ANNINA YLÄ-KAPEE

Telling Madness

Narrative, Diagnosis, Power, and Literary Theory

ACADEMIC DISSERTATION
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UNIVERSITY OF TAMPERE

ANNINA YLÄ-KAPEE

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ABSTRACT

My work is divided into two parts: Part I: Telling Madness – Narrative, Diagnosis, and Power; and Part II: Telling Madness – Madness and Literary Theory.

Part I: Telling Madness – Narrative, Diagnosis, and Power

In Part I, I practice what I term the 'psychiatric literature research' of fictitious madness narratives. (I define a 'madness narrative' as a narrative containing a character(s) or narrator(s) who can be diagnosed as mad by the other character(s), narrator(s) and/or the authorial audience.) In constructing the analyses of my eight target novels, I combine five psycho-scientific and counter-force frameworks (Freudian psychoanalysis and modern diagnostic psychiatry, and the counter-forces of Laingian anti-psychiatry, Szaszian critical psychiatry and Foucault's madness philosophy) with Foucauldian power analysis and a narratological and Phelanian rhetorical study of narratives and their Keenian empathy-engendering structures. I explore the combination of these theoretical frameworks in order to understand the forces present in my madness narratives and to show how narratorial agendas and madness diagnostic agendas become intertwined.

My psychiatric literature research is directed, first of all, at reading through the psychiatric, psycho-scientific paradigms and their counter-forces and asking how these psycho-sciences are depicted in madness narratives. Furthermore, my research examines the way these depictions represent the target of psycho-scientific research and treatment, that is, madness itself. Secondly, it aims to elucidate the conditions needed for reading through psycho-scientific and counter-force paradigms, questioning the limits of this approach and the ways these fictitious narratives challenge,

supplement, or ignore the paradigms as interpretative frameworks and parts of their narrative structures. Thirdly, my study foregrounds precisely madness literature's way of *using* psycho-scientific paradigms – and also lay frameworks of madness – to its own ends, and the way the professional or lay madness diagnoses made by characters, narrators and audiences are integrated into the narrative and literary process of communication to further the narratorial and authorial agendas in specific ways. My central focus is on the nexus of what I see as *narrative and diagnostic powers*: the former power is connected to my way of seeing fiction as a rhetorical communication aiming for specific reactions from its audience (which has many features common with Foucauldian subjectifying power), the latter power is connected to how a madness diagnosis perfectly exemplifies the Foucauldian use of subjectifying power.

Thus, in the first part, I describe the way these two powers interact to produce the literary and rhetorically persuasive structures that narrators and implied authors use to direct their audiences' interpretation of madness and the psycho-sciences.

Part II: Telling Madness – Madness and Literary Theory

In Part II, by analysing a number of various madness narratives from different angles, I explore the concept of madness in order to elucidate certain literary theoretical issues. I examine the way madness narratives offer the possibility of studying fiction's world-building force by highlighting the role of 'fictions-inside-fiction'. I analyse how madness can be used as a literary device or a theme analysed in its own right, and I also investigate the value of madness as a literary-analytical concept. In addition, I consider how the reader of madness narratives may be faced with ethical problems of reading and diagnosis, and how madness and aesthetic production can be intertwined in madness narrative. Furthermore, to explain how literature gives meaning to something brain psychiatry seems to side-step, I take up the issue of the meaning of literary psychosis as juxtaposed to the meaninglessness of psychosis as seen by modern brain psychiatry. Finally, I reconsider the term of 'unreliability' in connection to madness narratives: if the mad narrator/focaliser is honest when depicting her madness, is it not misleading to call her 'unreliable'? Therefore, I suggest complementary notions of 'intra-mental reliability/unreliability' and 'inter-personal reliability/unreliability', which in my opinion give literary scholars more finely tuned tools and spectrums to interpret and diagnose literary personae.

TIIVISTELMÄ

Jaan työni kahteen osaan: Osa I, Kerrottu hulluus – kertomus, diagnoosi ja valta; sekä Osa II, Kerrottu hulluus – hulluus ja kirjallisuusteoria.

Osa I: Kerrottu hulluus – kertomus, diagnoosi ja valta

Työni ensimmäisessä osassa sovellan ja testaan kehittämääni tutkimusmetodia, jota kutsun ”psykiatriseksi kirjallisuudentutkimukseksi”; sen kohteena ovat fiktiiviset hulluuskertomukset. Määritelmäni mukaan ”hulluuskertomukset” kuvaavat hulluutta siten, että kertomuksissa on hahmoja ja/tai kertojia, jotka toiset hahmot, kertojat tai sisäislukijat voivat diagnosoida mielisairaiksi. Tutkin kohdeteksteinäni kahdeksaa tällaista kertomusta, seitsemää romaania sekä yhtä omaelämäkertaa; ja yhdistän luennoissani viisi psyko-tieteellistä viitekehystä (freudilaisen psykoanalyysin, modernin diagnostisen psykiatrian, ja näiden valtavirtateorioiden vastateorioista Laingin anti-psykiatrian, Szaszin kriittisen psykiatrian sekä Foucault'n hulluusfilosofian) Foucault'n valta-analyysiin, Phelanin kertomusten retoriseen analyysiin, kognitiiviseen näkemykseen kerronnan kokemuksellisista sisällöistä ja Keenin fiktion empatiarakenteiden tutkimukseen. Luen tämän viitekehysten yhdistelmän valossa ymmärtääkseni kertomuksissa läsnä olevia voimia: kuinka kerronnalliset agendat kietoutuvat yhteen diagnostisten agendojen kanssa.

Tämä kehittämäni psykiatrinen kirjallisuudentutkimus suuntautuu ensinnäkin lukemaan psykiatristen paradigmojen ja niiden vastateorioiden lävitse ja tutkimaan, millä tavoin näitä paradigmoja kuvataan hulluuskertomuksissa; ja myös sitä, miten nämä kuvaukset hahmottavat psykotieteellisen tutkimuksen ja hoidon kohdetta: mielisairautta itseään. Toiseksi, tutkimussuunta tähtää valottamaan niitä ehtoja,

joita tällaisella psykotieteiden ja niiden vastateorioiden lävitse lukemisella on: mitä rajoituksia tällaisella lähestymistavalla on, ja miten fiktiiviset kertomukset haastavat, täydentävät tai jättävät huomiotta psykotieteellisiä paradigmoja rakentaessaan kerronnallisia rakenteitaan ja lukijan mahdollisuuksia tulkita niitä. Kolmanneksi, se asettaa etualalle juuri kirjallisuuden tavan *käyttää omalla tavallaan* psykotieteellisiä paradigmoja, ja myös maallikkojen luomia mielisairauden tulkintakehyksiä. Tämä kolmas näkökulma korostaa sitä, miten hahmojen, kertojien ja yleisöjen tekemät diagnoosit integroituvat kerronnallisiin kommunikaatioprosesseihin samalla edistäen kertojien ja tekijöiden agendoja erityisillä tavoilla. Yhdistäessäni psykiatrisen tarkastelun hulluuskertomuksien tulkintaan huomioni keskiössä on *kerronnallisen ja diagnostisen vallan* yhteenkietoutuma. Ensimmäinen näistä valloista liittyy tapaani nähdä fiktio retorisena kommunikaationa, joka tähtää tiettyihin yleisöjen reaktioihin; näkemykseni mukaan tällä retorisella kommunikaatiolla on paljon yhteneväisyyksiä Foucault'n muotoileman subjektivoivan vallan kanssa. Toinen vallan muodoista liittyy Foucault'n tapaan nähdä mielisairausdiagnoosi subjektivoivan vallan malliesimerkkinä.

Tuloksenani on tässä työni ensimmäisessä osassa kuvaus siitä tavasta, jolla nämä kaksi valtaa toimivat vuorovaikutuksessa keskenään ja tuottavat kirjallisia ja retorisesti ohjailevia kerronnan rakenteita; näitä rakenteita kertojat ja sisäistekijät käyttävät ohjatakseen yleisöjensä tulkintoja mielisairaudesta ja psykotieteistä. Tuloksissani totean lisäksi sen, että kohdetekstini asettuvat eri tavoin psykotieteiden ja niiden vastateorioiden kartalle, osa tukien psykotieteellisiä lähestymistapoja mielisairauden hahmottamisessa ja hoidossa, monet suoraan problematisoiden niitä, jotkut jättäen ne kokonaan huomiotta. Tämä tukee näkemystäni siitä, että psykotieteiden lävitse lukeminen on usein perusteltu lähestymistapa hulluuskertomuksiin. Toisaalta kohdeteksteistäni kahdessa ei mainita psykotieteitä lainkaan, mikä toimii hedelmällisenä peilinä ja muistutuksena siitä, että psykiatrisella kirjallisuudentutkimuksella on rajansa: on olemassa myös ”puhtaasti kaunokirjallista” hulluuskuvausta, joka ei välttämättä väkivallatta taivu psykotieteelliseen analyysiin.

Osa II: Kerrottu hulluus – hulluus ja kirjallisuusteoria

Työni toisessa osassa luen kohdetekstejäni ja kirjallisuusteoreettisia kysymyksenasetteluja hulluuden käsitteen lävitse valottaakseni näitä kysymyksiä eri kulmista.

Kohdeteksteinäni on laaja joukko hulluuskertomuksia, joista joitakin tarkastelen pidemmin, toisia lyhyemmin.

Ensinnäkin tutkin sitä tapaa, jolla hulluuskertomukset antavat mahdollisuuden tarkastella fiktion kykyä rakentaa maailmoja; hulluuskertomuksissa näet usein rakentuu fiktion sisäisiä fiktioita. Tuloksenani on, että hulluuskertomukset – manipuloimalla käsitteellisiä kahtiajakojaan (esim. hulluus/normaalius; hulluus/yliluonnollinen; hulluus/todellinen), jotka määrittävät (hulluus)fiktion rajoja – osoittavat meille miten (hulluus)fiktion rajat ovat häilyviä ja riippuvat tulkintalähtökohdasta.

Toiseksi, analysoin tapaa, jolla hulluus valottaa kirjallisen keinon käsitettä: kysyn kysymyksiä siitä, miten hulluutta voi käyttää kirjallisena keinona tai itsessään arvokkaana kaunokirjallisena teemana. Kyseenalaistan sen, että jako kirjallinen keino / itsessään arvokas teema olisi niin jyrkkä hulluuskertomusten kohdalla kuin Robin Downie antaa ymmärtää.

Valotan myös hulluuskertomusten lukemisen ja diagnosoinnin eettistä puolta: kahden kohderomaanin, McGrathin *Spiderin* ja Nabokovin *Lolitan*, analyysin avulla analysoin tapaa, jolla hulluuden ja terveyden maailmat hankaavat vastakkain, kun on kyse hulluuskertomusten eettisestä tulkinnasta. Näiden kahden hulluuskertomuksen eettiset kerrontarakenteet esittävät hulluuden ja terveyden maailmojen suhteet monimerkityksisinä, mikä aiheuttaa lukijan eettiselle tulkinnalle omat ongelmansa.

Käsittelen myös estetiikan kysymystä hulluuskerronnan kohdalla: Nabokovin romaani *Pale Fire* antaa minulle mahdollisuuden kysyä kysymyksiä hulluuden ja estetiikan suhteista, esimerkiksi sitä, voiko mielisairas tuottaa esteettisesti arvokasta fiktiota. Tämä teksti ei tosin helpota lukijan urakkaa, vaan esittää ilmiönsä monisärmäisenä, usein lopullista vastausta vaille jäävien kysymyksien herättäjänä.

Otan esiin myös ilmiön, joka liittyy modernin aivopsykiatrian ja kaunokirjallisen psykoosikuvauksen rinnastamiseen: että kaunokirjallisuus antaa merkityksen jollekin, minkä aivopsykiatria jättää kokonaan merkitystä vaille. Kaunokirjallisuuden psykoosikuvaukset merkityksellistävät psykoosin kokemuksen ja sisällön aivan eri tavalla kuin aivopsykiatria antaa olettaa. Tämä korostaa toisaalta kaunokirjallisuuden kykyä luoda merkityksiä ja metaforisia sisältöjä psykoosille, ja toisaalta sitä, miten kauas aivopsykiatria on etääntynyt psykoosipotilaan kokemuksien sisällöistä ja merkityksistä.

Lopuksi tahdon uudelleenmäärittää käsitteen kerronnan tai fokalisoinnin ”epäluotettavuudesta” hulluuskertomusten yhteydessä. Lähtökohtani on se, että jos hullu kertoja/fokalisoija kertoo rehellisesti omasta sairaudestaan ja sen eri ilmiöistä,

eikö silloin ole harhaanjohtavaa kutsua häntä ”epäluotettavaksi”? Ehdotankin, että käyttöön otettaisiin kaksi yhteen liittyvää termiä ”mielensisäinen epä/luotettavuus” ja ”henkilöiden välinen epä/luotettavuus”, jotka mielestäni yhdessä käytettyinä antaisivat paremmin työkaluja tulkita ja diagnosoida kaunokirjallisia hahmoja.

1 INTRODUCTION: TELLING MADNESS

Jim, Hammond Innes's narrator, makes us feel afraid of a madman, of his unpredictability and his murderous monomania. Sylvia Plath's Esther makes her audience feel for her in her terror of going mad, of desperately wishing and attempting to die, in her treatment with frightening psychiatric techniques. Pat Barker's narrator gives her audience direct access into the minds of shell-shocked soldiers and their psychiatrists to make her audience see the madness – not only of those Great War soldiers – but most importantly, of war itself. Jane Urquhart's narrator makes us wonder whether Mary is really mad or a pure example of a dying culture. What is happening here? We, as readers – the final audience of these narratives – are influenced by these narratorial impulses that gain part of their driving force from diagnostic power patterns: diagnoses of madness made by narrators, characters, or by the reader herself. There are multiple forces in play here, and multiple dynamisms. We are led to wonder about psychiatry, about patients and stigmas. Sometimes we are nudged towards understanding something utterly strange to many of us. We are asked to empathise and interpret in a particular manner, and to hear the narrator out, to take in the experiential spheres of her characters, and sometimes her own experiential sphere. I intend to address these dynamisms in the first part of my study: Telling Madness – Narrative, Diagnosis, and Power.

In the second part, Telling Madness – Madness and Literary Theory, I address different kinds of questions, those arising from the status of madness narratives as interesting examples in the field of literary theoretical study. I observe that madness narratives form an example shedding light on some important questions, such as how these fictional worlds work, how madness functions as a literary device, how literary structures give rise to concerns of ethical interpretation, how madness is

related to the question of aesthetic production, how madness narratives highlight the literary capacity for making meaningful something the now dominant branch of psychiatric analysis has seen as devoid of meaning, and how we should speak about unreliability in the field of literary studies.

But first, in this introduction, I specify and offer the background to my central research questions, clarify some of my terms, and explain my choice of corpus for each part.

1.1 Research Questions Part I: Telling Madness – Narrative, Diagnosis, and Power

In Part I, I take as my object of analysis certain aspects of fictional madness narratives that I approach by interlinking a Foucauldian-like power analysis to the rhetorical-structural analysis of madness narratives and the psycho-scientific analyses of madness. This is done in order to understand the forces present in these narratives – forces referred to above in which the narratorial agendas become intertwined with diagnostic agendas. With the help of these frameworks, I ask questions about the power relational side of madness narratives.

In order to achieve my objectives, I aim to practice something that I dub the 'psychiatric literature research' of fictitious madness narratives, which combines the psycho-scientific frameworks I will specify shortly with Foucauldian-like power analysis and the narratological and rhetorical study of narratives. This research is directed, first of all, at reading through the psychiatric, psycho-scientific paradigms and their counter-forces, and asking about the way the psycho-sciences are depicted in madness narratives; and further, the way these depictions represent the target of psycho-scientific research and treatment – madness itself. Secondly, it aims to elucidate the conditions of precisely this kind of reading through the psycho-scientific and counter-force paradigms, to ask about the limits of this approach, and the ways these fictitious narratives challenge, supplement, or ignore the paradigms as interpretative frameworks and parts of their narrative structures. Thirdly, it foregrounds precisely this literature's way of *using* the psycho-scientific paradigms – and also lay frameworks of madness – to its own ends, the way the professional or lay madness diagnoses made by characters, narrators and audiences are integrated into the narrative and literary process of communication to further narratorial and authorial agendas in specific ways.

At the centre of my attention to the application of psychiatry to madness narratives as literature is the nexus of what I see as *narrative and diagnostic powers*, which I begin to describe below and elucidate in greater detail in Chapter 3. This nexus connects the three viewpoints of the psychiatric literature research described above: the psycho-scientific theories of madness in their (1) possibilities; (2) limits as narrative and reading strategies; and (3) the literary uses of these depictions of psycho-sciences and madness itself. The nexus also ties together all my research questions in the first part of my study.

The coupling of madness with literature and its study is, of course, much older than psychiatry as a modern science. One can go to Homer to find mad fictional characters, or Plato to find analyses of the connection of madness to aesthetics and literature. The theme of madness has followed the history of literature, all the way from Antiquity up to today, as shown by Allen Thiher in his *Revels in Madness* and Lillian Feder in her *Madness in Literature*. My own historical scope is, however, much more delimited: I focus on modern clinical psychiatry of the 20th century and 21st century and its counter-forces, and the way these rather young theories interact with my target texts of literature from the same period of time.

Thus far there have been published works, like Louis A. Sass's *Madness and Modernism. Insanity in the Light of Modern Art, Literature, and Thought*, which are examples of the study of literature or arts in general that aim to elucidate the connections between the real world psycho-scientific notions and paradigms and literary depictions of madness. Many, if not most, studies on madness literature have some kind of theoretical basis in one or other branch of the psycho-sciences, e.g. Lillian Feder uses psychoanalysis as the madness theoretical basis in *Madness in Literature*, as does Evelyn Keitel in her *Reading Psychosis. Readers, Texts and Psychoanalysis*, and Glenn Rohrer in his textbook (2005) proposes mainstream DSM[1] psychiatry as the interpretative framework for his excerpts of literature. The counter-forces to the established psycho-sciences have their own studies as well, e.g. John Vernon's *The Garden and the Map. Schizophrenia in Twentieth-century Literature and Culture* bases its notion of madness on Laing's anti-psychiatry. As can be seen, psychiatric theorising in different guises is not new perspective in the study of literature.

My own line of 'psychiatric literature research' of madness narratives, then, targets something I see as an important area of study in this field that has not been raised before: the experience and significance of the diagnostic relationship between

1. The American Psychiatric Association's diagnostic manual: *Diagnostic and Statistical Manual of Mental Disorders*.

the person making a diagnosis of madness and the person receiving the diagnosis inside the narrative world. This viewpoint focuses on the power present in diagnosis – both in real life and in fictitious depictions of madness and the psycho-sciences. This viewpoint is significant because the power aspect of psycho-scientific – and lay – madness diagnosis is central to the experience of both real patients and diagnosticians, and those narrated about in fiction – it defines them elementally. My focus is thus on the clinical side of the psycho-sciences, not so much on their possible cultural theoretical aspects (as could be in the case of psychoanalysis as a branch of the psycho-sciences) or the metaphorical uses of their basic notions like 'madness' (as in the case of seeing 'madness' as a philosophical category that can be opposed to, e.g. the notion of 'Reason'). I am seeking the basic experience of being mad, of diagnosing madness, of encountering and telling about it in fictitious narratives, and as a clinically seen phenomenon.

Thus, in this first part, I aim to study the representations and power structures of diagnosing madness in a chosen corpus of longer Anglo-American fictional madness narratives. One of my aims is to ask, in relation to these narratives, how, why and by utilising what narrative power structures does madness fiction as literature depict – tell of – madness? In addition, how do the fictional narratives at the same time position themselves in the diagnostic power field of clinical psycho-sciences and their counter-forces, by debating with and commenting on them? These questions, in the end, may elucidate the core concept of 'madness' itself – but if and when this occurs, it happens in the context of fictitious narratives and their complex relationships to reality, as I will describe shortly. Again, these questions connect to the nexus of narrative and diagnostic powers.

I aim to study, in the light of my theoretical frameworks – both narrative-analytical and psycho-scientific – the ways these questions of the literary meaning, form, and the psycho-scientific ramifications of madness relate to questions of power. I consider this elemental connection to come from the social nature of madness and the psycho-scientific theories of madness as power fields in the world we live. In my opinion, a madness diagnosis is never a neutral issue. It is connected to the possibly stigmatic aspect of madness which points to madness as a burning social category, and to clinical psycho-sciences being powerful societal actors – which materialises, e.g. in the forced treatment of some of the mental patients, making visible psychiatry's function as a societal keeper of those mentally ill persons who are seen to be dangerous to themselves and/or others. The clinical psycho-sciences centrally aim at classification and, also by the aid of this classification, the changing of the

phenomenon of madness, thus making madness an object of study and treatment: both aspects of clinical psychiatry can be seen as unequal power relationships. These non-neutral sides of psychiatry and madness also make one alert to the power issues in diagnosing madness in the literary context. The diagnosis is never neutral in the literary context either: the characters, narrators and implied authors always have their own reasons for using this burning category. These reasons may be connected to psycho-scientific power agendas, e.g. representing certain forms of psycho-science in a particular manner, or to narrative power agendas, e.g. supporting the narrative's plot thickening structures.

It is for these reasons that I make the analytical claim that there are two distinct types of power used in madness fictions: diagnostic and narrative. The use of *diagnostic power* inside or in connection to the specific narrative makes it an example of a madness narrative in the first place: under my definition of 'madness narrative', someone inside that narrative (character/narrator) has to be defined mad for the narrative to be perceived as a madness narrative. The *narrative power*, then, is a matter of seeing the narrative rhetorically. The Phelanian school of rhetorical studies of narratives emphasises the seeing of narrative as aiming at a certain interpretation that the audiences of the narrative should make. The narrators – and the implied authors in the end – have narrative agendas: they want the audiences to interpret the aesthetic and ethical structures of the narrative in specific ways. This I interpret as a founding feature of narrative power.

As mentioned, I approach the issue of literary representations of madness with the aid of diagnostic power and narrative power, two analytical tools that cast light on the literary processes of representing madness and diagnosis-making. I define my conception of these powers *as powers* in Chapter 3 using Michel Foucault's 1982 formulations on power. Diagnostic power, as will be seen, is a 'proper' Foucauldian subjectifying power; narrative power, then, is not a 'proper' Foucauldian power as it is a form of communication – it has certain characteristics of a Foucauldian subjectifying power, but not all. It exhibits, however, so many of the Foucauldian power aspects that I nevertheless call it a 'power'. In addition to the Foucauldian confrontational or combative subjectifying power, which a diagnosis may be regarded as, I introduce Michael Karlberg's formulations on assistant empowering power, which I use to enlighten the positively productive and healing side of the psycho-sciences. This Karlbergian empowering power can be, like narrative power, at least partly synchronised with the Foucauldian scheme of subjectifying power.

In Chapter 3, I thus build my Foucauldian-Phelanian model of narrative power specifically for use in connection with madness narratives. In this, I use Foucault's theories on the intertwining of knowledge and power, James Phelan's notions on rhetorical persuasion in fiction, Suzanne Keen's analyses of empathy in fiction, and David Herman's and Monika Fludernik's cognitivist notions of the experiential essence of narratives. On this basis, I define four specific literary-analytical instruments to decipher the dynamisms of narrative power: two narrative techniques (narrative situations and narrative progress) and two thematic tools (groupings and experientiality). From these parts, I weld together my model of narrative power, which I see as a separate but interlinking category to the diagnostic power used in the madness narratives analysed. I use these tools to follow the literary structures that carry the representations of madness and the psycho-sciences and their counter-forces in my target texts, and to examine the complex intertwining of the narrative and diagnostic powers.

The acknowledgement of the diagnostic relation as a power relation is elemental to the rhetorical study of madness narratives: one cannot escape the presence of the diagnostic power relation as a rhetorical structure in these narratives. On the other hand, perceiving madness narratives through the notion of rhetorics – of narrative power – is equally as important: when one studies madness narratives as fictional narratives, the aspect of rhetorics, the power of fictitiously layered narration, that shapes the picture of the diagnostic relationship must be reckoned with.

I practise my vein of psychiatric research of madness narratives for the reason that, in my opinion, the psycho-scientific and their counter-theories strongly define the ways our culture perceives madness – they also affect those of us who are not professional representatives of the psycho-sciences. I define the contents of the terms 'psycho-sciences' and their 'counter-forces' briefly in this introduction; in Chapter 2 I establish these madness theoretical frameworks in detail.

By reading madness narratives in the light of the clinical psycho-sciences and their counter-forces, and by asking questions about their depictions, one can achieve a double effect: psychiatry and its madness philosophical and critical psychiatric counter-forces – as the science of madness and its counter-theories – can offer valuable insights into the interpretation of literary madnesses, such as better recognition and perception of the types of madness. Conversely, literature supplements and challenges these psychiatric – and also counter-force theoretic – interpretations by giving information about their objects, e.g. about the subjective experiential spheres of mad people. This emphasises the nature of literature as a phenomenon in its own

right, as something that does not always submit to theoretical tools, such as strict psychiatric diagnosis, which are used to analyse it. This tension caused by the double effect of interpreting through the madness theoretical frameworks is one of the questions I take up: how and why do different literary works submit to or challenge the psychiatric diagnosis or reading through the counter-forces? This tension is one part of the nexus of diagnostic and narrative power, as the narrative power may use the diagnostic agenda to its own ends (by, e.g. challenging the diagnosis), and as the diagnostic power may be elemental to the use of narrative power (the narrative's submitting to psychiatric diagnosis).

Thus, I keep the literary essence of the studied corpus in central focus; and I ask important supplementary questions: Is it always justified to read through the frameworks of psychiatry or its counter-forces? Is there something that could be termed as 'literary', non-psychiatric madness? When is the strict psycho-scientific diagnostic a welcome, fruitful reading strategy? In this way, I aim to be sensitive to the unique, literary aspects of my target narratives, in order not to reduce them, or even their representations of diagnosis, to the psycho-science/counter-force debate – even if this debate is an elemental part of our culture's way of understanding madness. In this way, I again keep the nexus of narrative and diagnostic powers in view: in the target analyses, I will ask about how the narratives may use not only the strictly psychiatric diagnostic power, but also lay variations of it to further their narrative power use; and about the ways the narrative power, even in madness narratives, may not be totally dependent on psycho-scientific agendas, but capable of forming its unique expressions. Therefore, by emphasising the power aspects of narration and diagnosis, I also emphasise the literariness of literature: the narrative power patterns which in their own part regulate the diagnostic power patterns in the narratives are always unique, even when they seem to take part in the more general, societal power fields of psycho-scientific debates.

My setting of these research questions links to Robin Downie's perception of how literature, at its best, gives information about madness that is complementary to scientific, psychiatric knowledge (Downie 2005, p. 49). He wishes to 'make a plea for the kind of understanding which comes from literature, an understanding in which the reader can move from a total involvement with an individual case in its full context to something universal' (ibid., p. 61). This 'involvement with an individual case' I interpret as likening to my perception of the understanding of the experiential depth and situation of the fictional character, which may be, at the same time, unique and common to all humans. I do, however, have certain

reservations with Downie's way of overvaluing psychiatric knowledge. Psychiatry, as I hope to demonstrate throughout the first part of my study, is not a monolithic, stable science, it is racked with tensions and controversies that threaten the whole psychiatric scene precisely with questions querying the scientific base of psychiatry. In my own analyses, I am conscious of these tensions, and aim to elucidate the ways in which literature not only complements but also contests psychiatric theories. The literary use of madness depiction is another matter that I share with Downie, as he analyses the difference between literature giving, on one hand, the above kind of 'universal' understanding, and on the other, reducing madness to the status of a 'literary device only'. In Chapter 4, when analysing my target texts, I keep in mind this madness-as-a-literary-device vs. madness-as-a-phenomenon-in-its-own-right, as it is one of the aspects of the type of analysis of the narrative power patterns I give to these texts. In Chapter 5, I further discuss Downie's conceptions on the status of madness as a literary device.

To sum up: in the first part of my study, I approach my target madness narratives and their representations of madness through the eyes of madness theories and my narrative-analytical tools. I do this in order to ask questions about – and to shed light on – the nexus of narrative and diagnostic powers. In this way, I hope to produce a description of one side of these narratives: the fascinating way they regulate the rhetorical and fictitious communication of madness, in connection with madness theories, to elucidate the different ways madness can be persuaded to be seen in and by these narratives.

1.2 Why this Corpus? Part I

In the first part of my study, I have chosen eight madness narratives as my corpus to analyse in greater detail; I give sub-chapter-long analyses of each of these narratives. These narratives are:

- Patrick McGrath: *Asylum*
- Hammond Innes: *The Killer Mine*
- Sylvia Plath: *The Bell Jar*
- Susanna Kaysen: *Girl, Interrupted*

- Pat Barker: *Regeneration*
- Marge Piercy: *Woman on the Edge of Time*
- Patrick McCabe: *The Butcher Boy*
- Jane Urquhart: *Away*

The criteria behind my choices are: 1) the narratives represent examples of the different ways narrative and diagnostic powers intertwine. They offer opportunities to study the phenomena of narrative and diagnostic power in a rich manner; 2) the narratives depict different kinds of diagnoses from the wide spectrum of psychiatric nosologies (e.g. Borderline Personality Disorder, shell shock, schizophrenia, depression, etc.); 3) the narratives make it possible to analyse the psycho-sciences and the way they are represented in the narratives; and 4) the narratives are positioned temporally from mid-20th century onwards so that they can be meaningfully placed in discussions about the psycho-sciences and their counter-forces, whose debates can also be located precisely from the mid-20th century onwards. I have chosen one non-fictitious text, Susanna Kaysen's autobiography *Girl, Interrupted*, as one of my target texts in order to be able to juxtapose and compare some of this text's methods of depicting and commenting on the psycho-sciences, and the way the narrative and diagnostic powers can be handled differently by a factual text's narrator-author from fictional narrators. All of the narratives take up their own position on the map of the debate between the psycho-sciences and their counter-forces, and they also have their unique manners of employing the narrative and diagnostic powers, which I will compare and juxtapose along the way.

The corpus is arranged to follow a three-fold logic:

1) the diegetic level of diagnosis-making: homodiegesis (the homodiegetic narrator makes a diagnosis of herself or the diagnosis is made of a character who is situated on the same diegetic level as the homodiegetic narrator: McGrath, Innes, Plath, Kaysen); heterodiegesis (the diagnosis is made of characters who are situated 'inside' heterodiegetic narration: Barker, Piercy); and readerly diagnosis (the diagnosis of an unreliable, mad narrator/focaliser may be made finally by the reader alone following the hints given by the implied author – the narrator/focaliser does not make a direct diagnosis of herself: McCabe, Urquhart);

2) the mode of diagnosis: professional and lay diagnosis (i.e. is the diagnostician a professional or a lay person? Does she use strict psycho-scientific terminology? The narrative may use one or both of these modes: professional diagnosis: McGrath, Kaysen, Barker, Piercy; lay diagnosis: Innes, Plath, Kaysen, Barker, Piercy, McCabe, Urquhart; a lay person can make a strict psycho-scientific diagnosis and a professional may use vaguer lay terms – there is always some kind of agenda behind the terminology and mode of diagnosis that has to be kept in mind);

3) the direction of diagnosis: internal (self-)diagnosis and external diagnosis (of another person), this difference is important to keep in mind, as the direction of diagnosis affects the use of diagnostic and narrative power in significant ways (e.g. the direction of the possibly stigmatic content of a diagnosis is different in self-diagnosis than in an external one, and the narrators and characters handle this content differently, according to the direction of diagnosis; external diagnosis: McGrath, Innes, Plath, Barker, Piercy, McCabe, Urquhart; internal diagnosis: Plath, Kaysen, Barker, Piercy).

1.3 Terminology

The terminology of the first part of my study is rather complex and tentative, more so than that of the second part in which I operate with theoretical tools that are fairly well established in the study of literature. Therefore, I will concentrate here on the issues of defining and justifying the terms used in the first part.

1.3.1 What Are 'Psycho-Sciences' and Their 'Counter-Forces'?

I operate with a theoretical dichotomy: 'psycho-sciences' vs their 'counter-forces'. By 'psycho-sciences' I denote modern Western established mainstream clinical psychiatry (20th–21st century) including, but not especially concentrating on, Freudian psychoanalysis as a part of that mainstream. By 'counter-forces', I mean Foucauldian madness philosophy, Szasz's critical psychiatry and Laingian anti-psychiatry.

This dichotomy can easily be regarded as partly artificial: what 'Western established mainstream clinical psychiatry' – if seen as a conglomerate of psychiatry

and psychoanalysis – means in different countries varies. For example, in France Lacanian psychoanalysis is mainstream, whereas in England it is not. Thus, I will be delimiting my study to the part of Western mainstream psychiatry that was and is prevalent in the Anglo-American context (i.e. the context of my novels): Freudian-based psychoanalysis, which was dominant in the first part of the 20th century; and biological, brain psychiatry, which has gained the upper hand since then. This delimitation is urgently needed as the field of 'psycho-sciences', if defined in its widest scopes to include all forms of psychiatry and psychology, is far from monolithic; the history of even mainstream Western psychiatry is not uniform but a story of contest between different schools of thought and theory. 'Psycho-sciences', which I delimit to be a conglomerate of psychoanalysis-cum-brain-psychiatry, already points to this: the two schools of thought could not be less similar in their viewpoints. However, they do form a historic continuum, albeit a very bumpy one, and I see this continuum as powerful: the two schools of thought, when dominant, have been and are significant forces inside the walls of mental clinics and the society at large. My concentrating on *clinical* mainstream psychiatry is based on the way I delimit my scope to study the *clinical move* of defining a person mad. This focus excludes those forms of psycho-sciences, like certain forms of psychiatry, e.g. Basaglia's democratic psychiatry handled briefly in Chapter 2, which do not place much weight on diagnoses and do not emphasise the clinical move of diagnostic finesse of either the psychoanalytical vein or the ornate descriptive diagnostic manuals (DSM and ICD[2]) in use in Western psychiatry. Psychoanalysis, as will be seen in Chapter 2, has a much cruder nosology and places much less weight on accurate diagnosis. Psychoanalysis basically has only a few diagnostic categories and their delineation depends on the point of view, but still, it connects treatment solutions with a diagnostic move (psychoanalytical treatment of psychosis is different from that of neurosis), and for this reason I see it as a part of established Western clinical psychiatry.

The 'counter-force' side is no less problematical: Western mainstream psychiatry has been contested by many forces that do not form a unitary actor. The views of people and the phenomena seen as linked together by a critical stance towards psychiatry in the movements started in the 1960s and 1970s are highly fragmented. The movement includes such thinkers as R.D. Laing, a leftist British psychiatrist, who can be regarded as the main founder and formulator of the movement called 'anti-psychiatry'; David Cooper, Laing's colleague and co-author; the American

2. World Health Organisation's diagnostic manual: *The International Statistical Classification of Diseases and Related Health Problems.*

libertarian psychiatrist Thomas S. Szasz, who, though critical towards psychiatry, did not want to be called an anti-psychiatrist because of political disagreements with the Laingian vein of the anti-psychiatric movement; writers such as Ken Kesey and Valery Tarsis, whose novels depict psychiatric treatment in a critical manner; Basaglia and other Italian psychiatric reformers; Michel Foucault, who had an influence on the anti-psychiatric thinking, though he himself did not label himself as an anti-psychiatrist; and sociologists such as Erving Goffman and Thomas Scheff. (Miller 2004, p. 19.)

I concentrate on Foucault as the most prominent philosopher who can be described as having chosen a critical position in relation to psychiatry and its power structures and who has given an immensely rich analysis of these structures (Hämäläinen, forthcoming). I also give space to Laingian anti-psychiatry as an Anglo-American movement loosely inspired by and connected to Foucault's work and relevant to the cultural context of my target texts. I also apply the thought world of Szasz because he has been regarded, like Laing, as a central figure in criticising psychiatry in the Anglo-American context by commentators like Pietikäinen (2013, p. 382), Shorter (2005, p. 322–323) and Hämäläinen (forthcoming). These choices are well defendable. Each of the actors, Foucault, Szasz, and Laing, can be claimed to be of central importance in their stances 'against' psychiatry: Laing for giving his face to the British anti-psychiatric movement; Szasz for building his American counter-argument to both Laing and psychiatry; and Foucault for concentrating on the philosophical side of analysing psychiatric power structures. Nevertheless, these choices are partly arbitrary, just for the fact that the movements 'against' psychiatry can be seen to be so fragmented. Pertti Hämäläinen (ibid.) emphasises just this fragmentation, the movements 'against' psychiatry should not be lumped together carelessly. Szasz, Foucault and Laing can all be seen as central actors, but they have perhaps surprisingly little in common besides a very loosely definable position of being somehow 'against' psychiatry.

1.3.1.1 Why is Foucault so Prominent Here? On the Balance between Psychiatry and Its Counter-Theories

In following my themes of diagnosis-making, I use both the psycho-scientific approach – 'What can be defined to be madness in the first place?' – and the counter approach – 'What can be said of the power structures of defining someone mad?'

Therefore, I am not going to perform a 'proper' Foucauldian historical-discursive analysis of the development of psychiatry as a science (after all, he has already done it) or a pure psychiatric analysis of the topic. Instead I aim to do a different kind of study by using both psychiatric and counter-force theories. I will examine what goes on when a psychiatric diagnosis is made of a literary persona, how the problematics of psychiatric diagnosis-making are represented in fictional worlds through literary-narrative devices, and how and why the diagnoses are being used and defined in these fictional contexts. Again, I will be keeping my nexus of narrative and diagnostic power in mind.

One can still ask: 'Why Foucault? What makes him such central character of my study?'[3] His viewpoint, unarguably, dominates much of my perception of the power structures of psychiatric knowledge. I agree with him on the issue of psychiatry being the use of power – either to empower or to confront. Foucault has also been undoubtedly the most prominent theoretician of psychiatric power. He is the philosopher of psychiatry *par excellence*, for modern psychiatry has not produced a thorough analysis of itself since the days of Karl Jaspers in the 1910s. Thus, Foucault's prominence comes from his giving a mirror to psychiatry, it may be a distorting mirror or painfully accurate, but it is a significant mirror, something that must be reckoned with. In Foucault's work, psychiatry may see something of itself, and students of psychiatry cannot ignore it: his theories offer arguments that cannot be sidestepped. However, I do not wish to come across as a strictly 'Foucauldian scholar'. I agree with him largely on the issue of diagnostic power – but, as will be seen in Chapter 3, I include in that notion the aspect of the Karlbergian *empowering use of power*: emphasising the potentiality that psychiatry may truly attempt and succeed to affect the patient favourably. Through the ensuing emphases on either the Foucauldian and other counter-force-theoretic, or on the psycho-scientific side of the diagnostic coin, I aim to balance the issues according to the emphases given in the target texts: How do they see the diagnostic move? How can they be brought to debate on the power field of diagnostics, on the use of diagnostic power? Therefore, I do not take sides, I do not wish to declare which side is 'right' – I only aim to study their representations and tensions in the target texts.

3. The French context produced also other critics of psychiatry, such as Felix Guattari and Gilles Deleuze, who among other writings co-authored the popular *Anti-Oedipus* – a critique of capitalism and psychoanalysis. I see Foucault, however, as the most central and influential figure in building my target text analyses, because he also influenced the Anglo-American context more than the other French philosopher or critic of psychiatry of his day.

1.3.2 Two Definitions of 'Madness': Why this Word?

The concept of 'mental illness' or 'madness' is kaleidoscopic rather than monolithic. This can easily be seen in that modern Western mainstream psychiatry and psychoanalysis use very different kinds of maps of the terrain of mental illness. Indeed, they do not agree even within their own ranks, for there are a number of quite different schools in each of them, e.g. brain psychiatrists, social psychiatrists, evolutionary psychiatrists, Freudians, Jungians, Lacanians, ego psychoanalysts, and so on. This kaleidoscope gets a further twist from, e.g. non-psychoanalytical branches of psychology and anti-psychiatry, plus Szaszian critical psychiatry's way of perceiving the issue of mental illness. Therefore, I must justify why I have chosen to use the word 'madness' to refer to the phenomenon of mental disturbance.

The word 'madness' is situated in a power field of differing definitions:

1) First, I need to offer a counter-definition for the term 'madness'. 'Madness' is not a term used by the psychiatric establishment. This is because 'madness' is not seen as a sufficiently neutral, scientific, or non-stigmatising term for those diagnosed and doing the diagnosing. The psychiatric establishment thus substitutes the terms 'mental illness/disease/disorder' for the more provocative and colloquial 'madness'.

   In my first tentative definition, the psychiatric establishment regards mental illnesses as *essentially universally applicable, more or less stably categorisable, psycho-socially and/or biologically caused and structured mental dysfunctions which cause true distress for those suffering from them* – and it thus focuses on the changing of the conditions of mental illness through treatment (by drugs, hospitalisation, psychotherapy, psychosurgery).

2) Mental illness, as seen by the analysts and critics of psychiatric establishment is 'madness'. (Foucault's thesis was named *Histoire de la Folie à l'âge classique*, translated in 2006 as *History of Madness*; one of Laing's central works was named *Sanity, Madness and the Family*.) The critics wish to reveal the hidden power structures and problematic base of the alleged scientific and neutral pursuit of psychiatric diagnosis-making and treatment. They uncover the nature of mental illness – 'madness' – as essentially and emphatically *a social construct*. As a term and phenomenon it is not historically invariable, universally applicable or stable

like established psychiatry often claims (Foucault 2006), it is in fact in constant fluctuation in connection to the social and societal environment in which it is defined. (Foucault 2006 and Laing & Esterson 1990.) Szasz (1975) takes the issue even further and maintains that mental illness is not a real illness category at all, but a role and language game forced on the environment of the patient by the person feigning madness in order to gain from it: in Szasz's view, then, madness is truly a social rather than a stable medical category. What is common to all these 'counter' approaches is their insistence on the social and societal antagonisms and struggles present in the formation and perception of the notion of madness, and on the viewpoint that the phenomenon of madness should not be perceived and/ or treated psychiatrically.

Therefore, the alignment to the issue of a cure is also different. Foucault as a historian and scholar of the discursive formation of psychiatry as a science sees that the psychiatric cure is about a battle of wills between the doctor and her patient that may have little to do with practising the medical science of psychiatry. (Foucault 2006b.)

Laing, as a practising anti-psychiatrist and thus a person trying to implement his critical viewpoints to the everyday situations of psychiatric care, first saw that madness as a social construct should not be treated with the tools of a psychiatric cure, for it is partly *caused* as a phenomenon by the psychiatric way of seeing certain behaviour as mentally ill, when in fact the behaviour is only a *reaction* to that psychiatric way of seeing it – not illness per se (Laing & Esterson 1990). Later on, Laing even saw that what is considered as mental illness in the established psychiatric scene is in fact a kind of shamanist journey through psychic spaces that is invaluable in itself and definitely should not be treated away by psychiatric techniques (Laing 1967).

Szasz regards (especially forced) psychiatric treatment in even stronger terms, seeing it as unjustifiable torture. The question is not about curing a mental illness, but about seeing 'madness' as a move in a role and language game that does not warrant a person being locked up, even if she feigns madness (Szasz 1975).

I choose to use 'madness' as the basic, most general term throughout the thesis because I see it as the one offering the widest scope in this terminological power field: it is the word lay people often use when addressing issues of mental illness (together with other everyday words like 'lunacy', 'craziness', etc. I do not differentiate these from the word 'madness' because they are used as casually and pretty much interchangeably in colloquial language). It is also the word analysts critical of psychiatry often use when addressing the issues of psychiatric power, and it is the

word the psychiatric establishment tries to avoid, for the reason of trying to lessen the stigmatism of psychiatric diagnosis. 'Madness' is a term always hovering over the power field of psychiatric and lay diagnosis-making: *it must be reckoned with*.

I have chosen to use this word even though some may find it offensive. My point is not to further stigmatise those who feel they have been labelled by words signifying psychiatric conditions. If someone takes this as my goal I apologise for the offense taken – it is not my intention. My point is to take the term and analyse it. By using it in my analyses of the target texts, I hope to reach the goal of seeing what madness means, or, to put it more accurately, to discover what the phenomena denoted by it mean in the narrative contexts, in all their diverse faces: lay, professional, caring, insulting, and theoretical. It is a word that easily causes offence; it can be injurious to both those suffering from being thus labelled and also those genuinely trying to help those suffering. This is not perhaps so much because of the word itself, but because of the social interactions to which the word connects: stigmatisation, exclusion, the possible sad day to day aspects and side-effects of diagnostic power, constructed in each social encounter in its own particular ways. Still, I also consciously choose to use the word in order to get to the bottom of this stigmatisation, injury and affront – not to stigmatise, injure and affront, but to understand what the word means. I further support my choice of the word by noting that other scholars of madness literature have used it before me, and also in a manner that is non-stigmatising. 'Madness' is used by Thiher (*Revels in Madness*), Feder (*Madness in Literature*), and even Sass (*Madness and Modernism*), whose work especially I see as most appreciating and giving value to the existential spheres of mentally ill people. The word is a loaded one, true, but it offers the possibility of referring to the phenomenon in all its complexity: as suffering and stigmatisation, but also as helping, understanding and healing – showing how people have moved across the stigmatising borders drawn by the use of the word 'madness'.

I do not make a third definition of the word 'madness' that would be different from those of psychiatric establishment and its counter-forces as outlined above. I aim to study the tension between the two definitions above as I examine their manifestations in my target texts. In addition, I use the word 'madness' as the basic, general term for the sake of simplicity as well.

In Chapter 2, I analyse the shifting perceptions of both these above given tentative definitions, and we will see, for example, that there is discussion on the phenomenon of social constructedness of *all* illnesses, somatic illnesses included, which makes the picture more complex than just an opposition: social construct vs

some kind of 'natural' disease entity. Thus, I will use these tentative definitions as starting points for discussion.

1.3.3 What Is a 'Madness Diagnosis'?

I use the term 'madness[4] diagnosis' very widely as meaning 'attaching the label of madness to oneself or someone else'. I see that the basic type of diagnosis-making is that between a psychiatrist and her patient. But I do not limit my scope to this type, for I also see that the basic diagnostic type is adopted by lay people as well. Thus, it is not limited only to the diagnosis-making by psychiatric professionals; it also covers the lay usage of madness words. I choose to use the term 'diagnosis' this widely because I am also interested in the way ordinary people, as characters and narrators in my narratives, navigate the diagnostic power fields and thus inevitably participate, more or less overtly, in the debates on diagnostic moves.

As I argue in Chapter 3, the diagnostic relationship is basically a relationship of power: it either empowers or is combative, confrontational. This power aspect can easily be seen at the level of psychiatric establishment in that when psychiatry is practiced, one has to be very careful to act ethically because there is always the danger of misuse of diagnostic power. At the level of lay use, every one of us knows the edge the word 'mad' and its associated words have as insults. Thus, unavoidably, the scenes depicted in this first part of the study are often those of struggle – between the person diagnosing and the person diagnosed. The *empowering use of power,* also related to psychiatric practice, is a different kind of power relation, not so much a struggle but an agreement; a relationship I define in Chapter 3 and give its due analytical space in Chapter 4.

The reader's solo diagnosis, as I practice it in applying my vein of psychiatric literature research, is more attuned to psychiatric terminology than simple lay usage of the diagnostic words, like 'crazy', 'lunatic' or 'mad'. Very intentionally and consciously, I put the texts that I read into the power field of psychiatric diagnosis, testing out the possibilities of this strict diagnosis-making in connection to my target texts. This I defend by noting that six of my eight target texts in the first part of my study (McGrath, Plath, Kaysen, Barker, Piercy, McCabe) are already elementally in

4. The word 'mad' does have, of course, other connotations than being mentally ill, such as 'angry', 'furious', 'romantically infatuated' 'absurd' etc., however, I will not be tackling these connotations but concentrating on the connotation of mental illness, for the fact that this is the connotation the works I analyse employ.

the power field of psychiatry by being situated at least partly inside the confining walls of psychiatric institutions and narrating about psychiatric treatments. The remaining two texts that do not feature overtly psycho-scientific themes, (Innes and Urquhart), I use as juxtapositions, as counter-examples and test cases, which enable me to ask questions about the universality of my vein of psychiatric literature research: is it always possible and justified to read through psycho-scientific paradigms, even though the text seems to somehow evoke the theme of madness? Is the diagnostic power always connected to psycho-sciences and their definitions? In Chapter 4, I rely heavily on my discussions with psychiatrist Pertti Hämäläinen to make my psychiatric diagnoses more accurate.

This readerly psychiatric solo diagnosis is surely a problematic way of approaching some of these texts, but this is part of my intention: I aim to show just this problematic nature of psychiatric diagnosis-making in the context of literature. I am conscious of – and hope to make my readers as conscious of – the danger of 'mental colonialism', that is, making psychiatric diagnoses that are unwarranted, and I address this question directly in Chapter 4.

1.3.4 Why Madness Fiction – Why Madness Narrative?

Mine is a study of narrative fiction, of *literary representations in the narrative form* of madness and diagnosis. One might ask: Why have I chosen fiction as my data? What kind of special aspects do the fictitiousness of my target narratives bring to the analysis of madness representations and diagnosis? I have chosen madness narratives as my target texts because I am interested in the *narrative power structures* of these texts, the way narrators and implied authors use narrative power in constructing the diagnostic power relationships they depict. As I elucidate in detail in Chapter 3, I am also seeking the *experiential* aspect of madness diagnosis that some narratologists, especially of the cognitive vein (Fludernik 2005, 2003; and Herman 2009), have seen as linked to the narrative form. The question of the *fictitiousness* of my narratives, then, is another issue defining my target texts. Here, one can ask: How are the worlds of fictitious madness and its real life correspondents related?

First of all, one must recognise the aspect of the 'accessibility' of the experience of madness through fictitious representation. We gain access through the fictional depiction of worlds that may appear very unfamiliar to many a reader (c.f. Bernaerts 2009, p. 375). This is supported by Dorrit Cohn's analysis (2000) of the distinction

of fiction from factual texts. She has argued that there are distinctions that makes fiction a special group of narratives, such as the 'transparency' of third person narrative which enables the possibility of the narrator 'seeing inside' the psyches and experiential worlds of her characters (as Cohn states emphatically: 'the minds of imaginary figures can be known in ways that those of real persons can not' Cohn 2000, p. 118), and the non-identity of the narrator and author of a fictitious narrative (Cohn 2000, p. 130). I see that these structures make it possible for the implied authors[5] of madness fictions to construct narratives that tell about the experiences of mad persons and their diagnoses in a heightened capability when compared to factual descriptions of madness: they do not have to constrain themselves only to that which is historically and factually verifiable when construing their representations of mad experiences (Cohn 2000, p. 118). A third person fictitious narrative can, in a 'natural'-seeming way to us readers, expose another person's mind with literary techniques, e.g. free indirect discourse or focalisation, in a way that a factual report cannot easily do without becoming 'illicit' in its appropriation of the other subject's mind. First person madness fiction, then, makes it possible for the implied author to imagine and thus construct and expose directly the experiential worlds of her first person narrator, a person different from the author – again a technique that is not as available to the authors of factual texts.

