

TOO MUCH INFORMATION:
AGENCY AND DISRUPTIONS OF POWER IN PERSONAL NARRATIVES OF
MENTAL ILLNESS AND SUFFERING

by

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DEDICATION

To E.H.B, C.W.J., C.M., J.L.M., A.N., and C.L.V.

and

In loving memory of George C. W. Chun and Lei Muraki Chun

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ABSTRACT

Healing in the mental health system of the 21st century is difficult as the credibility of mental health users is constantly called into question, their experiences and perceptions of their “illness” undervalued or even completely ignored. This attitude towards mental health users must be changed in order to work towards truly alleviating mental illness and suffering.

Careful analysis of the rhetoric of published personal narratives written by women describing their experiences with mental healthcare reveals the ways in which medical knowledge is created, owned, and disseminated only by the “authoritative expert,” defined as healthcare professionals who categorize, taxonomize, and pathologize in order to treat both physical and mental illness. I argue the authoritative expert marginalizes the “everyday expert,” exemplified through the perceptions of women who, in their narratives, record realities that do not always match the diagnoses and prognoses assigned to them by their healthcare providers. My project’s central question asks: In what ways do personal narratives of mental illness and suffering illuminate the ways in which language constructs reality?

My research illuminates the ways in which narratives of mental illness and suffering are healing, and thus serves as an advocate for patient rights, both by empowering patients and by furthering discussion among medical professionals regarding problematizing “standard” treatment. My work advances the connection between politics and language as it takes a commonly undervalued form of language and lived experience—narrative—and researches the ways in which it has been and can continue to

ABSTRACT—*Continued*

be used as a powerful political agent to empower mental health users by giving them a voice. Specifically, I demonstrate how patients' personal experiences should and can be valued as a way to illuminate their own understanding of their dis/ease as well as to inform their treatment.

This project lays the foundation for future research examining ways treatment for mental illness should be differentiated from treatment for physical illness. I am interested in ways to further combat the stigma of mental illness by looking at ways providers can honor and respect the opinions and values of mental health patients in non-pejorative ways.

CHAPTER ONE: INTRODUCTION—THE AUTHORITATIVE EXPERT, THE
EVERYDAY EXPERT, AGENCY AND THIRD-SPACE

“People define you by your problems,” I was once told, and this continues to haunt me. I have been taught to keep things inside, to “bottle them up,” and a part of me wants to rebel completely from such mandates, to disclose what I please to whomever I please. I tend to go from one extreme to the other. My dissertation is born out of an awakening that encourages me to think past such linear thinking, to not see things as “either/or” but rather to question the framework completely. Questioning the framework means approaching the issue of self-disclosure from another angle. Questioning the framework means replacing inquiries regarding whether people do, indeed, define me by my problems and even the perhaps naïve belief that some people won’t define me by my problems, no matter what I say. Questioning the framework means embracing third-space: moving past identity, the notion of a static self, and discourses that would construct absolutes, in order to transform ways of understanding and existing in the world, the ways in which we live.

Joan Didion famously asserts that, “we tell ourselves stories in order to live.” This dissertation examines one aspect in which stories enable us to live. Here, I examine the rhetorical function of everyday stories about mental illness and suffering. Specifically, I research narratives authored by those writers detailing their journeys through mental healthcare as recipients, a group I understand to be composed of people in a range of complex positions. My project’s central question asks: How do personal narratives of mental illness and suffering illuminate the ways in which language constructs reality?

Critical to answering this question is an appreciation of how these narratives inform and are informed by third-space. In particular, I exemplify the ways in which medical knowledge is created, owned, and disseminated primarily by the “authoritative expert,” defined as healthcare professionals who categorize, taxonomize, and pathologize in order to treat both physical and mental illness. I argue the authoritative expert marginalizes the “everyday expert,” defined as healthcare recipients whose experiences are commonly non-dominant in medicalized forms of knowledge. Recognizing the everyday expert—especially as s/he brings together both authorized and unauthorized knowledges—means recognizing third-space and the ways in which narrative disrupts the commonly understood sources of medical knowledge.

Based on its potential to illuminate the ways in which narratives of mental illness and suffering are healing, my project functions as a way to advocate for patient rights, both by bolstering a patient’s self-validation and by furthering discussion among medical professionals regarding problematizing “standard” treatment. This dissertation scrutinizes the connection between politics and language as it researches the ways in which narrative has been, and can continue to be, used as a powerful political agent to empower mental health users. Bruce M.Z. Cohen, in his 2008 *Mental Health User Narratives*, declares that “narrative work within medicine and the social sciences [...] calls for a reassessment of the way we research mental health users, arguing that users are active participants and experts on their own state of being” (xi). My project supports Cohen’s call for such a reassessment. I believe mental health users are active participants and experts on their own state of being and should be treated as such by their healthcare providers.

Specifically, I will demonstrate how patients' personal experiences should and can be valued as a way to illuminate their own understanding of their dis/ease as well as to inform their treatment.

Throughout this project, I refer to the narratives of peoples' encounters with the mental health system as personal narratives of mental illness and suffering. I use the terms "illness" and "suffering" deliberately. My reason for using "illness" echoes Frederick White's description of the concept. White explains that

"Disease" is the clinical term for a medical condition; for example, cancer is a disease. "Illness," however, is the experience of being sick—the lived experience of certain ailments. It is in view of this distinction that we can talk about illness narrative as the explication of how it feels to be ill—what one experiences physically, emotionally, and psychologically when one suffers from a disease [...]. Illness narrative makes public a private experience, competes for an individual voice against the powerful voices of medicine, and balances the illness experience against the life as a larger whole. (68)

Rather than categorize these narratives with stigmatizing labels in an attempt to identify the particular genre I am analyzing, I have tried to emphasize the personal experience over the diagnostic label. Additionally, given that "illness" is connected with "disease," which is itself defined by White as a "clinical term for a *medical* condition," I include "suffering" with my description to acknowledge the validity of pain that might not "officially" be recognized as a medical condition. I focus on mental illness and suffering

specifically in order to explore a medical field where the dominance of authoritative knowledge is particularly insidious, as the validity of everyday contexts and knowledges is especially tenuous as a result of characteristics associated with mental disease as a whole.

I have designed my project to enact in form that which I argue, through its content, is valuable. That is, because I am studying the rhetoric, and demonstrating the value, of personal experience as a source of knowledge, my intention for this project has been to move in “seamless transition from spellbinding autobiography to scintillating theoretical analysis” (Rudnytsky 11). Part of what is at stake for me in this project is the implementation of my own experiences as constructive and instructive for others. I am thus advocating the value of others’ personal experiences, in part, by drawing from my own personal experiences.

This project examines how personal narratives of mental illness and suffering provide agency to both their authors and readers and disrupt hierarchical power structures within the healthcare system. In this chapter I concentrate on scholarship that defines four areas: the authoritative expert, the everyday expert, third-space, and the function of narrative. These concepts provide the foundation for my analysis of personal narratives. Scholarship concerning the authoritative expert incorporates texts discussing medical knowledge and discourse as authorized/dominant knowledge and discourse. Scholarship concerning the everyday expert incorporates texts that either comment discursively on or themselves recount how personal narratives of illness and suffering are currently

emplotted¹ in relation to authorized forms of knowledge. Scholarship concerning third-space considers the juxtaposition of authoritative and everyday forms of knowledge, investigating new ways of being and knowing. Finally, scholarship concerning the function of narrative considers how such functions can be determined. This discussion segues into my description of the framework for the rest of the project, which analyzes select narratives.

The Authoritative Expert

My discussion of the authoritative expert is, in part, grounded by Michel Foucault's exposition of privileged forms of knowing and being. In *Birth of the Clinic*, Foucault analyzes medical discourse, tracing the ways in which the field's approach to the concept of the individual as a relational being has evolved. Specifically, Foucault's delineation detailing the medical field's separation of knowledge regarding pathology from the individual patient characterizes the separation of objective versus subjective knowledge. In this instance, subjective knowledge refers to an individual's perception of his or her experience, in contrast to objective knowledge understood as viewing the "overall" picture from a distance thus enabling unbiased and detached pronouncements. Foucault's exposition of the subjective and the objective also involves recognizing the medical field's appreciation of the objective—detached and therefore scientific and closer

¹ Diane R. Wiener's "A Meditation on Depression, Time, and Narrative Peregrination in the Film *The Hours*" in *Depression and Narrative: Telling the Dark* (2008) describes "emplotment" as a term that was "developed by philosopher Paul Ricoeur and has been adapted by numerous writers from a range of disciplines to describe the processes by which subjects are repeatedly placed, place themselves, and may resist placement in relation to specific identities, stories, images, histories, events, meanings, and so on" (157).

to the “truth”—*over* the subjective—biased towards a particular viewpoint built upon mercurial emotions and therefore unreliable.

According to Cohen, medical discourse contained within the field of psychiatry echoes a favoring of the objective over the subjective. Cohen explains that “psychiatry has a myth of choice—the choice of treatment, to engage with staff, to accept diagnosis, to change doctors and so forth—whereas in reality there is little choice. The bottom line remains biomedical treatment” (*Mental Health User Narratives* 179). Biomedical treatment is in some ways synonymous with a regard for the detached over the personal, as Judith Segal explains in her 1994 “Patient Compliance, the Rhetoric of Rhetoric, and the Rhetoric of Persuasion.” Quoting Howard Stern’s 1990 *American Medicine as Culture*, Segal portrays biomedicine as centered around the beliefs that (1) “medical science is and should be based upon rational, scientific, dispassionate, objective, professional judgment” and (2) “disease and its attendant suffering are ultimately to be understood in terms of pathological entity, organic in nature, and that treatment optimally consists of a technological procedure or intervention that results in a cure” (Stein xiv qtd. in Segal 93). This characterization of biomedicine highlights how rationality is equated with detachment that itself is viewed as objective and therefore scientific. Segal points out that in correlation with these beliefs, “a significant feature of biomedical practice is distance between the physician and patient [...]. [T]he patient, who adopts a ‘sick role’ in order to be a patient, is necessarily the *other*” (93). While this separation is purported to “protect the physician from devastation [and from becoming] overwhelmed by suffering [...] one consequence of the distance [...] is dialogic incommensurability” (93, 94). This

disparity remains even when “doctors and patients are ‘pals’” and “patients [...] are themselves physicians” (95). The immutable otherness of the patient is integral to the biomedical model. The belief that a personal account of one’s illness must be measured against supposedly objective psychiatric diagnostic criteria aligns with Michel Foucault’s description of authorized forms of knowing. In particular, forms of knowing that view a situation from a distance are believed to enable unbiased conclusions, and therefore are authorized over personal, subjective, and therefore biased ways of knowing.

Exemplifying Cohen’s observation that psychiatry is based on biomedical treatment is the 2007 “Reports from the Psych Wars,” in which Richard Ingram reports on the function of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM, created by the American Psychiatric Association, is meant to be a near-comprehensive listing of mental health disorders and their characteristics and manifestations. Ingram explains that while “the DSM may once have been compiled from ‘case studies,’ or narratives of investigation into the aetiology and trajectory of ‘mental disorders’ [...] a threshold has been crossed so that it is the lives of patients that are now expected to conform to the models of ‘mental disorders,’ rather than the other way round” (240). Seen in this light, the DSM, which provides the primary framework for diagnoses in mental health, represents an authorized form of psychiatric knowledge that obscures the individual patient’s experiences in favor of “objective” models that can be generalized to the greatest number of patients—the description of the mental disorder takes precedence over the individual experience of illness.

In her 2008 study “Fact Sheets as Gendered Narratives of Depression,” Linda M. McMullen refines descriptions of the subjective as the devalued individual to focus on the marginalized woman. Upon discovering that “‘official’ psychological narratives of depression [...] fail to include story lines from lay women’s accounts,” McMullen declares that such findings “suggest that [lay women’s accounts] have not achieved the status of evidence in the judgment of many experts” (138). Understanding objective accounts as a privileged form of discourse over the subjective accounts of women specifically details my investigation of authoritative forms of knowledge to include an analysis of societal functions of gender. In her 2008 *Sciences from Below*, Sandra Harding analyzes manifestations of gender bias in her critique of the binary between “institutions of Western modernity and their scientific and political philosophies, designed by and for men in elite classes” and “‘the feminine’ and ‘the primitive’” (2). Harding uses the terms of “the feminine and the primitive” to refer to “the needs and desires of women and of traditional cultures as irrational, incomprehensible, and irrelevant—or even a powerful obstacle—to ideals and strategies for social progress” (3). Juxtaposing Harding and Foucault creates a more comprehensive picture of that which composes privileged forms of knowledge. A description of these privileged forms of knowledge echoes the values of biomedicine: “objectivity, rationality, good method, real science, social progress [and] civilization” (Harding 3). Harding explains that championing values such as objectivity and rationality reflects a “conflat[ion] [of] the West’s idealized understandings of its own practices with the universal human impulse to understand ourselves and the world around us in ways that permit effective interactions

with such worlds” (4). Authorized forms of knowledge thus lack accountability from everyday users, as self-analyses of strengths and limitations take place “only ‘from above’” and often refrain from “taking the standpoint of women and the world’s other least-advantaged citizens on such topics” (Harding 5). Chronicling her interactions in talk therapy, Adrienne Ross observes, “My therapist had her own answers. Therapy’s core dogma is that the therapist sees what the client cannot” (157). Ross’ experience provides a concrete example of the distancing authoritative knowledge can adopt, a distancing that can discredit the validity of everyday knowledge. As Harding insightfully points out, “dominant groups cannot understand the nature and causes of their own social situations if they examine such topics only from their own ‘native’ perspectives” (14). Explained this way, the objectivity championed in biomedicine becomes dangerous as this form of authorized knowledge obscures other ways of seeing and knowing.

In medicine, authorized forms of knowledge affect the doctor-patient relationship, as so-called objective medical knowledge can discredit subjective individual experiences. In her 2002 “Foreword: Women as Subjects of Their Experiences” to the anthology *Women’s Encounters with the Mental Health Establishment: Escaping the Yellow Wallpaper*, Kelley L. Phillips addresses those who work in the mental health field, detailing the damaging effects of medical approaches based on “objective science.” Phillips points out to her colleagues that

Those of us who work in the mental health field [...] usually offer [methods] from the perspective of clinicians and scientists who capture at best one or two dimensions of an individual. We often lose the real person

with these approaches. We measure what we know how to measure, not what is. We attempt to offer empathy, skills, and techniques to assist with healing for those who seek our help. Yet, the current environment, structure, and discourse are often not conducive to women's healing [...]. We know a little about disease but not much about women and the reality of their lives [...] We cling to a duality of mind and body and thus we miss the complex, multidimensional person altogether. (xxi)

Far from being an attack on the intentions of mental healthcare providers, Phillips' observation can be recognized as a plea to shift from healthcare approaches that focus on interpreting a disease to understanding the experience of a particular person. In her afterword to the same anthology, Wanda K. Mohr echoes Phillips' plea, asserting that, "when placed within the context of psychiatric diagnoses and milieu [...] every word, every action takes meaning from the [diagnostic] label because there is no longer a person there" (216). Narrative can serve as a place in which writers can resist such dehumanizing practices. Ross' experience also exemplifies this sentiment as she observes that "the more I heard my therapist's voice, the harder it became to hear my own" (159). In contrast, when the individual narrative is perceived not as a manifestation of a diagnosis but as the life events of a suffering person, a more holistic treatment of disease can result. This more holistic treatment would balance "objective" knowledge with individual perceptions that compose everyday contexts and knowledges. Indeed, it is the recognition of the subjectivity of their own experiences that constitutes, in part, the mindset of the everyday expert.

The Everyday Expert

The acknowledgment of and esteem for an awareness of situatedness and, therefore, the limitations and strengths of one's perspective signifies, for me, the mindset of the everyday expert. An example of this mindset can be seen in Edith Turner's 1992 *Experiencing Ritual*. Turner is critical of methods of anthropology that distance one's subjects of study by viewing them through lenses formulated by a Westernized understanding of the world. Turner is quick to position herself, if not completely outside of this group, then as a dissenting member. Turner explains that early on in her anthropological work, she "felt there must be a more humanistic way to explain human behavior and events than the methods we were supposed to be learning in the world of anthropology" (xi). The "we" she refers to here is in reference to herself and her husband, Victor Turner, through whom "the academic world was mediated" for Turner, since she could not attend formal classes while she was raising their five children (xi). Turner maintains that the fact that she did not learn about anthropology through a formal classroom experience enabled the participants in her studies to be "peculiarly alive for [her], never dead" (xi). In this way Turner distances herself from a discipline she often criticizes for remaining separate from its objects of study. In contrast, Turner posits herself as more willing to embody and be a part of "the 'material,' that is, human beings" (xi).

What makes Turner's knowledge constitutive of an everyday expert, however, is not the degree to which she claims to assimilate into the culture. Rather, Turner embodies the everyday expert's approach to knowledge as she is able to see the limitations of

integration without using it as an excuse for not embracing other cultural experiences.

This ability of Turner's is exemplified when she muses:

When anthropologists do fieldwork, they try to participate in the life of the people they are studying, but there appear to be limits. Geertz wrote, "We cannot live other people's lives, and it is a piece of bad faith to try" [...] (1986, 373). This is partly true [...]. But there are times when an ethnographer involved in an event of ultimate concern to the subjects of her work goes deeply into an experience herself—something which at least may be said to parallel theirs. (1)

The way Turner positions herself as both an outsider and an insider—an action capable of being recognized as a third-space practice for its blurring of boundaries—honors the exclusiveness of another culture while at the same time refraining from using that separation as a reason to, as she reports the "vast majority" of anthropologists do, "witness from the outside" (2). In Turner's specific case, when completing the ethnography of ritual, she found "it was essential to be an actual participant, not just an actor going through the motions" (5). Not using her status as an outsider to separate herself, Turner actively engages with and invests herself in those she is learning about. This engagement is what constitutes her knowledge as belonging—primarily though not exclusively—to the everyday expert, as a kind of participant observer.

Key to inhabiting and practicing this middle-ground between being a part of versus separate from is recognizing the boundaries between one's self and another. When examining the function of mental health narratives of illness and suffering for their ability

to disrupt authorized ways of knowing and being, it thus becomes imperative to acknowledge the unique set of restrictions that using narrative as a medium entails. In the introduction to the “Metanarrative Politics and Polemics” section of their 2007 edited collection, *Unfitting Stories: Narrative Approaches to Disease, Disability, and Trauma*, Valerie Raoul, Connie Canam, Angela D. Henderson, and Carla Paterson direct attention towards the conditions of narrative. The extent to which narratives can function include, but are not limited to (1) the context which surrounds both the experience itself and when the experience is received by the reader and (2) the agency of the narrator.

When commenting on the influence of context on the function of narrative, Raoul et al. point out that “broader socio-political contexts and ideological frames or metanarratives [...] influence the creation and exchange of stories of disease, disability, and trauma” (203). Perceiving the background in which a narrative takes place allows a fuller interpretation of the narrative itself, as well as an understanding of how a narrative embodies everyday ways of being and knowing. In particular, readers can understand the motives for narratives in more complex ways. In their 2007 “Narratives and Advocacy: A Gendered Connection,” Marsha Hurst and Sayantani DasGupta illuminate the ways in which narrators must balance the drive to make the personal public for political reasons while still maintaining the integrity of the personal account. Hurst and DasGupta explain that “there is a tension [...] between the power of a personal life story, power that resides in its experiential uniqueness and voice, and the purpose of advocacy, which is to construct meaning for a larger public” (276). This tension, in turn, can intensify “the drive to make the personal public” and “may inherently manipulate and even distort the

personal truth” (277). When understanding narrative as a means to both embodying and constituting everyday knowledge, one must understand its larger socio-political implications and the possible ramifications for sharing that particular personal experience. This awareness is necessary in order for such forms of knowledge as recounted in these narratives to maintain an awareness of and value for its subjectivity and thus remain distinct from authorized forms of knowledge.

Recognizing and valuing situatedness and therefore everyday knowledge as subjective includes being cognizant of the agency of the narrator. In his 2007 “The Negative Privilege of Women’s Illness Narratives,” Arthur Frank recognizes the restrictions imposed on the credibility of authors who narrate negative mental health experiences. When discussing rationalizations that reduce the validity of narratives, Frank muses:

I can imagine some readers, desperate to affirm the primacy of the bright side, reacting to these stories by shooting the messengers and dismissing these stories as doctor bashing [...]. The experience of illness has many facets [...]. Reading these stories, people should be angry but neither discouraged to continue medical work nor fearful to become ill. The difficulty is to make the anger work for change, without allowing it to become a generalized fear of life. (72)

Perhaps it would be more accurate to describe an assessment of the agency of narratives about mental illness and suffering as measuring not their level of agency but their lack thereof. Frank raises an important matter when drawing attention to possible hindrances

to accepting these forms of everyday knowledge. Frank reassures those who might feel implicated in the marginalization of these narrators, confronting possible reactions of defensiveness and subsequent denials of culpability with an acknowledgment of the complexity involved in mental healthcare and in the general undertaking of improving a system. This inviting, rather than confrontational, approach is one way narratives themselves can exhibit characteristics of everyday knowledge. In contrast to authorized forms of knowledge that can silence and subjugate, everyday knowledge strives to use its agency cooperatively.

Perhaps paradoxically, it is the recognition of its limitations and its value for them that serve as one of the everyday experts' greatest strengths. Specifically, when recognizing the boundaries of narrative as a medium, narrative becomes a fitting vehicle for everyday knowledge. In her 2007 "Telling Trauma: Two Narratives of Psychiatric Hospitalization," Hilary Clark illustrates the ways in which the rhetoric of narratives of mental illness and suffering can serve as "instances of therapeutic expression (catharsis), but also more importantly as testimonies aiming to affect and persuade, and to find or create a receptive audience for their narrative of a highly stigmatized experience" (46). Clark demonstrates how this catharsis is unique to narrative in her own analyses, observing that "each author tells her own hospital story as a way of reclaiming the illness experience (Frank 1995) from the institutional discourse of doctors' case notes and hospital reports" (46). It is the positionality of the narrator as patient that allows this reclamation to take place. Additionally, it is narrative's intimate form—the relationship the author creates with the reader through telling his or her experience in this way—that

constitutes narrative as an expression of everyday knowledge and a site for this expression to take place.

Agency and Third-Space



Authoritative Expert	Everyday Expert
Brain chemistry	Alternative Practices (e.g. acupuncture)
Categorizes/Taxonomizes/ Pathologizes	

Table 1: Disrupting Binaries

Narrative's ability to be both an expression of everyday knowledge and a site for this expression to take place constitutes, in part, its agentic function (see Table 1).

Understanding agency as representative of everyday knowledge and therefore solely self-empowered, however, can be an overgeneralization of a complex concept. Carl G. Herndl and Adela C. Licona, in their 2007 "Shifting Agency: Agency, Kairos, and the Possibilities of Social Action" explain that "agency" and "authority" do not constitute a dichotomy, as both are dependent on socio-cultural contexts. They explain that "agency is the conjunction of a set of social and subjective relations that constitute the possibility of action" (135). Discerning the social characteristics of agency is one step towards separating one's self from the notion of agency as centered around the individual.

Acknowledging agency's social characteristics means recognizing that "agency cannot be seized, assumed, claimed, had, possessed [...]. [T]he reality of agency is a question of positioning within" (Herndl and Licona 137). A person as an agent cannot operate in a vacuum.

Contributing to the intricacies of the notion of agency is agency's "necessary relationship" with authority (Herndl and Licona 135). Herndl and Licona "identify [...] authority as both a potential constraint and a potential resource to agency depending upon specific contexts" (Herndl and Licona 135). One way to reconcile these seemingly contradictory traits is to envision "how [...] agency and authority interact when subjects are authorized to speak against the dominant practices or when their discourse maintains dominant social relations" (Herndl and Licona 134). In a sense, authority is needed in order for agentive action to take place. Herndl and Licona note that "authority, like agency, exceeds the subject" (142), and I understand this to mean that it is not the individual subject who creates agency and defies authority. Rather, socio-cultural norms that define authoritative functions also create spaces for agency. In this project, I examine specifically agency located in and practiced through third-space.

My exploration of the agency located in and practiced through third-space begins with a review of theoretical discussions of space that consider how story, narrative, and the composing process disrupt systems that create normative and oppressive structures. I subsequently extend this analysis of third-space that consists of deliberations about the representational strategies of real and imagined places in order to center more specifically on agency enacted in third-space.

In her 2005 "(B)orderlands' Rhetorics and Representations: The Transformative Potential of Feminist Third-Space Scholarship and Zines," Adela C. Licona begins her discussion on third-space scholarship by categorizing third-space as "location and/or practice" (105). My understanding of third-space is driven by this recognition of the

concept as both noun and verb. The principal aspect of third-space I will be focusing on is how marginalized space—composed of the non-dominant, everyday expert’s experience—embodies third-space.²

In this project, I regard agency in third-space from three angles: (1) third-space as practice, (2) third-space as location, and (3) third-space as practice and location (see Table 2). Conceptualizing third-space through these three perspectives allows me to analyze the effect of the multi-faceted nature of third-space on agency. Additionally, I deepen my analysis of agency in third-space by further identifying distinguishing characteristics within these three aspects of third-space. Specifically, my understanding of third-space as practice examines the ways in which it: (a) challenges dichotomies, (b) makes meaning of the everyday, and (c) works against Western consciousness as defined by the seven principle poses Roland Barthes names. I differentiate third-space as location by considering the ways in which third-space functions as a “space of shared understanding and meaning-making,” where the invisible is made visible and the “limitations of language are explored” (Herndl and Licona 105, 111).

Third-Space	
As practice	As location
Challenges dichotomies;	Spaced of shared understanding and meaning-making;
Makes meaning of the everyday;	Where the invisible is made visible;
Works against Western consciousness.	Where the limitations of language are explored.

Table 2: Third-Space

² While I am looking primarily at marginalized space constituted by the non-dominant, everyday expert’s experience, I recognize that the everyday expert is not necessarily always marginalized.

One way to conceptualize the “both/and” relationship of third-space, practice, and location, is to consider third-space as the bridge between the corporeal and the immaterial. Henri Lefebvre in *The Production of Space* accuses Noam Chomsky of “completely ignor[ing] the yawning gap that separates the linguistic mental space from that social space wherein language becomes practice” (5). Lefebvre’s indictment functions, in part, to indirectly define a sphere that constitutes third-space. The sphere I see defined in Lefebvre’s work examines how language functions in society. Specifically, I understand the “yawning gap” Lefebvre references to be a consideration of how language affects and is affected by our interactions with others. Edward Soja complicates this understanding by positing third-space as a merging between communication and an understanding of societal synergy. Soja reminds readers in *Postmodern Geographies: The Reassertion of Space in Critical Social Theory* that “the reassertion of space” is not “simply a metaphorical recomposition of social theory, a superficial linguistic spatialization that makes geography appear to matter theoretically as much as history” (7). Soja argues that “taking space seriously requires a much deeper deconstruction and reconstitution of critical thought and analysis at every level of abstraction, including ontology” (7). One way to examine third-space therefore, is to consider how the expression of language functions to contribute to theories on social interaction as well as the space and processes by which ideas in the mind become verbalized beyond the individual body.

Michel de Certeau further complicates the concept of third-space by pointing out that, “*space is a practiced place*” (117). De Certeau expands on this idea by providing the

following example, “the street geometrically defined by urban planning is transformed into a space by walkers” (117). Something can be theoretically geometrically defined but the act of walking and those who do so create and enact the function of that space. “In the same way,” de Certeau continues, “an act of reading is the space produced by the practice of a particular place: a written text, i.e., a place constituted by a system of signs” (117). The practice of the written text produces the space for and the act of reading. Third-space can be understood in a similar manner, produced by a recognition of language as a key component to sociological understandings and the practices of individuals in communication.

Comprehending third-space as an interaction between language’s role in sociological understandings and the practices of individuals in communication further defines third-space as moving beyond knowledge produced by either the authoritative or the everyday expert. To some extent, the recognition of language as a key component to sociological understandings can be seen as reflecting the way knowledge is validated according to biomedicine. Specifically, biomedicine’s belief that “disease and its attendant suffering are ultimately to be understood in terms of pathological entity” is echoed in methods that understand language in terms of its sociological implications. Thus, recognizing language as a key component to sociological understandings can be seen as a form of authoritative ways of knowing and being. In contrast, paying attention to the practices of individuals in communication can be understood to be subjective renderings and therefore exemplifying everyday ways of knowing and being. Realizing third-space through an examination of language’s role in sociological understandings and

the practice of individuals therefore conceives of third-space in relation to authoritative and everyday ways of knowing and being.

Recognizing third-space as a practiced place echoes Herndl and Licona's conception of agency as unable to be created by the individual, or even be in existence without authority. Instead, the agency of third-space exists through the recognition of dichotomous structures. Thus, somewhat paradoxically, the agency of third-space is, in some instances, dependent on the very binary it disrupts.

