorm solutions to problems, trade inside information about doctors and treatment facilities, and extend encouragement and support. In the process, they nurture empathic investments in each other from which they ultimately cull political solidarity. Campbell also foregrounds these groups' pedagogical functions, documenting how their facilitators and guest speakers indoctrinate members into community politics and advocacy initiatives via crash-courses and 'Q&As' on new drug therapies, self-care, safety planning, and petitioning for conservatorship.

As *72 Hour Hold's* pedagogue in residence, Campbell (2005) excels at matching punchy dialogue with sophisticated characters and storylines to excavate the major social and political contests surrounding the current crisis in mental health. The 'seventy-two-hour hold,' of course serves this purpose most explicitly. Campbell uses it throughout her novel to highlight a number of problems currently plaguing mental health care, as well as the systems and ideologies that administrate it. She foregrounds, in particular, the ways in which police, community intervention teams, and medical personnel err in determining who meets the criteria for a psychiatric hold and when. Keri shows that this 'frontline' decision is pivotal in securing a conservatorship petition. Unfortunately, however, Keri finds that these first responders must catch Trina in the act of harming herself or others before officially meeting the criteria for a hold. This task proves exceedingly difficult when Trina manages to "pull herself together" as soon as the team arrives (p. 133); in fact, Keri must call them out half a dozen times before she succeeds in securing an involuntary hold on Trina.

72 Hour Hold (Campbell, 2005) derives much of its plot and political material from the tension between patients' rights and their caretakers' wishes. The novel impresses that patients' rights "often clash with what's best for a mentally ill person " (p. 226), and it works to demonstrate how these rights obstruct an ally's/parent's ability to monitor or direct an adult child's care. The parents of *72 Hour Hold* show that, without the requisite transfer of legal authority, adult children can refuse or terminate care at their choosing, as well as deny their parent-caregivers' access to their medical information. Keri enlivens the resulting parental predicament when making an appeal to a hospital attendant who has just informed her of Trina's decision to restrict her access to her medication information. "But I'm her mother. She lives with me," Keri pleads indignantly, "She's my dependent. I'll be paying her bill…I have a right to know what's going on. She may be coming home tonight. I have to know what I'm dealing with!" (p. 102).

The 'seventy-two hour hold,' once again, acts as ground zero in this battle between parental caretaker, ill adult child, and The System. By choosing it as her novel's title, Campbell (2005) indicates that much of her text's action and political 'might' will emanate from the tensions a 'hold' both incites and emblematizes between parent and patient. This is especially the case as it comes to symbolize 'system breakdown,' inefficiency, and ineptitude. Campbell shows that, to this extent, the 'hold' is often the currency of system action and inaction. She also develops other literary sites of political contest and concern, however, and the most important of which centers on her characters' quests to secure high quality, affordable care in safe, competently-staffed treatment facilities—a top priority for allies and 'patients' alike.

Keri's support group members devote much of their brainstorming and strategizing to this subject and, in the process, highlight the most urgent problems inhering in this task. A woman whose daughter's recent incarceration suspended her treatment comments revealingly on the considerable cost of mental health care. She notes that jail was at least far cheaper than the private care facility she was still paying off for her daughter's previous hospitalization. Tallying the cost of that treatment, she tells Keri: "Six grand for a four week stay. That's room and board, program sessions, private counseling, family counseling. The insurance is only paying half, and it took about twenty phone calls, and I don't know how many letters to get them to pay anything" (p. 52). Even with the best insurance plans, coverage can be limited by lack of mental health insurance parity (still an ongoing battle in both nominal legislative and practical terms) and contingent upon the availability of space at overcrowded and under-funded treatment facilities. For example, although Keri has a decent policy and finds a county facility willing to subsidize her costs, she has to wait for an extended period for an opening and, in the meantime, has no other place to keep Trina.

Campbell (2005) emphasizes that this quest for affordable, accessible, and effective care is driven by parents' concerns for their children's safety. Keri's ex-husband, Clyde, whose involvement in their daughter's care has been largely incidental and monetary, articulates these concerns while scouting local centers with Keri: "What if somebody jumps on her? What is she's raped? She could get killed. People die in places like that." Keri shares his concern but poignantly replies: "Trina may die *if she doesn't get help*" (p. 295). Campbell also enlists the combative ex-spouses as additional purveyors of her narrative pedagogy near the novel's end. She mines the dramaturgical bounty of their embattled personal history and contrasting ideo-political persuasions as occasions for staging the real contestations, antipathy, and relational brokering that families in crisis experience. Keri, in particular, is tasked with synthesizing information for Clyde's (and the reader's) edification about everything from the physiological processes underlying manic-depressive illness to the politically-reformulated vocabularies of mental health activism (i.e. people *have* mental illness—not 'are' mental illness) to the savvy required to outmaneuver system apathy and inefficiency.

Keri and Clyde give more than superficial attention to these issues, however, they engage and debate them in the most crucial moments of their literary lives. As their 'reconnaissance' tour to local treatment centers in preparation for Trina's transition to long-term care demonstrates, they use these occasions to delineate the stakes of these issues, as well as complicate their terms in accessible and instructive dramatic sequences. As Keri and Clyde debate the merits of these centers and dredge up unfinished feuds from their marriage, they outline contemporary mental health advocacy's primary political preoccupations. These issues include: the ethics of involuntary commitment; the devastating impact of social and financial under-investment in mental health care in American culture; and the absence of social health and welfare programs providing transitional services and educational and vocational training for people living with mental illness (Campbell, 2005, pp. 292-295).

Keri and Clyde share an exchange about the criminalization of mental illness that illuminates Campbell's (2005) narrative pedagogy at work, giving a sense of its tone and didactic approach to explicating contemporary mental health politics. After touring facility that houses both criminal inmates and regular patients (in two separate wings), Clyde becomes incensed by the prospect of their daughter being locked up with 'those people:' "I mean, who the hell would mix criminals with the people who are mentally ill?" he exclaims (p. 293). Keri, seasoned from her hard knocks mental health education, replies: "They're all mentally ill, Clyde, and they're in separate buildings. And who the hell would put mentally ill people in jail in the first place? Let me tell you something: The way Trina was going, only the grace of God prevented her from having a permanent room on the [criminal inmate] side. So don't get to feeling too superior, my friend" (p. 294).

72 Hour Hold as Philosophical Dramaturgy

The Moral of the Story

As Campbell (2005) documents the hardships associated with mental illness, she also delineates its moral implications and, by extension, the moral(s) of her story: resilience, determination, and reverence for life. First and foremost, Campbell honors the fortitude of people and families coping with mental distress in documenting how they re-engineer its destructive properties into occasions for productive re-tooling of their lives and relationships. Arthur Frank (1995) describes this process of re-evaluation and reconfiguration as the 'moral occasion of illness.' He argues that illness calls people to introspection about what has been lost and/or gained in their lives in its wake—reflective analysis that, in turn, often transforms the direction and meaning of their lives. In Campbell's (2005) novel, 'program' leader, Brad, poignantly articulates the web of moral imperatives that inhere in families' experiences with mental illness while confronting Keri about the realities of Trina's bipolar disorder. "It will not go away," he tells her, "and recovery will be ongoing for the rest of [Trina's] life and the rest of yours. Those years can be disappointing or painful, or they can be productive maybe even joyful. It depends on your attitude" (p. 216). Brad further exhorts Keri to recognize that Trina's illness is not *her* personal tragedy—it is Trina's. He continues: "You want the bright child back, who attends Brown and gets straight A's. Well, don't we all. You have to accept Trina the way she is. She's not something you ordered from a catalogue. She's a gift from God. You need to treat her that way…I'm not talking about love, Keri, I'm talking about reverence for her life" (pp. 216-217).

Keri's time in the 'underground' ultimately compels her to accept Brad's message and finally embrace Trina's illness and its transformation of their 'life plans.' Furthermore, she returns from the program armed with a new resolve to re-engage with the system and stop "holding out for miracles, rescues, and easy fixes" (Campbell, 2005, p. 301). This change is most evident when Keri returns to her old support group and begins the process of re-imaging her life's 'script.' Her fellow group members offer guidance in revising her 'happy endings.' As the other parents share updates on their children's lives, Keri realizes that these new endings are not only 'good enough,' but worthy of celebration and gratitude. As Keri describes: "The happy endings [now] were when the social security disability checks came through before all the money ran out…When there was a vacancy at a decent residential facility, when the shrink or the therapist knew what the hell she was talking about. When the kid took the medication on her own, without being prompted, because she knew she needed it" (pp. 302-303). Listening to the other parents, Keri also realizes that "many people were holding steady on the seesaw of mental illness;" their stories of "just doing *pretty well"* had simply been attenuated in her mind by her determination to find a different, 'better' ending (p. 303). Keri scans the room and adds: "I am not alone, I thought, looking around the circle. Not everyone here is sad" (p. 303).

Campbell's (2005) characters also experience mental illness as a moral occasion to the extent that it reunites them and rejuvenates their relationships. Just as Trina's illness renews her relationships with Keri and Clyde, as well as their relationships with each other, it sparks a series of reconciliations that radically transform their family structure. When all is said and done, it brings two new additions to Keri and Trina's household: Keri's estranged mother, a recovering alcoholic with whom she finally makes amends, and Keri's ex-boyfriend, Orlando, with whom she rekindles a romance after he emerges as her most ardent supporter. Furthermore, Trina's illness also solidifies and transforms Keri's personal and political investments in the mental health community. She eventually co-founds a support group for "newly-liberated black people who love someone with a brain disease" (p. 315). The group's first project is a play staged by its 'consumer' participants, and it serves as the novel's final 'set' and the backdrop against which Keri and Bethany deliver a (if not *the*) 'moral of the story' about mental illness and the nature of caring for someone who has one. The two 'war buddies' reunite on the play's opening night and reflect on the arduous journey that led them there. As they marvel at their survival and newfound strength, the lights go down in the theater. Bethany quickly leans over and tells Keri: "Honey, this is what you call a breather" (p. 318). As the play begins, Keri ruminates on the notion of a 'breather:"

> Maybe, after the devastation, what you're supposed to do is rebuild the space in your mind that's been blown away, but never fool yourself into thinking that it's stronger, that you're erected some impenetrable fortress that won't be hit again and again and again. Things fall down, people, too. Crazy men wander the land, crashing and crumbling, and nobody gets a warning. There is always another swamp to cross…Ol' Harriet learned that the hard way, the first time she retraced her path, erased her scent, outwitted the dogs, and followed the only star that lit

> the way, only to discover that when she got where she was going, new hounds were waiting. But there was that cool space on the bank of that murky water where she lay on fragrant moss, undisturbed for hours, and there was no barking, no sound of twigs snapping. A breather. (p. 319)

Conclusion

Like Bebe Moore Campbell, Dorothy Allison's literary proclivities defy genre but settle with particular fervor and skill on fiction and the novel. In her memoir, *Two or Things I Know for Sure*, Allison (1995) declares her narrative identity and expounds on the art and imperatives of storytelling:

> I am a storyteller. I'll work to make you believe me. Throw in some real stuff, change a few details, add the certainty of outrage. I know the use of fiction in a world of hard truth. The story of what happened, or what did not happen but should have—that story can become a curtain drawn shut, a piece of insulation, a disguise, a razor, a tool that changes every time it is used and sometimes becomes something other than we intended. The story becomes the thing needed. (p. 3)

Richard Kearney's (2002) work on narrative ethics gives dimension to Allison's assessment of storytelling and its possibilities for truth telling. In positing that, "what is impossible in reality is made possible in fiction" (p. 139), Kearney offers some support to Allison's claim that storytelling can, in fact, produce a 'harder truth.' Kearney identifies three distinct but interconnected 'senses of storytelling:' there are stories we inherit from our family, culture, or religion that function as "purveyors of tradition, heritage, or ideological illusion;" stories that serve the purpose of creation, "in the sense of pure *creatio ex nihilo;*" and stories that operate as "creative solutions for actual problems" (pp.

29-30). In this latter sense, Kearney argues that “narrative fiction draws from the first two functions while adding a supplementary one—that of cathartic survival” (p. 30).

Sociopolitical Fiction and Social Change

Kearney (2002) argues that novels are uniquely capable of assuming the narrative task “of transmuting the grist of everyday suffering into a sublimated work of art” and, thus, of fulfilling fiction’s potential “as healing and transformative fantasy” (p. 30). Furthermore, Kearney contends that the novel is distinguished by its “extraordinary ‘synthetic’ power in drawing liberally from a diverse array of literary conventions,” however, most importantly “in its audacity in experimenting and evolving, metamorphosizing and mutating into an amazingly rich range of narrative possibilities…” (p. 10). He underscores that the mimetic-mythos role of fiction is particularly important, as mimetic re-creation allows for creating “a connection between fiction and life while also acknowledging the difference between them;” in fact, he maintains that “life can be properly understood only by being re-told mimetically through stories” (p. 132). In consequence, the ‘untold life’ is less rich than a told one, as “the recounted life pries open perspectives inaccessible to ordinary perception. It marks a poetic extrapolation of possible worlds which supplement and refashion our referential relations to the life-world existing prior to the act of recounting” (p. 132). This exposure to new possibilities of being, in turn, “refigures our everyday being-in-the-world. So that when we return from the story-world to the real-world, our sensibility is enriched and amplified in important respects” (p. 133).

Kearney (2002) identifies ‘catharsis’ (or ‘release’) as an enduring function of storytelling that sits at the heart of its political and ethical work. He maintains that stories are cathartic in that they ‘alter’ us, “transporting us to other times and places where we can experience things *otherwise*…” (p. 137). Stories let us “know what it is like to be in someone else’s head, shoes, or skin;” in short, they are endowed with “the power of *vicarious* imagination” (p. 137). Readers/listeners may experience cathartic release from the “tragic sufferings of existence in [their] roles as spectators,” as “the very contrivance and artifice of *mimesis* detaches us from the action unfolding before us, affording us sufficient distance to grasp the meaning of it all” (p. 138). Kearney attributes the “distancing or fearful aspect of catharsis” to the ‘gap’ opened up between “the literal and figural by the art of imitated action” and further indicates its role in provoking ‘awe’ in a story’s recipients (p. 138). He argues that this cathartic awe “stops us in our tracks, throws us off kilter, deworlds us…enabling us to see through things, however troubling, to their inner or ultimate meaning” (p. 138). Drawing on an Aristotlian notion of catharsis as “purging us by pity as well as fear,” Kearney emphasizes that catharsis “comprises a double attitude of both empathy and detachment” (p. 138). Readers/listeners, while needing distance from a narrative, must also be “sufficiently *involved* in the action to feel that it matters.” Furthermore, they must also develop the particular mode of sympathy that narrated action can uniquely solicit via its poetic license in “suspending our normal protective reflexes,” as well as through its ability “to amplify the range of those we might empathize with—reaching beyond family, friends, and familiars of all kinds of foreigners” (p. 138).

Kearney (2002) firmly links narrative’s empathic and cathartic facilities with its ethical and political imperatives. He indicates that the ability to empathize with other living things (“the stranger the better”) is “a major test not just of poetic imagination but of ethical sensitivity" (p. 139). He goes so far as to contend that, "genocides and atrocities presuppose a radical failure of narrative imagination." Narrative sympathy allows us to see the world from other people's points of view, therefore, if we possess it, we cannot kill—just as, if we *do not* possess it, we cannot love (p. 139). By affording "a singular mix of pity and fear whereby we experience the suffering of other beings *as* if we were them," catharsis and its "double-take of difference and identity—experiencing oneself as another and the other of oneself—provokes a reversal of our natural attitude to things and opens us to novel ways of seeing and being" (p. 140). Furthermore, it calls us to acknowledge "painful truths—through the 'gap' of narrative imitation—rather than some magic potion which miraculously resolves them" (p. 142). Kearney determines, then, that narrative "catharsis is a matter of recognition, not remedy," therefore, all narrative forms, especially fiction, should be considered alongside of and do justice to "the ethical significance of stories of *real* suffering" (p. 37).

Narrative ethicists, such as Nelson (1997) and Nussbaum (1992, 1995), have noted similar promise and limitation in narrative/fiction's role in expanding moral imagination and ethical practice. Nussbaum (1992, 1995) has explored at great length the political implications of reading fiction and the importance of emotion evoked by the literary work on political reasoning. Nelson (1997) cites as particularly important to narrative ethics Nussbaum's explications of fiction's ability to help people imagine "the concrete ways in which people different from oneself grapple with disadvantage" (x). She notes that this capacity has great practical value "given the vast amounts of racism, homophobia, ethnic animosity, sexism, and other invidious hatreds that run rampant in the world" (x). Fiction, therefore, may serve as a "moral laboratory" in which readers can engage with narrative in ways that "supplement, interpret, and even restructure [their] perceptions about our lived lives" (Montello, 1997, p. 187). Moreover, this moral space may encourage readers to open themselves to multiple world views that allow them access to the moral reality of others while clarifying their own moral values (p. 187). Although narrative ethicists recognize that narrative's ability to challenge deeply entrenched prejudices and/or substitute for 'witnessing' the suffering of *real* people can be fairly limited (Nelson, 1997, x), they are undaunted in their support of narrative work. They maintain that repudiating the literary imagination is not an effective means of addressing these limitations; rather, the 'imagination' itself "must be cultivated more consistently and humanely" (Nelson, 1997, x-xi).

Bebe Moore Campbell's *72 Hour Hold* (2005) does its part in 'cultivating' the literary imagination. It also fairs well in filling the tall narrative order outlined by the narrative ethicists above in both expanding and enriching the reader's moral imagination in ways that call 'imagination' itself to practical action and effect. As those scholars indicated, narrative and storytelling can function as agents of progressive sociopolitical work by opening readers to the experiences of 'others.' In doing so, they facilitate the cathartic empathy and awe that precondition social change (Kearney, 2002). Campbell (2005) masterfully wields fiction to initiate her readers into an'other' world. Her novel demonstrates how storytellers can use well-crafted, socially sophisticated fiction to tell a 'harder truth' than might be possible to convey outside its narrative elasticity, capaciousness, and dramatic scope.

Campbell's (2005) 'truth'—an engaging, multi-perspective, didactic portrait of a complex social issue—demonstrates fiction's pedagogical utility. Her novel, therefore, serves as an excellent demonstration of how mental health communities may seize fiction’s unique potential to educate popular audiences about mental health issues. This service is particularly important for those whose access to mental health information may be limited or whose interest in mental health issues might not otherwise be piqued. Finally, Campbell and her novel are remarkable for modeling an extraordinarily productive merging of storyteller, storytelling, and activism in mental health domains. Although the mental health community is well known for its literati (Jamison, 1993), few other writer-activists have risen to the ‘civic-storytelling’ occasion and served its duties with Campbell’s grace, authenticity, and fervor.

Chapter 4

Hysterical Strength:
Carrie Fisher's *Wishful Drinking*

Carrie Fisher's *Wishful Drinking* (2008) opens philosophically: "I have to start by telling you that my entire existence could be summed up in one phrase and that is: If my life wasn't funny it would just be true, and that is unacceptable" (p. 17). Fisher, best known for her iconic role as Princess Leia in the *Star Wars* trilogy and even more iconic showbiz family, is expert in wielding humor as deflection and self-preservation. In the case of her memoir, however, she also enlists it as a narrative edict assiduously employed in service of her most hallowed personal commandment: thou shall beat the press, public, and hardship itself to the punch line of the tragic and shocking in life. The title, 'Wishful Drinking,' as well as the text's cover art—an image of Princess Leia passed out on a table, clutching an empty martini glass—epitomize Fisher's penchant for using a fierce but self-deprecating wit to outdraw detractors and personal misfortune.