There is also the issue of the 'acceptability' of the encounter between a fictional madwoman and a reader of madness fiction. One can illustrate this side of the distinction between fictitious and factual madness texts with an example: the fate of a real autobiography of a mental patient described by Pietikäinen. In Finland, in 1935, Aino Manner tried to get her partly negative experiences at the hands of her care-givers heard in public by writing her autobiography. She was marginalised by the psychiatric establishment, which claimed that her story was the absolute fantasy of a madwoman, and thus should not be reckoned with on an equal footing. (Pietikäinen 2013, p. 358.) This can be read both as an example of the Foucauldian silencing of the mad by psychiatry (Foucault 2006), and as an actual realisation of Keen's hypothesis that a factual report containing worrying subject matter seeking to elicit a real-world active response from the audience may get a more negative response than a fictitious one. A factual text's wish for action in the real world can be sensed as an unpleasant exertion of pressure on the reader (in this case most notably on the psychiatrists to change their treatment of patients, and on the public to demand this change), whereas fictitious texts, even with their worrying subject

5. I define my concept of implied author in Chapter 3; Cohn does not use this notion.

matter, may find a more understanding audience, as the pressure to act in the real world is not as emphasised or direct. (Keen 2007, p. 4.)

Both the Foucauldian and Keenian perceptions seem to direct us in our search for the possibility of finding in madness *fiction* something that we cannot as easily find in factual reports of madness, like the autobiography of Manner's, and their reception – the opportunity to encounter another's madness on a more equal footing, and, also, in a 'safer' manner for the reader, if one can put it this way. Foucault (2006) and Shoshana Felman (1987) after him have both emphasised that literature has been a haven for madness after it was expelled from the realms of society, science and philosophy. Only in literature, they argue, is the voice of madness still heard; the *pathos* of literature is the same as that of madness in their common blindness to their own meaning and the non-mastery of their fictitiousness (Felman 1987, p. 49). Another side of this issue is the fact that when a fictional character's madness is represented to us, we can encounter it in that world of fiction in a way we might not want to encounter a real mad person (cf. Keen 2007, p. 131). Thus, one can argue that the access to a mad character's mind is something we get from fiction perhaps more easily, more acceptably, and more frequently, than from factual texts. Though there are by now more factual reports of the experience of madness, like Kaysen's autobiography I study in Chapter 4 – and she is not alone – there are still many more fictitious madness narratives than autobiographies and biographies of mentally ill people.

The 'truth value', or the correspondence of these representations with the real, shared world, is, then, another matter. The argument that literature can give valuable insight in the *true perception of madness* is supported by Downie's above-mentioned argument of fiction complementing scientific psychiatry in portraying madness. There is still the question, however, of the factual side of fictitious representations: when the author *imagines* madness, cannot she formulate this portrait of madness into whichever form she wishes? This would make the connection between real life madness and its fictional representation very tenuous indeed. Of course, some authors, like Sylvia Plath, do write autobiographical fiction about their own lives as mental patients. Others do not use their own lives, but do extensive research on their subject matter, like Pat Barker and Marge Piercy. In their cases, the bond between fact and fiction seems more secure in their portrayal of madness. The rest may not give the audience any reassurance of the 'truth value' of their narratives. Should they?

Howard Sklar argues that 'as natural – and indeed, *unavoidable,* – as it may seem for writers and readers to "exercise subjective imagination" in imagining the

realities of fictional characters […], it does call upon them to develop unusually high levels of insight and sensitivity, or to recognise, as Lundeen concludes "that all literature, as in life, there are shared borders of identity that we are compelled to recognise but cannot cross". […] I believe that it is entirely reasonable that readers expect that novelists not cross these borders without great care, and that the results of that border crossing be subject to examination regarding the accuracy of the work.' (Sklar 2013b, p. 172.) "'Accuracy'", as Sklar sees it, 'means here "true" to the types of experiences that [members of differing groups] go through, regardless whether they have actually gone through them themselves, and however distant from the experience of the character their own experiences may be' (ibid. p. 171). In Sklar's argument, the possibility in the representation of a different group, especially like the group of mentally disabled (and I would also add, mentally ill), the risk is great of the narrative becoming 'ventriloquism' (Sklar 2013c, p. 55), that is, of speaking for a group having no clear voice of its own in ways that are not ethically sustainable. However, since I have no recourse to reader response studies concerning the way mentally ill people perceive madness fiction, I will not be concentrating on the ethical question of 'accuracy', as Sklar formulates it, but instead, in Chapters 4 and 5, I will touch upon other ethical issues Sklar takes up, e.g. persuasive effects on reader, ethical relations between characters, and raising ethical questions regarding a particular work (Sklar 2013b, p. 169).

The relationships between real life phenomena and experiences of madness and diagnosis, and their literary representations are not, therefore, simple or straightforward. The aspect of fictitiousness makes literary depiction somewhat unstable in its relationship to shared reality. As Cohn puts it, fiction is 'non-referential' narrative, which means that it builds its own world and *may, but does not have to,* refer to the shared reality[6] (Cohn 2000, p. 15). This makes the literary representation of madness a special kind of *source of information* on madness and its features: it may refer to and comment on real life equivalents but does not have to, and the ethical portrayal of fictitious mentally ill people has its own problems. Therefore, one has to analyse the relationship specific fictitious texts have to real life madness phenomena on a case-by-case basis.

However, like Allen Thiher, I do see that the fictitious depictions of madness are in a meaningful relationship with the real life phenomena of madness – and to our shared world's psycho-sciences: 'we see that the mad inhabiting reality and

6. I do, however, as I argue in Chapter 5, see Cohn's definition as problematic, for can anyone even imagine a piece of narration that would not refer to real life at all? Would that even be conceivable? Cohn's point is important though, as it points to a real difference between fact and fiction.

the mad found in fictions live and experience their insanity in conformity with the explanatory paradigms that their era uses to understand madness' (Thiher 2002, p. 162). The explanatory, clashing paradigms which I partly seek in the first part of my study are thus intrinsically related to their fictitious depictions. However, what makes things more complex is that Thiher sees *literature* as offering a paradigm itself: 'Medicine and literature offer models for madness to which the mad usually conform because they have no other way to give shape to their madness' (ibid.). This complexity points to polyvalent relationships between literature, madness, and the clashing frameworks. On the one hand, real life paradigms (the clashing frameworks) shape real-life experiences and perceptions of madness – and the perception of madness literature (e.g. how 'truthful' its depiction of the experience of madness is, in the light of the paradigms). On the other hand, fictitious madness experiences offer paradigms, besides those given by the clashing frameworks, to readers who can thus compare and contrast these narrated experiences with their own perceptions of the forms of madness and with the real life, clashing paradigms.

Thus, that my texts are *artful constructions* has to be taken into account when analysing their diagnostic and narrative power structures. The non-identity of the narrator and the author means that special, *fictitious* narrative structures are built inside the narrative that have to be studied as such (cf. Cohn 2000, p. 130). Narratology offers me the tools to handle these artful literary structures of narration – fictitious narrators, characters, implied authors and authorial audiences – which are not acute in or applicable to factual depictions. The complex relationships between narrators, implied authors, and their audiences on the issue of experiencing and narrating madness shape the reader's perceptions of madness – the fictitious, and, by extension and in comparison to, the real. This problematic is one of the central forces in Chapter 4, where I address the issues of narrative and diagnostic power; I examine how the different narrators use the different narrative and diagnostic tools to further their diagnostic and narrative agendas. Thus, the narrative structures, most notably the narrative power tools, and diagnostic agendas intertwine in these fictional madness narratives to produce the unique literary portrayals of madness and the psycho-sciences. These portrayals are in their dynamic relation to their real world equivalents, commenting on them, contesting them, and relying on them to be understood in the first place.

1.4 Research Questions and the Choice of Corpus Part II: Telling Madness – Madness and Literary Theory

In Part II**,** Chapter 5, I turn to a wider array of literary theoretical questions pertaining to the study of madness fictions, the central question being: what can madness fictions tell and teach us about the theories of (madness) fiction and fictional worlds? Here, I do not concentrate so much on the clinical psycho-sciences, except in the section focusing on the differences between brain psychiatric and literary depictions of psychosis, but my focus is on the *reading through the notion of madness itself*: how does this notion and phenomenon of madness, as an unavoidable category of interpretation of madness fiction, affect our ways of interpretation, our perceptions of fictional world-building, and ethics and aesthetics?

First, I concentrate on the special bond I perceive between madness fictional world-building and fictional world-building in general: madness fictions, when analysed with the aid of literary theoretical tools, most prominently offered by Ryan's possible worlds theory, can be seen to be a type of texts that present the reader possibilities of studying fictional world-building. This feature is based on that perception of Ryan's theory in which she gives room for embedded fantasies that include hallucinations, thus making it possible to see narrated madness as a special world-building force. By being fiction-inside-fiction, narrated madness offers possibilities of reflecting on the nature of fictitiousness itself. One can ask: how do madness narratives play with the borders of their foundational dichotomies (like mad/sane, mad/normal, mad/supernatural, mad/real) – and make the borders of their different fictional worlds hazy? It is this haziness that alerts the reader to see the multiple natures of both madness and madness literature. As briefly analysed examples in this first section, I have chosen a number of madness narratives that elucidate the problem of world-building in madness fiction from various angles: Timothy Findley's *Pilgrim*; F. Scott Fitzgerald's *Tender Is the Night*; Bessie Head's *A Question of Power*; Andrew Miller's *Ingenious Pain*; Henry James's *Turn of the Screw*; Pat Barker's *Regeneration*; Dennis MacFarland's *A Face at the Window*; David Markson's *Wittgenstein's Mistress*; Vladimir Nabokov's *Lolita*; Will Self's *Great Apes*; and Ken Kesey's *One Flew over the Cuckoo's Nest.*

I also examine the role of madness in fiction from the viewpoint of how depictions of madness function as literary devices: Is madness somehow impoverished in the process of fictional depiction – making madness a *mere literary device* that lacks the true depth of analysis of the phenomenon of the worlds of madness in its

own right? What are the gains in knowledge about madness offered to the reader by reading madness narratives? These questions interlink with the other side of the same coin of the valuation of madness vs. literature: the problematics of the value of madness as an analytical concept. Does a literary madness diagnosis somehow devalue the work of literature – or is madness as a phenomenon or viewpoint a valuable interpretative contribution to the analysis of literary works? As briefly analysed and compared examples, I have chosen detective and adventure stories like Chandler's *The Big Sleep,* Dibdin's *The Last Sherlock Holmes Story*, Innes's *The Killer Mine*, Sheldon's *Tell Me Your Dreams* and Appignanesi's *Paris Requiem*, because they all use madness as a way of building suspense in the hunt for the perpetrator of a crime, and thus make good examples of the possibility of using madness as a literary device.

I also study the ethics of diagnosis-making by considering two cases in two sub-chapters which shed light on various aspects of this process. The ethics of irresponsibility and narrative structure are examined in Patrick McGrath's novel *Spider*, and the possibility of unethical madness is more briefly considered in Vladimir Nabokov's novel *Lolita*. I have chosen these two cases because they shed light on special ethical questions that arise when a piece of literature handles or points towards the issue of diagnosing madness and because the reader is faced with the ethical problem of relating to this diagnosis-making. In McGrath's *Spider*, the issue of ethical reading is seen from the viewpoint of the ethics of reading a tale of a mad, irresponsible murderer. I ask what it means for the reader to know more than the mad character, and how to read responsibly in such a case. I also consider a very different viewpoint to the ethics of reading madness fiction. Whereas in *Spider* the person whom the reader and the characters should be interpreting and treating ethically seems to be the mad person, in case of Nabokov's *Lolita*, I ask whether the mad person, Humbert Humbert, is an *unethical* character-narrator *because of his madness*. When the worlds of sanity and madness make contact, their ethical relationships can be very difficult to unravel and fathom.

I also study in more detail the more aesthetic side of madness and production by analysing Nabokov's *Pale Fire* as an example of a fictitiously mad production which crystallises and richly studies the multifaceted relationships between art and madness: Is it possible for a mad person to make real, valuable art? How do the relationships between the worlds of sanity and madness affect the process of art-making? Is it possible for an unintentionally fictitious, autobiographically intended work to be art? By juxtaposing the poetry of John Shade and Charles Kinbote's commentary-cum-novel, Nabokov offers delightful insights into the workings of sane and mad artistry.

I also take up the issue of the *meaning of madness,* more specifically psychosis, given in madness narratives as opposed to the *meaninglessness of the 'contents' of madness* ('contents' denoting here the existential significance of different kinds of psychotic experiences to the psychotic person herself) given in brain psychiatric theory. By making this contrast between brain psychiatry and three briefly analysed examples of madness narratives that build huge fictional worlds devoted to depicting psychosis – Doris Lessing's *Briefing for a Descent into Hell*, Ken Kesey's *One Flew over the Cuckoo's Nest*, and Bessie Head's *A Question of Power* – I intentionally juxtapose two very different kinds of viewpoints on the issue of psychosis. In this contrast, one can ask how and why literature makes significant something that brain theory sidesteps or ignores.

Finally, I reconsider the term 'unreliability' in connection to madness narratives. As my briefly analysed examples of unreliable focalisation/narration, I use Head's *A Question of Power*, Findley's *Pilgrim*, Kesey's *One Flew over the Cuckoo's Nest*, Nabokov's *Lolita,* Jenefer Shute's *Life-Size,* and Lessing's *Briefing for a Descent into Hell.* I ask: Since these mad narrators and focalisers are most often sincere in their mad narration/focalisation, is not the term 'unreliable' misleading? It is not a willing deception on the mad person's part to become an 'unreliable' narrator/focaliser, rather it is something involuntary. I do not argue that mad narration/focalisation should be seen as factually reliable, but it should be seen as ethically reliable. I wish to take even a further step from the position Phelan takes (2007) by introducing the term 'bonding unreliability' to express the possible ethical closeness between an unreliable narrator/focaliser and the authorial audience. Should not the core term 'unreliability' be reconsidered? In my approach, I take Foucault's theory of subjugated knowledge and give the unreliable narration/focalisation central stage – as the mad person's own testimony of her mental world. Cannot it be argued that mad narration/focalisation is *not* unreliable, but *actually completely reliable*: as a mad person's depiction of her own mental state and inner world in which she herself truly believes? Therefore, I propose supplementary notions of 'intra-mental reliability/unreliability' and 'inter-personal reliability/unreliability' which give us more finely tuned tools and spectrums to interpret and diagnose our literary personae.

1.5 The Use of the Corpora

I use my target texts somewhat differently in Part I and Part II: in the first part, I compose eight relatively long analyses, one text at a time; in Part II, I take brief examples of more texts in addition to two longer analyses (*Spider* and *Pale Fire*). This is because in Part I, I need to follow longer narrative lines in order to establish the way these narratives can be analysed with the analytical tools that attempt to capture the narrative forces penetrating the whole narrative. In Part II, I build most of my analyses by finding evidence from a greater number of target texts in order to support my arguments on literary theoretical matters that do not demand the handling of the detailed totality of each narrative. These features, in my understanding, apply to many if not most or even all madness narratives. My two longer case studies in Part II (*Spider* and *Pale Fire*) are used like those in Part I to elucidate the way the whole narrative in its thematic structures can be seen to work to produce the interpretation in the reader, whether it is ethical or aesthetic in its emphasis.

With these introductory remarks in mind, let us begin our voyage.

PART I

TELLING MADNESS
– NARRATIVE, DIAGNOSIS, AND POWER

2 FRAMEWORKS:
FOR AND AGAINST THE PSYCHO-SCIENCES

To practice my vein of 'psychiatric literature research' in madness narratives, I need to establish the different parts of the nexus that I will be analysing in my target texts: the interlinking of psycho-scientific theories on madness, their madness theoretical counter-forces, and the power features of both narration and diagnosis-making. In this chapter, I delve deeper into the former two. I examine particular theoretical aspects of my framework madness theories to establish certain historical and theoretical continuums and gaps between the two established psycho-scientific branches of psychoanalysis and psychiatry. I consider the possibilities and difficulties of psychiatrically defining madness/mental disorder/mental illness, and establish the critical counter-forces' viewpoint of understanding madness and its treatment outside mainstream psychiatric theory formation. My overall aim is to lay grounds for my target text analyses, to be able to ask some of my research questions targeting the depiction in the narratives of the psycho-sciences, their counter-forces, and the core issue of madness itself. How do my target texts use these theories and their oppositions and juxtapositions in their depictions of madness, its diagnosis, and treatment? How do they make interpretation possible through these theories? Do psycho-scientific perceptions or their critiques affect the way madness is – or can be – perceived in these works? How are the clinical psycho-sciences and their theoretical bases depicted in these works?

Throughout this first part of my study, I will be emphasising the representations of the clinical aspect of psycho-sciences in my target texts, namely the making of diagnoses and the treatment of madness. In this endeavour, I will need an additional interpretative layer to perceive the represented (often clinical) diagnostic relationships in the light of their power aspects, both diagnostic and narrative. Building this layer will be one of the tasks of Chapter 3.

A Few Words before Beginning: A Short History of Psychiatry

Psychiatry is either a very old branch of thought, or a very young one. 'Madness may be as old as mankind' (Porter 2002, p. 10). Archaeologists have found trepanned skulls dating back as far as 5000 BC, and it has been suggested that the reason for this operation was to try to cure a possessed person, i.e. a person who would probably be diagnosed as mentally ill nowadays. On the other hand, psychiatry as a science, as a distinct branch of medicine in the Western culture, is only around two hundred years old. Before the end of the 18th century, there was no psychiatry as a branch of science that would give an occupational identity to its practitioners. However, there were no other medical specialties either, only surgery was differentiated as a distinct branch of medicine. Medical differentiation is a phenomenon of the 19th century. (Shorter 2005, p. 1.)

In the beginning, there was, of course, the famous – and contested – 'liberation of the mad' by Philippe Pinel. The mad who were 'liberated' in this 'historical tableau' were locked up in the Salpêtrière and Bicêtre general hospitals in Paris. These hospitals were institutions of detention, and typically they contained not only mad people but also criminals, the poor, and delinquents. No treatment was available for the mad; the principal aim of these institutions was containment not a cure. There had been mental asylums intended for mad people only from the Middle Ages onwards already, but these did not intend to cure either. (Shorter 2005, p. 5.)

The evolution of modern psychiatry thus began after this differentiation; mad people were selected as patients who needed psychiatric care. First there were the moral hospitals, formulated by Tukes and Pinel, in which psychiatric treatment was envisaged as something that would reanimate the reason or conscience of the mad person, whose madness was seen as breakdown of internal, rational discipline. (Porter 2002, pp.105–106.) If the therapeutic hospital and Esquirol's romantic psychiatry with its theory of passions as the cause of madness laid the grounds for the psycho-social line of psychiatry, the birth of biological psychiatry was also seen before the beginning of the 20th century. According to Shorter, this line of thought was the dominant one at the beginning of professional psychiatry. (Shorter 2005, p. 30.) It believed in neurology and in research of the brain and heredity in the pursuit of the aetiology of madness. Thus, we have two chief competing paradigms of psychiatry that have tried to cover the whole field of mental illness.

Before the 20th century began, the bright hopes for effective psychiatric care dwindled. The promises made by psychiatrists, that many of the aberrant and

antisocial behaviours traditionally labelled as vices could be handled and cured by psychiatric care, meant that asylums soon were flooded by the former inmates of work-houses or jails. The senile, paralytics, epileptics, and those with tertiary syphilis (GPI) and other degenerative neurological disorders also augmented the number of hopeless cases. (Porter 2002, p. 119.) Brain research died down, as well. This happened, according to Shorter, simply because Kraepelin with his longitudinal case analyses (trying to understand the symptoms in the light of biographical data on the patient, and creating disease groups based on this long-term analysis of patients and their illnesses) brought a more interesting way of looking at madness than the cross-section studies (comparing symptoms with brain dissections) of brain researchers. (Shorter 2005, p. 116.) Thus, when the 20th century dawned, the promising start of psychiatry had stalled and its prospects seemed gloomy.

The 20th century brought a number of competing ways of attempting to cure mental illness, based on the older grounds of psychosocial and biological psychiatry, which all attempted to raise the hopes of psychiatric movement again. There were the biological methods – older ones like fever, convulsive and coma therapies, and newer ones like psychosurgery and drugs – and psychosocial methods, such as psychoanalysis, which reigned from the first part of the century until about the 1970s. There was also social psychiatry, which developed during World War II in Britain and offered an alternative to the other two forms by focusing on therapeutic group treatment.

The classification of diseases became more sophisticated – or at least more complicated – as the American Psychiatric Association started to publish the DSM, which is now in its fifth edition, and WHO started to publish its international counterpart, the ICD, which has reached its 10th edition. The number of diagnostic categories has exploded with each new edition of DSM and ICD, creating new diagnostic categories. There has been discussion on psycho-medicalisation: ever more human conditions are seen as psychiatrically pathological and under too great an influence of pharmaceutical companies, which tend to widen the scope of conditions that can and have to be treated with psychiatric drugs. Drugs have become more effective, and after the scandals of the widespread and high-handed use of lobotomy and Electric Shock Treatment (EST) in the 1950s and '60s (when the anti-psychiatric movement started to fight against these methods of treatment because of their alleged inhumanity), the biological branch has gained in force and developed new methods of research and cure (SPET imaging, genetics) and re-appropriating old ones (EST has started to be used as a method again, and psychosurgery has been reactivated

and developed as a method as well; both methods have been modified to meet the criteria of more humane treatment). After the spell of psychoanalytical psychiatry, one can say that the biological paradigm has gained in force and is dominant at the beginning of 21st century. Psychoanalysis continues to be used as a psychotherapeutic method even though it is no longer the dominant paradigm, and social psychiatry is still practiced as well.

Thus, one can see how the paradigms of different perceptions of mental illness have developed and struggled, and that the map of psychiatry is very kaleidoscopic: there are a number of actors whose viewpoints differ enormously. Next, I attempt to shed light on my two camps – the psycho-sciences and their counter-forces – they form two frontlines in this debate over the essence of madness.

2.1 The Established Psycho-Sciences: From Dynamic to Diagnostic

One of my central focuses in this first part of my study is literary diagnosis-making as it is represented in my target texts. In order to shed light on the issue of literary diagnosis-making, I need to outline the theoretical psycho-scientific delimitations on what 'madness'/'mental illness/disease/disorder'[1] means: what is this notion in mainstream Western psychiatry? This is my starting point in analysing what happens when a diagnosis is made, when this more or less specific 'disorder tag' is attached to a collection of symptoms and a human face.

2.1.1 Psychoanalysis: Pathologising Everyday Life

I approach the issue of established psycho-sciences as a historical – though a very patchy – continuum: the psychoanalytical trend flourished and dominated at the beginning of the 20th century and was followed, after a drastic change in psychiatric thinking at the beginning of the 1980s, by modern brain-oriented psychiatry. Allan Horwitz has studied this historical continuum by noting that psychoanalysis, preceding brain psychiatry, already laid the grounds for the latter's trend of expanding

1. In what follows, I will be using these terms (illness/disorder/disease) interchangeably. In section 2.3, in which I introduce Horwitz's definition of these terms' specific meanings, these terms receive definite connotations. However, as I will explain in that section, I will not be using Horwitz's schema, because I do not seek that type of synthesis, but rather an analysis and juxtaposition.

diagnostics by pathologising everyday life and thus importing the notions of mental abnormality into the sphere of life that had previously been seen as normal before (Horwitz 2003, pp. 50–51). In comparison to 'diagnostic psychiatry', as Horwitz calls the (brain) psychiatric era of expanding diagnostic manuals (from DSM-III onwards), psychoanalysis operated with far fewer disease categories, and saw symptoms not as direct indications of specific diseases but as *symbols* of unconscious conflicts that involved the entire personality (Horwitz 2003, p. 44). Psychoanalysis thus developed only a rough and general diagnostic system that was based on general aetiological schemes: the disease tags were not as important as the attempt to understand and cure specific patients with specific mental configurations.

Here I will offer a very brief sketch of Freudian psychoanalytical theory formation. I will give more details of particular illnesses and their aetiological and theoretical formation as psychoanalysis sees them in connection with the specific text analyses in Chapter 4.

Psychoanalysis is perhaps the best-known branch of psychology and psychiatry – at least in the popular mind, and Sigmund Freud was the most influential single physician of the 20th century (Millon 2004, p. 257). His meta-theoretical and psychotherapeutic innovations have left a permanent trace on how we perceive ourselves and others, our mental difficulties, and the means to cure them.

The belief in unconscious processes as the primal reason for mental illness is the central theory of psychoanalysis. Freud regarded his new theory of psychoanalysis and the unconscious as an improvement on the clinical psychiatry of his time; his was a theory which could explain far better how mental disorders are formed. As Freud saw it, all that clinical psychiatry could offer to the aetiology of psychiatric diseases was degeneration. (Freud 1978a, p. 278.) Freud did not build his theories on the biological configuration of the human brain but on the psychical currents of libidinal energies. Freud was also in favour of global diagnostics. In comparison to Kraepelinian psychiatry's dozens and dozens of diagnostic categories, Freud came up with only a few broad categories. Millon writes: 'Unlike his great German contemporary Kraepelin, who sought to classify broad groups of disorders with a common course and symptoms, Freud stressed the brightly etched inner memories, the feverish imaginations, and the unique attributes of each patient' (Millon 2004, p. 258). Individual, personal symptoms are those that psychoanalysis seeks to connect to the patient's personal past – typical symptoms may help in the formation of diagnosis, but they are more difficult to bring into connection with the patient's past (Freud 1978a, pp. 270–271). Freud's sheer speculative novelty of the unconscious

aetiology of mental disorders replaced meticulous formation of disease categories. The content and signification of neurosis is seen in connection to its aetiology, to its relationship with the metapsychological superstructure – which for Freud was a universal component of neurosis: 'For Freud neuroses stemmed from universal childhood experiences[…]' (Horwitz 2003, p. 41)

There are, however, some gaps in the Freudian scheme. Freud cannot exhaustively explain why certain people fall ill with a neurosis and some other people do not (Block Lewis 1981, p. 22). In fact, he blurred the border between sickness and health by repeatedly stating that everyone is neurotic to a certain degree:

> Since this outcome [i.e. the formation of a neurosis] depends mainly on the quantity of the energy which is thus absorbed [in the symptom formation], you will easily see that 'being ill' is in its essence a practical concept. But if you take up a theoretical point of view and disregard this matter of quantity, you may quite well say that we are *all* ill – that is, neurotic – since the preconditions for the formation of symptoms can also be observed in normal people. (Freud 1978a, p. 358, Freud's emphasis.)

This blurring of the border between sickness and health, together with global diagnoses, points toward a Freudian therapeutic emphasis on character reorganisation instead of the simple curing of symptoms (Block Lewis 1981, p. 214). What is more, Freud, especially in his later years, tended to favour scientific research of the mind rather than the therapeutic function as the main aim of psychoanalytic work (Freud 1978b, p. 151). This was the case even if Freud perceived psychoanalytic treatment as the most effective: 'Compared with the other psychotherapeutic procedures psycho-analysis is beyond doubt the most powerful' (Freud 1978b, p. 153). However, Freud's partial rejection of the therapeutic aim did not hinder his disciples from taking the therapeutic work to new levels, taking it out of analysts' private receptions and bringing it into psychiatric clinics.

Freud calls most mental disorders 'neuroses'. Alongside these, he talks about perversions, character disorders, and psychoses. Nevertheless, neuroses are the most important group of disorders in the psychoanalytical field. Block Lewis points out the similarity between dream formation and neurosis formation: both are shaped by 'primary processes' that transform forbidden unconscious sexual longings into pathological symptoms of various forms (Block Lewis 1981, p. 2) by a process Freud calls 'repression'. Freud writes:

We already know [...] that there is a precondition for the existence of a symptom: some mental process must not have been brought to an end normally – so that it could become conscious. The symptom is a substitute for what did not happen at that point. We now know the point at which we must locate the operation of the force which we have surmised. A violent opposition must have started against the entry into consciousness of the questionable mental process, and for that reason it remained unconscious. As being something unconscious, it had the power to construct a symptom. This same opposition, during psychoanalytic treatment, sets itself up once more against our effort to transform what is unconscious into what is conscious. This is what we perceive as resistance. We have proposed to give the pathogenic process which is demonstrated by resistance the name *repression*. (Freud 1978a, p. 294, Freud's emphasis.)

Thus, for Freud, the formation of a symptom of a mental illness is tied to the repression into the unconscious of some mental process that has not been brought to an end normally (e.g. the oedipal conflict, or some other features of sexual development of the patient). This repression has not become conscious, and the resistance of a patient in psychoanalytical treatment points towards this process of repression, i.e. to the source of the symptom formation, and thus to the direction the analysis should take in working through these mental processes that have led to the repression and symptom formation. The person falls mentally ill because of the failed processing of difficult, sexual, mental contents that are therefore pushed into the unconscious and thus given the force to produce a symptom.[2]

Freud divided the field of mental disorders in a number of ways. One dividing line cuts through psychoneuroses/actual neuroses. The latter are neuroses in which the symptoms, though originating in the psychic energy of the libido, have no psychological 'sense': they are manifested predominately in the body and are entirely

2. Darian Leader and David Corfield (2008) have proposed a psychoanalytically based psychogenic formation of *somatic* diseases, e.g. heart condition or asthma, by arguing that these usually purely somatically perceived diseases may have, besides biological, medical, and bodily causes, very elemental connections to the patient's ability to process her life events, psychic world and their meanings. Leader and Corfield see that some somatically ill people fall ill very forcefully because of unconscious conflicts and their inability to process them consciously by using language – just like Freud saw in the case of mental illnesses – and that Freudian conversion symptoms (e.g. unconsciously driven hysterical paralysis) can be seen as elementally connected to somatic illnesses. A somatic illness may present conversion symptoms that point towards a question, (such as, 'Am I worthy of love?' or 'What do my parents want from me?') or conflicts that can be even more basically blocked from the mind that they are not allowed to enter even the unconscious, but are directly inscribed into the body of the patient in a form of a somatic illness. Thus, they see that perceiving the whole life situation and history of the patient is crucial to the understanding of the disease, just like the psychoanalytical perception of mentally ill patients emphasises.

somatic processes. (Freud 1978a, p. 387.) Freud gladly left actual neuroses to medicine. Psychoneuroses then, are psychogenic and their symptoms are like dreams; they are the codes of unconscious processes which have to be decoded. Thus, we can see how Freud saw in psychoneuroses the kind of mental illness I tentatively described as the psycho-scientific approach to madness in the introduction above: *essentially universally applicable,* (neuroses stem from universal childhood experiences), *more or less stably categorisable,* (neuroses can be recognised as neuroses even though their symptoms may vary considerably*), psycho-socially and/or biologically caused and structured mental dysfunctions which cause true distress for those suffering from them* (Freud of course emphasised the psychogenic aetiology of neuroses over the biological causation).

Another division of Freud's separates transference neuroses from disorders that were not curable by transference. The phenomenon of transference is central to psychoanalysis as a therapeutic practice, i.e. clinical treatment by psychoanalysis. Freud described it in the following way:

> We mean [by the word transference] a transference of feelings on the person of the doctor, since we do not believe that the situation in the treatment could justify the development of such feelings. We suspect, on the contrary, that the whole readiness for these feelings is derived from elsewhere, that they were already prepared in the patient and, upon the opportunity offered by the analytic treatment, are transferred on to the person of the doctor. (Freud 1978a, p. 442.)

Transference is a major tool of psychoanalysis, a way of influencing the patient. With this powerful tool psychoanalysis effects its cure:

> The beginning of treatment does not put an end to this development [of the disease]; when, however, the treatment has obtained mastery over the patient, what happens is that the whole of his illness's new production is concentrated upon a single point – his relation to the doctor. [...] All the patient's symptoms have abandoned the original meaning and have taken on a new sense which lies in a relation to the transference [...] But the mastering of this new, artificial neurosis coincides with getting rid of the illness which was originally brought to the treatment – with the accomplishment of our therapeutic task. (Freud 1978a, p. 444.)

What is significant, though, is that Freud saw the psychoanalytic method and tools were limited in their powers. Not all disorders yielded to the might of psychoanalysis. Freud formulated this limitation in the following manner: 'These three disorders [anxiety hysteria, conversion hysteria and obsessional neurosis] which we are accustomed to group together as *"transference neuroses"*, also circumscribe the region in which psycho-analytic therapy can function' (Freud 1978a, p. 299, Freud's emphasis). If the patient could not develop a transference relationship with the doctor – if she was psychotic – the treatment could not progress. Freud thus left another group of patients, alongside the actual neurotics, to clinical psychiatry and medicine.

The three central disease categories Freud formulated are: 1) transference neuroses (conversion hysteria, obsessional neurosis, anxiety hysteria = phobia); 2) psychoses (paranoia and melancholia); and 3) perversion. I will not go into detailed descriptions of these disease categories but note only that they all have their distinct aetiological formations in the unconscious processes of the human mind. I will give more information on the features of these conditions when I examine my target texts depicting some of these phenomena.

Freud died in 1939, but his followers cherished and renewed his theories. Several schools of psychoanalysis developed, such as the classical (which retained the core concepts of Freud's theories), the neo-social (which believed in Adler's theory of social strivings being the root of human development), neo-Freudian ego theory (which minimised the emphasis on Freud's theories on sexual instincts and proposed the existence of constructive ego instincts), object relations theory (which states that object relations, along with self-image, are the major components and content of mind), and renewed developmental model theories (which build new theories of the early development of the human child). The Lacanian branch of psychoanalysis, developed after the death of Freud by the French psychoanalyst Jacques Lacan, must be mentioned as well; Lacan's thinking connects the development of language in a child to her unconscious in an innovative and ground-breaking manner. Lacan was also among those psychoanalysts who developed psychoanalytical treatments for psychoses,[3] and he contributed greatly to the psychoanalytical branch of literature research as well. (I will not, however, be concentrating on Lacanian psychoanalysis because it has not gained a strong *clinical* foothold outside the French-speaking world, or in the Anglo-American context of my target texts.)

There were, however, from the very beginning of psychoanalysis, and already during Freud's time, undercurrents of anti-Freudian thought, which gained in

3. For a good introduction to clinical Lacanian psychoanalysis, see Fink 1997.

strength as the psychoanalytical golden age started to wane. The main accusation was that psychoanalysis was very simply unscientific (Shorter 2005, p. 171), meaning that it was impossible to prove scientifically. Shorter is one of the most vehement opponents of Freudian thinking, perceiving psychoanalysis more as a Weltanschaaung than a serious way of curing severely mentally ill people (ibid., pp. 178–179). This accusation points to the development of psychoanalytical thought aiming at curing illnesses which Freud himself had excluded from the realm of psychoanalytically curable disorders, such as psychoses. Others have also noted certain weaknesses in Freud's thinking. It has been noted, for example, that Freud never published a case history that could be regarded as a complete cure, and that many case histories show signs of Freud's psychoanalytical method being suggestive, thus the stories that the patients told did not contradict the method that provoked them (Grünbaum 1999, p. 81). Barbara von Eckardt sums it up:

> Two requirements are the so-called requirement of a good scientific test and the so-called requirement of objectivity. The way Freud typically went about justifying his theoretical claims fails both of these requirements. His research methodology fails the requirement of a good scientific test because of his reliance on the clinical setting for gathering data and because of his reliance on explanatory power as a sufficient mark of truth. It fails the requirement of objectivity because the sort of data he relied on most heavily, interpretative data, was typically arrived at by assuming the truth of the very theories it was intended to support. (von Eckardt, 1999, p. 114.)

There are others, such as Fisher and Greenberg (1996) who see that it is possible to gather scientific proof for at least some psychoanalytical theories. The discussion continues, even though the influence of psychoanalytic theories has diminished, at least in the sphere of mainstream Western psychiatry.

2.1.1.1 To Sum Up

Freud's contribution to the mapping of mental illnesses has been lasting but controversial. His way of seeing the phenomenon of psychic illness as psychogenic meant that, when psychoanalysis was dominant in mainstream psychiatry, biological explanations were pushed to the margin. It also meant the extension of psychopathology to regions

where it was a newcomer: neuroses were rampant after it was seen that every one of us is more or less neurotic. The clinical schema of diagnostic array that Freud offered was rough and individually modulated. This meant that the diagnostic moment at which the person diagnosed is seen in her neurosis/psychosis/perversion could take almost any guise: the symptom as a symbol had far more complex and individual relationships to the psychopathological forces inside the mad person's psyche than Kraepelinian psychiatry – or diagnostic psychiatry following psychoanalysis – would concede. The main tool of the psychoanalytical cure, the handling of the artificial neurosis built in the transference relationship, was also a psychotherapeutic innovation that deeply affected the clinical relationship between doctor and patient. I will not be concentrating solely on Freudian psychoanalysis; I can only note that the field of psychoanalysis is immensely rich and multiform. I will be using psychoanalysis as a part of the framework of general mainstream psychiatry (which it represented for a number of decades) when the issue of psychoanalytical diagnostics is relevant for the interpretation of my target texts.

2.1.2 After Freud: The Brain and the Explosion of Diagnostics

A radical shift in mainstream Western psychiatric thinking took place at the beginning of the 1980s. The global diagnostics of dynamic psychiatry gave way to brain theoretical and symptom-oriented psychiatry, which attempted to answer the new era's call for scientific quantification, testability, and distinct disease categories. This change, as Horwitz sees it, was due to changes demanded in psychiatry's social, economic and political environment (Horwitz 2003, p. 56). Brain psychiatry saw in symptoms, not symbols, but the direct links to existing disorders. 'In contrast to the dynamic model, diagnostic psychiatry defines diseases through the presence of overt symptoms, regardless of the causes of these symptoms. It regards diseases as natural entities that exist in the body and that generate the particular symptoms a person displays. These diseases became the object of scientific claims that can be made in isolation from the personalities and social contexts in which they arise, an abstraction that would be unthinkable in the dynamic model.' (Horwitz 2003, pp. 57–58.) The new brain theory did not, however, invent from thin air the great variety of diagnostic categories. On the contrary, it assimilated the psychic entities and problems that were already being treated as mental disorders by the preceding dynamic model as psychiatric diseases: '[DSM-III – the first non-dynamic diagnostic

manual of the American Psychiatric Association] simply recategorized as discrete diagnostic entities the wide range of problems that dynamic psychiatry had already pathologized' (Horwitz 2003, pp. 71–72). (Horwitz sees this pathologisation as a serious flaw in psychiatry; I will return to his criticism at the end of this chapter.) Thus, dynamic psychiatry's legacy – the pathologisation of the everyday life – continued as brain psychiatry secured the existing psychiatric clientele (ibid., p. 71), but renamed the disease categories and redirected the theoretic paradigm of aetiology and treatment. Therefore, the historical transition from psychoanalysis to diagnostic psychiatry is both a major disruption and an extension to the continuum.

The question of defining 'mental illness/disorder/disease' in modern psycho-science is a pressing one. As will be seen in the coming pages, it seems to be a central issue of the scientific nature of brain psychiatry: if psychiatry cannot delimit its own subject matter – how valid a science can it be? This question reverberates throughout the following pages, as I examine the various attempts there have been to try to medically define madness – or 'mental illness/disorder/disease', as psychiatry prefers to call it.

My own rough definition given in the introduction that mental disesases as *essentially universally applicable, more or less stably categorisable, psycho-socially and/or biologically caused and structured mental dysfunctions* is placed into the debate of how to *exactly and rigorously* define and delimit the subject matter that psychiatry attempts to handle. As will be seen, modern brain psychiatry has had considerable troubles in trying to do just that. The road that I have to direct the reader along is rocky; defining mental illness has been a matter of contention both for those demanding a definition from the psychiatric establishment and for those trying to coin one themselves.

2.1.2.1 What Is Mental Illness? A Psychiatric Point of View

I begin with the remark of the most prominent philosopher that psychiatry has produced from its own ranks, Karl Jaspers:

> Everyone uses the concepts of healthy and sick when judging the phenomena of life, human performance and people themselves. The naïve certainty with which such concepts are used is often surprising and so is the anxiety which invests them. We will deride people and dub them with psychiatric labels and yet look askance

> at psychiatrists as 'born ignoramuses' who have set up a sort of 'Inquisition' without its blood-stained seriousness. It may sometimes be the 'thing' to despise the 'psychiatric point of view' but the same individual who expresses this scorn may on another occasion talk of 'degenerate' and 'unhealthy' when faced with certain personalities, psychic phenomena or performances. (Jaspers 1997, pp. 779–780.)

Jaspers here crystallises one side to the problem of psychiatric diagnosis: we think we recognise mental illness or madness when we encounter it, at the diagnostic moment, but do not quite know how this recognition is made. This knowledge would endow us with the ability to differentiate derision from psychiatry. The class of phenomena that are called mentally ill seem like a compelling and natural group of phenomena that one can talk about without much thought about what is being said, however, the concept still does not seem to be a clear, unified whole. There also remains the question of the possibility of stigma. What Jaspers strives to make concrete is that when the stigma or label comes from an authority, a psychiatrist, it becomes almost as serious as the Spanish Inquisition. Psychiatric diagnosis rarely kills anyone, but it is still rather a serious business.

Jaspers wrote in the 1910s, but his work is still relevant, as the writer of the foreword to Jasper's 1997 edition, Paul R. McHugh, remarks, 'despite these many scientific advances, most of the problems that Jaspers noted in 1913 remain as problems to psychiatry today' (Jaspers 1997, p. xi). I will be following many of Jaspers's ideas, because he offers such a clear-sighted, philosophical viewpoint to the problem of psychiatric diagnosis, which, after him, was more or less ignored by psychiatrists themselves.

There is a tension present in psychiatric notions of madness (especially in 20th century psychiatry). On the one hand there are unitary, formal concepts of the form 'madness is (always) X' (like my own working definition), on the other hand there are dozens of diagnostic categories. Do all these categories truly have something in common, something giving a clearly formed character or core to madness as psychiatry sees it that could be crystallised into a uniform concept? Or is madness as multifaceted as it appears when one leafs through diagnostic manuals?

2.1.2.2 Old Cultural Concepts of Madness

I will go through some of those (at the same time pre-psychiatric yet still existent) notions of madness that persist in our Western cultures and echo through our minds when we encounter 'non-sane' people or worlds of representation.

'Madness is irrationality, a condition involving decline or even disappearance of the role of rational factors in the organization of human conduct and experience: this is the core idea that, in various forms but with few true exceptions, has echoed down through the ages' (Sass 1998, p. 1). Sass states that this conception has evolved from Heraclitus, Plato and the Enlightenment to modern psychiatry (ibid., pp. 1–2). He writes:

> In one sense, of course, an equation of madness and irrationality can hardly be questioned. If we *define* rationality in pragmatic and social terms – as a matter of practical efficiency in the attainment of goals generally accepted as being reasonable, as a tendency for one's perceptions and judgments to agree with general opinion, or as openness to dialogue – then it is practically a tautology to equate insanity with the irrational: isn't this just what we *mean* when we refer to some person as mad, crazy, lunatic, or insane? (Sass 1998, p. 2.)

So, there is the tendency to look for familiarity, the sharing of opinions and conduct, and general acceptability of behaviour as signs of 'normality', and their oppositions as 'abnormality' and 'irrationality', i.e. madness. This is, of course, a matter of defining the twin poles of madness and rationality, but the above-mentioned ideas are recurrent themes throughout psychiatric writing. However, one can object to this definition, like Roy Porter (2002, p. 160), Jorma Laitinen (1996, p. 141) and Sass himself have done, by saying that there is reasonableness in madness, and that it is not necessarily the rational that dies in madness, sometimes madness can even heighten the rational side of the mind (Sass 1998, pp. 6–7).

Madness has not only been seen as a lack of reason – and thus also a lack of humanity (as reason is considered to be the essential quality of humanity and personhood) (ibid, p. 1). There have also been those, like Nietzsche, who emphasise the life force of the madman, the vitality of his passions and creativity, (though Sass reminds us that 'most of these writers have had little or no experience with the realities of chronic insanity' (ibid, p. 4).) There are other old bipolar oppositions that need to be taken into consideration. Sass writes:

> Here, then, are the poles around which images of madness have revolved for so many centuries: on the one hand, notions of emptiness, of defect and decrepitude, of blindness, even death itself; on the other, ideas of plenitude, energy, and irrepressible vitality [...] (ibid., p. 3.)

And:

> Nearly always insanity involves a shift from human to animal, from culture to nature, from thought to emotion, from maturity to the infantile and the archaic. (ibid., p. 4.)

The picture could not be more varied. Madness is both a lack and abundance, emptiness and plenitude, energy and death. Madness is irrational, animalistic, naturalistic, emotional, infantile and archaic. The limitation of all these concepts and characterisations is that they are not very helpful. They do not help us see the picture clearly, to understand madness better, or to even recognise it. One reason might be that they come from very different ages, some dating back as far as antiquity. They have proved to be very resilient, but they do not form a coherent whole. One can always also object to them by saying that they are over-inclusive. Not everything that belongs to irrationality or nature or emotion is madness. The drawing of boundaries is extremely difficult, and these characterisations do not give us any clue of how to do it. Nevertheless, these ideas lurk at the backs of our minds as some kind of formless idea of what madness is.

2.1.2.3 Textbook Definitions

If antiquarian definitions of madness did not get us very far, rigorous psychiatric textbook definitions have their own problems. Psychiatrists have been with psychic phenomena that seem real and specific, yet they have had considerable difficulties in delineating just what they see in them. As psychiatry has evolved, the tension between the reality of a multitude of diagnostic categories and the need for a uniform and formal definition of madness has grown. Jaspers wrote in the first part of the 20th century:

> The multiplicity of psychic standards means much greater fluctuation in what should be styled 'psychically sick' than in what should be styled 'somatic illness'

> – which by comparison seems almost constant. The application of the concept of illness to the psychic field in general remained in abeyance longer than its application to physical matters. It was thought that demons, guilt and wickedness were responsible rather than natural processes which could be studied empirically and their causes learnt. Then only idiots and those who were raving mad were thought to be ill, later melancholics as well, but during the last century the circle has widened continually [...] (Jaspers 1997, p. 783.)

The circle of clinically treated madness has continued to widen after Jaspers, and the tension has grown with it. Psychiatry has struggled to reach and maintain the status of a medical science. I will return later to the question of differences between somatic and psychiatric medicine; it now suffices to say that the struggle towards the status of medicine has also been political. It is not only a matter of empirical, scientific research, but also a matter of who defines what, with what right, and how.

The two most widely acknowledged psychiatric manuals today are the Diagnostic and Statistical Manual of Mental Disorders (the present edition being the DSM-5 – the 5th edition of DSM) of the American Psychiatric Association, and World Health Organisation's International Classification of Diseases (ICD-10 – the 10th edition of ICD; the 11th edition of ICD is due in 2015). They are for the most part mutually compatible, as they (i.e. the latest editions) have been developed together. They differ mainly in their ways of dividing mental disorders into greater categories, although the descriptions of mental disorders themselves also differ in certain cases, however, the two manuals can be used in a parallel fashion (Lönnqvist 1999, p. 35).

Undoubtedly, there have been some sorts of diagnostic manuals for as long as there have been doctors dealing with insanity. The contents of these have been as varied as the time span has been long, ranging from ancient Greek humour theories to phrenology in the 19th century. In the 20th century, however, one can detect a somewhat straight line connecting the beginning of the century to its end: Emil Kraepelin's work at the end of the 19th century became the basis of modern manuals, including the DSM. His division of non-organic ('functional') psychoses into two major groups, the affective (manic-depressive) and the non-affective (schizophrenia; or dementia praecox, as Kraepelin called the disease), has remained valid. Naturally, the contents of these psychoses and the other diseases he catalogued in his famous textbooks have changed somewhat since 1899, and many more disorders have been added. Regardless, the basis is there. (Shorter 2005, p. 125.)

The first ICD manual was published in 1949 (ICD-6) and the first DSM was published in 1952 (DSM-I), during the psychoanalytical reign. The processes of formulating both manuals have been fairly similar, as the work to define the criteria for determining mental disorders is done by numerous committees and sub-committees involving a great number of people with psychiatric expertise. The greatest difference between the two manuals is that ICD is an international effort whereas DSM is purely American. I will concentrate mostly on the DSM, as it has achieved a leading position in international research and teaching (Lönnqvist 1999, p. 35).

However, it took a rather long time before a uniform and formal definition of madness – or as DSM psychiatry prefers to put it 'mental disorder' – became an issue even for such an important and influential manual as the DSM. Before the paradigm change in the 1980s, DSM provided no formal definition of mental disorder because the dynamic model did not demand one. Before that, whatever psychiatrists wanted to treat as mental illness was generally accepted by the public and other professions as mental illness. (Kutchins & Kirk 1997, p. 29.) The clinical setting was enough to establish (any form of) madness as a phenomenon demanding treatment. Kutchins and Kirk describe the changing situation as the American psychiatric field started to come under pressure:

> Now we have many professionals and self-help groups that claim expertise in helping with life's problems; social workers, clinical and community psychologists, psychiatric nurses, marriage and family counselors, and self-help groups provide services to alcoholics, drug abusers, battered women, and many others. By 1980, psychiatry as a medical specialty needed to demarcate its boundaries but to do so in some conceptually coherent way, not merely by asserting its authority. (ibid.)

This 'conceptually coherent way' was the launching of a uniform and formal definition of mental disorder. What is more, the definition was created partly in response to political pressure from gay rights activists who demanded an explanation of why homosexuality was included in the manual. What is a disorder then? What is included, what is excluded? This is how the DSM answers these questions in its latest edition:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant dis-

> tress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (DSM-5, p. 20.)

In comparison, ICD-10 is more reticent, but echoes the DSM definition:

> The term 'disorder' is used throughout the classification, so as to avoid even greater problems inherent in the use of terms such as 'disease' and 'illness'. 'Disorder' is not an exact term, but it is used here to imply the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here. (ICD-10, p. 5.)

These definitions markedly try to delimit and define more rigorously the phenomenon of mental illness than the definition I offered in the introduction as the starting point for our exploration. (*"Essentially universally applicable, more or less stably categorisable, psycho-socially and/or biologically caused and structured mental dysfunctions which cause true distress for those suffering from them"*) They try to cover as far as possible the dozens of diagnostic categories that the manuals contain, and they certainly offer considerably more specificity than my own rough psycho-scientific definition of mental illness.[4] The DSM definition in particular promises a lot, as Kutchins and Kirk have analysed (I will here modify their DSM-IV critique to suit the DSM-5 edition): 1) by locating the disorder 'inside the individual', not outside, it tries to counter those critics who claim that mental illness is purely social; and 2) by defining disorder as a dysfunction, it tries to include some notion of internal causation and pathology. (Kutchins & Kirk 1997, pp. 31–32.) What is more, in the light of my definition: both manuals certainly stress the stable categorisability of mental illness, and (as will be seen in more detail in Chapter 4) they try to be universal and to cover the mental illnesses of the whole human race in all of its social, cultural and historical variation.