Third-Space as Practice

Describing third-space as a practice, Licona explains that it “reveals a differential consciousness capable of engaging creative and coalitional forms of opposition to the limits of dichotomous (mis)representations” (105). Licona's description of the capabilities of this differential consciousness as engaging opposition to the limits of dichotomous (mis)representations overlaps the differential consciousness Chela Sandoval, in her 2000 *Methodology of the Oppressed*, describes as called for by Louis Althusser, “permit[ting] functioning within, yet beyond, the demands of dominant ideology” (44). Juxtaposed with Sandoval, Licona's characterization of third-space as a practice can then be understood as detailing those acts that resist widespread, often taken for granted, systems of thought. Specifically, these systems of thought are resisted because of the limits of their dichotomous (mis)representations, or, to put it in other terms, the either/or thinking these systems of thought perpetuate. For the purposes of this project, then, using the concept of third-space as a practice means recognizing how

personal narratives challenge binaries. One specific example of a naturalized binary I will be examining is the notion of either being healthy or being sick.

Licona's description of third-space as practice that functions to alter naturalized binaries includes the ways in which third-space "dilutes notions of purity and authenticity" (106) and creates other ways of being in order to make meaning of the everyday. In particular, valuing what is perceived to be authentic over what is perceived to be contrived is challenged as third-space in practice creates paradox. For example, the degree to which a personal narrative is pure and/or authentic is constantly evaluated as a result of its "non-fiction" categorization. Considering personal narrative as practicing third-space changes the terms through which personal narratives are scrutinized. Specifically, analysis of personal narratives becomes no longer centered in an evaluation of credibility but rather open to allowing a space for both the factual and the inconceivable to coexist—or perhaps even evolving past understandings of actuality as composing the framework for inquiry.

Creating a space for both the factual and the inconceivable to exist challenges not only traditional views of what constitutes authenticity but also the very validity of the concept of authenticity. Challenging authenticity's place in the evaluation of a text involves re-conceiving the function of language. Licona observes that "third-space subjects put language into play by using disruptive discursive strategies that reflect our lived experiences as fragmented, partial, real, and imagined, and always in the process of becoming" (106). Licona's observation identifies how measures of authenticity rely, in part, on that which would normally be expected—that is, lived experiences as whole and

real, not partial, and simultaneously real and imagined. Licona's description demonstrates that what composes normality—that is, the validity of a person's lived experience as based on his/her productivity, unitariness, moderation, and rationality³—is taken out of this discussion in third-space and considered on a different plane. In particular, when a lived experience is represented as fragmented, partial, real, and imagined, such characteristics do not automatically disqualify it from being legitimate. Rather, the process of relating lived experience is expanded to no longer require the experiences to be fixed in a point of time but instead to more accurately reflect what it means to live—never fixed, but always in the process of becoming. As Paul Ricoeur notes in “The Self and Narrative Identity”:

As for the notion of the narrative unity of a life, it must be seen as an unstable mixture of fabulation and actual experience. It is precisely because of the elusive character of real life that we need the help of fiction

³ I am referring here to the four attributes Marie Crowe, in “Constructing Normality: A Discourse Analysis of the DSM-IV” (2000) asserts that the DSM-IV claims composes normality (72). For productivity, Crowe explains that “when the success of societies is evaluated on purely economic criteria it becomes critical that individuals can participate in enterprises of production and reproduction” (73). Crowe sees unitariness valued when “the DSM-IV (APA 1994) perpetuates a western construction of normal subjectivity which emphasizes individuality and requires an ability to distinguish self from others; interiority from exteriority” (73). Thus, measuring unitariness means evaluating the degree to which a person sets him/herself apart from others. Crowe postulates that, for the DSM-IV, the degree to which traits exhibit moderation is determined by “subjective evaluations of activity levels, speech production and regard for self and colleagues. What this means for those defined as either male or female is that behavior and speech are interpreted in relation to the sex of the subject” (74). Thus the DSM-IV's moderation measurements can be seen as one way norms concerning power are reinforced. Crowe observes that “cultural processes for ensuring moderation could be regarded as disciplinary procedures (Foucault 1977): coercions that act upon the body in a calculated manipulation of its elements, gestures and behaviors” (74). In regards to rationality, Crowe explains that “there is a cultural assumption that there is only one authorized version of reality or framework for interpreting experiences” (74) and that “if individuals do not perceive reality in a manner that is consistent with cultural norms or their speech pattern lacks the requisite literalness, or they have beliefs and experiences that fall outside the criteria for normal experience, these may be regarded as symptoms of mental disorder” (75).

to organize life retrospectively, after the fact, prepared to take as provisional and open to revision any figure of emplotment borrowed from fiction or from history. (162)

That third-space enables this fluid representation of life allows for a fuller appreciation of what Licona refers to as the “generative potential of third space” (107).

Third-space as practice also creates other ways of being by making meaning of the everyday. In the case of mental health narratives, I understand “the everyday” to be patients’ accounts of their experiences of illness and suffering, as opposed to impersonal and exclusively medicalized discourse. Wanda K. Mohr, in her “Afterword” to *Women’s Encounters with the Mental Health Establishment*, explains that the anthology, which is composed of narratives written by women who have experienced mental illness, serve “two very important functions” (215). I see these functions as having the possibility to be applicable to many types of mental health narratives. Mohr describes the first function as:

Represent[ing] a way for these women to connect with others who can give the kind of support, affirmation, care, and strength that only another person who has experienced the same events can furnish [...]. They give name to a suffering that too often remains unspoken in therapy. (215)

As an expression of the everyday, these narratives allow the distressed to hear from others in their position and to converse about the disorienting effects of conditions with people for whom these symptoms are not merely routine matters, that is, simply a manifestation of a diagnosed condition.

In addition to creating community and agency, Mohr also sees *Women's Narratives* as:

Speak[ing] powerfully to professionals in conveying the complex world of mental illness to us that no DSM list of symptoms can. The understanding of certain experiences, such as the anguish of mental illness, can only be grasped fully by way of an inward appropriation of that experience. It cannot be approached by way of dispassionate description, such as those included in textbooks. Obviously we cannot all experience every human condition directly, but we can empathize through carefully selected examples of literary works. The language of the pieces of this collection has the power to awaken the total sensibility of professionals, students, and lay persons to new levels of consciousness. (215)

Evolving past evaluations that are grounded in assessments of validity—that is, a determination of the level of care given by health professionals based on a judgment of the believability of a patient and/or his or her symptoms—empower “theoretical undertakings in third-space sites [...] to uncover Other ways of being, and of knowing, in order to make meaning of the everyday” (Licona 106). No longer bound by either/or mentalities, third-space enables the very method of inquiry to change. In the case of medical knowledge, other ways of being and knowing can be considered that no longer privilege information that can be most widely applied. Rather, third-space enables an assessment of the very definition of what it means to advance medical knowledge, as well as assessing the priority given to advancement in the first place. Of particular importance

in Licona's description of third-space is the reason she points out for uncovering Other ways of being and knowing: to make meaning of the everyday. Third-space thus adds the everyday expert to the discourse of analysis, though it is important to note that this addition of the everyday expert is not meant to displace the authoritative expert and thus simply reverse a dichotomous system of thought. Ultimately, studying that which third-space empowers reveals a common thread throughout: disruptions to the "perceived and materialized order by rendering visible the previously invisible, invalid, and unacceptable" (Licona 119).

Contributing to third-space as practice are the ways in which this space functions to work against Western consciousness, as defined by Barthes' seven principle poses. Sandoval explains that Barthes analyzes Western consciousness to be "disperse[d] around seven principle poses [...]. These are 'the inoculation,' 'the privation of history,' 'identification,' [...] 'tautology,' 'neither-norism,' 'the quantification of quality,' and 'the statement of fact' (118). Sandoval goes on to further clarify these categories as "constitut[ing] a 'set of fixed, regulated, insistent figures' around which ideological-Signifiers (Sr's) become arranged in order to generate reality" (118). Thus, Western consciousness is, in part, characterized by an adherence to these seven principle poses. Sandoval believes these seven traits "generate a structure, a rhetoric for being that orders and regulates Western social space and consciousness" (118). Consequentially, this rhetoric "animates the great ideological perversions, especially those that invite citizen-subjects to faultlessly consume ideology, and to guilelessly reproduce 'depoliticized' and supremacist forms of speech, consciousness, morality, values, law, family life, and

personal relations” (Sandoval 118). That which functions to work against these dominant ways of being and knowing therefore practices third-space. Minh-ha Trinh eloquently illustrates the practice of third-space that works against Western consciousness:

In certain societies where sounds have become letters with sharps and flats, those unfortunate enough not to fit into these letters are tossed out of the system and qualified unmusical. They are called noises [...]. A music bound up with movement, dance and speech, one in which the listener becomes a co-performer, one that has no overall form except one of continually recurring sequences of notes and rhythms, one that plays endlessly—*for nobody has enough of life*—has been repeatedly called elemental or rudimentary. It is irritable to most Westerners’ ears. (Naked Spaces--Living is Round 23)

Through Trinh’s illustration, readers are able to understand third-space as practice for the ways in which dominant ideological norms in Western cultures are defied. This defiance is jarring and does not fit standard ways of knowing.

Third-Space as Location

In addition to being a practice, third-space can be understood as a location which “has the potential to be a space of shared understanding and meaning-making” (Licona 105). Thus, when personal narratives bring people together by identifying similar experiences, they enact third-space as location. In her 2008 “A Meditation on Depression, Time, and Narrative Peregrination in the Film *The Hours*,” Diane R. Wiener explains how narratives create a space of shared understanding as they “problematize the idea that

time, human responsibility, trauma, and suffering are ever limited to a single life” (163). Wiener’s observation of the ways in which narratives universalize singular experiences describes, to me, how narratives can enact third-space as a location that fosters connections. Gloria Anzaldúa complicates the idea of narrative as a space of shared understanding and meaning-making in her description of a specific type of narrative writing, declaring that “writing is a collaborative, communal activity not done in a room of one’s own. It is an act informed and supported by the books the author reads, the people s/he interacts with, and the centuries of cultural history that seethe under her skin” (“To(o) Queer the Writer” 169). Thus, when narrative is the product of “shared writing,” it becomes a location for third-space.

Related to creating a space for shared understanding and meaning-making, third-space as location can also be a site where the invisible is made visible. Narratives of illness and suffering can constitute this space as “many narrators [of accounts of ill health and suffering] emphasize that their experience combines elements of physical and mental suffering with acute and chronic effects, and involves visible and invisible factors” (Raoul et al. 5). Third-space thus serves as a site for previously concealed ways of knowing and being. In her 2007 “Social Trauma and Serial Autobiography: Healing and Beyond,” Bina Toledo Freiwald describes how published personal narratives, as a space where the invisible is made visible, can overtly influence society. Freiwald explains that “intervention in the public sphere” takes place when personal narratives “create [...] an alternative jurisdiction [...]; dare to contest oppressive master narratives [...]; [and] militate against—and compel the reader to reconsider—the social and material conditions

that engender trauma” (235). As a third-space location, personal narratives can therefore function as an area where private experiences become public to affect positive societal change.

Third-space can also be understood as the location that signifies language’s both liberating potential and limitations. Licona acknowledges the ways in which third-space reveals the limitations of language when she describes third-space as being composed of “acts of survival in which language in both its liberating and limiting potential is explored and exposed” (111). Mental health narratives serve as particularly apt settings for sharing these acts of survival. In their introduction to the 2010 *Exploring Learning, Identity and Power through Life History and Narrative Research*, Ann-Marie Bathmaker points out that “narrative inquiry, through rich accounts of the complexities of real life and an emphasis on the particular, may call into question dominant narratives that do not match the experience of life as lived” (3). When giving voice to one’s own particular experience, narrative can serve as a place to show language’s liberating potential. Also important to note are the ways in which narrative can demonstrate language’s limitations. In her 2007 “Writing About Illness: Therapy? Or Testimony?” Ann Hunsaker Hawkins confides that

I’ve also learned that neither treatment nor testimony can ever fully achieve its goal—healing, in the case of therapy, or witnessing, in the case of testimony. With neither model is there a total and final cure or reparation: survivors of trauma are never able totally to put the experience behind them and move on in life as though it didn’t happen. (127)

While I question Hawkins' definition of healing—which seems to be implied here as complete erasure of the traumatic event—I think it is important to note that complete erasure, whether that is called “healing” or not, is simply not possible. Narratives that compose third-space can express the ways in which language helps people deal with their pain but it cannot, nor should it, completely nullify what happened to them.

Language's liberation and limitation as located in third-space is perhaps best understood when third-space is continuously reiterated as practices and locations that disrupt the framework on which dominant ways of thinking are based.⁴ Conceived this way, the limitations exposed become those concepts of language that are incongruous with lived experience, such as legitimacy that requires sameness in identity.⁵ Similarly, that which is liberated becomes the acceptance of incertitude: “no longer something to be reconciled in an either/or context, [third-space] is instead desire(able) in its ambiguity” (Licona 112).

⁴ The DSM is one example of a framework on which dominant ways of thinking, such as standard approaches to mental healthcare, are based. As Herb Kutchins and Stuart A. Kirk in *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders* (1997) point out, motivations for using the DSM as a framework include its connection to insurance coverage. Kutchins and Kirk explain that “this vital connection exists because all mental health professionals must list a psychiatric diagnostic label [...] on their claims for insurance reimbursement [...] Because of the financial incentives structured into the development and use of the DSM, decisions about which human problems get included as mental disorders in the DSM and who qualifies for the reimbursable diagnostic label are vulnerable to pressure from advocacy groups, professional associations, and corporations” (12).

⁵ I am referring here to Paul Ricoeur's “Personal Identity and Narrative Identity,” in which he posits that “the problem of personal identity constitutes [...] a privileged place of confrontation between the two major uses of the concept of identity [...] on one side, identity as *sameness* [...] on the other, identity as *selfhood*” (115-6) in conjunction with Marie Crowe's discourse analysis of the DSM-IV and its definition of unitariness (see footnote 2)

Determining the Function of Narrative through Dialogical Narrative Analysis:

Commitments and Crucial Questions

Having reviewed the literature that has considered narrative's function in relationship to authorized and everyday forms of knowledge, as well as third-space as practice and location, I now consider how to determine narrative's function in the healing process. This discussion lays the framework for subsequent chapters which analyze select narratives specifically.

In order to determine narrative's function in the healing process, I have decided in the following chapters to consult nine personal narratives written by women describing their experiences as psychiatric patients. I use "narrative" here to name published works written for mass distribution and presented by authors and publishers to be read as a memoir of the author's experiences. I have appointed these parameters in part for the ways in which such characteristics embody that which is invisible, invalid, and unacceptable for 21st century mental healthcare. Consulting personal narratives by those who identify themselves as women, for example, addresses the aspects of feminism that Harding reveals to be controversial to dominant ideologies and thus constitutive of the everyday expert's body of knowledge. Harding reminds readers that "there is considerable disagreement about just what women's conditions are, what the social causes of these conditions are, and how best to improve women's lives" (13). Explicating women's personal narratives of mental illness and suffering studies one aspect of women's conditions, hopefully serving to further advance the transformation of "the

sciences into more competent knowledge-producers as well as into resources for democratic social relations” (Harding 17).

In the following three chapters, I employ the three types of illness stories Arthur Frank identifies in his 1995 *The Wounded Storyteller* as frameworks through which to understand the nine narratives I have selected. Frank recognizes three core narratives that most specific stories depend on: the restitution narrative, the chaos narrative, and the quest narrative (see Fig. 1 for an illustration of each narrative). These narratives are not mutually exclusive, as Frank explains, “actual telling combines all three [narratives], each perpetually interrupting the other two” (*The Wounded Storyteller* 76). Frank is careful to note, however, that this recognition is not meant to be reductive:

These three types are not descriptions of personalities or dispositional structures of ill people. My interest was not in looking for principles that could predict which individuals would represent their illnesses in which combination of narrative types. (“Practicing Dialogical Narrative Analysis” 48)

Rather than being used as a tool to categorize people, Frank sees understanding narratives in light of these three types of illness stories as illuminating the “narrative resources available to ill people. In particular, what constrained ill people’s mobilization of different resources?” (“Practicing Dialogical Narrative Analysis” 48). I wish to deploy Frank’s classifications in the spirit in which they were intended, and avoid judging a person’s psyche based on what type of framework their narrative seems to predominantly

how these fluctuations are in part the product of circumstances of being—as the saying goes, “no [person] is an island,” and therefore is necessarily affected by his/her surrounding environment. This recognition, in turn, results in a dedication to “sustain a tension between dialogue and analysis [...]. DNA’s concern is how to speak *with* a research participant rather than about him or her. Analysis, however, seems to require speaking *about* one who becomes the object of analysts’ talk” (A. W. Frank, "Practicing Dialogical Narrative Analysis" 34). In addition to sustaining a tension between dialogue and analysis, or perhaps what fuels this sustainment is the fact that DNA “sets aside, at least provisionally, the idea of people telling stories, and it thinks instead of stories imposing themselves on people, and these people then being limited to representing their lives according to whatever imagination the stories make available” (A. W. Frank, "Practicing Dialogical Narrative Analysis" 49). Viewing the reason for variations in narratives in this way emphasizes investigating to what extent stories impact the people who tell them. This investigation defies standard analyses that assume a person’s agency—in whatever varying degrees—and instead understands a person’s agency as being initially necessarily affected by the resources available to him/her. Thus DNA, in a way, creates third-space as it reconstitutes frameworks for analysis.

DNA’s Commitments
<ol style="list-style-type: none"> 1. One voice is comprised of multiple voices; 2. Challenges the notion of a fixed identity; 3. We constantly tell stories and stories compose our existence; 4. Narrative resources contribute to fluctuations in identity; 5. Don’t summarize findings.

Table 3: DNA’s Commitments

DNA concentrates on five main areas when analyzing narratives (see Table 3). Frank explains DNA's "first commitment" as one that "recognize[s] that any individual voice is actually a dialogue between voices [...] Dialogue is not simply two or more persons talking. Any one voice always comprises multiple voices" ("Practicing Dialogical Narrative Analysis" 34-5). Thus, when analyzing narratives through DNA, I am asking questions that are built on an understanding of those narrators as socially constructed. DNA's undertaking to view the self as encompassing multiple perspectives is part of what enables its potential to reveal third-space as a space of shared understanding.

Similar to the recognition of the self as comprised of multiple voices, DNA's second commitment disrupts ideas of the self as static. Frank describes what this means:

DNA's second commitment is to remain suspicious of what Bakhtin (1984) posited as the opposite of dialogue, which is *monologue*. "In a monological design," Bakhtin wrote, "the hero is closed... he acts, experiences, thinks, and is conscious within the limits of what he is... he cannot cease to be himself" (p. 52). Most social science is monological. The ideal type as a methodological device imagines people within limits that define who they can be (Schultz, 1967). The ideal type of actor "cannot cease to be himself," in Bakhtin's phrase. ("Practicing Dialogical Narrative Analysis" 35)

DNA's second commitment's "suspiciousness" to monologue indicates to me a challenge to the notion of an "essential self"—that is, the idea of that which comprises "personal

identity” as fixed. Challenging this notion of a fixed identity, in turn, highlights the very existence of this mindset. Perhaps perceptions of the self as unchanging necessarily demand—or at least encourage—all-or-nothing stances: a person is either depressed or not, and so a person must choose to exist in one state or another. In this way, DNA’s second commitment also illuminates a tension between the authoritative and the everyday expert and a call for third-space. Specifically, contesting monologue contests authoritative stances that see the world in inflexible terms. This challenge carves a space for everyday ways of knowing: conceptions of reality as in constant flux.

DNA’s third commitment builds on its second, explaining in what ways nature is constantly changing. Frank describes this third commitment as:

Seek[ing] to extend the dialogue further than Bakhtin explicitly [said] stories have provisionally independent lives. To say that humans live in a storied world means not only that we incessantly tell stories. Stories are presences that surround us, call for our attention, offer themselves for our adaptation, and have a symbiotic existence with us. ("Practicing Dialogical Narrative Analysis" 36)

This third commitment joins the first two commitments which state that (1) one voice is comprised of multiple voices and (2) things are in a constant state of flux. This third commitment thus adds a new dimension to what DNA reveals. Specifically, DNA demonstrates that (1) we constantly tell stories and (2) stories compose our existence. Understanding these things, in turn, frees the narrator and the reader from being required to determine fact from fiction, because a narrative is understood to exist simultaneously

with a multitude of stories. The seeming contradiction that results when these stories exist simultaneously, in turn, is hosted by third-space. DNA's third commitment declares that one can understand his/her illness experience as a certain type of narrative while at the same understanding this typology as, perhaps, completely meaningless—because DNA understands that more than one story exists.

DNA is also committed to recognizing the “unfinalized nature of persons” (A. W. Frank, "Practicing Dialogical Narrative Analysis" 36). This fourth commitment echoes the second commitment's challenge to the notion of a fixed identity. The fourth commitment's understanding of the nature of persons as unfinalized, however, is distinct from the second commitment in its implications for analysis:

To understand research as a dialogue requires respecting each participant's capacity for continuing change. Then tension is that analysis requires that something remain constant. What remains remarkably the same are not storytellers but rather narrative resources. (A. W. Frank, "Practicing Dialogical Narrative Analysis" 37)

The fourth commitment's implications for analysis involve a shift in what is being analyzed. That is, by prioritizing an awareness of the fluidity of identity, DNA shifts its focus from the storyteller to the narrative resources available to the storyteller during the creation of the account. In this way, the fourth commitment echoes the emphasis of previous commitments to entertaining contradiction, which itself is a hallmark of third-space.

Rounding out DNA's commitments is an undertaking "not to summarize *findings*" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 37). Frank explains that the word "findings" itself is "an undialogical word, with its implication of ending the conversation and taking a position apart from and above it" ("Practicing Dialogical Narrative Analysis" 37). Rather than take this stance, Frank explains that DNA is dedicated to "open continuing possibilities of listening and of responding to what is heard [...] increasing people's possibilities for hearing themselves and others" ("Practicing Dialogical Narrative Analysis" 37). This ending with openness seems like a natural denouement to dialogical narrative analysis, given its penchant for entertaining contradictions. DNA's fifth commitment reminds analyzers to resist accepting a "neat" ending. Rather than claim to conduct an analysis that generates any kind of decisive conclusion, those who conduct DNA can instead seek to establish an awareness of ever-changing possibilities.

DNA's Crucial Questions
<ol style="list-style-type: none"> 1. What multiple voices can be heard in any single speaker's voice, how do these voices merge, and when do they contest each other?; 2. What makes stories distinct from other forms of narration; what counts as a story, and what does not?; 3. Why is someone choosing to tell a story, among other expressive possibilities? What particular capacities of stories does the storyteller seek to utilize?; 4. What stakes does the storyteller have riding on telling this story, at this time, to these listeners? Or as I prefer to phrase it, How is the storyteller holding his or her own in the act of storytelling? By <i>holding one's own</i>, I mean seeking to sustain the value of one's self or identity in response to whatever threatens to diminish that self or identity. Groups also hold their own by means of their stories; thus, how do stories create group identities and boundaries?

Table 4: DNA's Crucial Questions

In addition to specifying dialogical narrative analysis' five commitments, Arthur Frank describes DNA's "most crucial questions" (see Table 4) in order to best understand

“stories as artful representations of lives,” how they “reshape the past and imaginatively project the future [and] revise people’s sense of self” (“Practicing Dialogical Narrative Analysis” 33). Together these questions help DNA maintain its five commitments that center around “the dialogical commitment to unfinalizability” (A. W. Frank, “Practicing Dialogical Narrative Analysis” 44). A thorough explication of these questions will hopefully help demonstrate how DNA’s commitments are put into action.

In “Practicing Dialogical Narrative Analysis,” Arthur Frank describes DNA’s first set of crucial questions as asking “What multiple voices can be heard in any single speaker’s voice?” (“Practicing Dialogical Narrative Analysis” 33). Asking this first crucial question in regards to a specific text requires readers to recognize DNA’s first commitment which points out that one voice is comprised of multiple voices. DNA’s crucial questions also ask researchers to identify how these voices merge, and when they contest each other (A. W. Frank, “Practicing Dialogical Narrative Analysis” 33). This set of questions thus contributes to DNA’s recognition of the multi-faceted, sometimes contradictory nature of the narrator. Additionally, these questions reinforce DNA’s second commitment to challenging the notion of a fixed identity. Specifically, by recognizing the multiple voices in any single speaker’s voice, researchers can complicate the idea of identity as steadfast and unchanging.

DNA’s second set of crucial questions ask, “What makes stories distinct from other forms of narration; what counts as a story, and what does not?” (A. W. Frank, “Practicing Dialogical Narrative Analysis” 33). In general, this set of questions encourages researchers to acknowledge the form and function of the texts they are

analyzing. This second set of questions explores DNA's third commitment to the fact that stories compose our existence, helping researchers understand the nature of these stories.

Researchers can observe DNA's third commitment to highlighting the ways in which we constantly tell stories and how stories compose our existence with DNA's third and fourth set of crucial questions. DNA's third set of questions ask, "Why is someone choosing to tell a story, among other expressive possibilities? What particular capacities of stories does the storyteller seek to utilize?" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 33). DNA's third set of crucial questions is similar to its second set. Engaging in these third set of questions for a specific text, however, requires the researcher to move from the general to the particular, asking: What makes this particular story distinct? In doing so, researchers can identify how stories compose our existence, DNA's third commitment. Additionally, researchers can recognize possible resources that influenced the creation of an exact story, which is DNA's fourth commitment.

DNA's fourth set of crucial questions ask, "What stakes does the storyteller have riding on telling this story, at this time, to these listeners?" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 33). Frank explains how he prefers to phrase these set of questions: "How is the storyteller holding his or her own in the act of storytelling? By *holding one's own*, I mean seeking to sustain the value of one's self or identity in response to whatever threatens to diminish that self or identity" ("Practicing Dialogical Narrative Analysis" 33). By figuring out the significance of telling a particular story, in a specific way, for a certain audience, researchers can bring attention to or just make a case for DNA's third commitment to stating that stories compose our existence. We can look

at the stakes involved in a specific story to understand how stories are integral to a person's being overall. By emphasizing the unique circumstances surrounding a story—what exactly is told, how it is told, and who it is told to—this fourth set of questions also uphold DNA's fifth commitment to a resistance to summarize findings. Rather than generalize the significance of a story to a type of circumstance, these fourth set of questions produce answers that resist overgeneralization.

In lieu of using narratives as a means to reduce people's lives, analyzing a body of work in order to create generalized knowledge of the author, DNA focuses on the availability of the resources that enable these stories. Consequently, DNA is freed from the trap of reductively abstracting the narrator while analyzing the narrative. Focusing on the resources available suggests that the narrator and even his/her life could be different, given a change in circumstances. Arthur Frank characterizes this particular form of DNA as "structur[ing] the research report around a typology of stories" ("Practicing Dialogical Narrative Analysis" 46). In this project, I focus on the typology of the three types of illness stories Frank introduces in *The Wounded Storyteller*. While it is possible to see identifying stories according to a specific typology as a kind of reductive categorization in and of itself, such an identification can, as Frank describes it, "encourage closer attention to the stories ill persons tell" (*The Wounded Storyteller* 76). Frank explains that "listening is difficult because illness stories mix and weave different narrative threads. The rationale for proposing some general types of narratives is to sort out those threads" (*The Wounded Storyteller* 76). Having a specific typology to identify can become the first step in moving past culturally conditioned biases against stories that can initially feel

uncomfortable to listen to. Additionally, Frank himself acknowledges that these categories are not mutually exclusive:

In any illness, *all* three narrative types are told, alternatively and repeatedly. At one moment in an illness, one type may guide the story; as the illness progresses, the story becomes told through other narratives. The particularity of any experiential moment can thus be described by the narrative type that predominates at that moment. The three narratives are like patterns in a kaleidoscope: for a moment the different colors are given one specific form, then the tube shifts and another form emerges. (*The Wounded Storyteller* 76)

Understanding stories according to these typologies can thus be understood as one way to understand the multifaceted nature in any one story.

The Work Ahead: 3 Types of Illness Stories as Core Narratives of Illness and Suffering

The Restitution Narrative

Chapter Two marks the first part of the three-part case study portion of my project. Frank describes the first core narrative, the restitution narrative, as containing a plot in which:

Someone gets sick, is treated, the treatment is eventually successful, and the person is restored to at least a reasonable approximation of the life that was led before illness. The primary actors are medical staff, especially physicians, supported by nurses and technologies (machines,

pharmaceuticals). The suspense is whether the person actually will be restored to a version of his or her life before illness. ("Practicing Dialogical Narrative Analysis" 47-8)

For the restitution narrative specifically, part of analyzing my three chosen narratives for the ways in which the narrators are constrained involves recognizing the preference given to restitution narratives by those who represent authoritative forms of knowledge. Frank reveals that “medical staff effectively convey their preference that patients frame their stories as restitution narratives” ("Practicing Dialogical Narrative Analysis" 48). Staff members convey this preference, Frank explains, as they “tell patients restitution stories, either about other patients with whom a comparison is proposed, or about the present patient’s future, as the medical staff claim authority to imagine that” ("Practicing Dialogical Narrative Analysis" 48). Particularly significant here are the ways in which restitution narratives can function to reaffirm authoritative forms of knowledge. I argue that promoting restitution narratives reflects a need to affirm the worth of the individual.