Wishful Drinking (2008) indicates that Fisher owes much of her 'hysterical strength' to her parents, screen and music legends Debbie Reynolds and Eddie Fisher.[25] Fisher's parents, however, did more than provide the genetic foundations of her wit. They nurtured its development by conscripting her into the family trade at a very early age and have been supplying it with an exorbitant amount of creative material ever since. Although Fisher pilfers liberally from this treasure trove of family secrets and scandal in procuring her memoir's most salacious anecdotal spoils, her portrayal of her larger-than-

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[25] 'Hysterical strength' refers to an actual medical phenomenon in which extreme situations endow people with the ability to perform extraordinary (usually physical) feats, e.g. 'lifting' cars to rescue someone trapped beneath.

life family and Hollywood upbringing is as much affectionate, doting tribute as it is sardonic indictment and caricature. Fisher presents her own life in equally stark but measured terms, however, in documenting the decidedly unglamorous setbacks with which she has been saddled despite the privileges of wealth and fame. Importantly, Fisher distinguishes a 'problem' from an 'inconvenience,' noting that the former derails one's life while the latter means only having to forgo 'the nice seat on an un-derailed train' (p. 104). She then determines that exactly three and a half problems have truly beset her: finding a dead man in her bed, substance abuse, manic depression, and, "the little problem-ette" of being left by the father of her child for another man (p. 105). These 'problems,' therefore, come to organize the life story and illness narrative she recounts in her memoir.

Fisher's (2008) memoir, however, is not the first narrative station of her public disclosure and attempted literary/artistic resolution of these 'problems;' in fact, she dabbled extensively in their sublimation into other forms of creative enterprise before turning to memoir as a preferred narrative forum. En route to this newest 'home' genre, Fisher diversified her narrative portfolio across media by working in television, film, theater, and fiction-literature. In the process, she also nurtured an entrepreneurial storytelling impulse unrivaled by any other storyteller featured in this project.[26] Although Fisher's acting career has sputtered along haphazardly (and insipidly) since its liberation from the intergalactic gulag of George Lucas's *Star Wars* industry, she has enjoyed considerable critical and commercial success in the literary world. She published four best-selling novels before *Wishful Drinking* that, in effect, presaged it as

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[26] This 'impulse' arguably has produced an oeuvre more often impressive in quantity and breadth than quality.

perfunctorily fictionalized accounts of her struggles with addiction (*Postcards from the Edge* [1987]), manic-depressive (*The Best Awful* [2004]), and romantic calamity (*Surrender the Pink* [1991]).

Fisher's fitful showbiz career and slightly self-preoccupied literary oeuvre share a powerful animating force: a dexterous but essential performativity that Fisher herself embodies as, above all else, a show-woman—a jack of all performative trades, compelling master of at least one or two (the text and stage). She embraces this identity and artistic disposition as the central apparatus of her selfhood, and, therefore, it not only directs her self-understanding and 'life pursuits,' but defines her craft as a storyteller—the mission and method of which *Wishful Drinking* is demonstration *par excellence*. As the narrative culmination of a life lived and 'self' shaped on the public stage, *Wishful Drinking*, appropriately, was developed initially for the *theatrical* stage as a one-woman show. This production enjoyed a successful run in theaters across the country for nearly two years before being adapted for literary publication in 2008. It even made its Broadway debut in Fall 2009. Each of these performative incarnations of Fisher's 'memoir' bears its own narrative possibilities; however, collectively, they transact Fisher's life story through a common performative methodology, each preserving the original's theatrical and performative esprit with its own media and narrative resources.

This chapter takes Fisher's *Wishful Drinking* (2008) as an excellent occasion for exploring performative storytelling in mental health. It elucidates the particular narrative promise and contingencies of employing performative writing methodologies and personal narrative genres in storying manic-depressive illness. My primary contention is that these modalities are most valuable to BP storytellers for their ability to 'show' rather than simply ‘tell’ an illness story. I argue that this narrative facility is vital to accommodating the experiential and literary exigencies that inhere in manic-depressive storytelling. Moreover, I contend that it is attended by a performative ethic that, in privileging didactic, self-reflexive, and embodied narrative work, is better suited than less representationally and communicatively dynamic narrative forms to meet BP narration’s sociopolitical and intrapsychic demands.

After certifying Fisher’s (2008) memoir as an exemplary *performative* narrative project, I divide the bulk of this chapter’s inquiry into two major evaluative sections. Each one bears different but overlapping and complementary goals in issuing a call to performative storytelling in mental health domains while also stipulating the terms of its use. The *first section* takes Fisher’s storying of manic-depressive illness as its organizing subject and the explication of *Wishful Drinking* as exemplary performative writing and personal narrative in style, mission, and method as its guiding objective. I proceed by tracking three narrative arcs that structure and distinguish Fisher’s illness story substantively and methodologically in BP narrative work: 1.) an engaging, iconoclastic account of bipolar symptomatology and embodiment; 2.) a cogent and provocative portrayal of addiction in manic-depressive experience; and 3). a candid testimonial about the nature and effects of electroconvulsive therapy (ECT). As I map these narrative vectors across the thematic axes structuring this project’s broader analytical architecture,[27] I focus on elucidating the performative means and values that underwrite their unique narrative production and impact. Finally, I extrapolate the practical and political application of performative approaches to manic-depressive storytelling writ

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[27] i.e. the ‘work of narrative’ in bipolar selfhood/identity, experience, and politics

large, emphasizing their possibilities in transliterating the complexities of BP embodiment into digestible, even comedic narrative terms.

The *second section* of this chapter takes Fisher herself as a principal analytical interest, using her as a case study in evaluating celebrity storytelling as a staple of activist narrative practice that reveals both the currency and hierarchization of storytelling in mental health domains. Furthermore, I also enlist Fisher's 'case' in pursuing a secondary line of inquiry in which Fisher and her memoir act as points of departure in discussing the ethics of life writing about manic depression in a "decadent culture of disclosure" (Eakin, 1999, p. 157). As Eakin (1999) has argued, this 'culture' is marked by the 'merchandizing' of personal pain and rapacious public appetites for (especially celebrity) 'confession' that pose grave social and moral dangers to American culture (pp. 151-157). In examining *Wishful Drinking* (Fisher, 2008) within these broader contexts, I consider celebrity BP memoir's role in authorizing the preeminence of celebrity spokespeople and, concomitantly, solidifying the literary franchising of their activism. Furthermore, I also implicate the celebrity BP memoir genre itself in producing an insidious form of BP meta-narrative that threatens to displace and de-legitimize 'ordinary' BP experiences and materialities. Ultimately, however, I posit Fisher as a less imperiling, more politically productive model of celebrity storytelling-as-activism. I contend that her assumption of a performative ethic attenuates these risks by compelling her to recognize her story (even if serendipitously) as an asset to the mental health community only to the extent that it is highly-contextualized and committed to authorial accountability. I conclude, therefore, that Fisher's excellence as a model of celebrity storytelling depends on two things: First, her ability to situate herself and her illness narrative *with* 'the people' without pretending to be *of* ‘the people.’ Second, her unique illumination of the peculiar ethical contingencies of life writing published by inordinately famous people who, like Fisher, may be distinctly positioned to assume the personal and political risks that bold manic-depressive storytelling often entails.

I *conclude* this chapter with the assertion that contemporary mental health advocates must grapple with how to enlist celebrity stories and storytellers more responsibly and efficaciously. I argue that they must employ them with greater moral vision than the exigencies of the present political moment will allow if they are to advance the interests of the mental health community meaningfully and ethically. I affirm performative writing and personal narrative genres as promising storytelling modalities that promote ethically- and experientially-sound storytelling for all BP authors and reiterate their particular appeal for celebrity storytellers. Finally, I briefly suggest the burgeoning field of media-based mental health activism as an especially promising arena for celebrity advocates. I contend that their roots in popular media (professionally cultivated and/or indigenous, as in Fisher’s case) make them ideal liaisons for mental health organizations in partnering with media groups to promote better informed and more accurate representations of mental illness in film and television programming.

‘Bipolar Woman of the Year’ Stories Manic-Depressive Illness

As daughter to “the Brad Pitt and Jennifer Anniston of the late ‘50s,” Carrie Fisher (2008) has only *ever* known the “hot-house plant existence” of celebrity (p. 4). She readily concedes, therefore, that fame has played a significant role in determining and (ultimately) distorting her sense of ‘reality.’ In Fisher’s experience, reality was a place, where ‘real life’ and ‘the movies’ overlapped considerably, so that “movies became home movies…and home became another place on the movie star map" (p. 8). *Wishful Drinking* begins befittingly, then, with the "headlines" of Carrie Fisher's life. First, in the first person:

> I am fifty-two years old.
> I am Carrie Fisher
> I live in a really nice house in Los Angeles.
> I have two dogs.
> I have a daughter named Billie. (p. 1)

And then in the third:

> Carrie Fisher is apparently a celebrity of sorts.
> I mean she was (is) the daughter of famous parents.
> One an icon, the other a consort to icons. (pp. 1-2)

By opening her memoir in cheeky homage to the public medium of her fame—the 'headline'—Fisher (2008) immediately conditions the genealogically and culturally extraordinary in her life and text with the autobiographically banal. Moreover, this narrative choice demonstrates a commitment to *owning* Celebrity as a central condition of her life story. She intimates from *Wishful Drinking's* outset that its ostensible preoccupations—mental illness, alcoholism, and drug addiction—have competed as only one tripartite of pathologies among many that have commandeered her sense of self and world order over the years. As a result, *Wishful Drinking* recognizes these 'pathologies,' too, as directing the course and character of her life. Fisher's cognizance of the ways in which these personal dysfunctions, relational disruptions, and Celebrity 'intrusions' have colluded with her experiences of mental distress distinguishes her illness narrative as one of the most self-aware and streamlined examined in this project. This integrative, reflexive narrative approach ultimately plays a pivotal role in suspending *Wishful Drinking's* descent into the vulgarities of damaged celebrity 'tell-all,' with its shameless traffic in fallen cultural icons' time spent circling the public drain.

Explicating Wishful Drinking *as Performative Writing Text*

This prefatory section prepares *Wishful Drinking* (Fisher, 2008) for analytical inspection by anatomizing its narrative machinery as a performative text that exemplifies the possibilities of performative storytelling in mental health. This section, therefore, stipulates how Fisher employs *performative writing* as the primary *method* by which she 'tells' her story in/through *Wishful Drinking*. Next, it investigates how *Wishful Drinking,* as the story thus told, functions as *personal performance narrative*—a designation of *genre* that describes what kind of story the memoir tells as the narrative Fisher has authorized as the story of her life. Furthermore, in positing Fisher's methodology as distinctly performative, this section also establishes *Wishful Drinking's* performative ethic and apparatus as its connective narrative tissue. This line of inquiry seeks to account for the how, why, and 'to what effect' of Fisher's decision to tell *this* particular story, in *this* particular way.

Any evaluation of *Wishful Drinking's* (Fisher, 2008) performative mettle must begin with a concession of its sovereignty as a textual artifact that not only channels, but co-authors a particular interpretation of Fisher's 'memoir' broadly-conceived. Such a study, however, must also confront *Wishful Drinking's* inescapably theatrical origins. The text itself continually reasserts this heritage; its yearning for the stage is palpable as it bubbles up in the deletions and omissions that frequently haunt its revision to page,[28] and its (occasional) animus for the Text is appreciable in the half-heartedly sutured narrative wounds its structure and 'grammar' still bear from its uneasy transition from theater to performative text. Fisher perseveres through this narrative-transliterational distraction, however, and achieves a textual transmorgification of her 'memoir' that is

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[28] As is the case for many adaptations of narrative across media (Ryan, 2004).

performatively impressive in its own right. She achieves this interpretive and medial feat by marshalling the range of narrative resources that performative personal narrative makes available to manic-depressive storytellers. Norman Denzin (2003) describes this genre as “radically contextualized self-story or personal story (mystory)” and identifies several subtypes with which it is associated, including personal experience story, self-story, personal history, and testimony (p. 38). *Wishful Drinking* (Fisher, 2008) ultimately percolates between these subtypes, which, although distinct, share a narrative genetic code that selects for poetic, nuanced, and evocative storytelling capable of mediating, interpreting, and representing experience (p. 94). These characteristics open up key narrative facilities on which BP storytellers depend in producing experientially- and ethically-sound narrative work. Furthermore, these forms of storytelling are also fundamentally didactic, instruct *and* entertain, and, at the moment of performance, “invok[e] style and character by interweaving aesthetics, politics, and history” (p. 39). As a result, they (and their parent genre as a whole) also demonstrate additional promise as a narrative resource in satisfying the political and pedagogical imperatives of manic-depressive narrative work.

As a performative storytelling model, however, *Wishful Drinking* (Fisher, 2008) is less remarkable for demonstrating ‘genre’ than for exemplifying ‘method’ and technique. Fisher manages to parlay the frustrations of adapting her memoir across media into an imaginative performative text. Fisher’s memoir, in this capacity, most showcases the effectiveness of performative writing as a medium through which to ‘show’ rather than simply ‘tell’ a manic-depressive illness narrative. A performative writing text “speaks performatively and enacts what it describes,” therefore, it acts as "inquiry into the limits and possibilities of the intersections between speech and writing" (Denzin, 2003, p. 95). This type of writing is dramatic and embodied, as well as writing that is "meant to be read [and] performed." As such, it is ultimately writing that is *transformative*—its makes "literal and transcribed speech active" as a performer's performance creates a unique space into which her audience may then enter (p. 95).

Performative writing, however, is *not* a matter of formal style; rather, as evocative, reflexive, and multi-voiced narrative work, it is likely to cut across genres and assume a variety of forms (Denzin, 2003, p. 94). It may, for example, contain pictures or photographs, take distinctive shape on page, and/or combining several different types of text, such as personal reflection, scholarship, and the daily newspaper. Whatever its permutation, performative writing demands performative reading—an active and collaborative practice that creates "a union between reader and writer that is 'seriate, simultaneous, sketch-driven, [and] improvisational…" (p. 94). By writing performatively and engaging performative readers, then, a performative writer compels his or her reading audience to "experience their own subjectivity in the moment of [the text's] performance" (p. 94). He or she achieves this feat by seizing a performative writing text's ability to "recover what appears and then disappears—the performance itself—the original and the copy" (p. 95).

As an exemplary performative writing text, *Wishful Drinking* (Fisher, 2008) is distinguished, *first*, in design and aesthetic and, *second*, in narrative 'voice' and content. In the *first* instance, Fisher's memoir is most notable for its manipulation of textual format and layout, as well as its use of photographic installations and other visual aids to complement its predominant textual thread. In the *second*, its privileging of vernacular and direct engagement with readers proves most compelling, followed closely by its irreverent treatment of controversial social issues via Fisher's campy theatrical signature as a writer-performer.[29] These distinctive textual features reflect Fisher's narrative priorities in reformulating *Wishful Drinking* to/for the page. Her emphasis on provocative, entertaining, and dynamic self-story prose, however, also serves a larger, not-so-thinly-veiled mission to recuperate textually the storytelling accoutrements of the stage. She is most preoccupied with recapturing the conspiratorial, embodied interplay the stage allows with an audience, as live performance gave her a direct portal through which to inject herself into its members' collective bloodstream. Fisher warns readers from *Wishful Drinking's* outset that she intends to satisfy this raconteurial craving through *textual* performance, writing: "I realize we don't know each other that well yet, but I promise you that's going to change drastically until you might actually feel the need to divorce me, for that reason there are lawyers standing by" (p. 18).

Fisher's (2008) systematic attempts to forge a connection with her reading audience, hailing them to performative readership through the systematic address of "you," also underscores embodied *writing* as a defining feature of *Wishful Drinking* as a performative writing text. She develops this 'feature,' in large part, to help offset the loss of her body as a storytelling implement. After all, text simply cannot capture her skin mottling with shame or scandalous reverie at some especially sordid revelation that, no matter how many times or how publicly it has been disclosed, *still* elicits such rogue self-incrimination. As a stage performer, Fisher undoubtedly grew dependent on these unruly responses. She recognizes her body and its interplay with the audience as party to the

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[29] Interestingly, *Wishful Drinking* resembles a "gift book," which Fisher discloses was precisely the impetus for its hasty publication just before Holiday Season 2008 ("Talk of the Nation" interview on NPR).

Story itself and comments on their elusive, collaborative narrative symbiosis in noting that, despite performing the same show dozens of times, in dozens of cities, “somehow—depending on the audience—it’s always a little different” (p. 15).

Fisher (2008) combats textual foreclosure of interactive, embodied performance by adopting performative writing techniques that re-instate her into the text as a discernable, almost sentient presence. The success of this strategy depends entirely on Fisher’s remarkable feel for narrative tensility, her manipulation of readers’ emotions, and her instincts for fomenting and seizing audience attention. Fisher is expert in knowing exactly when to pull the literary trigger and collect on narrative debts her readers have incurred from taking pleasure in her stories of dysfunction and pain. Furthermore, she buttresses this textual play with reader psychology by bombarding them with “narrative collage,” a performative writing technique central to the ‘showing’ of Fisher’s memoir (Denzin, 2003, p. 93). *Wishful Drinking’s* ‘collage’ relies heavily on Fisher’s (2008) appropriation of “headlines” as a principal motif organizing her memoir’s vibrant visual landscape. They act as a kind of haphazard wallpaper of newspaper clippings and tabloid covers (some actual, some parodies) that blare the sensational and mundane being detailed about Fisher’s life in adjacent text and storylines. Finally, but crucially, Fisher consolidates her presence in the text, as well as settles the disorder of her memoir’s mock-journalistic montage by accenting it with splashes of family photographs. These pictures are dispersed strategically throughout her memoir in an attempt to re-infuse the famous faces and events they depict with the humanity their mass-circulation and commodification in the ‘headlines’ necessarily extracts.

Fisher's (2008) deft deployment of performative writing, as well as her interest in privileging accessible and dynamic content, under girds the strength of her illness narrative as it unfurls along three interconnected narrative arcs: a testimonial about electroconvulsive therapy (ECT), an exposition of bipolar embodiment and symptomatology, and a pointed discussion about drug and alcohol abuse in manic-depressive experience. The next section of this chapter seeks to capture *Wishful Drinking*—as exemplary performative writing text—in the act of 'telling' Fisher's illness story and, thus, in performing (in multiple senses of the word) the 'work of narrative' in BP selfhood/identity, experience, and political subjectivity. In executing its analysis, this section also works to demonstrate how performative storytelling modalities' representational dynamism and communicative unboundedness make them well suited for the experiential and narrative demands of manic-depressive storytelling.

Electroconvulsive Therapy (ECT)

Fisher's memory loss following a stint in electroconvulsive therapy (ECT) acts as an organizing conceit of her memoir, as well as fires the opening salvo of her illness narrative. "I tell this story partly as a means to reclaim whatever I can of my former life," Fisher (2008) writes, "What hasn't been eaten by electroconvulsive therapy—and partly because I heard someone once say that we're only as sick as our secrets" (p. 15). The long-demonized treatment modality, in fact, can cause significant memory loss and other problems with memory function (Mondimore, 1999, p. 128). Fisher (2008) describes her own post-ECT mnemonic dilemmas as rendering her a "newly-made bystander" in her own life (p. 7). This new location of 'self' called Fisher to personal and existential re-evaluation, and, although it demanded a disturbing re-introduction to the scope and surreal-ness of her celebrity, it forced her to appreciate her life with “a kind of giddy gratitude” (p. 11). Unlike ordinary people negotiating the mnemonic haze of ECT, however, Fisher’s process of reacquainting herself with her life involved having to reckon with the cultural ubiquity of her likeness as Princess Leia on toys, clothes, posters, body soaps, and far more unsavory kinds of merchandise (p. 9).