4. However, the DSM-5 cautions that 'no definition can capture all aspects or all disorders in the range contained in DSM-5' (p. 20).

However, it is not surprising that even these specific definitions contain problems. Kutchins and Kirk list some of DSM's problems: The required 'unexpectability' of the reaction is both over-inclusive and too narrow at the same time; depression is an expectable response to a major loss, and all unexpected reactions are not madness. The definition tries to locate the disorder inside the individual in order to distinguish disorders from mere social deviance. However, even in medicine, diseases caused by external factors (e.g. radiation) are still diseases. The DSM definition appears to exclude all disorders caused by factors outside of the individual (e.g. a child's anxiety disorder due to sexual abuse). (ibid., pp. 32–34.) Lastly, the crucial word 'dysfunction' contains certain problems. Kutchins and Kirk write:

> When our mental mechanisms dysfunction, we speak of mental disorders. But this approach to identifying mental disorders *requires that the natural functions of mental mechanisms be known before claims of dysfunction can be made*. Because we have limited knowledge of the purpose for which many mental mechanisms were designed, the arguments for what constitutes a mental dysfunction are frequently confused, tautological, and controversial. (ibid., p. 35, original empahsis.)

What can follow is that phenomena which seem in themselves all very normal and everyday behaviours, for example sadness or sleeplessness, can be found in DSM's pages as symptoms of mental disorder. This does not help in the process of recognising madness because the border between the normal and abnormal is blurred.

All these complaints against the DSM definition of mental disorder, perhaps most of all the complaint that we cannot know what is dysfunctional if we do not know first what is functional, point to the very core of psychiatric diagnosis: trying to figure out what is 'normal' and what is 'sick'. These two poles cannot be clearly demarked from each other. Thus, one Finnish textbook of psychiatry opens with the WHO definition of health: 'WHO has defined health as a perfect state of physical, psychical, and social well-being, not just lack of diseases or injuries' (Lönnqvist & Lehtonen. 1999, p. 13, my translation). The text goes on to list the characteristics of mental health, as follows: the ability to maintain human relationships, caring for others and being capable of love, the ability and will to have reciprocal relationships and personal expression of emotions; the ability to work, to participate socially and to take care of one's own interests properly; when meeting troubles, working to overcome them; sufficient control of anxiety, coping with losses and readiness to face life's changes; the centrality of a sense of reality; social independence and a

well-developed identity; and creativity (Lönnqvist & Lehtonen. 1999, pp. 15–16). Who would not agree that all these characteristics are desirable? Yet as the authors of this textbook say: 'Clinical practice and research demand that one must define limits to mental health and its disorders. The continually changing and partly undefined character would need to be frozen before one could examine it. We cannot define mental health practically in any other way. We cannot know for sure the answer to the question: "What is mental health?"' (Lönnqvist & Lehtonen, 1999, p.15, my translation.)

Here we have the first serious glimpses of the 'counter-forces' of psycho-science: if mental health escapes rigid definitions, so does, as we already have seen in one way, the concept of mental disorder. Kutchins and Kirk point out a very crucial aspect: 'First, you must appreciate that the notion of mental disorder is what social scientists call a construct. [...] Constructs are shared ideas, supported by general agreement [...] and [...] agreements change over time.' (Kutchins and Kirk 1997, p. 23.)

This changing of agreement has been seen in the history of the DSM several times. Gay rights activists lobbied against the continuing inclusion of homosexuality as a mental disorder and succeeded.[5] Vietnam veterans lobbied to have post-traumatic stress disorder included (in order to be able to get health insurance coverage for their treatment) and also succeeded. Other battles have been fought as well, but these two cases already point to the question: is this sort of shuffling of diagnoses according to political agendas really scientific, or any kind of medicine? Is the question of this peculiar kind of illness – madness – such an issue that the diagnosis-makers are not able to separate it from everything else that is human? How do we recognise madness, then, or distinguish its contents from normality? Is mental illness – any kind of mental illness – really an essentially stable, universal psychic phenomenon? I will come back to these questions after a short detour through two more attempts to give madness a uniform formal definition.

2.1.2.4 Social and Moral Definitions

I will now tackle two more definitions hovering around the psychiatric field that give a different kind of answer to the clinical question of how to recognise madness. They do not fit that well to my initial definition, as they stress the social and moral factors of mental illness (and not the universalizability or categorisability of

5. On the question on homosexuality as a mental disease and the process by which it was finally eliminated from the list of mental diseases, see Stålström 1998, especially chapter 7.

mental illness), but they are nevertheless worthy of inspection as commentary to established psycho-sciences. Markku Salo has studied the social psychiatric reforms in Italy, where in the 1970s, in a relatively short period of time, mental hospitals were run down and the care of patients was conducted on an open clinic basis. It was a radical change and it had roots in radical thinking, as Salo puts it: 'Madness is produced juridically, thus a madman becomes the "exemplary stranger" (cf. "exemplary citizen"). The madman is person left outside the [social] contract and upon whose destiny others make agreements[.]' (Salo 1996, p. 50, my translation.) Thus, madness is seen as a threat to society that lives on its margins. The Italian reformer and social psychiatrist Franco Basaglia based his thinking on phenomenological and existentialist philosophy. For him, the target of treatment and research should not be a natural scientifically explained disorder, but a phenomenologically and existentially interpreted disturbed way of being in the world (ibid., p. 84). 'Madness is there where it is put. More important than the status quo is change, liberation. The source of madness is not in the individual, nor is the individual guilty of his own suffering. [...] the reason and guilt of madness are defined socially.' (ibid., p. 88, my translation.) One of the reform's goals was to socially negate the role of 'patient' – and that of 'staff'. The patient was no longer studied as an example of a disorder, but instead treated as a fellow human being. The mental hospital was interpreted as a place that entrenched madness. (ibid., p. 111.) This demanded the reorganisation of units giving treatment. Basaglia managed to get a law passed in Italy that obliged the government to run down mental hospitals and provide care for the patients in the community. He led two pilot projects that succeeded fairly well. However, Basaglia's legacy has been seen as somewhat ambiguous. 'Although he has been widely credited as the architect and inspiration for the sweeping mental health reform enacted in 1978, the so-called Basaglia Law has been only patchily implemented' (Donnelly 1999, p. 272).

Basaglia's viewpoint can be seen as quite radical, though he did stay within the boundaries of clinical psychiatry. His definition of madness as a social problem, socially constructed and socially treatable, is at odds with biological psychiatrists and those who believe that the mental hospital is the best place to treat the most severe cases of mental illness. It is nonetheless an existent psychiatric way of looking at the problem of how to treat madness. There is one problem though, from the viewpoint of recognition. If the disorder or illness is negated and refused to be acknowledged as the patient's 'name tag', how does one recognise madness? Even if madness is defined as a 'phenomenologically and existentially interpreted disturbed way of being

in the world', the word 'disturbed' at least should be defined accurately before one can use that phrase as a yardstick for madness. What kind of disturbance counts? Where are the boundaries? These questions are left unanswered, but the whole idea of the reform was to get rid of label tags; there were only human beings, who tried to find new ways of having relations with each other, the established categorisations had to give way to the ideal of equality.

Another fairly similar viewpoint comes from Jorma Laitinen, who has studied the moral philosophical aspect of compulsory treatment. In his opinion, madness is a social matter as well: 'We start to suspect the possibility of mental illness precisely when morality as an ability does not seem to apply to the person's case. We are prone to think that the loss of moral capability must somehow be connected to the possibility of behaving irrationally. [...] the ability to morally evaluate [...] always presupposes some kind of ability to register in an adequate manner the shades of social interaction.' (Laitinen 1996, p. 35, my translation.) It is noteworthy that Laitinen evokes the old 'madness as irrationality' theme, only to place it into the new surroundings of moral philosophy. A madwoman is an immoral or amoral woman, and as such, irrational. Laitinen continues: 'The doctor [...] has reasons to suspect that X [the patient] may suffer from mental disorder that demands compulsory treatment because she has behaved in a manner that is in contradiction to expected social roles' (ibid., p. 80, my translation). This behaving against social roles is a breach of social obligations, which is, again an immoral act.

But are all morally deviants mad? Criminals break the moral and social rules as well, but they are not (all) locked up in mental hospitals. Laitinen helps to make some differentiations: 'In short, if no one can share the contents of X's intentions from the viewpoint of the shared commonality of symbolic and social environment, we can easily take the cultural pattern of "mental illness requiring compulsory treatment" as an assisting tool' (ibid., p. 109, my translation). The problem with Laitinen's definitions is that the scope in which they are meant to be used is quite narrow. There are innumerable people with disorders who will never be treated against the sick person's will. So, are all mad people out of synchrony with the shared symbolic and social environment? Many have said so, e.g. those favouring the irrationality thesis. But as we have seen, there are no easy answers to the question of what madness is. The multitude of disorders point out to the multitude of ways of breaking the moral and social rules. Are there even the same rules for all disorders? What common features are shared, for example, by a practising paedophile, who from the viewpoint of the surrounding community breaks the social, juridical and moral laws

in a clear way, and a melancholic, who may keep to herself, and whose only clear social breach is killing herself? We have seen by now that carving out a coherent uniform definition for madness is extremely difficult, as is getting an accurate map of the territory of madness.

2.1.2.5 Medicine vs Psychiatry

I will turn to the conflict between medicine and psychiatry, and how the psychiatric concept of illness differs from that of medicine proper. This helps us to see psychiatry more clearly as a branch of medicine – and what an extraordinary branch it is. Like medicine, clinical psychiatry aims to cure, but how different is this wish to cure (by first defining) mental illness from that of curing and defining a somatic one? Lönnqvist writes:

> In medicine in general, and no less in psychiatry, there are no accurate and unchanging definitions of illnesses, with the use of which one could decide whether a certain deviance from health fulfils the criteria of a certain illness. Illness concepts are thus always contractual and relative, as can be seen from the discussion about the limiting values of hypertension. At best, disease concepts are based on known aetiology [...] and structural pathology. Often a disease is called a disease only after there are subjective symptoms, personal significances and social repercussions in relation to it.' (Lönnqvist 1999, p. 31, my translation.)

This medical characterisation of illness shows the starting point: there are certain similarities between psychiatric illnesses and somatic illnesses, which is hardly surprising, as psychiatry has strived to become a respectable branch of medicine, and this also means that the two should share basic concepts. However, there also are differences, and these differences make psychiatry somewhat unique as a branch of medicine.

Let me return to Jaspers's characterisation of the difference between psychiatry and medicine: 'The multiplicity of psychic standards means much greater fluctuation in what should be styled "psychically sick" than in what should be styled "somatic illness" – which by comparison seems almost constant. The application of the concept of illness to the psychic field in general remained in abeyance longer than its application to physical matters.' (Jaspers 1997, p. 783.) Jaspers points to the direction of disease concepts being constructs and changing over time. But is this

true even of somatic medical disease concepts? As Lönnqvist pointed out above and further states: on the somatic side as well, different diagnoses originate in different times and are always contractual (Lönnqvist 1999, p. 31). Here, one can see how the psychiatric establishment may recognise one of the main counter-force arguments: the constructed nature of all illnesses – mental illnesses included. However, there still is discussion on the differences between mental and somatic illnesses that is central to our understanding of the category of mental illness.

Another point worth noting in Jaspers's above quote is that he says that the fluctuation in what should be styled somatic illness seems almost constant. The reason for this constancy in comparison to psychiatric illnesses comes, in Laitinen's opinion, from the fact that there are in psychiatry no such methods of research that are independent of the symptom-descriptions, such as laboratory tests that could verify, independently of symptoms, if the person is ill or not. (Laitinen 1996, p. 18.) This lack of independent tests is due to the fact that the aetiology and pathophysiology are not known for the great majority of disorders (Lönnqvist 1999, p. 32). Instead of building the disorder as a state whose origin and physiological malfunctions are known, most mental illnesses are syndromes, like in the times of Kraepelin. For Kraepelin, the prognosis and development of the illness were of utmost importance, and they are still to this day. (Lönnqvist 1999, p. 32.)

However, independent testing is a problem for somatic medicine as well. This is visible in the discussion of what is 'sick' and what is 'normal' in medicine (and in psychiatry). Jasper writes:

> If we consider the host of ways in which the concept of illness has been used and look for a common factor we find no constant similarity between any of the forms of being or events that have been called 'sick'. Rather the only single thing in common is that a value-judgment is expressed. In some sense, but not always the same sense 'sick' implies something harmful, unwanted and of an inferior character. If we want to get away from value-concepts and value-judgments of this sort we have to look for an empirical concept of what sickness is. The concept of the average affords us such a concept. Healthy is what accords with the majority, the average. Sick is what is rare and deviates beyond a certain point from the average. (Jaspers 1997, p. 780.)

The whole controversy of sickness and health can be crystallised into this question of the 'average' and 'values'. Canguilhem writes about determining 'normal' through

averages: 'But in the end the problem is to know within what range of oscillation around a purely theoretical average value individuals will be considered normal' (Canguilhem 1989, p. 154). Jaspers points out: 'One almost never knows what the average is' (Jaspers 1997, p. 782).

Thus, though in somatic medicine there are tests that help to identify certain conditions, the laws of mathematics or biology or chemistry do not tell alone where the line between normal and healthy lies – it is always random to certain degree, though the existence of tests have made fluctuation inside somatic medicine less pronounced than in psychiatry – all this implying that all diseases, *mental and physical*, are in a way constructs.

So, there still remains the question of value. Jaspers defines illness as follows: '"Ill" is a depreciatory concept which covers every possible kind of negative value. The simple statement "ill" therefore in all its generality says absolutely nothing in the psychic field since the word includes idiots as well as the genius and can embrace everyone.' (Jaspers 1997, p. 784.) For Jaspers, then, 'ill' is an empty word, something used without guarantee that the sense is the same every time we use it. The word evaporates in front of our eyes, even if it should be an important moral and medical yardstick. Canguilhem, then, describes the purpose of medicine: 'It is true that in medicine the normal state of the human body is the state one wants to re-establish' (Canguilhem 1989, p. 126). From this, there is only a small step to recognising: 'Be that as it may, the practicing physician is very often happy to agree with his patients in defining the normal and abnormal according to their individual norms, except of course, in the case of gross ignorance on their part of the minimal anatomical and physiological conditions of plant and animal life' (Canguilhem 1989, p. 121). There are as many definitions of 'ill' as there are persons complaining that they are 'ill'. From such plurality, it is hardly surprising that a uniform definition of illness, mental illness included, is hard to formulate.

Laitinen has claimed that especially a diagnosis of such a severe disorder as schizophrenia labels the whole human being, including his personality, it does not just identify a certain entity of sickness in him like medicine claims it is doing (Laitinen 1996, p. 16). This question of stigma is often seen as one of the biggest differences between psychiatric and somatic illnesses. Sass writes: 'It has been assumed that the madman's point of view is not simply idiosyncratic but actually incorrect, or otherwise inferior, according to some universal standard; and that this inferiority reflects some lack or defect of the defining human ability' (Sass 1998, p. 2). However, Canguilhem points out while talking about somatic illnesses: '[...]

pain-disease, so to speak [...] is a fact at the level of the entire conscious individual [...]' (Canguilhem 1989, p. 98). He also characterises the experience of a somatic disease as a 'new life' (Canguihem 1989, p. 188), in the sense that it is completely different from the life before disease. Thus, it would seem fair to say that the issue of stigmatisation is more complicated than Laitinen sees. Somatic illness may concern the whole human being and still not necessarily stigmatise him in the way psychiatric labelling may do in the social circumstances it is applied. This all points towards the perception that – like all illnesses, (somatic or mental) also the psychiatric stigma is a social construct: formed and given in social circumstances.

I think that one of the most important differences between somatic and psychiatric illnesses – which also may cause stigmatisation – is the issue of awareness of illness (or the lack of it) in psychiatric patients. As Lönnqvist points out: 'Often a disease is called a disease only after there are subjective symptoms, personal significances and social repercussions in relation to it' (Lönnqvist 1999, p. 31, my translation). However, he states:

> The awareness of illness may be disturbed for many reasons, such as the diminishing of intellectual functions, psychotic symptoms, and psychic protection against a disease that is experienced as menacing. The awareness of illness is also always relative and easily changing, as the patient's factual and emotional facilities at the beginning of the treatment are for natural reasons diminished. In severe disorders, there is also the fact that one must evaluate whether the patient is capable of giving her valid consent to the treatment of her illness. Awareness of illness is not always the same as the consent to treatment. Some patients who sense that they are ill are not cooperative in treatment. On the other hand, some of those patients who do not admit they are ill are nonetheless ready to receive the treatment that is deemed necessary for them. (Lönnqvist 1999, p. 30, my translation.)

The awareness of illness is very different in somatic medicine. The main difference between the awareness of illness in somatic and psychiatric patients is that on the somatic side, the feeling of illness coincides by and large with some objective somatic finding. (Jaspers 1997, p. 782.) The conflict is felt only with borderline cases, as Jaspers writes: 'There is either somatic finding without any awareness of illness [...] or there are feelings of illness without any objective finding' (ibid.). In the latter case, the patient may be defined as a hypochondriac and sent to a psychiatrist. Jaspers continues:

> The concept of illness in psychiatry is characterised by the fact that the patient's attitude to his illness, his feeling of being ill, his awareness of illness or the complete absence of both, is not something additional to be easily corrected as in the purely somatic disorders but always an integral part of the illness itself. In many cases it is not the patient himself but only the observer of the patient who accepts the illness. (ibid., p. 788.)

This need for an observer to decide whether a person is ill or not is a clear indicator of that which is perhaps one of the most special features about psychiatry in comparison to somatic medicine: the madman – the psychiatric patient – is not quite 'master of himself' (Jaspers 1997, p. 789) but needs another person to define the borders of his sanity. This can be part of the stigmatisation process in some conditions; the disease takes away the basic (adult) human need to be one's own master. Psychiatric diagnosis is a one-way route: the psychiatrist observes and defines the patient, the patient's most important role is to give enough information to be scrutinised and diagnosed.

2.1.2.6 Multiplicity vs Unity

In both somatic medicine and psychiatry, there have been discussions about the need and sense of formal uniform definitions of illness. Canguilhem writes about somatic medicine and its formal definition of illness: 'It is perfectly understandable, then, that physicians are not interested in a concept which seems to them to be too vulgar or too metaphysical. What interests them is diagnosis and cure.' (Canguilhem 1989, p. 122.) Jaspers writes similarly: 'The medical person is least of all concerned with what healthy and sick mean in general. He is scientifically concerned with a host of living processes and well-defined illnesses. What "sick" in general may mean depends less on a doctor's judgment than on the judgement of the patients and the prevailing conceptions of the contemporary culture.' (Jaspers 1997, p. 780.) Thus, the pursuit for a uniform category of illness, and its social constructedness is a trouble that medical doctors treating the somatic and mental problems of their patients face – or ignore.

There have been a variety of answers to the problem of uniform definition. Some social psychiatrists have answered by putting all diagnostic categories in parentheses. Others have strived to come up with a single definition. Others still, like Canguil-

hem and Jaspers, have promoted the idea that we do not need one single definition of mental illness at all. Jaspers's solution is to study and examine the pathological phenomena at every level of human psyche, from basic phenomena to the level of human race. He does, finally, give a unified typology of mental illness, in the vein of those that were later structured in the DSM and ICD manuals: 'Disease is defined: (1) as a somatic process; (2) as a serious event which breaks into a healthy life for the first time and procures a psychic change; a somatic base is suspected for this but as yet not known; (3) as a variation of human life far removed from the average and somehow undesired by the affected person or by his environment and therefore in need of treatment.' (Jaspers 1997, p. 789, italics removed.) To Jaspers, 'Only those psychic events ought to be called morbid or treated as illness, which are due to morbid processes in the brain' (ibid.). So, Jaspers draws the line biologically, like the brain psychiatrists of the 20th and 21st centuries. He is suspicious of 'purely psychic' changes, but sees that (at least some) mental illnesses are 'real' in the meaning of being experienced by the sufferers. Thus, the support Jaspers gives to my tentative definition (mental illnesses being *essentially universally applicable, more or less stably categorisable, psycho-socially and/or biologically caused and structured mental dysfunctions which cause true distress for those suffering from them*) is in my argument at least partial: the biological basis he suspects mental illnesses have is a fairly good ground to argue that they also would be both essentially universally applicable and stably catgorisable as pathological processes any brains in any historical and cultural circumstances could go through; that they are biologically caused and structured (he is more cautious about the purely psychic change); and that they are undesired, i.e. cause true distress for the sufferers.

If, like Jaspers, one supports the 'multiplicity thesis' – that one should forget about the quest to define mental illness in a uniform manner and recognise and diagnose madness according to specific diagnostic criteria – problems still remain. 'What is a disease-entity and how are they grouped?' would be the first of the questions to be asked. Jaspers writes:

> Neither the *basic psychological forms* nor the *teaching on causes* (aetiology) nor the *cerebral findings* have yet provided us with a system of disease-entities within which all the psychoses could be accommodated. *Kahlbaum* and later *Kraepelin* embarked on a new approach which hoped to arrive at disease-entities in spite of everything. Kahlbaum formulated two fundamental requirements: firstly, the entire course of the mental illness must be taken as basically the most important

> thing for any formulation of disease-entities and secondly one must base oneself on the total picture of the psychosis as obtained by comprehensive clinical observation. In emphasising the course of the illness he added a new viewpoint to the three which preceded and by his second requirement he brought *all the previous viewpoints together*: they were to work together in the construction of disease-entities rather than continue to work in opposition. (Jaspers 1997, p. 566.)

The system sounds plausible. However, Jaspers continues: 'No real disease-entity has been discovered by this method of approach. We have no scientific knowledge of any disease which satisfies the claims made for a disease-entity.' (Jaspers 1997, p. 567.) All propositions fail somehow: GPI (neurosyphilis) has the neurological, brain-histological and aetiological viewpoints covered, but lacks the characterisation of psychic events; the two great disease-groupings – manic-depressive psychosis and schizophrenia – are unknown as to their causes and cerebral pathology; and so on. Nevertheless, Kraepelin's grouping of diseases survives at least partially today. Jaspers raises three objections to Kraepelin's work: 1) 'Diagnosis can only be made from the total picture when one knows "a priori" of a definite illness that can be diagnosed. The total picture does not provide us with any clearly defined illnesses; it only gives us types which in individual cases continually show "transitions"'; 2) 'That the outcome is the same is no proof that the disease is the same'; and 3) 'The idea of the disease-entity never reaches realisation in the individual case.' (Jaspers 1997, p. 569.) Thus, Jaspers concludes that the idea of disease-entity is not an objective to be reached but a point of orientation. If one tries to rigidly define its contents and have, instead of an idea, an apparent accomplishment of the idea, the whole effort collapses. Jaspers writes: 'If the reader tries to get a precise hold of the entity involved, he will find it melts away from him even as he looks at it. The question as to what underlies all phenomena in general used to be answered in the old days by the notion of evil spirits. These later turned into disease-entities which could be found by empirical investigation. They have proved themselves however to be mere ideas.' (Jaspers 1997, p. 570.)

The concept of disease-entity seems troubled no less than the uniform definition of disorder. However, psychiatrists every day have to work with these definitions – these diagnostic categories – of illness. During the course of the 20th century, there have been a number of diagnostic manuals. The two already mentioned, the DSM and ICD, have several greatly differing editions. In addition to these, there are textbooks written before the manuals, e.g. those of Kraepelin, Bleuler and others.

Since my foremost intention is not to write medical history – I am using psychiatric theory only to recognise and understand the contents of madness texts – I will only very briefly summarise here the latest two classifications, ICD-10 and DSM-5, in order to give an outlook of all those things considered mentally ill by these manuals. I will give more details of various illnesses as psychiatry sees them in the context of the texts that contain representations of them.

ICD-10 List of Categories:

Organic, including symptomatic, mental disorders (e.g. dementia)
Mental and behavioural disorders due to psychoactive substance use (e.g. alcoholism)
Schizophrenia, schizotypal and delusional disorders
Mood [affective] disorders (e.g. mania)
Neurotic, stress-related and somatoform disorders (e.g. panic disorder)
Behavioural syndromes associated with physiological disturbances and physical factors (e.g. anorexia nervosa)
Disorders of adult personality and behaviour (e.g. paranoid personality disorder)
Mental retardation
Disorders of psychological development (e.g. specific speech articulation disorder)
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (e.g. disturbance of activity and attention)

DSM-5 List of Categories:

Neurodevelopmental Disorders (e.g. Language Disorder)
Schizophrenia Spectrum and other Psychotic Disorders
Bipolar and Related Disorders
Depressive Disorders
Anxiety Disorders
Obsessive-Compulsive and Related Disorders
Trauma- and Stressor Related Disorders (e.g. Post-Traumatic Stress Disorder)
Dissociative Disorders (e.g. Dissociative Amnesia)
Somatic Symptom and Related Disorders (e.g. Illness Anxiety Disorder)
Feeding and Eating Disorders (e.g. Anorexia Nervosa)
Elimination Disorders (e.g. Enuresis)

Sleep-Wake Disorders (e.g. Insomnia Disorder)
Sexual Dysfunctions (e.g. Erectile Disorder)
Gender Dysphoria
Disruptive, Impulse-Control, and Conduct Disorders
Substance-Related and Addictive Disorders
Neurocognitive Disorders (e.g. Delirium)
Personality Disorders
Paraphilic Disorders (e.g. Exhibitionistic Disorder)
Other Mental Disorders
Medication-Induced Movement Disorders and Other Adverse Effects of Medication
Other Conditions That May Be a Focus of Clinical Attention

The tension between the two camps of 'uniform' and 'multiple' definitions is real. We have seen when discussing the development of the DSM that sometimes politics interfere with science and cause significant changes in both the diagnostic categories and even in the uniform definition of mental disorders. So, the whole business of producing a single definition to cover the entire field of psychiatry may seem odd and less trustworthy. Jaspers has stressed that we do not need one to be good psychiatrists; clinical psychiatrists are not interested in the definition, but in the cure. On the other hand, it would seem almost as odd if a branch of medicine had no clear uniting concept of what it is trying to treat. This is especially the case when new disorders seem to appear in every new edition of the manuals; how do they recognise this new disorder as a disorder if they do not have a working definition of a disorder in the first place?

2.1.2.7 To Sum Up

What is madness or mental disorder as we recognise it at the diagnostic moment? This is the question I have attempted to answer, only to realise that the question has no clear answer from modern diagnostic psychiatry – at least not the kind of answer that everyone in the field would endorse. There are numerous actors who have their own ideas and theories.

I have examined various definitions of mental illness, psychiatry's special nature as a branch of medicine, and the controversy between uniform and multiple defini-

tions, only to find contradictory information. The only thing it seems one can do is to follow the lead of all the psychiatrists who practice their discipline every day. They identify illness in their patients, not merely by using some uniform definition of mental disorder, but by using their manuals and their lists of symptoms. To nowadays recognise madness, one takes the ICD-10 or DSM-5 and tries to connect a person with a diagnosis: this is the requirement and pivotal act of the diagnostic moment. The underlying way of thinking that is the foundation of the efforts of these professionals is that the patients are complaining of something that has to be reckoned with: they are suffering from something real and often ask for something real from their psychiatrists as well – they ask for help. This is the *raison d'être* of psycho-science, and the one of the core focuses of my initial definition.

As an initial starting point, I want to state that clinical psychiatry often offers a new perspective to literary study of madness narratives, and as such it is valuable. However, the picture of psychiatry as a psycho-science is very varied, both within the field and outside it. It is a very diverse yet strong power in society; it diagnoses and divides people according to their psychical state in order to treat those who are diagnosed 'ill' as well as possible, to enable them to live as normal a life as possible. Whether everybody is in agreement on how 'normal' and 'abnormal' or 'sanity' and 'sickness' are defined and delimited – and who should be treated and how – is a completely different issue. This questioning is part of the basis on which the 'counter-forces' to the psycho-sciences stand.

2.2 The 'Counter-Forces': Foucault, Critical Psychiatrists, and the Questioning of the Psycho-Sciences

In this sub-chapter, I will analyse and give a background to the second definition I gave in the introduction. For the 'counter-forces', mental illness is 'madness', not something that can be neutralised by a change of vocabulary; as a notion, madness is forcefully and emphatically seen as a social construct: a phenomenon that is non-universalisable across historical borderlines, or scientifically unstable in essence. I will begin by making a rather long detour through Foucault's histories of psychiatry, because they build the basis for his arguments on the power structures of psycho-sciences and their effect on the nature of the diagnostic moment. After presenting Foucault's theories, I will briefly summarise the thought worlds of an-

ti-psychiatry, which are more or less loosely connected to Foucauldian argumentation, and Szaszian critical psychiatry.

2.2.1 Foucault and the History and Power of Psychiatry

Michel Foucault[6] (1926–1984) is indisputably the most famous and prominent philosopher of madness in 20th century Western philosophy. Naturally, there are others, such as Derrida, Blanchot, Deleuze and Guattari, but it can be argued that Foucault has made the greatest contribution, first with his doctoral thesis, *History of Madness* (*Folie et Déraison: Historie de la folie à l'âge classique*, 1961, the abridged English version of the name is *Madness and Civilization*), and then, among other writings, with his lectures at the Collège de France on *Psychiatric Power* (*Pouvoir Psychiatrique* 1973–74). I will consider here these two major works on Foucault's developing insight into madness. They show polarities and shifting focuses, but they can be considered two different viewpoints on the same theme of madness.

Foucault became famous for his theorem in the *History of Madness* that madness is not a perceptibly stable entity; it is more than anything else a social construct. For example, he contested the prevailing clinical psychiatric view that disease entities are unchangeable and recoverable even through the different disguises they take through ages. In later lectures, he further developed his ideas on psychiatric power structures. He considered the deciphering of these power structures more important than the earlier insights into the representations of madness, which he came to consider too elusive a subject. In both works, Foucault analyses the encounter between psychiatry and madness, which has repercussions for my notion of the diagnostic moment. He bases his thinking on the basic observation that the relationship between psychiatry and madness has never been easy, and that psychiatry as a branch of science has developed as a monological observation of madness, rather than building dialogues with madness.

First, I will unravel the *History of Madness* and some of its main themes: the development of classical unreason; the development thereof of proto-psychiatric practice; and Foucault's dispute with psychiatry. Then I will compare this earlier work with a later work, the Collège de France *Psychiatric Power* lectures, to see what Foucault wanted to change with his theories about madness.

6. In Chapter 3, I will be giving further details of Foucault's ideas on power. Here, I delimit my enquiry to the strictly madness theoretical side of Foucault's thinking.

2.2.1.1 Madness as Part of Classical Unreason and Confinement

Michel Foucault makes a rough four-fold division of the different phases in the development of Western societies' relations to madness. I say rough, because the phases overlap and show no clear-cut borders, and one can find traces of the different phases in an earlier or later phase. The four phases are: 1) the Middle Ages and Renaissance, whose relation to madness is exemplified by the wandering madness of the *Narrenschiff*, where madness roamed freely in the cultural and real landscape; 2) the birth of reason, whose relation's embodiment is Descartes' cogito and the rise of confinement with its exclusion by inclusion; 3) the birth of science and the norm, which is built into the development of proto-psychiatry; and 4) modern psychiatry. I will concentrate on the three later phases and especially that of the birth of reason, because Foucault himself does so.

Foucault begins his thesis by building a bridge between the diminishing figure of the leper and the rising masses of 'unreason' in the classical age:

> Abandonment is his [the leper's] salvation, and exclusion offers an unusual form of communion. Once leprosy had gone, and the figure of the leper was no more than a distant memory, these structures still remained. The game of exclusion would be played again, often in these same places, in an oddly similar fashion two or more centuries later. The role of the leper was to be played by the poor and by the vagrant, by prisoners and by the 'alienated' [...] The form this exclusion took would continue, in a radically different culture and with a new meaning, but remaining essentially the major form of a rigorous division, at the same time social exclusion and spiritual reintegration. (Foucault 2006, p. 6.)

According to Foucault, the structure of exclusion is the same in the case of the medieval leper and the group of those who fell under the title of 'unreason' in the classical age. What was this 'classical unreason' then? Foucault shows the root of this grouping by stating that the relationship to something called either Madness, Dementia or Unreason has been at the centre of the European experience ever since the Middle Ages. He writes: 'In any case, the Reason-Unreason relation constitutes for Western culture one of the dimensions of its originality [...]' (Foucault 2006, p. xxix). Western man has a long history in relation to madness, to unreason, (ibid.) but in the classical age, something rather peculiar happened: during this time, groups of people who had previously not belonged together were lumped together. The

classical age created a form of exclusion by inclusion, in the form of confinement, for all those whom the society wanted to discipline, take off the streets, and put to work. In this confinement an interesting mix of unfortunate people was found. Foucault's argument is worth citing here at more length:

> For confinement did not simply play the negative role of exclusion, but also had a positive organising role. Its practices and regulations constituted a domain of experience that had unity, coherence and function. It brought together in one field characters and values where preceding cultures had seen no resemblance, and it imperceptibly nudged them towards madness, laying the ground for an experience – our own – where they identified themselves as clearly belonging to the realm of mental alienation. For such a *rapprochement* to be carried out, a whole reorganisation of the ethical world was necessary, and a new dividing line was needed between good and evil, the acceptable and blameworthy, and new social norms were required for social integration. Confinement was merely the visible phenomenon on the surface of this deeper process, and an integral part of the whole classical culture. There were certain experiences that the sixteenth century had either accepted or refused, formulated or sidelined, which were now taken up by the seventeenth century and grouped together and banished *en masse,* exiling them together with madness, creating a uniform world of Unreason. These experiences can be summed up by saying that they all touched either on sexuality and its relation with the organisation of the bourgeois family, or on profanation in relation to the new conception of the sacred and of religious rituals, or on *libertinage*, i.e. the new relations that were beginning to emerge between free thinking and the system of passions. Together with madness, these three domains of experience form a homogeneous world in the space of confinement where the meaning of mental alienation as we know it today was born. (Foucault 2006, p. 82.)

Foucault stresses the idea that classical conception of unreason did not make a clear-cut difference between all the groups – the mad, libertines, vagabonds, suicides, blasphemers, the poor etc. – that were confined together. Madness as a medical phenomenon did not exist in confinement; it was not a medical space that offered a cure. So what made the classical age put all these groups together under the roof of the space of confinement? What was the guiding principle? Foucault answers: 'Obviously that of a social reality' (Foucault 2006, p. 102). Unreason as a social type took over from what the previous centuries had considered as 'an inevitable peril for

things and the language of men, their reason and their land' (ibid.). Unreason was thus no longer a natural dimension of reason; it came to be considered as a certain distance from a social norm – i.e. a social construct. To Foucault, one very significant manoeuvre in this development of classical unreason was Descartes' cogito, a move by which, according to Foucault, philosophy excluded madness from its sphere, making it its Other. What is striking in Foucault's theories about the classical conception of madness is the idea that the perception of madness was radically different, yet (perhaps even more striking) not discontinued from our own. It was not medicalised, or at least it was not medicalised completely. The group of unreason was uniform even if it seems to us as being heterogeneous. The space of confinement had doctors in it, but they did not to cure or treat madness, instead they took care of the physical ailments of the occupants. Madness did retain its status of illness, but only outside of confinement, (Foucault 2006, p. 114) and most of the mad were confined (ibid., p. 111). Why then is the classical conception of unreason important for our conception of madness? If previous ages treated madness in a manner that seems to us strange or incomprehensible, is this not because the reforms of psychiatry that began with Tukes and Pinel have disposed of the 'oddities' in the classical age's conception of madness? The point Foucault is really making is that what may first seem odd to us really has a root in our conception: there is a continuum between the classical age and that of ours, and there is, under the surface of our psychiatry, a layer of perception that is inherited from classical confinement. Foucault writes:

> The positivist psychiatry of the nineteenth century, like our own, may no longer have used the knowledge and practices handed on from the previous age, but they secretly inherited the relationship that classical culture as a whole had set up with unreason. They modified and displaced, and it was thought that madness was purely being studied from the point of view of an objective pathology; but despite those good intentions, the truth was that madness was still haunted by an ethical view of unreason, and the scandal of its animal nature. (Foucault 2006, p. 159.)

The space of confinement was a space of ethics – of morality – not of medicine, and Foucault claims that traces of this moral viewpoint of madness are very much alive in our modern psychiatry.

In between confinement and the modern psychiatry of our times there was the age of proto-psychiatry, of Tukes, Pinel and their heirs, during which the norms and bases of psychiatric science were laid. It started off from where confinement left off:

madness slowly started to gain independence as a phenomenon to be distinguished from the other forms of classical unreason. It was regarded as a phenomenon that required separate institutions to handle it. This does not mean that these separate institutions were quite yet medical institutions, for there was little space for medicine, but in these new spaces of exclusion, madness 'had found its own homeland' (Foucault 2006, p. 286). 'The difference was barely perceptible, as the new style of confinement resembled the one that had preceded it so closely, but it indicated nonetheless that something essential was happening, isolating madness and granting autonomy from the unreason with which it had been confused.' (ibid.)

The 'great reformers' of the history of psychiatry, the proto-psychiatrists Tukes and Pinel, are put in a new perspective in Foucault's work. He sees that they did not quite liberate the mad, who had just started to be distinguished from the other examples of classical unreason. Quite on the contrary, they created in their asylums systems that had fear, guilt, religion (in Tukes' Quaker community) and morality (in both asylums) as their building blocks. These Foucault sees as alienating forces that cast madness only deeper into its muteness. He argues that proto-psychiatry built a whole science of mind on the basis of silencing the mad: 'The science of mental illness, such as it was to develop in the asylums, was only ever of the order of observation and classification. It was never to be a dialogue.' (Foucault 2006, p. 486.) This silencing of the mad that started in classical confinement, Foucault claims, was an integral step towards our modern psychiatry, as Foucault, in the 1961 preface to his thesis, claims: 'The language of psychiatry, which is monologue by reason *about* madness, could only have come into existence in such a silence [of the mad]' (Foucault 2006, p. xxviii). So, claims Foucault, there are continuums from the age of confinement present today.

Foucault was infamous for his antipathy towards modern psychiatry. In the *History of Madness*, he attacks the age-old conceptions of the psychiatric reform started by Tukes and Pinel and championed in the following ages. He states:

> People who claim that madness became an object of calm scientific psychiatric study when freed from the ethical and religious associations with which it had been saddled by the Middle Ages should be brought back to this decisive moment when unreason was made into an object and thrown into an exile where it was to remain mute for centuries. They should have this original sin constantly before their eyes, and be ceaselessly reminded that it was only this obscure condemnation that opened the way for a discourse about unreason, reduced to silence at last,

> whose neutrality is proportionate to its own forgetfulness. Is it not important for our culture that unreason could only become an object of knowledge after it had been subjected to a process of social excommunication? (Foucault 2006, pp. 103–104.)

The process of confinement is thus the root of our 'calm scientific psychiatric study'; the diagnostic move is apparently divested of its neutral, scientific disguise. Foucault contests the view of psychiatrists that the psychiatric reforms were progress compared to the previous ways of treating the mad. It also is naïve, writes Foucault, to believe that we could capture the 'true face of madness', when it keeps changing all the time. (Foucault 2006, p. 122.) There are no disease entities either, or nosologies, that would remain the same from the classical age to ours (Foucault 2006, p.132). Thus, the psychiatric effort to build up and cherish its nosologies as the scientific base for the diagnostic moments, with all their repercussions for the mad patients, are unveiled as something utterly heinous. Foucault takes away something he sees as psychiatry's scientific fig leaf and confronts established psycho-science and its 'original sin' with vehemence. One can agree or disagree with Foucault. It is possible to defend clinical psychiatry as at least an effort to help, to cure true distress (remembering the first definition I gave in the introduction). Alternatively, one can attack it by using the ammunition Foucault offers (in the manner of the second definition). Either way, Foucault's argument must be reckoned with; and the tension between the camps of psycho-science and the counter-forces is an interesting and enduring phenomenon.

What then, is madness in Foucault's opinion? In the *History of Madness*, the changing face of madness is traced across the centuries' relation to unreason. Foucault is careful not to state that he has captured madness 'as it is', outside the different perceptions of it. Madness is protean; it is formed anew every time it is examined. Foucault states:

> One simple truth about madness should never be overlooked. The consciousness of madness, in European culture at least, has never formed an obvious and monolithic fact, undergoing metamorphosis as a homogeneous ensemble. For the Western consciousness, madness has always welled up simultaneously at multiple points, forming a constellation that slowly shifts from one form to another, its face perhaps hiding an enigmatic truth. Meaning here is always fractured. (Foucault 2006, p. 163.)

There is perhaps an 'enigmatic truth', that is to say there may be some more or less solid essence of madness that is reflected in the European consciousness through the ages, as Foucault may be stating between the lines in this, his early work.

Even though Foucault is very careful not to state that he has encapsulated madness per se, as one of his main theses is that madness was silenced in the classical era and that this institutional silencing has persisted into our times as well, he surprisingly often still uses expressions in the *History of Madness* that refer to the 'essence' of madness or hint at some kind of hidden power that madness has. It is as if he still looks for some solid core of madness under the changing face of the 'social type' or construct. Perhaps it is a question of the capability of our times to encounter madness 'as it is', to take it in and deal with it at the level of reciprocity and equality. It is clear to Foucault that the modern science of madness (i.e. psychiatry and psychology) has silenced madness in its structures of silent observation, and it has continued to confine madness in its institutions. In his later work, he picks up this theme of institutions and the structures of power in the science of madness. Before delving deeper into this area, however, let us pause for a moment to consider the essence of madness Foucault continues to talk about in his *History of Madness*.

In the preface to the 1961 edition of his thesis, Foucault expresses, in perhaps the most manifest form, the belief that madness has a kind of power of its own. He refers to madness as a 'primitive purity', a 'wild state' that can 'never be reconstituted', and states that madness constituted the 'dark powers of the world' up until the Renaissance. (Foucault 2006, p. xxxiii.) In 1972, when the next edition was published, Foucault wrote a new preface to replace the older one, because he felt that the book and its preface had aged. Perhaps one of the reasons why he felt this way was his shifting focus in regarding the face of psychiatry vis-à-vis madness, which had changed remarkably over a period of ten years. In his thesis, Foucault describes the relationship between psychiatry and madness in the following manner:

> All that remains is the calm certainty that madness should be reduced to silence. It is an ambiguous form of consciousness, serene in the confidence that it is the keeper of the truth, but worried at recognising *the obscure power of madness*. Against reason, madness now seems disarmed, but in the struggle against order, and against all that reason can show of itself in the laws of men and things, *it reveals itself to have strange powers*. (Foucault 2006, pp. 165–166, my emphasis.)

Is there, or is there not, a solid core to the 'strange powers' of madness? Later on, Foucault refers to the 'truth of madness' (ibid., p. 173 and p. 238), 'the active force of unreason, the secret kernel of the classical experience of madness' (ibid., p. 207), and to 'the essence of madness' on a number of occasions (ibid., p. 243, 252, 339). This seems to be the underlying current of thought under the surface of the idea of madness as a social construct. This current was to change in a drastic manner in the years between the *History of Madness* and the lectures on *Psychiatric Power* in 1973–1974. The two works appear as both a continuum (*History of Madness* breaks off historically where *Psychiatric Power* starts: from the beginning of the proto-psychiatric era) and a shift of focus, as the *Psychiatric Power* seeks to comment on, criticise and write anew certain main points of the *History of Madness*.

Before I tackle the *Psychiatric Power* lectures, let me briefly examine Jacques Derrida's criticism of Foucault's reading of the Cartesian cogito in his *History of Madness*. This dispute is a famous example of the criticism Foucault faced because of his notions of madness. (I will also be referring to this dispute later, in Chapter 5 in my analysis of *Pale Fire*.)

2.2.1.2 Descartes' Cogito, Foucault and Derrida

In the wake of Foucault's thesis, a heated discussion broke out between Jacques Derrida and Foucault on Foucault's reading of Descartes' cogito. This discussion centred on the position and meaning given to madness in Descartes' method of doubt. Here I will outline Rosi Braidotti's analysis and give a brief description of this discussion between two of the most prominent French philosophers of the 20th century.

Braidotti places Foucault's reading of the cogito at the centre of his 'archaeological' phase. She claims that the archaeological project of analysing the birth and legitimation of scientific discourses, which Foucault also pursues in his thesis, is based on his criticism of the Cartesian subject's unity. (Braidotti 1993, p. 35.) In the place of this unified subject, Foucault proposes a shattered subject and a disjointed epistemology. Foucault also claims that reason is a historical construct, because philosophy is necessarily *the history of philosophy* and one cannot sever reason from history. Reason has been moulded by the materials and theoretical tools with which it operates. (ibid.)

In his reading of Descartes's cogito, Foucault stresses the significance of the strategic position of the cogito in its role in geometrically conceptualising mental space.

The Cartesian method is above all a method of building a wall between reason and the chaos that surrounds it; the building of this wall is the duty of a subject in his pursuit of scientific order. (ibid., p. 37.) In Foucault's opinion, the cogito concerns the warfare between reason and its adversaries. In his dualistic model which divides mind from matter, Descartes also defines the cogito as a bearer of reason, which represents God through its metaphysical inheritance. In his reading of Descartes, Foucault places the gap between Reason and its Others at the centre of the method of doubt; and Foucault sees that the Reason's Other is embodied in madness. The method of doubt is in Foucault's eyes a tactic or discursive tool with which the cogito can exorcise all that could threaten reason and its certainty, namely dreams, errors, perceptions and madness, in essence, all reason's Others. (ibid., p. 38.) Descartes' choice here is to defend reason by building, through the cogito, a scientific system in which the programme of reason is realised with a severe hand; it attempts to control and isolate all choices deemed dangerous (ibid., p. 39). This means the exclusion of madness and all unreason from reason, which is the philosophical counterpart of the physical exclusion-by-inclusion of the classical confinement of unreason. Rational philosophy is created *inside denial and through denial*; exclusion is necessary for the cogito to function. (ibid., p.40.)

Foucault notes that Descartes gives a different meaning to madness from that which he gives to other examples of Reason's Others – error, dreams and imagination:

> Madness is an altogether different affair. If its dangers compromise neither the enterprise nor the essential truth that is found, this is not because *this thing,* even in the thoughts of a madman, cannot be untrue, but rather because *I,* when I think, cannot be considered insane. [...] It is not the permanence of truth that ensures that thought is not madness, in the way that it freed it from an error of perception or a dream; it is an impossibility of being mad which is inherent in the thinking subject rather than the object of his thoughts. If one admits the possibility that one might be dreaming, and one identifies with that dreaming subject to find 'some grounds for doubt', truth still appears, as one of the conditions of possibility for the dream. By contrast, one cannot suppose that one is mad, even in thought, for madness is precisely a condition of impossibility for thought: 'I would be thought equally mad.' (Foucault 2006, p. 45.)

Thus, the doubting subject completely excludes madness from the area of thinking. Madness can only be cast out of the classical system of reason, but in this move,

classical reason is dependent on the existence of madness as an Other. (Braidotti 1993, p. 41.) This closure of the space of reason makes it possible for the subject to be a thinking subject. The cogito, together with the classical confinement of the mad, brought about the correspondence between the category of 'mad' and everything that threatened the discursive and material order that was deemed correct. This exclusion was essential to justify the certainty of reason, but because the exclusion is structural, thinking is also based on the mechanism of exclusion. The silencing of the other makes it possible for the subject to speak. (Braidotti 1993, pp. 42–43.)

Jacques Derrida refutes and criticises Foucault's reading of Descartes' cogito step by step. To sum it up, Braidotti formulates Derrida's counterargument as follows: 1) Derrida opposes vehemently all such claims that attempt to define Western reason through the exclusion of madness: he refutes the claim that the exclusion of unreason could be presented as the precondition for justifying reason; 2) If the research takes as its presupposition the claim that there is nothing else but the history of reason, is it even possible to produce history that would not repeat the original violence of exclusion (like Foucault, in Derrida's viewpoint, sets out to do in his thesis)? 3) Derrida's argument rests on the belief that unreason is always condemned *inside* the area of reason; 4) Derrida claims that Descartes' cogito is both a pedagogical and juridical manoeuvre in which he excludes madness *de facto*, not *de jure*, which would mean that madness is a kind of ground zero that defines the history of meaning as a some kind of leftover that is pointed at nothingness or infinity; 5) in Descartes' cogito, dreams and madness are not 'conquered' by reason, and madness is only one way of shaking the foundations of reason; 6) the division between reason and unreason, logos and madness, is all about the structure of *différance*, which is not based on exclusion or denial, but recognition: philosophy is a (recognised) fear of madness. (Braidotti 1993, p. 44–45.)

Foucault responded to Derrida's challenge in the epilogue of his thesis' second edition (1972). He defends his prior position that the cogito is more like a pedagogical exercise than a juridical text, and that it is aimed at justifying a certain philosophical view. The discussion between the two philosophers is very detailed and I will not go too deeply into the details, but aim to give a brief summary of the disagreement (as seen by Braidotti).

Derrida places to the fore the possibility of undoing the relationship between reason and history. Foucault then wants to concentrate on the truth value of theoretical claims and their consequences: normativity and exclusion. Foucault stresses the exclusion of all unreason as the origin of subject; but Derrida then thinks it is

all about an illusory, but phallogocentric, belief in full presence. Foucault's central methodological interest lies in the analysis of exclusion, whereas Derrida develops the hypothesis that such thinking would respect the principle of non-uniformity and non-presence. (Braidotti 1993, p. 47–48.) For Derrida, philosophy is a branch of the science of thinking which, as the only truly democratic school, forms a real threat to bureaucratic public order. For Foucault, philosophy must be open towards modern society, it must be placed under new challenges, and this includes the criticism of power inside different branches of science and institutions that are embodiments of power, such as universities. Both Foucault and Derrida stress the problematic of exclusion and negation in which the role of cogito is central. Derrida places the war *inside* discourse, where violence is defined as the presence of the unsaid and silent inside the core of the said, whereas Foucault sees that the bonds of discourse and warfare join in the body, which is completely politicised. It is about power: philosophical texts are formed by power structures in which knowledge means the formulation of new norms. In this situation, philosophy cannot be struggle *for the truth*, but struggle *for the status of truth*. From this, it follows that the political duty of an intellectual or a philosopher is to be critical. (Braidotti 1993, pp. 54–56.)