The Chaos Narrative

Chapter Three analyzes the chaos narrative’s commitment to creating a space for silence, similar to the restitution narrative’s philosophy of individual affirmation. This similarity can be seen when interpreting the formation of the space for silence as an affirmative act. This second part of the three-part case study portion of my project scrutinizes the motivations behind the structure of the chaos narratives. Frank describes the chaos narrative as containing a plot in which the protagonist

has multiple problems, crystallized by an illness (or illnesses) but usually not limited to that illness. One bad thing has led to another, and life is collapsing around this person. Efforts to stop the collapse are futile; everything has been tried, and each potential form of assistance is blocked. All the actors are buffeted by forces they cannot control, and the plot leads to no resolution, which is its chaos. Chaos narratives are *anti*-narrative in the sense that while one thing happens after another, none of it goes anywhere. The sense of simultaneity stifles suspense; things will worsen, but too slowly for the expected end to offer any relief. ("Practicing Dialogical Narrative Analysis" 47-8)

As in the second chapter, I examine three narratives for the ways in which they exhibit Frank's typology of a chaos narrative. Frank notes that "naming" this type of illness story "opened a silence in clinical practice. It helped ill people to hear a previously unacknowledged aspect of their own stories" ("Practicing Dialogical Narrative Analysis" 48). Thus an analysis of the ways in which select narratives embody the chaos structure is also an investigation of third-space as practice and location that makes meaning of the everyday, where "everyday" is understood to mean once marginalized accounts. Consequently, I deduce that chaos narratives are driven by a desire to create a space for what was once represented by silence.

The Quest Narrative

Echoing the restitution and chaos narrative's considerations for confirming individual self-worth is the quest narrative's drive to promote self-sufficiency. In fact,

promotion of self-sufficiency can in some ways be equated with confirming individual self-worth. This fourth chapter evaluating the quest narrative marks the third and final part of my three-part case study portion of my project. Frank describes the quest narrative as:

based on an explicit or implicit journey metaphor. In genre terms, they are romances, in which a character encounters a sequence of obstacles and gains wisdom and stature through the process of overcoming these (Frye, 1957). The suspense is whether the sufferer's original attitude toward the illness will transform into understanding the transformative potential in the illness experience. The storyteller of quest narratives is most likely to claim to have elaborated the narrative resources available to future ill people—that elaboration is part of the quest. ("Practicing Dialogical Narrative Analysis" 47-8)

My exploration of this aspect of an illness story highlights how Frank's depiction of quest narratives reveals his own biases for this third type of account. I search claims that idealize resources that empower such narratives, investigating how the quest narrative promotes self-sufficiency, examining the ways authorized forms of knowledge and everyday lived experiences are revealed through this narrative typology. This revealing will serve to further inform my understanding of a third-space constructed through narratives of mental illness and suffering.

My final chapter discusses how employing Frank's narrative frameworks as tools for analysis can contribute to growing scholarship on the need to rethink literary criticism

founded on a hermeneutics of suspicion. I reiterate my commitment to ensuring that the application of Frank's frameworks to personal narratives of mental illness and suffering illuminates the ways in which narrative can bestow agency on its authors and challenge hierarchical power relations within the medical system. I also discuss the necessity of paying careful attention to make sure that employing Frank's frameworks does not reinforce categorizations that would stereotype "descriptions of personalities or dispositional structures of ill people" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 48). Echoing DNA's commitment to the dynamic individual, my dissertation focuses on the everyday individual's ways of being in the context of third-space where narrative disrupts authorized forms of medicalized knowledge.

CHAPTER TWO: THE RESTITUTION NARRATIVE

As an undergraduate at a small, conservative, Christian liberal arts college in Chicago, I was diagnosed with major depression. Wary of the possibility of suspension should my depression interfere with my academic studies, I voluntarily took a semester off. Upon reapplying to the college, however, the dean of students informed me that I would not be readmitted unless I signed a contract. This contract included allowing my therapist and psychiatrist to communicate with the dean about my sessions, effectively giving up my rights to doctor-patient confidentiality. I was also required not to tell anyone of my depression or therapy so as not to “disturb the community.” When I refused to sign the contract, I was denied readmission.

Despair is alienating. Part of this alienation arises from personal discomfort over feeling helpless in the face of misery. It is perhaps this uneasiness that motivates the characterization of certain types of sadness as mental illness, including “depression.” Designating despondency as a sickness ascribes at least some causality to such anguish. In this way, the disconsolate are separated from the rest of society: ill, not healthy, and therefore set apart.

In *Illness as Metaphor*, Susan Sontag marks the causes of this false construct of the debilitated and the flourishing. Sontag emphasizes that “illness is *not* a metaphor, and [...] the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphoric thinking” (3). Yet, according to Sontag, illness is often understood through metaphors and in so doing becomes a metaphor itself. Ailments as metaphors are dangerous “as long as a particular disease is

treated as an evil, invincible predator, not just a disease” (Sontag 7). When a particular disease becomes representative of evil, the one afflicted with the disease becomes imbued with the resulting stigma. People start believing that “disease is the will speaking through the body, a language for dramatizing the mental: a form of self-expression” (Sontag 44). When viewed as a metaphor for evil, then, responsibility for the disease becomes indirectly placed on the injured. Sontag describes the chain reaction that results when the “onus of the disease” is put on the patient, explaining that such consignments:

not only weaken the patient’s ability to understand the range of plausible medical treatment but also, implicitly, direct the patient away from such treatment. Cure is thought to depend principally on the patient’s already sorely tested or enfeebled capacity for self-love. (47)

In this way, the cause of a previous unexplained malady is further specified: not just an evil brought on by the distressed, but an evil brought on by a lack of self-esteem. Returning to the idea of despair as alienating, those who are despondent, when placed in the model outlined by Sontag, are subsequently rendered sick, which itself can be understood to be loathsome. Consequently, being repulsive is considered to be one’s own fault, a fault rooted in a person’s psyche. Thus, the false construct of the unwell versus the well is driven by the overall psychological need for comprehension, an ability to create an explanation for an unsettling event.

This need to create an explanation is perhaps related to, or driven by, the compulsion to find meaning. If the circumstances of one’s life are not meaningful, of

what possible purpose could one's life ultimately hold? Sontag connects people's need to ascribe meaning with their knowledge of their own mortality, stating that

A large part of the popularity and persuasiveness of psychology comes from its being a sublimated spiritualism: a secular, ostensibly scientific way of affirming the primacy of "spirit" over matter. That ineluctably material reality, disease, can be given a psychological explanation. Death itself can be considered, ultimately, a psychological phenomenon. (55-6)

A focus on one's spirit can be seen as instilling meaning within life through the concept of an individual's essence existing separate from the body, and therefore, impervious to the death of the body. Here, Sontag illustrates how psychology can separate this concept of a self apart from the body from the religions that typically accompany spiritualisms. Psychological ways of imbuing meaning within life, however, also hold the risk of blaming the victim. Regardless of whether what is understood as comprising the self is termed a "spirit" explainable by religion or the "psyche" explainable by psychology, each one, when situating the meaning of life on the self's continued existence, holds the danger of ascribing responsibility for the circumstances within that existence on the self. Placing responsibility on the individual for seemingly unexplainable events such as ailments thus becomes a roundabout way of making individual lives meaningful in both profound and problematical ways.

Affirming the Worth of the Individual: The Restitution Narrative

Restitution Framework: Affirming the Worth of the Individual
<ul style="list-style-type: none"> • Someone gets sick, is treated, the treatment is eventually successful, and the person is restored to at least a reasonable approximation of the life that was led

before illness;

- Primary actors are medical staff, especially physicians, supported by nurses and technologies (machines, pharmaceuticals);
- Suspense is whether the person actually will be restored to a version of his or her life before illness.

Table 5: The Restitution Narrative Framework

When understood as a consequence of efforts to give individual lives significance, it seems logical that, as Frank points out, the restitution narrative is deemed preferable by medical staff for their patients (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). Recalling Frank's assertion, "the restitution narrative's plot is that someone gets sick, is treated, the treatment is eventually successful, and the person is restored to at least a reasonable approximation of the life that was led before illness" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). This plot can be seen as affirming the value of a single person's experience because (1) restitution depends on a return to the patient's life before his/her illness, and (2) there is a discernible resolution to the suffering—the treatment is effectual. Restitution validates the patient's life before, during, and after illness because each experience is useful, meaningful, and ultimately finishes positively.

In addition, the restitution narrative gives value to the quality of life lived before illness. The danger with understanding illness as a "necessary evil" that results in a more meaningful life is its devaluation of the life lived before illness. In contrast, the restitution narrative portrays the return to the life led before illness as a desirable end result to a tumultuous experience, thus affirming the worth of the life one lived prior to illness. This affirmation echoes the sentiment that "you don't know what you have until it's gone." In this light, the illness serves as the "wake-up call" for the afflicted, a reminder of the sheer

inestimable worth of simply having a life to live. Such a return, then, can also be seen as imbuing the experience of illness with meaning in its function as a revelation for the individual.

The individual experience is also deemed meaningful because the treatment itself is not in vain. Like the revelatory benefits of the illness experience in its entirety, the treatment journey is revelatory and, ultimately, life-affirming. The treatment has a purpose—recovery—and that purpose is accomplished. Thus the individual's time undergoing treatment serves its function and ultimately comprises what makes the individual's life meaningful. There are no wasted efforts or meaningless endeavors here.

In what follows, I conduct careful dialogical narrative analysis (DNA) on three personal narratives written by women detailing their own psychiatric treatment. In addition to DNA, I use Frank's restitution narrative typology (see Table 5) to examine how narratives can and do create a third-space of agency and disruptions of power. I organize my discussion of the ways in which the narrator's various experiences fulfill these functions according to the chronological order in which the narrator introduces her experiences.

Case Study 1: Susan Rose Blauner's *How I Stayed Alive When My Brain Was Trying to Kill Me: One Person's Guide to Suicide Prevention*

Susan Rose Blauner's 2002 memoir presents itself as an instruction manual primarily addressed to those who are currently suffering from suicidal ideation. Yet, despite its guide-book-like format—or perhaps because of it—Blauner manages to share with readers her own, deeply personal experiences as a woman who struggled with severe

mental issues. This intersection of the revelatory and the instructive is what, for me, characterizes Blauner's narrative as most closely following Frank's restitution framework. Specifically, Blauner grounds the validity of her advice by positioning herself as a person "restored to at least a reasonable approximation of the life that was led before [her] illness" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). Her title itself conveys this stance towards her mental health issues as in the past: the phrase, "how I stayed alive when my brain was trying to kill me" implies both a speaker who has personally experienced suicidal ideation and a speaker whose brain is no longer trying to cease its existence.

Blauner portrays herself as a person who has evolved past suicidal thoughts by beginning her first chapter with an antagonistic tone. Though perhaps unintentional, this attitude begins with the chapter's very title, challenging readers with the question, "so you think you want to die?" The first subsection of chapter one, titled simply, "Hello," continues this somewhat puzzling approach of hostility to an audience possibly struggling with suicidal ideation. "Congratulations," Blauner writes, then continues:

Your lungs are breathing, your fingers are touching these pages, and your eyes are reading these words. At this very moment the part of you wanting life is stronger than the part of you that thinks it doesn't—otherwise you wouldn't be reading this book. (3)

In a context where people might be likely to resent automatic, unquestioned assumptions regarding the nature of their innermost thoughts and feelings, Blauner's use of the second-person point of view can come across as abrasive. Blauner is telling her readers,

in no uncertain terms, what their actions mean, and while her logic and conclusions make sense, I find myself resisting what seems like presumptuous posturing. While it might be true that someone may be reading Blauner's book because at that very moment the desire to live is stronger than the desire to die, the desire to live could be just as likely to fizzle. Blauner's first few sentences depict a fragile audience yet simultaneously are off-putting in her stance towards her self-defined audience. Her first chapter's title combined with its introductory sentences work together to form a kind of cruel trick-question: "So you think you want to die? Yes? Ha! Fooled you! You're reading my book so technically you actually want to live!"

Rather than using her first-hand knowledge to empathize with others going through similar experiences, Blauner uses her own struggles with suicidal ideation as a way to give authority to her advice. As a result, what was once knowledge applicable specifically to her own situation becomes knowledge that is presumed to be broadly appropriate. The authorization of Blauner's knowledge, given her identity as a person who has struggled with serious mental health issues, may initially appear to disrupt authorized ways of knowing and being that privilege so-called objective knowledge over subjective experience. Upon closer examination, however, the authorization of Blauner's knowledge maintains the dichotomy of authorized versus everyday ways of knowing and being. Blauner's thoughts and perceptions that were once indicative of an underlying pathology become subsumed into authorized knowledge that exists, in part, through the dismissal of other ways of knowing and being.

One example of a way in which Blauner's narrative perpetuates the dichotomy between authorized and everyday ways of knowing and being is her attempt to alter her readers' personal language—that is, how they initially perceive a situation. Blauner attacks the use of the phrase “feeling suicidal” in an effort to persuade readers to adopt the language and by extension, the mentality, that has assimilated her. Blauner adamantly states, “‘Suicidal’ is not a feeling, it is a state of being. Anger is a feeling. Sadness and loneliness are feelings” (33). What troubles me is Blauner's need to dictate how others choose to describe what they are feeling. Blauner explains that “The mystery began to unravel for me when I realized that feelings groaned beneath my suicidal thoughts. I began to use other words, like ‘angry,’ ‘sad,’ ‘afraid,’ ‘frustrated,’ or ‘lonely’ to express my state of mind” (33). I agree that it is important to understand why a person may be choosing to describe themselves as “feeling suicidal.” I do not think, however, that “unraveling the mystery” necessarily entails the absolute disqualification of “suicidal” as a feeling. I agree with Blauner that “language is powerful; it helps create our reality” (32). To disavow “suicidal” as a feeling, however, is to deny a person the authority to describe his or her own, unique illness experience. Blauner argues that “practice in language awareness gave me positive power because I was no longer bound by the suicide box” (33). Yet I would argue that the way Blauner practices “language awareness” on the word “suicide” creates a denial which is disempowering, and ultimately contrary to the empowerment needed to, as Blauner describes it, “break the suicide cycle” (33). It is equally important to note that one can advocate for the ability to describe one's self as suicidal without “encouraging” suicidal feelings. Rather, I see an

acceptance of a self-description such as “feeling suicidal” to empower a person to move past these feelings. Free to acknowledge his or her feelings, someone who is feeling suicidal is apt to feel less so when his or her efforts to articulate his or her state of mind is not judged as incorrect and repulsive. In trying to persuade readers to follow her way of naming the world around her, Blauner borders on mocking her readers when she explains, “Unless you’re doing something drastic like eating a Breakfast of Gillettes instead of the Breakfast of Champions, the phrase ‘I’m suicidal’ is also inaccurate” (33). Blauner seems almost condescending, shaming who she seems to view as the ignorant fools who say things they don’t actually mean.

Although—or perhaps because—I find Blauner’s approach to aiding those struggling with mental health issues as disempowering, I would be remiss if I did not recognize the ways in which I myself am discounting the ways in which Blauner’s narrative empowers Blauner herself. DNA’s fourth set of “crucial questions” ask “how is the storyteller holding his or her own in the act of storytelling?” (A. W. Frank, "Practicing Dialogical Narrative Analysis" 33). The restitution narrative framework allows Blauner to “hold her own” as it provides her with the structure to justify the pain she has gone through. What is important to note is that Blauner has *gone through* this pain—it is in the past and no longer part of her present day experience. Relegating such suffering to the past initially strikes me as problematic given the inherent complexities of emotion. While it is theoretically possible for a person to no longer be as affected by a particularly emotional experience that happened in the past, it seems far more accurate to understand events and emotions as having lasting effects on a person, even after one has

recovered from the immediate trauma of the incident. For example, a mother can forgive the killer who murdered her son but that does not mean the pain of her son's murder will ever completely dissipate. Rather than encouraging people to move beyond their pain—which seems to me as much more likely to promote unhealthy coping skills such as repression and denial—encouraging people to live with their pain appears to be far more attainable. However, even given the problematics of positioning suffering in the past, this aspect of the restitution narrative can also imbue the suffering that has occurred with a sense of purpose and meaning. Now no longer part of the community whose members “mistakenly” describe themselves as “feeling suicidal,” Blauner can interpret the misery that once consumed her as an experience vital to her development. Blauner describes herself as a “work in progress [...] complete as I can be in the present moment, still changing all the while [...]. I have felt the depths of despair, risen from the fire, and many of my dreams have and are still coming true” (22). The restitution narrative framework thus appears to allow Blauner to practice third-space by transforming her previous understandings to “find new ways to be in the world, those very actions a way of creating a positive self” (Pratt 267).

What might initially be mistaken for new ways to be in the world, however, can also be seen as authoritative knowledge disguised as everyday knowledge, just enlightened. Using the restitution narrative framework does not guarantee that the author will perpetuate the dichotomy between authoritative and everyday ways of knowing and being, nor does its use guarantee the agency to successfully challenge the dichotomy. At times, elements of the restitution narrative framework appear to evidence an agency of

everyday knowledge, yet in other instances everyday knowledge seems to be subsumed by authoritative knowledge. For Blauner's narrative, in addition to giving her a lens through which to understand the pain she has gone through, the restitution narrative framework seems to provide a purpose for Blauner's future, enabling her to use her past experiences as a way to instruct others who are going through similar experiences. This new function for Blauner's past experiences may present itself as a middle ground between the binary of authoritative and everyday ways of knowing and being. Specifically in Blauner's example, her narrative may initially convey a blending of her perspective of the experiences she has gone through and the interpretation she has been taught to adopt through therapy.

DNA's first set of crucial questions include the query, "What multiple voices can be heard in any single speaker's voice?" and in answering this question we can see how Blauner's story follows the restitution framework by containing as its "primary actors [...] medical staff, especially physicians, supported by nurses and technologies (medicines, pharmaceuticals)" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). Woven throughout Blauner's advice are the voices of those who have helped her. On *How I Stayed Alive*'s dedication page, Blauner makes special acknowledgement of her therapist Sylvia as she thanks "all who have been my legs when I could not walk and my eyes when I could not see, but most of all I thank Sylvia, for teaching me how to be a person on this planet" (n.p.). Blauner portrays Sylvia as a central factor in her recovery throughout her guide, citing what she has learned in therapy to help others who may be similarly struggling. Additionally, Blauner's formal introduction of Sylvia in the text of

How I Stayed Alive as “the therapist who helped me save my life” (4), suggests Blauner’s recognition of her own agency in the narrative of her recovery.

Blauner also seems to create a space to maintain agentic action by functioning, to some extent, as therapist to her readers, thus appropriating her therapist’s voice. The adoption of her therapist’s voice thus reflects characteristics unique to agency that involve an empowerment fueled by a kind of merging between authoritative and everyday ways of knowing and being.⁶ For example, immediately after imparting the rather stern, condescending statement informing readers that the part of them wanting life is stronger than the part of them that doesn’t, Blauner becomes more conciliatory, informing readers:

I wish I could make your suicidal thoughts disappear, but I can’t. What I *can* do is teach you how to get through those excruciating moments when every cell in your brain and body is screaming, “I want to die!” By surviving those moments unharmed and learning new ways of coping, you will gradually create a set of tools that can make life more manageable.

Suicidal thoughts will occur less frequently and with less severity. (3)

The agency, or empowerment, fueled by both everyday and authoritative ways of knowing and being, that Blauner claims in her relationship with readers involves a positioning which allows her to give others the self-confidence Blauner believes she has been given by her own therapist. On the one hand, Blauner places responsibility for the

⁶ Chapter 1’s section, “Agency and Third-Space,” discusses how “agency” and “authority” do not constitute a dichotomy.

alleviation of suicidal thoughts with the person struggling with such thoughts: she can *teach the reader* to learn new ways of coping, not force the reader to adopt new ways of coping. Yet on the other hand, Blauner assumes she can influence her readers' lives to such an extent as to lessen the frequency and severity of their suicidal thoughts.

It is difficult to determine if it is possible for the restitution framework to both emphasize authoritative knowledge as embodied in medical staff as primary actors and provide meaning to everyday experience as people learn to use their personal struggles to perpetuate authoritative knowledge. I believe Anzaldúa describes how practicing third-space challenges dichotomies when she describes *la mestiza*. Anzaldúa explains that

La mestiza constantly has to shift out of habitual formations, from convergent thinking, analytical reasoning that tends to use rationality as a single goal (a Western mode), to divergent thinking, characterized by movement away from set patterns and goals and toward a more whole perspective, one that includes rather than excludes. (255)

Blauner's recovery and subsequent ability to use what she has learned to help others alleviate their own pain seems to indicate the "shift out of habitual formations" Anzaldúa is referencing. Yet this shift is not from convergent to divergent thinking, but rather it promotes analytical reasoning with rationality as a single goal.

Blauner's creation of what she calls "tricks of the trade" encourages analytical reasoning in order to counteract what she describes as her "brain constricted with tunnel vision" (60). In this state of contraction, Blauner explains, "I'd find myself left with two choices (or so I thought): life or death" (60). In order to break free from this dualistic

thinking, Blauner emphasizes the importance of “learn[ing] how to outthink the brain, push beyond what you *think* is real, and reach out for the help that is available” (60). Blauner teaches readers how to “outthink” their brains by describing twenty-five “tricks of the trade.” Trick #5, “Feelings Versus Facts,” exemplifies one way Blauner encourages her readers to rationally analyze their feelings. As a way of introduction, Blauner discloses that such an analysis is necessary because “feelings can be complex and confusing. Moreover, they can get exaggerated by the past and have nothing to do with present reality, *even though the feelings are very real*” (94, my emphasis). Blauner’s attempt to both validate the reality of people’s feelings while at the same time persuade them that their feelings may have nothing to do with the present reality seems contradictory to me. In particular, I question whether a person’s feelings can be validated without also validating his/her perceptions. I see third-space as able to acknowledge the reality of a person’s feelings *and* perceptions by illuminating the simultaneous existence of multiple, often conflicting realities. I believe the requirement of dismissing the accuracy of a person’s perception of the present reality in Blauner’s “feelings versus facts” can ultimately prove debilitating to the agency needed to move beyond self-destructive thoughts. The idea that one can discount a person’s interpretation of reality while also validating their feelings seems to reflect the dichotomy between authoritative and everyday knowledge, indicating a mindset that believes in its own power to enable even as it simultaneously disables. Blauner accurately points out that facts can be used to create different realities. It is her dismissal of the coexistence of these realities that is troubling to me.

I believe Blauner wrote *How I Stayed Alive* out of a genuine desire to help others learn how to alleviate their own distress. While I understand the logic that drives trained professionals in the mental health field to teach clients to challenge self-destructive thoughts, I worry that such challenges may not be handled in sensitive enough ways so as to prevent a mentality that may perpetuate the dichotomy between authoritative and everyday knowledge. While some may find Blauner's suggestions helpful, others may find it difficult to learn how to value themselves if they have been taught to question their interpretation of reality. I believe Chela Sandoval suggests one way representatives of authoritative knowledge might be mindful of everyday experiences when she describes the "enactment of the differential social movement." Sandoval explains that this enactment is

designed [...] to act upon social reality while at the same time transforming the practitioner's relation to it; for differential social movement can only function through a metatransitivity, "a similar kind of dual action on an object and on oneself." (155)

Cultivating a sensitive awareness of the positionality of one's knowledge can then contribute to a therapeutic approach that practices third-space. The mindfulness of mental health practitioners can help combat a patient's dependence on them, as the practitioner actively reminds the patient, and him/herself, of the weaknesses and strengths of therapeutic exercises such as Blauner's "tricks of the trade."

Acknowledging the strengths and weaknesses of authorized ways of knowing and being can help, to some extent, combat the often ready acceptance that privileges

authorized over everyday ways of knowing and being. Similarly, examining the weaknesses and strengths of the restitution narrative can illuminate how this framework exposes authorized and everyday ways of knowing and being to a certain extent. Analyzing the ways in which Blauner's narrative follows the restitution framework reveals how this narrative structure can perpetuate a mindset that reinforces this dichotomy. Blauner does recognize the ways in which her suggestions can reduce the complexities involved in suicidal ideation when she states, "If anything I say sounds simplistic, know that I am well aware of the difficulty involved. My road to freedom was wracked with obstacles and setbacks" (224). This recognition, however, is marginal in comparison to her work as a whole, which, despite her claims of awareness, do not adequately address the difficulty involved in the "road to freedom." Analyzing the restitution framework as exemplified in Blauner's *How I Stayed Alive* thus reveals how this narrative structure has the potential to create a false sense of agency for the author, as any credibility the author may appear to have may be viewed as contingent on the author's adherence to already widely accepted, authorized ways of knowing and being.

Case Study 2: Martha Manning's *Undercurrents: A Therapist's Reckoning with Her Own Depression*

Written by a clinical psychologist detailing her personal struggles with depression, including in-patient hospitalization and electro-convulsive therapy (ECT), Martha Manning's 1994 *Undercurrents: A Therapist's Reckoning with Her Own Depression*, sets itself apart due to the unique positionality of Manning. Specifically, because Manning herself is a clinical psychologist, her everyday knowledge and

experience as shared through her personal narrative can also be seen as representative of authorized ways of knowing and being. Therefore, any agency her narrative may evidence affirms what Herndl and Licona describe as agency's "necessary relationship" with authority (Shifting Agency: Agency, Kairos, and the Possibilities of Social Action 135). An analysis of Manning's positionality as both a clinical psychologist and mental health patient, then, is an examination of the extent to which agency is dependent on authority. Using DNA to determine to what extent Manning's authority influences her agency also reveals the ways in which her narrative both follows and deviates from the restitution framework.

The agency demonstrated in Manning's *Undercurrents* provides the opportunity to practice third-space by challenging, in part, the dichotomy between mental healthcare provider and mental healthcare patient. Whether Manning actually problematizes this dichotomy, however, is difficult to determine, and is to some extent dependent on the personal position of each unique reader. The difficulty of this determination also lies, in part, in Manning's struggles, throughout her narrative, to reconcile her identity as both mental health provider and patient. Specifically, Manning constantly emphasizes what she views as a paradox: providing mental healthcare for others while also needing to receive mental healthcare. I am uncertain as to what extent this emphasis may reflect an awareness of the false construct between provider and patient and/or perpetuate this false construct and/or something in between these two options.

For example, it is debatable whether or not Manning exposes or maintains the artificial dichotomy between provider and patient when she describes herself in dual

voices as therapist and patient preparing for her first visit as a patient to a psychopharmacologist. Manning informs readers that this experience as a patient gave her a new perspective, helping her to realize that what once seemed simple to her as a mental health practitioner actually required a great deal of complex thought from her patients. Manning muses:

Every week I blithely ask new patients the seemingly innocuous questions, “What brings you here?” and “How can I help you?” Now, as I anticipate this appointment, I realize how those questions are so much easier to ask than answer. How does one condense a life into an answer? (59)

Faced with the possibility of seeking mental health treatment rather than providing it, Manning seems to gain a renewed sense of empathy for her patients. While I agree with her conclusions, I also find it disturbing that Manning had not appreciated the complexity of these questions as a therapist, prior to becoming a patient. It is possible, however, that this perception could only happen primarily through experience. Yet Manning herself does not always seem to recognize her disconnect from patients as a therapist, as she tends to describe events as either a therapist or a patient, rather than as both.

Manning seems to perceive the constructed divide between provider and patient when describing herself as a patient in physical distress, consulting a urologist for side effects she thinks are related to the cocktail of psychotropic medications she is taking.

Manning describes her consultation with the urologist after his examination:

I tell him about the new medicine and my suspicion that it is related to the current problem. He looks it up in the *Physicians' Desk Reference*, doesn't

see acute urinary retention in the list of side effects from the drug, and dismisses my hypothesis. I am always amazed at the way physicians treat the *PDR* like the damned Holy Bible. (63)

Manning is frustrated by the urologist's disregard for her perceptions as a patient, his invalidation of her everyday experience in favor of the knowledge authorized by the *PDR*. Manning's sense of entitlement as a healthcare provider may also add to her frustration of being viewed as "only" a patient. Not only does the urologist dismiss Manning's experiences as a patient, he also seems to challenge Manning's validity as a healthcare provider because of her affiliation with the mind, and not the body.

Specifically, the urologist suggests Manning's symptoms are simply a matter of suffering from "hysteria," and suggests that she, as a therapist, might know something about this (64). Manning rails against his audacity, and her indignation seems to be an indication that she is aware and outraged by the disparity between the extent to which he values her knowledge and experience as both a patient and *mental* healthcare provider versus the extent to which he values the knowledge that has been scientifically proven and therefore is authorized.