Despite its significant side effects and attendant existential crises, Fisher (2008) emphasizes that ECT was extraordinarily effective in alleviating her mental suffering. Along with the obliderative impact on her memory, ECT also eviscerated “the crippling feeling of defeat and hopelessness” that had occasioned its use. Dire life circumstances and a bonecrushing bout of depression had forced Fisher to overcome her reservations about even considering ECT as a possible therapeutic option. “When the choice is ECT or DOA,” she writes, the decision “to ride the lightening instead of extinguishing the light of the life that had once shone out of my eyes” was ultimately easy to make (p.14). Fisher’s willingness to speak candidly and even-handedly about ECT—particularly while promoting *Wishful Drinking* in the popular press—has catapulted her into the cultural limelight as one of the controversial treatment method’s most visible proponents today (a distant second to Olympia Dukakis).

Fisher’s (2008) compelling but unceremoniously delivered ECT testimonial not only publicizes, but humanizes the plight of people whose mental suffering has reached such a critical, miserable pique as to warrant the use of such a radical treatment option. Moreover, it challenges (albeit with a small stick) the reigning iconography and cultural discourses that surround ‘electroshock’ therapy in contemporary culture. Films like Oscar Award winner, *One Flew Over the Cuckoo’s Nest* (1975), have installed extremely unfavorable and outdated images of ECT into the popular consciousness. Unfortunately, they continue to defy culture correction or be challenged seriously by the mass circulation of more accurate and up-to-date information about how—and how *well*—ECT works for many people who undergo it voluntarily (Mondimore, 1999, pp.125-126). In addition to advancing popular discussion about ECT, then, Fisher's (2008) testimony also challenges stigma that (among other things) discourages people living with mental distress to consider ECT as a viable and effective treatment alternative.

'Roy and Pam'

Although the catastrophic depressive episode from which ECT rescued Fisher was exceptional in her clinical rapsheet, it counts as only one period of mental distress among many that she has endured while struggling with manic-depressive illness, alcoholism, and drug addiction. Like many manic-depressives living with co-occurring psychiatric conditions (*especially* alcoholism and drug addiction), Fisher's diagnostic process was slow and desultory. Muddied and complicated by substance abuse, Fisher's medical team did not recognize or treat her manic-depressive symptoms as "bipolar disorder" until she achieved an extended period of sobriety that, at last, revealed their true etiology. Although Fisher (2008) was understandably frustrated by her doctors' failure to identify and address her illness, she acknowledges the futility of trying to diagnosis an active addict with manic-depressive illness. As she writes, "drug addiction and alcoholism, done properly…classically mimics [the illness's] symptoms" (pp. 116-117).

Although Fisher declares alcoholism her primary 'pathology' and, thus, alcoholics her primary community of 'pathological' affiliation, she clearly embraces the BP community as a second mental health home-base. She confesses that, following her diagnosis, she even contemplated commemorating her "newfound ascent into the lofty heights of this noble group" by inaugurating a "Bipolar Pride Day." She describes this extravaganza as replete with parade floats onto which "bed-bound depressives would be rolled and allowed to continue staring off miserably into space." Meanwhile, she imagines that the buzzing players in a manic marching band would soundtrack the whole affair and/or be "laughing and talking and shopping and fucking, and making bad judgment calls" (p. 127).

Fisher's (2008) 'Bipolar Pride Day' festivities, with their mood appropriate division of celebratory labor, typify her disarmingly comedic storying of manic-depressive illness. They also signal the start of her irreverent elucidation of BP symptomatology and embodiment in a segment of her illness narrative that showcases *Wishful Drinking* at its most charming *and* fallible as a performative writing text. At its best, Fisher's memoir chronicles the neurochemical and cognitive-behavioral misadventures of "Roy" and "Pam"—Fisher's affective 'alters' whom she inventively employs as a psycho-anthropomorphized shorthand for the 'polar' ends of her two moods. "Roy is Rollicking Roy, the wild ride of a mood, and Pam is Sediment Pam, who stands on the shore and sobs. (Pam stands for 'piss and moan.')." Succinctly assessing the affective economy of her experience of manic-depressive illness, Fisher concludes that "One mood is the meal, and the next mood is the check" (p. 121). Fisher intensifies her direct address of readers while explaining the significance of 'Roy' and 'Pam' in her life and illness story. "There are a couple of reasons why I take comfort in being able to put all this in my own vernacular and present it to you," she tells them, "For one thing, because then I'm not completely alone with it. And for another, it gives me a sense of being in control of the craziness." She adds, "It's sort of like: I have problems but problems don't have me" (p. 122).

After cajoling readers with 'Bipolar Pride Day' fanfare and 'Roy' and 'Pam's' affective mischief, Fisher's (2008) short but lyrical exposition of BP embodiment rounds out *Wishful Drinking's* showing as a performative writing at its best in storying manic-depressive illness. This brief description also further bolsters Fisher's evocative and clinically compelling treatment of how manic-depressive illness's organic processes *feel* 'in the body.' Seizing the narrative moment, Fisher leans in furtively from the page and implores readers to:

> Imagine this though. Imagine having a mood system that functions essentially like weather—independently of whatever's going on in your life. So the facts of your life remain the same, just the emotional fiction that you're responding to differs. It's like I'm not properly insulated—so all the bad and good ways that you and most of the people in adjacent neighborhoods and around the world feel—that pours directly into my system unchecked…I call it 'getting on my grid' or ESP: Egregious Sensory Protection. (pp. 113-114)

Although Fisher claims that she feels "very sane about how crazy [she is]" and assures readers that her mental "explosions" have dissipated over time, she confesses that she feels all but certain that she *will* 'explode' again…and again. By recognizing that bipolar disorder is a relapsing and remitting illness whose chronicity and recurrence is often inescapable, Fisher closes her elucidation of the BP 'condition' with an important refusal of the recovery paradigm in conceptualizing and structuring her illness narrative.

For all its wit and cleverness, Fisher's (2008) performative rendering of manic-depressive illness takes an unfortunate turn when she attempts to supplement performative 'self-story' with a foray into creative non-fiction meant to explicate bipolar disorder's various diagnostic profiles. While telling the story of her own diagnosis, Fisher significantly botches a review of bipolar disorder's two major subtypes—'Bipolar I' and 'Bipolar II'—as they are described in the *Diagnostic and Statistics Manual-IV (DSM-IV)* (1994). In short, she transposes the *DSM* criteria delineated for each subtype. This error spawns a slew of clinical misrepresentations in which Fisher fails to identify 'Bipolar I' as the "classic" and most severe form of the illness and 'Bipolar II' as its 'softer,' or 'lesser' version.[30] Fisher's mistake is significant because these two subtypes signify medical and experiential differences consequential to the people who actually live with these illnesses.[31] This storytelling misstep, however, becomes a narrative crime when one considers that Nosology is king in contemporary mental health contexts. 'Diagnosis,' therefore, is both the premier currency of its court and the primary identificatory locus of its political communities, whose illness narratives, consequently, take 'diagnosis' as a crucial node that helps culturally and medically legitimize the suffering they describe.

Fisher's (2008) ruthless pursuit of the one-liner poses the greatest threat of narrative breakdown to her performative rendering of bipolar symptomatology and embodiment. As a result, her memoir's edgy humor often gets overrun by shtick and,

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[30] See Chapter 1 and its preceding information sheet on bipolar disorder for more information about BP diagnoses and symptoms.

[31] The Bipolar I and II subtypes are differentiated, in large part, by the course and character of a patient's manic episode. BP IIs experience *hypo*manias, not full-blown manias, and often struggle more significantly with depressive episodes. As Mondimore (1999) describes the two subtypes, "Bipolar II is the more common and 'simpler' disorder, and Bipolar I is its more complicated and more severe form" (p. 41).

with it, disingenuous and dismissive levity. This tendency is exemplified by floundering jokes, such as: “My diagnosis was manic-depression. I think today they call it bipolar—so you might say I swing both ways!” (p. 113), or, “You know how most illnesses have symptoms you can recognize? Like fever, upset stomach, chills, whatever. Well, with manic-depression, it’s sexual promiscuity, excessive spending, and substance abuse—and that just sounds like a fantastic weekend in Vegas to me!” (p. 114). Given the high stigma, marginalization, and/or desperate material circumstances that attend mental illness for most people who have one, ‘shtick’—especially poorly done—is not subversive or performatively progressive. It simply marks a narrative point at which Fisher’s humor no longer advances any cause but her own.

Although Fisher (2008) shows that humor can serve as a powerful form of social commentary in storying manic-depressive illness, she also demonstrates how it can become an ethical and political minefield when wielded by storytellers (and for audiences) whose ‘in’ on the joke is *not* ensured by their reverence for the stakes of its punch line. Fisher’s occasional devolution into shticky antics threatens to forfeit *Wishful Drinking’s* narrative transgressiveness as a comedic performance of bipolar illness. Most importantly, it leaves open the narrative door for audiences to laugh at jokes of which mental illness and people living with mental illness become objects, not ‘subjects,’ and thus that demean or dismiss their suffering. These perils collectively trouble *Wishful Drinking’s* ethical integrity as a narrative project. Fisher, for example, repeatedly refuses to sacrifice the punch line of substance abuse-related jokes for the sake of her illness story’s narrative continuity or to advance an accurate and politically progressive portrayal of addiction in manic-depressive experience. Fisher’s illness narrative often vacillates between alcoholism and drug addiction as its etiological center, designating one (usually alcoholism) over the other as her primary 'affliction' until the other gets a bigger laugh. Although Fisher's inextricably entwined psychiatric problems need not have only one 'heart,' *she* maintains that one exists and yet forsakes whatever power that assignation may hold as a defining node of her illness narrative by subordinating its importance to 'The Joke.'

'Compulsion for Comfort': Addiction

Fisher (2008) describes herself as someone perpetually "eager for the altered state" (p. 125). Not surprisingly, then, her battles with alcohol and drug addiction began when she was just a teenager and discovered marijuana. After Harrison Ford's pot "suddenly and rather rudely" turned on her during the filming of *Star Wars*, she abandoned it as a drug of choice and took up hallucinogens and painkillers. She abused these "replacement drugs" until "they became mind relievers and pain expanders—a place where everything hurt and nothing made sense" (pp. 132-133). Fisher's mother became so distraught over her "acid problem" around this time of her life that she enlisted family friend, Cary Grant, to stage a drug intervention. Although Fisher considered her mother's worried gesture "an incredibly darling thing" to do, she insists that she did not actually have an 'acid problem.' "What I *did* have," she clarifies, "was an opiate problem, but frankly that was none of Cary Grant's fucking business. No matter how much I admired him" (p. 136).

In chronicling her history with alcohol and drug abuse, Fisher (2008) explicitly distances herself from the 'fallen Hollywood icon' cliché she is all too aware she embodies. She all but absolves her "goofy childhood" for any blame in fostering her ‘eagerness for the altered state’ by noting that her brother, who “had the same exact childhood and, freakishly, the same parents” (p. 99) never struggled similarly. “So,” she writes, “it’s not what you’re given, it’s how you take it” (p. 99). This espousal of/commitment to ‘personal responsibility’ and ‘self-determination’ pervades Fisher’s account of alcohol and drug addiction and reflects her longtime participation in Alcoholics Anonymous (AA). Her internalization of the “12-step recovery” philosophy gives this arc of her illness narrative a distinctive structure and vocabulary that renders it the ‘tightest’ but least performative of the three explored here.

The first ‘step’ one must take in AA is admitting that he or she has ‘a problem,’ and Fisher (2008) admits that she had “no problem at all” accepting the fact she was an alcoholic: “Not that I drank all that much,” she quips, “you might say I took pills alcoholically”(p. 119). She also had no difficulty conceding that drug addiction had made her life unmanageable. By that point in her life, she had not only undergone unnecessary gum surgery for the morphine, she also nearly ‘tripped into her grave’ after accidentally overdosing (p. 119). Unlike her fumbling with bipolar disorder’s diagnostic profile, Fisher’s grasp of the psychology of addiction is complex and astute. No doubt informed by AA’s focus on addressing addiction’s underlying drives, then, Fisher situates a “compulsion for comfort” at the heart of her problems with both alcohol and drugs (p. 106).

Fisher (2008) threw herself into AA and 12-step recovery after a string of psychiatrists and psychotherapists failed to address her alcoholism or properly diagnose her with manic-depressive illness. While the rest of her AA cohort began “calming down and leveling out,” however, she became increasingly manic (p. 120). “Without the substances I had used to distort and mask my symptoms," she explains, "it was now all too clear that I was a bona fide, wild-ride manic-depressive" (p. 121). After a year of erratic sobriety, Fisher finally re-engaged with the medical establishment but continued her participation in AA, believing (as she still does) that alcohol was the 'headline' of what was 'wrong' with her. She credits the 12-step process and formal psychotherapy, more than psychiatric intervention, with enabling her to manage her addictions. She indicates that the greatest lesson she has learned about addiction during her time in 'the program' is that she simply cannot expect to be happy and 'comfortable' *all the time* (p. 105). The structure and rigor of the 12-step program disciplined Fisher's need for comfort, and she cites the compulsory "group meeting," the hallmark of its culture of regimentation, as particularly important in producing the cognitive and attitudinal changes on which her sobriety depends. She recalls realizing that she did not have to like AA meetings, she just had to attend them: "I thought I had to like everything I did," she exclaims, "And for me to like everything I did meant—well, among things—that I needed to take a boat load of dope" (p. 106). She continues, "If I could, in fact, learn to experience a quota of discomfort…I could consistently go to that three-hour meeting, I could also exercise, and I could write. In short, I could actually be responsible" (p. 106).

Although Fisher (2008) has counted herself among the impassioned 12-step faithful since her late twenties, she concludes her storying of addiction and manic-depressive experience by disclosing that she has not maintained long-term sobriety. She emphasizes, however, that the four or five "slips-ups" she has had over the past twenty-three years reflect personal shortcomings—*not* a failure of AA as a program (p. 119). Fisher expresses extreme distress over these lapses in sobriety, in particular, after her daughter was born. She recognizes that her daughter "would have to suffer the most from these largely inexcusable forays back down the dark path" of addiction (p. 119). "The most painful thing about returning to this dark planet," she writes, "is seeing the look of disappointment and hurt that these forays invariably put in the eyes of your loved ones" (p. 119).

Celebrity Storytelling-as-Activism and The Ethics of BP Life Writing

Carrie Fisher's iconic cultural status fast-tracked her rise to stardom on the celebrity mental health spokesperson circuit. Fisher's (2008) memoir highlights the bizarre confluence of these two spheres of Fisher's fame—'the cultural' and 'the pathological'—in revealing that she has been featured in an abnormal psychology textbook as the 'face' of bipolar disorder. "Obviously my family is so proud," she jokes. "Keep in mind though, I'm a [Princess Leia] PEZ dispenser and I'm in the *Abnormal Psychology* textbook. Who says you can't have it all?" (p. 114). Fisher was surprised, however, by the chapter's accompanying photograph, as the book's editors never called and asked, "'Have you got a little snapshot of yourself looking depressed or manic?'" (p. 115). Instead of simply describing this picture, Fisher reproduces it for readers—inserting into the text a brooding image of herself *in character* as Princess Leia. "So," Fisher writes, "I'm not crazy, *that* bitch is. Anyone who would wear a hairstyle like that *has* to be nuts! Right?" (p. 116).

Fisher as Celebrity BP

This image of Fisher as Leia/Leia as Fisher and both as bipolar captures the strange nexus of cultural significations that have converged in the discursive production of Fisher's *BP* celebrity. As such, it demonstrates the extent to which mental health advocates should consider 'Leia's' subsumption of Fisher's cultural identity a potential hazard in mediating who and what Fisher represents when she 'speaks' for the mental health community. Fisher's BP celebrity is distinguished from that of her peers (e.g. Patty Duke and Jane Pauley) less by its scale than its staying power. Although a present-day Carrie Fisher may be somewhat unrecognizable to popular audiences, the cultural purchase of *Star Wars* perseveres across time and place (p. 79). Few in Fisher's famous BP cohort can rival this high public profile and cross-generational appeal (let alone match her showbiz pedigree). This exceptionality—BP celebrity at its apogee—makes Fisher an excellent case study with which to explore celebrity storytelling-as-activism.

The rest of this chapter uses Fisher's 'case' to examine celebrity storytelling as a staple of activist narrative practice and the 'celebrity BP memoir' as this form of storytelling's most salient narrative 'product.' In authorizing both the preeminence of celebrity spokespeople and the literary franchising of their activism, celebrity BP memoir may also support a class of BP meta-narrative that threatens to displace and de-legitimize 'ordinary' BP experiences and materialities. I argue that Fisher's (2008) adherence to a performative ethic offers some measure of protection against the most egregious of these (meta-)narrative hazards. This ethic privileges highly-contextualized storytelling and authorial accountability and, therefore, obliges Fisher to recognize that she is valuable to the mental health community as a storytelling only to the extent that she situates herself *with* 'the people' without pretending to be *of* 'the people.'

Fisher's (2008) commitments to self-reflexivity in constructing *Wishful Drinking* ultimately underwrite a less imperiling model of celebrity storytelling-as-activism. This model derives its power and legitimacy from Fisher's attempts to foster solidarity between everyday and celebrity BPs that is not predicated on the pretense of 'shared struggle.' These groups' differential access to resources necessarily stratifies the material terms and outcomes of that 'struggle.' Fisher imagines 'solidarity' being based, instead, on manic-depressive illness itself—in particular, the organic processes and experiences of symptoms that bind all BPs (to some extent) clinically and diagnostically (p. 159). These 'pathological' forces and the psychopharmacological interventions employed to arrest their advance, may similarly upset a BP person's way of knowing, being, and feeling in the world even as they are mediated by crucial markers of individual differentiation.

The ease with which Fisher (2008) 'owns' and interrogates her celebrity throughout her memoir suggests a lifetime of practice in having to answer for it. As noted, Fisher's memoir takes her self-reflexivity about fame and its extravagant trappings as a dominant narrative thread. Fisher then diligently knits that 'thread' into the fabric of *Wishful Drinking's* droll, self-disparaging landscapes in a crisp but deliberative accounting of the wealth and privilege celebrity has afforded Fisher. Fisher's self-sniping commentary about the first time she publicly disclosed her illness (in a television interview on *20/20*) emblematizes this incorporative, playfully self-deprecating approach. After relaying the anecdote about her disclosure in some detail, Fisher promptly mocks herself for making the revelation in the first place: "Like anyone really needed to know that…," she jokes, "Don't you hate it when celebrities blahblahblah—talk about themselves—I mean, who asked? I find it all so wearying…" (p. 130).

Fisher's wry indictment of celebrity overexposure and mental health 'boosterism' has deterred neither mainstream mental health groups' courtship of her services as a spokesperson or Fisher's interest in accepting their requests. Fisher, in fact, has fulfilled them with such gusto that she now boasts a host of awards from mental health organizations eager to recognize her efforts to use 'celebrity' in advancing the mental health cause. For her part, Fisher (2008) seems pleasantly befuddled but honored to hold an eminent position in the mental health community and admits enjoying the plaudits with more than a little irony:

> So having waited my entire life to get an award for something, anything (okay fine, not acting, but what about a tiny little award for writing? Nope), I now get awards all the time for being mentally ill. I'm apparently very good at it and get honored for it regularly…Hey, it's better than being bad at being mentally ill, right? How tragic would it be to be runner-up for Bipolar Woman of the Year? (p. 131)

If it had been in doubt, NAMI recently cinched Fisher's place in the Mental Health pantheon of exceptional famous BPs when it included her name alongside Virginia Wolf, Vincent Van Gogh, and Kurt Cobain on a poster commemorating the achievements of people with mental illnesses who have transformed public and creative cultures (See NAMI website). The ubiquity of such 'celebrity inventories' in contemporary mental health advocacy underscores the value of celebrity spokespeople and their stories in 'stigma-busting' and/or raising awareness about mental health issues. Nevertheless, they represent more than just utilitarian forms of mental health outreach and social marketing. The super-reliance on these stories and their storytellers may also signal a more pernicious surrender to powerlessness and political expediency in mental health activism. Advocates perpetually struggling to gain political traction against the high stigma and low priority assigned their work and constituencies may find these celebrity resources irresistible (Bracken & Thomas, 2005).