Foucault's system of thought could be (and was) attacked by different kinds of philosophical thinking. However, the two philosophers, while quarrelling, showed together that the meaning of madness is central to their structures of ideas. As its Other, madness plays a definite role in shaping Western reason, whether from outside or inside, or from a textual or political basis.

Now, let us proceed with Foucault's project.

2.2.1.3 Psychiatric Power

In the *Psychiatric Power* lectures, Foucault himself criticises the starting points of the *History of Madness* in the following manner:

> First of all, I think it was still an analysis of representations. It seems to me that, above all, I was trying to study the image of madness produced in the seventeenth and eighteenth centuries, the fear it aroused, and the knowledge formed in reference to it, either traditionally, or according to botanical, naturalistic, and medical models, etcetera. It was this core of representations, of both traditional and non-traditional images, fantasies, and knowledge, this kind of core of representa-

> tions that I situated as the point of departure, as the site of origin of the practices concerning madness that managed to establish themselves in the seventeenth and eighteenth centuries. In short, I accorded a privileged role to what could be called the perception of madness. (Foucault 2006b pp. 12–13.)

Foucault here announces his own doubt of the viewpoint in his thesis, that it is futile to try to capture madness or its representation. He says:

> Here, in this second volume, I would like to see if it is possible to make a radically different analysis and if, instead of starting from the analysis of this kind of representational core, which inevitably refers to a history of mentalities, of thought, we could start from an apparatus (dispositif) of power. That is to say, to what extent can an apparatus of power produce statements, discourses and, consequently, all the forms of representation that may then derive from it. (Foucault 2006b, p. 13.)

Foucault's aim in the lectures is to study the apparatus of power that creates the representations, not just the representations themselves that are the end product of the functioning of this apparatus of power. This viewpoint is dramatically different. The lectures on psychiatric power centre on precisely this: the power structures of clinical psychiatric practices. Madness as such is presented only as an opposing force to these practices. Foucault regards the psychiatric power relations as a 'battle, a relationship of force', (ibid., p. 10) where psychiatry tries to contain and control the anarchical force of madness.

In his first lecture, he summarises the content of the lectures by condensing them into five points of departure: 1) the therapeutic operation takes place outside of nosographies or medical diagnosis and does not require any medical knowledge to be successful; 2) instead of applying technical medical formula to something seen as a pathological process of behaviour, what takes place is a battle of wills, a relationship of force; 3) this first relationship of force produces a second relationship of force inside the patient. A struggle takes place within the patient between the fixed idea to which the patient is attached and the fear of punishment, and if there is to be success or cure, there must be a victory in both struggles, that between the doctor and the patient, and that between the two conflicting ideas inside the patient; 4) what is important in this scene is that there is a moment when truth comes out, i.e. when the patient recognises that her mad beliefs are erroneous and delirious, and

when she confesses her experience of hesitation or torment etc. This is the moment when truth comes forth, the truth that was hitherto absent from the process of curing the patient; 5) the process of the cure is effectuated when the truth has been acquired through the patient's confession, not through piecing together medical knowledge. (Foucault 2006b, pp. 10–11.) It is remarkable that Foucault divests the psychiatric practice almost if not completely of the status of medical knowledge: 'curing' the patient is about winning a struggle, and securing a 'truth' that is not a truth of a medical nature but a truth and recognition of the stronger power of the psychiatrist's perspective over the erroneousness of the patient's belief.

In Foucault's thesis he traced, together with the forms of classical ways of coping with madness, the many contours of madness in all its multiform nature. What is significant in the context of this study is that, in comparison to his thesis, Foucault's focus is on the side of psychiatry as a power structure that regards madness as a seemingly uniform force whose only characteristic is that it opposes psychiatric power. This may be only a mirage caused by the different perspective and emphasis put on the side of psychiatry as a phenomenon. Regardless, it is in marked contrast to his earlier work, which concentrated on the many faces of madness.

2.2.1.4 To Sum Up

Compared to the psycho-scientific approach outlined earlier, Foucault presents the face of psychiatric diagnostics in an entirely different manner. For Foucault, the clinical diagnostic move is a move of societal power, of silencing and exclusion by inclusion. Foucault stresses the power aspect of the diagnostic move. The move is not defendable by science and (universalising) nosologies; it should be seen in its essence of battle. Madness is a social construct, a notional tool of control. There may be a core essence in madness, something 'wild' or 'powerful', but still protean, ever changing. Alternatively, madness is just an opposing force for psychiatric power – what remains is that there are two forces, madness and psychiatry, which are locked in endless struggle. I do not, however, wish to commit myself completely to Foucauldian theories; I only aim to juxtapose them against the psycho-scientific approach. What interests me is their tension, not whether one or the other is the 'right' or even 'more in the right'. As will be seen in Chapter 4, the target texts can be brought into the power field of debate between psycho-sciences and their Foucauldian and anti-psychiatric counter-forces; it is this debate and power field that I find interesting.

Even though Foucault did not regard himself as an anti-psychiatrist, his oeuvre did inspire the anti-psychiatric movement. Foucault himself gets a very critical hearing from some of his critics, such as Sengoopta: his flaws, historical and philosophical, 'were legion'; his work was not a work of history, but a philosopher's abstract analysis of 'how psychiatry *might* have evolved' (Sengoopta 1999, p. 248). Sengoopta refers to the studies of Roy Porter who maintains that, for example, at least in British context, the supposition of a general confinement of the motley group of 'unreason' is not defendable (see also Fabrega 1991). Pietikäinen (2013) also follows Porter in his criticism of Foucault for basing his analysis on the historically supposed 'great confinement'; that it did not happen in Europe or even in France in quite the way Foucault claims, which Pietikäinen considers a major flaw in Foucault's work (Pietikäinen 2013, pp. 139–144). I have no competence to analyse the historical value of Foucault's work, I only can note that it is far from uncontroversial. As stated, my own stance is one of juxtaposition: I pit Foucault and other critics of psychiatry against the establishment and analyse the ways my different target texts use these various theories of madness, and I examine how these theories can be made to reverberate with my target texts' interpretations. Sengoopta does, however, give Foucault some credit as an agent for opening up the discussion, and notes the influences Foucault has had on the anti-psychiatric movement:

> [*History of Madness*] was written during the 1960s, when psychiatry was demonised as an oppressive force in modern society[...]. For the intellectual radicals of that era, mental illness was a category invented to imprison the human spirit; Foucault's work resonated well with such sentiments. Laing and the British anti-psychiatric movement, expectedly enough, held *Madness and Civilization* [the alternative abridged name of the English translation of the *History of Madness*] in high esteem [...] and ever more marginal countercultural voices tried to speak in Foucault's voice. Madness, it seemed, could be written out of existence by a radical Parisian philosopher. Whether the anti-psychiatric movement and its countercultural associates understood Foucault correctly or not, critics of anti-psychiatry ever since have considered him, perhaps unfairly, to be one of its spiritual mentors. (Sengoopta 1999, p. 248.)

Pietikäinen, too, sees the importance of Foucault's work in the challenge it poses to the study of psychiatry and its history: when one sets aside Foucault's (in Pietikäinen's terms, my translation) 'wrong timing, overextending universalism, and

exaggerated or simply wrong arguments' one can start to ask whether one's historical data confirms the Foucauldian patterns and logics of confinement, of the silencing of the mad and so forth (Pietikäinen 2013, p. 142).

2.2.2 Criticising Psychiatry: R.D. Laing and Thomas Szasz

I next offer a sketch of the main theoretical works of the very fragmented political-cultural movement against psychiatry. Critics of psychiatry are as heterogeneous as the frontline of the psycho-sciences. Together with Foucault above, I have chosen only two thinkers, but two of the most prominent: the British leftist R.D. Laing (who was more or less directly influenced by Foucault), and the American libertarian, Thomas Szasz, both of whom develop ideas that perceive madness essentially as a social construct rather than a universalisable, categorisable, stable psychic dysfunction that should be treated and perceived psychiatrically.

2.2.2.1 R.D. Laing and the Understanding of Schizophrenia

R.D. Laing's main work was in making schizophrenia and psychosis understandable. In his influential book, often regarded as his masterpiece, *The Divided Self* (first published in 1959), his central argument is that schizophrenia and the schizoid condition can and must be *understood* as existential states, not *explained* in a scientific, psychiatric, objectifying manner. Laing's thought is most influenced by philosophers such as Heidegger and Sartre. He replaces the mainstream psychiatric method with existential analysis of the schizophrenic condition, and thus tries to shed light on the phenomenon and make it understandable in the new context of the patient's existential status and family relations (this line of thought is developed in Laing and A. Esterson's book *Sanity, Madness and the Family*, first published in 1964; I will return to this work below). Laing departs from clinical and theoretical psychiatry by criticising their way of using language and theoretical terms which, in his opinion, 'split man up verbally in a way which is analogous to the existential splits' (Laing 1990, p. 19) which he describes in his work. The existential splits Laing refers to comprise the central phenomenon of the schizoid condition, which can deteriorate into full psychosis. Laing refers to this condition as a state of 'ontological insecurity' in which the borders of the person's mind and body are fragile

and easily violated. This is opposed to the sane and healthy 'ontological security', in which the person is strong enough to maintain her personality borders without the fear of being 'engulfed' by others when she comes into contact with them. The ontological insecurity as Laing sees the matter leads to a state in which the person splits her being into an 'outer sphere', that is mainly the body and the appearance others can see, and an 'inner, true self' which she tries to defend with the mind-body split. This is a very painful and precarious mental configuration that the person herself would like to abandon but cannot. (Laing 1990, p. 161.) Understanding this mind-body dualism in the schizoid condition, says Laing, makes the phenomenon of schizophrenia comprehensible (Laing 1990, p. 162).

What is curious in this is that Laing sees a strong resemblance between the Western philosophical and psychiatric way of splitting the person into a dualistic mind-body on one hand, and the psychopathological, schizoid splitting. He targets philosophical and psychiatric language and terminology: 'The thought is the language' he says, like Wittgenstein, and claims that psychiatric terminology is infested with the mind-body dualism that makes the patient's condition abstract, either by referring to the patient in isolation from the other people and the world, or by referring to falsely substantialised aspects of this isolated entity; it is this terminology that hinders the true, existential analysis of the patient's condition (Laing 1990, p. 19). Laing therefore sees a continuum between the psychopathological condition of schizophrenia and philosophical thinking from the times of Descartes onwards (Miller 2004, p. 69). Thus, the conception of the essence or nature of madness, as Laing sees it, is an exaggerated version of the basic dualistic stream of thought in the Western tradition. The essential difference between schizoid mind-body dualism and that of philosophical thinking is that the schizoid lives through and believes firmly in this dualism, whereas the philosophical thinking about the same dualism is only a stratagem to explain away certain aspects of philosophical thinking which seem unintelligible to most of us.

How should one define psychosis then, if the normative psychiatric and philosophical language and theories that are used to define madness themselves include the same pattern of thought manifested in the schizoid and schizophrenic condition? Laing resorts to an existential and interpersonal definition of psychosis:

> I have no difficulty in regarding another person as psychotic, if for instance:
>
> he says he is Napoleon, whereas I say he is not;

> *or if* he says I am Napoleon, whereas I say I am not;
>
> *or if* he thinks that I wish to seduce him, whereas I think that I have given no grounds in actuality for supporting that such is my intention;
>
> *or if* he thinks that I am afraid he will murder me, whereas I am not afraid of this, and have given him no reason to think that I am.
>
> I suggest, therefore, that sanity or psychosis is tested by degree of conjunction or disjunction between two persons where the one is sane by common consent. The critical test of whether or not a patient is psychotic is a lack of congruity, an incongruity, a clash, between him and me. The 'psychotic' is the name we have for the other person in a disjunctive relationship of a particular kind. It is only because of this interpersonal disjunction that we start to examine his urine, and look for anomalies in the graphs of the electrical activity of his brain. (Laing 1990, p. 36.)

This perception of psychosis and the diagnostic moment that forms it is essentially different from those propagated by biological psychiatry that seeks 'extra-personal', 'objective' and 'scientific' explanations and definitions for mental illnesses. Laing's definition of psychosis is one way of finding an outlet from the impasse of the failure of biological objective tests for mental illness: in his perception, madness is formed between persons in social interaction that, however, assumes certain basic necessities of both madness and sanity. Madness is, nonetheless and *more than anything else*, a social construct, an agreement between those who see themselves as sufficiently sane to be able to detect madness in others. Clearly, this can be posed against the mainstream psychiatric notion of 'biological objectivity'. It is, however, a rather disconcerting outlet because there is no way of firmly and objectively establishing the mental sanity of the investigator of mental illness, which is the prerequisite for establishing the madness of the investigated. 'By common consent' is the only guarantee for the investigator, but how many people are required in order the 'consent' to be 'common'; and how are these people selected? Laing does not answer these questions. The diagnostic moment, as delimited by Laing, is therefore on as at least as shaky ground as the psychiatric diagnostic moves (the urine samples and EEG) he criticises.

One way Laing proceeds to unravel the enigma of how and why mental illness erupts in certain persons is by placing the patient in her social and interpersonal

context – her family. This investigation is conducted in Laing and Esterson's study, *Sanity, Madness and the Family*, in which a selected group of female schizophrenic patients is interviewed about, and with, their family members. The study does not claim to be a comprehensive study of how schizophrenia develops in all patients, but wishes to elucidate only the specific situations the patients have in their nearest social relationships that Laing and Esterson see as 'schizophrenogenic'. (The term defined already in Laing 1990, p. 190.) What is repeated time and time again in Laing and Esterson's study is the way the families of the schizophrenic women place them in situations in which it is virtually impossible for them to cope with the contradictory demands, innuendoes and desires the family members communicate to them in different ways. The patients cannot make sense of their surroundings, not because of some kind of illness they have (i.e. schizophrenia) but because the surroundings would simply be incomprehensible to anyone. For example, a patient called Sarah was caught in a serious social double bind, (i.e. a situation in which the patient is placed under contradictory demands), in which she could not avoid being treated in hospital, no matter what she did or how she behaved:

> Her dilemma [...] appeared to be that if she talked about what she thought, she would have to remain in the hospital, and if she remained silent her family would have to see this as deception, and would demand of the doctor that she be detained and 'treated' until she had the 'right' ideas. If she tried to impose the 'right' ideas on herself, then in a sense she would be killing herself. But even this would not save her from mental hospital, and from being cut off from her family, because then she would be 'dead', 'a shadow of herself', 'personalityless', to use her brothers description, and so would still need 'treatment'. (Laing & Esterson 1990, pp. 124–125.)

The social double bind is a notion of social construction: social double binds reveal social agreements of those around the mad person who decide among themselves what is seen as madness and what is not. The women Laing and Esterson describe are seen to disintegrate in front of the impossible demands they are placed under, and all the time Laing and Esterson insist on the intelligibility of this disintegration from the viewpoint of the impossible family circumstances. Laing and Esterson sum up their criticism of mainstream psychiatric theories and clinical methods by wondering: 'We have clinical terms for disturbed, but not for *disturbing* persons' (Laing & Esterson 1990, p. 149). When much of the clinical 'data' the diagnostic

move requires as its justification is explained by the family dynamisms of the patient's social surroundings (e.g. the 'disturbing parents'), they claim it is truly surprising that this side of the phenomenon is largely omitted from the mainstream psychiatric account of schizophrenia.

What makes Laing's contribution to the understanding of psychosis and schizophrenia compromised, in many people's eyes, are his later, exaggerated views about drug use, controversial therapies and the apology of schizophrenia. Miller writes:

> [T]his was the period [from 1964 to 1969] in which Laing assumed too readily that all psychotic breakdowns could involve a process of spiritual rebirth. This obsession with birth and rebirth intensified in the later period where Laing developed various extraordinary hypotheses on how uterine experience could affect the course of one's entire life. (Miller 2004, p. 131.)

Laing succumbed to extremes in his later life, fostering extraordinary views about psychiatric phenomena, but his position on schizophrenia tried to accomplish what was, and often still is, thought impossible: understanding something as opaque as the schizophrenic condition. Even though Laing professes to analyse and understand schizophrenia as an existential condition and an alternative way of experiencing the world, he does not claim to know his subject thoroughly: there is always something inexplicable in psychosis.

> When someone says he is an unreal man or that he is dead, in all seriousness, expressing in radical terms the stark truth of his existence as he experiences it, that is – insanity. What is required of us? Understand him? The kernel of the schizophrenic's experience of himself must remain incomprehensible to us. As long as we are sane and he is insane, it will remain so. But comprehension as an effort to reach and grasp him, while remaining within our own world and judging him by our own categories whereby he inevitably falls short, is not what the schizophrenic either wants or requires. We have to recognize all the time his distinctiveness and differentness, his separateness and loneliness and despair. (Laing 1990, p. 38.)

This epigraph should remind us of the difficulties we must face when encountering psychosis, the most severe form of madness.

2.2.2.2 Thomas S. Szasz and Critical Psychiatry

The work of Thomas S. Szasz[7] offers a completely different viewpoint from that of Laing's into the enigma of madness, yet it is still a parallel one for its criticism of mainstream psychiatry. One of his most influential works is *The Myth of Mental Illness* (first published in 1962), in which he studies madness through one of its examples, hysteria, focusing on its nature as a kind of language and role and rule game. His starting point is that the concept of 'illness' can only refer to bodily illness; 'mental illness' is only a myth, or, at best, a metaphorically true concept:

> [B]ut only when we call minds 'sick' do we systematically mistake metaphor for fact; and send for a doctor to 'cure' the 'illness'. It's as if a television viewer were to send for a TV repairman because he disapproves of the programme he is watching. (Szasz 1975, p. 11.)

One of Szasz's and Laing's main differences lies in their different political viewpoints. Szasz is a right-wing libertarian for whom the rights of the individual form the most important ethical value base. Laing, on the other hand, is more of a leftist thinker, the community is more his focus when talking about mental illness and methods of cure. Szasz's focus is also different from that of Laing's in that he does not try to understand madness by using an existential framework; instead he puts the phenomenon of madness into the framework of language and role and rule games. Another pivotal idea for Szasz is that 'mentally ill' people feign illness (that is, demand that their mental difficulties, or 'problems of living', as Szasz puts it, are regarded as proper illnesses in the vein of bodily ailments) to be able to receive care and treatment from their communities. Doctors also play this game in order to secure their professional basis and income.

Szasz uses hysteria as his main example of mental illness because it is a meeting point between the mental and physical, but he maintains that what he says about hysteria is true for other mental illnesses as well. He sums up his main argument:

> [C]onversion hysteria provides an excellent example of how so-called mental illness can best be conceptualized in terms of sign-using, rule-following, and game-playing, because (1) Hysteria is a form of non-verbal communication, making use of

7. Szasz's oeuvre is substantial, and I have chosen only one book featuring his critique of defining madness as a mental illness because this work has been seen as one of his most influential – and because it gives us his definition of madness – the central issue of this chapter.

> a special set of signs. (2) It is a system of rule-following behaviour, making special use of the rules of helplessness, illness, and coercion. (3) It is a game characterised by, among other things, the end-goals of domination and interpersonal control and strategies of deceit. (Szasz 1975, p. 25.)

If mental illness is seen as a language rather than a disease, it becomes ridiculous to talk about the 'causes' of mental illness or its 'cures', because a language does not have a cause or a cure (Szasz 1975, p. 28). Szasz builds his theory of mental illness as a language and role game on the assumption that the phenomenon of mental illness becomes understandable as a game among other communicational games that a human being plays during his life (Szasz 1975, p. 30–31).

'Mentally ill' people are thus only playing a game or using a language (which are almost the same thing for Szasz) that others do not fully recognise or master, making the clinical diagnostic moment very significantly different from the psycho-scientific, or even Laingian perception. As with Foucault, there seems to be a power struggle, but the winners in the Szaszian model are the 'mad'. Their behaviour is as goal-directed as other (sane) people's, and their goals can be grasped. Thus, mental illness can be understood; it is not a complete mystery. This is the main similarity between Laing and Szasz, the notion that mental illness can be understood; only their respective notions of this understanding are quite different. This can be best seen in Szasz's argument that mentally ill people seek gains in playing their 'sickness game'. Among these gains are, for example, 'certain comforts and gratifications lacking in their ordinary social environment' (Szasz 1975, p. 40). The basic way that the hysterics seek to attain their goals is by forcing the other (therapist, husband etc.) to react in a certain way, or in any way, by using the mightiest weapons they possess: the hysteric 'illness' that simulates bodily illness, and its discomforting symptoms that coerce the other to react (Szasz 1975, p. 141). This viewpoint of 'mental illness' definitely lacks what Laing emphasised: attuning to the suffering of the 'mentally ill'.

Why is this game so successful, then? What makes the others, the sane, conform to the game of 'insanity'? Szasz formulates the basis of this game by drawing parallels between the status of the 'sick' to that of the child in relation to her caretakers, or Christians in relation to their God. Western society encourages adults to behave like children because the human child is so completely dependent of her caretakers in order to survive, and this influences the child's later behaviour. It is also because of the 'complicated patterns of paired activities characterised by the helplessness of one member and the helpfulness of the other' (Szasz 1975, p. 30). Szasz also

formulates that the Christian religion, by emphasising meekness, subservience and humility as values of behaviour, creates similar patterns of helplessness in Western societies (Szasz 1975, pp. 177–178). Thus, Szasz claims, the game of 'mental illness' is wrought with false and ethically suspicious aspects (from the viewpoint of his libertarian values): the values of the 'helplessness game' are encouraged by our education and child-rearing methods; the mental 'patient', while playing this game, lies about her 'illness', it is not a mistake, but a lie that is goal-directed and used as a weapon in a social game (Szasz 1975, p. 136). For Szasz, madness, for sure, is not 'a universally existing psychic dysfunction causing distress for the mad', but a willing deception *by* the 'mad', a kind of social-construct-conspiracy at the moment of the alleged or pretended diagnosis: it is a successful large scale deception that leads to the suffering of the coerced party, the sane. The 'mad' decide that they are 'mad' and make others play along.

Szasz targets mainstream psychiatry, like Laing, but with different ammunition: while Laing emphasises the harmfulness of 'scientific' and 'objective' psychiatry which clouds the true, existential condition of schizophrenia, Szasz puts more weight on the harmfulness to individual rights caused by psychiatric labelling and the 'sickness game' it encourages. He writes: 'In short, while medical diagnoses are the names of genuine diseases, psychiatric diagnoses are stigmatizing labels. [. . .M]ental illness is a myth, psychiatric intervention is a type of social action, and involuntary psychiatric therapy is not treatment but torture.' (Szasz 1975, p. 12.) Szasz does here recognise the suffering of those diagnosed mentally ill, those 'tortured' and 'labelled' by clinical psychiatry, but in a context that is dramatically different from that of Laing's: the self-reliance of an individual is the most precious concept to Szasz, the individual must learn to stand alone as a responsible adult. Szasz sums up his ethics and his criticism of psychiatry:

> Similarly, much of what passes for 'medical ethics' is a set of paternalistic rules the net effect of which is the persistent infantilization and domination of the patient by the physician. A shift towards greater dignity, freedom, and self-responsibility for the disenfranchised – whether slave, sinner or patient – can be secured only at the cost of honest and serious commitment to an ethic of autonomy and egality. This implies that all persons are treated with respect, consideration, and dignity. While accorded the opportunities for more decent human relationships, the formerly disenfranchised must, at the same time, be expected to shoulder certain

responsibilities, among them the responsibility to be maximally self-reliant and responsible even when ill or disabled. (Szasz 1975, p. 174.)

Gavin Miller points out the danger in Szasz's position, his 'almost inhuman libertarianism' (Miller 2004, p. 122) as he puts it, when Szasz takes his insistence on the intentionality of the 'mentally ill' to its extreme. Miller writes:

> Yet, given the enormous disadvantages which surround those who are 'mentally ill,' one really has to wonder about this supposed forgery of signs and symptoms by the mentally ill. It seems far more likely that the 'mentally ill' lack self-understanding – something even Szasz must suppose, if their dissimulation is 'unconscious.' And without self-understanding, it is hard to see how anyone can choose in their own interest. (Miller 2004, p. 123.)

This lack of self-understanding, as Miller claims, means that the patient has limited responsibility 'precisely because they cannot properly represent to themselves their own motives and experiences'. The lack of self-understanding also is the central reason why others find the patient unintelligible, and it is the psychiatrist's task, as Laing argued, to assist in the patient's self-interpretation. (ibid.)

2.2.2.3 To Sum Up

One needs to assess the relevance of the critics of psychiatry in understanding madness. Both Szasz and Laing aim to understand madness from a viewpoint that was formerly unknown to mainstream psychiatry, thus contesting the psychiatric perception on and treatment of madness.[8] They cast the mental patient as an intentional agent, whose reactions are comprehensible when put into their context, and not just as presentation of 'symptoms' of a 'mental illness' or 'dysfunction' but as a part of social and societal power patterns that form the category of madness in the first place. There are certain limitations, however; in Laing's case, he does not offer a comprehensive study of even one, though very central, disease. His study does not satisfy the needs of an 'objective' or 'scientific' clinical survey, but aims to

8. A more recent contribution to the discussion on the understandability of madness – and particularly certain forms of schizophrenia – that could be placed into continuum of anti-psychiatric (Laingian) thinking is Louis A. Sass's work *Madness and Modernity* (1998). Sass aims at a rather similar kind of existential understanding of schizophrenia as Laing, without Laing's later extravagant agendas.

highlight certain aspects of the particular disease he handles. This is not necessarily a problem, as he himself states in the preface to *The Divided Self*, because he aims at the elucidation of an existential status, not a comprehensive theory of the causes and effects of all types of schizophrenia (which in itself is an enormously varied phenomenon). However, the handicap is still there: he does not cast light on anything else that could be amassed under the heading of 'mental illness.' He did open a path, though, a philosophical and theoretical opportunity to try to existentially comprehend other forms of mental illness as well.

Szasz's study also opens up opportunities for understanding all kinds of mental problems from the viewpoint of intentional language/role/rule game-playing. However, his insistence on the absolute value of illness to its sufferer does seem, both to Miller and me, an exaggerated viewpoint, much in the same way as Laing's views about the significance of the uterine experience.

Laing and Szasz tried to challenge the prevailing psychiatric elite. Their work did encourage the civil rights movements of mental patients; for example, the use of electric shock treatment and lobotomy were almost if not totally discontinued (at least for a while) because of the increased awareness of their possible harmful effects on the patients' mental health and quality of life; and when the use of electric shock treatment was resumed later, it was modified considerably to take notice of the lessons learned from the anti-psychiatric movement and its opposition to the treatment.

What both men share is the conviction that madness is some kind of changing social construct, rather than an unchanging, universal, natural disease entity. In Laing's studies, the 'illness' of his schizophrenics permutate according to the family situations that engender the 'symptoms'. In Szasz's work, hysterical patients choose to use a form of language or game that has nothing to do with stable, somatic illnesses. Both are positioned against mainstream psychiatry. However, they may disagree even more in their understanding of madness: for Szasz, it is deception through and through; for Laing it is deep, real suffering. Laing is thus closer to mainstream psycho-science in seeing that the patients truly have something to complain about – the *raison d'être* of psycho-sciences – and he was himself a practicing psychiatrist (only a very original one, especially in his later years). Their perceptions of the diagnostic move were also different: for Szasz it is a moment of cheating and a power struggle between the deceiver (the 'mad') and the deceived (the sane). For Laing, the moment of diagnosis is a moment of social relationship and comparison between the sane and the mad. The sane person compares his sanity to the insanity of the mad person; it is only this comparison that grounds biological psychiatric testing.

Laing's common sense definition of psychosis is thus many notches closer to the mainstream psychiatric viewpoint, even when it is positioned against and aimed to ridicule scientific psychiatric practice. Laing never gives up his sympathy for the suffering of the psychotic patient; Szasz sees psychiatry as torture, but does not give up his thesis of madness-as-deception. This only heightens the fragmented nature of the critical psychiatry movement.

2.3 Coda: Horwitz's Criticism of Psychiatry and Social Constructionism

Allan Horwitz makes a critical analysis of both currents of my frameworks: the psycho-sciences[9] (the continuum between dynamic and 'diagnostic', as he likes to call it, modern brain oriented psychiatry) and their counter-forces – the social constructionists. He considers that the disease definitions of both the psycho-sciences and the social constructionists are too inclusive; they lump together a wide array of phenomena that should be kept distinct. One camp claims that all these phenomena are mental disorders, the other camp claims that none are. (Horwitz 2003, p. 10.) Thus, even though in the above pages we have seen that the psycho-scientific camp has at least partly admitted the social constructionist side of mental disorders (of all diseases, somatic or mental), and the two definitions I gave in the introduction can be seen to lose some of their juxtaposition and distinctions, in Horwitz's eyes, there still is a contradiction and quarrel between the two camps of psycho-sciences and social constructionists on the issue of ontology of mental disorders.

One of Horwitz's central theses is that the notion of mental disorder has been expanded in an unwarranted manner, from dynamic psychiatry onwards, to include psychic states that do not have a real connection to genuine mental disorders that only should be called and treated as such. Horwitz uses a three-fold definition of the area of mental problems treated by psychiatry (thus differentiating terms that I have used interchangeably): 1) *mental diseases*: 'conditions where symptoms indicate underlying internal dysfunctions, are distinct from other disease conditions, and have certain universal features'; 2) *mental disorders*: 'all mental diseases as well as psychological dysfunctions whose overt symptoms are shaped by cultural as well as

9. He does not use this term but makes a historical continuum between dynamic and diagnostic psychiatry in the way I do as well, which in my opinion warrants my using of my term in connection to Horwitz's analyses.

natural processes'; and 3) *mental illnesses*: 'whatever conditions a particular group defines as such'. (Horwitz 2003, p. 15.) The psychoses belong to the first category, being the only group of diseases that clearly has a universal component, symptoms that are comparable across time and space (Horwitz 2003, p. 13). Mental disorders in his categorisation are a group that, apart from psychoses, shows greater variation in symptoms and course of illness – indicating that the symptoms reflect underlying psychological vulnerabilities rather than universal distinct causes: 'their symptoms are often products of particular cultural contexts rather than invariant reflections of disease entities' (Horwitz 2003, p. 14.) These disorders vary from time to time. Horwitz claims that, for example, hysteria, now almost extinct, and the late newcomer, anorexia, are just such disorders indicating the same general vulnerability. Horwitz wants to exclude social deviance from the group of real mental disorders, as well as those conditions that are normal reactions to stress which abate even without psychiatric treatment after the stressor has vanished. Both groups are treated as mental illnesses by DSM psychiatry even against the manual's own stated criteria of mental disorder. (As stated above, the DSM tries to exclude in its own definition of disorder expectable reactions to external causes of mental distress – like depression after bereavement – and plain social deviance.) He stresses that these two phenomena, stressor-caused reaction and social deviance, are not genuine dysfunctions and should not be treated as such. He thus vehemently opposes the diagnostic psychiatry which in his opinion pathologises perfectly normal phenomena (as an inheritance from dynamic psychiatry).

Horwitz opposes pure social constructionist theory as well. He sees three major problems with it: 1) 'pure constructionist premises preclude the possibility of defining mental illness in ways that are independent of any particular social context'. They cannot explain or include in their theoretical framework the possibility of biological factors limiting social variations in the construction of mental symptoms; 2) they are unable 'to develop standards for comparing divergent views of mental illness'. Comparison is possible only if something constant serves as a point of reference to observe variation; 3) they cannot offer tools for 'critiquing any particular view of mental disorder'. (Horwitz 2003, p. 9.) Therefore, Horwitz finds himself opposing the extremes of both frameworks.

He gives his own definition of a valid mental disorder (which he borrows from J.C. Wakefield): 'some internal psychological system is unable to function as it is designed to function and [...] this dysfunction is defined inappropriate in a particular social context' (Horwitz 2003, p. 11). Thus, in his own definition of mental disorder,

he does offer a hybrid of diagnostic psychiatry and social construct theory; mental disorders meet in the middle and have components of both the psycho-sciences and their counter-forces. He presents the opportunity to see that the general, universal vulnerability – the 'dysfunction' causing non-psychotic mental disorders – is shaped by cultural factors; the dysfunction is 'defined inappropriate in a particular social context'.

Certain questions arise though when one considers Horwitz's premises: why cannot a disorder be considered proper even when it is caused by stressors, by external forces shaping the psyche? Like Kirk and Kutchins above, I regard even an externally caused mental disorder to be a disorder: a child may develop 'real' depression because she is being sexually abused – and this depression, even if it has elements of 'normal' reactions to the stressful situation (causing such widespread phenomena as sleeplessness, sadness, fatigue etc.), is still a 'real' disorder. The distress is real and it can be meaningfully and effectively treated by psychiatric techniques. In addition, how can Horwitz so vehemently propagate the distinction between social causation (social stress) and internal dysfunction when in most cases the exact causation of mental disorders (be it psychological, social or biological) is far from clear and established? He states: 'Much distress emerges from factors that are neither aspects of particular individuals nor universal properties [like the internal dysfunction] but elements of social environments' (Horwitz 2003, p. 160). I would say that even though Horwitz's criticism of social constructionist theory and psychiatry is at least partly well grounded, his own argument on the distinction between internal and external causes of mental disorders is not well founded so long as there is uncertainty about the exact causation of exact disorders.

The implications to my study of Horwitz's criticism are in his insights into the distortions he finds in the thinking of both theoretical camps concerning the psycho-sciences. He clearly elucidates the tension between the two, and also highlights their similarities: the overextension of the phenomena lumped under the diagnostic categories; what is seen as madness and what is not acknowledged as madness. I do not, however, proceed to adopt his definition of mental disorder. I do not do this because I am not interested in synthesis, but rather the *tension* between the two camps that Horwitz partly synthesises in his own definition, and – most importantly – in the ways my target texts appear to *use* and *create* possibilities of interpretation through these theoretic categories. The two camps, in all their societal significance, propagate their own definitions, and these definitions I aim to study in the light of my target literature in Chapter 4.

Before this, I need to construct the literary theoretical framework that I require to study my sample literature – the literary representations of these various theoretically defined phenomena of diagnosing and curing madness that I have tried to elucidate here. I will undertake this task in the next chapter.

3 DIAGNOSIS, NARRATION AND POWER

In this chapter, I will theoretically ground, define and describe the two main analytical tools that I use in the next chapter to analyse the eight target texts. These are 'diagnostic power' and 'narrative power'. I do this in order to establish the narrative-theoretical part of the nexus I seek in the first part of my study, namely the ways literature *uses* psycho-scientific theories (and, as I will describe, also the lay viewpoints of madness) in connection with diagnostic power, which I will shortly formulate. In this way, my vein of 'psychiatric literature research' aims to be sensitive to the special character of literature as rhetorical, layered communication.

My narrative theoretical framework sustaining these analytical tools of narrative and diagnostic power is a conglomeration of rhetorical and certain cognitive narratological theories supported by a number of aspects of Foucault's ideas on the interweaving of knowledge and power. After describing this conglomeration in detail, I will justify it and establish its cohesion at the end of this chapter.

Before I can get to the business of delineating the notions of diagnostic and narrative power, I need a basic theory of what power is in the first place. For this, I refer to the theories of Michel Foucault, a prominent – if not the most famous – theoretician of power, and especially that of psychiatric power, of the 20th century.[1] The choice of following Foucault's ideas on power carries with it a power critical attitude: Foucault studies (also psychiatric) power in order to reveal its often adversarial character for those targeted by it. However, I will be referring to another set of ideas on power, termed 'mutualistic power relations' by Michael Karlberg (2005),

1. As I noted in the introduction, Foucault is not, however, completely alone as a theoretician and critic of psychiatry: in France, one can name people like Gilles Deleuze and Felix Guattari as other prominent philosophers of psychiatry. But Foucault's influence has been greater also outside France, as he inspired the Laingian vein of anti-psychiatrists, and his position as one of the most famous theoreticians of power is unquestionable.

who draws on various feminist, system theoretical, and peace research sources to coin this group of power relations that serve as an alternative to 'adversarial power relations'.[2] I include Karlberg's notion to ensure I do not miss the productive, beneficial side to psychiatric and diagnostic relationships.

3.1 Foucault's (1982) Conception of Power

In describing the Foucauldian conception of power, I use his 1982 essay, 'The Subject and Power', written during his 'genealogical phase',[3] two years before his death. In his essay, Foucault gives a concise description[4] of the ideas on power he held at that point.

In 'The Subject and Power', Foucault reflects on twenty years of his work and formulates his main objective as being not the study of power as such, but 'creating a history of the different modes by which, in our culture, human beings are made subjects' (ibid., p. 777). This human, historically perceived subject he sees as being moulded by the three modes of objectification he has studied during his career: 'modes of inquiry which try to give themselves the status of sciences'; 'dividing practices' which either divide the subject internally or from other subjects; and 'the ways a human being turns himself into a subject'. (Foucault 1982, pp. 777–778.) He goes on to argue that 'while the human subject is placed into relations of production and signification, he is equally placed in power relations which are complex' (Foucault 1982, p. 778). The three subject-moulding forces are inseparable from power relations, and it became necessary for Foucault, in order to study their subject-moulding objectifying aspects, to expand the dimensions of the definition of power from the

2. Karlberg considers that Foucault operates within the traditional 'power over' or power as domination theory, even if he acknowledges the productive side of power as well (Karlberg 2005, p. 4).
3. Foucault's life's work is usually divided into two main phases: an 'archaeological phase', in the 1960s, during which he was most interested in epistemological questions of 'archives', 'discourses', and 'epistemes' asking, e.g.: 'what can be known in a given period of history – what are the historically aprioristic limits of knowledge?' (*The History of Madness* is from this era); and a 'genealogical phase', from the 1970s onwards, during which Foucault concentrated on questions of power, 'dispositifs', 'matrixes' and 'governmentality' asking, e.g.: 'how do the strategic and tactical networks of power mould the field of knowledge?' (*The Psychiatric Power* is from this era). During his last few years, in the 1980s, Foucault turned to questions of ethics, thus enabling Koivusalo (2012) to make a tripartite division of his lifework into three subdivisions, all of which contend with a particular problem of human experience: knowledge (the archaeological phase), power (the early genealogical phase), and subjectivity (the late genealogical phase).
4. However, he calls this description neither 'theory' nor 'methodology', only 'ideas' (Foucault 1982, p. 777).

traditional legal or institutional power theories ('What legitimates power?'; 'What is the state?'; ibid.) to taking forms of resistance against power as his starting point. He thus analyses power relations through the antagonism of 'strategies', a notion which he defines as having three different meanings: 1) 'rationality functioning to arrive at an objective'; 2) 'the way in which one seeks to have the advantage over others'; and 3) 'the means destined to obtain victory'. (ibid., p. 793.) These three meanings come together in situations of confrontation – war or games – but, in relation to the first meaning, 'one may call *power strategy* the totality of means put into operation to implement power effectively or to maintain it'. (ibid., emphasis added.) He argues for the importance of the viewpoint of these antagonistic strategies: 'For example, to find out what our society means by sanity, perhaps we should investigate what is happening in the field of insanity' (ibid., p. 780).

Foucault goes on to characterise different sides of these strategic antagonisms, (ibid., pp. 780–794, placed here in a different order) which I summarise as a list:

1. Power brings into play relations between individuals (or between groups).
2. The exercise of power is not simply a relationship between partners, individuals or collective; it is a way in which certain actions modify others. Power relationship is a mode of action which does not act directly or immediately on others. Instead, it acts upon their actions. *Power exists only when it is put into action.*
3. Power is not a function of consent; the relationship of power can be the result of a prior or permanent consent, but it is not by nature a manifestation of a consensus.
4. Power relationships can only be articulated on the basis that 'the other' (the one over whom power is exercised) is recognised and maintained to be *a person* who acts and that, when this person is faced with a power relation, a whole field of responses, reactions, results, and possible inventions may open up for her. (That is: the relation is not one of *violence*, which sees its objects as a mere body or a thing.)
5. Power is exercised only over free subjects, and only insofar as they are free.
6. There is no relationship of power without the means of escape or possible flight. Every power relationship implies, at least *in potentia*, a strategy of struggle. In effect, between a relationship of power and a strategy of struggle, there is a reciprocal appeal, a perpetual linking and a perpetual reversal: at every moment the relationship of power may become a confrontation; equally, the relationship between adversaries in society may, at every moment, give place to the putting into operation of mechanisms of power.

7. The exercise of power consists in guiding the possibility of conduct (behaviour) and putting in order the possible outcome.
8. This form of power characterising the antagonism of strategies *makes individuals subjects*, in two meanings of the word: subject to someone else by control or dependence; and tied to her own identity by a conscience or self-knowledge.
9. The power relation demands the concrete establishment of the system of differentiation, which permits one to act upon the actions of others, determined by the law or by traditions of status and privilege. These differentiations are at the same time the power's conditions and results.
10. The types of objectives pursued by one who exercises power, that is, acts upon the actions of others, must be concretely established.
11. The exerciser of power must have the means to bring power relations into being (threat of arms, the effects of word, by means of economic disparities etc.).
12. The forms of institutionalisation must be concretely established, (e.g. traditional predispositions; legal structures; phenomena relating to custom or fashion; a separate form of an apparatus closed in upon itself with its own carefully defined hierarchies and relative autonomy; complex systems, like the state).
13. Degrees of rationalisation must be established alike: the bringing into play of power relations as action in a field of possibilities may be more or less elaborate in relation to the effectiveness of the instruments and the certainty of the results (greater or lesser technological refinements employed in the exercise of power) or again in proportion to the possible cost (be it the economic cost or the cost in terms of reaction constituted by the resistance which is encountered); the exercise of power is not a naked fact, an institutional right, nor is it a structure which holds out or is smashed: it is elaborated, transformed, organised; it endows itself with processes which are more or less adjusted to the situation.
14. These power relations have effects linked with the circulation of knowledge, competence and qualification; that is, the *régime du savoir*.

The essay implies that each of these 14 points characterise the relation of power in the Foucauldian, antagonistic-strategic sense. As must be remembered, Foucault was interested in the historical forces moulding the human experience, and this historical perspective also applies to the experience of power: in the Foucauldian scheme, societal power relations show historical variance; in different epochs they have materialised differently.[5] (Foucault also emphasises in this essay the importance

5. When, in the 1970s, Foucault started to fervently formulate his conceptions of societal power relations, he saw that there was a succession in types of societal power, contrasting the 'sovereign'

of historical awareness in 'checking' our conceptualisations (Foucault 1982, p. 778).) For the present purposes, the above list serves as a starting point for defining whether – and to what degree – we are dealing with (Foucauldian) power relations when talking about diagnostic and narrative relationships.

3.2 Diagnostic Power

Foucault places the opposition between psychiatry and the mentally ill onto the list of oppositions he describes as examples of his 'antagonistic strategies'. Therefore, for Foucault, the psychiatry/mental illness relation (which I see to also incorporate the diagnostic relation as one of its tools and loci of action), is a power relation *par excellence*. (Foucault 1982, p. 780.) (The other items on the list are: opposition to the power of men over women, parents over children, medicine over the population, and the administration over the ways people live.)[6] We can see how the paradigmatic diagnostic relationship – that between psychiatrist and her patient – fits the Foucauldian list of antagonistic-strategic power relations given above: 1) the diagnostic relation involves the relationship between the individuals of the psychiatrist and the

form of power with the 'disciplinary' form of power that he then saw as the most modern type: 'It seems to me that disciplinary power can be characterized first of all by the fact that it does not involve imposing a levy on the product or on a part of time, or on this or that category of service [like sovereignty], but that it is a total hold, or, at any rate, tends to be an exhaustive capture of the individual's body, actions, time, and behavior. It is a seizure of the body, and not of the product; it is a seizure of time in its totality, and not the time of service.' (Foucault 2006b, p. 46.) The disciplinary power he saw in *Discipline and Punish* being embodied most clearly in the Benthamite panopticon that was being applied to multifarious societal power structures of governing criminals, patients in hospitals, schools, garrisons etc. (Foucault 2000). However, later, in the 1980s, Foucault came to revise this historical continuum and saw that there was an even more modern type of societal power structure, which he called 'biopower': power that aims to control and produce the societal mechanisms of security (*dispositif du securité*) (Koivusalo 2012, p. 196). Each of these three forms of power produce power relations that conform to the above list of characteristics of what could be – at least heuristically – dubbed the 'Foucauldian conception of power'.

6. Foucault goes on to describe the antagonisms on his list. He states: 1) they are struggles that are not limited to one country; 2) they are aimed at the power effect of the power-exercising actor itself, for example, not only the medical profession as a profit-making concern, but because it exercises an uncontrolled power over people's bodies, their life and death; 3) they are immediate struggles: they criticise the closest actors of power – the immediate enemy – to those being acted upon, and they do not look into the far future to find a solution; 4) they are struggles which question the status of the individual: on one hand they assert the individual's right to be different, on the other, they criticise that which separates the individual and breaks his links with the community: they are struggles against the 'government of individualization'; 5) they are oppositions to the effect of power that is linked to knowledge and opposed to secrecy; and finally 6) they revolve around the question 'Who are we?', and they refuse the abstractions of economic and ideological state violence which ignores who we are individually, and they are also a refusal of scientific or administrative inquisition which determines who one is. (Foucault 1982, pp. 780–781.)

patient; 2) the psychiatrist acts upon the actions of the patient: by first defining the patient's specific form of madness, by concentrating on her patient's pathological acts, she then aims to change the pathologies of the patient's acts by intervening with her own acts through the practice of psychiatry; 3) the diagnostic relationship may be built on the consent of the patient – but it does not have to be, the situation may be entirely coercive (a diagnosis unwanted by the patient, evolving into treatment against the patient's will); 4); 5) and 6) the patient may react to the power relation in a gamut of ways (e.g. she may try to deny the diagnosis); she is treated like a thinking and acting person, not a mere body; both the psychiatrist and her patient are free subjects, they are free to choose their actions; and there is the *in potentia* possibility of open confrontation, of struggle, or flight; 7) the psychiatrist tries to affect her patient's conduct through making a diagnosis of this conduct first; 8) the diagnostic relationship moulds the patient's subject by placing her into a relationship of control with the psychiatrist (diagnosis as a tool of psychiatric intervention into the life of the patient leading to a possible dependent and controlling treatment relation) and ties to her the identity of a mental patient with a specific mental condition or form of madness given in the diagnosis; 9) the system of differentiation is present as well: the power of the psychiatrist over the patient – her right to make the diagnosis – is determined in law and the tradition of the medical occupational status; 10) the psychiatrist establishes concrete aims for her actions: that of curing the patient, for example, through first making an accurate diagnosis; 11) the psychiatrist has a range of means to establish her power over the patient (e.g. forced treatment); 12) and 13) psychiatric diagnosis and treatment is clearly institutionalised and rationalised, e.g. in the form of diagnostic manuals and hospitals; and 14) psychiatry is a science with its own circulation of knowledge, competence and qualification, which is also expressed in the system of diagnostics.

Therefore, it should be clear that the nature of the diagnostic relationship is one of (Foucauldian) power.[7]

7. To further bolster my argument that the diagnostic relationship is one of power, I refer to Lars Bernaerts's article in which he points out a peculiar feature of psychiatric diagnosis: that it changes reality as well as states a fact. Bernaerts analyses the relation between a psychiatrist and a patient in the act of making a diagnosis, which he perceives and analyses as a speech act. He writes: 'In the diagnosis, the psychiatrist seems to get the word to match the world, to use John Searle's terms, which means that the psychiatrist represents a state of affairs by pronouncing the diagnosis. However, a lot of literary as well as real-world cases show us that the diagnosis does not simply belong to the class of the assertives, but rather to the class of the declarations, which realize the correspondence between the proposition and reality. Searle explains that declarations typically require an extra-linguistic institution and specific speaker and hearer positions. This necessity is obviously the case in the interaction between the psychiatrist and the patient. [...] The diagnosis, the admission, and the dismissal are constituted by institutional speech acts with an inevitable effect on the

The issue of the possible stigma further enforces the idea of the diagnostic relationship being a power relation: often, if not always, the giving of a psychiatric diagnosis, in the individual social pattern, forces a stigma onto the patient; being treated as a psychiatric patient has more to it than just being cared for and cured of an illness. As noted in Chapter 2, this is perhaps one of the biggest differences between somatic and psychiatric medicine. Fabrega (1991) sums up the nexus of psychiatric stigma in the era of modernity by claiming: 'As individual freedom, autonomy, and the exercise of civil liberties became increasing attributes of personhood in Western societies, the mad took on the anomalous identity of sequestration, dependence, and enforced nonparticipation in social and civil affairs. It is attested that psychiatry became identified with these political actions: in a sense, the discipline contributed to the stigmatisation of the mad through its patently social control functions and also took on aspects of the negative image increasingly surrounding the mad.' (Fabrega 1991, p. 111.) Fabrega also states that '[t]he poor, the sick, the deprived, and the marginal – including the mad – are said to constitute the group against which the majority developed its own identity' (ibid., p. 109). I will return to the issue of stigma and the interrelated aspect of dividing people into identity groups many times in this chapter and the next, because the stigma is such a central notion to my target madness narratives: all of my target texts tend to comment on the possibility of psychiatric stigma. To foreground my ideas, I see stigmatisation as one of the issues when the diagnostician handles (Foucauldian) exclusion by confinement (described above in Chapter 2) – and the more loose (valid also outside of confining walls of mental hospitals) in-group/out-group relations that are central to our perception of madness and those mad and sane. Thus, the possibility of stigma can be seen as one of the hallmarks of the psychiatric use of power, as formulated by Foucault: the never-neutral, often-oppressive societal use of power in practised by psychiatric science.

However, one must contrast this more oppressive aspect of the power politics of diagnosis making with the aspect of the psychiatrists' genuine will and ability to help the patient. The curative relationship is not any less a power relation, though, given the fact that the relationship is lopsided: there is no equality between the

patient's identity and biography.' (Bernaerts 2010, p. 290.) I would see this speech act relation between the patient and her psychiatrist as *a relation of power*. The psychiatrist has the institution behind her speech act which gives her the power to declare her patient to be a mad person. This declaration, as Bernaerts points out, affects the patient's identity and biography, i.e. her entire life. (Cf. Foucault's referring to the subject-moulding, objectivising aspect of power relations.) Thus, this brief excursion via speech act theory also introduces my perception that making a diagnosis can be seen as a tool of power.

doctor and her patient in effecting change in the patient's condition, and this was emphasised by Foucault (the established system of differentiation, point number 9 on the list). The concept of beneficent, 'assisted empowerment' (Karlberg 2005, p. 10) means there is a power relation in which there is inequality between the actors but the result is beneficent: 'power inequality within a mutualistic relationship results in the "assisted empowerment" of the less powerful agent(s) by the more powerful agent(s)' (ibid.). He describes this relationship as one in which 'people [...] are acting in a cooperative or mutualistic manner in the pursuit of a common goal' (ibid., p. 9). Karlberg sees the more traditional, in his view also Foucauldian, 'power over' analysis as valuable in its potential to highlight the social issues pertaining to 'power as domination', which is a real force in society, (ibid., pp. 8–9) but calls for a substantial discursive innovation to bolster our struggle towards more equal and benign power relations.