And yet, shortly after Manning's encounter with the urologist, she seems to reinforce the hierarchy of authorized, objective knowledge over everyday, subjective experience. When consulting the *Diagnostic and Statistical Manual for Mental Disorders* (DSM) with a patient, Manning becomes unsettled as she realizes that she has been exhibiting all the criteria for Major Depression. Manning confides:

I am rattled for the rest of the day. Seeing myself in black and white [in the DSM criteria for major depression] turns my subjective experience of depression into an objective one. I'm not an outside observer in this office anymore. I'm a card-carrying, dues-paying member of the club. (73)

Manning's use of the terms "subjective" and "objective" returns us to the discussion in the first chapter explaining how "everyday experience" is viewed as subjective and "authorized knowledge" is viewed as objective. Manning is "rattled" that what she has been subjectively experiencing on a personal level has now been validated as real from an "objective," and therefore authorized source of knowledge: the DSM. What bothers me is her subsequent definition of herself as "not an outside observer in this office anymore" (Manning 73). This definition implies the extent to which Manning differentiated herself from her patients. Viewing herself as an outside observer seems to require a mentality of immunity to some degree. This mentality of immunity, in turn, seems to indicate a kind of moral positioning over those afflicted. One may argue that whatever Manning thought before no longer matters because she now recognizes herself as "one of them," that is, no different than her patients distressed by their ailments. This recognition might then be interpreted as practicing third-space, as Manning challenges dichotomies by recognizing her positionality. Yet, in addition to the fact that practicing third-space requires, to some extent, a consciousness of the act, I don't believe Manning is challenging binaries in her recognition that she now belongs to "the club." I don't believe Manning challenges the binary between authorized and everyday ways of knowing and being partly because she describes herself as "not an outsider observer [...] *anymore*" (Manning 73, my emphasis).

Her use of the word “anymore” suggests she still believes there was a time when she was not like one of her patients, a belief in the division between those who experience subjectively and those who *know*, objectively.

Moreover, Manning fails to adequately recognize the implications of her positionality as a person struggling with a mental health condition. As the depression worsens and Manning attempts to maintain her busy schedule, she constantly doubts her efficacy. At one point Manning questions, “How can I possibly be helping people? If only I had something else, they’d be sure to see it. Like a person with a broken leg consulting an orthopedist in a full body cast” (84). I’m not sure what, exactly, Manning believes will be accomplished if her patients could see her suffering. What will knowing that their therapist is in pain accomplish? Shame for seeking out help for what is clearly a less-pressing ailment? Perhaps Manning is simply assuming that her inability to help anyone would be readily apparent. Additionally, the fact that her metaphor to describe her suffering is an orthopedist in a full body cast might more readily indicate that even designated healers (of the skeletal system, of the emotions) are vulnerable to (skeletal, emotional) afflictions themselves. Yet, like most metaphors, Manning’s can only be taken so far. Comparing mental health treatment and physical health treatment might be as inaccurate as comparing apples and oranges. A mental health ailment is distinct from a physical health ailment, which is not to say that one is more important than the other. It is equally vital to note the dangers of suggesting that physical and mental health issues are interchangeable. In using a physical healthcare situation to explain her mental healthcare

situation, Manning seems to overlook the necessarily nuanced distinctions between physical and mental health.

Furthermore, Manning seems to perpetuate the doctor-patient binary by implying that a doctor needs to be relatively free of the illness from which his/her patients are suffering. The belief that a doctor in distress cannot adequately help those in similar distress seems to necessarily imply the mentality that only doctors free of ailments can treat those who are ill. This mentality, in turn, imbues the image of the healthcare worker with unrealistic, God-like powers that paints those who are rendering healthcare, in some ways, better than those who are seeking healthcare. While it may be argued that those who are in a position to provide help to others in a particular area must be especially adept in that area themselves (the writing teacher must be a good writer to help poor writers improve, someone who repairs laptops needs to be comfortable around computers), it is important to recognize the difference between the necessity of being knowledgeable in a field and the reality of helpers being equally vulnerable to situations that may lead people to seek help. While the doctor is expected to know more about the workings of the body than the patient, this does not mean that the doctor should be expected to be immune from similar ailments (nor should the writing teacher be expected to never struggle with writing, or the computer technician to never have his/her personal computer crash). Minh-Ha Trinh describes the dangers of intervening in people's lives without recognizing one's situatedness:

In poetical language, there is no 'I' that stands for just *myself*. The 'I' is there; it has to be there, but it is there as the site where all the other 'I's'

can enter and cut across one another. This is an example of the very strength and vitality of poetical language and of how it can radically contribute to the questioning of the relationship of subjects to power, language and meaning in theory. Theory as practiced by many is often caught in a positioning where the theorist continues to stand in a 'safe place' to theorize about others. ("Film as Translation: A Net with No Fisherman" 122)

Prior to experiencing depression to this extent, Manning had seen herself as an outside observer, perhaps even as empathetic to her patients' distress, but always from a hierarchical position that made her separate from her patients. Towards the beginning of her narrative, Manning explains that she and her husband "as therapists [...] both make our living from being professional voyeurs" (13). Manning's description of herself as a professional voyeur further evidences her self-positioning as "set apart" from her patients. Manning's distancing of herself from her patients in turn, reinforces the hierarchy of objective over subjective knowledge in her belief that, because she is no longer exclusively a part of those who know objectively, she can no longer adequately treat those who experience subjectively. To some extent, medical training is implicated as a reinforcement of this hierarchy, as well as cultural contexts that would reinforce patient expectations of such invulnerable health providers.

Manning further perpetuates a hierarchy of authorized over everyday knowledge even as she recognizes her helplessness as a patient. Manning points out the flaws of the system not as a patient, but as a therapist, someone who understands the system and

therefore is qualified to critique it. Manning's critique of in-patient psychiatric treatment is one example of how she uses her voice as a therapist to bestow her wisdom on the best methods to treat patients. Manning states, "We in mental health sometimes assume that because we have positive intentions, our actions will automatically be positive and helpful. But benign tyranny is no less oppressive than malevolent tyranny" (134). In this observation, Manning as therapist is dominant, her ethos created by her role as mental health provider. As the professional, Manning can critique intentions and effects. But what if Manning had stated her criticism without situating herself as a member of the community she is judging? Becoming a patient serves as the catalyst for Manning's recognition of flaws in the mental healthcare system. Yet Manning assesses the system primarily as a therapist, reinforcing the mentality of "us vs. them." Manning's evaluation of the system as primarily therapist, not patient, seems to exemplify the "straight counterdiscourse" Trinh denounces as "no longer threatening" and "ultimately contribut[ing] to things remaining in place [...] tend[ing] more often than not to block critical thinking; it is unable to do much but repeat itself through the same anti-repressive rhetoric of modernist ideology" ("From a Hybrid Place" 138). Manning is essentially asking her fellow mental health practitioners to consider how they might better serve their patients, rather than acknowledging the vulnerability of mental health professionals and patients alike, and asking instead how people in general can best care and be cared for.

Manning offers a glimmer of a mentality that challenges the binary between doctor and patient when she reflects on her journey as a patient. Manning muses:

I tend to look only at actual outcomes to judge my goodness as “doctor.”
But my memories of my own doctors remind me that the process of just walking the road with someone is so important. The communication of hope, the administration of gentleness, and the sharing of some part of self can make a long lonely journey, in all its circuitousness, almost bearable.
(151)

I believe that what Manning describes as “just walking the road with someone” is the mentality that practices a third-space that contests the power structure of doctor over patient. Manning discloses that her self-assessment of her effectiveness as mental health professional examines “actual outcomes,” thus demonstrating how, when understanding herself primarily as a doctor, she perpetuates the dichotomy between herself and her patients. “Assessing outcomes” communicates a division between the one affecting the outcome and the outcome itself, and places Manning in a position of power over her patients. In contrast, “walking the road” implies companionship, with the doctor and patient on equal levels. It also removes the doctor, at least to some extent, from the all powerful position of being able to affect the destination of the journey, i.e., the outcome.

Manning moves closer to merging her selves as therapist and patient when she describes her life after her hospitalization. Manning confides that

The therapist in me knows intellectually that this is an anniversary reaction to my hospitalization last fall. But knowledge is different from experience. I thought anniversary reactions meant being tuned into the calendar on the wall. You notice a date and think, “Oh no, at this time last

year that bad thing happened.” Then you feel the grief and the pain. But that’s not it at all. Your memory isn’t in the calendar. It’s in your bones. Your body remembers what your mind forgets. (185)

Initially, Manning once again separates her therapist self from the rest of her self, making a revealing distinction between knowledge and experience. Manning seems to equate the therapist in her primarily with the knowledge she has and then separates this knowledge from the experience she has gained, outside of being a therapist. This seems to further the dichotomy between therapist and patient, with the therapist having knowledge and the patient having experience, distinct from knowledge. Manning goes on to point out, however, that “knowledge is different from experience,” and in noticing the difference she seems to call for a valuing of experience, not necessarily as better than knowledge, but as a way to recognize the ways in which experience is individually distinct from knowledge as Manning defines it. There are some things about experience that knowledge cannot address, Manning seems to be saying, and in making this observation she is not simply reversing the hierarchy of knowledge and experience but simply valuing them for their differences, thereby taking a step toward practicing a third-space that transcends duality (Anzaldúa 256).

The restoration portrayed at the end of an illness narrative is key to categorizing such a narrative as following the restitution narrative framework. From the outset, Manning appears to deliberately avoid concluding her overall narrative in this way. When directly reflecting on her life before and after the illness, Manning notes the impossibility of such a recovery:

For so long now I have waited to get back to baseline and return to exactly the same point from which I originally set out on these travels. My criterion for healing has been able to pick up right where I left off, like midpage in a novel. I have waited and waited, but I'm still not back to that page. Kay and Lew try to tell me, in their own gentle ways, to stop waiting. I think they're trying to tell me that I'm never going to get back to that page. That I'm in an entirely new book now, most of it unwritten.

(186)

Manning's analogy of being in an "entirely new book" signifies to me a recognition of the ways in which her experience has irreparably changed her. This recognition seems to acknowledge the "always becoming" of third-space, and a shift away from the restitution narrative framework's "reasonable approximation of life before the illness," if "reasonable approximation" is interpreted to mean resumption.

Manning further demonstrates her awareness of the unfeasibility of returning to her "previous life" when she reflects on where she is situated in the present moment:

I have come to some fragile place with the trials of the past years. But the peace only works when I think of depression in the safe and distant "past." The terror of possible depression in the "future" haunts me daily. I hate that dragon. It is my enemy. I am vigilant for it, scrambling to find out how I can prevent it from returning. (196)

The place Manning is describing here hardly seems like a restoration, given its delicate nature and constant hauntings. The dread of anticipation regarding a relapse of her

depression keeps Manning from rebounding back to the place she inhabited before her illness, as the self she once was. Yet the fact that Manning holds no illusions of such a return seems almost comforting to me, an indication of a kind of meta-cognitive awareness that practices third-space in its resistance to neat, tidy, stagnant endings—a resistance Chela Sandoval seems to advocate for as she describes the methodology of the oppressed as “the differential movement that keeps all aspects of being in motion and mutation” (130). Recognizing the ways she has necessarily changed as a result of her experience seems to go against the restitution narrative framework’s definition of a “happy ending” as a return to life before the illness. Ultimately, however, I believe Manning’s narrative upholds the restitution framework due, in part, to the negativity which surrounds her acknowledgment of the impossibility of what she calls getting “back to baseline” (186). Her inability to be as “carefree” as she was before her depression makes her current state fragile and keeps her constantly on her toes, ever fearful of a relapse.

How Manning chooses to end her narrative largely influences my understanding of her story as most closely following a restitution framework. Manning describes her journey home from a retreat she has been on, one where she found herself renewed in body, spirit, and mind. Before she leaves, she buys some freshly baked bread and homemade jam from the monks who run the retreat:

Out on Route 7 I begin to smell the bread. The fresh yeastiness of it is too much for me. The impulse control I struggle so hard to maintain succumbs in one second to the pleasures of the flesh. I can’t find anything to use to

spread the wicked jam on the freshly baked bread. So I pull over to the side of the road. I open the jar of peach preserves, stick my fingers down deep in the jar, and slap the jam on the bread. Before I can eat the bread, I have to clean my hands. I can't find anything for cleaning. So I lick each finger, carefully, to get everything. The bread goes down fast. Then come to the inevitable empirical questions about which jam will taste best on which bread. I pull over too many times and eat too many bread-and-jam and finger sandwiches. But I can honestly say that the ride home, with all its bread and jam and licking and dripping, is one of the happiest moments I have known. Ever. (197)

As Manning prepares to conclude her narrative, she is careful to note the impossibility of returning to baseline, and seems to almost mourn this. Yet her actual ending is full of joy, and she labels the experience as “one of the happiest moments [she has] known. Ever” (197). Juxtaposing this moment with Manning's grim previous descriptions of the lasting effects of her illness reveals the ways in which recognizing the absence of a complete, permanent restoration can, perhaps paradoxically, instill a greater appreciation for the joy experience by “little” things, like bread and jam. Manning may not be able to be the exact same person she was before her illness, but her conclusion demonstrates a way in which restoration can occur in spite of this. This restoration is not a literal returning to a state of being devoid of the fear of relapse and absent the scars of sickness. Yet it is restorative in its recognition of the beauty that can still be found despite depression. Thus, this ending

can be seen as giving purpose to all that Manning has endured, an ending that portrays Manning as vibrantly alive and “on the other side” of journey through depression.

I understand Manning’s *Undercurrents* to, as a whole, be most closely following the restitution framework due in large part to the way in which Manning concludes her narrative and looks towards the future. I also recognize Manning’s narrative as a complicated practice of third-space because she alternates between challenging and reinforcing the dichotomy between “doctor” and “patient.” By observing the ways in which she simultaneously inhabits and resists both these roles, readers can gain a clearer understanding of the power dynamics inherent in mental health treatment, attaining further insight into the ways in which language constructs reality in the mental health field.

Case Study 3: Norah Vincent’s *Voluntary Madness: My Year Lost and Found in the Loony Bin*

Voluntary Madness: My Year Lost and Found in the Loony Bin is an intriguing exposé-turned-memoir. Self-described as an “immersive journalist,” Norah Vincent sets out to investigate, as a patient herself, varying approaches to in-patient psychiatric treatment. Vincent details her experiences as a patient in three institutions: a large, state-run psychiatric ward, a small, private psychiatric hospital, and an independent, behavioral therapy facility. I believe Vincent’s narrative most closely follows the restitution narrative framework in large part because of her eventual conclusion: “In the end, and after a long, long trip, there’s only one thing I can tell you about happiness, about well-being, as I understand it. You want to be happy? You want to be well? Then put your

boots on” (283). I see the restitution framework’s emphasis on affirming the worth of the individual reflected in this “can do” attitude that believes happiness is basically a matter of tenacity.

In keeping with the restitution framework, Vincent’s narrative begins with a recounting of what led to her illness. Vincent’s narrative deviates slightly from the restitution framework, however, as her initial treatment is what is shown to be the partial cause of her illness. Vincent sets out to explore in-patient psychiatric treatment by posing as a patient herself. The need for pretending, though, quickly evaporates as Vincent becomes consumed with depression. Vincent reflects on the inaccuracy of mental health diagnosis when pondering her intake interview for the first facility she studies: a psychiatric ward at a large, state-run hospital:

Certainly, I knew what to say, and how slowly and disconsolately to say it. Whether I was really well or ill, no one but I could really know. How would the docs tell the difference? As in all psych wards, when you check yourself in with only a backpack to your name, saying you are suicidally depressed, they take you at your word. There is nothing else to go on. Diagnoses are made on hearsay. There is no test, nothing independently verifiable. Just the swordplay of soft interrogation. (18)

Both Vincent’s portrayal of and her reflections on the relapse of her clinical depression practice third-space as she challenges the dichotomy between authorized knowledge defining clinical depression and her everyday experience with her despondency. Vincent struggles with the ways in which authorized knowledge, as represented in the *Diagnostic*

and Statistical Manual of Mental Disorders (DSM), conflates physical and mental illness. Specifically, Vincent points out the inaccurate nature of a diagnosis that is determined largely by the patient's subjective report and the practitioner's biased observations. While a patient's self-report on symptoms and a practitioner's subsequent examination can be verifiable, to some extent, with largely physical maladies, Vincent questions the applications of this diagnostic model on illnesses that have been categorized to affect mainly the mind.⁷ By pointing out the inappropriateness of treating mental issues similarly to physical issues, Vincent also highlights the ways in which conflating two previously dichotomized issues—physical health and mental health—fails to successfully challenge the binary of the two.

Vincent also brings attention to the incongruity between the declared goals of mental health treatment and the actual results of such therapy. Vincent concisely sums up the discrepancy between mental health treatment's proclaimed goals and actual results of their practices:

This is the paradox of asylums, and their fatal flaw. Put a person in a cage and you cannot help him. But leave him to his devices and he cannot help himself, or will not. Freedom is a prerequisite for healing a broken mind. It cannot be fixed against its will. Yet a broken mind is a broken will, a freedom that does harm, even potentially serious physical harm to itself

⁷ I do not wish to perpetuate a dichotomy between physical and mental illness. I do, however, recognize the need to acknowledge a distinction, to some extent, between the two.

and possibly others, a freedom that can attack or maim. So, how else to heal but by force? (24)

Here, Vincent describes the contradiction of mental health treatment: in order to be treated, the patient must give up his/her autonomy and accede to the “better” judgment of the mental health provider. Effective treatment is indicated primarily by the patient’s ability to regain the autonomy taken away, by making decisions that are deemed acceptable by the mental health professional. Theoretically, the sign of healing and therefore, a successful treatment, is when the patient has the self-confidence and autonomy to no longer need the therapist’s guidance to make “healthy” decisions. Yet how does one have the self-confidence and autonomy to trust he/she is making “healthy” decisions in the face of the trauma of having such independence stripped from him/her? That Vincent raises this important question reveals, in part, the answer to DNA’s fourth set of crucial questions which seek to determine the “stakes [...] the storyteller [has] riding on telling this story, at this time, to these listeners” (A. W. Frank, "Practicing Dialogical Narrative Analysis" 33). I understand Vincent’s narrative, in part, as a way to, at the very least, begin a dialogue about the disparities inherent in mental health treatment.

Vincent also focuses on the harms that result from the disconnect between authorized knowledge and everyday ways of knowing and being in mental healthcare. Vincent explains how a fellow patient left the psychiatric ward at the large, public hospital “bitter, angry, and frightened,” having learned the lesson that “no matter how bad you feel [...] never confess enough to your therapist to give her even the slightest

inclination to commit you to the bin” (86). Vincent supports her argument by pointing out how the separation between mental health care professional and patient compromises the effectiveness of mental health treatment, counseling readers:

Don’t assume [your therapist] will be able to tell the difference between contained, nonspecific suicidal thoughts and real, imminent danger to self or others, because the truth is, more often than not, she’ll probably commit you either way, just to cover her ass in case you do end up trying something. (86)

Here, Vincent highlights the ways in which the executors of authorized knowledge, as represented by mental health professionals, separate themselves—either consciously or unconsciously—from everyday ways of knowing and being, as represented by their patients’ experiences. By failing to take the time to discern between “nonspecific suicidal thoughts” and “real, imminent danger to self or others,” therapists prioritize concerns regarding liability over alleviating their patients’ suffering.⁸ Furthermore, the fact that Vincent illustrates this accusation by grounding it in the personal story of a fellow patient demonstrates the ways in which Vincent’s narrative creates a story that is “distinct from other forms of narration,” according to Arthur Frank in *The Wounded Storyteller*. Specifically, Vincent’s story allows her to “not only recover her voice” which was lost as a mental health patient deprived of her freedom, but also allows her to “become a witness to the conditions that rob others of their voices” (Frank, *The Wounded Storyteller* xii).

⁸ Therapists’ prioritization of obeying the law, sometimes at the expense of what is in the best interest of their patients, is an important topic for future discussion.

Vincent's narrative thus serves as a location for third-space by visibilizing the invisible, making her private experiences public to potentially affect positive social change.

Vincent further clarifies why those struggling with mental health issues would be wise to be wary of wholly confiding in mental health professionals. Vincent returns to a discussion on the dangers of conflating mental health treatment with physical health treatment. She declares that, "Discernment can be hard to come by in psychiatrists [...]. The human touch is not very often their strong suit. Nor is true empathy [...]. [T]he emphasis is far and away on the science, not the emotional intelligence" (86). Vincent resumes her discussion on the conflation of mental and physical health as she notes the psychiatric profession's attention to science, as opposed to emotional intelligence. Vincent seems to equate "emotional intelligence" with "true empathy," the lack of which, she implies, motivates a similar dearth of discernment. Vincent's description of the mental health profession's preoccupation with "the science," coupled with a discussion on the profession's lack of discernment, advances the idea that using the treatment of physical health issues as a model for addressing mental health issues is insufficient. Vincent indicates the ways in which mental health issues differ from physical health issues, asserting that:

The brain is like no other organ, and does not submit, at least in the lived experience of the patient, to anatomy and chemistry alone. How can we treat it the way we treat, for example, a kidney? There is the brain, whose business is thought and feeling and judgment and even mystical experience. And there is the kidney, whose business is piss. (87)

While it is important to be wary of delegitimizing physical health issues in an effort to advance the distinct treatment of mental health issues, Vincent's analogy does clarify, albeit somewhat problematically, the ludicrousness of approaches to addressing mental health issues that would treat the mind as a clearly categorizable and observable entity. Yet Vincent's analogy is also problematic in its simple reversal of the hierarchy between physical and mental health, the dangers of which are illuminated by the practice of third-space. Anzaldúa's description of the *mestiza* consciousness explains how such a hierarchy can be fully displaced through "attempting to work out a synthesis" with the self adding "a third element which is greater than the sum of its severed parts," that is, the *mestiza* consciousness (256). Anzaldúa discloses that, although this new consciousness is "a source of intense pain, its energy comes from continual creative motion that keeps breaking down the unitary aspect of each new paradigm" (256).

Vincent's subsequent suggestion of one way in which mental health treatment might be improved does, however, potentially echo Anzaldúa's description of how a *mestiza* consciousness is created. Vincent postulates:

It might do wonders for the profession if all psych residents were required to spend ten days incognito as a patient in a locked ward [...]. Then, at least, they would know a bit more whereof they committed, prescribed, and consulted, and they'd think twice before suggesting hospitalization.
(87-8)

It is important to recognize the contrived nature unavoidably inherent in such a requirement for training. The manufactured nature of this experience may not be enough

to foster empathy within mental health professionals that truly reflects the mestiza consciousness described by Anzaldúa in its merging of the roles often prescribed in a doctor-patient relationship. Yet even the slightest troubling of the mentality of approaching treatment decisions from the stance of objective omniscience, however, can create a positionality that dissolves the dichotomy between authorized knowledge and everyday ways of knowing and being. Vincent's proposition thus demonstrates one way in which she uses the "capacity of stories" to challenge dichotomies and subsequently practice third-space (33).

That Vincent's critiques of the mental health care system are grounded in her personal experience also evinces narrative's potential to practice third-space. In particular, because Vincent primarily supports her conclusions from the positionality of a patient, responses regarding the validity of Vincent's conclusions manifest the ways in which credibility can be established with the reader through personal, subjective accounts, as opposed to that which is claimed to be purely objective. Consider, for example, Vincent's interrogation of the efficacy of forcible in-patient psychiatric hospitalization that uses her background as a patient to establish credibility with her audience. This rhetorical technique reflects Chela Sandoval's description of "practitioners of the differential mode of social movement" who "develop and mobilize identity as political tactic in order to renegotiate power" (Sandoval 145). The fact that Vincent has established her inquiries into the mental health system within her own experience practices third-space as it engages her identity as a patient to trouble distributions of

power. Specifically, Vincent demands readers appraise the efficacy of mental health treatment that strips the patient of free will:

Does it make sense to put someone [...] away, and keep her away despite her assertion of the plain fact that being in the bin was making her feel worse, not better? Wasn't that kind of treatment just going to make her, and me, and a hell of a lot of other people, shy away from consulting psychiatrists at all, for fear of being dangerously overmedicated and incarcerated? (88)

Here, Vincent makes a plea for readers to consider the inadequacies of mental health treatment from the patient's perspective. Yet how likely is it that Vincent's opinion, as a person who freely admits to being a patient, will be considered as "evidence" to mobilize change among practitioners of mental healthcare? If Vincent's purpose is to affect change in the mental healthcare system, is it rhetorically effective to speak primarily from a patient perspective, and therefore have a higher probability of establishing a receptive audience among fellow patients? To what extent does appealing to fellow patients alienate mental health practitioners? I see Vincent's narrative as practicing third-space precisely because it is grounded in her personal experience, which makes me question the capability of third-space as practice to affect change. Returning to Sandoval's quote, however, provides some insight into third-space's potential, as she points out that "identity is [...] both disguised and not disguised in a form of differential consciousness that thrives on oscillation" (145). Once again, I am reminded of the essence of third-space as a concept, a way of understanding the world that confronts binaries that divide things

into “either/or” categories. In this particular case, Vincent’s use of subjectivity as a rhetorical tactic exemplifies third-space not simply because it is subjective and not objective, but because it is a manifestation of the adaptability of third-space to give credence to a variety of approaches to expression.

Vincent specifically addresses her use of subjectivity as a means to an end when she shares the reasons she stopped taking her medication. Vincent states that “there are really two reasons why I went off my meds. One good and one not so good” and then goes on to explain that the good reason was because she wanted “not to succumb without a fight to what I considered to be the drug company’s and my doctor’s less than disinterested suggestions that I needed them” (104). Vincent presents her “not so good” reason by admitting that her decision to stop her medication was because:

I did it for the book. I did it because, as I have said before, my brand of journalism is immersive. You have to have the whole experience, or as much of it as you can. You can’t just stand outside as an observer [...].

The whole point is that you are not objective. (104)

I find it intriguing that Vincent’s journalism approach conceptualizes reporting as fully engaged with the subject matter, given journalism’s potential position as authorized knowledge if given from an objective standpoint. Vincent’s planned use of her subjectivity signifies, to me, the ways in which she uses the capacity of stories to be personalized sources of information that engage the reader in ways contrived attempts at objectivity cannot. Admittedly, the fact that Vincent intentionally goes off her meds for the sake of her book can be seen as a contrived way for Vincent to promote her

subjectivity. However, I believe a person's subjectivity is an inescapable condition that will exist whether we fabricate it or not. In contrast, I see complete objectivity as an always already impossible mindset to practice. Ultimately, the trust Vincent establishes with her readers through her use of personal ethos attests, in turn, to the ways in which traditional understandings of narrative as subjective and therefore untrustworthy can be disproven.

Vincent's deliberate employment of subjectivity to authorize her perspectives further exhibit the multiple voices that can be heard in her single voice, which DNA's first set of crucial questions draws attention to (A. W. Frank, "Practicing Dialogical Narrative Analysis" 33). Vincent intertwines her reflections on her personal struggle with depression and critiques of the mental health system with direct calls to action, demanding readers themselves resist the role of passive observer. Vincent confronts her audience, pronouncing, "But you, reader, are the sane person reading this now, and you are thinking that these people on this page are not you. They are the other, put away, out of sight—and yes, I, too, laugh at this expression newly now—out of mind" (153). That Vincent specifically addresses her readers is, in some respects, a refreshing acknowledgment of the reality of published narrative. While what is shared in a published narrative is usually considered a private experience, the context of being published often creates a strange disconnect between how the author is portraying her/himself and the realities of sharing such personal events in such a public venue. Rather than limit herself to a façade that lets the reader into her life without acknowledging the readers' presence in the narrative itself, Vincent allows herself the freedom to acknowledge the multiple

voices she inhabits. This freedom, in turn, demonstrates the ways in which Vincent's narrative recognizes its situatedness. Vincent does not simply write about the injustices she sees and hope readers will take the appropriate action. Instead, Vincent takes ownership of the possible effect her text may have on her readers by speaking directly to them. Vincent's use of multiple voices thus moves her narrative from a kind of safe space that would permit her to speak about an uncomfortable subject without directly implicating her reader. This move seems to embody what Trinh describes as "theory as a practice that changes your life entirely, because it acts on your conscience" ("Film as Translation: A Net with No Fisherman" 123).

Vincent's meta-reflections from her perspective as someone reflecting on previous experiences are also influenced by the voices of others. In keeping with the restitution framework, Vincent incorporates the voices of "medical staff," specifically, her therapist at the third facility which she describes as a "sanctum" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). Vincent's therapist, Carol, is a "primary actor" within Vincent's narrative. Carol's advice impacts Vincent, and Vincent describes "hear[ing] [Carol's] words and [...] internaliz[ing] their meaning" (236). It is Carol who gives Vincent, "exactly what [Vincent] needed" (Vincent 244). Vincent explains that Carol "brought a tremendous amount of dedication and self-sacrifice to her work, and if you opened yourself to her, she would open herself to you in matching style" (Vincent 244). Vincent describes this mutual vulnerability as:

The antithesis of clinically detached. When you did therapy with [Carol], you felt as though you were talking to a very insightful and selfless old

friend, and while this may not have been an approach that worked for everyone, it was exactly what I needed. (244)

Vincent's therapy with Carol allows Vincent to gain insight on how her past experiences influence her present behaviors. This insight is especially significant given Vincent's previous therapy experiences at the large, public psychiatric ward and the small, private one. Finally, in the third facility she visits, Vincent finds a therapy approach that works for her. For Vincent, it is her relationship with her therapist that determines the therapy's efficacy. Vincent thus assigns her therapist a pivotal role in her story, thus reflecting Frank's restitution narrative framework.