Fisher (2008), like many of the mainstream mental health groups with whom she may partner, also embraces the celebrity inventory as a consolatory device extended to the recently psychiatrically-initiated to ‘soften the blow’ of their new diagnoses. As Fisher suggests, these lists encourage ‘newbies’ “to not feel bad” about their illnesses because “they are joining an illustrious group” (p. 126). Despite the considerable stock Fisher places in these inventories, she shows little reverence for their content. In devising her own ‘lists’ for *Wishful Drinking*, she strays significantly from the usual cast of luminous characters that populate these celebrity inventories. Her first list counts her among “the famous and accomplished folks who have struggled with and enjoyed alcoholism,” including Scott Fitzgerald, Dylan Thomas, Ireland, Lindsay Lohan, Rush Limbaugh, and Russia (p. 125). The second list counts her among esteemed manic-depressives, including Abraham Lincoln, Mark Twain, Kristy MacNichol, Saint Francis, Saint Theresa, Korea, and ‘Poor Britney Spears’ (pp. 126-127).

Since storytelling, arguably, is celebrity advocacy’s primary medium, the content and reception of celebrity stories is paramount in determining its potential merits and liabilities as mental health activism. Celebrity illness stories are most often enlisted as testimony. They serve as a narrative means by which to raise awareness about mental illness, challenge its stigmatization, and normalize ‘mentally ill people’ for a general public often unwilling to have meaningful social contact with this population subset (Ritterfeld & Seung, 1996; Stout & Villegas, 2004). Mental health outreach campaigns are most effective when they couple educational information about mental illness with direct contact between the campaign's population of interest and people who live with the illnesses around which the campaign's substantive content is organized (Pinfold, Thornicroft, & Huxley, 2005; Ritterfeld & Seung, 1996). Although such encounters are difficult to arrange organically or even experimentally in 'normal' life, celebrities may act as proxies for 'real' mentally ill people in that the public's imagined familiarity with and pre-existing investments in their lives simulates a kind of 'direct contact.' Effective outreach campaigns may then seize this connection to elicit attitudinal change in their target population. Nevertheless, understanding how best to employ celebrity resources does not resolve the more fundamental concern of how to enlist them without further marginalizing the experiences of ordinary BPs. The general public is far more likely to encounter *these* BP people in their classrooms, workplaces, and houses of worship. Celebrities simply cannot act as surrogates for these everyday encounters, nor can their stories substitute for everyday BPs' stories about their lives and illnesses experiences. Mental health advocates, therefore, must be diligent in considering these ethical implications if they continue to use celebrity storytelling as a major facet of their activist narrative practice programs (Bracken & Thomas, 2005).

Celebrity BP storytellers' varying but distinctive abilities to assume the personal, social, and financial risks that bold manic-depressive storytelling entails acts as a far more compelling (and less ethically fraught) point of departure in arguing for celebrity storytelling-as-activism. In chronicling Fisher's (2008) "all too eventful and by necessity amusing, Leia-laden life" (p. 15), for example, *Wishful Drinking* tackles controversial facets of manic-depressive experience that non-celebrity BP memoirs would be unable to address with similar daring while still attracting comparable cultural and commercial notice. Although Fisher makes a concerted effort to use her appeal on so grand a stage for ‘good’ in publicizing controversial issues like ECT and substance abuse, she does not frame her ‘work’ as valorous or heroic celebrity service. In keeping with her self-reflexive self-denigration, Fisher casts her celebrity ‘activism,’ instead, as a quasi-form of reparations made to the mental health community itself for having the social and material resources to ‘speak out’ so irreverently in the first place. Ultimately, Fisher’s cultural cachet has been built (in large part) on the backs of outrageousness and eccentricity. Bolstered by wealth and a permanent seat in the popular cultural consciousness, Fisher has relatively little to lose in revealing deeply personal or sordid things about her life and illness in *Wishful Drinking*—reprisals for spilling Hollywood secrets notwithstanding.

The Ethics of Life Writing and Manic-Depressive Life Writing

Paul John Eakin (1999) would object vehemently to any suggestion that Fisher’s disclosures are innocuous to those who hear or read about them—let alone to those whose privacy they may violate directly. He identifies the proliferation of ‘tell-all’ memoirs in contemporary culture, as well as the commercial opportunism that drives their ‘merchandizing of personal pain’ (p. 155), as social and moral threats to American culture that demand priority attention in the ethics of life writing. Eakin contends that the ‘unseemly disclosure’ rampant in these texts is most damaging to the people whose privacy lies most directly in its line of fire: family members, friends, and acquaintances whose ‘secrets’ may be exposed by a memoirist’s unsavory ‘truth-telling’ (p. 156). Eakin maintains, however, that the collateral damage incurred by these revelations also extends to society at large, as they constitute fundamental assaults on the right to privacy (p. 157).

Furthermore, he argues that the ‘indiscriminately confessional’ memoir has become “socially, because morally dangerous” because, like the television “talk show confessional” that currently dominates television programming, it contributes to the erosion of “our collective ability to make causal connections between actions and consequences” (p. 157). Eakin concurs with Margo Jefferson’s determination, therefore, that ‘the memoir’s’ primary ethical task in this “decadent culture of disclosure” must be “figuring out how to examine and dramatize ourselves without forgetting to pay the same attention to the larger historical and spiritual forces that have made us” (p. 155).

Celebrity memoirs are an especially profitable but ethically fraught subset of this confessional marketplace, as rapacious public appetites for sensationalism and scandal feed a booming industry of tabloids, magazines, websites, and television programming dedicated to the traffic in celebrity ‘dirt’ (Cloud, 1998; Eakin, 1999, p. 143). *Wishful Drinking* (Fisher, 2008) is complicit in this commodificatory scheme in that it abounds in Hollywood gossip that further fuels this overly-disclosive cultural fire. In the process, it also contributes yet another ‘tell-all’ to the trade in authorial flesh that Eakin (1999) deems the commercial lifeblood of contemporary culture’s merchandizing of personal misfortune (p. 143). Fisher (2008) forestalls some of the ethical chaos to which Eakin argues ‘revealing’ memoirs are prone by supporting her use of a performative ethic in constructing *Wishful Drinking* with external corroboration of its content. She gave each of the people whom her memoir features most prominently a chance to both review and object to her material before approving the text for publication (*Talk of the Nation*, November 2008). Although such ‘fact-checking’ and authorial accountability are legally and ethically judicious life writing practices, Eakin (1999) notes they are far from standard fare in the production and circulation of contemporary memoir and autobiography.

While Fisher's (2008) ethical diligence is commendable, it also demands further qualification. The *scale* of her fame factors significantly in *Wishful Drinking's* ethical calculus as a life writing text—perhaps acting as a mitigating factor in determining the impact of Fisher's 'truth-telling' and sordid revelations about family members and friends. The people about whom Fisher writes most provocatively—her parents, Paul Simon, Elizabeth Taylor, and George Lucas—are also extraordinarily public figures whose lives the Press has scrutinized exhaustively. Although even the inordinately famous are entitled to privacy and 'secrets' (and the culture at large their revelation), these people may have relatively few 'secrets' left. 'Privacy,' therefore, may sit differently for people whose place in the limelight begets the airing of their secrets than for those suddenly thrown into the public eye *because* of an unscrupulous life writer's revelation of their secrets.

Conclusion

Carrie Fisher's 'case' highlights the rewards and liabilities of enlisting celebrity BP stories for/as mental health advocacy, public outreach, and political work. Celebrity storytellers' predominance in contemporary mental health narrative enterprise both reflects and reifies the celebrity memoir's currency (and profitability) in modern American culture. This genre supports a strain of BP meta-narrative that marginalizes ordinary BP stories and experiences. These master texts, however, are also capable of codifying into popular 'knowledge' erroneous information about manic-depressive illness that they may circulate with unchecked authority in their stories to a sizeable (and impressionable) public readership. Fisher's misrepresentation of crucial diagnostic information about bipolar disorder is a prime example of this potentially perilous propagation of specious information to mass audiences via the mass systems of communication at many celebrities' disposal. After all, *Wishful Drinking* (in any of its performative incarnations) is likely to garner far greater popular interest, as well as register with a broader swath of everyday people than any narrative work Kay Jamison might publish, no matter how medically or politically decisive.

Relinquishing narrative authority to 'experts' like Jamison, however, does not serve *any* BP subset's interests either; it simply replaces one form of BP meta-narrative for another, and, in the process, further marginalizes ordinary BP storytellers while undercutting the contributions celebrity storytellers can and *do* make to mental health work when responsibly capitalized. Contemporary economic, political, and cultural conditions have conspired to create a climate in which a super-reliance on celebrity spokespeople is more than irresistible temptation—it is good common sense. Mental health advocates' dependence on celebrity storytellers like Fisher is a pragmatic response to the grim arithmetic they face in allocating scant resources to a panoply of financially-strapped mental health programs while combating the stigma and discrimination that plague their work and constituencies (Caplan & Cosgrove, 2004).

In light of these deeply entrenched incentives, broadening the manic-depressive narrative palette and, thus, reducing mental health's dependence on celebrity storytelling will take time. These incentives must be dismantled incrementally as celebrity storytelling is re-imagined for less ethically perilous activism, such as the media-based advocacy now flourishing in contemporary mental health work (Pinfold, Thornicroft, &

Huxley, 2005; Ritterfeld & Seung, 1996; Stout & Villegas, 2004). Ultimately, Carrie Fisher (2008) and her memoir suggest that the re-imagination of celebrity storytelling-as-activism must begin with celebrity storytellers themselves. These author-advocates must work to reduce their stories' risks as meta-narratives and optimize their rewards as sources of political and cultural capital for the mental health communities on whose behalf they are so often called upon to speak. Celebrity storytellers, therefore, must begin to approach their narrative activism by explicitly and deliberatively situating themselves with ordinary BPs without pretending to be 'of' them. Fisher's model of celebrity storytelling-as-activism suggests that highly contextualized, politically and morally self-aware celebrity stories, therefore, should act as the minimum requirements for celebrity storytelling in the years to come.

Chapter 5

Mad People Without Instruments

The heat of our Argument was settling on skin, its sticky perspiration the conductive medium of a low, furious hum building between us. I had suspended all eye contact with the group and plunged my thumbs nervously beneath my thighs in a gesture of misdirection—shielding the industry of my desperate fingertips prestidigitating an ejection button in the disemboweling underbelly of my chair. *I wanted out*. While my fingers schemed with magic, I fixed my gaze on the filthy wedge of carpet beneath my feet with Talmudic study and considered how much the hospital room in which we held our group sessions looked and smelled like an adult preschool. Its cheap Berber stained and rank with old throw-up, mildew, and souring piss; its air heavy with residual cigarette smoke burrowed surreptitiously into curtains and clothing and laced with a chemical aftertaste that Bleached raw your throat when you finally made it home and into bed. As the Squabble around me swelled and grated against itself, it was clear that my escape plans would only ever be escape plans. I was stuck and bracing for the inevitable pyrotechnics: the kindling of crazy folk and the crackling, asthmatic hiss of my panicked-stricken lungs dousing their fires with oxygen. All that was left was a sigh and a survey of the room.

Kat was sitting behind me. She had been elected spokeswoman by the Schizophrenics and was the first person to offer a suggestion. She was an ample woman, as generous in height as she was in weight, and, as she spoke, unsolicited parts of her body sometimes

jiggled unpredictably. At that moment, her left leg fidgeted musically, bouncing up and down in short staccato beats, and somehow, in the grand scheme of her body, her neck and cheeks began to ripple as she said:
"What about Guided by Voices or The Shockers?"

My lips wrestled with a grimace, my shoulders against a dismissive shrug. I wasn't particularly thrilled about either one of those offerings, but Kat was one of my closest friends in our motley intensive outpatient crew, and I felt a tinge of guilt for wanting to strike down her contributions. There were allegiances to consider here—confidences, moral accounting—and Kat and I had spent long hours together disentangling our respective lives over the past few weeks. Nevertheless, I reminded myself, personal integrity didn't qualify a person to competently name a rock band, and we *were* playing a high-stakes game: if we were a band, what would we call ourselves?

Before I had a chance to parade diplomatic aplomb, an unidentified voice in the Bipolar camp interrupted me, informing the group that 'Guided by Voices' was already taken by a Christian band and that naming us 'The Shockers' was "prejudicial" given that the only people currently receiving ECT were three or four schizophrenics. "If we're going to name the band only for them," he said, "why not just call it "Paranoid and Constipated?"

We had re-arranged our chairs from their usual unkempt sigh of oval-ish resignation into a tightly wound ring so as to conspire in peace, with poise, and avoid any public revelation that we were, indeed, having this conversation. I'm not sure why the people who run psych hospitals insist on foisting upon their patients strange reproductions of childhood—mandating that we sit in circles, play volleyball, eat from lime-green plastic cafeteria trays, and do useless arts and crafts projects with blonde-haired women short on self-esteem and long on pretentious cheer—when, in fact, many of us were there to begin with because of how unhappy we had been the first time around. In any case, our new geometry still made it difficult to match the disembodied voice with its owner, but as I bent my neck around several big bodies like an awkward and exceedingly melancholic periscope, I spotted Danny looking self-righteous.

Danny was an angry bipolar hoodlum—as if there's any other kind—and whenever he spoke, it occurred to me that if reincarnation really were a thing, he must've been a pirate in a former life. He was short and skinny, with dark chestnut skin impressed with long years of bright, unimpeded Texas sunshine; he had unruly, smoky-colored hair that was perpetually wind-blown and translucent blue eyes that hid sheepishly behind unnaturally thick eyebrow-growth, as if they were appalled or embarrassed by what the rest of him did or said. On any given day, I expected that the eyeball on the right would tuck itself violently into its socket and pop out as an eye-patch or that his wide crowded smile would suddenly shed itself into a toothless grin that yapped, yapped, yapped in our direction as he gleefully detailed the business of raiding cargo ships and sailboats that buoyed vulnerably through international waters.

Captain Danny's assault on Kat and her schizophrenic constituents had hushed all side conversations. We were waiting in silence, anxiously, for her reply—and retaliation.

Gulping back outrage and tears, however, Kat only turned away and muttered something that involved the words ‘douche bag’ and ‘lithium’ in Danny’s direction.

Sure, we had averted crisis for now, but more conflict seemed imminent. At its best, group was a place where grief was spared the parasitic indignity of self-righteous wallowing; where tending to one’s wounds was restorative, not self-consuming or enabling of the unwillingness to risk ever being wounded again; where denial and resentment were revealed and confronted for what they really were: fear and shame. At its worst, however, our little circle was nothing more than an arena in which to showcase petty grievances—cockfights—the settling of scores between people, who in most cases, were not even in the room.

Since I had started our little game, I felt obliged to mediate any subsequent disputes that arose. *It’s all fun and games until someone tries to rip out and eat his own or another group member’s eye,* or so we had learned in rec therapy last week. But as the room erupted into jeers (at Danny) and an impromptu girl-power pep-rally (for Kat), I simply couldn’t force myself to speak, let alone intervene in a meaningful way. It would be a long time before I felt like I actually had something to say. Besides, the atmosphere had become too delicate, and I wasn’t yet equipped to deal with these stakes.

In lieu of speaking, then, I took refuge in the creature comforts of my beloved chair now in tufts of synthetic duress, with each kneading fingertip more resigned to being resigned. This time, however, I took to rocking in it autistically, with a pace and intensity that suggested I was making a bid to catapult myself out of this Argument for good. I was on the brink of launch when Samantha, another trusted ally in group, screamed out a new band name—her voice the invisible button, it seemed, that controlled Our Noise.

“What about The Hopeless or Desperate to Die?” she repeated again, this time in her usual soft East Texas slur.

How relieved I was to be rescued by a voice that lilted in Southern lullaby. I was even more relieved by Sam’s willingness to speak up on behalf of Team Depression. I had worried that they wouldn’t be able to pull it together long enough to anoint a leader, and she was a fine choice for the job. Despite the tragic CEO tenure that landed her here in the first place, Sam had unrivaled administrative and management skills. Just take a look around the room. Plus, her physical presence—the imposition of her lanky, Amazonian height—announced and authorized her genetic imperative to lead and give orders. Manifest destiny aside, Sam was also impossibly kind, disarming, and warm—a palette of late autumn colors that stumbled through rooms with grasshopper-like physics and Xanax-wrecked sententiousness.

Before I could enjoy—let alone extend—her reinstatement of civility, however, Danny ambushed the group again with yet another insensitive gibe, this time directed at our often hygienically challenged, existentially impaired depressed brethren (his favorite punching bag). “How ‘bout Stinky Pajamas or For God’s Sake Get Over It?” he snickered.

The thing about depressed people is that they may be boring and annoying and adverse to showering when they are at their worst, but one must always keep in mind that a switch is begging to be thrown in their heads—the current of self-hate turned violently outward and reborn as anger, rage, indignant apathy, even a troubling passion for spray paint and superglue. Anything that frees the charge and suffuses it with strength to slash a throat the next time someone assures her that 'time is a healer'—anything that stirs its verve and pride the next time a cackling, maniacal jackyl calls her a loser.

Danny's vituperation finally incited the murderous, swashbuckling depressed people among us. The heat and convection of their roaring bursts of Skirmish threw my rocking into its second wind, giving it a mission and trajectory. *Block them out,* I told myself, *and don't forget that, even for its problems, this hospital was* way *better than the last one down the interstate*, where "group counseling" consisted of rounding everybody up around the TV to watch *Dumb and Dumber* or *The Naked Gun*— movies whole sole therapeutic value rested in making us feel slightly less bizarre.

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The next few minutes were a blur of illness-based trench warfare—groups pummeling each other with rapid-fire 'name'-storming for our fictitious, but now very seriously undertaken band: Things That End With -Otic ("What else besides neuro- and psycho- ?"), Circle Jerks (adolescent laughter, but it turns out, it's already a real band name), Vertiginous Poles (despite haughty bipolar approval, a politically distraught schizophrenic—as if there's any other kind—took offense), Benzodiazipine Dreams (alliteration overkill, besides, none of us was really sure how to spell it)..

Samantha, once again, stepped up to the plate and stopped the mishigausse of the increasingly contentious discharge of names. She looked my way and hurled a pencil at my fiddling attention.

"Hey. HEY," she said sternly.

Startled, with a hush of voices now settling around me, I caught the end of an exchange between two women on my left who were debating earnestly whether or not we'd even have an audience for this scheme. Without hesitation or comedic irony, one said to the other: "Well, maybe in Utah or somewhere in the old East German bloc."

Fuck, I thought, *If we are going on the road, I better get it together*.
"Yes, Samantha," I finally managed to reply, with a little too much resolve.

"You started this whole thing," she said, like she hated me. "What do *you* think we should be called?"

I sighed the deflated tire of my patience and considered her question—*my* question—but, after a few seconds, I simply shook my head slowly and belaboredly—like I was drowning in a vat of thickening mud and was signaling to my rescuers to let it be. Sam respected my decision to abstain from the game, but only after the mischievous smile I rolled slyly across my face told her I'd best keep my suggestion to myself: *Mad People Without Instruments.*

*

BASS GUITAR: MADDIE

Maddie had been here before. I could tell just like I could tell with all the other repeat offenders. They looked like old timers drinking beer at a cowboy bar at ten o'clock on a Tuesday morning. In truth, however, Maddie's history was a little difficult to pin down; she was young, like me, and it takes time for youthful bodies to be disciplined into vessels for the old and disenchanted souls they're often forced to lug along.