Karlberg divides the whole field of power relations ('power' seen generally as 'power as capacity') into two broad categories (Adversarial relations or 'power against' and Mutualistic relations or 'power with'). These two categories are further subdivided into relationships with inequality or equality among the actors, resulting in a four-fold typology: 1) (adversarial relations) 'power over' – the view of power as domination that has been the chief notion in Western power studies, including Foucault's, in which there is inequality between adversaries; 2) (adversarial relations) a 'balance of power' in which the adversaries have recourse to equal amounts of power; 3) (mutualistic relations) 'assisted empowerment' in which the actors are unequal; and 4) (mutualistic relations) 'mutual empowerment' in which the actors are equal. (Karlberg 2005, p. 10.) Thus, in his terms, there are also power relations between equals. However, I will only use the unequal power relations because psychiatric and diagnostic relations are essentially unequal in nature.

I would like to bridge Karlberg's and Foucault's power notions by arguing that the Foucauldian power schema I sketched above can be seen to partly accommodate the notion of assisted empowerment. I believe that, excluding Foucault's points 3, 6, and 8 that speak explicitly of non-consensus, confrontation, struggle, and antagonism, the Foucauldian notion supports the assisted empowerment schema. When stripped of these explicit confrontational markers, the Foucauldian notion of power (e.g. that it is exercised over free subjects by other free subjects; that the actors are individuals, differentiated by status, and that power is exercised upon others' actions is goal-directed, institutionalised, and governed by *regimés du savoir*, etc.) can assimilate the Karlbergian notion of assisted empowerment, namely a mutual,

cooperative action between the more powerful and the less powerful, resulting in the empowerment of the latter. I will be using this empowering use of psychiatry as a balance in my analyses to delineate the differences between Foucauldian 'proper' use of power as domination and this more benign, Karlbergian analysis of assisted empowerment.[8]

The psycho-scientific viewpoint acknowledges the issue of power and the potentially stigmatising nature of diagnosis, but it argues that it is possible to treat patients with humane consideration and thus alleviate the possibility of psychiatric oppression and the stigmatisation by labelling. Irving B. Weiner writes in the *Encyclopedia of Psychiatry, Psychology, and Psychoanalysis* about the stigmatising nature of the differential diagnosis[9] being used in psychiatry and psychoanalysis:

> Despite the important purposes that differential diagnosis serves, it is at times criticized as being a dehumanizing and stigmatizing procedure that puts people in pejorative pigeonholes, exposes them to devastating experiences of prejudice and rejection, and gives professionals unseemly power to pass judgment on their patients. From a humanistic perspective, in particular, it has been asserted that people should be considered in their own uniqueness and individuality and not be stripped of their dignity by being assigned classificatory labels that are shared by groups of people. (Weiner 1996, p. 172.)

He continues:

> Although personality classification and diagnostic labeling can be used in ways that stigmatize or disadvantage people, such outcomes represent a misuse of dif-

8. This empowering use of psychiatric power can also be seen to be partly in motion in Horwitz's viewpoint that is radically different from the Foucauldian 'struggle perception' of diagnosis-making (he described in his *Psychiatric Power* lectures): that '[m]ental professionals rarely impose labels of mental illness on resisting clients; instead, professionals and clients alike are more likely to participate in a shared culture of medicalized mental disorders' (Horwitz 2003, p. 213). Horwitz's perception differs radically from those seeing psychiatry as a mighty tool of power. He stresses this 'co-operational' viewpoint partly because his focus is on the spreading of psychiatric territory into society at large, as he sees that both parties – professionals and patients alike – benefit from this (over)extension of the psychiatric territory. In Horwitz's schema, professionals use empowering psychiatric power in mutual agreement with their patients in a relationship of consent. What Horwitz stresses though, is that this mutual agreement and the empowering use of psychiatric power is on an unsound scientific basis (most of the 'mental illnesses' professionals treat are not 'proper' mental disorders; see above and the end of Chapter 2), and thus there is often nothing 'real' to cure. (Horwitz comes close to Szasz's viewpoint that patients gain from being labelled mad.) The empowering use of power can therefore have different forms and patterns.
9. Differential diagnosis aims to relate whatever patterns of disturbance are present to some cohesive and recognisable form of psychopathology, e.g. depressive disorder or passive-aggressive personality disorder (Weiner 1996, p. 172).

> ferential diagnosis rather than any misanthropy intrinsic in its procedures. […] In the eyes of caring clinicians, an individual's uniqueness surely survives her being identified as sharing certain characteristics with other people. How people are alike and how they differ from each other are, in fact, complementary bits of information that clinicians can and should use together in their efforts to understand their patients. If they do so conscientiously, their differential diagnoses can leave humanistic values unscathed. (Weiner 1996, p. 172.)

I concede this and acknowledge that psychiatry and psychoanalysis can and do have a genuine will to help those who seem to need help with mental problems which can be truly disabling (I do not take sides on the issue of Horwitz's perception that most of these problems are not proper disorders). I do, however, see that these two sides to the question of diagnosis, humane and inhumane, *are present at the same time*. The psychiatric diagnosis *can* be used as an oppressive power tool, and this possibility is always present in the situation of making a diagnosis. That professionals have to be careful in case they should err on the side of inhumanity is a reminder of the power relation present in the situation of making a diagnosis. It is a move in a power relationship to try to treat the other person with respect and to avoid the always present threat of misusing the power possessed in diagnosis-making. This can be seen in the criticism that anti-psychiatry and Foucault direct at psychiatry, and in the definite need for ethics in psychiatric and psychoanalytic practices: where there is a possibility of power misuse, there must be ethical rules that try to check that misuse.

What, then, can be said of the lay diagnoses that we will encounter in the target texts from time to time? They lack the institutionalised and scientific character of the psychiatrist-patient relationship, but on the other hand they often have many, if not most, of the other characteristics on the list of Foucauldian characteristics of power above. They can be seen to practice diagnostic power often with a similar kind of thrust as institutionalised psychiatry: for example, to use the circulation of (more or less specific) knowledge in the power strategy of making a diagnosis; to establish a subject's limits and to control her through the objectification of diagnosis-making; or to maintain and reach a system of differentiation between the diagnostician and her object, etc.

However, a caveat is in order: the pattern of any literary diagnosis must be checked, case by case, during the analyses, because the question of the literary use

of *any* diagnosis, lay or professional, must be reckoned with. This is why it is now necessary to consider the narrative side of the power politics of madness narration.

3.3 Narrative Power

When one approaches the theme of madness in madness narratives, one is unavoidably faced with diagnostic relationships within the narratives' fictional worlds: narrators and characters are all seen to make diagnoses, and the reader, guided by the implied author, makes diagnoses as well. Indeed, the reader may be the only diagnosis-maker if the madness of a narrator or character goes unnoticed by the fictional world's participants (e.g. in cases of unreliable,[10] mad narration or focalisation). I argue that this diagnostic relation is a grounding fact of *noticing madness* – of interpreting a madness narrative as a madness narrative in the first place: one cannot talk about 'madness narratives' without someone, somehow making some kind of madness diagnosis of a character or a narrator. Therefore, it is possible, even essential, to ask who uses this diagnostic power in the madness narrative. The answer, in each unique case, is the narrator/character/reader: any of these actors may use diagnostic power of defining another person – or (in the case of narrators and characters) oneself – as mad. (I will be differentiating self-diagnoses from diagnoses of others in more detail later, and will also delineate readerly diagnostic power from intra-fictitious diagnostic power.)

However, as we are dealing with literature, and thus with fictional artefacts, the picture must be enriched by the *literary aspects* of this use of diagnostic power: the fictional world of literature not only faithfully copies or depicts 'real life' diagnostic relationships, it also *uses* them in its own ways and *for its own purposes*. Who in literature uses this power of using a diagnosis as a means for some end – other than practice of pure psychiatry? Is this literary use of madness a form of the use of power, in the Foucauldian sense of the word? Furthermore, if there is such a thing as *narrative power*, with what sort of literary analytical tools should one approach it?

Before I begin to answer these questions, and to hone my theoretical-analytical tools, I will make a brief detour through the already existing literary analytical, narratological applications of Foucault to see what kinds of problems there have been with previous attempts to combine Foucault with literary analysis.

10. I will be reconsidering the term 'unreliability' at the end of the next part of my study; in this part, I will be using, for the sake of simplicity, the term as it is traditionally used in literary studies.

3.3.1 Foucauldian Narratives?

In the 1980s, three substantial studies of (more or less) Foucauldian approaches to literature appeared: D.A. Miller's *The Novel and the Police*, Mark Seltzer's *Henry James and the Art of Power*, and John Bender's *Imagining the Penitentiary. Fiction and the Architecture of Mind in Eighteenth-Century England*.[11] Their projects offer certain insights into how Foucault's ideas could interact with literary theory: the core issues here are the roles of so-called omniscient narration and free indirect discourse (FID). Each of these writers maintains that one form of narration or the other is bound with social power in the sense Foucault formulated it, especially in *Discipline and Punish*. In this work, Foucault formulated his notion of 'disciplinary' power, which he argued to be plainly seen in the Benthamite plan for a panoptic prison. In this prison the guards exercise power over the prisoners by placing the prisoners into cells where they are unaware of whether they are being observed by a guard, or indeed, whether there is a guard at all. (Foucault 2000.)

Seltzer argues that omniscient narration 'grants the narrative voice an unlimited authority over the novel's "world," a world thoroughly known and thoroughly mastered by the panoptic "eye" of the narration' (Seltzer 1984, p. 54). Miller targets the FID mode of narration by claiming that: 'The panopticism of the novel […] coincides with what Mikhail Bakhtin has called its "monologism": the working of the master-voice […that] never simply soliloquies. It continually needs to confirm its authority by qualifying, cancelling, endorsing, subsuming all the other voices it lets speak. No doubt the need stands behind the great prominence the nineteenth-century novel gives to *style indirect libre*, [= free indirect discourse] in which, respeaking a character's thoughts or speeches, the narration simultaneously subverts their authority and secures its own.' (Miller 1988, pp. 24–25.) Bender argues further that 'in the realist novel the means of representation do more than record multiple voices: the convention of transparency treats the one presence within which all other presences are staged as if its embrace were invisible. Transparency absorbs the heterodox within tacit authority. Free indirect discourse represents the fullest possible control of narrative resources.' (Bender 1987, p. 213.)

In all these viewpoints, the message is clear: the narrative power exercised by omniscient narrators or narrators using free indirect discourse is panoptical in the

11. Bender is the 'least' Foucauldian of the three: he refers to Foucault by saying: 'Without his precedent, my ideas could scarcely have been thought, but instead of pursuing his project, I have moved in directions he left unexplored or did not foresee' (Bender 1987, p. xv). Thus, he scarcely mentions Foucault in his study, quite unlike the other two, who openly use Foucault as their referent.

Foucauldian sense. The power of vision the narrator has is just that: the exercising of power. To see is to control, to be gazed at (especially if the spectator is unseen by the object) is to be an object of power. The (omniscient) narrator controls the voices of others in the narrative to the degree that she becomes god-like.

These articulations have met opposition from Dorrit Cohn, Monika Fludernik, Brian McHale, and Jonathan Culler. Cohn has argued most vehemently against Seltzer, Miller and Bender: 'They all tend to present the novel, particularly in its realist guise, as a genre whose form replicates the malevolent power structures of a society […] a genre that […] exists largely in order to wield absolute cognitive control over the lives of the characters it incarcerates and whose psyches it maliciously invades and inspects' (Cohn 2000, p. 166). She questions the Foucauldian base the three stand on by arguing that they have made at least two mistakes: firstly in placing authors or heterodiegetic narrators on the same ontological plane as the characters they narrate about, which, in Cohn's opinion conflicts with the Foucauldian paradigm that power is exercised only by and against free subjects in a potentially reversible relation; for another, they depart from Foucault's own stance toward literature,[12] which is that it is a more problematic and undecidable phenomenon: the transfer from Foucault's socio-historical mode of writing is not that easy to realise in regard to literature (ibid., pp. 171–172). She goes on to criticise the role omniscience has in the Miller's, Seltzer's and Bender's theories by stating that the panoptic guardian *cannot* see inside the others' mind like an omniscient narrator, what she *can* see is only their manifest behaviour (ibid., p.175). Thus the narratological concept of the omniscient narrator remains intact of the horrors of panopticism, but exhibits a totally different ontological status. In regard to free indirect discourse and its power political status, Cohn writes: '[I]n my view, free indirect discourse can no more be understood as bearing a single, fixed ideological-cultural meaning, than can the figurally focalised type of fiction in which it is most often found and than can the contrastive, authorially focalised fictional type' (ibid., p. 179).

In McHale's opinion, as well, 'the consensus' that has been reached on FID 'has to do with its diversity of forms and functions' (McHale 1994, p. 61), and thus, FID cannot be seen *only* as a coercive narrative structure, as Miller does. McHale writes: 'In other words, there are many documented instances of FID in which Miller's characterization of the form might very nearly be inverted, in which the narration does not subvert the characters' authority in order to secure its own, but the other way around, secures the characters' authority at the risk of subverting its own' (ibid.,

12. I will detail Foucault's own direct participation in the discussions on the essence of literature below.

p. 62). Thus, both Cohn and McHale argue for the diversity of the form and use of FID in various narratives; one cannot *coerce* (as McHale ironically puts it) all of the instances of FID to conform to this one ('Foucauldian = Panoptic') view of it.

On the issue of omniscient narration, Fludernik approaches the same criticism from a slightly different point of view by arguing that 'the omniscient narrator [...] enjoys the full privilege of access to his characters' most private thoughts but lacks the Benthamite prison's machinery of disciplinary resources. It is these policies of relentless surveillance and absolute control which turns the potentially benign faculty of all-encompassing vision into the oppressive horrors of the Panopticon where they serve to subject the incarcerated to their dehumanizing effect of abject humiliation.' (Fludernik 2005, p. 371.) She further characterises the omniscient narrator as having a 'potentially benign' faculty of an all-encompassing vision (ibid., p. 370).

Mark Seltzer has replied to Cohn's criticism of his reading of power structures in Henry James' novels by pressing another point: that authors, narrators, and characters *are* all subjects of power on the same ontological level as understood by Foucault. Seltzer writes:

> But whereas for Foucault this [that power is exercised only over free subjects and only insofar as they are free] is to indicate the manner in which power requires the 'fabrication' and 'qualification' of the subject *as* the subject of power [...], for Cohn this reduces to the absolute *non*relation or rupture in 'an author's (or heterodiegetic narrator's) relationship to his fictional characters. The latter do not exist on the same ontological plane as the former.' Put simply, for Cohn, authors (and some narrators) are persons, whereas representations are not, and thus it 'make(s) no sense' to 'transfer' power relations to formal [i.e. fictional] relations. This is, on several accounts, nonsense. (Seltzer 1995, p. 24.)

Seltzer refers to the Foucauldian paradigm of power making the subject *as* a subject (of power). For Seltzer, the representation and the uncertainty of distance between the subject and representation is a central matter: 'identifications bring identity of the subject into being and not the other way round' (ibid.). Thus, there is no ontological difference between narrators and characters: 'And the tendency to understand representations as such as conveying a critical and self-conscious distance, such that the representation of power in effect affirms one's exteriority from it, occludes just these intimate relays between persons and representations' (ibid.).

Now, what comes of this argument? To my mind, on the one hand, this argument seems to revolve around the problem of fiction being *a phenomenon of multi-layered worlds,* and on the other, it revolves around the range of uses certain kinds of narrative techniques can be put to. In the case of the latter problem, I am inclined to take McHale's and Cohn's[13] side: one cannot *a priori* define certain narrative techniques, FID or omniscience or anything, to have only one kind of relation to ideologies or power use within the narrative. For example, FID, as McHale emphasises, is a form that has various implementations, contents, and meanings that vary from work to work and from instance to instance. Furthermore, like Fludernik, I believe that the analogy between Benthamite prison guard and the realistic, omniscient narrator is a little forced. (I shall return to this shortly.)

With regard to the first problem – that of the layering of fictional worlds actualised in narrating and reading – I maintain, like Cohn, that there is an ontological difference between the worlds of the omniscient or FID-using (heterodiegetic) narrator and that of the characters being narrated about. There is a further difference between the worlds of the author and reader on one hand, and those of the fictional worlds they write and read about on the other. Can Foucault's theories on the socio-historical 'real world' we all live in be applied to this multi-layered world-building the way Seltzer, Miller and Bender have done (in the cases of omniscience and FID)?

I would like to add to this discussion on the panoptic nature of narration the remark Foucault makes in *Discipline and Punish*, in which he formulates his notion of the disciplinary, panoptic society: the object of panoptic power in a way 'internalises' the power structures and lets them mould her. She starts to play the roles of both the observing power and the observed, and thus she becomes the basis of her own subjugation. (Foucault 2000, p. 277.) How could this be made to tally with omniscient or FID-using narrators and their characters? Do the characters know that they are under surveillance? Have they internalised their subjugated power position? I would say not, and this is one of the reasons why the analogy between omniscient or FID narration and Benthamite prison guards fails. Foucault makes a fleeting remark that when the literary form of the novel was invented, it took place in connection to the birth of disciplinary techniques that produce detailed information about the most hidden parts of the human being in order to better control

13. In a more recent article, Gunther Martens has joined forces with Cohn in this dispute by stating: '[…] I fundamentally share Cohn's "skeptical assessment of all manners of simple and stable correspondences of modal type and moral stance" and the investigation of alternatives to what she calls "the traditional link between authorially focalized novels and clear normative values". (Martens 2009, p. 390.) I find myself inclined to support this thesis, at least in the openness to alternatives and viewpoints that differ from that of the 'Foucauldians'.

her (ibid., p. 264). This is perhaps the basis on which the Foucauldian narratologists establish their analyses, but I would still maintain that their interpretations are not wholly satisfactory.

One must find another way of combining Foucault and literary analysis, one that takes into consideration the multi-layered world-building of fiction, and the fact that there are definite differences, also of an ontological nature, between the various layers of fiction. These differences make the direct application of Foucauldian-like power structures difficult, as the Foucauldian notion of power is so strongly rooted in the idea of free subjects in the power relationship being able to reciprocate power, to react to it, and struggle against it, not just succumbing to it unawares (as we have already seen above with the aid of my list of the Foucauldian characteristics of power).

3.3.2 Towards a Model of Narrative Power: Rhetorics, Cognition, Narrative Empathy, and Foucault

I will now bring together my narrative-analytical theory bases: rhetorical and cognitive narratology, theories on narrative empathy, and Foucault's theories on knowledge and power.

My starting point to the delineation of the possibility of there being such a thing as 'narrative power' in force in madness narratives was in the remark that fictional narration does not only faithfully copy the 'real life' diagnostic relationships when depicting them, but integrates them into the fabric of fictional world-building, i.e. narration. Thus, there are always some narrative purposes behind the representations of a diagnostic relationship in madness literature. How should one approach these purposes? Whose purposes are they anyway? To answer these questions, I refer to James Phelan's formulation of rhetorical narratology, because it is, in my opinion, the best form of narratology oriented towards studying persuasive – and I argue, power – relations in narratives.[14]

14. It should be remembered that rhetoric was actually born of the political and juridical needs of Ancient Greece, i.e. the needs to handle the juridical and political possibilities of individuals to affect their community. Therefore, the step I am about to take, to return to the power basis of narrative seen through the rhetorical lens, is, I argue, warrantable. In this step, I only emphasise the power aspect of producing an effect on another person. As Wayne C. Booth has argued, the scope of rhetoric has, since being born of the political needs of Ancient Greece's males, widened to cover all communication: 'In short, rhetoric will be seen as the entire range of resources that human beings share for producing effects on one another: effects ethical (including everything about the character), practical (including political), emotional (including aesthetic), and intellectual (including every academic field).' (Booth 2004, p. xi.)

3.3.2.1 Phelan's Model and Foucault: My Definition of Narrative Power

The Phelanian rhetorical model of narrative is based on double dynamics: 'the rhetorical understanding of narrativity, […] is tied 1) to the rhetorical definition of narrative as somebody telling somebody else on some occasion and for some purpose that something happened and 2) to the concept of narrative progression' (Phelan 2005b, p. 323).

I will soon tackle the issue of narrative progression in connection to madness narratives, but first I will take up the issue of the *purpose* behind narration that Phelan refers to in the quotation above. I argue that it is possible to combine most of the aspects of the aforementioned Foucauldian 14-point characterisation of power with this Phelanian model of rhetorical narratology on the grounds of seeing fiction as rhetorical communication, the narrators and implied author of which aim at specific reactions in their respective audience(s), namely narratee(s) and the authorial audience. (I will define and describe the notions of the implied author and the authorial audience, as well as the relationship between narrators and implied authors, in more detail, later.) This is the way, I regard the Phelanian formulation of 'for some purpose'[15] – that the narrator aims for *specific reactions* from her audience, as does the implied author in hers – as the result the narrator wishes to achieve in her audiences, and I will call this result-reaching activity the narrative agenda. (I will shortly go into more detail on the issue of what these reactions are and how they are sought.)

15. Peter Brooks has emphasised this purpose-orientation of narration with his notion of the 'transferential' thrust of every narrative:
 '[…T]he model of psychoanalytic transference has the advantage of imaging the productive encounter of teller and listener, text and reader, and of suggesting how their interaction takes place in a special "artificial" medium [as Freud called transference an "artificial illness"] obeying its own rules – those of the [Lacanian] symbolic order – yet vitally engaged with the histories and intentions of desire. In other words, the transference, like the text as read, becomes a peculiar space of deadly serious play, in which affect, repeated from the past, is acted out as if it were present, yet eventually in the knowledge that the persons and relations involved are surrogates and mummers.' (Brooks 1992, pp. 234–235.)
 This points Brooks to enquire what narrative is for, what its stakes are, why is it told, and what it seeks not only to say but to do (ibid., p. 236). He goes on to state that there is a range of reasons for telling a story, from self-interestedness to altruism. Seduction of the reader as well as aggression toward her can both be reasons for telling. The textual energies are partly directed towards the transferential (power) relationship between the narrator and her narratee. In a later article, Brooks states explicitly the power dimension of transferential relationship: 'Freud repeatedly describes the relation of analyst and analysand in the transference as one of struggle, struggle for mastery of resistances and the lifting of repressions, which continually evokes a realm of the daemonic. With reader and text, the struggle must eventually put into question any assumed position of mastery or privilege, which is why we must reread, speak again, retransmit.' (Brooks 1987, p. 12.) Brooksian transferentiality is a good reminder of the possibility of narrative power struggles.

The rhetorical model builds on this notion of fiction being a multi-layered communication (Phelan 2009, p. 310) between the implied author and her audience via the narrator's narration directed at fictional narratee(s) within the fictional world (Phelan 2005, p. 1). The layers of author-to-reader and narrator-to-narratee are distinct and in specific, dynamic relationships. Phelan states: 'the dynamics of audience response (or, in terms of the definition, the role of the "somebody else"), narrativity encourages two main activities: observing and judging. The authorial audience perceives the characters as external to themselves and as distinct from their implied authors, and the authorial audience passes interpretive and ethical judgements on them, their situations, and their choices.' (Phelan 2005b, p. 323.) Phelan further clarifies this stratification (in footnote 2): 'The narrative audience typically makes such judgements as well, but the authorial audience's role is more crucial to the rhetorical understanding of narrativity' (ibid., p. 336). (I will shortly go into more detail about the notion of 'narrative audience' and its relations to 'authorial audience' and 'narratee'.) The narratees, (narrative audiences) and authorial audiences are therefore on different levels of this communicative model, as are narrators and authors. I will elaborate on this rhetorical model of narrativity in more detail below, but for now it suffices to say that here we have a model attuned to the multi-layered nature of fiction as a communication between various actors on different levels of narrative. This stratification is distinct to fictitiousness, as the persona of implied author and authorial audience (as separate from the narrators, narrative audiences and narratees) are typical to fiction and in contrast to all factual narration. How then, is this made tally with Foucault and his characterisations of power relations?

Foucault, in his 1982 essay on the subject and power, makes a distinction between communication and power relations:

> It is necessary also to distinguish power relations from relationships of communication which transmit information by means of a language […]. No doubt communicating is always a certain way of acting upon another person or persons. But the production and circulation of elements of meaning can have as their objective or as their consequence certain results in the realm of power; the latter are not simply an aspect of the former. […P]ower relations have a specific nature. Power relations, relationships of communication, and objective capacities should not therefore be confused. This is not to say that there is a question of three separate domains. […] It is a question of three types of relationships which in fact always

overlap one another, support one another reciprocally, and use each other mutually as means to an end. (Foucault 1982, pp. 786–787.)

Power overlaps communication and vice versa; they may support each other or use each other as a means to an end. Is there, therefore, 'narrative power'? One could say that if narration is conceptualised as rhetorical communication, one can see some – but not all – of the above-listed Foucauldian power characteristics realised by fictional types of narration. If one checks the list, one can see whether each item could be applied to the instance of fictional narrative as seen by rhetorical narratology and its multi-layered communication model:

1) Fictional narratives, their writing, reading and interpretation do bring into play relations between individuals, the narrator to narratee, the author to audience; 2) the act of narrating may be seen to act on the actions of the audience(s), their ways of relating to what is told and their acts of interpretation; 3) the narration can be seen to be a function of consent: the narratee consenting to being told something; the narrative may have, though (like Peter Brooks (1987) maintains) coercive aspects, as the narrator imposes her own ideas on the audience; 4) the narrative relation is based on the other as being seen as a person, not a mere body; 5) the subjects in narrative relations are all free to act in ways they wish; 6) there are at least *in potentia* possibilities for the object of narrative power to react to the power used (e.g. discontinuing reading, or interpreting the narrative in a different manner from the one intended for by the narrator); 7) the narrator/implied author tries to guide the interpretive conduct of the audience; 8) the issue of subjectification of the object of power is more tricky: is the audience subject to control or dependence (in meanings other than depending on the source of information for the informative basis for interpretation)? Is the object of narrative power use, the audience, tied to her own identity by self-knowledge due to the narrative power relation? This is one of the points at which narrative power may differ significantly from 'power relations proper'; 9) the narrative system of differentiation into narrator and narratee, author to audience, is perhaps weaker than in, say, diagnosis, but one can see something of this in the narrator's 'taking the floor', by her acting on the traditional privilege of all narrators and of assuming the right to be heard; 10) the objectives of the narrator/author may be quite hidden, but they do exist nonetheless – the interpreters' consensus on what these objectives are may be lacking, though; 11) the narrator/author has only the means of her words to bring power relations into being; 12) can one call narration an 'institutionalised' form of power? At least it is not as in-

stitutionalised as, say, diagnostics (as in the meaning of having a large organisation behind it), but it does have an established customary basis (that of certain forms and situations of narration), therefore one can claim that narration is, in a weak sense, institutionalised; 13) the same can be said of the rationalisation of narrative: in a weak sense, narrative power relations may be seen to be more or less elaborate in relation to the effectiveness of their instruments and the certainty of the effect of their results, (the narrative effect, the reaction the narration seeks, as will be soon seen, is a rather uncertain thing to achieve: there are definite tools to achieve it, but the effect on the audience often has an unsound basis); and 14) the knowledge basis the narrative power relation rests on is not only scientific, but extends to all knowledge relayed in the communication streams of a narrative.

Narrative power can often be seen to make (in items 11, 12, and 13) a weaker claim to be called a Foucauldian 'power', and in the central question of narrative power's potential for subjectification (in item 8), the case is unclear. Is narrative power a subjectivising force in the Foucauldian meaning of the word? I would say no, not exactly. These differences support the Foucauldian position that communication can be differentiated from power relation as such.

Therefore, the 14-point list of Foucauldian power characteristics cannot be completely realised in the case of fictional narration, precisely due to its nature as communication (a type of activity Foucault himself sets apart from the exercise of power). This is one way I intend to connect Foucault and rhetorical narratology, by noticing certain power results that rhetorical fictitious communications can have in the relationships between narrators and narratees, and authors and readers.[16]

My 'Foucauldian-Phelanian' model therefore differs from the above-described 'Foucauldian narratologies' by establishing a clear stratification of the fictional world: *the power relations that are present in narrative are not between narrators and characters* (like Bender, Seltzer and Miller propose), *but between narrators and narratees, authors and authorial audiences*, *in which the formulation of the audiences' reactions to the told are what the exercisers of narrative power seek to direct and control by using definite thematic tools and narrative techniques.* This is my definition of narrative power, and in this formulation, the exerciser of narrative power (narrator, author) is on the same ontological level as those on whom the power is exercised (narratee, authorial audience). This gives the object of the power relation at least a theoretical

16. This is not, however, the way Foucault himself saw 'literature' when he overtly tackled the notion. I will outline Foucault's way of handling and defining 'literature' at the end of this chapter, where I will also justify the linking of my three different literary analytical tools: rhetorical narratology, cognitive narratology and Foucault's theories.

possibility of reacting to the use of power, e.g. the reader could discontinue her reading or make a decisively different interpretation of the narrative from the ideas of the narrator or even implied author, or the narratee could object to the narration (these possibilities are perhaps sometimes rather theoretical, I admit, especially in the case of fictional narratees, who do not necessarily get much space in the narrative in the first place, but can sometimes only be inferred from the narrator's act of narrating. Nevertheless, these still remain possibilities, since the actors are on the same ontological level, i.e. the same level of communication with each other). Furthermore, I make the crucial distinction that 'narrative power' is not a fully developed form of power in the Foucauldian sense. Narrative power only displays certain characteristics of power relationships; some characteristics have been shown to be weaker than in 'proper' Foucauldian power relations. This is also the basis for my distinction between the readerly diagnostic move and those made intra-textually: as the reader makes a diagnosis, she is only reacting to information given to her by the text's communicative structure, i.e. its narrative power structures; she is not in a 'proper' Foucauldian, reciprocal power relation with the character/narrator she is diagnosing. Thus, she is not exercising 'proper' power – even if she is making a diagnosis. This is an important distinction, as it underlines my model's communicative and ontological layers. I will still refer to this literary phenomenon of influencing the audiences' reactions as 'narrative power' for the sake of simplicity, and because, as Foucault points out in his essay, these power characteristics of communication are distinctively just that: power characteristics.

In the context of madness narration, and in the scope of this study, the thrust of the narrative power can be seen to specifically focus on the *depictions of madness*: how madness is depicted and described, how the psycho-sciences are perceived in particular narratives, etc. Therefore, the narrative power thrust I focus on is not an over-arching narrative force, it is instead tuned to the specific nuances of the depiction of madness and its relations to the depiction of psycho-sciences, in the vein of the psychiatric literature research I am establishing here. I do not argue that narrative power should always be thus confined (even in the case of the study of madness narratives) to cover only this theme and depiction, nor do I develop the notion to cover all its contingencies and variations – for that would be beyond the scope of my study. I aim to use the notion of narrative power in a restricted manner, to decipher the depiction of madness and the psycho-sciences in madness narratives, because I seek the nexus of narrative power and the way it uses the madness theoretical frameworks I simultaneously put into play here. The study of this nexus

enables me to ask the thematic question: What does fiction tell us about madness and the psycho-sciences, and how does it do it? At the end of Chapter 4, I will briefly consider the limitations of my approach to these questions and the future possibilities the study of narrative power might hold in general.

3.3.2.2 Foucault's Knowledge-Power: A Basic Force in Narration

I shall now further add more detail to the notion of fusing Phelanian rhetorics with Foucauldian ideas on power by introducing Foucault's notions on *knowledge intertwining with power, the régime du savoir*, in more detail. (See the Foucauldian list, point 14; here, I will follow Martin Kusch's summary.) This Foucauldian theory on knowledge-power is crucial for my notion of rhetorical 'narrative power', as it sheds light on the narrators' and implied author's one central instrument in directing the audiences' reactions on what is being narrated about: the streams of narrative knowledge (in analysing madness narratives, this knowledge especially pertains to diagnoses: their justifications, aims, social meanings, etc.).

Foucault claims in his genealogical studies that 'the truth' is a group of rules and regulations produced by scientific statements; he calls these groups 'the regimes of truth' (*régimes du savoir*), meaning that *these groups or frameworks that formulate knowledge are linked to systems of social power and strengthen, sustain, and utilize the produced knowledge* (Kusch 1993, p. 170). According to Foucault, knowledge can be produced only inside social power systems and against their background (ibid., p. 171). Thus, in the Foucauldian model of the history of science, the process of producing knowledge is thoroughly permeated by Nietzschean agonism: the structures of science are results of endless power struggles between scientists, and these struggles do not cease when the structures are born, which means that they are always to some degree contestable (ibid., p. 144).

This is linked to Foucault's conception of scientific 'facts' as 'man-made' or produced in the process of making science, rather than 'discovered' in the same process. This viewpoint is called 'irrealism', and it is rather easy to see that Foucault is an irrealist: already in his archaeological study, *The History of Madness*, Foucault states that the object called 'madness' is constituted in different contingent processes and through them. This means that madness is not a given fact, ready to be 'discovered' by psychiatry, 'out there' in the nature or society; it can be discovered only after

being constituted in different practices and struggles between different actors in society and science. (ibid., p. 161.)

The formation of psychiatry as a science is thus unavoidably linked to these power structures and struggles. The birth of psychiatry as a 'liberator of the mad' and the progress in caring for and curing the mad is therefore seen in the Foucauldian manner as something not at all splendid: Foucault is very sceptical about the 'progress' of psychiatry and science in general. He does not deny the possibility of progress; he only contests the assumption that it is always an improvement that comes without costs. (ibid., pp. 158–159.) Foucault attacks psychiatry's claim to base itself on 'humane' principles by placing the history of psychiatry in a Nietzschean ironical light: he states that the humanitarian influences that psychiatry claims to be founded upon must be revealed to be influences of power struggles and manipulation.[17] This interchanging of something valuable (the integrity and humanitarianism of the science of psychiatry) for something low (psychiatry as power-ridden and manipulative) has generated much criticism (ibid., p. 155) from those who regard the purity of science as a precious notion.

Foucault also aims to recover what he calls 'subjugated knowledge', knowledge that is excluded from the prevailing scientific canon as unscientific, naïve or untrue (this exclusion of certain kinds of knowledge is one aspect of the on-going power struggles that govern and form science) (ibid., p. 129). One example of subjugated knowledge is a mental patient's knowledge. This is the famous 'silencing of the mad' that Foucault traces in his *History of Madness*. Foucault sums it up by stating that one can belong to the power system of truth only by obeying the rules of some 'discursive police' (ibid.).

This very brief presentation of Foucault's theories on power and scientific knowledge still needs a connecting bridge to the lay use of knowledge in making a diagnosis of oneself or another person, which I also include in my definition of 'diagnosis'. Kusch states that scientific knowledge usually spreads into society at large and changes and strengthens the pre-existing power networks, and it also offers new and improved power mechanisms, resources and means to different individuals and groups (ibid., p. 132). Scientific knowledge does not live only in laboratories; it is at large in society.

17. For example, Foucault traces the 19th century's psychiatric concept of 'monomaniac homicide' to the need of the psychiatric community to strengthen its social status by claiming that only a psychiatrist can identify a monomaniac murderer (whose only symptom of madness is the unexplained murder) and treat her. By thus entering the judicial world as experts of monomaniac homicide, psychiatrists could gain in importance; and when this goal had been achieved, the concept was quickly disposed of. (Kusch 1993, pp. 152–154.)

From this brief outline, we can already see how knowledge intertwines inexorably with social power: it is produced inside power relations, supported by them and in return supports them (as Foucault also maintained in his aforementioned 1982 essay).

How, then, does this connect with fictitious madness narratives and Phelanian rhetorics?

Even though Foucault himself would not probably have been interested in such micro-levels as narration seen rhetorically and the *pieces* of knowledge circulated therein, but rather on the scientific knowledge *systems* (like narratology for example) and their interlinkings with social power, I wish to apply Foucault's concept of knowledge-power on the micro-levels of rhetorical communication and be thus inspired by Foucault's tying together of social power and knowledge. (Like I will press at the end of this chapter, I am not a 'proper' Foucauldian scholar; Foucault was a fervent anti-humanist for one, whereas I am a humanist reading and applying him, perhaps in an unotrhodoxical manner, humanistically.) I argue that if narrative is seen as rhetorical communication, there has to be information – knowledge – relayed from one communicating actor to another, be they characters, narrators, narratees, readers or implied authors. When one adds to this picture the notion of narrative agents in madness narratives making and receiving diagnoses (which, as we saw above, is a power relation *par excellence*) which are represented and formed inside specific narrative techniques and thematic structures that form and direct streams of narrative knowledge to further certain narrative agendas, one can start to perceive the possibilities of building a madness-narrative power-structural notion of narrative power.

Thus, in the Phelanian rhetorical model of narrative, readers make three kinds of judgements– the interpretive, the ethical and the aesthetic – when reading. These three forms of judgement overlap or affect each other. Interpretive judgments about 'the nature of actions or other elements of the narrative' thus react with the ethical and aesthetical judgements the readers make.[18] (Phelan 2005b, p. 324.) The knowledge content of narrative is obviously a vital layer of meaning when the reader starts to

18. I will be dealing with the aesthetics of madness narration in more detail in the second part of the study. In the first part of my study, I will be concentrating more on the interpretive judgements of delineating the ways my target narratives build the themes of psycho-science and madness depiction, because I see this interpretive layer as the most fundamental to my research question of psychiatric literature research: e.g. in the ways the target texts use psycho-scientific information and theory formation in supporting their narrative agendas. Of course, strict drawing of borderlines between interpretation, ethics and aesthetics is impossible, like Phelan notes, and I will also highlight the way narrative power directs the ethical interpretations of the audience. In the second part of my study, I will ask more questions about the ethical and aesthetic structures of madness narratives.

form her ethical reactions to the text, and where is ethics needed, I argue, there is always at least a vestige of power used. The Phelanian perception of interpretation is further supported by the Foucauldian notion of knowledge intertwining with power: the information supplied in the narrative by the narrative figures (narrators, and characters inside narration) is unavoidably interconnected with narrative power, because it is linked to the narrator's and author's wish to control the audiences' reaction to this information.

This presents one more reason for me to call the narrator's persuasive thrust narrative 'power', as the rhetorical formulation of 'for some purpose' for which each narrative is narrated is pregnant with issues of power and ethics. I therefore take the Phelanian emphasis on the ethical aspects of narrating and reading a small step further by my own emphasis on the *power relational side* of the communication in madness narratives: my emphasis is on the *persuasive, even coercive act* of narration and the audience's at least *in potentia* possibility of resisting this persuasion by their own acts of receiving and interpreting; there is, therefore, at least the potential for a relationship of struggle, and thus the presence of power. 'Narrative power' is, further and importantly, a specific, heuristic tool for me to decipher how particular madness narratives depict, in their unique ways, madness and the psycho-sciences: not only 'what madness is', or 'what the psycho-sciences are like', but also 'how they are depicted, with what literary devices, and for what purposes'. This combining of the levels of 'diagnostic content' (the representation of the diagnostic relationship, the 'what') and the 'narrative power relational vehicle' (the 'why' and 'how' of madness narration, the purpose for which the diagnostic relationship is being depicted in a definite manner) is essential – obvious even – because it belongs to the nature of fiction when seen as rhetorical communication. The issues of 'what' cannot be severed from the 'why and the 'how'. (Phelan also sees this, as he makes the interpretive, ethical and aesthetic link with each other (ibid.).)

I will now elucidate in more detail what the narrative power includes in practice in the specific context of madness narration. I formulate, using Phelanian rhetorics, Suzanne Keen's narrative empathy theories, and cognitive narratology, two narrative techniques and two thematic tools (with one specific sub-section) that madness narrative narrators and authors use as instruments when attempting to direct the audiences' reactions. The thematic tools are: experientiality (based on cognitive narratology); and in-group/out-group positioning (based on Keen) under which there is the special case of stigmatisation as a tool of controlling the specific madness narratives' groupings. The narrative techniques are: narrative situations (based on

Phelan and Keen, and further elucidated by certain classics of narratology); and narrative progression (based on Phelan). All of these techniques and tools intertwine inexorably with (my interpretation of) the Foucauldian force of knowledge-power. The techniques order and organise narrative knowledge and the thematic tools use narrative knowledge in their building of thematic structures, all in an attempt to direct the audiences' interpretations.

One can further link these techniques and tools with each other: the techniques of narrative progression and narrative situations support the whole narrative's structures, including the thematic structures built by the thematic tools. Experientiality as a theme also pervades the other thematic tool's area of influence (in-group/out-group positioning, and stigmatisation as a special case of this) by being the 'currency' with which the group positioning functions (the depiction of in-group or out-group members' experientiality is, e.g. used in moulding the picture the audience gets of the in-group or out-group, or of stigmatisation). Thus, the two techniques (narrative progression and situations) are 'pure' narrative technical means to order and structure the narratives – the 'how' of narration – and they affect the thematic tools (experientiality, grouping, stigmatisation), which pertain to the 'contents' of madness narratives – the 'what' narrated. Therefore, in my analyses of the target texts, I will move between the narrative technical basis of narrative situations and plotting, and the elucidation of how different narrative situations and plot structures support and construe the 'what' – the contents of madness narration (the experientiality, grouping, and stigmatisation).

In using these techniques and tools to analyse my target texts, I will ask questions like: *Through whose point of view does the narrator narrate, and for what purposes (= Narrative situations)? How do the madness depictions and their diagnostic relationships evolve through narrative time (= Narrative progression)? Who gets space for her expressions of experientiality in the narrative? Whose point is expressed in the narrative, from whose point of view is it tellable? Whose qualia are in question (= Experientiality)? What kinds of groupings are there in the narratives? To which group do the narrator and characters belong (= In-group/out-group relations)? How does the narrator handle the group positioning through the handling of the social construction of psychiatric stigma (= Stigmatisation)?*

In my following presentation, I will first outline the thematic tools and then the narrative techniques used in madness narratives to direct the audiences' reactions.

3.3.2.3 The Concepts of Implied Author, Authorial Audience and Narrative Audience, and the Relationship between Narrators and Implied Authors

Before I go on to define the tools and techniques of narrative power, I will first establish definitions of the concepts of 'implied author', 'authorial audience', and 'narrative audience', which have figured frequently above without being properly defined. They are central to the building of my rhetorical-communicative model of narrative power, because the authorial audience's reactions are those that are most important for the rhetorical model of narrative persuasion, and also because the implied author as a narrative power agent is in a crucial position in determining the rhetorical thrust of her narrative. The narrator/narratee link can be seen to be subordinate to the implied author/authorial audience link, as the authorial audience observes and judges (Phelan 2005b, p. 323) the fictitious world and its inhabitants by joining the narrative audience – that is: also, the narrator/narratee link and its functioning.

The concepts of implied reader/authorial audience and especially implied author have been the focus of a heated discussion that has revolved mainly around the question of the unreliability of narration. Ansgar F. Nünning among others has voiced his doubts about the necessity of the whole concept of implied author as formulated by Booth: Nünning regards it as poorly defined, dysfunctional and unnecessary, and the reader could do very well without it. He believes that the reader herself 'naturalises' the inconsistencies of the text (i.e. makes an interpretation that the text contains unreliable narration) by using her own cognitive frameworks, which change over time and from person to person. Nünning writes: 'In other words: whether a narrator is called unreliable or not does not depend on the distance between the norms and values of the narrator and those of the implied author [as in the famous Booth model] but between the distance that separates the narrator's view of the world from the reader's or critic's world-model and standards of normalcy' (Nünning 1999, p. 61). James Phelan sums up the discussion on implied author as follows:

The debates about implied author, then, entail several underlying and interrelated theoretical issues:

1. the elegance and effectiveness of the communication model: Booth, Chatman, and Rimmon-Kenan all find implied author to be a necessary part of such a model; Genette finds it to be (largely) unnecessary; and Bal and Nünning find it to be an impediment to narratological analysis;

2. the role of human agents in the communication model: Booth's idea of the implied author as a second self entails the view that the implied author is a human agent; Chatman and Rimmon-Kenan, however, explicitly reject what they refer to as an anthropomorphic conception of the implied author; Nünning agrees with that rejection but wants to take the additional step of eliminating the category completely;
3. authorial intention: Booth's concept of the implied author does not explicitly embrace authorial intention as the key to interpretation, but it does not deny a role to intentionality either; Chatman, Rimmon-Kenan, and Nünning, on the other hand, carefully distance themselves from any allegiance to interpretations based on authorial intentions;
4. the role of the reader: in Booth's model, the reader infers what the author implies; in Nünning's model, the reader constructs the text's structure and, indeed, various features of the author;
5. the relation between narratology and other developments in criticism such as constructivism and cognitive models of understanding. (Phelan 2005, pp. 44–45.)

Thus, different solutions to the problem of who or what is 'behind' the narrative's overall meaning or message, and its values and norms have been formed. Chatman and Rimmon-Kenan have offered the notion that the implied author is a purely textual function, something that must be depersonalised and seen as more or less equalled with the whole of the text. Nünning has proposed that the whole concept be disposed of. Phelan, however, regards it is a valuable concept and has suggested a new version of how to conceptualise the implied author in a more suitable and heuristic way. Phelan's formulation is as follows: '[T]he implied author is a streamlined version of the real author, an actual or purported subset of the real author's capacities, traits, attitudes, beliefs, values, and other properties that play an active role in the construction of the particular text' (Phelan 2005, 45; I will come back to Phelan's definition and its problematics in Chapter 5).

I agree with Phelan on the question of the utility of the concept of the implied author for the simple reason that there must be some kind of purpose and plan behind the inconsistencies in the text that the reader then, as Nünning states, naturalises as unreliability: one cannot forget about the intent behind the text – the reader cannot naturalise the text in any way she pleases, there must be some constrains or directions in the text itself. In addition, there must be ways to conceptualise the situations in which the actual author differs from the writing self, for example, in ghost writing

and collaboratively written works. This implied author's intent behind the text is, I admit (as will be discussed below), only recoverable through readerly interpretation of the text, and one interpretation of authorial reading may not coincide with other readers' interpretations of the same authorial reading – which makes the pattern more fuzzy. But still, I would argue that the notion of implied author – and of the authorial reading – is important: it is the point of orientation in the text the reader in my argument seeks – to recover or to overthrow by critical reading of it.

Certain questions arise, though: what are the positions of flesh-and-blood readers in relation to the text and its implied author and authorial audience (as Phelan calls the implied reader)? Is the text's authorial audience position intra- or extra-textual? How perceptive is the authorial audience? Can it read against the grain, perceive different ways of seeing, e.g. the implied author's values (does the authorial audience of *One Flew over the Cuckoo's Nest* see the sexism and racism inherent in the novel, for example)? How does the authorial audience relate to narrative audience? I will consider Phelan's and Rabinowitz's answers to these questions.

In Phelan's model, 'The implied author moves outside the text, while the implied reader, which, in my rhetorical model is equivalent to the authorial audience, remains inside the text. The implied author as the constructive agent of the text builds into that text explicit and tacit assumptions and signals for the hypothetical ideal audience, the audience that flesh-and-blood readers seek to become.' (Phelan 2005, p. 47.) The authorial audience is an ideal audience which perfectly understands the implied author's intentions (ibid., p. 213). Thus, it can be inferred that while the authorial audience is intra-textual and the flesh-and-blood reader and the implied author are extra-textual, the implied author can only be known through and in her text – in her designed assumptions and signals that the authorial audience then decodes. Can the authorial audience read against the grain, then? What does 'ideal' mean in the 'ideal audience'? Phelan's own reading of Ishiguro's *The Remains of the Day* offers some clues: he comes to the conclusion that the authorial audience cannot disambiguate the climactic scene; its interpretation remains inconclusive. However, this does not prevent flesh-and-blood readers from coming up with resolutions to that ambiguity, resolutions which may vary considerably but which different readers may feel to be self-evident, even if not shared. (ibid., p. 59.) Thus, the question of the extent of authorial audience's readings – or what we, the flesh-and-blood readers may know of them – is perhaps unanswerable: how does one know when one's reading is a successful joining to the authorial audience and when not? Phelan states: '[T]he flesh-and-blood reader will attempt to enter

the authorial audience, but that entrance can be affected by the reader's own set of beliefs and values. Recognizing this phenomenon is one reason that the rhetorical model does not privilege authorial intention over textual phenomena or reader response but instead proposes a feedback loop among these three components of the rhetorical exchange.' (ibid.) The flesh-and-blood reader may misread, but can she ever know when? Additionally, there is no absolutely sure way of telling how wide the authorial audience's perception is: in the case of Ishiguro's climactic scene and the two differing interpretations that Phelan and Mary Patricia Martin give (Phelan 2005, pp. 53–65), is the authorial reading such that it covers the two very different viewpoints, or is one of them, or both, a misreading?

In his model, Peter J. Rabinowitz does privilege the authorial reading – a reading in which, like in Phelan, the flesh-and-blood reader (or the actual audience, as Rabinowitz terms it) tries to join the authorial audience. Regarding the value of authorial reading, Rabinowitz states that most people try to read as the authorial audience; and that authorial reading is necessary for grounding many other types of reading, be they resistant or critical: 'But while authorial reading without further critique is often incomplete, so is critical reading without an understanding of the authorial audience as its base' (Rabinowitz 1998, p. 32).

According to Rabinowitz, though, the authorial audience is not a Phelanian ideal audience which perfectly understands the implied author's intentions, but rather a matter of social convention; the actual author writes to a hypothetical, more or less specific audience – the authorial audience (ibid., p. 21). The author cannot trust or be completely sure that her work is met by the ideal audience, as the real readers (the actual audience as Rabinowitz calls us) are totally out of the author's control and all she can do, when designing her work, is to guess (ibid.). What does it mean, then, to read as the authorial audience? Rabinowitz states: '[S]ince the structure of a work is designed with the authorial audience in mind, actual readers must come to share its characteristics as they read if they are to experience the text as the author wished. Reading as authorial audience therefore involves a kind of distancing from the actual audience, from one's own immediate needs and interests.' (ibid., p. 25.) The reader must become part of the social community that the author had in mind when writing: 'To join the authorial audience, then, you should not ask what a *pure* reading of a given text would be. Rather, you need to ask what sort of *corrupted* reader this particular author wrote for: what were the reader's beliefs, engagements, commitments, prejudices, and stampeding of pity and terror?' (ibid., p. 26.) Reading as the authorial audience, and reading that reading, makes it possi-

ble to reveal social and political frameworks the work presupposes; for Rabinowitz, reading is thoroughly political.