While emphasizing the role of her therapist in her narrative, Vincent is also careful to recognize the patient's own responsibility for the outcome of his or her treatment. This self-accountability is also reflective of the restitution narrative framework as it highlights the culpability of a single person, thus affirming the worth of the individual. Vincent muses that her narrative as a whole "turned inward more and more as it went along [...] relinquishing even the vaguest objectivity [...]. I began to feel that the point of interest, the point of healing, and the target of rebuke was less the institution [...] than the individual" (278). Vincent describes her journey towards healing as a solitary one, referencing the Latin phrase *Tertium non datur* as her model. She gives two translations for this phrase: "'The third is not given.' Or alternatively, 'There is no third possibility'" (Vincent 278). Initially, Vincent translates this idea of an absent third as refusing to "do the expected thing, the prescribed thing. Do it yourself in whatever fashion suits you best" (278). Vincent re-examines her initial understanding of the phrase,

however, when she does her own research and discovers “it’s a principle of logic called the law of the excluded middle. It means that something is either *X* or not *X*, or, as it is more commonly heard in general conversation, you can’t be a little pregnant. You either are or you aren’t” (279). Vincent combines these two explanations of the phrase to come up with her own meaning:

The third is not given [...]. It meant that the script was not yet written. It meant that there was a middle way between resignation and folly, between my nightmare au naturel and the tinker-bludgeon approach of modern alchemic psychiatry. It was a place in my mind where I could put all of my aspirations and keep them alive, stocking my vision of the future with the belief that I could exert some influence over it, and over my condition.

(279)

Vincent’s personal interpretation is, arguably, exactly the opposite of the literal meaning of *tertium non datur*. In a way, Vincent’s ability to adapt varying interpretations of the phrase to suit her own ends reflects a third-space mentality in and of itself. Rather than force herself to choose between one translation or the other, Vincent attempts to find a middle ground between the two. The middle ground she settles upon, however, seems very rigid: “If the question is, What’s the point? The answer is, Just do it. Doing it is the point. Don’t think. Do” (Vincent 281). Vincent does not ever claim and in fact actively discourages readers from thinking that she has been completely healed. Yet Vincent’s ending reflects the restitution narrative’s framework as I understand her ultimate state of mind at the end of all her experiences to be, while not “healed,” “restored to at least a

reasonable approximation of the life that was led before illness” (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). Vincent’s narrative thus challenges assumptions that would equate “restitution” with “healing.”

Voluntary Madness manages to address some of my initial misgivings concerning the restitution narrative. In particular, Vincent’s narrative demonstrates how the concept of restitution can be complicated and move beyond the binary of either being “sick” or “well.” In addition, Vincent provides a unique perspective on third-space, demonstrating how this concept can be used to cultivate a “restitution framework state of mind,” one that stresses personal responsibility and action.

Analyzing the Restitution Narrative: Authoritative Assimilation

Before conducting a thorough dialectical narrative analysis on three select narratives, I was wary of even assigning narratives to this category. The restitution framework, as described by Frank, seemed to describe narratives with an oversimplified understanding of an illness experience. I came to this impression mainly from the description of a person being “restored to at least a reasonable approximation of the life that was led before illness” (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). I understand illness to be unavoidably life-changing, and the portrayal of being restored to a “reasonable approximation” of a life before illness seemed to contradict the inescapable consequences of illness. Additionally, by invisibilizing the inevitable repercussions of illness, the restitution framework seemed to be a way to deny the validity of other narrative frameworks. I could picture a person who could fashion his or her misfortune into a restitution narrative judging others who could not: “I changed my

thinking, so you can, too!” The restitution narrative framework thus seemed to represent everyday ways of knowing and being’s assimilation into authorized ways of knowing and being, a wolf disguised in sheep’s clothing.

Despite my misgivings, I was conscious of the ways my interpretation of the restitution framework perpetuated binaries between the authorized and the everyday. I consciously set out to discover and acknowledge what the restitution framework gave people, and I learned that it wasn’t all illusions promoting simplistic understandings of complex, far-reaching experiences. In particular, I realized that “restitution” need not necessarily mean “restoration.” Instead, restitution could mean a way of living with the aftermath of illness. I therefore determined that analyzing narratives for the ways in which they reflected the restitution framework necessarily required me to critique how such a framework obligated the narrator to position herself. Understanding narratives according to the restitution framework thus enabled me to challenge dualistic thinking that automatically assumed those who considered themselves “restored” were necessarily misguided.

CHAPTER THREE: THE CHAOS NARRATIVE

“Wait—isn’t that a funeral home?” asks Alice. The question is directed at the realtor who is showing Alice and her boyfriend a prospective duplex. Alice is referring to the brick building they are suddenly confronted with once the garage door of the duplex is opened.

This is a scene from an episode of *House Hunters*, a cable reality series on the home and garden network. Each episode of the show is typically centered around people interested in buying a home. The show follows them as they and their realtor tour three potential places. The denouement is their ultimate choice.

In this particular episode of *House Hunters*, the buyers are an industrious couple in their early-20s who, according to the narrator of the show, have a \$400,000 budget to buy a duplex in Chicago thanks to having well-paying jobs and being diligent about saving. At this point in the episode, their realtor has shown them two duplexes, each with their pros and cons. This third duplex had been looking particularly attractive to the couple for its distance from Chicago’s public transportation system—not too far, not too close—and windows that display leafy, green views of bordering trees. And then they encounter the funeral home.

In a separate shot, Alice’s boyfriend, Ali, confides to the camera, “I’m a little worried about funeral processions going through [the alley that backs the garage] or [me] taking a stroll around the block and running into people in mourning. That would be something that would put a damper in your day” (4:33 left, about 16:54 min in). When I first watched this episode, I burst out laughing. While I could understand what I felt was

the practical concern of getting in and out of one's garage, I did not expect Ali's other concern about living next to a funeral home. His worries that running into people in mourning would "put a damper in his day" seemed comical to me, maybe, in part, for the ways in which it signaled to me a kind of pretentiousness and naïveté towards life in general. I thought, 'Is this guy serious? How can you admit on national television that you're worried about encountering sad people who might bring you down?' I pictured Ali taking a random stroll around the block of his duplex, hands in his pockets, whistling a carefree tune, only to stop dead in his tracks by a line of weepy folks in black attire, dabbing their eyes with handkerchiefs. What a bummer that would be.

Upon thinking about his comment and my reaction more, I wondered how much of Ali's reservations to living next to a funeral home reflected a prevalent intolerance in Westernized societies to visible unhappiness in general. I became unsure as to whether what seemed absurd to me would seem absurd to others. Perhaps Ali's reactions would be shared by the audience—*of course* a person wouldn't want to live next to a funeral home because of the potential of having to encounter sadness. Who would want to live next to *that*?

Allowing Room for Ambiguity: The Chaos Narrative

Chaos Framework: Allowing Silence
<ul style="list-style-type: none"> • The protagonist has multiple problems, crystallized by an illness (or illnesses) but usually not limited to that illness; • Efforts to stop the collapse are futile; everything has been tried, and each potential form of assistance is blocked; • The plot leads to no resolution, which is its chaos; • The sense of simultaneity stifles suspense; things will worsen, but too slowly for the expected end to offer any relief.

Table 6: The Chaos Narrative Framework

As in the second chapter, I use a narrative typology formulated by Arthur Frank as a way to closely examine three select narratives. This chapter, however, uses the chaos narrative typology as a framework, vastly different from the restitution framework previously discussed (see Table 6). The chaos narrative is described by Frank as containing a plot in which (1) the protagonist “has multiple problems, crystallized by an illness (or illnesses) but usually not limited to that illness”; (2) “efforts to stop the collapse are futile; everything has been tried, and each potential form of assistance is blocked”; (3) “the plot leads to no resolution, which is its chaos”; and (4) “the sense of simultaneity stifles suspense; things will worsen, but too slowly for the expected end to offer any relief” (“Practicing Dialogical Narrative Analysis” 47). Frank details the chaos narrative as “*anti*-narrative in the sense that while one thing happens after another, none of it goes anywhere” (“Practicing” 47). It is Frank’s description of the futility of this narrative which is striking to me. In what follows, I also analyze the ways in which Frank’s characterization of chaos narratives as hopeless indicates the discomfort towards grief in Western society as a whole. I examine the consequences that result when narratives are understood through the chaos framework, determining the ways in which a third-space of always-constrained agency is created. In particular, my analysis of third-space in this chapter studies how the chaos narrative framework allows room for ambiguity. I examine how the chaos framework goes against authorized knowledge as well as authorized ways of knowing and being that would equate objectivity with reliability, determining the extent to which the chaos framework’s association with subjective narratives compromises its perceived credibility. I also analyze the

implications of the anti-narrative framework. If the anti-narrative goes nowhere, does that mean the opposite: that the narrative framework will necessarily go somewhere, that is, provide a purpose for each experience? If a narrative framework indeed means linking a purpose to each experience, does an acceptance of the anti-narrative chaos framework dismantle the need to find meaning? In a culture where healthcare compels patients to frame their stories as restitution narratives, I seek to determine whether the chaos framework can recognize the therapeutic benefits of narratives.⁹ Exploring narratives as a chaotic type of interpretation of life experiences further adds to the complexity of my discourse narrative analysis on how stories enable us to live.¹⁰

Case Study 1: Anonymous, “For Love Nor Money”

“For Love Nor Money,” published in the edited collection, *Women’s Encounters with the Mental Health Establishment: Escaping the Yellow Wallpaper*, is written anonymously, the reasons for which are made clear throughout the course of the narrative. The narrator’s description of her experiences allow readers to deduce that she is female, in a master’s creative writing program working on her thesis, in her early-thirties, and independently wealthy. These characteristics help explain key events of her story, which center not so much on the narrator but rather on the hazards of being in acute psychiatric distress and seeking help from the US mental health system. The narrator’s

⁹ Arthur Frank, “Practicing Dialogical Narrative Analysis” (2012). I describe this facet of restitution narratives at the end of Chapter 1: The Work Ahead: Outline of Chapters to Follow and in Chapter 2: Affirming the Worth of the Individual: The Restitution Narrative.

¹⁰ Joan Didion. See my discussion of this quote in my opening to Chapter 1.

focus on these perils is what caused me ultimately to characterize this story as mostly following Arthur Frank's chaos narrative typology.

The author practices third-space in her first sentence by situating herself outside of the dichotomy of a single versus a multiple self. Rather than portray herself as either feeling solely one way or feeling conflicted, the author describes her inner monologue in a way that reflects what Sandoval describes as a "consciousness of situated knowledges" (175). Sandoval explains that those who have a "consciousness of situated knowledges [...] develop a different kind of relation to perception, objectivity, understanding, and production that is akin to White's and Derrida's descriptions of the middle voice" (Sandoval 175). This middle voice is exemplified by the narrator as she describes her numerous problems characteristic of the chaos typology (A. W. Frank, "Practicing" 47). The narrator bluntly states, "From the moment I awoke, I began battling urges to swallow entire bottles of pills," signaling the problem of suicidal ideations as well as the existence of contesting voices fighting for and against the urge to die (45). This sense of ambivalence is further emphasized as the narrator continues, "By 11:00 a.m. I had the pills spread out before me. I called my therapist and left her a message: *I am feeling suicidal. I have all my pills in front of me and I feel out of control*" (45). The desire the narrator claims to have could possibly be seen as a contradiction to the actions she recounts: why call a therapist and leave a message if she wanted to die? Or is feeling out of control not the same as wanting to die? Rather than rectify this discrepancy with the conclusion that she didn't *really* want to die, the narrator continues to attempt to portray her conflicting state of mind. Even after she specifies relating her feeling of suicide to her

therapist, she contextualizes the seemingly straightforward statement with the acknowledgment that:

It took me a while to work up to those words. I spent the first five minutes of the message talking about bad dreams I'd had. Bob Dylan blared in the background. My therapist [...] didn't understand the urgency of the situation. My suicidality was nothing new to her, nor were my long ramblings on her message machine. (45)

In this way the narrator positions herself outside portrayals that would paint things as “either/or”: Either she wanted to die or she didn't. Either she communicated her feelings of suicidality or she didn't. Instead readers are left with “both/and”: She both wanted to die and she didn't. She both communicated her feelings of suicidality and she didn't. Thus her own expression of feeling out of control demonstrated the existence of a “both/and” state of mind.

This anonymous author, unexplained to us in name but not in feeling, creates a location for third-space as her narrative portrays the limitations of language (Licona 111). These limitations are made apparent through the circumstances leading up to the narrator's intense urges to overdose:

I had started antidepressants nearly a year before, when after several episodes of severe, suicidal depression, my psychologist had given me an ultimatum: either you take antidepressants, or I stop working with you. I couldn't stand the thought of starting over with another therapist, so I had agreed. At first, the drugs worked. I was happy for the first time in

decades. For the first time in my life, I wrote poetry about joy. As the months passed, however, the drugs did less to quell the depression. When we increased the dosage, I started to feel out of control of my poetry, my body, and my life. My therapist seemed to understand, but she was adamant about her requirements for working with me. (46)

The narrator introduces readers to her numerous troubles which include not only the illness of severe, suicidal depression but also the agony she experiences using antidepressants. Her misery is as much the result of the medication's ineffectiveness to quell her depression as it is part of the existential crisis she grapples with surrounding the moral ramifications of taking drugs designed to alter her temperament. Compounding these concerns are the consequences her actions regarding the antidepressants will have on her relationship with her therapist. Specifically, her therapist's directive to be on medication seems to add to her sense of being/living out of control. In the narrator's mind, what was supposedly a mandate intended for therapeutic benefit has only exacerbated the narrator's distress, stripping her of the support she needs to help her cope. I believe the failure of her therapist's order to have any restorative effect evidences the limitations of language. That is, the therapist's capacity to alleviate her patient's distress is restricted by the extent to which their communication can mitigate emotion. While it is true that the therapist's recognition of the limitations of language in the effectiveness of talk therapy may have prompted her to require the narrator to take medication as part of treatment, it is also those same limitations of language which restrain the narrator's ability to effectively convey the impossible position she feels her

therapist has placed her in. “I started to feel out of control,” the narrator writes, and “my therapist *seemed* to understand [emphasis added],” but had her therapist truly understood, one wonders if the narrator would have come to this point at all, that is, on the brink of an overdose (46). I see the fact that the narrator felt understood is evidence of the limitations of language that impeded her from fully communicating with her therapist. However, because the narrator is able to convey this impasse between her and her therapist, I believe the narrator is able to create a location for third-space as she depicts the effects of the limitations of language.

“For Love Nor Money” also serves as a location for third-space as it brings people together by identifying similar experiences and fostering connections. This ability of a text to unite individuals is possible because, as Anzaldúa observes, “making meaning is a collaborative affair” (“To(o) Queer the Writer” 168). Anzaldúa describes this collaboration as involving three major players: the author, the text, and the reader. In “For Love Nor Money,” this “triangle of author-text-reader” is constructed by the narrator’s account of the copious efforts she makes to stop her collapse (Anzaldúa, “To(o) Queer the Writer” 168). After leaving a voice mail for her therapist, the narrator describes the three hours she tried to make it on her own:

I read T.S. Eliot. I wrote about my feelings. I slashed pieces of paper with a pen. I drew cuts on my wrist in red ink. And, in stages, I prepared my poison. First, I crushed all my antidepressants with a hammer, catching the orange powder on a paper towel [...] To the orange powder I added ten Percocet, stirring the mixture into a glass of orange juice. (45-6)

The narrator's description of the various "coping mechanisms" she employs is brutally descriptive, filled with details that for many would go beyond the statement "I struggled with suicidal feelings." With more specifics comes more vulnerability, exposing her to the criticism of others regarding the quality of her struggles to handle her emotions or, perhaps even worse, the refusal of others to even allow such suffering to affect their lives, to, as Ali from *House Hunters* stated, "put a damper in [their] day." A broad statement sharing these kinds of feelings is, in some ways, easier to gloss over than such severe depictions. Nevertheless, such specification and openness has the greater potential to connect those with similar feelings and perhaps experiences, creating meaning as factors of the author, text, and reader combine.

Inherent in the chaos narrative typology of attempts to stave off disaster is the futility of such undertakings and the obstruction of each potential form of assistance. The portrayal of this futility can also practice third-space as it challenges dichotomies. Specifically, the narrator once again illustrates how it is possible to simultaneously desire death and life. This is seen in the beginning of the narrator's attempts to stave off destruction, which include the copious amount of phone calls she makes both before and in the process of overdosing. After she stirs her Percocet/antidepressant/orange juice mixture, she again tries to call for help, this time dialing her psychiatrist's emergency number. Yet this endeavor, too, is unsuccessful and, after forty-five minutes, she "felt abandoned" (Anonymous 46). This is when she begins to drink. Even in the process of drinking, however, she still calls for help: "Before I drank anymore, I tried my psychiatrist again" (Anonymous 46). But: "as the minutes passed with no return call, I

took several more gulps of the mixture” (Anonymous 46). In keeping with the chaos narrative ideology, the narrator’s repeated calls for help both before and during her overdose prove futile as they are initially met with no answer. Yet she keeps persisting, even while she has already given in. Understanding the narrator’s contradictory acts as challenging dichotomies allows readers to move beyond their potential flippant observation that she never “really” wanted to die and was overdosing for the attention. In challenging the dichotomy of wanting to die versus wanting to live, this narrative opens up a third-space that acknowledges the existence of opposing feelings.

In yet another contradiction, even receiving what is perceived as therapeutic help proves unhelpful for the narrator. Given that the narrator herself does not find the responses to her distress helpful, I understand the narrator’s experiences with what might otherwise be understood as “help” as an example of what Frank describes as a failure to receive assistance, thus continuing the chaos narrative typology. Specifically, the narrator, despite her desire to remain unknown (as evidenced in the fact that we only know her as “Anonymous”) makes public her private experience in order to affect positive societal change. When her psychiatrist does call her back, the narrator is directed to the nearest emergency room. Seeking help from the emergency room, however, is fraught with its own traumas, as is forecasted early on in the narrative by the narrator’s description of the hospital as “where my true nightmare really started” (45). After having her stomach pumped and her belongings taken from her, she is threatened by a social worker about a possible stay in a mental institution (Anonymous 47-8). This threat is precipitated by the narrator’s disclosure that she has insurance but will be “paying for the

hospital visit myself” (48). The narrator explains to her readers that “I’ve read too much about how information on one’s insurance record can be accessed by people who have no business knowing it” (48). Therefore, in order to protect her privacy, the narrator is willing to spent “thousands of dollars” of her own money (49). The narrator discloses to readers that she is “independently wealthy,” yet has decided not to tell this to the social worker, reasoning that “she would resent me if she believed me, and if she didn’t believe me, she’d think I was delusional or a compulsive liar and add it to my chart” (48). In any case, the social worker herself explains that such a deviance from the normal way of paying would be punished, stating bluntly to the narrator that “Even if you got a statement from your bank and could produce it right now [...] it’s our policy to send people who aren’t paying with insurance to [a mental institution]” (49). In addition to this threat of being set to a mental institution, the narrator is also informed that the psychiatrist on call refuses to evaluate her because she is not paying with insurance (49). Calls to other psychiatrists produce similar results (Anonymous 50). The narrator sums up the effects of this treatment on her already fragile state: “Feeling out of control of my life had prompted the overdose. I had gone to the hospital and told the truth [...] And now I *am* out of control of my life” (49). The experience of the narrator evidences the sheer chaos of the mental health system itself.

Though the narrator’s inability to receive help reflects the futility characteristic of the chaos narrative, this inability to receive help also contributes to suspense that, according to Frank, is unusual for this narrative typology (“Practicing” 47). Even though the narrator’s numerous initial attempts to receive help are unsuccessful, I still waited

with anticipation for the attempt that would be successful. And even after the help she receives proves more destructive than restorative, I continued to wonder whether the narrator would finally see the “right” provider and get the “right” treatment. When the narrator is informed that the hospital has finally found a psychiatrist who is willing to see her, I worry along with her that her “scraggly hair,” the facts that she hasn’t “showered in two days, [has] yellow circles under [her] eyes from the Percocet, [and her] eyelids are swollen from tears and lack of sleep” will cause the psychiatrist to view her as a “wreck,” and consequently keep her in the hospital for weeks (Anonymous 52). My own perception of suspense in this narrative causes me to question Frank’s overall characterization of the chaos narrative typology as lacking suspense. In particular, it seems possible that this set of criteria for the chaos typology reflects an inherent intolerance for prolonged disorder. The inability to listen with interest to an extensive account of distress could thus indicate a general uneasiness with misery.

This difficulty with anguish could also explain why Frank defines the chaos in a chaos narrative as without resolution (“Practicing” 47). Also contrary to Frank’s chaos narrative typology, in “For Love Nor Money,” I found the conclusion to have a resolution. At the end of her narrative, the narrator ponders what has happened:

In spite of the costs, my hospital stay and what had precipitated it were useful in some ways. My therapist now allows me total control over decisions regarding antidepressants. She has promised to take me at my word always so that I won’t have to resort to dramatics, and she has made a commitment to overestimating instead of underestimating my level of

depression. I have promised to express my feelings as clearly as possible and to make a point of discussing problems instead of acting out [...] I've learned that if I ever get that depressed again, I should check myself into the best hospital around *before* making a suicidal gesture. Preferably I'd do that with a friend in tow. And I'd make damn sure whoever it is just happens to be a lawyer. (53)

The narrative's closing paragraph thus provides a solution of sorts to the major problems explored throughout the story: the narrator's struggles with taking medication and its consequences on her relationship with her therapist, feelings of suicidality, and dubious hospital procedures. This resolution, however, does not eliminate the chaos so much as it offers a way to hopefully manage it in the future. The absence of the complete expulsion of chaos in this specific chaos narrative coupled with the declaration of an omitted resolution in chaos narratives as a whole could also evidence an instinctive disdain for despondency.

The narrator herself can be seen as combating this disdain through the act of telling of her story. DNA's fourth set of crucial questions ask readers to consider the stakes involved for the storyteller when telling the story (A. W. Frank, "Practicing" 33). "For Love Nor Money" appears to provide a voice for the voiceless and, in so doing, creates a location for third space as it visibilizes the previously invisible. The narrative reveals the ways in which hospital policy can obstruct patient care as the narrator recounts constant threats to be sent to a mental institution. The fact that she is not sent there is due in large part to her private psychiatrist, who informs her that such actions are

“called patient dumping” and that the narrator has “a right to pay however [she] choose[s]” (51). Her psychiatrist advises her to threaten to sue (51). The narrator admits to her readers that she doesn’t quite “feel up” to this, given that she is “still groggy and now [...] more depressed than [she] was [that] morning” (51). Yet she declares, “I simply won’t be controlled. I won’t let them cart me off like a piece of trash” (51). Her narrative has the potential to function for others in a way similar to how the narrator’s psychiatrist functions for her—as a motivator, and a reminder to one’s inherent self-worth. The psychiatrist names the hospital’s actions—“that’s called patient dumping”—and in doing so exposes the narrator’s “treatment” for what it is: abusive. The narrator, in turn, “begin[s] to understand the pattern,” realizing “I’m an inferior being here, a person who didn’t try hard; a person who does stupid things [...]—if I’m a person at all. I suspect I’m merely a source of income, susceptible to being bludgeoned with threats whenever payment is in question” (52). The narrative thus serves as a location for third-space, empowering the non-dominant, everyday expert. Trinh describes this function of the writer to help the reader as a “political responsibility [...] to offer meaning in such a way that each reader, going through the same statements and the same text, would find tools for herself (or himself) to carry on the fight in his (or her) own terms” (“Between Theory and Poetry” 154). As a reader, I find myself feel empowered by this woman’s assertion of herself, and her willingness to share an experience that so often stigmatizes the person who admits to having gone through it.

The anonymity of “For Love Nor Money” lends an overall gravity to the offenses it portrays, serving as further evidence of the reality of the stigma of mental health

treatment and its negative consequences. This explication of the damaging effects of seeking help, combined with the narrative's unflinching details of what it means to grapple with suicidality, lead me to ultimately characterize this narrative as most likely an example of Frank's chaos narrative typology. While not completely fulfilling the particulars of the chaos narrative, I believe such lacks could be the result of an overall variance in perception towards emotions that do not fit within the Western societal norm. In particular, the inability to tolerate what is commonly described as a completely negative outlook can lead to such generalities that would dismiss such stories entirely. "For Love Nor Money" fights against this dismissal, disrupting ideologies that would fit emotions and actions into "either/or" categories. In this way, the narrative both practices and serves as a location for third-space.

Case Study 2: Susanna Kaysen's *Girl, Interrupted*

The majority of Susanna Kaysen's widely-known 1993 memoir, *Girl, Interrupted*, chronicles her 18-month hospitalization as a teenager in a psychiatric ward in the 1960s. I understand Kaysen's narrative to reflect Frank's chaos framework based on his ideas that such a narrative must be constituted by an overall lack of a resolution to the problems Kaysen presents. In particular, Kaysen does not find a way to benefit from the existing structure of the mental health system, nor does she suggest that any reform is possible. Kaysen's narrative thus eschews the narrative frameworks often preferred by authoritative sources of knowledge such as healthcare professionals. This distancing from authorized knowledge is thus in keeping with the way in which the chaos framework accepts uncertainty, rather than glossing over or over-simplifying troubling events.

The beginning of Kaysen's narrative includes a description of the events leading up to her hospitalization. Kaysen's report, however, is devoid of a definitive explanation as to the reason for her hospitalization. According to Kaysen, what began as a simple consultation with a new psychiatrist ended inexplicably in institutionalization. The initial description of her interaction with this psychiatrist is brief, and then, abruptly, a new chapter is started and Kaysen is a patient on a psychiatric ward, describing her life there and the situations of the patients with her. It is not until about sixty pages later that Kaysen returns to the encounter that started it all. The chapter title is apropos of Kaysen's general stance towards her audience: "Do You Believe Him or Me?" (71). The question Kaysen poses moves her readers to take a side before they are given all the facts. The notion of an availability of, or even overall existence of "facts," however, is perhaps what Kaysen is ultimately trying to trouble. Kaysen explains that the doctor claims their consultation was three hours, while she maintains that it was "twenty minutes between my walking in the door and his deciding to send me to McLean" (71). She concedes that she "might have" spent, at the most, another hour and a half in his office as he made various phone calls to get her admitted (71). Having disclosed all this, I, as the reader, am inclined to believe Kaysen's version of events. Kaysen goes on to point that, "We can't both be right," a rather obvious statement given the huge difference in time: three hours versus an hour and a half (71). Having declared as impossible the accuracy of both versions of events, Kaysen then poses the question, "Does it matter which of us is right?" (71). Kaysen admits that it matters to her, but then confides, "it turns out I'm wrong" (71). Kaysen reveals:

I have a piece of hard evidence, the Time Admitted line from the Nurse's Report of Patient on Admission. From that I can reconstruct everything. It reads: 1:30PM [...] I said I left home early. But my idea of early might have been as late as nine in the morning. I'd switched night and day—that was one of the things the doctor harped on. (72)

Kaysen continues her description, pointing out areas in which her perspective might be invalid. After making a strong case in favor of the doctor, however, Kaysen declares, "I still think I'm right" (72). Is it possible for Kaysen to think that she is right even after she has stated that she is wrong? Kaysen qualifies her assertion by adding, "I'm right about what counts" (72). Then she challenges the reader again. "But now you believe him" (72). Her statement feels accusatory, and is confusing given the trouble she has gone through to establish the credibility of the doctor's story, only to imply that if readers believe his version of events, they are somehow betraying Kaysen. After making a strong case for the doctor's version of events, Kaysen then adds another piece of "evidence" to the mix:

The Admission Note, written by the doctor who supervised my case, and who evidently took an extensive history before I reached that nurse. At the top right corner, at the line Hour of Adm., it reads: 11:30AM. (72)

The Admission Note thus puts Kaysen at the hospital a full two hours earlier than the Nurse's Report, which was previously the only piece of information readers had to go on to construct a timetable for that day. With this new report comes a new reconstruction of events, and this version is closer to Kaysen's 20 minutes than it is to the doctor's three

hours: 30 minutes, to be exact. Kaysen ends the chapter smugly, announcing, “Now you believe me” (72). While Kaysen may have proved her accuracy when describing how long the doctor interviewed her, she has also deconstructed her reliability as a narrator. I interpret the uncertainty Kaysen creates to be a reflection of the chaos in the chaos narrative framework. Readers are left confused and uncertain of who to trust, and this is perhaps partly because Kaysen challenges her readers to go against normalized thinking that would trustingly believe whatever the author portrays. Thus Kaysen practices a third-space tactic as she fights against automatic acceptance of her reliability due to her authorized position as the narrator. That Kaysen introduces evidence in sections seems to be a manipulation of her readers’ opinions in order to encourage them to pass judgment only to have to suspend it soon after, thus demonstrating the need for readers to remain skeptical, always cognizant of the fact that we don’t know “the whole story.”