It took us awhile to talk. The first week or so, I spent my group-time in an undignified heap at the back of the room—my anesthetized fish-head bobbing, mouth wide open and eyes tightly shut, as if something mysterious and excruciating were happening to them all at once. When I was wake, I was embroiled in a battle against nausea. The smell of myself made me gag. I reeked of decaying medication and could imagine the path my drugs were clearing with tiny chemical machetes as they fought their way to the outskirts of my terrorized vital organs. They chose my liver as an outpost, a launching pad from which to slash and burn their way through my bloodstream—thrashing around viciously inside me until they besieged my urine, vomit, morning nose-blows, pores, tears, taste.

We *all* smelled like me, and, together, we seemed flammable. When our coffee maker erupted in plumes of thick gray smoke one day and spewed mucky coffee-ground-lava all over the floor, I held my breath and frantically scanned the room for an exit. We were going to blow at any second, I could feel it, and that feeling never really went away.

It was soon after the coffee explosion incident that Maddie and I became friends. She braced her arm around my chair like a bodyguard charged with it for life or limb, an appendage planked from the torso of an unknown body that tried to console my uncontrollable crying when it set in without notice or provocation. The first time it happened, I detested Maddie's outreach—her charity. Touch made this real. Over time, however, I craved it—depended on it—*because* it made this real. I'd grown more afraid of not truly knowing what *was* 'real' than of accepting this fundamental Upheaval as a permanent presence in my life. After all, Crazy had already set up shop in my head, fallen in love with itself and fruitfully multiplied.

Fortified by lower anti-psychotic doses, I finally possessed the motor skills and fortitude required to steady my neck and press my head upwards to survey the room. And there she was sitting next to me—Maddie—the lazy eyes of an equally medicated stranger. The first thing I remember seeing was acne, an unlikely and decidedly unromantic revelation, but it was hardly catastrophic or grotesque. I realized this once I figured out that I was simply seeing two or three or four of everything since I started taking meds. Psychotropic drugs make uncertain minds dependent on even more uncertain and distorted senses.

But when it *finally* happened, Maddie materialized in waves: first the details of her face taken separately, then together; the blurry outlines of her extremeties, the fineness of her short dark hair, the golden rings embedded around the irises of her even darker eyes. She was my height, my build and had a confusing paradox of a voice: it dribbled from her lips when she spoke but boomed from the back of her belly when she laughed—which was often. Maddie was a rare breed—a mental health myth or a unicorn: she was an honest-to-God jolly depressive. She wasn't masking pain, morbid obesity, or heroine addiction; in fact, the 'jolly' seemed to vanquish or, at least, keep them all at bay.

Incidentally, Maddie was also the only personal I'd ever met whose mental illness had a gesture: a shrug of both shoulders in time with an ambivalent sigh ramified into three invisible streams of breath, three competing catastrophes: Life with Illness, Life as Illness, Life. Sometimes if I looked at Maddie too long, I would quiver—not only because the sight of her in so much pain was deeply unnerving, but because she embodied—completely—the agony and Hollow that consumed me in those early days, day after relentless day. She was the mirror by which I, the grieving spectator, witnessed my own sadness and surrender. It was heartbreaking for us both.

Nevertheless, Maddie's wit and kindheartedness were indomitable, heroic, and contagious. She was morally opposed to platitudes and self-help bromides and hissed—like a viper, not like a cat—at offenders when they felt compelled to 'share one with the group.' And every time I said Natalie's name out loud, she booed at me *loudly*—like it was Purim and she was Haman—a 30 second penalty of public shaming that drove me mad…and, eventually, to a revelation about my imploded 'marriage,' now fully in rigor, that helped save my life: It wasn't all my fault. As the smoke of my pathology settled into more of an innocuous fog, I saw it there, all bright and shiny and smug—the true crux of what Our Problem had really been: Natalie and I could no longer hide what we each wanted and needed but were not getting—and we could no longer deny that our greatest relational achievement had become catching each other in the lie of pretending otherwise.

For all her garrulousness and wise sage-ness, Maddie was conspicuously quiet about the details of her own life. But silence has no future in a gaggle of crazy people—eventually, she had to come clean about what brought her here. The story was short, and she recounted it crisply one morning after breakfast. She had overdosed on the notoriously sedating drug, Klonopin. She felt like shit one day, so took one. She still felt like shit, so she took two. When she began to feel a slight sense of relief, she decided it would be nice to make it permanent and so resolved to take the whole bottle: she took one more and one more and one more and then…fell fast asleep before being able to feast on the pills that were left.

Listening to this story was like strolling casually down a street when the poor schlub in front of you trips and spills his scalding cup of coffee all over his best business suit—setting off a cruel cavalcade of disaster, as an air force of file-folders takes flight from his satchel—gone forever into the vortex of haplessness that is now his life. You want to laugh at this man; in fact, you *do* laugh even though you know it is both cruel and immature to do so—and only necessary because so often *you* are This Guy, and this identification fills you with contempt. It gives you motive, and somehow, you tell yourself, it gives you license to mock his pain.

The group laughed. I laughed. Maddie laughed. It was a funny story. No one, not even Maddie, could deny that falling asleep in the middle of trying to die was not only funny—it was a classic tale of Us, The Living Dead. As we talked on the phone later that day, rolling around in residual giggle, Maddie became uncharacteristically quiet. Finally, she said, “You know, I can’t even die properly. More and more, I think that maybe I was just trying to do *something* right.”

*

KEYBOARDS: DEANA

A few years ago, Natalie and I were driving home from my parents’ house when we got caught up in a torrential downpour on the interstate. I was unlucky enough to be driving, and as my car struggled up steep stretches of isolated highway at a slow and unsteady 55 miles per hour, I anxiously gripped the wheel—10 o’clock, 2 o’clock—and squinted isometrically to make out the faint white and yellow lines that now precariously aligned our fate. I was doing my best to ignore Natalie’s transparent attempts to prove that she was unaffected by traveling through a Biblical flood when, all of a sudden, I saw a flash of something in the road and then felt my tires spin over it viciously, shredding it like a two-ton lawnmower. There was a squealing grumble…then a thud, like a gigantic chunk of vulcanized rubber musically ricocheting off a giant sheet of plywood.

I had just run over a bunny rabbit.

I looked at Natalie pleadingly and sobbed for mercy and forgiveness, as if she was the bunny's lawyer, and I was on the witness stand. My shame and remorse—not the churning flood waters swelling along the low-lying areas around us—forced me off the road. What kind of monster murders innocent bunny rabbits?

My trauma was embarrassingly miniscule compared to Deana's, and I was astounded that she had made it as long as she did as an animal control officer before losing her mind. She said that she wasn't sure which came first—the depression or the job. Before her stint as Executioner, Deana worked as a medical technician and, before that, as an office manager at a real estate agency. She was certain that something about her professional de-evolution didn't quite add up but was hesitant at first to attribute it to her precipitously declining mental state over the years. Deana was an incredibly bright, middle-age-ish lady whose charismatic sheen stubbornly shone through her wounded exterior. Unfortunately, however, depression had pulverized her ability to think—to work—to do anything really, and soon the only job she could find to pay the bills was arguably the most horrific occupation on God's green earth: leading its unwitting creatures to their slaughter.

We all knew that Deana was simply doing what she had to do. We understood what it meant to lose one's self—and with it, one's skills, aspirations, motivations, and opportunities. Our empathy, however, did not change the fact that we were terrified of the Grim Reaper—no matter how incontestably lovely her personality. As Maddie once said, “I mean, she’s a *trained* assassin, and what *really* would stop her from turning on us?”

Yes, unfortunately, Deana’s job did cast an indelible stain across everything else she was or did. It’s not fair, but it’s simply impossible to dress up or pharmaceutically fumigate that kind of creepiness. It’s like how late model windowless vans fundamentally evoke kidnappers and serial killers (usually dressed as clowns) even when they’re hauling old people or elementary school field-trips—and just like middle-aged white guys with earnestly coiffed comb-overs and giant 1980s eye-ware are bound to be found behind the wheel of said vans and in pursuit of said murderous shenanigans. The ‘windowless’ windows and the crude illusions of hair are props—shields meant to protect someone who is hiding something, and yet, they declare that someone’s secret through the betrayal of Creepiness.

As the days passed, however, ‘creepy’ became the least of my misgiving about Deana. It turned out she had a fondness for soliloquy—and death—and ironically, my impatience with them both became a key metric of my own psychological improvement. I almost wanted to talk about life again, however miserable it was—or, at least, I finally wanted to talk about it more than I did canine- and feline-ocide.

Sometimes when Deana got lost in morose rapture, I’d close my eyes and transport her to another time and place without cages and small animals shrieking. I imagined her laughing flirtatiously with mysterious young men in dark smoke-filled rooms as bourbon swished to and fro in a bulbous goblet that dangled haphazardly from her fingertips. She wore a short, iridescent dress that pressed against its seams as she did a raucous rendition of the Charleston—a long string of pearls swinging around her neck wistfully like a hula-hoop while her body's reckless abandon held the jazz band soundtracking her debauchery hostage with its animated charm— commandeering their rhythm, the tempo, the backbeat blast of notes.

Deana was breathtakingly beautiful—the kind that hurts to look at—and, so it seems, she bore the sassy elegance of a 1920s throwback. Maybe it was her thick licorice hair bobbed just below the ears, or the way she glided, instead of walked, into a room on tomboy limbs that suggested balletic athleticism. Maybe it was the unfiltered cigarettes she smoked, or how she wept the previous night's drinking binge through her faded olive skin and deep green eyes when the room had become overheated with troubled stories.

Sometimes I would insert myself into these daydreams about her imagined life. Instead of this putrid room, I dreamt we met at Gatsby's house (because, you know, I summered there), out on the veranda where we marveled at a sparkling August evening as a squadron of socialites huddled around secrets and bottles of wine inside. We were basking in the laissez-faire of a late summer sunset—insouciant light defying the temper of dusk, bleeding itself silly across the electrified pastel of the horizon until it got sleepy and lapped against windows in a golden-hued luminance that settled on Life being lived in the rooms, in the people behind them.

Deana belonged in this scene—it lingered around her like Destiny. But, instead, she was forced to tell us stories about her soulcrushing job and Big Angry Love with the medievally abusive man who left her without warning the last time she was hospitalized. When she was released, she found his rather unimaginative note in their mailbox saying something painfully obvious and simple like "I'm leaving you" bundled up carelessly with his wedding ring and an old necklace she once gave him for his birthday.

This was the story that finally threw me over the edge—for so many reasons, for *every* reason. As Deana trudged through it in group one day, grinding His name between worn-out molars and worrying it with the rhythmic whip of her lips before spitting it out like bile again and again, I studied the crown of her head in Zen meditation. I was steadying my fomenting rage and respecting the privacy the rest of her body needed to purge him and mourn. As we observed a ceremonial moment of silence when she was done talking, I scanned the room frantically for potential co-conspirators who also believed that this man deserved to die and that we were just the crew for the job. But Deana quickly spotted my brewing anger and leaned forward for my wrist, as if to arrest my bloodlust, or as if she was setting me in place to say something profound.

Only she didn't. She simply wanted me to witness her, to watch as her eyes did something nautical—pitching and heaving salty wet things that shimmered then crashed from bubbles into waves that raced themselves into exhaustion down livid cheeks. They finally pooled in the dimpled bunker at the base of her throat—the place where her body seemed to inhale itself as she heaved tears, intermittently blasting back a lump the size of two whole lives. And then the silence…her body re-arranging grief, like old furniture it can't afford to toss but can't afford to keep…for long.

By the end of her time in group, Deana finally resigned her animal control post. The last time we spoke, she was newly in love, still unemployed, and in the process of fighting the state (to no avail) for the right to receive disability support under workers' compensation statues.

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GUITARS: KEVIN

"*Bonjour*, Kevin,"

"*Bonjour*. *Comment allez-vous*?"

"*Bien*. *Y tu*?"

"I thought we were doing French today?"

"We have officially exhausted my knowledge of French, Kevin. *Lo siento*."

Kevin was not French, but he was comparably exotic in that he was a gay man from East Texas who *wanted* to be French. He was single when we first met, and, in his estimation, since French men "get all the ass," it made sense to attempt to approximate their *je ne sais quoi* in any way possible. I understood his loneliness and respected his enthusiasm; for a while, I even considered becoming his understudy.

Masquerading as a Western European was a relatively easy task for Kevin—he was sophisticated, erudite, rolled his own cigarettes, and, in his finer days, looked fabulous in tight blue jeans. Much to his dismay, however, Kevin most resembled the Scandinavians, to whom, in solidarity with his adopted French homeland, he didn't extend any particular favor. He was tall, blonde, blue-eyed, and as bright-white as the brand new "man-Keds" he wore every day I knew him. His lips were always chapped (like those of most of us, from our meds), his eyes were eternally bloodshot and goopy-green with sleep at their edges, and his hair was alternately unkept and oily beneath a battered Houston Astros cap or exquisitely coiffed, gelled, and stylized. He once told me that there were only three things a person needed to know how to do in life: read a map, cook at least two good meals, and competently choose fragrant and reliable brands of hair-care products.

We were instant friends and allies. A seasoned veteran by the time Kevin arrived in group, I did everything I could to befriend him the second he hobbled through our door. He was a master at taking up space—gobbling up furniture, people, and oxygen with his elitist air and furious woundedness. Although the moment we met I knew him to be My People, he quickly came out to everyone else in the room. It was painful to watch. I hadn't had time to warn him that being gay in group was not always welcomed. The "don't ask, don't tell" policies of the outside world were more or less in place in our isolated universe; however, recently the group had taken a sharp turn to the right—the religious kind—after a bad batch of new recruits had come in and seized a moral majority, a formidable coalition of people who either believed they were Jesus or spoke for him personally. It didn't take Kevin long to learn this the hard way, and, in lieu of discussing our personal lives in group, we gabbed about them like 'tween'-age girls on the telephone until all hours of the night.

As we bested each other's dramas, made cases against our worthlessness as people, and studied to the point of proficiency in each other's interiority and epistemologies, we fell madly in 'friend' love—a development that was nothing short of revolutionary: It was Faith. It was Redemption.

Beyond this cosmic kinship with its rainbow streamers, however, Kevin and I were drawn together by age and a 'youth' sensibility that left us boyish and girlish in appearance and habits well into our twenties, as well as by similar mental afflictions that struck at similarly inopportune stages of our young adult lives. Although his struggles were significantly more severe than my own, we were both coming off long bouts of maniacally delusional behavior and, thus, had been forced to take Zyprexa—an anti-psychotic notorious for, among other things, weight-gain. Gutted and emaciated from months of psychosis, I was down to 90 pounds and thus needed a boost in body mass (a very quick 20 pounds of it, to be exact); Kevin, however, looked artificially inflated and unyielding. He used to joke that his head appeared to be peeping through one of those giant carnival cut-outs of muscle men or sea-faring animals. Eventually, we made a pact and abandoned our shared pharmaceutical enemy in what was my first attempt to overrule my treatment team with a fancy psychopharamacological internet education and an insufferable attitude.

Needless to say, it did not go well for me, but ol' Kevin was just fine. He was what we called a 'wonder wank'—group slang for 'still had a life' or, more often, 'still employed.'

He was not only brilliant—on his meds, off his meds—he was *indispensably* brilliant, and his software company quickly caught on that nothing would stymie the easy genius that oozed from his head and collected with maddening humility around everyone he knew—leaving them to writhe around uncomfortably in a demoralizing stew of envy. Despite his many spectacular breakdowns, heretofore, Kevin had been spared any worry about his employability. No matter what he did, it seemed, Life conspired to keep him safe. It wasn't through with him yet, this much was clear. He was like a comet—with encyclopedic knowledge of musical theater and paralyzing anguish in his eyes—and was slated to streak brilliantly across the midnight sky every thousand years. Maybe the universe was simply waiting for him to look up and notice that his time had come.

But here's the problem, he would say, '*brilliance' has its price and 'comets' don't get laid.*

Work was Kevin's outlet, much as school had been mine; our perceived inadequacies had been personal and intimate, not professional. We regarded these failures as the most devastating of losses, however, for both of us felt that we had always been valued for what we produced, not for who we were. In consequence, without the validation of a doting partner, we had become estranged from and even disinterested in who *we* understood ourselves to be. What was clear, however, was that we were both terrified of people but craved them insatiably. Kevin was even lonelier than I had been after Natalie left, which was scary and embarrassing for him. I, at least, had a family who loved me and stuck by my side when my partner finally set herself free from my chaos. Kevin wasn’t close to his family and had neither a love interest nor many friends to pick up the slack while he was sick. Most of us in group were either a). very, very single, b). divorced, c). in the process of getting a divorce, or d). walled up in our homes, afraid of contact with the outside world, which might actually explain a), b), and c). We were *hard*. Difficult to love, or so we had been told.

Eventually, Kevin confided that he had no relationship with his parents because they couldn’t accept that he was gay. His mother couldn’t handle life without grandchildren—to which she imagined the conjugal vagina the only possible avenue—and his father, well, let’s face it—he must’ve really, really wanted it up the ass because his vitriolic hatred for his ‘faggot’ son was too elaborate to pass as ordinary bigotry. Ultimately, neither parent could stomach the thought of having a queer child—let alone a *crazy* queer child (although Kevin assured me that, in his parents’ estimation, the two came as a set: twin mortal sins). Not surprisingly, they remained distant and disappointed even after Kevin was hospitalized.

Understandably, then, I was more than a little skeptical when Kevin came to my house one day and announced with ecstatic eyes and a beaming toothy grin that his mother had finally agreed to visit him. Before I had a chance to react, he rattled off a list of self-assigned chores to complete in preparation for her arrival. As he ran down his list, I noted that I had never seen someone so excited about the mere prospect of seeing one of his parents—much less a fascist homophobe who had refused him the respect and affection as was his due. I suppose my own parental wounds had just begun to heal, and I couldn't imagine ever going back to the way things had been. When I questioned Kevin about his eagerness to welcome back into his life a woman who had so fundamentally wronged him, he stared at me with his big blue, little boy eyes and a smile that punctuated his face with an authenticating glow: "Why would I want to be just like them?"

The day after his mother was supposed to have arrived, Kevin called me. It was early on a Thursday morning, and I had assumed my usual morning formation—splayed across the living room floor interpreting my ceiling fan on a butterscotch Washburn guitar. Forgoing any greeting, Kevin told me in an eerily composed tone that his mother had never showed up or even bothered to call and explain or apologize. And that's when it happened. I opened my mouth and let loose one of the biggest mistakes of my adult life. Failing to filter my rage or recall that 'Manic-Depression' derives from the Latin, "ingenious asshole-ness waiting to shine," I brusquely replied: "Well, really, Kevin, what did you expect?"

I couldn't make it out for the screaming, but I think he said something about me being "emotionally spoiled" or maybe "emotionally soiled." Before I could clarify this or truly understand the enormity of my mistake, he slammed down the phone and never called or returned my calls again. Friendship over, gone. For weeks, I replayed our conversation over and over again in my head, trying to will it differently, and agonized over whether I was, in fact, emotionally spoiled or soiled and speculated about what the different implications of each word might be. In the end, he was right on both accounts. I had failed and betrayed my friend and that was the only thing that mattered.

I've since tried to find Kevin, or, at the very least, find out how he's doing, but no one has seen or heard from him since our incident. He never came back to group. I like to imagine that he finally made his pilgrimage and moved to France, where he fell in love with a strapping young man named Jacques, who looks dapper in form-fitting clothing, and that the happy couple sits side by side reading James Baldwin novels in Parisian cafes, smoking cloves and drinking red wine. I also like to imagine that Kevin has forgiven me, even though we both know that he shouldn't.

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DRUMS: SARA

The power of being the Thing that satiates someone pales in comparison to the power of being the Thing that guts someone clean. The 'bottom' fallen out, held hostage or at bay by the ocular magician who catches you—red-handed—in the act of *not* being brave and loves you '*all the madder.'*

That was Sara.