What are the relations then, between the authorial audience, actual audience and the author?[19] The author is certainly extra-textual in Rabinowitz's model, and so is the actual audience, but what of the authorial audience? It is a hypothetical one, but having the form of a social convention – a community agreement – and as such it seems to me to be more extra-textual than intra-textual. In a successful authorial reading, the author and the reader are members of the same community. The rules that the actual reader applies to the text are given by the text itself only to certain degree, otherwise they *pre-exist* the reading of the text. (ibid., p. 42, p. 168 & p. 71.)

How about the width of the authorial audience's scope: can it read against the grain? The actual reader may very well read against the grain – but can do so effectually only if she perceives correctly the authorial reading. Rabinowitz thus gives us tools to handle a critical or resistant reading by distinguishing the actual audience's reading from the authorial one. (Here, Rabinowitz gives additional support to my interpretation that narrative power can be likened to Foucauldian 'proper' power: the reader may resist the exercising of (narrative) power by producing a critical, resistant reading of the narrative, like Foucault emphasised in his formulation of power.) Yet how are we to know what the authorial reading is? Can Rabinowitz give any better answers to this question than Phelan? I would say no. As a matter of fact, Rabinowitz himself states that authorial reading for the actual reader is *impossible* (ibid., p. 32) due to the actual/authorial split: '[T]here are many [texts] (perhaps all) where neither scholarship nor imagination is sufficient to allow us to recover the text in the sense of experiencing the full response that the author intended us to have as we read' (ibid., p. 33). The 'perhaps all' gives away a lot: as in Phelan above, it is impossible to know for sure whether one has successfully joined the authorial audience or not.

Thus it is necessary to keep in mind how flimsy the basis of the notion of authorial reading is: it is a social convention or text-based; it is desirable (in itself or as a basis for critical reading) but sometimes (always?) unattainable; it is contingent to speculation because it is not something straightforwardly, outspokenly manifest in the text but inferred from it as a whole (Phelan), or it pre-exists outside of the text as the rules of reading shared by a vast number of social reading and writing communities, and the specific application of the rules to specific texts is difficult (Rabinowitz). However, I maintain that the notions of implied author and authorial

19. Rabinowitz sees the term implied author only as 'variant formulations of the notion of authorial intention' (Rabinowitz 1998, p. 23).

audience are valuable. They only underline the difficult task of interpretation, but that should not hinder us from trying to join the authorial audience and, sometimes, even attempting a critical reading on its basis.

There is still one missing link that I have not addressed: the narrative audience. This is, for Rabinowitz, the audience for whom the narrator's tale is real, not fiction (as it is for the authorial audience and actual audience) (ibid., p. 100). For Phelan, the narrative audience is the 'observer role' the flesh-and-blood readers enter within the world of fiction (in Phelan's foreword to Rabinowitz 1998, p. xxii). For both Phelan and Rabinowitz, the narrative audience is the role flesh-and-blood readers take on in order to understand the fictitious world on its own terms. Thus, I see that it offers the missing link between the two ontologically different levels of fictitious narrative when it is seen as rhetorical communication – those between the implied author/authorial audience and the narrator/narratee. As Rabinowitz writes, 'In the proper reading of a novel, events that are portrayed must be treated as both true and untrue at the same time' (ibid., p. 94). Therefore, we need the narrative audience position to mediate between these layers of truth and untruth.

In the following pages I will apply the term 'reader' in the meaning of a person (myself) trying to join the authorial audience by also joining the narrative audience. Only when I attempt a critical reading, against the grain of what I perceive as the authorial reading (as far as I can tell), will I make distinctions between authorial audience and actual audience. The 'reader' I am and have in mind is an active agent who tries to decipher the text and its clues and cues as effectively as possible, both on the level of its fictitious truth and its level of being an artful representation. So, she is an extra-textual being (an actual audience member) trying to understand the intra-textual position that the text offers for its narrative audience, and finally, its (ideal) reader. In this manner, I attempt to combine what I find most useful in Phelan's and Rabinowitz's positions. This, I would like to claim, is the position of reading: to always move between the text and one's own characteristics as a reader, offering the dynamism of both intra- and extra-textual positions.

In the relationship between implied authors and narrators – the two groups of narrative agents that use narrative power in my model – I will stress (perhaps more forcefully than Phelan himself) the Phelanian notion of the implied author playing 'an active role in the construction of the particular text' (Phelan 2005, p. 45). In my view, the implied author creates the narrator who then 'makes visible' the fictitious world by narrating about it. Implied authors have their own narrative agendas (their own wishes to influence the authorial audience) but they have to go

through the detour of creating a narrator and her fictitious world through which to express their ethical and aesthetic values to the reader. The narratorial act is the elemental act of the fictional world, the narrator's use of narrative power tools is the basic level of narrative power on which the implied author and the authorial audience also base their communication.

I argue that the narrative power used by the implied author becomes most visible in the cases of unreliable narration and focalisation: as in Booth already, the implied author and her narrative agenda become most noticeable when the narrator or focaliser is unreliable – when the implied author, through handling the gaps and incongruities of the narrator's text, directs the authorial audience to see that not everything is in order in the narrative. When the narrator is reliable, the implied author's directing of the authorial audience's interpretations is in harmony with and comparable to the narrator's guiding of the narratee's interpretations. The guiding of the authorial audience's reading is the ultimate goal of the implied author, but she can only reach this goal by making her narrator narrate in a specific manner. In the context of madness narratives, I will mostly concentrate on the aspects of madness and psycho-science depiction: Is the narrator reliable in her depiction of madness or the psycho-sciences? How does the narrator's way of using the tools of narrative power affect the authorial audience's perceptions of madness or psycho-sciences?

Now, having clarified my positions on the author/audience debates, and the relationship between implied authors and narrators, it is time to see what sorts of tools and techniques the exercisers of narrative power – the narrators and implied authors creating narrators – have in their reserves when trying to influence their audiences' reactions.

3.3.2.4 The Thematic Tool of Experientiality

I argued above that the basic medium through which the other thematic tools of group positioning and stigmatisation function is experientiality. This is the general subject matter of narration seen in Fludernikian and Hermanian veins of cognitive narratology. I argue further that it also is the 'something' that the rhetorical 'somebody' tells to another 'somebody' for 'some purpose'. I take this slight detour through what Margolin calls the 'super-discipline' (Margolin 2003, p. 271) of cognitive narratology here precisely because rhetorical narratology leaves the narratives' paradigmatic content empty; it is only defined as 'something'. I claim that by filling

in that 'something' with cognitive 'experientiality,' I achieve some further sharpening of focus on which thematic tools narrative power operates with.

To address the issue of the contents of narrative, one can stress, like David Herman, the 'qualia', or the 'what's-it-like' feature of narratives (Herman 2009, p. 157), i.e. the experiential side to the issue of diagnosis-making; and the madness narrative is, I argue, a forceful medium for conveying this experiential side of diagnosis-making. Herman writes:

> Stories, thanks to the way they are anchored in a particular vantage-point on the storyworlds that they evoke, and thanks to their essentially durative or temporally extended profile, do not merely convey semantic content but furthermore encode in their very structure a way of experiencing events. [... N]arrative, unlike other modes of representation such as deductive arguments, stress equations, or the periodic table of the elements, is uniquely suited to capturing what the world is like from the situated perspective of an experiencing mind. (ibid.)

In emphasising experientiality as a constitutive basic building block of narrativity, Herman partly follows Fludernik, who in her seminal *Towards a 'Natural' Narratology* (1996) made experientiality the only definitive condition for interpreting narratives as narratives. In a later essay, Fludernik summarises her viewpoint on experientiality:

> ['Experientiality'] describes the typical quality of narratives in which surprising events impinge on the protagonist (usually coterminous with the narrator) and are resolved by his (or her) reaction(s) – a sequence that provides an illustrative 'point' to the story and links the telling to its immediate discourse context. [...] By introducing the concept of experientiality, I was concerned to characterize the purpose and function of the storytelling as a process that captures the narrator's past experience, reproduces it in a vivid manner, and then evaluates and resolves it in terms of the protagonist's reactions and of the narrator's often explicit linking of the meaning of this experience with the current discourse context. (Fludernik 2003, p. 245.)

Fludernik here refers to the Labovian 'evaluative functions', which Labov refers to as the '*raison d'être*' of narrative – the point of the story and its tellability. The evaluative functions consist of 'all the means used to establish and sustain the point, the contextual significance and tellability, or reportability, of a story. [...] It is the

pre-eminent constituent by means of which the narrator's personal involvement in a story is conveyed.' (Toolan 2001, pp. 151–152.)

Herman makes a slight reinterpretation of the centrality of experientiality to narrative, though, by saying that 'capturing what it's like to experience storyworld events constitutes a critical property of but not a sufficient condition for narrative' (Herman 2009, p. 141). This is a continuation of Herman's critique of the Fludernikian narrativity-as-experientiality. Herman points out that the role of 'Experiencer' is 'just one participant role made possible by the narrative system' (Herman 2004, p. 169) and 'that system allows different preference rankings for the role of Experiencer to be matched with different narrative genres'. (ibid.) Matti Hyvärinen has also made a point of keeping experientiality and narrativity further apart than perhaps Fludernik does; he contends that narratives are a way of reporting, understanding and structuring lived experiences – but that narrative should also be understood from a non-functional viewpoint so that it does not end up being a general category of all understanding of experience (Hyvärinen 2007, p. 137). He also argues that there are experiences that are not narrative in nature, and that there thus a gap between experience and narrative (Hyvärinen 2004, p. 301).

Herman and Hyvärinen therefore consider experientiality not to be the sole defining factor of narrativity – of the essence of narrative as narrative – but they nevertheless hold (Herman in 2009) a central role for experientiality. Herman also defines narrativity by using the notion of 'what it's like' in addition to other factors, such as that the representation is situated in 'a specific discourse context or occasion for telling'; it 'cues interpreters to draw interferences about a structured time-course of particularized events'; and these events introduce 'some sort of disruption' into a storyworld 'involving human or human-like agents' (Herman 2009, p. xvi).[20] I regard experientiality as *a* definer of narrativity in the same manner as Herman and Hyvärinen; it is an important factor in defining narrativity, but it is not the only one.

Both Fludernik and Herman seek the cognitive parameters and conditions of narrativity, i.e. what makes narratives narratives. My starting point is different, however. I am not interested in the cognitive framework as such, or how the reading or narrating mind in general works. What I am interested in is how the aspect of experientiality as a narrative function is controlled and used as a grounding thematic tool of narrative power, as an addition to my 'Foucauldian-Phelanian' rhetorical

20. Hyvärinen has stated that Herman's formulation creates a problem of perceiving the relations between the four elements of narrative; and that the four elements can be qualitatively differentiated (Hyvärinen 2010, pp. 148–149). However, he does not argue that Herman's model is dysfunctional; he only wishes to clarify the relationships between these four elements.

frame of analysis.[21] Thus, I take the cognitive narratologists' experientiality as one grounding, thematic tool of control through narrative power: *it is how narrators and authors control the experiential contents of narratives in order to direct their audiences' reactions.*[22]

3.3.2.5 The Thematic Tools of Group Positioning and Stigmatisation – and Towards the Narrative Technique of Narrative Situations

I base my delineations of the thematic tool of group positioning and (partly) the narrative technique of narrative situations on Suzanne Keen's study on narrative empathy. Keen defines empathy in the following manner: 'In empathy […] we feel what we believe to be the emotions of others. [...] although psychological and philosophical studies of empathy have tended to gravitate toward the negative, empathy also occurs for positive feelings of happiness, satisfaction, elation, triumph, and sexual arousal. All these positive kinds of empathy play into readers' pleasure[…]' (Keen 2007, p. 5.) The empathetic reaction of the audience is, according to Keen, a part of the structure of narratives and their reception: 'Narratives in prose and film infamously manipulate our feelings and call upon our built-in capacity to feel for others' (ibid., p. 6).

For a juxtaposition that elucidates the empathetic side of reading, one can refer to Howard Sklar's recent study on narrative *sympathy*. In his definition, sympathy is a much more restricted and specific emotional reaction. It involves more judgement and distance between the audience feeling sympathy and the character sympathised with than takes place in the Keenian empathetic relation. Sklar defines sympathy as consisting of: '1) Awareness of suffering as "something to be alleviated" […] 2) Frequently, the judgement that the suffering of another is underserved or unfair. […] 3) Negative, unpleasant or uncomfortable feelings on behalf of the sufferer. […] 4)

21. I am confident in making this link between cognitive parameters and rhetorical narratology, as the cognitive viewpoint's strength is, according to Zunshine, 'that it is highly compatible with well-thought-through literary criticism' (Zunshine 2006, p. 5). Other cognitivists have made remarks that easily bridge cognitive narratology with rhetorical narratology's emphasis on the purpose of narrating. (e.g. Palmer 2011, p. 279; Herman 2003, p. 19; and Herman 2003b p. 170.)
22. Suzanne Keen's study on narrative empathy further supports my thesis of the controlling of the experiential contents of narratives as a rhetorical tool. Sometimes the correct reaction in readers sought after by the author is seen to be achieved by the readers' learning 'by extending themselves into the experiences, motives, and emotions of fictional characters, to sympathize with real others in their everyday lives'. (Keen 2007, p. 38.) Keen also remarks on how (already in Aristotle) the evocation of feeling response serves as a rhetorical tool of persuasion (Keen 2007, p. 130).

Desire to help.' (Sklar 2013, p. 35.) Sklar concentrates in his study on the readers' sympathetic responses to the texts' features. He does not much tackle the other side of the relation between the reader and the narrator/author, i.e. that of the narratorial agendas, the concrete aims of the narrator and author to affect and manipulate the audiences' feelings. He does note that 'research is divided in supporting the claim that readers necessarily receive messages intended by authors' (ibid., p. 43).

However, what I aim to discover from my texts is specifically the factor of the narratorial/authorial agenda. I must especially grasp the 'desire to help' Sklar sees as an integral part of sympathy. In connection to Sklar's definition of sympathy and its ramifications in narratorial/authorial agendas, one can ask: would the authors of my target texts wish their readers to *desire to help* the sympathised character? Would this even make any sense, as the reader cannot cross the ontological boundary? (cf. Keen 2007, p. 16). Sklar does emphasise that the reader feels *real* emotions when reading (Sklar 2013, p. 20) and that reading may alter the reader's way of perceiving and acting in the real world (ibid., p. 22), thus making the crossing of the ontological boundary less important. Be that as it may, the desire to help is such a specific reaction to be aimed at that I would not presuppose it to cover all authors and their agendas universally. I would also apply this to the issue of the implied authors (whose agendas are by definition interpretable from the texts themselves, and do not require extra-textual information like the question of the *flesh-and-blood* authors and their motivations, which are left outside the scope of this study). When applied to the question of *narratorial* agendas, asking whether for example, Sylvia Plath's Esther, Pat Barker's heterodiegetic narrator, or Hammond Innes's Jim (among the narrators of my target texts) would wish the narratee to help the distressed characters/homodiegetic narrators themselves brings us again to the issue of specificity of this narratorial agenda. I do not see that producing the desire to help would be a universal wish of all the narrators, either. They all have their specific agendas; the aim of producing a Sklarian sympathetic reaction among the narratees may be part of their agendas, but it can hardly be extended to cover all narrators and all narratorial agendas.

Keenian *empathy*, however, is, in its more chameleon-like features, a more general aim of narratorial agendas, as it can be argued that it helps readers understand the narratives and their messages in the first place; in justifying this viewpoint, Keen refers to Tammy Bourg's studies (Keen 2007, pp. 87–88). I argue that empathy, with its potential to cause any kind of emotional reaction, including readerly pleasure, is a forceful component of interpretation and reading: the addition of positive feelings to the list of those readers react to (in contrast to Sklar's negative emotions

in sympathy) is an important act, as it widens the scope of the audiences' emotional reactions. The empathetic reaction can help the reader to align herself to all of the narrative's emotional structures, and thus to perceive the characters' and narrators' worlds (including their emotional worlds). Sklar emphasises that one does not need to understand a character to be able to sympathise with her (Sklar 2013 p. 53). I argue that the empathetic closeness to a character precisely assists the understanding of the character, and of the text as a whole. Thus, the narratorial agendas can be seen to aim to organise and administrate the audiences' emotional responses – their empathetic reactions to specific characters and narrators – in specific ways.

Not all readings of every text elicit empathy and not all readers empathise always, but many do, often, and empathy definitely affects the way the (empathising) reader interprets the text, and thus it is a definite narrative goal in itself. These are the reasons why I apply Keen's notions of narrative empathy as one part of my Foucauldian-Phelanian notion of narrative power.

Keen lists the narrative techniques and effects which are more or less widely seen as producing narrative empathy, and character identification and narrative situations are the two most often mentioned in studies on narrative empathy.

The first, character identification, is not a narrative technique but a reaction in readers seen to be precipitated by the use of a gamut of techniques of characterisation.[23] Similarity between the reader and character, a variety of empathy whereby the reader finds a character belonging to the same in-group as herself, is also widely believed to promote character identification (Keen 2007, p. 94).

In connection to the in-group/out-group identification, the author may attempt to direct an emotional transaction through a fictional work aimed at a particular audience. There are three kinds of these 'strategic empathizing' variations: 'bounded strategic empathy', which 'occurs within an in-group, stemming from experiences of mutuality, and leading to feeling with familiar others'; 'ambassadorial strategic empathy', which 'addresses chosen others with the aim of cultivating their empathy for the in-group, often to a specific end'; and 'broadcast strategic empathy', which 'calls upon every reader to feel with members of a group, by empathizing our common vulnerabilities and hopes' (ibid., p. 142). I will be applying these Keenian *authorial* empathy strategies to *homodiegetic narratorial empathy strategies* to ask how homodiegetic narrators situate themselves vis-à-vis the other characters in in-groups and out-groups. I make this application of an authorial feature at narratorial level

23. Such as naming, description, indirect implication of traits, reliance on types, relative flatness or roundness, depicted actions, roles in plot trajectories, quality of attributed speech, and mode of representation of consciousness (Keen 2007, p. 93).

because I leave the actual authorial intention outside the focus of this study, and see that the narrator's feat is parallel to the authorial act of composing a narrative and its groupings. Furthermore, deciphering the author's in-group status is less important to my study's focus on narrative power than the deciphering of the narrator's in-groups status (as the narrator's narrative act is the elemental act in building the fictitious world). I will not be asking 'Is Sylvia Plath mad?', but instead 'Is Sylvia Plath's Esther mad?'

However, critics of narrative empathy theories (which, like the 'strategic empathy' theory above, champion narratives as producers of readers' real-life sympathies for, e.g. stigmatised or otherwise differing groups of people) argue that the ethics of group protection rule empathy through identity: 'both identity and empathy are governed by "collective self-definition of an in-group, and opposition to out-group" [...] which limits the extension of empathy to all human beings on the basis of perceived otherness' (ibid., p. 164). The empathy produced by grouping into in-groups and out-groups is thus a subject of debate, but the debate shows that these groupings matter – *the way they matter* is the issue of debate. In Chapter 4, I examine some other problems with these empathy strategies, which arise in connection to my readings and which I summarise in the end section, e.g. the question of the homogeneity of the in-groups/out-groups and its effect on the reading through these categories.

The issue of possible stigmatisation is central to the theme of madness, as it is one of the forces in delineating mad from sane. Other sources of stigma than madness surely exist (e.g. being a criminal or having a sexual disease), and there are other out-groups than the mad (e.g. marginalised ethnic communities), but as I will argue in the next Chapter, in the context of madness narration, the theme of madness as a possible stigma and as a grouping force is elemental to our understanding of what fiction tells us about madness.

Keen emphasises that these hypotheses on how groupings produce character identification and, by extension, empathy, are not widely enough tested and studied in reader response studies to judge which of the hypotheses on character identification actually hold true. She ascribes to the view that character identification cannot be automated; it is rather precarious a matter for the author to achieve and control, and it depends on so many different factors in the readers and their circumstances that it is difficult to predict. (ibid., p. 72.)

The same caveat of being insufficiently tested enough also applies for the second major aspect seen to cause, as a narrative technique: narrative situations. It is widely held that internal perspective best promotes character identification and the reader's

empathy (ibid., p. 96). Again, a whole gamut of 'internal perspectives' – ranging from the omniscient view into the character's mind, FID, figural narration, quoted monologue to first-person narration – have been seen to promote reader empathy (ibid., pp. 96–97). This makes me wonder what is left out. Surely it is only 'purely externalised', Hemingwayesque narration? Furthermore, like Keen and Booth (ibid., p. 98), I tend to think that no single narrative technique can be seen to invariably produce given ethical or emotional reactions: as in the case above of character identification, all possible readerly reactions to narrative situations are difficult to predict if one bases the prediction solely on detecting some or other narrative situation.

What can be done then, to analyse the possible readerly empathy evoked by my target texts, without the corroboration of enough empirical evidence to definitively validate any of these hypotheses? I cannot offer the extensive psychological laboratory tests to prove[24] or disprove any of the above hypotheses on narrative empathy, but I can study the hierarchies of narrative situations and in-group/out-group positioning inherent in my target texts, both of which are proposed to have an empathetic effect on the reader. In the case of Keenian in-group/out-group positioning, I will study the way my target texts seem to organise and control this thematic tool. I examine the ways the audiences' are nudged, through the manipulation of the grouping structures of the texts, to empathise in a specific manner with the depicted characters. Sometimes, as will be seen, the group positions of the audience members become accentuated. Some of the texts e.g. seem to be written for a sane audience exclusively, in others, the preferred audience grouping is left ambiguous. I will be analysing this accentuation of the groupings and the reason for it along the way, trying to see to the heart of the narratorial and authorial preferences of audience groupings. Furthermore, in the light of the (Foucauldian-like) knowledge streams, as used by the above-formulated thematic tools and controlled by the organisation of narrative through the techniques of narrative situations and narrative progression, I can establish narrative power relations between narrators, implied authors, and their audiences. I cannot offer as corroboration more than my own readerly interpretative input, but it is as informed as I can make it. My focus is on the power networks of madness narration, and I argue that I can decipher these power networks by studying the narrative structures of my target texts. Now, I will take a closer look at the technique of narrative situations.

24. See Sklar (2013) for an interesting empirical test to measure narrative sympathy; it offers an example of the kind of reader response testing Keen also seems to call for.

3.3.2.6 The Narrative Technique of Narrative Situations

Having established the connection between narrative situations and Keen's study on empathy, I connect this narrative technique with the Phelanian model of rhetorical narratology, which, as was seen above already, is firmly based on the stratification of narrative layers embodied in narrative situations. In this section, I give a summary of the discussions on narrative situations, from the classics onward, paying special attention to the heavily debated notion of focalisation.

Genette, in his classical *Narrative Discourse*, gives a three-fold summary of the levels of focalisation: 1) nonfocalised narration or zero focalisation (also known as 'omniscient' narration, in which the narrator knows or says more than the characters know); 2) internal focalisation (in which the narrator says only what the given character knows; the focalisation can be fixed or variable in accordance to whether there are one or many focalisers); 3) external focalisation (in which the narrator says less than the character knows, thus not describing her inner thoughts or feelings but only the external actions or 'vision from without', which can also be called the 'objective' or 'behaviourist' narrative). (Genette 1983, pp. 188–190.) This three-fold schematisation clearly points to the varying degrees of knowledge the narrator has of her characters and delivers in her narration. It is indisputable that there are levels of knowledge in narrative. How do these levels, then, interact with power structures? Are there levels of power in the narratives, as well?

Stanzel, in his classical *A Theory of Narrative*, makes several points which can be used as a basis for building a theory of narrative power. He points out that '[t]he more a reader learns about the innermost motives for the behaviour of a character, the more inclined he tends to feel understanding, forbearance, tolerance, and so on, in respect to the conduct of this character' (Stanzel 1984, p. 128). One could, however, question the universal applicability of this statement: do we feel tolerance and forbearance – instead of irony – towards Madame Bovary, whose person the reader comes to know very thoroughly? Here we have one of the reminders that readerly empathy, the 'feeling understanding', is a tricky topic. Remembering this, Stanzel seems to give direct support to my conception of narrative power: there is here a delicate balance of knowledge and manipulation; what is at stake is the reader's empathy, which the narrator (and finally the implied author) strives to control by handling the streams of information directed at the reader. Stanzel's three-fold definition of different kinds of narrative situations: the authorial, figural and first-person (together with his notions taking the form of three polarities: internal versus

external perspective; identity versus non-identity of the realms of existence between the narrator and the character(s); and teller-character versus reflector-character) create a complex six-fold typological continuum which sheds light on the varieties of narrators. There are differences between narrators and their abilities to perform the controlling act through their control over the manifold narrative situations.

Stanzel formulates one difference between authorial and first-person narrators, which he also designates as 'disembodied' and 'embodied' respectively. This means that the first-person narrator is bound to her embodied self that occupies a position in the story she tells (in the internal perspective); whereas the authorial narrator, by not being a part of the story she tells, is free from such constraints (in the external perspective). Stanzel writes:

> Internal perspective necessarily results in a restriction of the kind and degree of knowledge (limited point of view) of the teller-character or the reflector-character. Omniscience[25] always presupposes the external perspective of an Olympian authorial narrator. The latter has at his disposal unlimited insight into the thoughts and feelings of the characters. (ibid., p. 126.)

Here, Stanzel's concepts of 'internal perspective' and 'external perspective' coincide with Genette's 'internal focalisation' and 'nonfocalisation' respectively. (Cohn synchronises Stanzel's model with the Genettean project in her 1981 article, and I intend

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25. Jonathan Culler questions the age-old notion of omniscience as a concept that confuses a number of issues under a term that does not hold: 'the conventional establishment of narrative authority, the imaginative or telepathic translation of inner thoughts, the playful and self-reflexive foregrounding of creative actions, and the production of wisdom through the multiplication of perspectives and the teasing out of intricacies in human affairs – are what have provoked the ascription of omniscience, the postulation of omniscient narrators, and have thereby not only obscured the distinctiveness or salience of these practices but have repeatedly obfuscated them so that we fail to see what is going on' (Culler 2007, p. 201). So, the question is: is there anything like omniscience anyway? Culler himself does not claim that those four aspects listed in the quotation above do not exist as literary phenomena, what he does oppose is their being called en masse omniscient narration. He goes on: 'Omniscient narration has often had bad press, as the literary agent of panoptic discipline and control, linked to the policing power of narrative and thus diverting narrative fiction from its inherent dialogism to a dubious monologism. But in fact, I would argue, it is the idea of omniscient narrative rather than the diverse practices to which the name applies that should sadden us or outrage us'. (Culler 2007, p. 201.) Despite Culler's objection to the concept of omniscience, it must be noted that he offers very little in its stead. (He only opens the discussion to 'explore alternative vocabularies' (Culler 2007, p. 201) or toys with the idea of 'telepathy' to replace one aspect of the cluster of what has been called omniscient.) When I encounter the four phenomena in the target texts that Culler analyses as the parts of 'omniscience', I will call them 'authorial narration', like, e.g. Stanzel and Phelan, in order to have as a tool a simple notion that does not tamper with the problematic 'omniscient' analogy.

to follow her simplification of Stanzel's model.)[26] The terms 'reflector-character' and 'teller-character' refer to two different kinds of attitudes or modes of narrating. The teller-character is consciously narrating, transmitting a piece of message to the 'receiver'. The reflector-character is not conscious or aware that she is part of the narrative; the reflector-characters are only experiencing selves, who 'restrict themselves to the reflection of experiences not overtly communicated' (ibid., p. 145). Teller-characters are common to almost all kinds of authorial narrators and first-person narrators in whom the narrating self is conspicuous.[27] The reflector-characters comprise all figural narrative situations and those first-person narrators who are not conscious of being narrators. The difference between the two in respect to the 'power situation' in narration is such that because they are conscious narrators, the teller-characters also are conscious of their having to influence the narratee (ibid., p. 151).

The reflector-character has no direct relation to the receiver, as she is completely unaware of being a reflector-character in a story. She thus has no power relation to the audience either, for she is not consciously building a network of suspense or influencing the sympathies of the audience. (ibid., p. 154.) Stanzel also implies that this means the reflector-character cannot be called unreliable in the post-Boothian sense (by 'reliability' Stanzel here means 'credibility' first and foremost). Since the reflector-character is only reflecting and being unaware that she is reflecting (and not building a relationship with an audience) she cannot be unreliable vis-à-vis the audience, only more torpid or lucid, more intellectual or dull and so on (ibid., p. 152).[28]

The Stanzelian discussion on power relations in a narrative in the form of 'who controls the effects of the text?' is very interesting. The fact that different kinds of

26. Cohn (1981) has proposed certain alterations to Stanzel's six-fold definitions, by claiming among other things that the opposition of external/internal perspective can be made to coincide with the modal axis of the opposition of narrator/reflector, thus remoulding the typological circle Stanzel built with six compartments to contain only four compartments: authorial third-person, figural third-person, consonant first-person and dissonant first-person (Cohn 1981, pp. 179–181). These and others of Cohn's suggestions seem to me to improve the Stanzelian typology, even though Stanzel himself opposes them (Stanzel 1984, p. 50). They do not affect the discussion above on the privileges and restrictions of different kinds of narrators. They do affect the interpretative and heuristic tools offered by Stanzel, though. Cohn's alterations simplify the picture, which is a good thing. I will follow her suggestions and treat the modal and perspectival categories together.
27. Stanzel here infers that authorial teller-characters have conspicuous features which does not tally completely with Genette's 'nonfocalisation', which emphasises the neutrality of the nonfocalised narration. (cf. Cohn 2000, Chapter 8, where Dorrit Cohn gives a very Stanzelian-like reading of an authorial narrator having a distinct personal voice and features.)
28. I do not know whether this delineation between reflector-characters and teller-characters is completely valid when it comes to reliability, because a narrator's unreliability, in my opinion, can very much be unaware. The narrator could be unaware of her own falseness so to speak.

narrators have different kinds of 'privileges' in terms of controlling the effects of a certain kind of text is an important issue.

Stanzel continues: 'In a novel with consistently internal perspective, the form of the narrative relativises the "validity" of the statement in a different way than in a novel with external perspective or with alternating perspectivization' (ibid., p. 134). Again, here one can detect a possibility of power structures, indicating an imbalance of power and control. An internal perspective (or reflector mode) is more easily regarded as 'relativised' in its 'validity', meaning that narration through a reflector has a different kind of value status from, say, authorial narration. What an authorial narrator claims cannot be doubted by the audience as easily as what a reflector claims. The reflector has no control over the narration, whereas the authorial narrator does.

From this sketch of Stanzel's theories, one can discern how to build narrative power structures: the possibilities of different Stanzelian narrative agents (reflector-characters, teller-characters, authorial, figural and first-person narrators) all have their different angles and opportunities to influence the narrative patterns in the project of directing the audience's sympathies and perceptions, which is, after all, the ultimate goal of a narrator's efforts. Genette offers support with his focalisation theories, which can be synchronised with Stanzel's model, with the clear patterns of levels of knowledge present in different types of focalisation. These can be seen to form a basis for a model of directing narrative knowledge – and ultimately, the precious reader's perceptions. I argue that narrators can be seen to use narrative power in persuading the narratees, and through the bend of narrative layers, the author persuades the reader by using various tools to further this cause.[29]

3.3.2.6.1 Phelan's Suggestions for the Notion of Focalisation

James Phelan has also taken part in the discussion on focalisation. In his opinion, which in my view comes close to Stanzel's (ibid., p. 89), 'a narrator cannot report without also revealing his or her perceptions' (Phelan 2005, p. 115), from which he draws the conclusion that narrators can be focalisers, even though this does not mean

29. Since Genette's and Stanzel's seminal works, there have been wide discussions in narratological circles about the usefulness of their terms. In the discussion about focalisation, a number of weaknesses have been pointed out (see Manfred Jahn's summary; 1996) in Genette's formulation of the concept. These weaknesses, as I see them, do not necessarily sink the Genettean, albeit refitted ship, as all of Jahn's criticisms can be answered by adjustments to Genettean viewpoints (such as conceding – unlike Genette – that narrators can be focalisers; or that it is important to widen the scope of the focaliser to include various facets of mentation, opinion, and cultural and ideological predispositions).

that every passage of narration would be focalised by the narrator (ibid., p. 116). He goes on to formulate his own model of focalisation by creating five combinations of the categories of focalisation/voice: 1) the narrator's focalisation and voice (as in something that Stanzel would call authorial narration); 2) the character's focalisation and the narrator's voice (certain passages of Humbert Humbert's narration in *Lolita*); 3) the character's focalisation and voice (e.g. stream-of-consciousness narration); 4) blends of the narrator's focalisation and voice with character's focalisation and voice (free indirect discourse); 5) the narrator's focalisation and the character's voice (as when a naïve character narrator unwittingly takes on the voice of another character). (ibid., p. 117.) Phelan states that this typology is difficult to match with Genette's, even though the types 2, 3, and 4 are cases of internal focalisation (ibid., p. 118).

His model is elegantly simple, but I would say that it is too simple: he does not make a distinction between first-person and third-person narrators, both of which can fall under the first type (the narrator's focalisation and voice); a loss that is, in my opinion, too great. Is it not one of the distinctions that heavily guide the reader's perception of the text and its basic features, including its reliability as a fictional account of the described storyworld? As he does not base his model on Genette's perception of the distinction between 'who perceives?' and 'how much does she perceive?', the hierarchies of knowledge (and power) are lost. He does, however use his elegant typology to analyse insightfully his target text, Nabokov's *Lolita*, by showing how the 'dual focalisation' of the narrating-I and experiencing-I of Humbert Humbert's narration vary and produce different effects of ethical perceptions in the reader. However, could what Phelan maps as the alteration of narrator-Humbert's and character-Humbert's focalisation in *Lolita* not be analysed by using Cohn's distinction between dissonant and consonant first-person narration? (Cohn 1981.) This would not require a completely new typology of focalisation.

I do recommend Phelan's emphasis of the fact that narrators can be focalisers, but I do not see the reason why I should abandon the Genettean-Stanzelian ship of focalisation. In my opinion, it still carries important meanings of hierarchies of power and knowledge, and their combinations in narratives.

3.3.2.7 The Narrative Technique of Narrative Progression

Now, I finally come to the other technique of narrative power, narrative progression. This technique can be said to offer a dynamism that 'moves' all the other aspects of

the tools of madness narrative power and techniques (narrative situations, and the experiential, group-positional, and possibly stigmatic contents of these narratives) in the time span of the narrative. Phelan defines the rhetorical concept of plotting, in a rather classical version of narrativity, as a sequence of related changes:

> The phrase 'somebody telling… that something happened' [gets at the layer of narrative change]: narrative involves the report of a sequence of related events during which the characters and/or their situations undergo some *change*. […T]he report of that change typically proceeds through the introduction, complication, and resolution […] of unstable situations within, between, or among the characters. These dynamics of instability may be accompanied by a dynamics of tension in the telling – unstable relations among authors, narrators, and audiences – and the interaction of the two sets of dynamics, as in narratives that employ unreliable narration, may have significant consequences for our understanding of the 'something happened'. (Phelan 2005b, p. 323.)

He then links this definition of narrative as a sequence of events undergoing change to the other layer of narrative dynamics, that of audience response, thus tying together the package of narration: 'In short, just as there is a progression of events, there is a progression of audience response to those events, a progression rooted in the twin activities of observing and judging. Thus, from the rhetorical perspective, narrativity involves *the interaction of two kinds of change*: that experienced by the characters and that experienced by the audience in its developing responses to the characters' change.' (ibid.)

This twin dynamism of events and audience responses in narrative progression forms the supportive core for the rest of my model's power aspects in madness narration, which all evolve through the time of the narrative: narrative situations, experientiality, group positioning, and stigmatisation. The concept of the 'diagnostic moment' is tied elementally to this dynamism of narrative progression, and it also interlinks the diagnostic and narrative powers present in madness narratives.

3.3.2.7.1 The Diagnostic Moment and Narrative Progression

By the term 'diagnostic moment' I mean the moment in the narrative at which a narrator, character or the reader (guided by the implied author) makes a diagnosis

of a character or a narrator. At that moment, something significant happens: the diagnosed person's status changes from sanity to insanity, and in a more or less definitive manner (or, if the diagnosed person is already defined as mad, her diagnosis is further strengthened and supported by an additional diagnostic moment). Therefore, two things take place: 1) the label of insanity is attached to a person; and 2) this label of insanity is given a more or less definitive content, because it can be claimed that it is not even possible to say someone is simply 'mad' – when seen strictly psychiatrically at least, as the established psycho-sciences are so elementally interested in categories of madness – without further defining the contents of the multifarious concept, i.e. the definitive mode of madness in question. (It remains to be seen in the following analyses of the target texts whether it is possible to call a person simply 'mad' in a lay variation of diagnosis, without further delineating the specific, psychiatrically conceived content of the concept.)

The diagnostic moment in madness narratives usually occurs repeatedly and all of these diagnoses may take various guises and meanings along the road of the unravelling plot. Therefore, I will follow the 'plotting of the meanings of diagnostic moments' by following the way the narrative unravels as a description of diagnosis (diagnoses) making and the ways the characters, narrators, and audiences relate to the various diagnosis makings – and the states of 'being mad' 'behind' the diagnostic words that try to capture this continuous state of being mad. These various diagnoses placed into oppositions, continuums, juxtapositions, inter-supportive structures, and so on, together create the narrative's specific texture of meanings of diagnosis making – and those of 'madness itself', as the 'content' of the diagnostic words – for those involved and for the reader at the end of it. The diagnostic moments, therefore, capture the nexus of diagnostic and narrative power: they are the moments in the narrative at which the narrator, more or less consciously, overtly, and directly, leads the narratee (and the reader with her who has joined the narrative audience), to the brink of seeing another character or the narrator herself as mad, in a more or less particular manner.

I believe that these two tools I have formulated – diagnostic power and narrative power – will help me to delineate the depiction of the psycho-sciences and the interlinking depiction of the contours of madness in my target texts. The signification given to madness and psycho-sciences through the narrative power use (the rhetorical 'purpose' behind the madness and psycho-science depiction) intertwines inseparably with the diagnostic power of defining a literary persona's madness. At the literary moment of diagnosis, the diagnostician and her object also relate somehow to the

field of psycho-sciences, e.g. by confirming their tenets, revolting against them, or being indifferent to them. The diagnostic power interconnects with narrative power, and this is this interconnection, the nexus, I will be most concentrating on in my analyses of the target texts.

3.4 Coda: Foucault and Literature

I have been using Michel Foucault's ideas on power and communication as one inspiration and basis of my rhetorical model of madness narration. I therefore apply his theories to an area of study upon which he, as a philosopher rather than a literature scholar, did not singularly concentrate. I have been building my own model knowing that Foucault's ideas on literature were quite different from mine; I thus apply his thinking in a way he would not have done himself. With this in mind, I will next delineate Foucault's own thinking on literature and the ways it differs from mine.

Michel Foucault did not create a systematic theory of literature, nor did he practise comparative literature on any larger scale.[30] Nevertheless, he did take a stand on certain literary theoretical issues and used literature and its study as examples and subjects of analysis in his philosophical research. The ways in which he did this throughout his multiphase career showed his definite attitudes towards literary theoretical concepts and debates. Foucault's philosophical theories and historical analyses of various topics have been used since as a basis for strictly literary theoretical and analytical discussions. This has also raised some serious objections from those who see Foucault's work as problematic or even largely unsuitable for the building of sound comprehensive literary theories and analytical interpretations of literary target texts (Freundlieb 1995).

The stand Foucault took on literature and its research varied throughout his career in accordance with the fluctuations that shaped his thinking in general. Literature was not his primary subject of research, and the importance and role he gave to it and its study in his own research and theory formation shifted according to his own changes of opinion concerning the substance and perception of his theories and subject matters. Foucault did not (nor wish to) create a complete or finished philosophical system (Koivusalo 2012), but his work does show developing and constant interest in certain topics and questions, which he elaborated on from var-

30. He did write one book-length study on Raymond Roussell (1963), a 'summer love' (Koivusalo 2012, p. 327).

ious perspectives at different times (most importantly the formation of subject and the relationship between power and knowledge and their philosophical-historical intertwining). Koivusalo has interpreted Foucault's life's work from the perspective of seeing the greater trends of development and constantly evolving themes of his thinking. This approach enables Koivusalo to reintegrate the different phases of Foucault's work into an ordered whole (most importantly, based on Koivusalo's interpretation of Foucault as a re-reader and re-writer of Kant's philosophical programme (ibid.)).

Foucault's main input to the academic study of literature consists of the various, originally non-literary-theoretical, theories that he formulated during the evolution of his philosophical thinking, which literary theorists have attempted to implement in the context of the study of literature. I have handled the most famous 'Foucauldian literary theorists' – Seltzer, Miller, and Bender – above, but here I will tackle certain questions Foucault himself took up explicitly in connection to his thinking on literature. In this, I will follow Koivusalo's (2012), Machado's (2012) and Freundlieb's (1995) analyses; and finally I will position my research in the space opened up by Foucault's own conceptions of literature and its academic study.

3.4.1 Foucault's Archaeological Phase: Counter-Discourse and Structuralist Conception of Literature

During his first, 'archaeological', phase, Foucault wrote his thesis on the history of madness and formulated his discourse theory. It was in this phase that Foucault expressed explicitly his interest and opinions he then had on literature, its academic study, and its philosophical and societal importance in the context of his more general views on the development of human sciences (Machado 2012, p. 227). His views on literature must therefore be positioned in his wider conception of these human sciences and the societal and historical development of their knowledge structures that he first referred to as 'discourses'. Foucault was a fervent anti-humanist, preaching for the end of the reign of such concepts as 'Man' and his 'finitude', which he regarded as falsely used both as the positive empirical object of study of, and the defining constitutive subject for, the human sciences (Koivusalo 2012, p. 248). In addition, he saw literature as one subject of the humanistic sciences, and a possible counter-force because of their perception of language and human subjectivity centred on 'Man' and his 'finitude' (Machado 2012, p. 232). The research of literature was

a central form of knowledge in the humanistic tradition, which the structuralist sciences started to challenge in the 1960s. This challenge did not intend to demolish literature or its study, but to liberate it from the old-fashioned notions of humanism and traditional critique. (Koivusalo 2012, p. 321.)

In *The History of Madness*, Foucault raised literature – or to be more specific, a certain type of literature – to the position of being capable of contesting the silencing of the mad effected by the development of modern psychiatry. This type of fiction could express something of the pre-classical experience of madness that had been silenced by the emerging development of psychiatric theories and techniques of treatment. This capability of literature to 'speak madness' was due to the fact that both madness and the modern literature Foucault had in mind exemplified the 'absence of the work' (oeuvre). '[B]oth lead to the collapse, the crack up, the falling apart of language' (Machado 2012, p. 229). Even though this similitude was not exact, madness being an even more radical silence and absence of oeuvre, (madness was a total breakdown, while literature was only a construction of the breakdown as it could only exist as work, as a realisation of *something*; (ibid.)) literature could nevertheless give at least a certain kind of glimpse into the realm of mad experience lost to the development of psychiatry. Machado writes: '[T]he intention Foucault [showed] was […] that, if rational knowledge excluded madness by considering it an absence of work, as something marginal in relation to the limits instituted by reason, literature, as it questioned the work as such, and expressed that absence, enclosed the otherness of reason within the limits of its own experience, placing itself beyond the boundaries established between madness and reason' (ibid.). This conception of literature as a 'counter-discourse' (Freundlieb 1995, p. 307) emphasises the importance of literature as a social and cultural force capable of questioning and criticising the autonomous subject (ibid., p. 308). Freundlieb points out that Foucault rejected the idea that subjects are in control of language, which, in the case of literature, led to his well-known critique of the figure of the author (ibid.). (I will briefly tackle this critique below.) Foucault was fascinated by what he saw as literature's capability of breaking down, rather than securing, the writing and reading subject (Koivusalo 2012, p. 326).

However, one should be careful to note that Foucault did not cover *all* literature when assigning something he called simply 'literature' this role as a forceful counter-discourse. He spoke only of a very limited number of writers, all of whom represent literature written after the 18th century, and a very specific type of literature (most prominently writers like Sade, Mallarmé, and Hölderlin). Foucault even

claimed in his article 'Language to infinity' that literature was born only at the end of the 18th century (Machado 2012, p. 230), which strongly points to a highly restricted view of what 'literature' is for Foucault. This has also been stressed by critics like Freundlieb, who regard Foucault's conception of literature as too narrow to apply to all that can and has been subsumed under this notion: 'In the case of early Foucault, on the one hand we have only a fairly small number of analyses, […] on the other hand, we have a concept of literature that is too specific, in that it illegitimately generalizes from the self-reflexive work of certain surrealist and modernist writers or those who suffered from mental illness (e.g. Hölderlin and Nietzsche) to a much broader notion of literature' (Freundlieb 1995, p. 310).

Later in the 1960s, in *The Order of Things* (*Le Mots et les Choses*) Foucault formulated perhaps his clearest conception of the notion of 'literature', basing it heavily on the structuralist theoretical system. Foucault's enthusiasm with literature as a counter-force to the humanistic sciences, which he regarded as being in 'anthropological sleep',[31] was also grounded in his conviction that literature should be conceptualised in the then new and fashionable structuralist vein as 'pure language speaking on its own' (Machado 2012, p. 232). This gave him the possibility to remove the figure of 'Man' as the basis of the sciences, and to steer them towards analysing systems and structures instead. Thus, this 'Man-less' focus would be a weapon against the humanistic sciences which were deeply rooted in their bases of human subjectivity. Koivusalo situates the debate on the nature of literature in relation to humanism in the French cultural atmosphere of the 1960s. According to Foucault, Sartrean existentialists, Christian democrats and Stalinist communists had used humanism since the 1940s as the 'little whore' of all their cultural, political or moral thinking (Koivusalo 2012, p. 303). Humanism, for Foucault, was utterly soiled by politics and ideology, as all these political movements, after the tragedy of the WWII, had used it as their justification and crutch, appropriating the human subject to support their causes by bending it to any form they deemed appropriate. By analysing systems and structures instead, one could be totally freed of the 'crimes of humanism' (Koivusalo 2012, p. 303), as Foucault formulated it. He emphatically demanded the possibility of handling politically the functioning of a society and the rights and needs of individuals without having to resort to a certain presupposed ideology of how to realise humanity in the same manner as the above-mentioned political movements had done (ibid., p. 304).

31. This refers to the conviction that 'Man', the human subject, is the rightful centre of scientific knowledge. Foucault claims in *The Order of Things* that 'Man' as such a centre is only a recent invention, and can and will be erased in due time (Machado 2012, p. 232).

Thus, for Foucault during his archaeological-structuralist phase, the essence of literature was definitely *not* human communication aimed at sending and receiving messages between different human subjects, whose encodings and interpretations of these messages would compose both the actual works of literature and their research. Literature would, instead, be a kind of a highway to the core of understanding language as a system that does not need the central figure of human subjectivity to be understood. In Foucault's opinion, fiction could reveal the workings of this human-less system, as it is speech from an empty subject position: the fictional narrator is no real human subject, but only an agent of pure language 'speaking on its own'. Machado writes: 'As Mallarmé postulated: in literary language, "it is the word that speaks". No one *speaks* this literary language.' (Machado 2012, p. 233.) Koivusalo points out that for Foucault, literature was not about the structure of text, nor about the mental state of the writer, but about the experience of literature as the speaking subject's relationship to the mysterious existence of a separate and independent language (Koivusalo 2012, p. 324).

3.4.2 Foucault's Concept of 'Author'

Before tackling Foucault's second, 'genealogical' phase and the way Foucault then changed his conception of literature and its role in his own studies, I will briefly take a look at Foucault's formulation of the concept of author, which he presented to the public in a single lecture in 1968, during his structuralist phase. In this lecture, Foucault expresses his hostility towards the humanistic viewpoint that authors are living human subjects influencing their works in significant manners. He also declaims the literary theoretical viewpoint that the author's conventional (and also biographical) study is relevant and central to the understanding of literature. As Freundlieb writes, 'Who speaks did not matter to Foucault because what always speaks is language itself' (Freundlieb 1995, pp. 310–311).

Foucault wishes to strip the concept of author of its centrality. He fragments its meaning into four functions, in order to stress the point that the concept is not about integrated, living subjects, but about 'discursive functions' that change historically and govern the reading and production of texts over and above any individual, creative, subjective influences of the real, human, living authors writing their texts. (ibid., pp. 313–317.) Foucault's formulation of the concept is interesting in itself; for example, he proposes a new branch of literary studies that would subject all prior

conceptions of the author to 'discourse analysis' (ibid., p. 311), namely a study of the concept's political-historical functioning that would uncover its operation as a notion by which the endless speech and discourses existing in the world are judged, governed, and ordered (Koivusalo 2012, p. 329). However, I will mention here only the immediate relevance of his lecture's ideas to my own work, that is, the role he assigns to the communication between the author and her reader.

Foucault denies the idea that literary texts are encodings of authorial hidden messages that readers then decode in their attempts at interpretation (Freundlieb 1995, p. 311). He maintains that the question of 'who is speaking?' is not important, or it is important only as a subject of discursive (i.e. Foucauldian) research. Thus, perhaps Foucault's clearest contribution to the practice of academic study of literature aims at a radical re-evaluation and even sheer demolition of certain central, established and conventional paradigms and methods of the discipline. It is one more fierce attack on what he saw as the 'anthropological sleep' of the human sciences, of which the research of literature is one example. Of course, such attacks on paradigms may take its study forward, even – or especially – when they are extreme and radical. Foucault did not, however, continue this type of direct contribution to literary-theoretical debates; he abandoned the field of academic literature scholarship during his next, genealogical, phase.

3.4.3 Foucault's Genealogical Phase: Abandoning Literature

In the 1970s, Foucault continued along the trajectory of his philosophical thinking and left the first phase of the archaeological study of discourse formations behind in order to concentrate on new, albeit connected, lines of thought. He began the ardent study of power as a societal and historical force that interlocks with knowledge and shapes the human subject from beginning to end. Again, Foucault's anti-humanist stance affected his path here. When human subjects are seen as creations of power relationships which no one can ultimately control (there was no God for Foucault; he was an emphatic follower of Nietzsche), one cannot rationally claim that human subjects create or possess power in any meaningful manner – power can only be *exercised* by a subject who has no escape from also being a target of the power of others. Thus, the centrality of the human subject to the workings of science, society and culture is stripped bare of its importance; the 'historically-aprioristic' power networks and structures become immensely more interesting and relevant focuses

of study in explaining the formation of human subjects, and not vice versa. Power creates subjectivity; subjects do not completely control or ever possess power.