The story of Kaysen’s 18-month stay at McLean Hospital, a psychiatric institute, is similarly fragmented. Kaysen does not recount events in chronological order, and she presents herself through multiple voices. This recognition of different facets of the self as seen in the multiple voices Kaysen presents practicing third-space as it challenges the notion of a singular identity. In some instances, however, the voice Kaysen embodies appears to be overgeneralizing a complex, multi-faceted community. For example, one voice Kaysen uses directs attention to the community of psychiatric in-patients, appearing to offer a universal experience of suicidal ideation. This voice occurs immediately after Kaysen’s first description of her encounter with the psychiatrist who committed her, at an unspecified time during her hospitalization:

Twenty aspirin, a little slit alongside the veins of the arm, maybe even a bad half hour standing on a roof: We've all had those. And somewhat more dangerous things, like putting a gun in your mouth. But you put it in there, you taste it, it's cold and greasy, your finger is on the trigger, and you find that a whole world lies between this moment and the moment you've been planning, when you'll pull the trigger. That world defeats you. (17)

Here, Kaysen's use of the second person to describe suicidal ideation bestows upon her narrative an authoritative undertone—a definitive description of what it feels like to suffer from depression to the extent of wanting to die yet be paralyzed from taking action because of the depression. Kaysen vividly conveys an aspect of mental suffering that is not readily apparent to the outside observer by using her own thoughts and experiences and positioning herself to speak for her fellow patients as well. By positioning herself in this way, Kaysen authorizes the experience she knows to be true as she imposes her reasoning on others who have acted in ways similar to her own actions, as seen in the above quote through her use of the second person. Analyzing Kaysen's narrative by separating her story into the various viewpoints she embodies therefore reveals the ways in which she sometimes authorizes her everyday experience at the cost of perpetuating a dichotomous framework that would view as legitimate those experiences that match with the majority.

Viewing Kaysen's narrative as a way to authenticate her own experience draws attention to the possible reasons Kaysen has chosen to share her experience. In *The*

Wounded Storyteller, Frank explains that stories have the potential to transform the “disease that sets the body apart from others” into “the common bond of suffering that joins bodies in their shared vulnerability” (xi). The transformative potential of the chaos narrative that Frank describes thus imbues stories, specifically personal narratives of illness and suffering, with a particular propensity to create a bond between the reader and writer. Additionally, this connection holds the possibility of consequently establishing the author’s credibility. Kaysen appears to be trying to capitalize on this function of stories through her narrative. For example, Kaysen describes watching with her fellow in-patients on the psychiatric ward Black Panther Party co-founder Bobby Seale “bound and gagged in a Chicago courtroom” (93). Kaysen characterizes fellow patient Cynthia as “particularly upset,” because Cynthia relates to being bound and gagged for her electroshock therapy. Cynthia’s reaction, however, angers another patient: “‘Don’t you see the difference?’ she snarled at Cynthia. ‘They have to gag him, because they’re afraid people will believe what he says’” (Kaysen 93). The difference between restraining an institutionalized person and an activist prompts Kaysen’s realization: “We looked at him, a tiny dark man in chains on our TV screen with the one thing we would always lack: credibility” (93). In some ways, this revelation manages to be simultaneously sobering and ironic when viewed in the context of being shared publicly years later in narrative format. While Kaysen at times seems herself unwilling to assume readers will view her as a reliable narrator, she somehow also manages to demand such trust from her readers. In the example with Bobby Seale, Kaysen portrays herself as permanently lacking credibility because of her psychiatric patient history. Yet believing the portrayal itself in

some ways means disproving its conclusion, as an acceptance of the bias Kaysen will face that would deem her as unreliable is itself an act that would give her reliability. Such a paradox appears to practice third-space as it upends dichotomous thinking that might overlook the meta-function of a text's effect on the meaning portrayed explicitly in the text.

Intentionally or not, Kaysen's narrative has the potential to bestow not just her but her fellow in-patients with credibility as well. Frank points out that, "In stories, the teller not only recovers her voice; she becomes a witness to the conditions that rob others of their voices. When any person recovers his voice, many people begin to speak through that story" (*The Wounded* xii). Thus the stakes for Kaysen when telling her narrative involves not only the validation of her own story but the recognition of the plight of fellow psychiatric in-patients as well. Kaysen complicates the idea of "craziness" as manufactured either by the diagnoser or diagnosee without going to the other extreme and declaring mental illnesses to be purely biological, and therefore immune to behavioral intervention. Kaysen explains the strange paradox of being a psychiatric in-patient, describing the hospital as both a "refuge" and a "prison," barring access to and from the "outside world":

In a strange way we were free [...]. We had nothing more to lose. Our privacy, our liberty, our dignity. All of this was gone and we were stripped down to the bare bones of our selves [...]. Naked, we needed protection, and the hospital protected us. Of course, the hospital had stripped us naked

in the first place—but that just underscored its obligation to shelter us.

(94)

Rather than indignantly deny the existence of the appeal of losing one's freedom, Kaysen acknowledges the ways in which being on a locked ward somewhat alleviates what can be the onerous responsibility of taking care of one's self. Yet Kaysen's recognition also stops short of rejecting institutional culpability for the infantilism of its patients. Kaysen reminds readers that the situation is complicated, with a myriad of factors involved. This admission provides more reason to trust Kaysen's reasonings as sound. Furthermore, an acceptance of the psychiatric in-patient as neither completely irresponsible or completely helpless restores at least a modicum of validity to this community as well. This recognition of the ways in which Kaysen's narrative can affect the public perception of the psychiatric in-patient community as a whole, however, does not contradict my earlier discussion critiquing Kaysen's tendency to presume to speak for her fellow patients when expressing her perceptions. Rather, the truth in both discussions functions per the chaos framework to allow room for ambiguity, both recognizing limitations and celebrating positive potential.

Conducting a dialogical narrative analysis of Kaysen's narrative in the context of the chaos framework consistently reveals Kaysen's efforts to avoid oversimplification. That the author of a narrative deemed to primarily follow the chaos framework would take such considerations might prove surprising to some who would be inclined to generalize chaos narratives as somewhat exaggerated, always leaning a bit more towards the negative. Yet Kaysen seems to be acutely attuned to those who would cope with such

an unsettling portrayal of the psychiatric system with a quick dismissal of her narrative as overwrought. What I initially interpreted as a defensive stance towards the audience might also be understood as a manifestation of Kaysen's sensitivity to such rejections of her trustworthiness. Consider, for example, Kaysen's depiction of various reactions to her psychiatric history:

“You spent nearly two years in a loony bin? Why in the world were you in there? I can't believe it!” Translation: If you're crazy, then I'm crazy, and I'm not, so the whole thing must have been a mistake.

“You spent nearly two years in a loony bin? What was wrong with you?” Translation: I need to know the particulars of craziness so I can assure myself that I'm not crazy.

“You spent nearly two years in a loony bin? Hmmm. When was that, exactly?” Translation: Are you still contagious? (125)

The reactions Kaysen recounts and interprets, while lighthearted in their presentation, also reflect Kaysen's awareness of the various judgments she is susceptible to when divulging her encounters with the mental health system. In particular, the people Kaysen describes tend to deny that Kaysen's experience is indicative of any need to change the system, telling themselves “the whole thing must have been a mistake.” People also may try to distance themselves from her by making Kaysen an “other,” set apart and therefore not applicable to anything that may affect them personally, as seen in concerns regarding the specifics of craziness. By reproducing these distinctions in her narrative, Kaysen demonstrates her ability to recognize the nuances composing people's varying responses

to her psychiatric hospitalization. Such attention to detail can thus counter any resistance to her narrative that would dismiss her negative representations as only manifestations of a mental illness.

The problem of critiquing a system that has the power to nullify a person's critiques as indicative of an underlying disorder is a predicament of which Kaysen seems acutely aware. This sensitivity is evidenced in my earlier discussions on the function of Kaysen's narrative in terms of bestowing credibility on her and her fellow patients. Kaysen also directly addresses the need for such mindfulness, declaring that her diagnosis of "borderline personality disorder" is something she is "tempted to try refuting [...] but then I would be open to further charges of 'defensiveness' and 'resistance'" (150). Kaysen admits, "I'm simplifying, I know. But these words taint everything. The fact that I was locked up taints everything" (151). In the end, revealing one's positionality as a psychiatric patient inevitably influences one's public image.

While narrative can serve as a unique way to communicate to others on a personal level, reader response is, ultimately, unable to be fully controlled or predicted by the author. Kaysen seems to structure her narrative around this fact, always acutely mindful of being doubted, questioned, and judged. Her narrative defies normative Western societal conventions of a happy ending, or even a nod to ways things might be improved, leaving Kaysen, as the author, especially vulnerable to outright dismissal, her story deemed untrustworthy as a source for information regarding the mental health system. Kaysen addresses her tenuous position as a reliable narrator with rhetoric that is sometimes marginally and other times outrightly defensive. This defensiveness has the

potential to eventually completely alienate her readers, prohibiting any possibility of her narrative functioning to help her gain what she seems to desire most: credibility. *Girl, Interrupted*, viewed through the lens of the chaos narrative framework, thus highlights for me the ways in which this framework depends on a strong relationship of trust between the reader as consumer and the writer as producer. Due to its overt positioning against authorized ways of knowing that intertwine objectivity and reliability, those employing the chaos narrative framework have the added task of maintaining the reader's trust. Much trust is needed in order to accept uncomfortable truths.

Case Study 3: Lauren Slater's *Lying: A Metaphorical Memoir*

Lauren Slater's 2000 *Lying: A Metaphorical Memoir* provides a rich example of what happens when the factual and inconceivable are intertwined. Analyzing Slater's narrative through the chaos framework challenges previous assumptions I held concerning the nature of "chaos" itself. In particular, Slater's narrative highlights for me the ways in which "chaos" describes a state of mind and is not necessarily solely a succession of negative events. While continuous misfortune can indeed be characterized as chaotic, my interpretation of Frank's chaos framework hinges on the irrationality of such events. Chaos, in some ways, describes to me that which cannot be categorized or clearly defined. It is this enigmatic nature that prompted me to analyze Slater's narrative with the chaos framework in mind.

I understand Slater's memoir to be primarily chaotic in its overall premise, which challenges the binary between fiction and nonfiction. While Slater purports her work to be a nonfiction memoir, she also blatantly acknowledges that some of the experiences she

relates are metaphorical—but refuses to let the reader know what is contrived and what is factual. Slater questions definitions of truth, specifically characterizations that would equate truth with “actual” events, claiming that her memoir cannot be completely honest because to be so would go against her “slippery” nature. Slater argues that, were she to pay strict attention to relating things exactly as they occurred, such concern would conflict with her authenticity as a “good nonfiction memoirist” (Slater 160). The purpose of good nonfiction memoirists, Slater asserts, is to “capture the *essence* of the narrator,” and this purpose could not be accomplished if she was overly concerned with facts (160). Slater chides her readers, exclaiming “I am passionately dedicated to the truth, which, by the way, is not necessarily the same thing as fact, so loosen up! Something can be true and untrue—it’s a paradox” (160). I find Slater’s attempts to define “truth” apart from “facts” particularly disconcerting, and it is this reaction that informs, in large part, my understanding of her narrative as both embodying and producing a chaotic state of mind. This is not to say, however, that I classify, a chaotic state of mind as only always disconcerting.

Slater’s refusal to distinguish between factual and metaphorical events withholds, for me, a resolution to her narrative, which, as Frank points out, is chaos (“Practicing” 47). In his introduction to Slater’s memoir, Hayward Krieger, then (2000) Professor of Philosophy at the University of Southern California, describes the piece as “unsettling,” and I am inclined to agree. In theory, I understand and even revel in the complication of “truth” in non-fiction and the memoir genre: Are the veracity of the facts as important as the message that is meant to be conveyed in the telling? And, given the known

unreliability of memory, to what degree can we expect an account to be “the truth”? Yet, despite my appreciation of the complex nature of demanding “truth” in non-fiction, I believe Slater is negatively distancing herself from her reader in her refusal to consistently distinguish between what she knows for herself to be “metaphorical truth” and what she believes to be the “factual truth.” Take, for example, her entire first chapter, which is composed of one sentence, and only two words, at that: “I exaggerate.” She tells us, her readers, that she may or may not have epilepsy, and this ambiguity is significant because her experience with epilepsy encompasses her entire book. Even if I, as her reader, tell myself it doesn’t matter whether or not the epilepsy is factually true, I am still perturbed. If the epilepsy is not a factual truth but a metaphorical truth, then what is the epilepsy a metaphor for? I believe it is of vital importance that the reader be able to trust the writer. This trust includes creating a safe space for the reader to be able to respond freely to any disclosures the writer may make without fearing retribution by the writer. Refraining from attacking the reader can ultimately help the author to communicate with the reader. If a reader is expected to experience an author’s story with that author, that reader is entitled to a level of honesty from the author. My inability as the reader to trust Slater as the writer is part of the reason I find no resolution, or at least, no reliable resolution, in Slater’s narrative.

Slater’s narrative also functions to reflect the ways in which a single speaker can have multiple voices. In fact, what I find most disturbing about *Lying* is the voice Slater uses that judges readers as unenlightened should they become frustrated with Slater’s

refusal to tell “the truth.” Slater reveals a voice that is almost combative in tone when she writes:

So, I suppose you want to know how much is true, how much untrue, and then we can do some sort of statistical analysis and come up with a precise percentage and figure out where the weight is. That, however, would go against my purpose, which is, among a lot of other things, to ponder the blurry line between novels and memories. Everyone knows that a lot of memoirs have made-up scenes; it’s obvious. And everyone knows that half the time at least fictions contain literal autobiographical truths. So how do we decide what’s what, and does it even matter? (160)

This aspect of Slater’s voice gives no room for disagreement, painting the reader who wants to know what is true as a bit absurd, in line with someone who demands a statistical analysis of her account. “Everyone knows,” Slater repeatedly asserts, leaving those who perhaps hadn’t known to feel foolish or at least insignificant to Slater. In theory, I admire what Slater seems to be enacting: a third-space questioning of what is “real.” Does it make me a hypocrite, then, to find Slater’s stance towards her reader frustrating? When returning to Licona’s discussion of third-space, however, I am reminded that “third-space subjects put language into play by using *disruptive* discursive strategies” (106, emphasis mine). I hadn’t been expecting third-space to be disruptive to me, a person who supposedly embraced the theory.

I find myself questioning my expectations further when I consider Slater’s memoir in light of the aspect of third-space theory that challenges the concept of

authenticity as well as its very definition. Slater would probably argue that she is, in some ways, being more honest with the reader by relating her story in metaphorical terms because these metaphors allow her to more accurately reflect what it means to live as acknowledged in third-space: never fixed, but always in the process of becoming. My own reaction is evidence of the fact that some readers' interpretations of a text will be influenced if not determined by whether it is categorized as fiction or non-fiction. Also evidence of this fact is mainstream controversies surrounding such works as James Frey's *A Million Little Pieces* and Augusten Burroughs *Running with Scissors*. Slater expands the possibilities of language by challenging categories such as fiction and non-fiction that limit the ways lived experiences can be told and consequently interpreted by readers.

Expanding the possibilities of language also occurs through a recognition of its current limitations. In a way, Slater's challenges to her audience are an acknowledgment of the current limitations of language and an attempt to dispute the reasoning that underlies these limitations. Slater provides her readers food for thought when she addresses concerns regarding whether a metaphorical memoir can be classified as nonfiction:

My good friend and novelist believes a book can qualify as nonfiction only if the literal facts are for the most part accurate. Therefore she thinks I should call this book fiction, but I disagree. After all, a lot, or at least some, or at least a few, of the literal facts are accurate. Second of all, even those things that are not literally true about me are metaphorically true about me, and that's an important point. (162)

In making a distinction between literal and metaphorical truth, Slater cleverly demonstrates the ways in which groupings such as fiction and non-fiction place limitations on language. Specifically, classifications such as fiction and non-fiction do not provide a place for that which is metaphorically, though not literally, true. When we determine authenticity by valuing only what is literally true, we lose an opportunity to share experiences with others in a new way: communication that conveys more than factual events as it focuses on reproducing the author's interpretation of those events, and shares with the reader that interpretation.

In her 2007 "Authorizing the Memoir Form: Lauren Slater's Three Memoirs of Mental Illness," Helen Buss analyzes the memoir form as specifically embodied in Slater's narratives in order to demonstrate its "special writing advantages" in the "authorization of self" (34). The memoir's special writing advantages include its illumination of the "joined nature of fact and fiction, literature and history, self and other, form and content, and illness and wellness" (Buss 43). When memoir is understood in this way, Buss asserts that readers will "understand the way contemporary memoir builds itself on the dynamic dialogic between binaries that have been traditionally dichotomized" (43). Thus what makes *Lying* particularly vexing for me also is a way in which this narrative practices third-space, challenging authoritative ways of knowing and being as it troubles the binary between fact and fiction.

In addition to defying conventional binaries, Slater's narrative also reflects the chaos framework in her attitude regarding "efforts to stop the collapse" (A. W. Frank,

"Practicing" 47). Slater describes every being as susceptible and even predisposed to some kind of collapse, noting:

I think you can hold out for only so long. I think secretly each and every one of us longs to fall, and knows in a deep wise place in our brains that surrender is the means by which we gain, not lose, our lives. We know this, and that is why we have bad backs and pulled necks and throbbing pain between our shoulder blades. We want to go down, and it hurts to fight the force of gravity. (51)

Frank explains that one attribute of the chaos framework is a narrative where “efforts to stop the collapse are futile” (“Practicing” 47). Initially, Slater’s description of the inevitability of collapse seems to embody this characteristic. Yet, further examination reveals the ways in which Slater problematizes the automatic conception of breakdowns as necessarily detrimental. Rather than equate collapse with failure, Slater compares such a falling to the concept of surrendering. Like collapse, surrendering itself is portrayed as a means to gaining, rather than losing. Slater’s narrative is thus fascinating in the ways in which it matches Frank’s chaos framework in description but defies his characterization of its attributes as adverse. This reconsideration of concepts often assumed as detrimental further demonstrates the potential of the chaos framework to instigate critical thinking by allowing room for ambiguity. Sometimes, one’s collapse doesn’t need to be stopped, and can be seen instead as a welcome respite.

When practicing dialogical narrative analysis, Frank encourages his readers to consider the “stakes” involved for the storyteller, in particular, how a narrative functions

to “sustain the value of one’s self or identity in response to whatever threatens to diminish that self or identity” (“Practicing” 33). In *Lying*, the stakes for Slater seem to hinge on disrupting the dichotomy between what is felt and what just “is.” Slater asks, “Why is what we feel less true than what is?” (162). *Lying* prioritizes the accurate portrayal of Slater’s feelings to the extent of distorting facts. This prioritization seems to indicate a belief that one’s identity is largely comprised by the emotions involved in experiences, over a memory of the “actual” physical events that occurred. Slater confirms this belief, declaring that “what matters in knowing and telling yourself is not the historical truth, which fades as our neurons decay and stutter, but the narrative truth, which is delightfully bendable and politically powerful” (219). This statement adds an additional component to what Slater seems to believe comprises the self. Specifically, Slater’s characterization of the “narrative truth” as “delightfully bendable” defies authoritative ways of knowing and being that would perhaps apply the same strict adherence to portraying an event according to what occurred in the moment rather than capturing the essence of that moment, regardless of whether this would require recounting facts or emotions. Thus, according to Slater, not only do emotions trump the facts of an incident, the continuously changing nature of emotions forever destabilizes the meaning of an experience. This perpetual fluctuation of meaning seems to reflect a third-space practice Minh-Ha Trinh observes: “*Reality and truth: neither relative nor absolute*” (Trinh 25). Reality and truth can never accurately be pinned down, as the fluidity of their very natures exemplifies third-space.

Lying: A Metaphorical Memoir advances everyday forms of knowledge that defy authorized forms which would equate truth with facts that are fixed in time. While authorized forms of knowledge would deem as valid depictions of events that were most consistent both among a substantial number of people, Slater's narrative opens up possibilities for the validity of an ambiguous experience. *Lying* also challenges formal definitions of "chaos" that would equate such a concept solely with negative events without meaning. In particular, *Lying* demonstrates for me the core of chaos to be instability, with a continued variation of significance for a variety of people or even the same person.

Analyzing the Chaos Narrative: Giving Credence to the Everyday

Susan Sontag's sentiment in *Illness in Metaphor* substantiates, to a degree, respect for the chaos narrative. Sontag declares that:

It is rational to tolerate a certain amount of irrationality [...]. [S]tern repressive measures are likely to aggravate disorder rather than cure it, turning a nuisance into a disaster. The body politics should not be overmedicalized; a remedy should not be sought for every disorder. (79-80)

The respect Sontag bestows on what she describes as "a certain amount of irrationality" appears to be absent in Frank's specifications of the chaos narrative typology. When applying the chaos typology, I came to understand how its oppositional structures necessarily limited the reader's interpretation of a narrative. The protagonist's actions were either "futile" or they were not. The narrative either lacked "suspense" or it did not.

There either was a “resolution” or there was not. Identifying narratives that followed the restitution typology did not seem to require a strict adherence to the aspects of that typology. I could freely admit that a narrative lacked a certain condition Frank had defined without feeling like the typology itself needed to be altered. Identifying narratives that most reflected the chaos typology, however, produced different results. I found myself perceiving the ways in which accounts could be interpreted as portraying characteristics typical of the chaos typology; I myself, however, held a different interpretation. The reason for these differing epistemological perceptions could be the effect of subjectivity. Given the indispensable need to account for the ways in which a reader’s background unavoidably affects his/her judgment of a text it would initially appear inaccurate to create typologies at all. The unreliability of such typologies remains even in the face of numerous disclaimers that insist on the absence of any judgment on the narrator. It is my belief that an evaluation of the narrator’s story never be completely separate from an assessment of the narrator him/herself. Moreover, such appraisals are equally, if not more, indicative of the reader him/herself.

Yet, despite the unreliability of classifications such as typologies, I still understand them to be vital methods that, when enacted, can help us understand the world. Such methods will necessarily be imperfect, but the way around these flaws appears to be a continued willingness for self-evaluation. In the case of the chaos typology, this evaluation would include complicating such terms as “futile,” “resolution,” and “suspense.” As this chapter demonstrates, framing my analysis of these narratives according to the chaos typology created the structure needed to understand their

manifestations of third-space as practice and location. My analysis also brought about an awareness of my positionality as a reader, and how my past experiences necessarily affected what I understood to be futile, suspenseful, and a resolution. In this way, the chaos narrative typology supports the everyday, or an acknowledgment of and esteem for an awareness of situatedness.¹¹ The following chapter continues to explore these issues of everyday ways of being vs. authorized forms of knowledge and third-space by utilizing Frank's quest narrative typology.

¹¹ See chapter one.

CHAPTER FOUR: THE QUEST NARRATIVE

Shortly before I was first diagnosed with depression, I sought help from my friends. I was a nineteen-year-old student far away from my home in Hawai‘i, attending a small, Christian liberal arts college in Chicago. I soon learned that pursuing guidance from my peers was not a solution, as one of my “friends” bluntly stated that, “No offense, Jessica, but I’m paying thousands of dollars to get an education, not to help you.” She then informed me that my therapist, and other “trained professionals” were the only ones who could truly help me, given that they were monetarily compensated.

Such compensation, however, only goes so far, and I was soon wrestling with the parameters my therapist established for my treatment. I understood the unhealthiness of depending too much on any one person—even, and especially, my therapist—but I felt that to actively work against this attachment would be to accept a solitary existence, to acknowledge that ultimately, the only person I could rely on was myself. As it is in so many other areas of my life, I have to learn how to balance—balance my need for others with my own self-fortitude. I needed to learn—and continue to learn—how to be self-sufficient and yet still allow room for other people in my life. My awareness of the importance of striving for a balance between self-sufficiency and accepting help informs my interpretation of Arthur Frank’s third narrative typology, the “quest narrative,” which seems to stress the necessity of independence. In what follows, I examine how personal narratives of mental illness and suffering can demonstrate the ideal of a balance between the need for others and self-sufficiency, while also managing to both practice and serve as a location for a third-space of agency and disruptions of power.

Promoting Self-Sufficiency: The Quest Narrative

Quest Framework: Promoting Self-Sufficiency
<ul style="list-style-type: none"> • Based on an explicit or implicit journey metaphor; a character encounters a sequence of obstacles and gains wisdom and stature through the process of overcoming them; • Suspense is created when readers wonder if the sufferer’s original attitude towards the illness will transform into understanding the transformative potential in the illness experience; • Storyteller of the quest narrative is most likely to claim to have elaborated the narrative resources available to future ill people—that elaboration is part of the quest.

Table 7: The Quest Narrative Framework

Arthur Frank defines the quest narrative by highlighting its three main aspects: (1) the fact that the story is “based on an explicit or implicit journey metaphor [...] in which a character encounters a sequence of obstacles and gains wisdom and stature through the process of overcoming these,” (2) that the story’s “suspense is whether the sufferer’s original attitude toward the illness will transform into understanding the transformative potential in the illness experience,” and (3) the storyteller’s “claim to have elaborated the narrative resources available to future ill people” (“Practicing Dialogical Narrative Analysis” 47). Most striking to me about these aspects of the quest narrative is the assumption of the subject’s ability to “take control” over his or her own life, where “take control” is understood to be the capacity to control one’s interpretation of life events. Mark Vonnegut summarizes this way of thinking when he writes, “Events don’t make me crazy and won’t make me well. What I need to do on a daily basis, whether or not I’m having symptoms of mental illness, is to work on my attitude so that I can see and make use of the positive in people, situations, events and things” (12). While a lack of influence over one’s life circumstances is certainly acknowledged, one’s own ability to “make use”

of the positive in any situation seems to be taken for granted. The process of doing so is recognized as laborious, but room for this process seems scant in Frank's typology of a quest narrative (see Table 7).

When compared to his descriptions of the restitution and chaos narratives, Arthur Frank's definition of the quest narrative seems almost idealistic, exemplifying a frame of mind that one would be wise to aspire to, even when faced with the certainty that some restitution and chaos thinking is inevitable. To recap, Frank's depiction of the restitution narrative seems to be one of naïveté, with the teller portraying (or at the very least, hoping) his or her life as restored to a version of his or her life before illness ("Practicing Dialogical Narrative Analysis" 47). The chaos narrative, on the other hand, starkly contrasts the unsuspecting confidence of the restitution narrative. The chaos narrative seems to swing to the opposite side of the spectrum, representing a frame of mind that, as Frank is careful to point out, can never fully be articulated because of its sheer turmoil ("Practicing Dialogical Narrative Analysis" 47). In comparison, the quest narrative's very placement in the middle of these two extremes seems enough to identify this typology of a story as exemplary. Thus Frank's depiction of the quest narrative seems to reveal his own biases for this third type of account.

Distinguishing the quest narrative as promoting self-sustainment and, therefore, a type of self-authorization, begins with the observation that, in opposition to the restitution and chaos aspects of a narrative, "only in quest stories does the *teller* have a story to tell" (Frank, *The Wounded Storyteller* 115). Frank elaborates: "Though both restitution and chaos remain background voices when the quest is foreground, the quest narrative speaks

from the ill person's perspective and holds chaos at bay" (*The Wounded Storyteller* 115). This distinction as to what drives the quest narrative is significant when considering the ways in which the act of telling one's narrative bestows agency, as well as some authority, on the teller. Thus, when reflected in a quest format, one's narrative holds greater potential to legitimize everyday forms of knowledge because the teller is claiming the story as his/her own. Frank describes this ownership characteristic of the quest as "defined by the ill person's belief that something is to be gained through the experience" (*The Wounded Storyteller* 115). Moreover, this guarantee of gain implies a kind of imperviousness to outside forces: "'Whatever has happened to me or will happen,' the storyteller as hero implicitly claims, 'the purpose remains mine to determine'" (Frank, *The Wounded Storyteller* 131). Frank's characterization of the quest narrative echoes psychiatrist Arthur Kleinman's description of the "quest for authenticity," which Kleinman describes in his 1988 *The Illness Narratives* as "the core moral requirement of the individual in American culture" (98). Kleinman sums up the quest ideology with the common adage (as well as the former slogan of the US Army) to "Be all that you can be" (98). The teller of the quest narrative thus becomes a kind of epitome of healing, an inspiration to others by leading through personal example.