She was the only person I'd ever known who'd been in a "solitary" something of any kind. I wasn't certain what the purpose of hiding her away from everyone else in the hospital could possibly have been, and when I asked one of the nurses on her floor why Sara had to be placed in a "single" room (i.e. solitary confinement), she only told me that the doctors had recommended it for the "good and peace of the floor," whatever that meant. I was further confused by this tactic when Sara and I were finally introduced, as this young woman seemed to me more lifeless than wet cardboard. I mean, really, is it possible that depression could be riotous in any way, shape, or form?

Why psychiatric hospitals choose to isolate people who loathe themselves—and, thus, who are least capable of managing self-hate when hermeneutically sealed *into* it while locked away in tiny rooms with only Civil War to keep them company—is anybody's guess.

When she emerged from captivity, Sara was predictably shell-shocked and desperate for, yet ambivalent about human contact. For the first few days, she moved about the hospital like an inquisitive child who had only recently tapped into the glories of physical self-awareness—for instance, discovering that she has peripheral vision and can pick up things with her hands. The world's novelty could be attributed partially to her negotiation of it as a newly-medicated person, a state which remarkably resembles toddler-hood. I realized this one day after catching a glimpse of Sara squirming down the hospital hallway on dopey legs, bouncing the way that children do when they dance like happy pogo sticks to any music within earshot of their wiggly bodies. Sara's gait, however, was hardly joyous, precious, or carefree joy. She was severely drugged, nearly to the point of catatonia it seemed, and hobbled forward and backward, swaying from side to side like a palm tree in a hurricane as her eyes ping-ponged absently across their stagnantly frustrated sockets.

Sara swirled like a giant hologram of herself, and I often felt myself preparing to catch her.

But, from the beginning, I liked her. Unconditionally. I wanted to know her story, and I wanted her to know mine. The first day she came to group, she was bundled up in a hunter green sweater three times the size of her emaciated petite frame. She wore her sandy-blonde hair up in a rag-tag bun held in place with a chopstick salvaged from last night's Chinese take-out. Throughout our session, I stared as she obsessively patrolled the perimeter of her makeshift 'do, pantomiming the patting of her head in an effort to round up any runaway hairs, and I watched as she patiently ate peanut M & M's in agonizing fifteen minute intervals—completely breaking down and swallowing one morsel, letting it snake through her body's intestinal maze, before picking up the next piece and putting it in her mouth. As she performed theses labors, she stretched a disgusted sneer across her face and shot menacing glares at anyone brave enough to catch her eye. She was obsessive-compulsive, paranoid, and vicious—it's a miracle I didn't propose marriage.

One day, after befriending each other, Sara and I were in the hospital lobby together waiting in line behind a man in a white technician's uniform to use the courtesy telephone. Sara needed to schedule an appointment with her psychiatrist, and it had become my practice to serve as entertainment as she completed such tasks, for when I first came to group, I had also enjoyed the support of such escorts and felt strongly about 'paying it forward' to the next generation of patients who crawled through our escapeproof doors.

It was an oppressively hot, May afternoon. As Sara and I waited anxiously for the phone, we could feel the impending summer heat pierce through the lobby's desiccated windows and roll like waves through the automatic doors that yawned open and closed in heavy beats whenever someone entered or exited the building. I was wearing a tank-top, shorts, and flip-flops. Sara, on the other hand, donned jeans and her hunter green sweater-uniform and thus began to suffer under its suffocating weight. As several minutes passed and the temperature became increasingly unbearable, she looked at me intently and told me she was going to have to take off some layers. I was a little suspicious of her need to make such an announcement, but I hadn't given much thought to what might be underneath to warrant such an introduction. *So, she wore the same sweater every day. Big deal. That guy, Jim, in our group thinks he's made of rubber, and we're under strict orders not to tell him otherwise.* I'd been around a place like this long enough to know that there are some things you don't question or assume. So, I told Sara that I agreed that it was probably a wise idea to strip down given that we had obviously been drugged and abandoned in a remote desert hospital somewhere without food or water and would probably perish in the next ten minutes if the jackass in front of us didn't stop fighting with his wife about who would be picking up their kids from school.

"Lean over and tell him that *you'll* pick up his fucking kids if he'll get off the fucking phone," Sara snarled. She was addicted to everything—sugar, alcohol, drugs, anger, terrible relationships, addiction itself, and cigarettes. Her tobacco habit had transformed her voice into an aged smoker's growl, mysteriously preserved in the pitch of youth but ground away in tone by nicotine and tar.

I rolled my eyes, shot her the finger, and pointed to the plastic yellow band strangling my left wrist that identified me as a part-time guest of our hospital. "I'm sure he'd be delighted to have a psych patient pick up his children up from school," I said.

Another handful of minutes passed, and the Saharan heat intensified. Sara, glistening with sweat, finally shimmied her way behind the cover of my body and gestured for me to produce the reserve light-weight fleece jacket she knew I always kept stowed in my bag to defend against the artic blast of air conditioning that assaulted our group meeting room every afternoon. As she quickly and nimbly disrobed and slipped on my jacket, I caught a glimpse of the most disturbing record of self-injury I have ever seen as it peeped out beneath her tussled shirt and materialized viciously across her arms and wrists. From afar, her skin might've only seemed creased and shadowed with folds of tissue and hair; proximity betrayed this optical illusion, however, and, instead gave focus to what were really crests and canyons of scarred, mutilated, disfigured flesh. Cuts. Slashes. Burns. Long. Short. Wide. Purples. Pinks. Blues. Yellows. Conquered landscapes, a despot and her enemies. I wondered how many nights Sara must've spent alone, sickened by any evidence that she existed in order to have accomplished a sadomasochistic feat of this caliber. The damage was ritualistic, surpassed even the most barbaric efforts at self-flagellation that I'd ever witnessed, and suggested that its purpose was beyond any attempt to shake herself free from numbness. To the contrary, it was supposed to *bind* her to the pain and be painful for painful's sake. It was, quite literally, Excavation: a violent removal of Self.

I tried my best to nudge my gaze away from her body. It wasn't the Horror that kept me lingering, however, it was the disbelief that, given the Horror, Sara had claimed a place for herself in public view. There was no way for me to fathom the arduous psychological labor and bravery that must've gone into that bold move. I wanted to smile, but Sara—no doubt long practiced in subjection, judgment, and reaction—preemptively mocked my response. She rolled her eyes, shot *me* the finger, and sternly pointed to the matching yellow plastic bands that strangled our respective wrists and then shot me a disarming but accusing smile.

Before we had time indulge a fight, real or staged, our nemesis finally struck a deal with his implacable other half and abruptly surrendered the courtesy telephone. As he walked away, Sara seared derisive thoughts into his back and, with wicked agitation, promptly seized his vacant spot. "Fucker," she snapped. I smiled sympathetically, gathered her face in my hands, and then directed her head towards the telephone. She exhaled her anger in practiced deflating sighs and steadied her internal tremor. I gently detached myself from her face, breaking away from her chin just as it made a move to burrow into my palms. As she shifted submissively in her seat and resigned herself to dialing the number of her doctor's office, I stabbed at her side with big left toe and picked my nose theatrically to get a laugh. God, was I thankful when she finally gave one up.

Today, we are safe.

Chapter 6

Conclusion

Arthur Frank cites (1995) “thinking *with* stories” as the foundation of narrative ethics, as well as the principal project of an ethical clinical praxis (p. 158). This chapter requisitions ‘thinking *with* stories’ as a methodological instrument in drawing concluding materiel from this project’s primary texts and drafting a final response to its guiding questions about how Narrative comes to matter most in manic-depressive storytellers’ lives. It begins by synthesizing this project’s major findings about the genres, media, and methodologies that best perform ‘the work of narrative’ in BP storytelling. In delineating terms for producing and deploying ‘good’ BP narratives, this chapter then broadens its analytical lens to consider the future of ‘good’ mental health storytelling more generally. It posits feminist clinicians and the “New Writing” (Denzin, 1997) as key coordinates directing the course of this work and identifies the ‘the political’ and ‘the interdisciplinary’ as its imminent venues and narrative values. Finally, this chapter concludes by staking a place for next-generation ‘text’ *bp Magazine* in this twenty-first century narrative milieu, pinpointing its location via political vetting against a seasoned feminist counterpart—*Ms. Magazine*.

‘Good’ BP Narratives

Cheney’s *Manic* (2008), Campbell’s *72 Hour Hold* (2005), Fisher’s *Wishful Drinking* (2008), and “Mad People Without Instruments” serve the work of narrative with distinction and panache. Over the course of this project, they have demonstrated in both the particular and aggregate Narrative’s facility in rendering manic-depressive illness less gouging in its inexplicability and destructiveness and, thus, more governable as a kind of volatile market economy where body, psyche, and neurochemistry strike affective, corporeal, and existential deals under Sociostructural and Political thumbs. In this world of negotiation and trade, *stories* are currency and 'illnesses' narratively-baited traps awaiting Storyteller prey to make them fungible. Good stories and deft storytellers transform them into assets for 'self,' identity, embodiment, and subjectivity—to Life with Illness and Life *as* Illness and to the art of storytelling itself. The texts at this project's narrative center have captured these assets at work by illuminating the host of services they provide manic-depressive storytellers and their communities.[32]

What 'Good' Manic-Depressive Narratives Do

In demonstrating what 'good' manic-depressive narratives, reviewed below as a summary of offer a response to this project's first guiding question about what storying manic-depression does (materially and metaphysically) for BP storytellers:

- 'Good' BP narratives authorize personal and public speech about manic-depressive illness and inject ethically-sound accounts of BP embodiment, epistemology, and subjugation into popular, medical, and political discourses surrounding the illness.
- They act as platforms from which BP storytellers may publicly refuse the shame and silence that keep stigma 'Stigma'—in the process furthering storytellers' pursuits of a narrative unity of life amid the disruptions of illness.
- Good narratives do not merely support progressive mental health political work—they constitute and incite it. They are its evidence and outcomes. In this sense, they

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[32] As noted, these 'services' reflect the findings of this particular project and its particular textual interests. Although I would (and will) argue that these findings are somewhat generalizable to other BP and even non-BP mental illness texts, I continue to recognize, without systematically studying, 'the illness' and 'the individual' as central analytical units in understanding story content and sociopolitical imperatives. See Chapter 1 and its preceding 'BP' information sheet for refresher details on Bipolar Disorder.

do more than humanize or enliven the deleterious effects of stigma, broken systems, and ‘assimilationist’ politics—they help set the terms of their debate and redress or remediation.

- They act as pedagogical weapons against popular ignorance and institutional indifference. They use the materialities of lived manic-depressive experience as their primary ammunition and both animate and affirm the ‘difference’ these experiences engender.
- ‘Good’ narratives solidify community bonds and sustain support networks through which many BPs secure the human and material resources that underwrite the management of their illnesses.
- Finally, they act as psychotherapeutic engines. They ‘tell’ the illness story as a means of ‘working through’ the losses and traumas it catalogues. In doing so, they help a BP storyteller incorporate his or her experiences of disruption and fragmentation into an *illness-informed* ‘self,’ as well as into the larger narrative of his or her life in an effort to move forward with the everyday business of living it.

‘Good’ narratives also ‘do’ by *not* doing. Most importantly, they do not succumb to the formulaic clutches of stock narrative structures or paradigms, especially those surrounding ‘recovery.’ Instead, they distinguish themselves by establishing their own narrative cachet rooted in a rejection of the recovery paradigm’s compulsions for closure, linearity, and cohesion, as well as its ‘bootstraps,’ New Age-y evangelistic fervor for ‘self-enhancement,’ ‘triumph,’ ‘redemption,’ and retail. In short, ‘good’ narratives *don’t* behave like homogenizing, depoliticizing, uncritical master texts that reify subjugating discourses surrounding mental illness and routinize their attendant disciplinary practices in any sector or domain of mental health work. They are ethically taut, materially pertinent, consequential texts that actuate the political, practical, and therapeutic potential intrinsic to the narrativization of experience. In and *through* their exercise of these facilities, good narratives assert the value of storytelling in private, public, and political life.

What 'Good' Narratives Are Made Of

In illuminating what good BP narratives do, the previous chapters have also indicated what good narratives are 'made of'—in particular, calling attention to the genre, medium, and/or methodology that underwrote a given text's performance of 'good' narrative work. Despite their divergent forms and formats, the texts revealed a core set of narrative attributes—a common 'Good Narrative' genetic code—that bound them genotypically while permitting phenotypic variations in structure, style, and aesthetic. The most prominent features linking them across narrative station and tool-kits were: *dynamism* (i.e. representationally and communicatively dynamic texts), *didacticism* (i.e. texts that instruct, inform, and empathically engage), and *self-reflexivity* (i.e. texts that are morally and politically self-aware). I specify the terms and action of each of these characteristics in the discussion below; however, for synoptic and prescriptive purposes, I recast them as guidelines for good narrative work that respond to this project's second guiding question about the kinds of narratives and experiential and sociopolitical conditions that best support BP storytelling:

Good narratives should be dynamic. Whether they showed rather than told or told so hauntingly or exhaustively they seized and subsumed, the texts foregrounded in this study succeeded as narrative projects because they were exceptionally dynamic in their representational schemas and transmission of ‘story’ and story content. Fisher (2008) enjoyed the narrative spoils of a genre and methodology dynamic *by design*: performative writing and personal narrative. Fisher playfully but trenchantly exploited the structural and stylistic permissiveness of performative storytelling to produce an iconoclastic rendering of manic-depressive experience that, like Fisher, is in perpetual motion—hustling the Story and the Joke in order to keep author and audience connected and amused. Although certainly not to the same extent, performativity also plays a crucial role in my own narrative’s dynamism. “Mad People’s” performative impulses drive the ethnographic sensibilities that shape its storylines, spotlighting a central facet of ‘dynamism’ in good BP narrative work that is particularly plentiful in performative storytelling modalities: the ability to account for and elucidate the heterogeneity of lived experience and the multiple versions of truth it necessarily produces.

Campbell’s *72 Hour Hold* (2005) showcases fiction’s own impressive cache of dynamic resources. The novel itself embodies its genre’s suppleness and vim and demonstrates its perspectival capaciousness and poly-vocality. For her part, Campbell shows tremendous skill in harnessing these tools to settle the genre’s anarchistic literary terrain with a sophisticated portrait of manic-depressive illness in contemporary culture ‘told’ from personal, familial, and systemic points of views without ever simplifying their chaotic interfacing and exchange. From the comparative ‘dynamic’ doldrums of traditional memoir, however, Terri Cheney (2008) manages to generate the most frenetic, viscerally thrashing account of manic-depressive experience this project features. Although the allowances of genre and media are vital to a narrative’s ‘dynamic’ prospects, Cheney affirms a definitive role for old-fashioned eloquence and ferocious wordsmithing in the ‘good’ narrative arsenal. Cheney’s own literary prowess acts not only as the source of her text’s *linguistic* dynamism, but also as its ethical insurance in protecting the experiential integrity of her illness narrative and (with it) her memoir’s potency as political testimony and intra-psychic revival.

Good narratives should be didactic. Arthur Frank (1995) describes a “pedagogy of suffering” taught in/through the testimony of ‘wounded storytellers.’ He contends that these illness narratives call listeners/readers to moral and sociopolitical reckoning by illuminating the storytellers’ marginalization and pain (pp. 154-155). Campbell’s (2005) *72 Hour Hold* is the embodiment of didactic manic-depressive storytelling—a microcosmic ‘pedagogy of suffering’ over which she presides as the vision of a narrative pedagogue. Campbell’s novel demonstrates brilliantly that fiction’s most powerful pedagogical gift is (to paraphrase Dorothy Allison) its ability to tell ‘a harder piece of truth.’ *72 Hour Hold* not only makes the contemporary mental health care crisis ‘of this world’ for a popular audience, it provides them with an accessible, informationally accurate review of the biopsychosocial processes that shape individual experiences of mental illness, as well as the institutional and cultural forces that then determine their differential outcomes across communities. “Mad People Without Instruments” operates in a similar “macro-pedagogical” vein, however, on a much smaller textual and topical scale. My primary didactic goal with this piece was to make it function as literary ‘ensemble teaching.’ Each vinette/character study generates distinctive points of entry (albeit through my singular narrative hand) into manic-depressive experience that indoctrinate readers into different experiential data sets and, therefore, present them with different possibilities for empathic engagement and cathartic revelation about people living with and/or undergoing treatment for a mental illness.

Although Carrie Fisher is less dutiful pedagogue than substitute teacher, *Wishful Drinking* (2008) poses an important challenge to the curricula and methodology of a BP ‘pedagogy of suffering’ by bringing forth the unassailable logic of mental health ‘infotainment’ in a culture that is simultaneously loathe to discuss mental illness and utterly addicted to being entertained. *Wishful Drinking* (perhaps inadvertently) reveals a starting point for mental health advocates and outreach coordinators in pursuing a responsible program of ‘infotainment.’ They face the daunting task of determining how best to play the intellectually- and civic-mindedly bankrupt pedagogical hand mental health has been dealt in order to maximize the popular reach of BP storytelling without compromising its political and ethical integrity.

Finally, the impossibility of reading Terri Cheney’s (2008) *Manic* without anything but an ache presents an entirely different route to didactic manic-depressive storytelling. Cheney’s excavations of BP embodiment and misdeed pin readers helplessly into her excruciating corner of the affective universe—functioning, therefore, as a kind of submersion learning. The consequent empathy and awe this immersion induces in readers affirms a pedagogical imperative at the *ethical* center of good BP narrative work.

Good narratives should be self-reflexive. Narratives that are self-reflexive and privilege moral and political self-awareness in their ‘telling’ locate themselves within the ‘worlds’ of their texts and the ‘worlds’ of their texts within the *actual* World and its systems of power. *72 Hour Hold’s* (2005) legitimacy and effectiveness as a political treatise/sociological primer hinges on its moral and political self-awareness, which Campbell's extensive 'off-page' activism amply supplies. Her novel's eclectic, well-developed cast of characters reveals the breadth of her empathic imagination as a storyteller—perhaps the strongest indicator of her authorial self-reflexivity and her greatest asset as a novelist. Fisher's (2008) *Wishful Drinking* is slightly compulsive in its self-reflexive declarations and disclosures—at times even feeling narratively pinched by Fisher's self-consciousness about 'owning' her privilege and fame with a sufficiently winsome balance of contrition and bawdiness. This fumbling narrative care, however, is compelled by a sense of duty to authorial accountability that ultimately grants Fisher and *Wishful Drinking* the moral advantage they enjoy among their celebrity contemporaries.

Cheney's *Manic* (2008) illuminates a different facility of 'self-reflexiveness' in good BP narratives: its role in preconditioning an author's ability to extract therapeutic value from storying his or her experiences of illness. If stories are to facilitate the process of working through trauma, then the storyteller's ability to reflect critically on the nature of those traumatic events in relation to their narrativization is paramount. Cheney is exceptionally aware of herself and her writing in this way and, in fact, incorporates the evolution of this consciousness into her memoir's predominant storyline. As the author of "Mad People Without Instruments," the most productive way for me to comment critically on its self-reflexivity is to note that 'self-reflexiveness' was a principal preoccupation for me in writing it. Writing about group-based experience grounded in both personal upheaval and collectivized struggle demanded a heightened sense of self-awareness that constantly forced me to interrogate my choices as both a narrator (within the piece itself) and a storyteller (*of* the piece as and after it was written).

How ‘Good’ Narratives May Be Applied

Shifts in mental health narrative practice reflect and incite shifts in mental health institutional and programmatic architectures. ‘Good’ or ‘bad’ narratives, therefore, matter deeply, as does the narrative real estate certain kinds of storytellers command over others in mental health advocacy, the mainstream press, and on the bookshelves of everyday people. My review of guidelines for ‘good narratives’ already suggested some of the most important practical implications posed by the work of narrative performed in this project’s primary texts. ‘Applied Pressured Speech,’ however, builds on the preceding section’s outline of the character, mechanisms, and impact of each of these texts in order to better specify their practical implications. In applying “Pressured Speech,” therefore, my objective is to issue general recommendations emerging from my materials of study about how mental health advocates, politicos, and narrative practitioners may promote ‘good’ narrative work in their respective mental health domains as part of a larger program of revitalized storytelling within mental health communities.