During this phase, Foucault also changed his opinion on the role and essence of literature. He no longer saw literature as a counter-discourse capable of unmasking and resisting humanistic scientific discourses like psychiatry, of realising political and social revolution, or as a highway to the essence of pure language. Instead, he saw it as an inseparable part of society's power networks, and it was as moulded by these networks as any other 'discourse' – or 'episteme', a term he preferred during this later period. At the same time, he lost interest in literature and its academic study as an object of analysis or philosophical example, and concentrated on narratives that were far from canonised literature. For example, in *Discipline and Punish,* he was concerned with stories of and by 'infamous' criminals whose stories had never achieved the acceptance of the 'higher strata' of literary cultures. He now saw the teaching of literature not as a valuable passing on of cultural knowledge to new generations, but as ethico-political training of human subjects disguised as a search for truth through literature (ibid., p. 330). Thus, literature, its teaching, and its study are societal power structures first and foremost, and must be unmasked as such. He therefore also belittled his own enthusiasm for literature, and even stated that the literary upheavals of the 1960s had not produced political or literary revolutions, only mediocre literature (Koivusalo 2012, p. 330). During this phase, Foucault denied language the basic role he gave it in his conception of culture in the 1960s, and wanted to give that basic role to power: history should be studied through the changes of power structures rather than language structures (ibid.).

Foucault did change course slightly once more before his death in 1984. This period is still considered a part of his genealogical phase, but it can be separated for its tone and its way of handling his central issues. In the latter part of his last long research, *The History of Sexuality,* he concentrated on the 'techniques of the self', showing interest in ethics and aesthetics as ways of improving one's self. Thus, one can say that he started to see the formation of human subjectivity in a new light, assigning more potential to the individual to mould herself in a fashion that suited her best (Freundlieb 1995, p. 333). He even called life a 'work of art' like the early aesthetes, seeing the aim of the aestheticisation of one's life as a means to reach the goal of a better, more ethical life (ibid., p. 336; Koivusalo 2012, p. 332). For Foucault, here, ethics and aesthetics become inseparable: the aestheticisation of life is seen as the highest form of good.

Foucault did not go back to the study of literature as a major subject of interest, but the notion of the aestheticisation of life also brings literature back into his thinking again, perhaps more forcefully than before, during his earlier genealogical phase. Critics, like Freundlieb, have pointed out the impossibility of basing ethics on this kind of egocentric aestheticisation of one's self and life: making life an art form is hardly attainable for all for the simple reason that such a lifestyle can be afforded by very few in any given society. To base the ideal of ethics on an egocentric lifestyle denied to most is, according to Freundlieb, rather unethical (Freundlieb 1995, pp. 336–337).

3.4.4 Foucault, Literature, and This Study

My own work benefits from and is inspired by certain of Foucault's ideas, such as the inescapable intertwining of power and knowledge, which he studied and formulated theoretically during his career. His conception of psychiatry also is a rather obligatory framework in a study which attempts to cover the most central theoretical thinking governing the perception of 20th–21st century psychiatry and the modern phenomenon of madness. However, I share Freundlieb's doubts in implementing Foucault's formulations of literary theoretical terminology and theory formation in a comprehensive manner in the study of *all* literature. Even when most enthusiastic about literature and its study, Foucault did not include all literature and literary language in its multiform nature in his notion of 'literature', which for me is also a deficiency. In addition, he ruled out of his perception the possibility of human creative and hermeneutic subjectivity as the founding, or at least even centrally interesting, phenomenon in literature, by making literature 'pure language speaking on its own'.

The above makes me rather doubtful of even considering the possibility of becoming a 'proper Foucauldian literary theorist'. This is due to the fact that my viewpoint of literature in this thesis is heavily based on the rhetorical-narratological notion of human communication between authors, narrators, characters and readers, all of whom are fundamentally seen as human subjects. Foucault's anti-humanism is a fairly foreign starting point for a researcher like me, who is, undoubtedly, deep in anthropological sleep. However, I see that in this sleep, I can best reach the meanings of those texts that are, in my perception, written and read in that sleep as well, if the 'sleep' means believing in real, human subjectivity capable of communicating with other embodiments of human subjectivity in truly intentional manners – through

literature. I choose this viewpoint of literature as a communication between human subjects, because I maintain that the target and performer of psychiatry or lay diagnosis making – the diagnosed person and the diagnosis-maker – are first and foremost both human subjects with subjective characteristics that affect the diagnosis-making, and because the central notions of communication and experientiality that I use in building my analysis of the narrative power strongly suggest the centrality of subjectivity. In my view, for experiences to exist, there must be a subject having and 'possessing' these experiences. For intentional communication to take place there must also be subjects performing this communication. My intention in applying the mimetic notion of narrating figures, of the idea that narrative is conceived mimetically as language produced by a human subject (rather than as seen as pure 'text mass', for example), can finally be supported by my way of using Foucault, as well: when I see narrators as persons, as free subjects, I can apply Foucault's notions of (communicative) power to the relationships between narrators and narratees, authors and audiences.

Foucauldian discourse analysis of literature may be an interesting branch of study, reaching 'behind' the sleep. It can offer refreshing viewpoints, highlighting the historical-societal forces behind something that has sometimes been seen even as almost immune to those kinds of forces in its 'artistic freedom'. But, it does not, in my opinion, *replace* all comparative literature, for literature can still be meaningfully seen to incorporate human, artistic, 'freely' composed and significant messages. (According to Freundlieb, even Foucault had to concede that some authors do change literature, and are not just 'functions of discourse' (ibid.).)

These two points of view may be seen to be mutually exclusive; they cannot be easily practised within the same framework of one study, for example. However, I believe that they still can coexist in the same field of research – especially in the contemporary study of literature, with all its plurality of methods, focuses, philosophical bases, and so on. It is a matter of choice, and I have chosen against Foucault's perceptions on literature.

For me, in this study, literature is about encoding and decoding communications, messages and meanings. It is not language 'speaking on its own'; the narratorial subject position is *not* empty in any exclusive, profound sense, because it usually can be deeply analysed to be a position with specific subjective characteristics. Most first-person narrators – even some of the third-person narrators, as Stanzel has proposed – are personalities, human subjects embodying human psychological traits that can be captured by analysing the way they narrate. Even those third-person

narrators whose subjective personality traits are more concealed to the degree of being virtually non-existent can still be seen to elementally pass on meaningful and intentional messages to their narratees – like most narrators. In my view, narrators are imbued with a Brooksian (1987) desire to narrate, to control the narrative, and to affect the narratee; it is not the case that literary language speaks on its own and uses narrators as empty surrogates for the exposition of the wildness of language.

This, of course, does not apply to the kind of literature Foucault rather symptomatically called 'literature' – a certain modern avant-garde literature precisely experimenting with the possibility of creating an empty narratorial subject position and of letting language speak 'on its own'. Obviously, I have no intention of denying avant-garde literature the essence of being real literature, simply for the fact that the experiments made in all kinds of literary avant-garde movements are indispensable to the development of literature as an art form – and consequently for the development of its study. I am only implying that those texts that I study in this work (which Foucault might have judged to be mere 'blathering' (Koivusalo 2012, p. 315)) are not examples of that kind of literature. The texts that I study are, I contend, still 'literature' – something that Foucault silently seems to deny with his connotation that only avant-garde literature could be considered as such. Thus, I cannot implement Foucault's notion of 'literature' in this study, because it does not recognise my target texts as literature in the first place.

I do, however, consider some of Foucault's more central thinking – that is, central to his own philosophical theory formation, his perceptions on power and knowledge – as an interesting starting point for building *rhetorical-narratological patterns of communication* between authors, narrators, characters and readers functioning on the power field of madness narration. This may seem an uneasy marriage – as the rhetorical model of narratology is, after all, such a humanistic viewpoint on literature – but I attempt to justify the creation of this chimera by ultimately making it work in my analyses.

The components of my chimera, Foucauldian knowledge/power conglomeration and the rhetorical-narratological conception of literary communication, are moulded together through my conception of narration. Narration, as I see it, is a socially sharable verbal formulation of ideas in the form of a narrative that has both a knowledge aspect – the 'what' that is said and meant – and a power aspect – the 'why' and to what end it is said and meant. Like Foucault, I like to regard the two aspects of power and knowledge as inescapably intertwined. This makes it hard to sever them from each other without losing sight of this basic, profound interweav-

ing. In addition, I maintain that the forces or notions of knowledge and power in my rhetorically perceived narration are vital components for analysing the messages given by narrators and authors to narratees and readers. In my model narratorial knowledge, shaped by the specific narrator's specifics of narration, is imbued with narratorial power. This power can influence the narratee's (and 'behind her back': the authorial audience's) evaluations of the narrator and the narrated, and vice versa; the narratorial power is affected by the knowledge contents it attempts to relay and use.

The entwining of narratorial power with knowledge is an especially central aspect of interpretation in *madness* narration, I claim, because the subject matter, essentially crystallised in the moment of diagnosis, is such a power field. The giving and receiving diagnoses – that is, also, making knowledge claims about the contents of diagnosis – are inevitably power relations, and when these relations are incorporated into narration, when narrators, characters and/or readers diagnose or are diagnosed, one simply cannot escape the fact of narratorial power linking with diagnostic knowledge. To me at least, it seems impossible to extricate a madness diagnosis from its human, psychological, social, societal significance, which means that it never is *neutral* to any degree. This is why I see that narrators use madness diagnoses to an end, more or less consciously – as an instrument of the narrative power of persuasion and influence (through its disguises of the thematic tools of group positioning and stigmatisation in my model). It is a powerful tool, to be sure, with its potential for stigma and exclusion from the communities of the sane and normal. Foucault studied these mechanisms of psychiatric knowledge and the power of exclusion in his thesis, stating among other things that madness as a phenomenon is excluded from the basis of scientific thinking through the move of the Cartesian Cogito.

The parts of my chimera are in position, I maintain, and the somewhat Foucauldian glue can be used to hold them together. I apply some of Foucault's ideas to literature, but, as I have indicated, I am not a 'Foucauldian scholar'.

3.5 What Lies Ahead

In the next chapter, I will examine eight target texts to elucidate different kinds of literary depictions of madness and the psycho-sciences, together with the narratological exposition of the intertwining of my two madness narrative analytical tools:

narrative and diagnostic power. The first four texts are homodiegetically narrated, the following two are heterodiegetically narrated, and final two exhibit (the possibility of) unreliable narration and the focalisation of madness. I will compare and juxtapose these texts on many levels: as examples of differently directed diagnoses (external diagnosis vs internal diagnosis); of depictions of different psycho-scientific frameworks (socio-psychological vs biological vs lay diagnosis); of different kinds of narrative structures (first-person v. third-person narration; reliable vs unreliable narration); and of the different ways the narrators and implied authors use narrative and diagnostic power (e.g. one form of power supporting the other vs open conflict between the two). I will build my analyses from the bottom upwards, starting with the intra-fictional relationships between characters and narrators, and building towards the audiences' interpretive judgements of these relationships in madness and psycho-science depiction and diagnosis. (I will handle the Phelanian theme of ethics in more detail in the second part of the study in the cases of McGrath's Spider and Nabokov's Lolita, and the theme of aesthetics in the case of Nabokov's Pale Fire. As these borderlines are not sharply defined, I will discuss ethics at times already in this first part; aesthetic structures are, of course, inseparable from interpretative judgements, as Phelan also states (Phelan 2005b, p. 324).)

In analysing my target texts, I will therefore examine what I perceive as the ways the narrative agents use power over their audiences, how they combine narrative power with diagnostic power, and how they depict madness and the psycho-sciences through use of these narrative power structures. At the end of the chapter, I will briefly summarise my findings and consider the process of reading through the psychiatric lens.

4 TARGET TEXT ANALYSES

4.1 Patrick McGrath's Asylum: A Psychiatrist's Point of View

I will start the analyses of my eight target texts with Patrick McGrath's novel Asylum (1997).

Patrick McGrath (born 1950) is a British novelist whose work has been categorized as gothic fiction. McGrath often uses the device of unreliable narration in his novels, and some of his central themes are mental illness, repressed homosexuality and adultery. He has written eight novels and two collections of short stories, and three of his novels have been filmed: *The Grotesque* (also released under the alternative title *Gentlemen Don't Eat Poets)* in 1995, *Spider* (which I will concentrate on in the second part of my study) in 2002, and *Asylum* in 2005. Very little has been written on McGrath or his work – I have found no research literature on the author, making my own analysis the first literary scholarship on *Asylum* that I am aware of.

I begin my analysis with *Asylum* because it exemplifies what can be regarded as the most elemental diagnostic relationship, namely the relationship between a psychiatrist and her patient; it is in this relationship that the psychiatrist makes a diagnosis of another person (i.e. an external diagnosis). I have also chosen to begin with *Asylum* because it exemplifies first-person narration.

Asylum is narrated by a psychiatrist, Doctor Peter Cleave, who forms his story as a sort of a psychiatric, psychoanalytical case history (the novel's storyworld is set in the late 1950s, when the psychoanalytical framework of psychiatry was still dominant and enjoying its heyday). It is, however, primarily a love story. This dual narrative dynamism can be seen to be intimately intertwined, because the psychoanalytical framework sees the unique human relationships (Millon 2004, p. 258) between the

mad person and her environment as the basic fabric and material of her madness: this can be seen to justify the heavy novelistic drive of Peter's narration.

4.1.1 Plot Summary

The story Peter tells concerns a colleague's wife, Stella Raphael, who falls in love and starts an obsessive sexual relationship with a paranoid murderer and artist, Edgar Stark, who is being treated by Peter in the hospital. Edgar works in the hospital's park, near the Raphaels' house, so it is possible for the lovers to meet fairly easily on the hospital premises. Stella also has the keys to staff cricket pavilion, a rendezvous where they can arrange their sexual meetings. Shortly after the affair starts, Edgar flees the institute wearing clothes he steals from Stella's husband's closet after a sexual encounter in the Raphaels' bedroom.

Later, Stella takes the leap and joins Edgar in his hide-out in London, where their relationship starts to take a dangerous turn. Like in his marriage with his wife, Ruth, whom he murdered and mutilated, Edgar becomes paranoid and jealous. Stella escapes his violence only to return to his lodgings, drawn by her obsessive love – even at the risk of her life. Edgar had fled the police, though, and Stella herself gets caught. After this, Stella's life disintegrates. Due to the scandal, Max, Stella's husband, is required to leave his job and his prospective career as the medical superintendent of the institute. Max gets a job at a Welsh country asylum, and their life together becomes punitive and recriminating. Max blames Stella intensely for ruining their lives, and Stella starts to sink into clinical depression. Her fate is sealed when she lets her son, Charlie, drown during a school expedition, and she herself is returned to the forensic mental hospital as a patient, to be taken care of by Peter, the narrator. After a while, Peter asks Stella to marry him, and she agrees – only to kill herself after the asylum dance party, where she looked in vain for Edgar.

4.1.2 Diagnostic Moments, Narrative Progression, and Psychiatric Control

From the very outset, it is made clear that we are dealing with a story of pathological love, as Peter begins his story by giving us the first of his numerous diagnostic moments. He states:

> The catastrophic love affair characterized by sexual obsession has been a professional interest of mine for many years now. Such relationships vary widely in duration and intensity but tend to pass through the same stages. Recognition. Identification. Assignation. Structure. Complication. And so on. Stella Rapahel's story is one of the saddest I know. A deeply frustrated woman, she suffered the predictable consequences of a long denial collapsing in the face of a sudden overwhelming temptation. And she was a romantic. She translated her experience with Edgar Stark into the stuff of melodrama, she made of it a tale of outcast lovers braving the world's contempt for the sake of a great passion. Four lives were destroyed in the process, but whatever remorse she may have felt she clung to her illusions to the end. I tried to help but she deflected me from the truth until it was too late. She had to. She couldn't afford to let me see it clearly, it would have been the ruin of the few flimsy psychic structures she had left. (*Asylum* p. 3.)

Here, Peter directs his audience's opening course with a firm grip: in the beginning, he gives the outline of his tale as a psychiatric case history with all its structuring, mentioning some of the technical terms for the psychiatric structures he sees in this tale: 'Recognition. Identification. Assignation. Structure. Complication. And so on.' He seems, however, to drop the act of building his story as a rigorous psychiatric case history in the course of his tale, but here, at the beginning, he makes the psychiatric grip clear. He also formulates one of his experiential anchors, the tellability of his tale (Toolan 2001, pp. 151–152): it is 'one of the saddest' he knows, therefore an interesting story to hear for his audience. The story is told almost exclusively through the viewpoint of Stella, but the anchoring point of tellability, the 'ownership' of this story is Peter's: it is for him to 'advertise'. I argue that even though he tends to evaporate to the background in his story, it is still strongly in his control.

Thus, from this very beginning, he positions himself as the authoritative psychiatrist giving a professionally fascinating and humanly interesting description of something he controls as a psychiatrist: a tale of the course of madness told expertly by a doctor. This is the case, even though he appears to fail to give us certain crucial facts that a psychoanalytically oriented psychiatric case study would offer, for example, the exact causation of Stella's illness. The diagnosis is meant to be unproblematic: it is a clear case of psychiatrically conceived madness. He also at least attempts to control the unwinding course of the illness he reports. Already on this first page, we learn that the love story is not only pathological, but also catastrophic, destroying four lives despite the efforts of Peter's clinical psychiatric intervention.

However, as the narration unfolds, the audience is led to understand why the narrative has another, very special, personal meaning for Peter himself: he takes part in the patterns of relationships that form around the pathological love of his protagonists, not just as a doctor, but also as one of the possible participants in the patterns of this pathological love. This development is only revealed at the very end of the story, though. In the course of the narrative progression, the audience is led to ponder what went wrong in these pathological and psychiatric relationships, giving us the double change of both the characters and the authorial audience's reactions to this change (Phelan 2005b, p. 323).

I begin with Peter's viewpoint. From the beginning, Peter firmly directs the audience's reactions to his tale by psychiatrising it; he encourages us to see his tale through the psychiatric lens. The psycho-scientific framework is thus intensely at the fore of his narration, and the institutionalised diagnostic power feeds the narrative power of controlling the audience's reactions (Peter takes the position of an authority of psychiatry, and also of this tale because it is a psychiatric story). The reverse is also true: this narrative power supports Peter's diagnostic efforts (Peter controls the story as the only reliable-sounding narrator in order to convey his psychiatric interpretations of this narrative material). The diagnostic moments he offers the audience can be seen to tie firmly together the narrative power and diagnostic power in an inter-supportive structure. The main Phelanian 'purpose of narrating' (Phelan 2005b, p. 323) can thus be perceived to be the directing of the audience towards receiving the story as a psychiatrically formulated one; and the rhetorical purpose (the 'why') of narrating is connected to the contents of diagnosis (the 'what') by making the revealing of the contents of diagnosis (that Stella and Edgar are both conceived in psychiatric-psychoanalytical terms) serve the rhetorical purpose of directing the audience to see the protagonists in psychiatric terms.

Peter narrates his story by leading the audience, step by step, to see the depth of the pathologies of both Edgar and Stella, and to see their love as sexual obsession,[1] rather than as a 'normal', though perhaps passionate and tragic, love affair. He does this by firmly controlling the diagnostic knowledge he feeds to the audience, morsel by morsel, building on the initial diagnoses of both Edgar and Stella that were given already in the first pages of the narrative: theirs are two pathologies that intertwine and feed each other until the bitter end.

1. There is no exact diagnosis of 'sexual obsession' even in the 1968 DSM-II, the second, and more developed of the two psychoanalytically oriented DSMs. This only heightens the fact that psychoanalytical diagnostics are far more fluid than the brain-oriented branch of diagnostics of the DSM-III onwards.

Edgar's pathology is established almost as early as Stella's (on page 5, 'Edgar was one of mine', i.e. Peter's patient), and his madness is made clear by Peter, as he gradually unveils Edgar's pathology in the same manner he does with Stella's. For example, after Edgar has fled, and Stella is still with Max at the hospital, the staff comes to the right conclusions about the lovers' relationship. Knowing Ruth's fate, Peter fears for Stella's safety; she is the first woman Edgar has been in contact with after the murder of his wife. (*Asylum* p. 100.) Peter does not explicitly tell Stella that they are aware of the affair, but warns her of Edgar's dangerous paranoia involving women he loves, and tries to make her tell him where Edgar is. His efforts are in vain, however, as Stella has already long before made her identification with Edgar as the person with whom she has fallen in love. Stella has even already made the counter-diagnosis that Edgar is not sick, but only a perpetrator of a crime of passion. (When Edgar says of himself and the other patients: 'We're all mad.', Stella answers: 'I don't think you're mad.' Edgar agrees: 'Neither do I.' (ibid., p. 18.)) Thus, we can see how the narration moves on the margins of sanity and madness, as Peter lets us see how Stella, in her emerging sexual obsession, must 'cleanse' her lover from the stigma of madness and see him through the eyes of a woman in love: he is perhaps imperfect, but wholly loveable. All this, in Peter's eyes, adds to his diagnostic evidence concerning Stella's pathological obsession with Edgar.

There are dozens of these diagnostic moments in the narration: they are moments, more or less overtly articulated, at which the audience is led to see some aspect of Stella's or Edgar's madness. They range from Peter's explicit announcement that Edgar is 'pretty sick' (ibid., p. 9) to Stella's own wondering 'am I mad?' (ibid., p. 80) to implicit hints of Stella's depressed mental state: 'It was an awful sensation, to feel the meaning drain out of everything' (ibid., p. 121). Peter is careful to imply that Stella at least moves at times in the direction of seeing her madness, and of asking herself whether her actions are indeed mad – only to abandon these thoughts as illicit for a woman in love. This only further strengthens Peter's growing evidence of Stella's hysterical obsession. Thus, Peter chains together a massive pool of evidence to support his view that, not only Edgar (who has been institutionally declared a madman from the beginning), but also Stella is mad and entering ever deeper into the realm of her madness. There is therefore also a narrative progression of the diagnostic moments, which are linked to each other and form a supporting (psychiatric) structure for the thickening (adventure narrative) plot. The audience follows this plot with growing tension as the transgressing lovers try to avoid being caught by the staff and later the police; as the depth and danger of Edgar's paranoia

starts to dawn on Stella (one, decisive diagnostic moment is when she understands Edgar is truly dangerously deluded: he is afraid of her poisoning his orange (ibid., p. 134)); and as she wanders ever deeper into madness, melancholy and personal tragedy after being caught.

Peter is careful to lead the audience to the recognition of Edgar's madness, to seeing Edgar through the clinical eye, which only strengthens Peter's belief – and the belief he wants to gradually strengthen in his audience – that Stella is mad to claim she sanely and truly loves Edgar. Stella leaves all safety behind as she joins her lover: her family, her husband, her son, high society, her friends (including Peter), and her personal safety (Edgar starts by hitting her, then proceeds to imply that she is trying to poison him and that she is cheating on him with his friend Nick, after which he becomes truly threatening to both Nick and Stella). In Peter's eyes, she is mad to cling on to her illusion of romantic love with a violent, dangerous, insane creature like Edgar. She seems even madder when she lets Charlie drown, watching idly as her son sinks below the marsh waters, seeing in his place, not Charlie, not even Max, whom she has started to hate vehemently, but Edgar. Peter interprets this as the desperate wish of a sexually obsessed woman to be free of the disastrous love: 'I told her this strongly suggested to me that she was desperate to let him go, to bring the pain of her compulsion to an end' (ibid., p. 216).

Thus, one can say that Peter skilfully uses the narrative technique of narrative progression to gradually reveal the fates of his tragic protagonists (also) by his chain of evidence and his diagnostic moments. The audience reaction to this narrative progression goes hand in hand with the thickening plot, which gradually reveals the viciousness of Edgar's madness towards Stella, and Stella's progressive mental disintegration. All the time, however, Peter is careful not to pass judgement or to moralise: like a proper psychoanalytical psychiatrist, he keeps his tone sympathetic towards both of his patients. Thus, I argue, the audience is also encouraged to empathise with the couple during their tribulations. Here, one can see Suzanne Keen's formulation of 'a standard feature of fiction in action': the audience has empathy for the stigmatised or repulsive others – the villains and madmen (Keen 2007, p. 131). I argue that in the case of McGrath's Peter, the audience's possible empathy for Stella and Edgar is – if achieved – a consciously sought for effect on the narrator's (and the implied McGrath's) part, who clearly wants to balance the prejudices of his audience by showing the pathological – and therefore pitiable and understandable[2] – nature of his two criminals and transgressors.

2. That is, understandable through a psychiatric lens.

4.1.3 Groupings

Peter also uses the thematic tool of group positioning to highlight the scale of the transgression Stella makes when she chooses Edgar as her lover. From the very beginning, Peter gives us the blueprints of the group positions held at the hospital by the staff and the patients. The patients are seen as an out-group by the psychiatrist-narrator. For example, they have to be kept under control with physical restraint (Peter describes the 'grim carceral architecture': bars in the hospital windows, for example (*Asylum* p. 4)); they 'dress eccentrically' and 'move awkwardly' (ibid., p. 6); making the annual dance party (where Edgar makes his first move to contact Stella) and its idea of uniting the communities of staff and patients for one night only an idea. Peter even explicitly says the patients are 'technically of lower caste' (ibid., p. 20) and the implication is that the word 'technically' can be more or less dropped; the custodial staff members 'like structure and hierarchy' (ibid., p. 42) and the medical staff and their spouses are simply offended and outraged when Stella's deception is exposed and they know that she transgressed with one of the forensic, criminally insane patients ('she was an affront to their sense of decency' (ibid., p. 148)). With her identification with the mad patient, Stella moves first onto the brink of transgression from being a sane staff-member's spouse and then into becoming a full mental patient herself: madness is almost seen as contagious, as Peter describes her transformation and changing group status through the stages of her illicit love.

As Peter mentioned on the first page of his tale, one stage in the process of sexual obsession is 'identification'. Stella makes the most drastic kind of identification when she gives up her socially more prestigious status as the sane wife of a psychiatrist and identifies with the mad artist. From the beginning she sees Edgar's humiliating, mute status as a patient. When the staff blames Edgar for bringing alcohol onto the ward, 'It was raw bare face of institutional power she was seeing on the back lawn that night, she was hearing the voice of the master. It hurt her cruelly, […] and what was worse was that that voice would not be contradicted, because Edgar *had* no voice; he was silent, just as she was silent on his behalf' (ibid., p. 50). Here, we have of course an almost verbatim echo of the Foucault's silencing of the mad by psychiatry (Foucault 2006, p. xxviii, pp. 103–104). Stella's echoing of Foucault only strengthens the impression of her identification with her mad lover, and her rejection of the sane and the psychiatric establishment her husband and, by extension, she herself is part of. Later, in London with Edgar, she is anxious to make Edgar see that she has truly transgressed and left the psychiatric establishment. Once, when Edgar wants

to group her with Max and Peter (after Edgar has threatened to hit her, and Stella has insulted him by calling him a 'psychopath'), she responds by thinking: 'But she didn't want this, she didn't want him grouping her with the psychiatrists' (*Asylum* p. 121). She has chosen her side, and she clings to it, because by living with Edgar she must become more like him, thinking like a fugitive mental patient.

This transgression is perhaps even starker than it would be nowadays, since it takes place within the worldview of the 1950s, when the anti-psychiatric movement had not yet made the meagre rights of the mad person a public and political issue, and when the British class society was more pronounced. Thus, the stigma of madness is strongly socially constructed and felt here as well, and it is a clear fact. Had Stella fallen in love with Peter, for example, the tragedy would not have amounted to such a transgression as it did. To love a criminally insane patient, to help him flee the institute, and later to join him is regarded as a full betrayal by her former in-group. Here we see how stigma is socially constructed by the in-group/out-group formations, the way people divide each other into the groups of the sane/insane, and what they mean socially: the majority of sane people may develop at least part of their own identity against the out-group of mad people. (Fabrega 1991, p. 109) Affronted, the staff members (with the exception of Peter) close ranks on Stella after she gets caught and is returned to the hospital.

In the final stages, after her being caught and succumbing to her depression, only Peter is capable of maintaining an amicable relationship with Stella. Due to his bitterness at having his life being ruined by his wife, Max cannot see Stella through the mitigating psychiatric lens like Peter, as a patient – a sick person with a hysterical illness in need of help. For Max, Stella is an example of 'perfidy' and 'mendacity' (*Asylum,* p. 228). For Peter, she is 'My poor, dear girl' (ibid., p. 203).

Peter's narration is thus also skilful in the handling of these in- and out-groups: he leads the reader to see, through the complicated human relationships in the hospital and the society at large, how Edgar's status of a mad person contributes to Stella's love for him (Stella sees him as a person being wronged by psychiatric authority), and how Stella's identification with her mad lover makes her take the dangerous leap into Edgar's world of madness – finally driving her to madness as well. Peter himself moves on the borders of these in- and out-groups in telling his tale of Stella's transgression; never once does he lose his sympathetic posture towards the fallen woman. Even to the point of falling in love with her as well?

4.1.4 Turning the Kaleidoscope: Illicit Control of Narrative Situations and Experientiality

The most surprising turn of the plot takes place at the end of the tale: Peter, after salvaging Stella from the trial of Charlie's death, takes her to the institute to treat her himself (Peter has taken the job Max so much coveted and become the medical superintendent), and finally asks her to marry him. Stella agrees, even though the novel ends with a final tragedy: she takes her own life after the annual dance party at the hospital, where she in vain looks for Edgar, whom she is still in love with, more than with Peter or anyone else. This morsel of information, that Peter wanted to marry Stella, seems to retrospectively supply the audience certain missing pieces of the puzzle. It explains why Peter has, all the way through the narration, so venomously pictured Max as an incompetent psychiatrist and husband; why Peter is so fascinated by Stella and her fate; and why he is so unrelentingly sympathetic, even when all the other members of her former community turn their backs on her. Has he been in love with her all along? This turn of the plot and development in the narrative progression demands some reaction on the audience's part. We have to ask whether this has been, all along, a story about Peter's own love. Alternatively, is Peter, as Stella has imagined him to be, only a homosexual in need of a domestic arrangement (*Asylum,* p. 236), seizing the opportunity to build a façade of a respectable marriage?

I now must also ask the questions that arise from this rather surprising development: what about Stella's viewpoint? What about the fact that she has been all the time the chief focaliser of this tale told by her psychiatrist? What about the narrative technique of managing narrative situations and the thematic tool of experientiality? What do they tell us about Peter and his use of narrative and diagnostic power – and about his proposal of marriage to Stella?

Giving a slight turn to the *Asylum's* interpretative kaleidoscope changes the viewpoint somewhat: Peter tells the story of Stella's transgression and madness almost exclusively from her viewpoint, through her focalisation and concentrating on her qualia. He justifies this controlling of the narrative situations by maintaining that he has discussed all these matters with her – all the turns of plot, her thoughts and emotions – on numerous occasions during their time together as patient and psychiatrist. It is also possible that he has taped these conversations, as he did with Edgar (*Asylum,* p. 42), which may be a standard procedure at the institute. Peter practises psychoanalytical psychiatry at the institute, based on long, deep directed

conversations between the analyst and analysand, during which the analyst tries to probe not only the conscious thoughts of the analysand, but her unconscious dynamisms as well. Thus, there is a lot to know for the psychiatrist.

However, one can ask whether Peter's narrative technique of building his narrative situations on Stella's focalisation is *illicit*. Whose voice do we hear when Peter narrates about Stella's qualia through her focal viewpoint? Peter does at times refer to the source of his narration by inserting a tag like 'she says that' to Stella's thoughts and emotions, but mostly he just narrates like a Stanzelian Olympian authorial narrator (Stanzel 1984, p. 126) capable of penetrating Stella's mind with ease. This penetration is deep: it reaches even her unconscious realms. For example, after her having sex with Edgar for the first time, Peter/Stella describes her feelings:

> She lay in the bath for an hour with her eyes closed and her mind empty, though not properly empty, for beneath the surface moved the knowledge of what she had just done. It was not to be looked at, it was not to be acknowledged at all; but there are forms of mental experience that exist outside the machinery of repression, and in those obscure regions of her psyche arose the question whether, having done this once, she would do it again, and *though she did not actually think this thought, and would have denied it vehemently had it flickered into consciousness,* she was aware, as one is aware of all such things that don't bear thinking about, that the answer was yes. (*Asylum,* p. 26, emphasis added.)

Here we have Peter's very fluent narration of Stella's conscious and unconscious thoughts: her qualia, her experience, her point of view. How can he know? Because he is her psychiatrist? We now encounter the deep waters of psychiatric power: I argue that one can see Peter's fluency – his merging of Stella's focus with his own narrative voice so seamlessly that the audience easily loses track of who thought this[3] or who narrates this and with what right – as strongly interlinked to Peter's clinical psychiatric agenda of seizing control of Stella's inner life as comprehensively as possible in order to change it as comprehensively. This control also materialises in his narrative about her: he usurps the rights of an authorial narrator even though he is still and always a first-person narrator. He is what Stanzel terms as 'embodied' narrator (Stanzel 1984, p. 90), who is constrained by being on the same ontological level as the other characters he is narrating about, and also a 'teller-character' (Stanzel 1984, p. 126), conscious of his need to direct the audience's reactions. Thus, as the

3. Cf. Lisa Zunshine's reading (2006) of Nabokov's *Lolita*, where Humbert Humbert likewise drops the source tags of his narrative's contents and the reader is easily deceived.

teller-character-narrator, Peter controls the narrative situations of his narrative, but these situations, most urgently Stella's focalisations, have an unsound basis. Peter, as an embodied narrator, cannot know them first-hand; he can only rely on what she tells him and on what he, as her psychiatrist, reads into them. However, Peter does not doubt his capability of telling *as if he were Stella, as if he knew*. Here, one can argue that Peter tries to direct the conglomerate of narrative and psychiatric-diagnostic power through his choice of focalising through Stella. In order to make a psychiatric diagnosis of her, Peter combines the internal perspective of another character with his own narrating voice, in a manner that seems to conquer Stella's inner world completely.

One is reminded of Foucault's notion of a power-hungry psychiatry that attempts to control the patient's actions (remember Foucault 1982, point 2 of my list); it does this also by controlling the diagnostic knowledge and by excluding the patient's subjugated knowledge of her own mental state from the status of real knowledge (Kusch 1993, p. 129). All this drives at the forced change of the patient's viewpoint of her own nature (Foucault 1982, point 8; Foucault 2006b, p. 10) even though the patient may resist the psychiatrist's designation of madness. Thus, one must ask: would Stella call her relationship with Edgar 'sexual obsession'? What the implied McGrath does by letting Peter take control of Stella's viewpoint is to make the audience ask questions about these tense relationships of psychiatric power – even to the point of questioning Peter's reliability as the narrator and the unproblematic nature of his diagnosis.

4.1.5 So, Is Peter Unreliable?[4]

I can point to a number of possible points of unreliability in Peter's narration. He may not, after all, truly know or narrate what Stella feels and wants, and his diagnosis of Stella, based on his possibly warped picturing of her, may not be accurate or unquestionable.

To start with the central theme of pathological love: is Stella's love for Edgar truly pathological, as Peter claims? The novel makes me ask questions like: What is love, then, if it is not potentially obsessional? Is it possible to see Stella's love as 'normal', though highly tragic and unfortunate? Charlie's death does suggest that

4. Throughout this chapter, I will be using the established manner of speaking about unreliability in the research of literature. At the end of the next part, I will be reconsidering the term and suggesting my own version of the terminology of unreliability.

Stella has a notion of love rather drastically different from many, as she seems to exclude the grief and guilt for her dead son from her mind and concentrate solely on Edgar, but still, does this make her 'sexually obsessed'? Are there not different shades and different types of love that are still normal? Edgar is alive and Charlie is dead; she may have to block out the dread and guilt and concentrate on what is still alive. Does this mean that her conception of 'love' for Edgar is pathological? (She seems to really sink into clinical depression, but this is not the primary diagnosis Peter gives: it is her 'sexual obsession' that most interests him, the depression is only a stage in this hysterical illness of obsession.) I am reminded of Horwitz's claim that psychoanalysis widened the scope of the psycho-sciences to cover realms that are not 'truly' pathogenic (Horwitz 2003, pp. 50–51); here, the realm is human love. I am also reminded of Freud's inability to strictly delineate the 'sick' from 'healthy': he regarded everybody as more or less neurotic (Block Lewis 1981, p. 22; Freud 1978a, p. 358). Peter would be following his master in pathologising Stella's concept of love.

On the other hand, we may ponder Jasper's notion of how the deluded person must cling on to her mistaken beliefs, since they have become integral to her own self and its basis, and correction would mean too great an upheaval to the patient's whole psyche (Jaspers 1997, p. 105). Is Stella thus deluded? She may have to cling onto her notions of love for Edgar in order to survive, as Peter implied already at the very beginning: 'She couldn't afford to let me see it clearly, it would have been the ruin of the few flimsy psychic structures she had left.' These are some of the questions McGrath's narrator's way of blending his voice with that of his protagonist makes me ask: what would be Stella's *own* viewpoint of all that is told about her?

One can further note how another slight turn in the interpretive kaleidoscope makes certain of Max's and Edgar's remarks seem as accurate as Peter's interpretations of Stella. Max, when Peter comes to ask his 'blessing' for his marriage with Stella, warns Peter of Stella's mendacity and perfidiousness. Max is bitter, for understandable reasons, and Peter dismisses his accusations, noting that 'He sounded like a Jesuit' (*Asylum,* p. 228). Nevertheless, has not Stella lied, and lied copiously during the course of her relationship with Edgar? She lies to Peter as well, about her true emotions and their object and depth: she does not tell Peter, her psychiatrist, that she is going to the dance party only to search for her lost lover, but pretends that she has forsaken Edgar for good. Peter sees her lies to Max and others as a symptom of her hysterical illness, her building of an obsessional relationship with an out-group member: surely, she has had to lie to her in-group members in order to keep her 'love' alive. But now, Stella is Peter's patient, and a future spouse, he trusts her words

and even more his own interpretations about her mental life, only to find out that he was mistaken. He still never drops his notion of her being mentally ill, and thus pitiable and understandable in her transgressions.

Edgar, then, is truly deluded (we, the audience, know because of the 'poisoned' orange incident), but still able to provoke a reaction in Peter when Peter probes Edgar's attachment to Stella after being caught and returned to the hospital. When Edgar says: 'Stella, she'll do it with anyone for nothing.' Peter is immediately reminded of an example which seems to corroborate this deluded man's words: Trevor Williams, the Raphaels' neighbour in Wales, who rather easily got what he was looking for from Stella. Peter feels a 'pang of unease', but he dismisses it by referring to Edgar's deluded character: 'I felt desperately sorry for him, sorry that everything he felt and thought about Stella was contaminated by this foul falseness' (ibid., p. 243).

Thus, Peter more or less wittingly gives room for these kinds of alternative interpretations of Stella, which only heightens the delicate balance of the authorial audience's drawing of the line: the border between sanity and madness is – even when the diagnostician is as sure of his diagnosis as Peter – an extremely fine line. Peter seems to be at least partly aware of this issue when one compares his notions of Stella with those of Max and Edgar: one could see Stella as sane, but perfidious, or sane but promiscuous, but he tends to disregard them, to close his eyes, in order to support his own notions of Stella's nature.

Here, I arrive at the issue of Peter's own part in the love patterns around Stella. He asks her to marry him, not to solve 'the problem of sex', but 'the problem of conversation' (ibid., p. 238). He leaves the question of sex – of passion – hanging in the air, answering Stella's question about the physical side of their future marriage only by saying: 'I think perhaps that's something we would have to discover.' Peter seems blind here, and what is more, self-deluded. He has all along pictured Stella as a passionate woman, a person with strong sexual drive, who, as he explicitly notes, is not satisfied by Max's weak libido and their cold marriage (ibid., p. 74), and is thus tempted by Edgar's powerful sexuality. How can he think that such a woman would be satisfied by a person who is possibly homosexual and who prefers conversation to sex? Furthermore, how can he think that a marriage, a personal relationship *with the doctor, the psychiatrist* would be desirable for someone looking for a reciprocal *love affair* as she was with Edgar? It seems to me that one can seriously question Peter's clarity of vision regarding what Stella really wanted.

4.1.6 Group Memberships and Transference Struggles

As psychoanalysis has emphasised from its Freudian beginnings, the relationship between the doctor and the patient, the transference, is basically one of struggle. ('Freud repeatedly describes the relation of analyst and analysand in the transference as one of struggle, struggle for mastery of resistances and the lifting of repressions, which continually evokes a realm of the daemonic.' (Brooks 1987, p. 12; see also e.g. Freud 1978a, p. 444, where Freud speaks of the 'mastery over the patient')) Stella was not looking for struggle, but for warmth and sexual love, and Peter seems to mix these two in his double role as prospective husband and psychiatrist. I will shortly return to this question of transferential struggle, but now I must ask: is Peter an unreliable narrator here, *even if he is the psychiatric authority*? He seems to be blind to Stella, and to his own psychiatric use of power, of appropriating Stella's voice and finally her as a whole person, in order to make her one of the precious objects of art that he collects. He says, 'In recent days I had more than once imagined her in my house, as she once so frequently had been, among my furniture, my books, my art. Oh, she had a place there, among my fine *objets* […]' (*Asylum,* p. 222) To me, this sounds like a classic Freudian slip, to make the audience unwittingly see how Peter objectifies Stella, making her one of his 'fine *objets*'. If this is so, how blind can Peter be to what Stella really wants and desires, he who so confidently narrates on her behalf?

Peter describes Stella's reaction to his proposal, but does not comment on it: 'Suddenly she found it all hilarious. A romantic proposition from the medical superintendent, with her husband's complicity, what an afternoon she was having. She felt like a consignment of damaged but retrievable womanhood, in the process of being transferred from old owner to new, after being stored for a while in a warehouse.' (ibid., pp. 232– 233.) What if Stella is dead serious here, only appearing to joke? Peter answers only: 'I know you don't love me, […] but I think you need me, you do at the moment anyway. I'd be prepared to gamble on that changing. Your affection for me deepening.' (ibid., p. 233.) Peter's answer seems to indicate that he does not see the depth of Stella's desires, and that should be the crux of Peter's narration – to tell us what Stella truly wants, thinks, needs, and feels.

In the end, Peter does become aware of Stella's unextinguished love for Edgar, but it is too late. He even narrates the last part of the tale, when Stella is in the hospital as his patient, in a kind of first-person dissonant (Cohn 1981) 'double mode', revealing with slight hints that Stella pretends to him that she has got over Edgar

and started to slowly recover from Charlie's death, even when she definitely has not. (E.g. Peter says directly: 'Oh, it was a subtle game she played with me' (*Asylum,* p. 236).) He comes to know that Stella still loves Edgar, but I argue that even this is not enough for Peter to become a reliable narrator *on Stella's behalf*. For, if we pause a while to think what the narrative would have looked like had it been narrated by Stella, we may surmise a considerable gap between Peter's and Stella's thought worlds. The patient's account of her own illness, at least before the transferential struggle and treatment is over with, must be different from that of her psychiatrist. This is what clinical psychiatry is about: changing mental landscapes. What Stella's narrative would be like is impossible to know for certain, obviously, because we are not given it: we are instead given a story controlled by Peter's psychiatric voice over Stella's. It is Stella's focalisation as supposed by Peter, that is: Peter's narrative. The rest is only speculation. We are given a psychiatric account of a patient's warped mind, but we are not given her own words about it. Therefore, I argue, we have only half the story, not all of it, which Peter seems to think he is offering us.

Here I return to the issue of in-groups and out-groups: what I see as the difficulty in this troubled relationship between the doctor and his patient can be translated into the language of Peter's handling of the in-group/out-group relations, and their experientiality.

However, one problem with my rendition of Keen's empathy strategies is manifested here: we have only Peter's narrative in which he does not explicitly specify his narratee – all we as readers can do is to interpret his narrative in order to come up with a notion of his narratee. I argue that Peter can be seen to attempt an empathetic strategy that likens to Keen's description of 'the broadcast empathetic strategy' (Keen 2007, p. 142) in trying to cultivate his narratee's empathy for a group (the insane), which is an out-group for most of the broader audience (madness being a marginal condition after all). He tells Stella's story at length, giving a depiction of her mental landscape, which may be seen as a strategy of immersing the audience in the internal perspective of the person whom the narrator wishes the audience to empathise with (cf. Keen 2007, p. 96). He himself maintains a sympathetic relation to Stella from the start, thus one can argue that he gives an example for his audience to follow in how to relate to Stella and the other mental patients. Furthermore, from Peter's narration concerning the question of how he would like his audience to receive his tale, one can extrapolate that Peter wants the audience to see Stella through the psychiatric lens: he wants his classifications to be met with approval. He bolsters the broadcast empathetic strategy by his firm narrative control of Stella's experientiality: he seems

to ask the audience, the narratee, to listen to Stella's story and to understand her, as he does, from the viewpoint of the psychiatrist. He does not belong to the out-group Stella becomes a member of; he remains on the border, as the doctor, who sympathetically, but firmly tries to control and change his patient's mind.

This narrative-psychiatric control alerts me to the accentuation of Peter's groupings: how is Peter positioned in relation to the audience he tries to direct so firmly? As said above, it seems to me that Peter's endeavour to elucidate Stella's mental state may be an important way of trying to enlarge his audience's understanding of perceptions of madness. However, if one tries to take Stella's position as the mental patient at the end of the tale, the picture may become more sinister. Thus, trying to see the difference there may be between the narratee, Peter's audience of the general public (which I extrapolated from his narrative), and that comprising Stella's new in-group (the mental patients) emphasises the way the difference between these audiences may make two very different readings of the depiction of the psycho-sciences and their target – madness itself. This difference crystallises around the question of Peter's unreliability. As stated, one cannot be completely sure whether Peter narrates to a sane or an insane audience; he does not address his audience directly, for one, and all our suppositions of the audience's characteristics are just that: suppositions. This makes the application of the Keenian strategic tools somewhat questionable.

First, Peter's psychiatric control of his tale makes me ask questions about Stella's experientiality, particularly of Peter's using her experientiality to further his own narrative and psychiatric agendas while trying to make her his spouse. Peter wants to have his cake and eat it: he tries to be the doctor, thus managing Stella's mental, experiential world as a member of the insane out-group; and he tries to include her in his in-group member as well, as the future spouse who is fit to be among his *objets*. 'She was my patient, but she was also a woman of taste, a woman of my class, and I was not blind to her qualities' (*Asylum,* p. 222). Peter is the only sympathetic former in-group member that Stella has after the disaster, but he tries to change her back into an in-group member also for his own benefit, while controlling her as a patient, and thus an out-group member. To my eye, Peter's use of her patient's status as the lever (remember the 'you need me, you do at the moment anyway') makes the pattern extremely charged from Stella's viewpoint. Peter's invasion as the narrator into the realm of Stella's experientiality and his invasion into her mind as the psychiatrist cannot go unnoticed. For example, in his proposal to Stella, he blends two very different kinds of relationships with very different kinds of social patterns. He also seems to be completely unaware of the position he puts Stella in, both in

narrative and social terms. From Stella's viewpoint, and from that of other mental patients, Peter's power as the narrator and psychiatrist is not solely benign; it is at least potentially dangerous for Stella's true voice and real experientiality: 'Nevertheless, there can be little doubt that the very persuasiveness of the stories in question obligates us to consider how that persuasion is accomplished, if we (as readers) are to retain the capacity to resist the sometimes malicious influences of narratives that prod us to feel and think in particular ways' (Sklar 2013, p. 162). As I see it, Peter's narration is not totally devoid of 'malicious influences' of illicit narrative control if one considers the viewpoint of Stella as its target and protagonist.

If Peter wants the audience to feel pity for Stella's ordeals, he must make her seem sick. Alternatively, we can see her as sane, but adulterous – like Edgar and Max – a woman who let son drown without remorse. Of these two alternatives, which would Stella herself choose? We are not given Stella's voice in her own words; we do not know what she thinks about Charlie's death, for example, which is a very central issue in deciding her mental status. Peter only gives the reader these two dreary alternatives: madness and irresponsibility, or full culpability for four ruined lives. She may think about the occurrences of her life like Peter – or she may not: we simply cannot know.

That Peter might be an unreliable narrator is for me a kind of authorial reading strategy that I hope the implied McGrath seeks: if Peter is meant to be a reliable narrator, his narrative and psychiatric intrusion into Stella's mental realms and his voice over Stella's voice become an extremely charged matter from Stella's viewpoint. And is not Stella precisely the character Peter's audience should build an understanding picture of, if Peter is to succeed in what I see as his broadcast empathetic strategy? Peter's apparent proposal that the audience feel empathy for Stella just because she is mad just emphasises the ethical weight of Peter's partly illicit way of narrating through Stella's experientiality. He depicts her through the category of the stigmatised other, which, for sure may help the sane audience to empathise, even sympathise (in the Sklarian vein; Sklar 2013) with her, but he never lets her own voice, her own ways of depicting herself, take the true foreground.

I cannot be certain what the authorial reading should be like, (can anyone? as both Phelan (2005, p. 59) and Rabinowitz (1987, p. 33) acknowledge) but Peter does, perhaps unwittingly, give tiny hints of the differing interpretations to what he tells (Edgar's, Max's, even Stella's own viewpoints concerning some aspects of Stella and her nature), so I have fairly good grounds to argue that the implied McGrath wishes us to see Stella also from a 'non-Peterian' viewpoint. In my model, the implied

McGrath creates Peter-the-narrator in order to further his own authorial narrative agendas. Thus, in this reading of Peter as unreliable, I seek to position Peter's unreliability – concerning my central question of psychiatric diagnosis-making – as something directed by the implied McGrath to the authorial audience through pointing at the gaps and incongruences in Peter's narration. For example, the audience is made to think about Stella's own voice getting lost in Peter's psychiatric interpretive machine and Peter's possible blindness in regard to Stella's true way of thinking. In this pondering lies the heart of the audience's Phelanian ethical judgement (Phelan 2005b, p. 324), which is connected to the Foucauldian knowledge-power conglomerate in my model. Through what I see as the illicit techniques of narrative situations, Peter's claiming to control the knowledge of Stella's inner world makes me, as an actual and narrative audience member attempting an authorial reading, suspect the ethical basis of Peter's narration. The two readings of the narratee and the authorial audience can be seen to stratify into hierarchies: Peter's narratee, the audience he addresses and hopes to convince, is not the authorial audience he gets, which is an audience that challenges and questions his narrative by also taking into consideration the viewpoint of the insane audience. Thus, it is possible to see here the rhetorical-narratological stratification of narrative-as-communication (Phelan 2009, p. 310) in the process of interpretation: the authorial audience can receive a different kind of message from what the narrator would have wished for.