In what follows, I conduct discourse narrative analysis (DNA) on three personal narratives, each written by a woman detailing her experience as an in-patient in a psychiatric ward. Through DNA, I create a framework by which I can carefully examine each woman's respective narrative as upholding DNA's first commitment, which understands that one voice is necessarily comprised of multiple voices (A. W. Frank,

"Practicing Dialogical Narrative Analysis" 37). DNA complicates the quest narrative ideal as it examines the relationship between authorized forms of knowledge and everyday lived experiences. My purpose is to use DNA in conjunction with Frank's quest typology as lenses through which to understand narratives of mental illness and suffering. Employing both DNA and the quest typology is vital to revealing how narratives can and do create third-spaces of agency and the possibility for disruptions of power.

Case Study 1: Mindy Lewis' "Life Inside"

Mindy Lewis' 2002 "Life Inside," is a personal narrative of her experiences in the late 1960s as a teenager in-patient in a psychiatric ward. In keeping with the quest framework, "Life Inside" describes Lewis' journey as she "encounters a sequence of obstacles" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). Lewis' account of her hardships begins in her narrative's opening paragraph, as she details the process by which she became a ward of the state shortly before her sixteenth birthday. Lewis explains that she became a ward of the state so that her mother "in a moment of weakness, [would] not have the power to sign [her] out" (21). Despite reassurances that Lewis could be in the New York State Psychiatric Institute for "as little as six months" (Lewis 21), Lewis remains a psychiatric in-patient for twenty-seven months. The remainder of her narrative is nearly entirely devoted to the horrors she endures in the psychiatric institute.

DNA's first set of crucial questions, focusing on the multiple voices heard in any single speaker's voice, illuminates one way in which Lewis' story becomes a location for third-space. Specifically, Lewis' story is characteristic of "acts of survival in which

language in both its liberating and limiting potential is explored and exposed” (Licona 111). Language’s liberating potential is explored in Lewis’ narrative as she resists the idea of a singular self, writing from both the perspective of her adolescent self and the adult self who is reflecting on her experiences as an adolescent. Lewis enables readers to understand her adolescent thinking through the lens of her adult mind. For example, readers learn of Lewis’ admission to the psychiatric institute through both her adolescent reactions and her adult reflections. The adolescent Lewis of the past responds to her mother’s observation that she has stopped “performing” by wondering inwardly, “Does she think I’m some sort of puppet or doll? Clown would be more like it, dressed as I am in yellow hospital pajamas a couple of sizes too large” (Lewis 21). The adult Lewis creating the narrative provides a retrospective account of the meeting, musing, “I had seen the impending date of my admission as a sort of token of a battle won; a badge of victory in my rebellion against my mother [...] It never occurs to me that I will have to live, as usual, through each day” (Lewis 21). It is Lewis’ adult self who is able to recognize her adolescent self’s understanding of those events, and her adult self who reflects on what had “never occurred” to her adolescent self. In this way Lewis demonstrates language’s ability to acknowledge and honor the adolescent she once was, while also incorporating what she has since learned and experienced as an adult.

Lewis’ narrative also expresses a third-space practice as it challenges the dichotomy between doctor and patient. This is perhaps most vividly seen when asking DNA’s third and fourth set of crucial questions: investigating why Lewis chose to tell her story and considering the stakes she has “riding on telling this story, at this time, to these

listeners” (A. W. Frank, "Practicing Dialogical Narrative Analysis" 33). Specifically, Lewis’ narrative problematizes the ways in which the dichotomy between doctor and patient guides the psychiatric institute’s treatment methods. Lewis addresses the disconnect she sees between the reasons for her adolescent behavior and the psychiatric institute’s subsequent responses:

“Inappropriate behavior!” the doctors tell us. *Appropriate* and *inappropriate* are the standards by which we live, by which privileges are meted out or taken away [...]. It is [...] inappropriate to ask too many questions, to swear, to get angry, to laugh too loudly, to have physical contact [...]. *What is appropriate behavior?* I ask. Particularly for adolescents, with our twitchy energy, uncommunicative moodiness, rising sexuality, innate rebelliousness, and contrary insistence on questioning authority. Where are we to funnel our energy, intelligence, mischief, pain, and rage? (27)

In what is perhaps an attempt to quell the angst of young adulthood, the psychiatric institute actually exacerbates Lewis’ distress. The psychiatric institute’s response to Lewis’ behavior dehumanizes Lewis, “treating” her with “drugs and extreme measures” when, as Lewis puts it, she “need[ed] a friend, an adult I [could] trust, nonjudgmental, on my side” (31). Lewis’ narrative reflects the “differential consciousness” that is “oppos[ing] [...] the limits of dichotomous (mis)representations” (Licona 106). The dichotomy between doctor and patient is interrogated as Lewis voices what would have been, to her, a far more humane treatment of her “inappropriate behavior”: having

someone to listen to her without judgment, or at least, without pathologizing her feelings and actions. Lewis' narrative thus practices a third-space of agency as the patient returns to engage the doctor as an equal, altering the naturalized binary between the "healer" and the one in need of healing, by creating a space for the formerly submissive patient to have a say in her treatment plan.

That Lewis, as a former patient, is inserting her own opinion into how she thinks she, and presumably other patients, should be treated—specifically, that they should be able to have a voice—fulfills the quest narrative's framework's description of the storyteller "elaborat[ing] the narrative resources available to future ill people" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). In particular, Lewis creates narrative resources for future patients when her narrative is understood as directed, in part, towards mental health professionals. Her reflections on the mistreatment that results from a dichotomy between doctor and patient seems to be best addressed by those working in the mental health system. One example of this can be seen in Lewis' portrayal of her relationship with a particularly empathetic psychiatrist:

He sits with me through my silences, enjoys my sense of irony and humor. I start to let down my guard. When I confide the painful emotions I often have listening to others, feeling that I have nothing of my own to contribute, my doctor tells me, 'Being a good listener is a talent in itself.' That little bit of support is a talisman I carry with me, a touchstone of self-worth. So much more than these drugs and extreme measures they treat me with, I need a friend, an adult I can trust, nonjudgmental, on my side.

That, more than anything else, is what I need. But it comes too late, and too briefly. (31)

Lewis is clear about what she needs and the communication of this need seems to be directed at those who have the power to fulfill that need in those who are currently in the position Lewis once was, as a patient. Lewis' narrative holds the potential for agentic action among mental health professionals. While such agentic action is not a disruption of the power such professionals hold over their patients, helping professionals use their power to empower their patients can extend agency to those suffering. In this way Lewis' narrative fulfills the quest narrative typology of creating narrative resources for future ill people.

The fact that Lewis as an older, wiser person is now using her experience as an adolescent patient to better the treatment of future patients appears to be, at first glance, exemplifying the quest narrative's description of a character "gain[ing] wisdom and stature through the process of overcoming [a sequence of obstacles]" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). Lewis' present wisdom as an adult, however, appears to be, to some extent, a part of her adolescent self as well, something she nourishes and reinforces rather than only acquires over time. Frank's description of ascertaining such wisdom and stature "through the process of overcoming [a sequence of obstacles]," whether intentional or not, seems to imply a necessity for obstacles when obtaining wisdom ("Practicing Dialogical Narrative Analysis" 47). If the quest narrative typology is indeed suggesting a kind of integral relationship between "overcoming" hardships and "gaining" wisdom, I suspect Lewis' narrative would not be in accordance

with this typology. The things Lewis must endure and eventually overcome in the psychiatric institute are hardships precisely because of the wisdom she *already* possesses that enables her to recognize dehumanizing practices. Consider, for example, Lewis' account of when she is sent to Manhattan State Hospital—a “regular state hospital,” a “fearsome institution [...] that warehouse[s] chronic cases” (Lewis 29):

My eighteenth birthday approaches. I sit on the card table in front of the staircase door swinging my legs. “Get off that table,” I am told. “Why?” I ask, “I’m just sitting here.” I anticipate the nurse’s answer before it comes. “Because it’s inappropriate. Go sit in a chair.” I ignore her and swing my legs a little faster. The nurse calls the male attendant and they both approach me. “If you don’t get off that table now, you will be taken off.” I do not move. The nurse nods to the attendant, a large powerful man, who walks toward me. I jump off the table, but it is too late. He tackles me with his full weight, and I am dragged down the hall to the quiet room, shot full of sodium amytal, tied into a straightjacket, and locked in. Twenty-four hours I am sent to another floor, my belongings dumped into a laundry bag; within days I am shipped to Manhattan State Hospital. This is the final insult—without being allowed to say goodbye to my friends, I am manhandled, drugged, and locked up... for sitting on a table. It is as if the hospital has to have the last word; unsuccessful in “treating” me, they can at least show me who’s boss. (35)

Did “overcoming” the “obstacle” of being treated in this manner cause Lewis to gain wisdom? That is, does being institutionalized “count” as overcoming an obstacle? It is possible to argue that Lewis gained wisdom when she recognized the hospital needed to “have the last word,” therefore making her institutionalization the obstacle she overcame in order to gain this wisdom. Yet this attempt to fit Lewis’ narrative into Frank’s restitution framework seems forced and even a bit perverse. Lewis’ “final insult” is just one example of the events Lewis recounts from her time in the psychiatric institute, but it does echo the majority of Lewis’ experiences overall. Lewis encounters obstacle after obstacle and what she learns isn’t necessarily the result of prevailing over these obstacles. Rather, Lewis evolves by managing to counter the negative effects of such treatment. While it is possible to argue that “overcoming an obstacle” could also describe “countering the negative effects” of that obstacle, it seems erroneous to then conclude by correlating Lewis’ experience in the psychiatric institute with any higher awareness she gained by “overcoming” it. I am resistant to make claims that suggest Lewis’ experience in the psychiatric institute is the catalyst that enables her to produce any kind of discernment. Rather, I would argue that Lewis’ quest—her “journey to wisdom”—lies in *both* her ability to understand what psychiatric institutionalization taught her and even more so dependent on her own resiliency to withstand the institutionalization itself. In fact, somewhat ironically, Lewis’ narrative fulfills the quest framework of “understanding the transformative potential in [her] illness experience” because of what supposedly makes her ill in the first place (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). In other words, that which, in part, categorizes Lewis as “ill” according to

the standards of the psychiatric institute—her anger and her rebelliousness—is what enables her to “transform” her “illness experience.”

Lewis’ transformation occurs when, in keeping with the quest narrative proclamation of self-sufficiency, she is able to finally speak for herself. Specifically, Lewis’ narrative, in some ways, promotes the ideal of self-sufficiency as her chronicle concludes with a resolution empowered mainly by her own ability to act. DNA’s fourth set of questions, which consider the “stakes” a storyteller has “riding on telling this story, at this time, to these listeners” help to identify the self-sufficiency which characterizes Lewis’ narrative (A. W. Frank, "Practicing Dialogical Narrative Analysis" 33). In fact, upon consideration of how Lewis is “holding her own” in the act of this storytelling, it becomes apparent that her narrative is that which, in part, empowers the self-sufficiency she is advocating. Twenty years after her stint in the psychiatric institute, Lewis is contacted by a doctor from the institute conducting a series of twenty-year follow-up interviews. After some initial misgivings, Lewis agrees to have a conversation with him: “I tell him I am fine; I work, I paint, I don’t take drugs or see a shrink, I am completely fine! In spite of the hospital, I add” (Lewis 39). Then she is asked, “Is there anything else you’d like to tell me?” (Lewis 39):

I wind up and let him have it: about being confined, misdiagnosed, medicated, traumatized; a shy, frightened, arrogant adolescent who takes years to live down an early, unnecessary, too-long incarceration in a loony bin. How hard it’s been. (Lewis 39)

This is Lewis standing up for herself, finally able to speak and be heard. The response from the doctor is, in some ways, unremarkable when compared to the sheer extent of the trauma Lewis endured: “‘I’m sorry,’ he says. ‘We didn’t know very much about treating adolescents in those days’” (Lewis 39). Yet it appears the reply is, while not completely inconsequential, only one part of that which composes Lewis’ “quest ending,” that which constitutes this “character-encounters-obstacles-and-gains-wisdom-through-the-process-of-overcoming” plot (“Practicing Dialogical Narrative Analysis” 47). That Lewis “overcomes” is not based so much on the quality of the reaction to her testimony but rather, on her own ability to acknowledge what has happened:

And that is it. Two hours on the phone, and I have reached back twenty years into the past and spoken for that girl who couldn’t speak for herself, and receive an answer and an apology—skimpy and scant and too late to make any real difference. And finally, I face that girl and claim her, embrace her and love her, knowing that she is an important part of me, that we are one. (39)

It is worth noting that Lewis does not dismiss the quality of the apology outright by claiming her response to the past as the only one that mattered. Rather, Lewis names the apology for what it is: inadequate. Yet in spite of this, Lewis recognizes her ability to advocate for the part of her that was mistreated, and appears to place the resolution to her narrative in her own capacity for self-fulfillment. Her resolution does not happen because the doctor apologized. Lewis empowers her own resolution. Bearing witness to what has happened to her is Lewis’ resolution advocating self-sufficiency, making her overall

narrative, in some regards, characteristic of a quest typology. It is Lewis herself who is able to express to the psychiatric institute the dichotomy between doctor and patient she has established throughout her narrative as a major problem. Lewis informs the psychiatric institute, as embodied through the doctor conducting the twenty-year follow-up, that she was mistreated, that her behavior did not warrant the resulting “treatment.” Thus Lewis’ narrative fulfills the quest narrative typology of advocating self-sufficiency as resolution and transformation take place when Lewis speaks for herself.

Overall, Lewis’ narrative fulfills a quest narrative typology as she recounts the obstacles she experiences, recognizes the transformative potential in her illness experience, and creates narrative resources for future ill people (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). Lewis’ narrative also challenges the quest narrative typology by demonstrating how “wisdom and stature” can be cultivated *in spite of* the obstacles one may face and not just in the process of overcoming the obstacles. Lewis’ narrative also creates a third-space of agency and disruptions of power as it embodies both third-space in practice and third-space as location. Specifically, Lewis challenges the dichotomy between doctor and patient and creates a space for the limitations of language to be explored as she resists the idea of a singular self, writing from both the perspectives and insights of her adolescent and adult self.

Case Study 2: Catherine Ann Fabio’s “Safe Places”

Catherine Ann Fabio’s 2002 “Safe Places” begins with a nod toward the quest narrative’s ideal, depicting the closure accomplished by Fabio’s self-sufficiency. This introduction commences with a description of Fabio in the present, well into the process

of healing from the experiences that the rest of her story unfolds. Fabio starts her narrative with the declaration, “I’m not hiding anymore,” and goes on to clarify that “it’s hard to create a life when you’re hiding from something you can’t even wholly name” (86). Fabio then illustrates the healing that has come from her own ability to start to name that something she had been hiding from. She explains, “I write from my heart and from my hands, and somehow, in the telling, my story retells itself, explaining to each part of me, reassuring me, as I come to understand, to make peace with myself and the world around me” (86). The peace Fabio describes is thus characterized as stimulated by her own ability to act, indicative of a quest narrative.

Fabio’s reference to “each part of me” in her opening paragraph foreshadows the framework for the rest of her narrative, as she practices third-space by moving beyond relating lived experience as fixed in a point of time to more accurately reflect what it means to live—a continuous merging of past and present selves (Du Bois 39). After introducing readers to her “present day” self, Fabio moves her narrative back in time to the self that lived in a safe house for battered woman. When reflecting on the question “‘Why are you here?’” Fabio recounts how, “The video projectors in my head began to play, and I found myself splitting inside, watching and responding to each of them” (86). When it comes time for her to speak, Fabio cannot “turn off the movie” (Fabio 87):

The videos continued to play—a guard at the state hospital throwing a young woman on the floor while four other uniformed officers stripped her down to her underwear, dragged her into a quiet room, and threw her onto a mattress where they spread her legs and arms and strapped her

down; me fishing tranquilizers from my mouth and hiding them in the seam of a red teddy bear; an eviction notice stapled to my front door; my suitcase and a box of Nancy Drew books on the driveway; a man driving his jeep with his left hand while punching me with his right. (Fabio 88)

Fabio's recollection of the events in the safe house for battered women is fragmented, interspersed by its own recollection of still more disjointed memories from her past. Fabio explains how she "channel-surfed through the videos [...] But the words just wouldn't come" (88). That Fabio portrays her experiences in this way creates a narrative that practices third-space through rememory. Rememory, as defined by an interpretation of Toni Morrison's use of the term in *Beloved*, is a "refutation of linear time [...] consistent with the definition of character as process, identity, and fluid" (Jablon 143). Thus Fabio's deviation from a chronological organization of her narrative represents more than a writerly technique designed to maintain the audience's interest. Instead, Fabio's narrative structure echoes the dissonant experience she describes in her narrative content, thereby enacting third-space.

In addition to fragmenting her story in this way, Fabio shares her story from the perspective of multiple parts of her self. Considering DNA's first set of crucial questions, which addresses the ways in which "multiple voices can be heard in any single speaker's voice" can help us understand how Fabio consciously reflects her experiences in a third-space manner (A. W. Frank, "Practicing Dialogical Narrative Analysis" 33). In particular, by telling her story from the perspective of these multiple parts, Fabio also practices third-space as she challenges dichotomies. Specifically, Fabio challenges the dichotomy

of the cohesive, singular self versus the disconnected, multiple self—often pathologized by authorized forms of knowledge. Fabio describes how she was pathologized when she moves her narrative from her experiences at the safe house for battered women to further in the past to recount her experiences as an in-patient in a psychiatric state hospital, Linwood, “where suicidal people without insurance get sent” (89). While conversing with a sympathetic doctor there Fabio ruminates on how descriptions of her many voices are repellant to others:

I watched the faces of past therapists flash before me [...] how many sessions did any of them ever have with me after I tried to tell them about how I feel like I’m two or three or six or even eight people at one time? None. They usually changed my diagnosis to 301.83—borderline personality disorder—and then they dropped me, because, as one therapist put it, “Borderlines don’t get better.” (89)

Fabio defies authorized forms of knowledge that create a binary between the cohesive, singular self and the disconnected, multiple self. Fabio resists being pathologized as she claims to be a single self even as she portrays the conflict between what she describes as her many “parts.” Another way of understanding the paradoxical existence as a singular self with many conflicting parts is demonstrated in Aimee Carrillo Rowe’s narrative, “Color in My Lines,” the preface to her 2008 *Power Lines: On the Subject of Feminist Alliances*. Carrillo Rowe describes her struggles to name her self in a way that honors her multicultural identity. “I am a woman who is split by categories, by worlds and words,” Carrillo Rowe proclaims (xix). Fabio’s and Carrillo Rowe’s insistence on maintaining

difference with the singular self is bold in the face of a Western consciousness that is “incapable of viewing actual differences in others, for everything is recognized only as the self—but in other guises” (Sandoval 121).

The co-existence of a singular, yet fragmented self is most distinct in the instances Fabio shares her ambivalence regarding suicide. Fabio remembers being released from the hospital, returning to her apartment, and then “flashing back” to the moments right before her hospitalization:

I had been afraid—was losing control. The suicidal parts of myself were winning the argument. They pulled out bottles of prescription drugs [...]. I began calling for help [...]. I didn’t know what I would say. It was so embarrassing, asking people to help me control myself. (98)

Here, Fabio explains her self in different parts by portraying the battle between the suicidal parts of her self, and the part, or parts, that were trying to regain control. Yet Fabio describes her efforts to receive help as “asking people to help me control *myself*,” indicating a claim of a singular self that is not cohesive, a self that is in conflict. W. E. B. Du Bois provides a powerful depiction of this inner collision:

It is a peculiar sensation, this double-consciousness [...]. One ever feels his two-ness [...] two souls, two thoughts, two unreconciled strivings; two warring ideals in one dark body, whose dogged strength alone keeps it from being torn asunder. (38)

Though the strife Du Bois describes results from reasons dissimilar to Fabio’s, both inner struggles share major components and thus can each function to further insights of the

other. While Du Bois aids comprehension of the individual, yet divided self, how Fabio portrays the conflict between her different parts while still claiming a singular self is significant. Fabio's depiction is meaningful, in part, given where it is situated—within her personal narrative of mental illness and suffering, a narrative that as a whole is practicing third-space to disrupt authorized forms of knowing and being. Fabio begins her narrative by declaring that she is no longer hiding, and the fact that she describes writing her narrative as a way to “make peace with myself and the world around me” imbues her acknowledgment of the multiple parts of her self with a validation that defies authorized forms of knowledge that would diagnose her with borderline personality disorder. Fabio's act of writing as an effort to make peace with her self, like her divergence from a chronological structure, therefore also echoes the consequences of rememory in Morrison's *Beloved*, “rais[ing] some complicated questions about the identity of the storyteller” (Jablon 144).

That Fabio's narrative is an acceptance of, rather than denouncement from, the multiple parts of her self is further indicative of the quest narrative typology. In particular, Fabio's journey in learning how to soothe the many parts of her self can be interpreted as the way in which she “gains wisdom and stature” (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). Fabio remembers being released from the hospital and soon feeling overwhelmed again, explaining, “Suicide was the only sensible option. At least that's what most of me thought” (100). Yet despite what most of her thought, Fabio recalls that

One stubborn part of me seemed to hang on though, struggled to search for a solution. That part of me gathered the rest of me around myself, like a mother gathering her children, and explained how we needed to try, how I needed their help... I asked them to trust me. Some of them did. (100)

Fragmented though it may be, Fabio's narrative does document a kind of interconnected reconnecting, at least in her ability to self-soothe. Like Lewis' narrative, however, Fabio's narrative deviates from the quest narrative framework in that she gains "wisdom and stature" not so much from the process of "overcoming obstacles," but rather, by learning to incorporate those "obstacles" into her way of being. In particular, the multiple parts of her self could be considered the "obstacle" that helps Fabio on her journey to wisdom and stature—only they are not obstacles so much as experiences she manages to live with. That Fabio's self is enhanced by what might be considered hindrances according to authorized definitions constitutes, in some ways, the "new consciousness" Anzaldúa calls for as an alternative to "counterstance." Anzaldúa explains that, rather than be "locked in mortal combat" with conventions that restrict and oppress, several alternatives are possible:

At some point, on our way to a new consciousness, we will have to leave the opposite bank, the split between the two mortal combatants somehow healed so that we are on both shores at once and, at once, see through serpent and eagle eyes. Or perhaps we will decide to disengage from the dominant culture, write it off altogether as a lost cause, and cross the border into a wholly new and separate territory. Or we might go another

route. The possibilities are numerous once we decide to act and not react.

(255)

Fabio's narrative practices Anzaldúa's new consciousness by defying linear perceptions of what it means to "overcome obstacles." In particular, for Fabio, "overcoming" a negative circumstance or event is not equivalent with "passing by" but rather involves an acknowledgment of the necessary lasting influence such circumstances or events leave. The acknowledgment of this inherent permanence in life events defies ideologies that would believe negative events can be "gotten through," conventions of the dominant culture that understand the impact of things from a chronological sense. Fabio thus disengages from this conception, creating an alternative action in the reality of difficulties, rather than a reaction that would diminish or deny such "abnormal" thinking of multiple selves by making such conceptions an illness.

Fabio's narrative also deviates from the quest narrative framework in relation to the suspense in her narrative. There is no suspense as to "whether [her] original attitude toward the illness will transform into understanding the transformative potential in the illness experience" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). This is because she begins with the end, with the self that is writing the narrative, in "a little place with rickety chairs, and hanging plants and a yellow dog who breathes softly on [her] foot as [she] clickity click[s] at [her] table, spilling [her] words and memories onto the screen" (Fabio 86). With such an introduction, we, as the readers, know there will be a transformation, and so whatever horrors she shares, traumatizing as they may be, will

end with this, a Fabio who is not hiding anymore. Rather, the suspense is not in *whether* Fabio will transform as it is in *how* Fabio transforms.

Fabio's transformation is crafted, in part, in ways that "elaborate the narrative resources available to future ill people" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). In particular, her narrative serves as a kind of reassurance and testimony to others who recognize the competing parts of their selves that they are not alone. In this way, her narrative also serves as a location for third-space, as Fabio brings people together by identifying similar experiences and fostering connections. This assemblage, in turn, allows Fabio's narrative to "problematize the idea that time, human responsibility, trauma, and suffering are ever limited to a single life" (Wiener 163). Fabio begins the conclusion to her narrative with a return to her first flashback, sitting in the safe house for battered women:

I wanted to be able to explain about how as my body grew, little pieces of myself seemed to chip off and become whole new parts of me—a six-year-old girl, two eight-year-old girls, a sad and thoughtful peer-rejected sixth-grader, an angry adolescent, a slightly self-absorbed bulimic beauty pageant contestant, a scholar [...]. I wanted them to listen and believe me without simply labeling me and then discarding me. I wanted to show the very me I was at that moment—all of me, and not be ashamed. (102)

Fabio's recollection of her longings to share these aspects of her self with these women, indeed, her whole narrative itself, leaves her vulnerable to her audience. This vulnerability, I believe, helps other people identify with her and recognize similar

longings within their selves. Thus Fabio's narrative brings people together by creating third-space, a space for identifying similar experiences and fostering connections.

Fabio concludes by creating a location for third-space that also makes the invisible visible. DNA's third set of crucial questions help reveal this, as they examine the author's reasons for telling a story and how the author utilizes the "capacities of stories" (A. W. Frank, "Practicing Dialogical Narrative Analysis" 33). Fabio seems to be using the capacity of stories to, as Frank describes in *The Wounded Storyteller*, assume responsibility for the life she is telling (xii). In particular, Fabio is assuming responsibility for her self as multiple parts. That Fabio takes responsibility for her life by writing this narrative makes the invisible visible. Specifically, the very existence of Fabio's narrative in published form exposes all the parts of her self, even as the majority of her narrative describes the need to hide those parts. Fabio's concluding paragraph summarizes her feelings of shame in the battered women's shelter:

I wanted to [show them all of me], but I knew I couldn't. Not just because it wasn't the appropriate place for me to share all of that—but because some small part of me worried that if I let on about the internal voices, about the different parts of myself, these women would abandon me too. So I reached inside and tried to soothe and silence each part of me, gently pushing them to the back of myself. Then, I pushed an adult part of me forward; I think it was the scholar. And slowly, she began to speak. (102)

Even though Fabio's narrative ends with her silencing the various parts of her self, the existence of her overall narrative gives voice to her disparate parts. That Fabio tells her

story in this public manner seems to be a way of making peace with not just the traumas she endured as a psychiatric patient but also making peace with her multiple selves. This narrative is the “appropriate place for [her] to share all of that” and thus makes the invisible visible (Fabio 102).

Fabio’s narrative practices third-space in several ways, enacting Michel de Certeau’s explanation of stories as “travers[ing] and organiz[ing] places; they select and link them together; they make sentences and itineraries out of them. They are spatial trajectories” (118). Additionally, Fabio’s narrative serves as a location for third-space, creating within the reader the resonance Minh-ha Trinh eloquently describes: “The correct vibration. A body resonates to music as does a string. / A music that elicits physical response and calls for mediated involvement. / It does not simply “play” / In such a way as *not* to impinge on the viewing” (4).

Fabio’s narrative also fulfills several criteria for the quest narrative typology as she achieves resolution through, in part, her self-sufficiency. Her narrative describes her journey to gaining wisdom and stature and, in so doing, “elaborates the narrative resources available to future ill people” (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). Fabio provides a testimonial for the people who seek acceptance for all aspects of their selves, letting us know that we are not alone.

Case Study 3: Nancy Mairs’ “On Living Behind Bars”

Nancy Mairs’ 1986 “On Living Behind Bars” begins with a description of her 1967 imprisonment in Metropolitan State Hospital (Met State) in Waltham, Massachusetts. Mairs lived in Met State, a mental hospital, for more than six months, and

her description of how she viewed the locked door to the ward sets the stage for the quest framework typology of suspense. Specifically, readers begin wondering to what extent the frame of mind Mairs describes in her opening paragraph “transforms” (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). Mairs writes that:

The door to the ward was locked at all times [...]. [I]mportant, for me at least, [was the fact that] no one could enter the ward unless invited. Thus, the terrible, complicated, demanding world, fear of which made me flush and tremble with feverish nausea, was kept at bay. (181)

Frank explains that the suspense of a quest narrative typology is in “whether the sufferer’s original attitude toward the illness will transform into understanding the transformative potential in the illness experience” ("Practicing Dialogical Narrative Analysis" 47). Mairs’ narrative thus begins with her agoraphobia: will Mairs embrace the “outside” world? Will this locked ward help Mairs to view the world in terms other than “terrible, complicated, [and] demanding”? Thus Mairs creates a quest narrative typology kind of suspense. This suspense, however, also deviates from the quest narrative typology in that Mairs’ original attitude is not necessarily regarding her illness. Rather, in an interesting twist, the uncertainty lies in whether or not Mairs’ original attitude towards living in a locked psychiatric ward will transform into understanding the transformative potential of the *treatment* experience. At the beginning of her narrative, the treatment of living in a locked psychiatric ward seems to be supporting her fear of the world rather than helping to dissipate it.