Applying ‘Pressured Speech’ in mental health domains. Mental health workers and advocates have already reached consensus about some of the most pressing recommendations emerging from these texts—most notably, their collective indictment of the employer-based insurance system currently at (or near) the center of health care/insurance reform initiatives. While this system is generally disastrous for the scores of people whose full-time, continuous participation in the American labor force is precluded or disrupted by a marginalized social station or exigent circumstance, it is particularly catastrophic for people also living the entirety of their life courses with a persistent and severe illness, physical and/or mental. Despite widespread concern about the tenability of this system, reform efforts have begun to stall and partylines entrench and rigidify. As a result, the most radical proposals for reforming American health care are in serious danger of being permanently tabled, shelved, or otherwise tossed aside, including a single-payer system, a mandate for universal coverage/care, and (so it seems) a ‘public option’ to compete and coexist with the private health insurance companies whose cloven hoofs and Republican puppets have steadily stomped the life out of Congressional efforts to advance substantive health care legislation that does more than simply widen and ‘arrest’ their own potential market interests. As President Obama’s first year in office draws to a close, the fate and particularities of *any* reform measure remains somewhat unknown, therefore, so does its potential impact on mental health care services and structures.

In this climate, Terri Cheney’s *Manic* (2008) is a directive reminding mental health advocates to hold their ground despite increasing pressure to settle for ‘compromise’ legislation that does very little for most people in the mental health community while reifying the institutional and ideological foundations that make the current system so impervious to change. *Manic* demonstrates just *how* vulnerable BP workforce participation is to illness-related disruptions by documenting the travails of even the most economically-, racially-, and socially-privileged members of the community. Although Cheney was an Ivy League-educated lawyer who had climbed her way into the upper echelons of her profession, chronic and unmanageable bouts of illness made it impossible for her to do her job, then keep her job, then pay her bills, then finance her treatment. As a result, Cheney landed on federal assistance and nearly lost the basic material means of her existence while trying to re-configure her life around meaningful work that would support—not derail—her sanity and stability. *Manic* is both a symbol and product of Cheney's eventual occupational turn toward professional narrative work and, thus, also acts as its own 'recommendation' for mental health advocates and clinicians in encouraging them to consider seriously narrative's therapeutic, political, and even economic value to BP storytellers. In light of current political circumstances, however, *Manic's* most pressing counsel continues to rest in its cautionary 'telling:' If Cheney's fate is the fate of even BP 'elite'—the most well-educated, advantaged, and employable among us—then the mainstream 'neolibber' mental health advocates currently on the political frontlines of health care reform must be extremely judicious in the concessions they are willing to make in lobbying for change over the months and years to come.

As explored elsewhere in this project, Fisher's *Wishful Drinking* (2008) suggests that mental health advocates curb their appetites for celebrity stories as sources of political and cultural capital in underwriting their perpetually undercapitalized work. Fisher's memoir and unconventional tenure as a celebrity advocate indicate that, if celebrity spokespeople and their stories are to continue their domination of mental health's narrative landscape, then their perceived value must, at least, be understood as contingent upon their adherence to the heightened ethical standards that must attend their use. Fisher establishes self-reflexivity and authorial accountability to 'Celebrity' itself as the foundations of such an ethics. Fisher and her memoir also suggest that mental health advocates also consider re-directing their use of celebrity storytellers to less ethically treacherous and (ultimately) more profitable narrative work, such as the media-based activism now thriving between mental health organizations and media networks partnering to promote accurate and ‘positive’ representations of mental illness in television and film. (NAMI’s long-standing relationship with the FOX show, *House*, is an excellent example of these collaborations.)

“Mad People’s” foregrounding of ‘patient’ subculture targets ‘the clinic’ (the literal, not Foucauldian kind) as the primary site of its recommendations. First and foremost, my piece indicates that clinicians and practitioners must be more cognizant of the extra-group ‘group’ as a salient player in and material resource for acute and long-term patient care. These micro-communities not only serve auxiliary support functions, they often serve as elective family structures for patients who have been abandoned by overwhelmed or reproachful family members—a unique feature of mental illness-based oppression that, although somewhat akin to queer subjugation, is distinguished by the weight that involuntary commitments and other treatment-based decisions bring to the former’s prevailing power dynamics. Secondly, “Mad People” advocates more frequent and more actionable dialogue about intra-community ‘cultural competence’ and social justice issues, particularly around homophobia. Although consciousness about racism and sexism within the mental health community is hardly sufficient or astute, these two systems of oppression are understood, at least, as morally and ethically troubling, as well as acknowledged as significant barriers to equitable and accessible care. Homophobia, by comparison, still functions as somewhat of an extraneous blip on Mental Health’s social justice radar screen. Just as American culture at large begins to grapple openly with its marginalization of queer people, so must Mental Health (Chesler, 2005).

Bebe Moore Campbell's death has struck a significant blow to mental health communities and the future of mental health narrative enterprise. Campbell's *72 Hour Hold* (2005) affirms fiction as a promising and powerful pedagogical weapon in the battle against public fear and ignorance about mental illness and the people—especially those of color—who live with mental illness. She also makes a compelling case for the installation of 'writers-in-residence' at advocacy organizations, policy centers, and research institutes by demonstrating 'good' storytelling's facility at clarifying obscenely opaque policy issues and disentangling complex systemic knots in understanding barriers and disparities in care. Why *not* let our best storytellers take charge of decoding and publicizing this work in digestible and engaging terms rooted firmly in the nuances of particular community contexts? As we wander around in the black hole of general and mental heath care reform, civic storytellers can and should be clarifying its stakes, debates, and parameters for mental health communities. Hiring writers whose professional hyphenates begin with 'writer' and assigning them positions alongside public education, policy, and lobbying specialists is not only a way of advancing progressive mental health agendas, it puts storytelling in its rightful place among the most critical enterprises driving mental health work in the upcoming century.

Extrapolating the work of BP narratives. This project's findings about the 'work' and practical applications of manic-depressive storytelling bear important implications for programs of revitalized narrative practice in contemporary mental health domains. The remainder of this chapter, therefore, works in pursuit of this project's third and final 'guiding question': How might the work of narrative revealed in storytelling about manic-depression be extrapolated for use within clinical, literary, and activist settings in the decades to come? How might it be employed to promote the individual (i.e. the intrapsychic and therapeutic) and collective (i.e. social and political) interests of storytellers living with manic-depressive and other mental illnesses?

I address these questions by arguing that 'the political' and 'the interdisciplinary' can and must act as the primary venues for and values of mental health storytelling in the twenty-first century. I establish the primacy of these venues by explicating the roles of the "New Writing" (Denzin, 1997) and feminist mental health clinicians in mapping the future trajectory of this narrative work. I contend that they are key sites of politico-narrative activism from which extrapolations of manic-depressive storytelling to general programs of progressive narrative practice may depart. As I proceed with these two spheres of analytical inquiry, I will also highlight 'the ethical' as a philosophical, material, and political tie that binds them and, thus, that will and must preoccupy mental health storytelling in the twenty-first century.

Future Directions: 'The Political' & 'The Interdisciplinary'

The "New Writing"

Norman Denzin's *Interpretive Ethnography: Ethnographic Practice for the 21st Century* (1997) examines the "prospects, problems, and forms of ethnographic, interpretive writing that can and must predominate in the 21st century" (xvii). Denzin argues that the turn of this century marked ethnography's entrée into a "Sixth Moment," a historical era distinguished from its predecessors by a postmodern ideo-political sensibility. This period has generated a new and distinctly postmodern ethnography that Denzin posits as a—if not *the*—critical moral discourse for the 21st century world (xi-xvi). He claims that the feminist, communitarian ethics that structures "the tales of agonies, pains, successes, and tragedies of human experience" that Sixth Moment ethnography and interpretive writing record render them allegorical, therapeutic, and *moral* narrative projects (xiv). As a result, he argues that writers and ethnographers working in this 'Moment' open up new arenas of moral and ethical inquiry in exploring experimental types of narrative and textual production, such as literary journalism, performance texts, and narratives of the self (pp. 199-200).

Importantly, Denzin (1997) views writing, ethnography, and theory in the 'Sixth Moment' as inseparable material practices, as "together they create the conditions that locate the social inside a text." In his estimation, then, "those who write culture also write theory and those who write theory write culture" (xii). He consequently positions the "New Writing" at the center of this new ethnographic era and the "New Writers," especially the 'new' journalists and non-fiction novelists, as its prime narrative innovators. In re-envisioning 'genre' and using narrative "in new ways to say new things about people in society" (p. 131), the 'New Writers' take on a central role in Denzin's re-imagining of twenty-first century narrative practice; in fact, he rejects extant literary categories for their hierarchization of narrative work and subsequent diminishment of the New Writers' currency in popular and academic domains. He argues that the 'objective' research and scholarship to which these transformative authors and their 'writing' are subordinated ultimately "work against the creation of an expansive, complex public discourse where multiple narrative forms circulate and inform one another." The 'New Writing,' in contrast, recognizes that "the discourses of the postmodern world involve the constant co-mingling of literary, journalistic, fictional, factual, and ethnographic writing" (p. 127). The new writing forms and formats that have emerged in response to these conditions of postmodernity, therefore, model progressive twenty-first narrative work and include “narratives of self, fiction, poetry, drama, performative science, polyvocal texts, responsive reading, comedy and satire, visual presentations and mixed genres (e.g. hypertexts)” (p. 26).

Although the ‘New Writing’ is necessarily iconoclastic, interdisciplinary, and ‘hyptertextual’/‘intertextual,’ Denzin (1997) draws from the literary catalogues of non-fiction novelists, new journalists, and experimental ethnographers to enumerate a set identifying features particular to new writing texts and narrative projects. He indicates that ‘New Writers’ model compelling but ethically sensible twenty-first century storytelling by: 1). treating ‘facts’ as social constructions and investigating their rich, multiplicitous ‘truths;’ 2). blurring writing genres (e.g. combining literary and investigative journalism with confession and autobiography); 3). using the scenic method to ‘show rather than tell’ or ‘report’ their stories; 4). writing about real people or (where appropriate) composite characters that narratively ‘vehicularize’ the polyphonia and materiality of ‘real life;’ 5). establishing authorial presence by using multiple points of view; 6). using multiple narrative strategies (e.g. flashbacks and interior monologues) to generate narrative ‘tension’ broadly conceived; and 7). positioning themselves as “moral witnesses to the radical changes occurring in American society” (p. 131).

Although ‘New Writers’ are not “cut from a single cloth” and may write variations on the non-fiction novel or produce “ethnographic and journalistic texts of the exegetical, testimonial, or notational variety,” their work collectively takes “the scene”—not “the fact”—as a basic unit of analysis (Denzin, 1997, p. 136). By focusing their narrativization of experience “on the situation in which events occurred or would have occurred" instead of on an 'objective' accounting or recounting of those events (p. 156), Denzin (1997) maintains that the 'New Writers' are able to locate "the real in its multiple forms" within the experience of a text itself rather than locate 'reality' in events per se. To the extent that they assume this critical stance, Denzin contends that both the 'New Writing' and the 'New Journalism' are appealing not for offering "the certainty of the factual" but, rather, for their resistance to uninterrogated empiricism and subsequent creation of "reflexive texts requiring self-conscious readers" (p. 156).

Denzin (1997) argues that the "Sixth Moment" of ethnographic and interpretive writing transacted and *enacted* by the 'New Writers' and 'New Writing' inaugurates a new era of narrative practice that both requires and necessarily creates new models of truth rooted in the "ethnographies and epistemologies of a postpragmatist social criticism." These models foster a "feminist, communitarian ethics connected to the radical democratic project of the new, civic [writing and] journalism" (xxi). He maintains that twenty-first century texts, therefore, "must do more than awaken moral sensibilities"—they must "move the other and the self to action" (p. 287). As he explains, "ethnography's future can only be written against the history of a radical democratic project that intends humane transformations in the public sphere." As we enter this new 'Moment,' therefore, writers and scholars must recognize that "[they are] not in the business of just interpreting but of changing the world." Denzin determines, then, that a feminist, communitarian, public ethnography, working hand in hand with public journalism is the way to move forward" as narrativists take on this work (p. 287).

Feminist Clinicians

Denzin's (1997) explication of the 'New Writing' as central to a feminist, communitarian ethical model that generates narratives capable of "[ennobling] human experience while facilitating civic transformations in the public (and private) spheres" (p. 277) sets important parameters for progressive narrative work *writ large* in the decades to come. In Denzin's estimation, therefore, the future of mental health storytelling hinges on its ability to act in accordance with his formulation of twenty-first century narrative work as necessarily interdisciplinary, reverent of lived experience, ethically accountable, critically engaged, and, most importantly, socially actionable for 'just' political ends (pp. 130-132).[33] If the 'New Writing' models a type of narrative enterprise conducive to the revitalization of mental health storytelling, then feminist clinicians[34] offer a potential prototype of its stewardship within contemporary and future mental health domains. These politically engaged practitioners already act as vehicles through which progressive narrative work is refined, applied, and administrated in mental health fields to improve the lives of people living with mental illness. Their greatest value as twenty-first century narrativists, therefore, rests in their unique placement at the intersection of politics, praxis, and 'New' narrative production—a location marked by the dedicated application of feminist critique to clinical work and the use of a feminist-informed clinical praxis itself as a site of social and political activism (Caplan & Cosgrove, 2004; Chesler, 2005).[35]

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[33] The guidelines for 'good' manic-depressive narrative work outlined earlier in this chapter are commensurate with these values and affirm their importance to the future of *manic-depressive* storytelling, too.

[34] Meant here to include psychologists, psychiatrists, psychotherapists, and other 'direct care' mental health workers

[35] In applying key feminist concepts to clinical work, for example, the Association for Women in Psychology (AWP) has helped expose how race, social class, age, physical disability, and sexual

Feminist clinicians' rich narrative and political traditions (Caplan & Cosgrove, 2004; Chesler, 2005) make them particularly important in uncovering how the 'New Writing' currently operates in mental health work and, therefore, in considering how these practices might be parlayed into the broader programs of intellectual, activist, and 'applied' narrative practice that Denzin (1997) describes as paramount in the contemporary world.[36] Feminist clinicians have supported 'New Writing'-type projects in adopting narrative practices that privilege 'patient' subjectivity, contextualize experiences of mental distress, and make mental illness and the 'mentally ill' intelligible to mental health professionals and associated 'others' (Bracken & Thomas, 2005). These practices act, in part, as 'corrective' responses to the dubious ways in which narrative is often employed to support hegemonic nosological systems and treatment paradigms, mediate patient-'clinic' relations, and consolidate medical professionals' social authority (Bracken & Thomas, 2005).

Although non-feminist-identified clinicians may also seize narrative's potential as a political and/or therapeutic tool, feminist clinicians have pioneered its use as an explicitly *activist* instrument on which they have relied in critiquing the mental health establishment and proposing measures to rectify its social, clinical, and political 'wrongs' (Caplan & Cosgrove, 2004). Their (quintessentially feminist) critiques have targeted institutional and interpersonal power relations within mental health domains and employed intersectional analyses and political consciousness raising as tools in exposing

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orientation have affected the classification of human beings into categories of psychiatric diagnosis (Caplan and Cosgrove 2004, xiv). Moreover, the AWP has also brought feminist frameworks of 'gender politics' to bear in clinical settings. Meant here as: "the experience of women (and men) as affected by the operation (and abuse) of power in interpersonal and institutional settings" (xv).

[36] Although a full consideration of such programs is beyond the scope of this project, I am interested in considering their basic stakes, features, and players.

and countering the marginalization of women in mental health fields and mental health fields' marginalization and oppression of women in society at large (Caplan & Cosgrove, 2004). These clinicians' application of feminist political theory and social criticism, as well as their adaptation of feminist activist models within and outside their 'home' institutions has led them to imagine storytelling as a means of contextualizing women's (and other clients') experiences of mental distress within the systems of inequality through which they ultimately are mediated. It also facilitated their empathic engagement with clients and bolstered their understanding of oppression in clients' everyday lives. Feminist clinicians used the moral and political awareness subsequently inspired to devise more effective, ethically-directed treatment practices that made clients subjects—not objects—of clinical 'intervention' (Bracken & Thomas, 2005; Caplan & Cosgrove, 2004; Chesler, 2005).

By re-imagining and enlisting narrative in this 'New' way, feminist clinicians have used narrative consciousness to make women the center of their own treatment and, thus, improve clinical care. They have also helped 'rewrite' the social and medical roles of 'Clinician' and 'Patient' in ways that disrupt the larger systems and discourses of power that oversee and administrate mental illness in contemporary culture. Feminist clinicians, to this extent, have employed narrative and storytelling as forms of 'New Writing' social activism in (re-)writing mental illness as 'theory' and 'cultural phenomena.'[37] They also have broken 'New' narrative-praxis ground and further positioned 'the interdisciplinary' and 'the political' at the center of twenty-first century mental health narrative work by 'blurring' scholarly and popular genres to support

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[37] I am invoking Denzin's (1997) assertion that 'Sixth Moment' narrative work recognizes that "those who write culture also write theory and those who write theory write culture" (xii).

progressive advocacy within and outside their fields (Caplan & Cosgrove, 2004; Chesler, 2005).

Feminist clinicians' narrative efforts to challenge bias and discrimination against women in mental health domains, improve care for women suffering with mental distress, and contest the subjugation of women in general culture carry broader implications for mental health storytelling (Chesler, 2005). The practical, political, and moral force of their efforts indicates that 'the interdisciplinary' and 'the political' can and should serve as primary venues for and values of 'good' twenty-first century narrative enterprise in mental health. Although Denzin (1997) describes 'writing across genres' as the primary mechanism of interdisciplinarity in a 'New Writing' era, feminist clinicians take 'the interdisciplinary' literally in bringing comprehensive, integrated, and politically conscientious treatment models to clinical praxis. They often couple their professional training with work in feminist political theory, social welfare policy, and public health, as well as collaborate with feminists working primarily in these fields (Caplan & Cosgrove, 2004; Chesler, 2005).

Feminist clinicians' trailblazing work in establishing this type of *socio-clinical* interdisciplinarity, therefore, sets an important standard for the 'New Writing' and other forms of mental health storytelling that seek to story mental illness and/or publicize mental health issues. Just as feminist clinicians must incorporate 'New Writing' moral awareness and social action into their professional practices, 'New Writers' must approach their narrative treatments of mental illness with the type of comprehensiveness and care feminist clinicians demonstrate. In short, these writers must understand that addressing mental illness's multi-facetedness is essential to producing and circulating information about it that is accurate, ethically directed, and *meaningful* to mental health communities. Keepers of 'next-generation' mental health texts, therefore, face the daunting task of diversifying and politicizing their narrative work while grounding its purpose and machinery in 'the ethical.'

Bp Magazine and BP Texts in the Twenty-First Century

Bp Magazine exemplifies a 'next-generation' text that has tasked itself with meeting the contemporary era's new narrative, political, and ethical demands. *Bp* embraces the interdisciplinarity championed by feminist clinicians as crucial to generating compelling and actionable mental health storytelling in the decades to come. The magazine also has assumed the narrative character and mission that Denzin (1997) assigns the "New Writing" in this 'Sixth Moment' of progressive narrative practice. The upstart publication, however, does not assume the moral and (explicitly) political orientation that Denzin deems definitive of this 'New' narrative work as writing and textual production that promises to 'change, not just interpret' the world. *Bp Magazine,* therefore, acts as a valuable test case in examining the potential difficulties and rewards that 'next generation' BP texts are likely to encounter in orienting their 'work' toward 'the political' and 'the interdisciplinary' in an increasingly 'digitized,' 'hybridized' narrative world (Ryan, 2006). As indicated, however, *bp* is most useful for giving a textual face to the political existential dilemma with which *all* mental health-based narrative projects must contend if they hope to generate and find productive application for future 'good' narrative work.