Mairs practices third-space by challenging, in particular, the dichotomy between the factual and the inconceivable, with the factual being measured by the degree of purity and authenticity (Licon 106). In yet another interesting twist, Mairs directly addresses the quality of her narrative, specifically, how thorough readers can expect her recollections to be. Mairs interrupts her recollection of Met State's various wards, to admit that, "maybe I made these up" (182). Mairs goes on to explain that, "this narrative will be full of such gaps and lapses, because during the latter part of my stay my brain was zapped twenty-one times" (182).¹² Mairs accounts for the existence of her narrative in the face of such absences by comparing "On Living Behind Bars" to a necklace she once owned:

I had once [...] a string of black clay Mexican beads on a nylon thread that snapped suddenly, in the middle of a class I was teaching, scattering little fish and birds and balls every which way. My students scrambled, retrieving many of them, and my foster son restrung them, in a new pattern necessitated by the missing pieces, into a shorter necklace. (182)

Mairs' narrative is the product of a similar "restringing," this time of not of fish and birds and balls, but of her "mostly random images, some in remarkable detail and clarity, but

¹² Mairs is referring here to her electroconvulsive treatment (ECT) for depression. ECT is a "psychiatric treatment in which seizures are electrically induced in anesthetized patients for therapeutic effect. Its mode of action is unknown" (Wikipedia "electroconvulsive therapy").

few embedded in any logical continuous context” (182).¹³ That Mairs feels the need to reveal these gaps in her recollection stands in contrast to a direct telling of one’s experiences, with the author’s assumption that readers will not question the veracity of the portrayal. This assumption may exist, in part, because any question of factuality would, by extension, be a question of authenticity. Such a question could be a particularly cutting insult when referring to an intensely personal narrative such as Mairs’, where questioning the validity of her experiences would be akin to questioning the validity of her self, as represented through those experiences. Instead, Mairs separates any judgment regarding the factual validity of her experiences from validation of their emotional repercussions. Thus, Mairs practices third-space by challenging an interconnectedness between the factual and valid, where what is valid is necessarily factually accurate and what is imaginary is necessarily invalid.

Mairs’ narrative also serves as a location for third-space as it disrupts the framework on which dominant ways of thinking are based. Specifically, Mairs challenges what society upholds as a woman’s ideal life by daring to acknowledge her unhappiness despite her comparatively privileged circumstances. In defiance to society’s ideals, Mairs

¹³ Mairs’ reconstitution of her memories that do remain mirrors the practice of “upstreaming” that Theda Perdue describes in her 1998 *Cherokee Women: Gender and Culture Change, 1700-1835*. Because most accounts of Cherokee women in the 18th century appeared biased towards American gender norms of that time period, Perdue decides to reconstruct a history of Cherokee women using the “well-established practice” that ethnohistorians call ‘upstreaming’” (8). Perdue explains that this practice “involves following cultural patterns from the known present to the less well understood past” (8). Mairs’ upstreaming is also indicative of a third-space that challenges the association of “factual” with what is “valid.”

declares that her unhappiness was not the result of her own inadequacy but was, in part, society's fault: "I was [...] not crazy but a sort of cultural prisoner" (191). Mairs' journey to this realization, however, was not easy. Reflecting on why she became a patient at Met State, Mairs confides:

I had no doubt that I was mad. How else account for the anguish I felt in the midst of a life in every way satisfactory: marriage to an intelligent, loving man; graduation with honors from a prestigious women's college; the birth of a healthy and charming daughter; a lively job in which I'd received a significant promotion within months of my hiring [...]. Not for many years [...] would I glimpse the possibility that, though I have often been in terrible trouble, I have never been insane. (184)

Mairs could not meet her own expectations for her feelings. Mairs' discontented state of being—her unhappiness in spite of having what society has painted as the near-perfect life—was, in some ways, a threat to the framework of society. In her 1983 "Identity: Skin, Blood, Heart," Minnie Bruce Pratt illustrates the social order that is endangered by Mairs' unhappiness. This structure that would have women be content in their domesticity is one of limits, Pratt explains, "based on places that had been secured [...] by omission, exclusion, or violence" (267). According to this construction, the circumstances of Mairs' life guaranteed her happiness. Therefore, Mairs could only be unhappy because she was mentally ill. In deference to this framework, however, Mairs acknowledges the existence of her unhappiness in spite of her circumstances—and still

claims to be sane. In this way, Mairs exemplifies Pratt's summons to "find new ways to be in the world, those very actions a way of creating a positive self" (267).

That Mairs eventually realizes she is not crazy is indicative of the quest framework's portrayal of a character who gains wisdom and stature through the process of overcoming a sequence of obstacles (A. W. Frank, "Practicing Dialogical Narrative Analysis" 47). After recounting her general state of unhappiness throughout her life, Mairs explains:

I have presented my early experiences at some length [...] because I believe now that they reveal that I was not crazy at all. I never heard voices or saw visions; I never confabulated; my affect, though often mournful, was never inappropriate; I often wished but never believed myself someone else; I never feared that objects or people were trying to harm me; I was neither violent and abusive nor totally withdrawn. (189)

If coming to the awareness that she is not crazy is, indeed, the wisdom Mairs "gains," what then was the sequence of obstacles? To view the self-described early experiences Mairs presents at some length as the obstacles that help her understand she is not crazy would be, I believe, missing the point. Mairs seems to recount her early experiences not to portray them as obstacles she overcomes that instill wisdom within her. Rather, Mairs relates these experiences as a way to promote *the reader's* wisdom. While this action defies the quest framework in one aspect it also fulfills the quest framework in another. Specifically, Mairs' narrative holds the potential to serve as a resource for others.

Describing the quest framework typology, Frank explains that its storyteller “is most likely to claim to have elaborated the narrative resources available to future ill people—that elaboration is part of the quest” (“Practicing Dialogical Narrative Analysis” 47). Mairs’ elaboration serves as a location for third-space, dispelling what Edward Soja describes as the “illusion of transparency” (7). Soja reveals that such an illusion, “prevents us from seeing [...] social construction” (7). Thus, when Mairs declares “My failure was not in perceiving reality; I perceived it full well, and despised it [...]. Such a person is not mad,” she informs her readers of a way of understanding that she herself had not been privy to (189, 190). In particular, Mairs reveals that discontent with societal norms is not an illness. Knowing this could have, perhaps, prevented her from seeking refuge in Met State which, Mairs confides, “certainly made a madwoman of me” (189-190, 191). Mairs continues to educate her audience, announcing that:

Introversion is no illness. It’s simply a habit of mind. Why then did I view it as the doom of my happiness and fulfillment? I could have done so only by believing that the one avenue to that happiness and fulfillment was laid not with my own insights and actions but with my relationships to others. And there, of course, is the paving stone of a womanly existence: to create and elaborate the social bonds that sustain community. (201)

By “de-pathologizing” introversion, Mairs’ narrative functions as a support for alternate ways of being. Rather than deny what is often seen as a negative character trait, Mairs questions the biases against introversion. This inquiry, in turn, reveals insidious societal expectations of women that necessarily discriminate the recluse as ill. Mairs thus

identifies a mentality that would pathologize the introvert in order to uphold the norm of the fulfilled woman as socializer. Mairs' narration of this process of identification helps others appropriate her recognition, thereby creating a third-space location that exposes the constructs of societal norms.

Mairs' narrative also fulfills the quest narrative typology of acting as a resource by providing guidance on how to navigate mental health treatment. Mairs relates an interaction with her psychiatrist: "When, after my release from the hospital, I fretted to Dr. Levine about a possible recurrence, he assured me that there was no reason to believe that I would ever have one" (206). Mairs speculates that her doctor's omission was indicative of "the typical medical stance, especially toward hysterical females: If you tell them about a symptom, they're sure to develop it, so the less said the better" (206). Mairs scoffs at this mentality, declaring that "he'd have done me better service to warn me that nearly half the people who experience one depressive episode will experience another, and that as a woman I was at an especially high risk" (206). Mairs' pronouncement is bold, and to some extent, revolutionary given her position as a mental health patient. Rather than let her mental health problems cast doubt on her ability to discern what she did and did not need to know, Mairs critiques her treatment. In doing so, Mairs elevates the patient role from one of abject submission. Mairs demonstrates the patient's own capacity for discernment in regards to his/her treatment, providing a model resource for patients.

Mairs continues to model a treatment for depression throughout the progression of her narrative. Recounting the summer of 1980, "almost exactly thirteen years after [her]

commitment to Met State, Mairs describes “another acute depressive episode” (209). Her description of this narrative episode, however, stands in stark contrast to the one nearly thirteen years earlier, this time chronicling treatments that challenge dichotomies and make meaning of the everyday. Mairs details her therapy:

And at last I began to learn about depression. I had, finally, a therapist who was willing to teach me and also to be taught by me as I began to explore the significance of my illness, and who could see that, even though I was a woman, my adjustment to marriage and motherhood was not, somehow, quite the point. I turned back and back into my experience, not to seek the origins of my illness in that experience, because I had stopped believing that any event or series of events had made me sick, but to find the structure of my dis-ease, the ways in which I had shaped my desires and disappointments into the depression that frames my way of being. (209)

Mairs’ therapy nearly thirteen years after her Met State experience challenges, in part, the dichotomy between doctor and patient. What was once an authoritative/submissive relationship became, for Mairs, more reciprocal, as she describes learning from and teaching to her therapist. Her treatment also gave meaning to her thoughts and feelings beyond her subject position as a woman, allowing her to move past societal standards of what happiness meant. Mairs alters the parameters on which her introspection had been based, expanding her introspections to move past seeking the causes of her illness to understanding “the ways in which [she] had shaped [...] that [which] frames [her] way of

being” (Mairs 209). This expansion thus allows Mairs to perceive her lived experiences as “always in the process of becoming,” and, subsequently, practice third-space by providing a model for how to make meaning of the everyday (Licona 106).

Mairs’ narrative concludes by upholding the quest typology ideal of self-sufficiency. While Mairs acknowledges that “nothing I know can free me from my depression,” she ends on a hopeful note established, in part, by her own self-sustainment:

Still, of late I’ve felt a difference. I’ve begun to notice how large the space that encloses me seems to be. It’s not a bad place really [...]. I’ve put up no curtains but I’ve hung some tapestries on the walls [...]. In the precise center of the room is a desk holding a black fountain pen, a bottle of black ink, and a tack of yellow legal-size pads, some of which are inscribed in a round black hand. (213)

Mairs returns to the idea she begins her narrative with, of “living behind bars,” to reinterpret the image. In this reinterpretation, she is in control, and she is the one who has made her circumstances not only habitable, but pleasant: she appreciates the space she has been given, she decorates, she writes. In this way, Mairs’ quest is fulfilled by her own self, and she demonstrates agency with her last line, a final declaration followed by an invitation to her readers: “This place is real. I can live here. Come by, and I’ll make you a cup of almond tea” (Mairs 213).

Mairs’ narrative portrays many aspects of the quest typology, most notably in the self-sufficiency she exhibits and the resources she provides to her readers. In doing so, Mairs’ narrative both practices third-space and serves as a location for third-space. Mairs

challenges dichotomies, makes meaning of the everyday, and fosters connections with her readers. Mairs' narrative also resists aspects of the quest narrative, most noticeably in the function of her "sequence of obstacles." Rather than use her descriptions of these hardships as a way to illustrate how she gained wisdom, Mairs overtly uses her narrative to teach readers how to gain wisdom themselves, informed by a third-space consciousness of "both/and" rather than "either/or."

Analyzing the Quest Narrative: Balancing the Authorized and the Everyday

At first glance, the parameters of Frank's quest narrative typology appear to describe an exemplary framework to give voice to everyday ways of being. Everyday ways of being, if viewed in opposition to authorized ways of knowing, seem to be given a voice as "only in quest stories does the *teller* have a story to tell" (Frank, *The Wounded Storyteller* 115).¹⁴ That the teller's voice becomes the forefront of a quest narrative provides the opportunity for the individual's experience to be showcased. Indeed, in all three case studies I have examined that exhibit characteristics of the quest narrative typology, each seem, for the most part, firmly situated in their own experience, and not given to claiming a universal formula for how people in similar situations should be treated.

Upon closer examination, however, the acknowledgment of and esteem for an awareness of situatedness that characterizes everyday ways of being become eclipsed to the extent that they conform to the quest narrative's third characteristic of "elaborat[ing] the narrative resources available to future ill people" (A. W. Frank, "Practicing Dialogical

¹⁴ See Chapter One. I am referring here to my description of authorized forms of knowledge as separating the objective from the subjective, thus devaluing individual experiences.

Narrative Analysis" 47). Such an elaboration holds the potential to adopt, in part, the attitude of authorized forms of knowledge. This attitude denies, to some extent, the individual experience in favor of extracting from the particular what can be generalized to the overall whole.

Yet, according to Carl G. Herndl and Adela C. Licona in their 2007 “Shifting Agency: Agency, *Kairos*, and the Possibilities of Social Action,” agency requires a balance of both authorized and everyday forms of knowledge, and third-space does not simply reverse hierarchical structures to perpetuate dichotomies. Thus the typology of the quest narrative does, in fact, prove itself to be ideal in its ability to balance these ways of knowing and being. In what follows, I discuss the implications of all three typologies I have examined.

CHAPTER FIVE: THIRD-SPACE IMPLICATIONS OF NARRATIVES OF MENTAL ILLNESS AND SUFFERING

This dissertation represents, in part, that which has influenced me to become the scholar I am today, immersed in the rhetoric surrounding mental health issues and committed to questioning prevailing normative modes of thought that cause people to fear saying too much, to sharing too much, information. In this, my concluding chapter, I consider the ways in which personal narratives of mental illness and suffering reveal the reality of third-space, offering alternative approaches to understanding mental health issues beyond the “authoritative knowledge vs. everyday expert” divide.

Rhetorical Criticism and the Hermeneutics of Suspicion

My examination of personal narratives of mental illness and suffering has elucidated the ways in which these narratives provide agency to both their authors and readers and disrupt hierarchical power structures within the healthcare system. These hierarchical power structures within the healthcare system were revealed to be influenced, to some extent, by the medical field’s privileging of biomedical treatment. Understanding biomedical treatment’s central role within the healthcare system thus further defined the nature of the hierarchical power structures that exist within such systems. Specifically, biomedical treatment’s emphasis on the validity of rationality equated with objectivity and therefore the invalidity of subjectivity provides one explanation for the devaluing of subjective patient narratives in the medical field.¹⁵ Thus

¹⁵ See chapter 1.

the divide of authoritative knowledge and the everyday expert was partially defined as the binary between objectivity and subjectivity, with objective knowledge being endorsed over subjective experiences.

The work of this project was to use Frank's narrative frameworks as a tool to help clarify how narratives empower patients to speak back to power structures that would devalue personal experiences. Reflecting on the completed work, however, has resulted in the unexpected discovery of an uncomfortable similarity between the methods of academic rhetorical criticism built on the hermeneutics of suspicion and the acts of a healthcare system upholding objectivity as the foundation of knowledge.

What is the appropriate way to respond to a person's public disclosure of mental illness and suffering? Figuring out an answer to this question becomes even more complicated when factoring in an academic context upholding what Ann Jurecic, in *Illness and Narrative*, calls "mainstream literary criticism" (3). Such "current critical practices," Jurecic explains, "are based in what Paul Ricoeur called the *hermeneutics of suspicion*" (3). Jurecic goes on to further elucidate, "In *Freud and Philosophy* Ricoeur writes that dual motives underlie literary interpretation: '[the] willingness to suspect, [and the] willingness to listen' (27)" (3). According to Jurecic, Ricoeur "sees suspicion and phenomenology as ideally counterbalancing each other in critical practice" (3). However, scholarship in more recent decades by "critics such as Eve Kosofsky Sedgwick, Bruno Latour, and Rita Felski have noted that the hermeneutics of suspicion has displaced what Ricoeur called listening and become 'nearly synonymous with criticism itself' (Sedgwick, *Touching Feeling*, 130)" (Jurecic 3). Such harsh scrutiny from literary critics

and, I would argue, rhetorical critics as well has the potential to do great emotional damage to authors whose personal illness narratives function as “testimonies aiming to affect and persuade, and [ways] to find or create a receptive audience for their narrative of a highly stigmatized experience” (Clark 6). Moreover, one need not have shared a highly stigmatized experience to be personally invested in his/her writing. “The academic life is a personal life,” Kate Ronald and Hephzibah Roskelly declare in “Learning to Take It Personally” (Ronald and Roskelly 253). “Professional activities and decisions are also deeply personal ones in great measure because writing and teaching are activities of the spirit and imagination” (Ronald and Roskelly 253). Given the inherent investment of the author in every piece of writing he/she produces, it is vital to acknowledge that, despite claims to the contrary, to judge one’s writing is to judge the writer as well. Ronald and Roskelly point out that, given that writing and teaching are activities of the spirit and imagination, “Evaluations, recommendations, reviews and other instruments that document performance *comment* on those spiritual, imaginative enterprises” (253). Therefore, when literary and rhetorical critics hide behind analyses of form over considerations of how the critic’s personal background affects his/her interpretation and the personal effects such texts cause on both authors and readers, they deny the implicit self-investment in all prose and create an evaluation that is ultimately, as Jurecic describes, incomplete. Jurecic expounds on this accusation against literary criticism rooted in the hermeneutics of suspicion:

For scholars trained in such habits of reading, the idea of trusting a narrative to provide access to the experience of another person indicates a

naïve understanding of how such texts function. Before a contemporary critic begins to read an autobiography about cancer or pain, she knows that it has been constructed by medical discourse and political, economic, and cultural forces. She also knows that common readers are likely to misread it because they will assume they can try on the experience of the author and that they will therefore succumb to the myriad powers of dominant discourse. She is also likely to assume that the narrative itself is not as sophisticated or knowing as the theory she uses to interpret it. Such a suspicious critical position is not necessarily wrong, but it is incomplete. Literary critics' disdain for or disinterest in illness memoirs suggests, above all, that contemporary critics have become alienated from ordinary motives for reading and writing. (3)

Jurecic elucidates the frame of mind the literary and rhetorical critic trained in the hermeneutics of suspicion often adopts. In doing so, Jurecic reveals such literary and rhetorical critics as positioning themselves above "common readers." This arrangement of the literary/rhetorical critic as more enlightened than the common reader enacts the hierarchy of knowledge produced by the medical field's privileging of biomedical treatment, validating rationality equated with objectivity and thus regarding subjective accounts as irrational. It would seem then, that literary and rhetorical criticism focused on the form of personal narrative at the expense of considering content perpetuates, either

consciously or unconsciously, a disregard for accounts that are deemed to be too personal.¹⁶

Alternative Approaches

How then to disrupt the dichotomy between authoritative forms of knowledge as manifested in academic rhetorical critique and everyday ways of knowing and being, described by Jurecic to be “ordinary motives for reading and writing” (3)? Alternative approaches to rhetorical critiques founded on the hermeneutics of suspicion include encouraging reviewers to (1) recognize their positionality in relation to the subject of the text under examination, (2) acknowledge the way such narratives “call into question dominant narratives that do not match the experience of life as lived,” (3) execute narrative analysis as embodied engagement, and (4) seek to discern how these narratives create gathering places (Bathmaker 3). “We have theorized how the personal has made its way into the academy, but we have yet to examine carefully how the academy has made its way into the private,” Julie Jung astutely observes (45). By proposing these alternative approaches to the hermeneutics of suspicion, I begin the careful examination Jung calls for, challenging the separation of authorized knowledge and everyday ways of knowing and being in rhetorical critique.

¹⁶ My research has revealed a variety of scholarship encouraging evaluations of narrative that privilege an analysis of form over content. This includes, but is not limited to, several selections from *Varieties of Narrative Analysis*, edited by James A. Holstein and Jaber F. Gubrium. Bloom’s “From Self to Society” encourages scholars to focus on the interplay between content and structure; Feldman and Almquist encourage analysis of what they call the explicit to recognizing the implicit in “Analyzing the Implicit in Stories”; McAdams emphasizes an evaluation of the interplay between theory and hypothesis in “Exploring Psychological Themes”; In “Exploring Narrative Interaction,” Shuman chooses to concentrate on recognizing cultural differences. Alternative approaches to such narrative analyses that believe judging structure will create an understanding of content are also included in *Varieties*.

Recognize One's Positionality in Relation to the Text

Recognizing one's positionality in relation to the subject of the text under examination begins with an awareness of how who one is and what she/he has experienced necessarily affects his/her interpretations of the world. "We comprehend our own and each other's lives through the stories that define us," Charles M. Anderson and Martha Montello declare, and therefore they advocate taking up Socrates' invitation in *Gorgias*

To imaginatively experience the narrative realities coiled within the arguments set before us, to inhabit these realities as fully as possible, and then to return to the present moment to consider in a more critical, more analytical way the knowledge gleaned from the experience. (85, 89)

This more critical, more analytical way, drastically differs from critique founded on the hermeneutics of suspicion because, as Anderson and Montello explain, "in this process, [a] destabilization of self [...] results" (89). The critic does not remain personally unaffected by the encounter because he/she has "give[n] [his/her]self over to the rhetorical power of the narrative" (Anderson and Montello 89). Anderson and Montello are careful to point out that the unsettling of the critic's self is "balanced by the stabilizing influence of critical conventions [and] analytical methodologies" but these conventions and methodologies are rooted in the "friendship shared by the participants in the conversation" (89). A more ethical critical engagement can occur when such interactions with personal narratives of mental illness and suffering are recognized as moral encounters. "Whether we want to or not, we bring everything we are to moral

encounters, and everything we bring shapes how we as readers and co-composers of moral narratives act, for good or ill,” Anderson and Montello conclude, and I believe such considerations are vital when seeking to enact a more complete critical response to narratives that are viewed as too personal, and therefore inappropriate for rigorous intellectual thought (91).

Pay Attention to the Way Such Narratives Call into Question Dominant Narratives that Do Not Match the Experience of Life as Lived

In addition to recognizing his/her positionality, the rhetorical critic would be wise to note how personal narratives of mental illness and suffering “call into question dominant narratives that do not match the experience of life as lived” (Bathmaker 10). This questioning is differentiated from critique based upon the hermeneutics of suspicion because of the way such an approach positions the critic in relation to the author. Specifically, the critic is not functioning to reveal insidious ideological constructs hidden in emotional appeals of which the author is not his/herself already aware. Rather, the critic is working with the author to enable the narrative to “speak the unspeakable” (Jurecic 10). Accomplishing this task means challenging prevailing beliefs that “illness is beyond expression in language” (Jurecic 10). Jurecic posits that the tendency to assume that some aspects of suffering are impossible to communicate is also a consequence of healthcare built upon a biomedical framework, “in which the body is an object and the focus of medicine is disease” (23). Consequentially, “contemporary physicians have no easily available language for suffering, no way of measuring it” (Jurecic 23). Stubbornly maintaining that the experience of certain types of suffering, because of its very nature,

cannot be put into words is inherently dangerous in how it denies those who are suffering the authority to narrate their own experiences. Perhaps what critics condemn as a failure on the author's part to capture a complex component of the human condition is in actuality the result of a deficit in the response of consumers of personal narratives of illness and suffering. Jurecic blames, in part, the inadequacy of critical responses on what she perceives to be numbness resulting from a relative surfeit of illness narratives:

While critical warnings to pay attention to how affect and ideology function in relation to texts have value, arguments that all testimony about suffering is mere repetition, and that our only hope as readers is to understand our failure to understand, express what I see as the academy's version of "compassion fatigue." (14)

Jurecic's identification of the academy's "compassion fatigue," however, is not an attempt to justify what she describes as "a blanket dismissal of testimony and emotional engagement" (14). In fact, Jurecic categorizes those critics who respond with such disregard as occupying "position[s] of distance and privilege. Such a critical stance imposes a falsely absolute divide between everyday experience and critical engagement" (14). Moreover, this broad disdain "does not serve literary and cultural criticism well as a tool for understanding life's precariousness" (Jurecic 14). In order to make the academy's "authoritative knowledge" more relevant to "everyday" reasons for reading and writing, rhetorical critics must be willing to move beyond focusing solely on the deficiencies of a text.

This is not to say, however, that alternative approaches to rhetorical critique founded on the hermeneutics of suspicion must overlook “weaknesses” within personal narratives of illness and suffering. Jurecic recognizes the importance of discerning the ways in which such narratives can sometimes attempt “to contain fear and uncertainty rather than explore the complexities of risk and normalcy, and their relationship to each other” (20). Drawing from narrative theorist’s David Herman’s work in “Stories as a Tool for Thinking,” Jurecic describes the distortions created when narrative, defined by Herman as “a basic pattern-forming cognitive system,” is used to organize events (24). Jurecic recounts Herman’s conclusion that “when one event follows another [...] the temptation is to tell a story of cause and effect, but such post hoc logic may not identify a valid relationship” (24). The application for rhetorical critics in light of Herman’s revelation, then, is the reminder that paying attention to the way narratives “call into question dominant narratives that do not match the experience of life as lived” will not always result in the discovery of challenges to such master narratives.

Embodied Engagement

Rhetorical critics interested in moving beyond the hermeneutics of suspicion are also encouraged to understand “narrative analysis as an embodied engagement with the lives of others” (Sparkes and Smith 53). Andrew C. Sparkes and Brett Smith demonstrate what it means to recognize the role of the body in research, describing this methodology as a combination of empathy, recognition of the other as other, and self-awareness. To describe empathy, Sparkes and Smith explain how they instruct students that “analysis begins the moment we adopt the reflective posture of *indwelling* [...] This posture,

according to Maykut and Morehouse (1994), ‘means to live within... understanding the person’s point of view from an empathetic rather than a sympathetic position’” (54). This position of empathy is not to be confused with the ability to completely understand another’s experience. Sparkes and Smith caution, “when empathizing as part of the analytical process, it is important to respect the other *as other*, thereby preserving what Levinas (1998) termed *alterity*—the person’s *otherness* that precedes any attributes. This respect can also prevent the critic from assuming a stance of superiority over the author with claims that he/she has him/herself been through the *exact same* experience and is thus entitled to pass judgment on the author’s ability (or lack thereof) to handle the situation. Also vital for embodied engagement according to Sparkes and Smith is “indicat[ing] the presence of our corporeal bodies and the part they might play in shaping our analysis of data” (64). Sparkes and Smith do not pretend such consciousness is easy, being careful to note that, “we recognize the difficulties of putting into words the feelings of the flesh” and tentatively offering suggestions such as “the use of a reflexive research journal or field diary as a useful starting point” (65). Of particular significance is Sparkes’ and Smith’s proposal that understanding one’s embodied engagement as a researcher/critic might necessarily entail a dialogue beyond the self. While “dialogue with the self when it comes to the ways in which our bodies shape the process of analysis [...] may be useful for exploring certain aspects of our conscious selves,” Sparkes and Smith begin, “It might be less useful for reflecting on issues related to our unconscious selves and might require the assistance of others” (67). Making rhetorical critics accountable to others in this way is laudable in that such a dependency would also

necessarily displace the critic as overseer of authoritative knowledge, thus dismantling the hierarchy over everyday ways of knowing and being.

Create Gathering Places

I find one of the most intriguing alternative approaches to rhetorical criticism based on the hermeneutics of suspicion to be the notion of critique as gathering place. Ann Jurecic analyzes Bruno Latour's "Why Has Critique Run Out of Steam? Matters of Fact to Matters of Concern," explaining that

As Woolf did in her essay some eighty years earlier, Latour encourages his readers to participate in a thought experiment. He invites us to reimagine the critic, not as "the one who lifts the rugs from under the feet of the naïve believers, but the one who offers the participants arenas in which to gather" (246). He continues, "The critic is not the one who alternates haphazardly between antifetishism and positivism...but the one for whom, if something is constructed, then it means it is fragile and thus in great need of care and caution" (246). He also asks us to imagine the circumstances in which we might *want* critics to address matters of concern we cherish—that is, to conceive of a critical practice that adds to our lived experience rather than stands apart from it (232). (16)

In some respects, Latour's concept is similar to the critical engagement detailed in Burke's parlor metaphor, if one understands Burke's "unending conversation" to be the

sustained evolution of literary critique.¹⁷ “The challenge Latour poses is twofold,” Jurecic sums up, “He wants critics to identify complex matters of concern that cannot be accounted for by existing critical approaches and for critics to allow these matters to enlarge the goals and the scope of criticism” (16). I see such a challenge as worth undertaking, something I am determined to pursue as I continue my work as a teacher, researcher, and writer dedicated to valuing knowledge in all its myriad forms.

I began my project with the question: How do personal narratives of mental illness and suffering illuminate the ways in which language constructs reality? Now, at the end of this journey, I understand this question to be one that can help rhetorical critics challenge the notion of critique as condemnatory, a question that, when kept at the forefront of a reader’s mind, can help expand one’s perspective and cultivate an open mind capable of respecting variations of knowing and being.

¹⁷ Burke, Kenneth. *The Philosophy of Literary Form: Studies in Symbolic Action*. Third Edition. Berkeley: University of California Press, 1974. Print.

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