I begin my analysis of *bp* by checking its 'political' and 'interdisciplinary' bearings via a survey of its content, format, and 'catalogue.' Following this general anatomization, I establish feminism as a critical analytical overlay in explicating *bp's* promise as a twenty-first century text capable of acting as a 'literature' for mental health-based movements—a politico-textual orientation for which I imagine *Ms. Magazine* a template. Although my analysis of *bp* recognizes the importance of its corresponding online resources in distinguishing its narrative 'work,' it is less interested in exploring this digital material as a separate 'content' than in considering the magazine's digital forays as indicators of its incorporation of the hybridized narrative forms and media that will mark manic-depressive storytelling in an increasingly 'transmedial' era (Ryan , 2006).

Bp *as 'Text:' Survey and Anatomization*

Bp is an organized tangle of original features, derivative news, self-help columns, and reader forums stretched across the glossy pages of its slender issues, published quarterly since 2004. The *bp* 'catalogue' is distinguished by its dedication to providing readers comprehensive but practical and accessible information about managing manic-depressive symptoms, treatment regimes, and personal or professional 'fall-out' in their everyday lives. The magazine's staff manages this ambitious range of content with considerable focus by positioning its mission to act 'as a beacon of hope' for people living with bipolar disorder as a principal editorial sieve.[38] *Bp* does more than simply offer compulsive 'hopeful' overtures to its readers, however, and exploits the versatility of the magazine genre to convene under one narrative roof every type of 'good' narrative and 'New Writing' championed in this project. Its commitment to working across genres and fields—in short, its 'interdisciplinarity'—is rooted firmly in its biopsychosocial

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[38] *Bp* is so committed to this mission that it also gives 'hope' top billing on the magazine's cover (via the tagline "Hope and Harmony for People with Bipolar"), in its website address (bphope.com), and even in its telephone number (1-877-575-HOPE).

understanding of manic-depressive illness itself. The magazine recognized 'the interdisciplinary' as a practical project governing its readers' lives and shrewdly made it one of its own. In privileging this multi-dimensionality and structuring itself textually to accommodate it accordingly, *bp* underscores that 'good' twenty-first century narratives must be, above all else, as agile and multifaceted as the illness(es) they story.

Bp's readers are central players in the magazine's 'apparatus' and content. Their *personal stories* permeate the magazine's pages and serve as one of the most distinguishing features of its narrative anatomy and 'work.' These stories function less like a guiding thread or narrative scaffolding, however, than a circulatory system that infuses *bp's* content with human weight and consequence. In short, readers' personal stories allow the magazine to *be* something rather than just *do* something. The *"Sound Off!"* forums published in every *bp* issue also insert readers into the body of the magazine. These forums reproduce reader feedback on a topic loosely organizing the issue itself, such as dealing with a particular manic-depressive symptom (e.g. anger, hypersexuality, and insomnia), making treatment-related decisions (e.g. maintaining medication adherence, starting ECT, and finding a medical team), and coping with the illness's devastating impact on one's relationships (e.g. making amends with loved ones, maintaining a marriage or partnership, and overcoming BP-related challenges in one's friendships). These forums, therefore, effectively act as collections of personal stories in 'reader feedback' guise. Although they most often work in the employ of *bp's* requisite 'hopefulness,' their steady filtration of reader resolve occasionally gives way to resignation and 'struggle' unimpressed by 'everything done right.' Positive-pitched mental health publications often stumble in confronting these harsh realities in print, however, the legitimacy of a magazine founded upon 'Hope' hinges on its grasp of the Hopelessness against which it has set itself. *Bp* is rare among its contemporaries for its willingness to risk the dreaded contagion of failure and demoralization that the airing of these stories is feared to unleash.

A trio of columnists rounds out the most distinctive features of *bp's* textual infrastructure. Julie Fast is known for high-profile book collaborations with clinicians and, therefore, devotes much of her column, "Fast Talk," to addressing reader concerns about medication, patient-doctor relationships, and treatment protocols. In contrast, Jeff Probst's column, "Mind Over Mood," reproduces motivational and 'self-help' materials drawn from his life coaching business that offer readers encouragement and self-care suggestions. Lizzie Simon's column, "20-Something" (recently renamed "30-Something" in accordance with Simon's aging) shares its counterparts' topical interests but addresses them from a younger generation's perspective. Simon's column recognizes that most people experience the onset of manic depression during adolescence and young adulthood. Most of its content, therefore, aspires to help young people negotiate the unique challenges that manic-depressive illness generates by disrupting young lives in the *prime* of life.[39] Importantly, these three columns, like most articles published in the *bp* catalogue, include a list of 'tips' submitted by the author (and/or his or her 'subject') that provide readers with practical advice about managing manic-depression. These tips act as one of the magazine's most community-spirited narrative gestures and go a long way in honoring its mission to be useful in its readers' everyday lives.

'Movement' Literature: Ms. *and* Bp.

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[39] Interestingly, *bp* published a cover story in 2007 called, "Growing Old BP: A New Specialty Emerges," that also recognizes the unique challenges of BP management at the other end of the life cycle.

Feminists know a thing or two about publishing a politically progressive magazine in the mainstream press, all but inventing the genre with the debut of *Ms. Magazine* in 1972 (Baumgardner & Richards, 2000). Feminist scholarship (Baumgardner & Richards, 2000; Rosen, 2000) tracking *Ms.'s* triumphs and failures over four (plus) decades of publication has produced a rich archive of commentary and analysis from which mental health and other narratively enterprising political communities may draw in negotiating the travails of their own activist media. I draw from the most recent layer of this scholarly sedimentation in adapting Baumgardner and Richards's (2000) analysis of *Ms.'s* enduring value to feminist communities to a study of *bp's* promise and durability as a 'next generation' BP text. My primary contention is that *bp's* strengths—its dexterity, pragmatism, and timeliness—are insufficient in ensuring the magazine's value in/for BP communities because they do not account for its primary failing as a *political* asset to mental health communities: although *bp* is driven in its political convictions, it is not 'called' to them in the way that *Ms.* is 'called' to feminism. I determine, therefore, that *bp's* 'place' within progressive twenty-first century narrative enterprise rests in its ability to re-envision itself (ideo-politically and materially) as the 'literature of a movement.' Although *bp* adopts this posture only anemically now, I argue that it may borrow from its feminist counterpart's narrative skill-set in making the politico-textual adjustments necessary to negotiate successfully 'the political' in a twenty-first century world.

Bp and *Ms. Magazine* are both progressive publications charged with convening, informing, and mobilizing diverse readerships on shoestring budgets in a notoriously cutthroat publishing industry. *Ms.'s* political sensibilities are far more radical than *bp's*, however, as evidenced by its conceptualization of readers as constituencies to be transformed into a well-educated, politically-galvanized movement base (Baumgardner & Richards, 2000). Although they are stuck in similarly unfortunate cultural and commercial ‘boats,’ the two magazines bear significantly different political prerogatives in piloting their ‘vessels’ through contemporary politico-textual waters, relying on significantly different rudders, motors, and deckhands in serving the dictates of their respective ‘motherships.’ After all, Mental Health is, first and foremost, an industry—not a movement or a ‘cause.’ This industry is a chaotic nexus of people, systems, institutions, and stakeholder interests vying for turf, resources, and paths-of-least-resistance in the gridlock that defines so much of its produce and work.

The inscrutable array of functions by which the actors in this industry come to perform their ‘work’ generate a workforce, a clientele, and a patronage—not the foot soldiers of a movement. Celebrated consumer-activist Larry Fricks succinctly articulates the priorities ordinary ‘consumers’ bring to this Mess in noting that, rather than reflecting political convictions or ambition, they reveal a longing for the basic units of human life: “a job, a home, and a date” (Bergeson, 2006, p. 496). Political scheming and substantive social change are difficult to imagine as ports of destination when staying shipside on a sinking, leaking, or otherwise irresolute boat overwhelms the business of everyday life. The inability to envision itself beyond the exigencies of the present political moment, however, is at the heart of *bp’s* (and Mental Health’s) political existential dilemma in the twenty-first century. Feminism’s continual re-mapping of ‘the political’ offers some direction to mental health advocates in moving their work beyond this limited line of political sight, and *Ms. Magazine’s* rise as a feminist media institution offers ‘next-generation' BP texts a model for orienting themselves toward 'the political' as potential 'literatures' for mental health movements in the decades to come.

The 'media sins.' Jennifer Baumgardner and Amy Richards (2000) certify *Ms.'s* value as feminist activist media by charting its performance against "Seven Deadly Media Sins Against Women" commonly perpetrated in/by the mainstream press. Their application of these criteria produces a critical framework within which to consider *bp's* own merits and liabilities as a progressive narrative project. The proceeding analysis, therefore, engages *bp* and *Ms. Magazine* dialogically across these evaluative terms and appropriates the enumerative structure of Baumgardner and Richards's 'Media Sins' framework:

1). *Ms. Magazine* crashed "The Byline Boys' Club" that dominated American publishing in the 1970s by cultivating a feminist 'press' that influenced popular media and gender politics in American culture for decades to come (Baumgardner & Richards, 2000, pp. 100-101). *Bp Magazine* has confronted its own 'by-line' woes with similar initiative, countering stigma-fuelled marginalization of mental illness and the 'mentally ill' in the media by developing a 'press' of *its* own. The magazine privileges work written by, about, and for people living with manic-depressive illness, offering a (admittedly tiny) pool of BP journalists, commentators, and industry professionals a narrative platform from which to write responsibly (and personally) about mental health issues. Similar opportunities are scarce in the mainstream press and often require journalists/writers to make concessions in their long-term investments in the mental health 'beat.'

2). “Cosmo-Girl Myopia” refers to shortsighted feminist critiques of women’s objectification in the media that focus solely on critical readings of advertising imagery (Baumgardner & Richards, 2000, p. 103). *Ms*. averts this transgression by coupling its skewering of sexist ads with the systematic application of a stringent gendered lens to its own and other magazines’ editorial content (pp. 103-104). *Bp* is less diligent in combating its own myopic demons; in fact, it rarely even comments (let alone comments critically) on the ‘big’ elephant dominating its Narrative room: big Pharma sponsorship and its potential influence on the magazine’s content. Although the exact nature and impact of this influence is beyond the scope of this study, Marcia Angell’s *The Truth About the Drug Companies: How They Deceive Us and What to do About It* (2004) suggests that it is always fair to assume drug company connivance in *trying* to manipulate the recipients of its ‘sponsorship.’ She notes that these companies typically exert their power and influence via direct-to-consumer advertising, sales visits, the distribution of ‘free samples,’ medical journal advertisements, and the subsidization or ‘fronting’ of patient advocacy groups (p. 123). *Bp’s* publisher, Joanne Doan, does not even feign ‘*myopic’* critique of these companies and their shenanigans. Her issuance of reassurances to readers about big Pharma’s benignity to the magazine’s content (Fall 2006, p. 10), however, also obscures the larger problem that Angell (2004) describes as being at hand: drug companies laundering their fleecing of everyday people, in part, through ‘stealth-marketing’ sponsorship of patient advocacy groups and initiatives, including the type of funding that *bp* receives (p. 123).

3). “The Scare Strategy” refers to the mainstream media practice of bombarding women with erroneous, sensationalist stories about threats to their safety and well-being (e.g. women of a certain age are more attractive as terrorist targets than life partners) as a means of 'punishing' them for making feminist-minded choices and partaking in hard-won civil rights (Baumgardner & Richards, 2000, pp. 103-104). Although *Ms*. dutifully reports on the everyday violence women encounter in American culture, Baumgardner and Richards note that its coverage is cast in exhortation to 'Get out, change the laws, and press charges' and resists fear-mongering that would keep them locked away in the 'safety' of their homes (p. 115). *Bp Magazine* is equally stalwart in claiming a productive place for BPs in public life, even as it documents the struggles they do and will encounter there. The permutation of the 'scare strategy' against which *bp* must battle is rooted in 'sanism' not misogyny, however, and its charge against 'fear-mongering' centers on widespread media demonization of the mentally ill (Perlin, 2000; Stefan, 2001). Ultimately, *bp* also resists this 'sin' by accompanying its reporting on readers' illness-based struggles with its unwavering support for their full participation in public domains and continual affirmation of their illness-based identities.

4). Baumgardner and Richards (2000) argue that *Ms*.'s ideo-political and commercial investments in diverse 'feminisms' have not exempted it from the sin of "Unequal Time." They note that *Ms.'s* popular circulation catapulted mostly white, mainstream feminists, such as Gloria Steinem and Naomi Wolf, into the public limelight while further marginalizing 'radical,' lesbian, and/or feminists of color (p. 105). In garnering disproportionate 'time,' these 'celebrity feminists' also amassed disproportionate political and cultural capital that skewed the magazine's—and its movement's— power structures even further toward its white, middle-class, straight and mainstream 'liberal' political leanings (pp. 105-106).

Bp also cedes an inordinate amount of its ‘time’ to celebrities, relinquishing roughly one-third of its covers (and even more of its secondary content) to famous BPs like Carrie Fisher, Jane Pauley, and Patty Duke. Although *bp* readers often protest this celebrity overexposure in letters to the editor and ‘Sound-off’ entries, the magazine’s leadership staunchly defends its use of celebrity spokespeople. It has opted instead to address reader concerns about ‘time’ disparities and the narrative hierarchies they both create and sustain by more systematically inserting ordinary BPs into its ‘lead’ content. For example, *bp* has devoted more cover space and copy to feature stories like, “Six Personal Stories: ‘People Like Me’” (Solovitch, 2006, pp. 28-39) and “The Many Faces and Facets of BP” (Roberts, 2007, pp. 33-40). Despite these commendable efforts, *bp* and other mental health press outlets will likely continue their ‘superdependence’ on celebrity spokespeople in (at least) the decade to come; famous BPs not only sell magazines, they sell mental health issues and communities.

5). Baumgardner and Richards (2000) hail *Ms*.’s journalistic rigor as its safeguard against the “Internet Incontinence” that runs rampant in online news and commentary today as a result of its reliance on largely unverified, hastily produced reporting (pp. 106-107). Although *bp* lacks *Ms*.’s journalistic chops and ambition, its judicious reporting practices and commitments to editorial accountability help forestall its commission of this ‘sin.’ A well-credentialed editorial board oversees *bp’s* content, and the magazine’s editors/writers excerpt most of its news and informational materials from verifiable, reliable sources. For example, the magazine’s “Newsline,” “Researchline,” and “Industry News” sections (all pillars of its narrative infrastructure) draw from reputable medical and public health journals in distilling the latest BP-related news in mental health politics, medical research, and pharmaceutical enterprise. *Bp* also has invested heavily in the Internet but employs it 'continently' in complementing and/or supplementing its print materials. The magazine's online community keeps readers connected between issue publication and offers them support in the event that their access to resources is insufficient or limited by stigma, geography, or material means. *Bp's* use of digital/e-technologies provides an early model of manic-depressive narrative work that has adapted productively to the narrative hybridization and multi-mediality that will attend effective storytelling in the twenty-first century (Denzin, 1997; Ryan, 2006).

6). The "Only Uber-Victims Need Apply" 'sin' refers to the media's tendency to avoid offending advertisers (politically or aesthetically) by placing women "who have been truly victimized but whose stories have been cosmetically enhanced for the magazine" at the center of stories about 'real' women struggling with 'real-life' social issues (Baumgardner & Richards, 2000, pp. 108-109). *Ms*. recognizes that 'uber-victims' only obstruct readers' connection to *real* 'victims' and social marginalization, therefore, it has eschewed the use of "correct victims" and cover models to sell 'real' stories (p. 115). Mainstream advertisers' reluctance "to be near (or even in the same issue as) anything depressing or political" (p. 110) might account, however, for *bp's* inability to attract non-big Pharma advertising suitors that it may one day alienate with non-cosmetically enhanced 'any-victims' of its own. *Bp's* publisher, Joanne Doan, responded to mounting reader concerns about the preponderance of drug ads in the magazine by confessing outright in an open letter that *bp* simply did not have other sponsorship offers. Although *bp* welcomes mainstream advertisers, Doan (2006) suggests that the stigma associated with mental illness has discouraged their interest in the magazine (p. 10).

Without these other sources of revenue (whatever *their* problems may be), *bp's* dependence on 'drug' money only thickens, as does its incentive to rely on celebrity spokespeople in selling magazines and mental health issues. Despite these problems and occasional genuflection to 'success stories' (another variation of the 'uber-victim' typology), *bp* proves morally opposed to sugarcoating manic-depressive experience. Like *Ms*., it resists the exaltation of 'correct victims' or 'poster children' (beyond the celebrities already filling that role) and even recognizes with some frequency that 'just getting by' and BP people in all states of health are laudable goals and subjects worth covering.

7). *Ms.'s* associations with a radical movement and tumultuous era have made it both a target and co-conspirator in media gang-ups against "Magazine[s] Everyone Loves to Hate" (Baumgardner & Richards, 2000, p. 110). As the first feminist magazine to circulate widely in American culture, *Ms*. set new parameters in the publishing industry by nudging its more traditional counterparts slightly to the left of where they had been on the political dial. *Ms*., in this sense, functioned as "a kind of unpaid research service for the rest of the media, both in its pages and as a result of its editors' willingness to help other editors [and] TV researchers" (p. 115). Mainstream women's magazines proved key beneficiaries of *Ms.'s* 'services,' as the programs of "self improvement" they propagated "[couldn't] go very far in a sexist culture." Moreover, *Ms.'s* infusion of political consciousness into their pages helped counter those magazines' popularization of the "change yourself, and then there will be no discrimination" approach to social change—revealing that it "places prejudices and violence on the shoulders of the victim rather than…those who make the laws that support these injustices in our culture" (p. 112).

Bp, in contrast, is a young publication with no 'enemies' or controversial cultural freight. It does, however, aspire to serve a similar 'clearinghouse' function in distributing information about manic-depressive illness and other mental health issues to everyday BPs, mental health professionals, and the general public. Nevertheless, *bp* must follow more deliberately in its feminist counterpart's footsteps by bringing a more rigorous political 'edge' to its content—especially *its* 'self-improvement' features. Baumgardner and Richards's (2002) review of *Ms*. underscores that the politicization and collectivization of personal struggle are essential to transforming a 'progressively-bent' magazine into a politically relevant device or 'literature.' They also note that *Ms*. has succeeded narratively because it has aligned itself *explicitly* with larger feminist interventions into the social justice issues and political contests that animate its narrative content.

Bp's mixed performance in the 'media sins' analysis detailed above suggests that it has plenty of room for improvement in satisfying the political, ethical, and narrative dictates of 'next-generation' texts outlined in this chapter. Although the magazine's negotiation of 'the political' was particularly troubled, its command of 'the interdisciplinary' was exceptional. *Bp's* biopsychosocial approach to addressing manic-depressive illness, as well as its inventive blurring of genres to provide readers the most comprehensive information possible about managing their illnesses, are its most important contributions to setting a course for twenty-first century narrative enterprise.

This chapter has positioned ‘the political’ and ‘the interdisciplinary’ as primary venues and values for this future narrative work and has identified feminist mental health clinicians and the ‘New Writing’ as its key politico-narrative activists. Furthermore, this chapter has supported this project’s larger explication of ‘the ethical’ as the philosophical *order* of manic-depressive and other mental illness-based narrative work. Twenty-first century scholars, clinicians, and storytellers, therefore, must orient themselves toward ‘the ethical’ if they hope to uncover not only how ‘narrative matters’ to people living with mental illness, but also why it *must* in the decades to come.

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