Finally, I return to the theme of the transferential struggle. Peter does explicitly bring forth the nature of struggle in psychoanalysis and transference. He uses military words like 'combative' (*Asylum,* p. 5) and 'strategy' (ibid., p. 211) in describing his relationships with Edgar and Stella. This combative nature is perhaps further heightened by the fact that we are talking about a *forensic* psychiatric hospital, where many of the patients, like Edgar, are presumably treated against their will. Their therapeutic relationships are thus seasoned with an additional aspect of struggle, as the patients treated against their will are in a way forced into transference. In Edgar's case, Peter very early on discloses his therapeutic goal to Edgar himself: 'I told him that what I wanted to do was break down his defences: strip away the façades, the pretenses, all the false structures of his disordered personality, and then start again, rebuild him from the ground up, as it were' (ibid., p. 24). This is a description of Freud's 'character reorganisation' which he sought for instead of simply curing symptoms (Block Lewis 1981, p. 214). This is also a very naked description of the kind of Foucauldian, subjectifying use of power (Foucault 1982) that also the empowering use (Karlberg 2005) of psychoanalytical-psychiatric power is. The aim is

beneficial from the viewpoint of the psychiatrist and society (to cure a criminally insane person), but we can surmise that the patient may feel this 'rebuilding from the ground up' is rather intrusive, particularly as she has not asked for it. What I seek is the juxtaposition of the dominant psychiatric diagnostic knowledge and the subjugated knowledge of the patient's own viewpoint to this use of psychiatric power. I seek the qualia of the patient, for after all, Peter narrates as if he knew what the qualia were as the psychiatrist. I do not claim that Edgar, as the patient, might not accept these parameters retrospectively at the end of the treatment (in this, the patient may finally consent to the calling of the therapeutic relation a proper Karlbergian 'assisted empowerment' (Karlberg 2005, p. 10)). I do argue, like the psychoanalysts, that this agreement may often be insurmountably difficult to obtain. The story of Stella would also most certainly look different if her treatment had succeeded and she had crossed the border safely back to her former in-group of the sane establishment. Peter might then have seemed to be right to take Stella as his patient and future wife. This, however, does not happen, and the implied McGrath allows the tragic events to escalate in what I see as a fairly well-grounded critique of psychiatric power use gone awry as a result of its mixing with another type of social institution – marriage.

Peter seems to fully enjoy his transferential struggles with his patients: 'I relished the prospect of stripping away [Stella's] defences and opening her up, seeing what that psyche of hers really looked like' (*Asylum,* p. 212). Like a proper analyst, he is very aware of the combative nature of his profession, and what was in the '50s largely still seen as the danger of counter-transference to the success of the analysis (Jacobs 1996). He is still entrapped in this combat and the counter-transferential emotions he finally – and only too late – becomes aware of having towards Stella (ibid., p. 251). He does say that it is 'unorthodox' and 'positively dangerous' (ibid., p. 204) to bring his former friend to the hospital as his own patient, but he does not explicitly take responsibility for Stella's death, even as it becomes clear that because of this unorthodox arrangement, he had completely misinterpreted her emotions towards Edgar. Of course, a suicide is always the decision of the person committing it, but Peter is too busy planning their marriage to see that his bride-to-be is still desperately pining for Edgar. Thus, one can argue that Peter's attempt to change the therapeutic relationship into a marriage can be seen as a grave error:[5] in his double

5. There is a parallel kind of depiction of a blend of a marriage and psychiatric relation in F. Scott Fitzgerald's *Tender is the Night*, which could be said to show how difficult this blend is to carry out without harming either or both parties.

role of a bridegroom and psychiatrist, he jeopardises Stella's treatment and life – and does not gain her as a spouse either.

Furthermore, thinking about psychoanalysis's efficacy in the context of a forensic psychiatric institution where the patients are also treated against their will (and Peter's attempts to treat psychotics like Edgar, whom Freud himself delineated as incurable by transference-based psychoanalytical treatment (Freud 1978a, p. 299) since they are incapable of transference) one can argue that *Asylum* makes one wonder about psychoanalytical treatment, its efficacy, application, and power relational aspects. One is reminded of Shorter's rather dismissive statement that psychoanalysis is not a proper method of cure, but a mere *Weltanschaaung* (Shorter 2005, pp. 178–179). As a psychiatrist, Peter is seen to attempt to use the empowering power of treatment (Karlberg 2005), which basically means that he means well for his patients. However, both Stella and Edgar seem to refuse this empowering power relation: they refuse to co-operate. This may be because this particular relation to Peter would attempt to completely change their psyches – their whole subject. This can be seen partly as a failure just because the treatment, even when meaning well, is administered against the patients' own will; Stella and Edgar just do not want to be 'cured'. In this, the novel is a skilful description of the human relationships that (especially psychoanalytical) clinical treatment relationships always are. The treatment relationship, as a power relationship, seems to coerce the participants towards a certain power pattern, which they can try to resist, but cannot completely escape. Peter's attempt to meddle with this power pattern by changing it into a pattern of marriage is a disaster.

Asylum paints a vivid picture of the psychiatric relation from the viewpoint of the psychiatrist – even (or especially) as this viewpoint also endeavours to impersonate the viewpoint of the patient. The psychoanalytically driven psychiatric relation is a variable human relationship first and foremost, and the picture we are given of Peter as a human being and psychiatrist is multifaceted and subtle. He can be seen as a caring friend to Stella until the end, a power-ridden psychiatrist appropriating Stella's experientiality, and, finally, a mistaken psychiatrist erring because of his double role of suitor and psychiatrist and the counter-transferential emotions he has for his patient. All the time, he can be seen as human and also likeable in his earnest, though perhaps blinkered, sympathy for Stella.

My model of Foucauldian-Phelanian interpretation emphasises the way the power patterns of these human relationships translate into power patterns of narration, as Peter uses his narrative skilfully in order to direct his audience's reactions to Stella. However, even though the implied McGrath makes Peter control his nar-

rative psychiatrically and narratively, we are led to see how he still cannot control the audience response completely. In attempting my authorial reading, I had more questions than answers about Peter's blindness as a narrator and psychiatrist. Even as he is the psychiatric authority, I see him as a partly unreliable narrator on the most important psychiatric question of all in his narrative: what does Stella really think, feel and want, and why is she seen as mad? This question arises from the ways he uses his narrative techniques of narrative progression and situations; and the thematic tools of experientiality and group formations. I argue that Stella is essentially more or less mute, no matter how much Peter tells us about her.[6] We seem to know only that the psychiatric grip has its power-ridden aspects as well as its attempts at true sympathy and caring.

What is madness, then, in McGrath's *Asylum*, relayed by Peter's use of the tools of narrative power? What kind of a portrait does Peter paint of Stella's madness? As Peter depicts it, for his narratee, Stella's condition is an extreme transgression, both social and mental, a transgression that is seen as madness by Peter's expert psychiatric eye. This transgression, as it is caused by an illness that the patient cannot control, is further depicted by Peter as something the audience should empathise with, feel for, and accept as a personal tragedy, not as something the ill person should be found culpable of (this convincing may point towards that Peter's narratee is sane: in this supposition, Peter would be seen to offer his narratee information and a viewpoint to madness that is new to her). Other expert eyes, those of Max, do not consider Stella's condition as madness, which emphasises my argument that madness in this novel is in the eye of the beholder. To see Stella as a madwoman gives certain benefits to Peter and his audience: they may see Stella through his understanding and sympathetic eyes, explain her actions as madness (when she seems to transgress so completely), and control and structure her behaviour psychiatrically through the universal categories of psychoanalysis. However, I argue that during this process we seem to lose sight of Stella's own viewpoint – how she herself would understand, explain and structure her own experience. The authorial audience, perceiving the tale also from what could be formulated as the viewpoint of an insane audience (which serves to accentuate the difference between the narrator's narratees and their wished-for empathetic alignment with the narrator's way of seeing Stella, and the way Stella herself might see herself, in her position as a mental patient), may see something different in Peter's story: the accentuation of psychiatric control that renders its target, the mental patient, almost if not completely mute. This reflects

6. Not unlike Nabokov's Dolores is mute no matter how much Humbert Humbert talks about her.

Foucault's explication that psychiatry is a monologue on madness, not a dialogue with it (Foucault 2006, p. 486). This is the juxtaposition which is central to my understanding of McGrath's portrait of Peter and Stella, her madness, and the psychiatric relationship.

However, I do not argue that the sane narratee or authorial audience could not see Stella the way an insane audience only could. After all, in my reading the authorial audience perceives the possible unreliability of Peter, and the authorial audience, like the heterodiegetic narrators we will encounter later, are not easily *proved to be insane*. I use these Keenian empathetic strategic tools only to emphasise the alignments inherent in different groups' general ways of relating to each other and the way these alignments may affect these groups' ways of receiving these stories. A real problem, however, is how watertight these groupings and group readings are, and I will return to this problem in the summary of this chapter.

Clinical psychiatry is about changing madness through classification, diagnosis, and control, and this is what Peter also aims for as Stella's psychiatrist. This endeavour to classify, control and change the condition of madness may then be seen in different ways: as the necessary use of Karlbergian empowering power, or as Foucauldian-like, more or less oppressive and power ridden. McGrath gives us the possibility of weighing up these alternatives, of choosing or letting the juxtaposition live on: his novel is a rich tapestry of psychiatric and narrative power patterns.

4.2 Hammond Innes's The Killer Mine: A Layman's Diagnosis

I have chosen Hammond Innes's adventure novel *The Killer Mine* (1947) as one of my target texts because it exemplifies lay diagnosis-making by another person (i.e. the external diagnostic gaze) in the homodiegetic mode. None of the characters in Innes's novel is a psychiatric professional, thus making a clear juxtaposition to McGrath's Peter and his psychiatric structuring in *Asylum*. By introducing this juxtaposition, I aim to ask questions about how the making of a lay diagnosis differs from a professional one on the level of diagnostic and narrative power, and about the picture the work gives of the psycho-sciences and madness. For example, is it justified to try read through psycho-scientific frameworks when the novel itself does not refer to any such frameworks and instead seems to side-step the whole issue of psycho-scientific argumentation?

Ralph Hammond Innes (1913–1998) was a British novelist who wrote over 30 novels, most of them of the adventure or thriller genre, as well as children's and travel books. Unusually for the thriller genre, Innes's protagonists were not 'heroes' in the typical sense, but ordinary men thrust into extreme situations by circumstance. Often, this involved being placed in a hostile environment, or becoming unwittingly involved in a larger conflict or conspiracy. *The Killer Mine* is a good example of Innes's way of writing an adventure story, and because it uses the literary device of a madman-cum-fiend, it offers me possibilities of analysing the relations between narrative and diagnostic powers: how is treating madness as one device through which the narrator handles his narrative power in building the adventure plot comparable with McGrath's Peter's treatment of madness as the most central theme? As in the case of McGrath, I have not found any literary-scholarly analyses of this novel, or of Hammond Innes.

4.2.1 Plot Summary

Jim Pryce, the protagonist and narrator in Innes's adventure story, accidentally becomes aware of the truth about his mother's fate and the tragic occurrences that drove her to madness and suicide. He is a deserter returning after WWII to his country of origin, England, illegally. He left the country at the age of four, and does not remember his mother, Ruth. She had left Jim's father, and Jim later moved to Canada together with his father. After landing in England, Jim gets involved in Captain Manack's alcohol smuggling. Manack's father, Manack Senior, vehemently opposes this because it endangers the mine he owns and the working of its huge lode of tin, which he discovered as a boy and which has since taken his mind captive: he cannot think about anything else. This dedication to his mine is interpreted by his community as 'daftness' – as madness – but he is not confined or treated in any way, only regarded as someone slightly bizarre. Manack Sr. has ordered his life around the mine, including arranging his marriages so that he has got hold of the shares of his two wives after their deaths. Jim learns that his mother ran away with Manack Sr. only to be kept by him as a housekeeper: he did not marry her, even though she was in love with him, apparently because Manack Sr. needed the shares of the mine too badly. Later, when his second wife died in suspicious circumstances, Manack Sr. blamed Ruth for her death, which broke the delicate woman's mind and drove her to madness and suicide. However, Manack Sr.'s madness is much deeper and more

dangerous than the larger community seems to know: he has not only driven Ruth mad by blaming her for the death of the second Mrs Manack, he actually committed this murder himself – and he is more than willing and able to keep on murdering people in order to keep his mine, as Jim learns as the story evolves. All of this dawns on Jim little by little, as he narrates his story as a consonant first-person narrator leading his audience through the same stages of recognition and interpretation he himself went through.

4.2.2 Diagnostic Moments, Narrative Progressions, and Experientiality: Leading to the Dangerous Madman

Like McGrath's Peter, Jim shows the 'possession' of his own tale by 'advertising' its tellability at the beginning: 'And yet, I will say this, that if I had been told as I strode over the mist-shrouded road to Penzance, that I was walking straight into a terrible mine disaster – not only that, but into a pitiful story of madness and greed that involved my own family history – then I just should not have believed it' (*The Killer Mine (TKM),* p. 23). We are given here a narrative position of Jim's strong control over what is told, and we are promised a tantalising tale as well. We also are reminded of the personal importance of this story for Jim, of the family history he is about to uncover, thus tying together the Labovian point and evaluation, and Fludernik's experientiality (Fludernik 2005; Fludernik 2003, p. 245; Toolan 2001, pp. 151–152).

Thus, Jim tells a story of double madness, murder, and suicide in the form of an adventure story meant to keep the audience in a state of suspense throughout the tale. Like McGrath's Peter, Jim also accumulates a mass of diagnostic moments to support his diagnosis of Manack Sr. and his own mother, Ruth. There is also a narrative progression (Phelan 2005b) to these moments: from the first hints Jim gets from the people in the pub near the mine: '"He's [Mr Manack sr.] just daft, that's all." […] "An then there was that 'ooman [Ruth] who went mad down there," put in another. "Iss," the landlord said to me, "walked over the cliff, she did."' (*TKM*, p. 63), to his own final recognition of Manack Sr.'s full murderous madness:

> The mine had killed them, he [Manack Sr.] had said. And he was the mine. That meant that he had killed them. He had killed his wife – he, and not my mother.

> My God, what a fiend! He'd killed his second wife and made my mother think she had done it. 'You crazy swine,' I muttered. (ibid., p. 220)

Here, one can say that Jim slowly comes to know what Ruth's and Manack Sr.'s closest community has decided upon already: that she was and he is mad. The narrative progression of this consonant first-person narration slowly reveals the true depths of Manack Sr.'s madness and its pitiful spreading to Ruth's vulnerable mind, and it functions as a strong device for creating suspense in the audience. Only when Jim understands Manack Sr.'s madness and its ramifications does he also know how dangerous he is to Jim, who threatens to blast his precious mine. Thus, one can note how the Phelanian double change of characters and the audience's reactions to the story told (Phelan 2005b, p. 323) is in progress: as Jim unravels his family history, the characters' story evolves together with the audience reactions to it. The audience follows Jim, goes through his stages of recognition, and reacts to them accordingly, with pity, empathy, and anger for wrongs done. Jim's beginning to know is elementally tied to the audiences' beginning to know, as well. As the narrator, Jim controls the knowledge streams of the narrative supremely, and as he seems to be a reliable narrator, the implied Innes backs his efforts of building a storyworld. Here, the contrast to McGrath's Peter is pronounced: as Jim seems to be a reliable narrator, there is not the kind of deep stratification of audience responses between the hoped for reaction of the narratee and the actual reaction of the authorial audience. While Peter in my reading seemed to be at least partly unreliable in his interpretations of Stella, Jim's interpretations of Manack Sr. and his own mother are not contested or contestable in the same way. Jim's diagnosis of Manack Sr. holds – it is backed up by his community which works finally in unison to contain the threat the insane person poses to Jim and the others wishing to destroy his mine – and it is received by the authorial audience as a plausible one.

Here, the power and knowledge relations show that Manack Sr.'s knowing what Jim's mother did not know (that he, not she, killed the second Mrs Manack), made it possible for him to manipulate her and to drive her mad. Like in Foucault, knowledge is power to the extreme, for the power here is literally that: it is the directing of the streams of knowledge that can enslave, make ill, or set free. At the level of Jim and his narration, then, one can note that Jim has the upper hand by knowing now what he did not know before about Manack Sr. and his craziness, and by making the diagnosis of madness about Manack Sr.: at least now he knows all the details, the dangerousness of the mad person, and can defend himself and

others. The Foucauldian paradigm of control through knowledge (Kusch 1993; also Foucault 1982, point 14) can thus be seen to be in effect here, adjusted to the lay variation of diagnosis-making that Manack Sr. uses as his tool of conviction. Manack Sr. places Ruth in the position of a mental patient ('He told her then that she was not responsible for her actions', explains Kitty, the daughter of the second Mrs Manack, to Jim, (*TKM*, p. 161)) and thus subjectifies her in this power relation as a dependent (Foucault 1982, point 8), rendering her irresponsible and someone who must be confined for the rest of her short life. The diagnosis realises itself; just by Manack Sr.'s claiming that Ruth is mad, she finally becomes mad: the mad subject position forced on Ruth after the murder becomes her position because no one denies Mr Manack Sr.'s claims.

This narrative progression of about thirty diagnostic moments in *The Killer Mine* can be compared with McGrath's narrative progression. Both build gradually thickening diagnostic evidence of the mad characters' madness, but in Peter's narration the progression is partly different from Jim's: Peter structures his narrative somewhat like a psychiatric case study, thus making the definitive diagnoses already on the first pages of his narrative and then accumulating further evidence for his positioning of Stella and Edgar as mad. Peter is therefore a forcefully dissonant narrator (Cohn 1981) who inverts the knowledge structure by implying he is narrating from a vantage point of knowing already at the beginning how the story will end, and employing the 'double mode' of narration at the end of his tale where he gives hints of Stella's deception towards him. Peter does tell a suspenseful story as well, but his command of the knowledge structures of his tale (the amount of information given at a certain moment in narrative progression) is differently proportioned, because he must give the sense of completely controlling his tale as the psychiatric expert. Jim's narrative, on the other hand, in its more clearly consonant manner, is built on another kind of tension – that of building the audience's knowledge structure together with the narrator's as the story evolves. Although Jim narrates retrospectively, in the past tense, he does not give the audience the crucial knowledge of madness before its due time, emphasising the struggle he had to fight in Manack Sr.'s mine. Thus, Jim applies an effective narrative structure in keeping the audience breathlessly following his own at times helpless struggle with the mine and its mad owner. The difference between Jim's consonant and Peter's dissonant narration is not, however, complete. Both aim at a suspenseful plot, which demands the careful drip-feeding of knowledge to the audience.

Jim's control of his narrative situations is different from Peter's as well: he keeps his focalisation strictly to his own viewpoint, not venturing much into the psychological, experiential spheres of others' qualia, or even his own. He applies a kind of behaviouristic mode of telling, in which the physical appearance of characters tells much more about their mental states than the words they use. Whereas Peter gave copious space for the mental evolution of Stella, Jim describes Manack Sr.'s madness only by noting physical manifestations: 'His lower lip was trembling visibly. Stark madness stared out of those pale eyes.' (*TKM*, p. 220.) This further supports Jim's narration as an adventure plot: the most sought for empathetic response from the audience seems to be of the mode of situational empathy (Keen 2007, p. 80), that is, empathy provoked by the turns of plot, and the dangerous and difficult situations Jim ends up in. The psychological and experiential depth of his characters, including himself, is built on the basis of plain oppositions: me vs the dangerous enemy; me vs my beloved one (Jim falls in love with the second Mrs Manack's daughter, Kitty, and finally takes her away from England to marry her in Italy). This behaviouristic mode of narrating and clear oppositions emphasises Jim's ability as the narrator to interpret his characters and himself: as stated, emotions are not much explained, but are shown by physical manifestations. Jim can thus much better justify his narrative situations than McGrath's Peter, as he does not offer his audience anything more than what he himself experiences. This may give us less knowledge about the other characters' emotions and mental states, but that knowledge is more reliable, at least in its justification in narration: the knowledge we are given is knowledge of Jim's interpretations, based on his own experience. This knowledge Jim uses as a narrative tool to secure his own narrative power.

4.2.3 Groupings

The in-groups and out-groups of this novel are markedly different from those in *Asylum*, as Jim himself is a member of a societal out-group. Like everyone else employed by Captain Manack at the mine, Jim is a deserter on the run, a person who must flee the authorities and take whichever job he is given, legal or illegal. The groupings thus coincide with both the axes of illegal vs legal and sane vs insane, making the empathetic structures perhaps more complicated than in *Asylum*. There, the psychiatric axis of sane/insane was the predominant one, structuring the experience of Stella, though in *Asylum* as well, the grouping of criminality was

present to a degree (the hospital was a forensic psychiatric hospital after all). This reverberates with what we can say about the way Jim directs his narratee. (Again, we are faced with the problem of knowing the narratee, as Jim, like Peter, does not specify his narratee.) As Jim's tale is not 'psychiatric' in the same manner as Peter's case history of Stella (in which Peter seems to evaporate into the background), but rather an adventure story in which Jim is clearly the protagonist, one can assume that Jim wishes his audience to empathise with *his own* experiences first and foremost; it is very much a tale by him about himself and his experiences with the mad Manack. The groupings he manipulates in his tale are connected to the legal/illegal axis, which is the axis of groupings that affects his own life most, perhaps even more so than the axis sane/insane (mad Mr Manack is just one adversary he must fight or escape, the police being another – and, I argue, more definitive and pressing – problem, as the police will continue to hunt him after the problem of the insane fiend has been lifted) and so it can be extrapolated that Jim would like the audience to see his group membership in the in-group of criminals in a specific manner: he may be a criminal by definition, but he is still an honest person. What is more, the mad characters Jim narrates about, namely Manack Sr. and his own mother, can be seen to form a polarity of disgusting madness/pitiable madness, which points to the interpretation that an insane audience would not find Jim's tale as easily offensive as perhaps it would find Peter's (in my reading at least), as Jim's narration gives both a very negative and a more understanding depiction of two kinds of madness. Madness, Jim seems to say, can be disgusting and pitiable, tragic and sad. If the insane audience would take offence at Jim's portrait of Manack Sr. or the lack of understanding of his predicament, it might be ameliorated with the portrait of Jim's mother. This, however, is dependent on whether the groupings really do direct the audience's empathetic reactions to this degree. I will come back to this problem in the summary of this chapter.

On the axis of legal/illegal, Manack Sr. is first an example of the 'legal group', because he wishes to reopen the mine and start producing tin legally. However, as his madness and its depth are revealed, he is clearly dropped, by Jim, to the lowest status of all, a mad murderer. As Jim is a sane person making a diagnosis of madness, he positions himself above Manack Sr. and, like McGrath's Peter, he employs his external diagnostic gaze; he can look down upon Mr Manack and despise and hate him for his madness and what it has made the 'crazy swine' do.

Jim's diagnosis is as much an insult as a diagnosis: the stigma of madness can here be seen to be given, not by psychiatry, but by the lay diagnostician to his object,

thus emphasising the fact that psychiatric stigma is not completely dependent on institutional psychiatry and its power structures; it can be handled and constructed simply by the lay community around the mad person. Jim has transgressed himself ('I felt like a leper.' (*TKM*, p. 25) – remember also Foucault's linking of leprosy and madness in his *History of Madness*, 2006, as two contiguous experiences of extreme exclusion from the communities of the healthy, thus making an interesting continuum: Jim here evokes the theme of exclusion and transgression, moving perhaps closer to the experience of madness) but Manack Sr.'s transgression seems greater in Jim's handling of it. Jim fled the army in order not kill or be killed, but Manack has murdered and driven an innocent woman to madness and suicide. Jim even says of himthat 'He was mad. And disgust, not anger, filled me.' (ibid., p. 234.) thus nakedly revealing his stigmatisation through the diagnosis of madness. Jim seems to define his own social position against that of Manack Sr.; even if Jim is marginal himself, Manack in his madness is even more marginal (cf. Fabrega 1991, p. 109).

This re-grouping of Manack Sr. into a 'disgusting' status is also further emphasised. As an in-group member together with Manack Sr., Jim, a miner, is at first capable of feeling sympathy for his great dream of reopening the mine (*TKM*, p. 99). On learning his mother's fate, he wants to ruin the mine as an act of justice for his mother's death. Obviously, Manack Sr. is also re-grouped in the group of criminals as a murderer. Manack is *both* mad and criminal; Jim is 'only' a criminal. Jim is capable of gaining the audience's empathy for himself, even though he is a criminal (an instance of broadcast empathetic strategy, where Jim controls the empathy of the audience by calling 'upon every reader to feel with members of a group, by empathizing our common vulnerabilities and hopes' (Keen 2007, p. 142).), because he narrates with candour and honesty, and shows loyalty to his co-workers in the mine, finally trying, though in vain, to save their lives, even when they have acted in the ensuing mine disaster in a manner that seems indifferent to Jim's life. He seems to say: I am only a deserter, but at least I am honest.

4.2.4 Negative Madness

In this rather rare novel, the madness of a person (Mr Manack Sr.) is seen only in a negative light and from without, without a thread of pity or compassion for him. Jim, as the first-person narrator and 'teller-character' (Stanzel 1984, p 144), is in command of the audience's stream of compassion. He is careful not to show any

mitigating background for Manack Sr.'s madness, other than pure greed for the rich lode of tin in the mine. However, at the level of the reader and readerly ethics, Jim's position and diagnosis-making must be weighed by balancing his venom-filled, stigmatising labelling of Manack Sr. with Manack Sr.'s deeds. The authorial audience may act in ways other than that wished by the narrator, as Phelan emphasises in his stratification of narrative and authorial audience and multi-layeredness of communication (Phelan 2009, p. 310; Phelan 2005b, p. 323 and 336). The audience must ask, when facing the madness of Manack Sr.: is his madness a good reason for Jim to label and stigmatise him? This is one of the key questions of the audience's ethical response to the narrator's way of directing the streams of diagnostic knowledge supporting the audiences' interpretations (ibid., p. 324).

Here, the narrator is careful to hammer home to both the narratee and authorial audience that the tragedy of Manack Sr.'s madness is more a tragedy of the destruction of others by a madman, not destruction of the mad person himself. The tragedy is the fate of Jim's mother. The two instances of madness in the novel, as said, show two complete opposites: the disgusting and the pitiable. Jim's mother's sad madness is an outcome of Manack Sr.'s disgusting madness, and thus it is even more pitiable. We again encounter the phenomenon of 'contagion', similar to the one encountered in Peter's account of Edgar's madness 'spreading' to Stella, but here perhaps it is in a strengthened form. Manack Sr.'s madness is the definite cause of Ruth's madness; he consciously causes Ruth's madness to further his own mad agenda. Stella's madness is connected to Edgar's, but not consciously sought after by him, at least not to our knowledge. Manack Sr.'s madness is disgusting precisely because of its sinister, determined nature of sacrificing Mrs Manack and Ruth in order to go on amassing his mining fortune. (Here, one can say that the madman *is* in an important way a 'master of himself' (cf. Jaspers 1997, p. 789), for Manack Sr. is capable of great determination and cunning.) Thus, the novel builds an opposite within the axis of out-groups as well: Manack Sr. is mad, and so was Ruth, but Ruth's out-group status as a madwoman is different because she can be seen as an innocent victim of Manack Sr. and his greed.

One can hear echoes of Foucault's notion that madness is haunted by classical confinement's lumping together of all the examples of 'unreason'. This causes society to view madness through the focus of unethical and immoral, 'the scandal of its animal nature' (Foucault 2006, p. 159) leading to the exclusion-by-inclusion in the confinement of the mad. This is also Mr Manack's fate, as he is, at the end of the tale, sequestered in the same room where he had confined Jim's mother. According

to Foucault, this moralisation of madness also continued into the psychiatric phase, but in Innes's tale, the psycho-sciences, clinical or otherwise, are completely absent from the storyworld, and their absence only strengthens Jim's apparent interpretation of Manack's madness through moral categories. Jim reacts to Manack's madness: 'He was mad. And disgust, not anger, filled me.' (*TKM*, p. 234.) This disgust is no doubt of the moral kind: Mr Manack has murdered and driven an innocent woman into suicide, he must be blamed for his deeds, his 'animal nature' that so forces him to commit brutal acts. What is also emphatically absent here is the absolution from culpability that we see in Peter's pitying treatment of Stella. Mr Manack may be mad, but it does not absolve him or make him pitiable in Jim's eyes. We do not get Manack's focus to balance Jim's portrayal: his subjugated knowledge (Kusch 1993, p. 129) as a madman is completely absent from Jim's narration, which only heightens the fact that the sane social environment around the madman silences him as effectively as the psycho-sciences in my reading of Peter's tale.

4.2.5 Lay vs Professional Diagnosis

I next come to the issue of the difference between lay and professional diagnoses. One sure explaining factor for the difference between Peter's tale and that of Jim's is the fact that even though both make an unproblematically meant external diagnosis of another character, Peter does so as a psychiatrist, whereas Jim (together with the other characters' in Innes's novel) is a lay diagnostician. The lay diagnosis in Innes's novel drives towards a communal understanding of the mad persons and their position in the community: they are dangerous (Ruth was locked up after the murder and had fits of rage, and Manack Sr. is locked up in his room at the end of the tale as well). The lay community does not need diagnostic finesse, explicitness in diagnosis, or Peter's thorough explanation of symptoms and mental configurations.

One could say that Innes's novel depicts a kind of pre-psychiatric reaction to madness: even though it is situated in post-WWII England, the mad characters are not treated but only confined at home, ensuring that their dangerousness is kept under restraint, not unlike how Foucault described the classical structures of confinement without cure (Foucault 2006). (This can be explained at least in Manack Sr.'s case by the fact that the community around him, which finally confines him in his own house, operates outside the legal, societal sphere: they simply cannot contact the police or the psychiatric authorities because they do not want to be in

contact with societal establishments.) Thus, in the lay diagnosis made of both Jim's mother and Manack Sr., the diagnostician does not use professional definitions of madness, but works from a simple dichotomy of mad vs sane. The name of Manack Sr.'s madness is not important to Jim or the other characters, it suffices that they all know what his madness means to them and their security: it represents danger and unpredictability. The reader, however, may surmise that the madness is a form of monomania, obsession, or anti-social personality disorder.

However, the modern Obsessive-Compulsive Disorder (OCD, diagnostic categories: DSM-5: 300.3 and ICD-10: F 42) does not cover well the area of the older notion of monomania, which was a psychiatric label formulated in 19th century psychiatry ('monomania' was coined by Etienne Esquirol in France, and the similar condition of 'moral insanity' by James Prichard in England; Snowden & Freeman 1999, p. 265; Pietikäinen 2013, pp. 115–117), meaning a single pathological preoccupation, an 'idée fixe', in an otherwise sound mind. Mr Manack seems to be otherwise mentally healthy but obsessed by the mine and its rich lode. The term 'monomania' was, however, quickly left out of the diagnostic categories by the end of the 19th century (Pietikäinen 2013, p. 117). OCD as perceived today, even though giving a pattern of obsessive behaviour, does not characterise Manack Sr. readily: it emphasises the patient's feeling of distress in the face of her obsession and her perception that the obsessive behaviour is unreasonable (ICD-10 p. 142). Neither of these elements figure in Manack Sr.'s thought world.[7] The Freudian obsession is perhaps even further from Mr Manack's madness, given its great emphasis on the sexual content of obsession and the regression to sadism and anal-eroticism of the person suffering from obsessional neurosis (Block Lewis 1981, p. 103).

One can say that Manack Sr. fulfils certain requirements of an antisocial personality: 'Failure to conform to social norms with respect to lawful behaviors' (he has murdered); 'Deceitfulness' (he lies to his social group with ease); and 'Reckless disregard for safety of others' (he tries to make Jim get lost in the labyrinthine mine in order to kill him) (DSM-5 p. 659). However, the differential diagnosis of this type of personality disorder is not a straightforward matter: we cannot know whether Manack Sr. had conduct disorder in youth (a requirement in DSM-5). Moreover, 'Antisocial personality disorder must be distinguished from criminal behavior undertaken for gain that is not accompanied by the personality features characteristic

7. The present edition of DSM specifies three levels of 'insight' into the truth of obsessive-compulsive disorder beliefs: 'with good or fair insight' – the beliefs of the patient are felt definitely or probably to be not true or that they may or may not be true; 'with poor insight' – patient holds the beliefs as probably true; and 'with absent insight/delusional beliefs' – the patient holds the beliefs as true (DSM-5 p. 237).

of this disorder. Only when antisocial personality traits are inflexible, maladaptive, and persistent and cause significant functional impairment or subjective distress do they constitute antisocial personality disorder.' (DSM-5, p. 663.) Manack Sr. is definitely after gain: he dreams of the rich lode, and he does not seem to suffer from significant functional impairment or experience any subjective distress for his madness. (His lack of awareness of his own illness is not, though, a definitive sign of mental health, as Lönnqvist (1999, p. 30) points out.) It is interesting that Esquirol's diagnostic category of monomania was one of the sources of the diagnostic category of psychopathy, (or anti-social personality as it is called in DSM-5), because it, too, shows impairment of only one mental function (Pietikäinen 2013, p. 243).

Thus, the reader may not have an unproblematic diagnostic label any more than the novel's characters, for whom the label is even less important. Ruth's and Manack's community seem to work more on the Laingian basis in delineating their madnesses: the community of sane simply decides who is mad and who is not, by common consent (Laing 1990, p. 36). The psycho-scientific details are left aside. As Jaspers notes (1997, pp. 779–780), Innes's characters fluently use the categories of mad/sane without pausing to think what they would mean psycho-scientifically. That the most closely fitting diagnostic category the authorial audience can come up with is an out-dated 19th century diagnosis – monomania – only strengthens this impression: the lay community around the mad characters would have no need to update their diagnostic categories or interpretations of the phenomenon of madness if they work in their own eyes. It is notable, however, that even though they do not use state-of-the-art clinical terms, they do, as we have seen above, operate with the social construction of stigma: Jim stigmatises Manack by determining his madness as 'disgusting' in his own eyes, rather than pitiable. This emphasises what Salo pointed out in Basaglia's viewpoint: the madman's guilt is defined socially (Salo 1996, p. 88). It also ties in with Sass's (1998, p. 2) remark that the madman's viewpoint is, by some universal standard, seen as inferior, incorrect and irrational. The social environment around Manack has decided upon his guilt, irrationality, and incorrect viewpoint on the issue of the mine, his *idée fixe*. He is thus a dangerous madman who must be kept under control by his environment.

One must ask: would it be feasible to read Innes's novel through psycho-scientific frameworks to try to find an exact diagnostic pigeon hole for Ruth and Manack Sr.? The novel completely side-steps the differential diagnostic question, but can the reader make a differential diagnosis – and what benefits would doing so bring? We saw above that the diagnosis of Manack Sr. is a difficult matter: the suggested

modern categories do not seem to fit accurately. Ruth might be termed a depressed person, her suicide is a marked symptom of depression, but even her diagnosis is questionable because we do not get much information about her, or what she thought and felt before her death. Was she psychotic perhaps, or suffering from amnesia? (Kitty tells Jim that Ruth lived in a 'dreamworld of her own' (*TKM*, p. 158) and did not remember anything of the night of the murder.)

In Innes's case, I argue that the differential diagnosis is not necessary. The oppositional axis of sane-insane is what the storyworld's occupants use; they are not capable or even interested in the diagnostic finesse of how to precisely delineate Ruth's or Manack Sr.'s madness from other forms of madness. The reader's efforts to find a pigeon hole for them results in the building of simple oppositions like mad/sane; out-group/in-group; greedy lunatic/woman deceived into madness. Therefore I argue that it is possible to make a lay diagnosis that does not need minute psycho-scientific diagnostic details to work: there exists 'literary madness' which functions primarily as a literary device, as Robin Downie (2005) maintains. Madness is not depicted for its own sake, like in McGrath's tale, which was emphatically focused on explaining and structuring the madness of Stella. In Innes's novel, madness is an inseparable part of the story's structure of building readerly suspense and the storyworld. This is the Phelanian rhetorical purpose (Phelan 2005b, p. 323) for depicting madness. The rhetorical purpose thus intertwines with the diagnostic content of narration: the madness factor explains Jim's and the other characters' actions and attitudes towards the mad characters. It explains why Manack Sr. is dangerous for Jim and the others working at the mine, and why Jim is opposed to Manack Sr. and hates him so vehemently that he wants to destroy his dream.

Therefore, one can claim that in this tale, the narratorial power is more pronounced than the diagnostic power: the madness element is used to support the narrator's rhetorical effort of building a suspenseful plot, and even though the madness factor is inseparable from the world of the story, it is not the most important thematic element and it is not studied as thoroughly as in *Asylum*.

When juxtaposing McGrath's Peter and Innes's Jim, one can see clearly the difference between lay and professional diagnosis-making. Both Jim and Peter make an external, unproblematically meant diagnosis, but Peter's conceives his diagnostic object as a professional psychiatrist (supporting his status as an expert both as a psychiatrist and a narrator of a psychiatric tale) whereas Jim's way of approaching his diagnostic object is more narratorial and communal: the lay diagnosis is made in the sane lay community surrounding the mad persons in a move that places the

mad people into a different group and under the community's control. This move also explains certain narratorial factors present in Jim's narration, such as how the mad characters affect the turns of the adventure plot, and the human relationships depicted by Jim. Jim's lay diagnostic relationship is emphatically a human relationship, stripped bare of the institutional, clinical treatment aspect present in Peter's handling of Stella and her story. The difference of the Foucauldian power relation in the lay diagnostic move, when compared to the professional move, is emphasised as well: psychiatry attempts to change the mad person's subject (Foucault 1982, point 8) to make her well again (like Peter attempted to impact a cure in Stella); Jim and his community clearly aim only at restraining the danger caused by the mad person to the community. The lay power relation is not, however, any less of a power relation: Innes's mad persons are also made subject to others by control or dependence, and tied to their own identity by a conscience or self-knowledge as mad persons (ibid.). This is most prominent in Ruth's case: her status was changed erroneously, making it self-fulfilling. What is prominently lacking in Innes's novel are the professional knowledge regimes, the psychiatric interpretative machine, and the institutional means of forcing the psychiatric agendas (ibid., points, 9, 12, 13, 14), but the subjectifying effect of the diagnoses and the aim to affect the acts of the object of power (point 2) are there to be seen.

For Jim, Manack Sr.'s madness diagnosis is a central literary device. It supports his narrative power, the control he has of his tale through its narrative situations and groupings, as the reliable teller-character (we are led to trust him in his interpretations of the mad person and his madness's ramifications for Jim's tale). This control aims to manipulate the audience's reactions. This is the reason for the narrative progression of the mass of diagnostic moments as well: the amassing of evidence buttresses Jim's interpretation of his characters, his own status and relationship to them, the importance of the story for Jim himself, and the justification of his own moves against Manack Sr. Thus, the diagnostic moments tie together the narrative and diagnostic power used by Jim.

As in McGrath's novel, madness is an explanatory factor in Innes's novel: madness as a phenomenon explains why Manack Sr. murders, and why Ruth kills herself. Madness diagnosis in this lay variation is the environment's attempt at rationalising the mad person's actions and motives: otherwise they would be inexplicable, unfathomable. What is curious in *The Killer Mine* in comparison to *Asylum* is that Innes's Jim gives much clearer psycho-social causation for Manack Sr.'s and Ruth's madness (the rich lode and greed; being abandoned and blamed for murder) than McGrath's

Peter does for Stella. (The causation of Stella's madness is left somewhat hazy. Peter only describes her on the first page of his tale as a 'deeply frustrated woman' and a 'romantic', but does not venture further into explaining the causation of her madness explicitly.) This difference is rather odd if one further considers Peter's tale as being the one attuned to psychiatric structures and explanations. One can perhaps account for this difference by noting that the explanatory repertoire of Jim's lay diagnostics is rather crude and that Peter is too experienced a psychiatrist to offer only one or two reasons for a madness as intricately complex as Stella's. Nevertheless, I argue this difference is worthy of note. The explanatory force of madness is, though, the same: like Manack Sr., because of her madness, Stella transgresses from an in-group into an out-group.

Finally, there is the question of the psycho-sciences and the problematisation of diagnostics. In comparison to Innes's novel, the usage of psychiatric tags in Peter's case in *Asylum* can be seen to be a thirst for power in the disguise of amiability, an altruistic consideration for the patient's welfare, or a problematic mixture of both. Thus, there are certain kinds of contradictory forces in Peter's narration: he claims to be Stella's friend, even a potential spouse, but also treats her like a scientific specimen. If, in Innes's novel, the power move comes from the crude usage of lay diagnosis as an insult ('You crazy swine.'), Peter's diagnosis is far more intricate in psychiatric terminology, but is no less a power move because Peter's partly illicit narrative strategies conquer Stella's own voice and invade her private mental landscape. The side-stepping of the mad person's experience (though in different guise of not depicting the mental world of Manack Sr.) can be seen to be the root of Jim's stigmatising insult in Innes's novel. Thus, both Peter and Jim – though in opposite manners – fail to give us the 'real' experience of the mad person. In my reading, Stella's voice gets lost in Peter's psychiatry; the deep experientiality of Manack Sr.'s madness is not elucidated through Jim's depiction. The diagnoses they make are thus possible to contest and are problematised as ones that may not reach the mad person's experience. (Again, a case of Foucauldian 'silencing of the mad' (ibid. 2006, p. xxviii, pp. 103–104).)

In both *The Killer Mine* and *Asylum*, the narrative and diagnostic power relation is supported by the narrative structure of first-person homodiegetic narration. The narrator is able to relay his message without higher level narration checking its contents. The pattern of human relationships (when built around the relationship of the sane diagnostician and her mad object) can be generalised as a basic relation between the psychiatrist and her patient, which is mirrored by a similar kind of pattern

of relationships between a sane *lay* diagnostician (like Jim) vis-à-vis his mad object of diagnosis, at least in the diagnostician-narrator's power position. The narratorial pattern and the relationship are essentially connected with the aspect of power. What is crucial, I argue, is the controlling of the experiential 'pool' of diagnosis-making. Innes and McGrath give an external viewpoint: the two diagnosticians, Peter and Jim, are not mad themselves; they only secondarily reach the experiential world of the mad persons they are diagnosing. Peter takes complete hold of Stella's experiential world to the point of vanquishing it, and Jim offers only external evidence of Manack Sr.'s madness.

The two instances of Peter and Jim making diagnoses can be juxtaposed on the issue of psycho-scientific diagnosis-making and its problematisation. Peter's diagnosis was (meant to be) a paragon of ethical psychiatric diagnosis-making, supported by his claim of being a true friend of the patient and connected to his desire of attempting to 'penetrate' the psyche of his specimen, both in narrative and diagnostic terms. His aim was to bolster psychiatric diagnosis-making by offering a finely tuned, insightful channel into Stella's pathological mind. Thus, one can see how the psycho-scientific diagnostics are used by Peter, as the narrator, as a tool to bolster both his diagnostic endeavour and narratorial agenda. Only the reader (that is, the authorial audience) may problematise his diagnosis-making by noting the possibility that Peter is, despite being a psychiatric expert, an unreliable narrator. Innes's Jim, then, does not operate with psychiatric tags, but his diagnosis-making is as little questioned by himself as Peter's is, making their diagnoses two sides of the same coin – the non-problematisation of diagnosis at the narratorial level. Both narrators take for granted their own right to diagnose the mad persons; Jim's lay diagnosis mirrors Peter's professional one in this respect.

One can argue that their acts of diagnosis can be seen in its barest form as the use of narratorial and diagnostic power. However, they do different things with their narrative and diagnostic power moves: Peter intertwines his narrative with psychiatric agendas; and Jim bolsters his adventure plot with the dangerousness of the madman, perceived in a simple, lay manner. Innes's Jim thus offers an interesting mirror to McGrath's Peter, both as a narrator and a diagnostician.

My Foucauldian-Phelanian model of narrative power use thus brings forth the narratorial use of the intertwining narrative and diagnostic powers. We are led to see how the narrative power tools of grouping, the revealing of experientiality, and narrative situations and progressions work in unison to produce the desired effect of building a suspenseful adventure plot.

Next, I will move on to the other side of the diagnostic relationship: that of the mad person.

4.3 Sylvia Plath's The Bell Jar: A Narrator's Internal Diagnosis

Sylvia Plath (1932–1963) was an American writer best known for her poetry (*Ariel* being her most famous collection of poems, published posthumously); she also published short stories and children's literature. Her works are intense and highly personal, and in her only novel, *The Bell Jar*, she depicts in a fictitious form her experiences in a mental hospital.

The Bell Jar (1963) is a classic of both feminism and madness narration. A great deal about this novel has been written since its publication, with the dominant themes being feminism and autobiography. Plath is considered an example of a woman author revealing and criticising the structures of a male-dominated world through her autobiographical poetry and fiction. I will concentrate on those themes of the novel that are most important for my study: the depiction of madness and the psycho-sciences, and how Plath's narrator handles the narrative and diagnostic powers of her tale. I will leave the autobiographical side of Plath's novel aside (for an analysis of Plath and her life's relation to her work, see e.g. Bronfen 2004); *The Bell Jar* is nevertheless a work of fiction and it can also be read without knowledge of Plath's life (cf. Hunt & Carter 2012, p. 29; Basnett 1987, p. 79).

4.3.1 Plot Summary

The Bell Jar is a depiction of a young college woman's succumbing to mental illness, her treatment, and subsequent recovery. As a consonant narrator (Cohn 1981), Esther describes the summer of 1953, during which she spends one month in New York as a guest editor of a fashion magazine. Afterwards, she returns home only to find out she has not been admitted to a writing course for the summer vacation, and she starts to fall gravely ill. She attempts suicide in a most determined manner and is hospitalised, treated, and the novel ends with the anticipation of her release from the hospital.

The novel has been seen by Wagner (1986) as a classic bildungsroman, and the most recurrent theme in research literature is the search for female identity in the male-dominated world of 1950s America (e.g. Ferreter 2010; Martin 1981; Smith 2010). Esther tries to find her place in a world that offers women – if they are to concur with the societal feminine ideals – sparse real choices beyond becoming a wife and a mother, even after successful studies. She is a prize-winning student (the guest editorship also was a prize in a competition), and she harbours hopes to become a writer – or anything other than a mere child-producing wife – only to crash headlong into the expectations of her surroundings, epitomised not only by men, like her boyfriend Buddy Willard, but by her mother and other women around her as well. Searching desperately for an identity she can accept, she drifts into the margins of society as a patient in a mental hospital, from which she then returns to society like a fixed tyre, 'patched, retreaded and approved for the road' (*The Bell Jar* (*TBJ*), p. 257). Thus, her madness has emphatically psycho-social, or one could also say, societal causes.

4.3.2 Narrative Situation, Experientiality, and Diagnostic Moments

Esther's viewpoint is focused upon through the narrative situation of first-person narration: her experientiality, her tellability, viewpoint and qualia – the way she perceives herself and the world. She constructs poetic metaphors and similes for her distress to convey its experiential nature (cf. Hunt & Carter 2012, p. 39 on Esther's repeated use of the word 'like'), the key one being the title of her tale, the bell jar: 'To the person in the bell jar, blank and stopped as a dead baby, the world itself is the bad dream' (*TBJ*, p. 250). Esther is here giving us a depiction of something strange, something different, but something she needs and wants to convey to her audience as an understandable notion, as her exposition of her own subjugated knowledge as a mental patient (Kusch 1993, p. 129). Like Innes's Jim and McGrath's Peter, she 'owns' her story and shows this by 'advertising' its tellability (Toolan 2001, p. 151–152): 'I knew something was wrong with me that summer[…] I was supposed to be having the time of my life.[…] Only I wasn't steering anything, not even myself.' (*TBJ*, p. 2) This is a promise of a story of a person in interesting circumstances: she is on top of the world, supposedly having the time of her life, but instead she becomes mad. It is important to note that Esther shows her control of her story: she knew then and knows at the time of narration what went wrong and why, and this

is part of the tellability; her control of the story promises us an insightful journey into something we might not otherwise encounter and understand.

Like Innes's Jim and McGrath's Peter, Esther also gives us a Phelanian narrative progression (2005b) of diagnostic moments. In Esther's tale, however, the diagnostic moments form a richer pattern, as Esther uses them to paint a vivid picture of her journey in and out of madness: she juxtaposes and chains together different internal diagnostic moments of herself and external diagnoses of those around her.

Thus, we get a cavalcade of external diagnoses of mad people ranging from 'shop dummies' (*TBJ*, p. 149) to a mad nun in a joke (ibid., p. 175) to fellow patients in the hospital (ibid., p. 192, p. 207). Even Esther's benefactress, the writer Philomena Guinea, who sponsors her studies and after the breakdown, pays for the expensive private mental hospital treatment, has been in an asylum once (ibid., p. 195). Therefore, Esther is not alone in trying to figure out her identity as a mad person. In the cases of Jim and Peter, the diagnostic moments were of the external type only and concentrated on two people (Mr Manack Sr. and Jim's mother; Stella and Edgar) and on making sure the audience sees them like the narrator does – as mad. In Esther's narration, on the other hand, this population of mad people forms a background for her search for an identity as a young and mad person, and in a Phelanian progression, the picture of madness changes, both for Esther herself, and for the audience, who must respond to the change in Esther and her perception of madness, thus exemplifying the Phelanian double change in narration. (Phelan 2005, p. 323.)

The external diagnoses start with the strangeness of the 'shop dummies', 'counterfeiting life' (*TBJ*, pp. 149–150) that she encounters in the private asylum of Dr Gordon, a psychiatrist who first uses his ECT machine on her, treatment she perceives as a punishment, not a cure. The experience of this punitive shock treatment seems to cast a shadow of horror over the whole scene, and Esther, after this first contact with asylums and mental patients, says to her mother: 'I'm through with that Doctor Gordon.' which her mother interprets (falsely) as a will to be 'all right' again: 'I knew my baby wasn't like […] those awful people. Those awful dead people at that hospital.' (ibid., p. 154.) This first encounter with mad people colours the following progression of Esther's illness, as she is juxtaposed, compared, and found (by the audience) likened to those 'shop dummies' after all in the depth and extremity of her illness. She must come to terms with the mad identity that her mother, along with most of the society, abhors.

In the private hospital to which she is admitted after the almost successful suicide attempt, she finds other patients, Joan first and foremost, with whom she compares her situation. Joan is Esther's double, and Esther remarks: 'In spite of the creepy feeling, and in spite of my old, ingrained dislike, Joan fascinated me. It was like observing a Martian, or a particularly warty toad. Her thoughts were not my thoughts, nor her feelings my feelings, but we were close enough so that her thoughts and feelings seemed a wry, black image of my own.' (ibid., p. 231.) Joan is Esther's acquaintance from before the asylum period; she has even dated Buddy Willard like Esther, and after Esther's suicide attempt Joan reads about it in the papers, which makes her attempt suicide as well. Thus, she is a kind of 'follower' of Esther's. Before Joan kills herself (she is the 'mad double' Esther must see buried before being able to leave the world of madness; Martin 1981) Esther admits: 'In spite of my profound reservations, I thought I would always treasure Joan. It was as if we had been forced together by some overwhelming circumstance, like war or plague, and shared a world of our own.' (*TBJ*, p. 237.) This juxtaposition with a person who completes the course of madness by killing herself gives a background to Esther's recovery; at Joan's funeral, she keeps on thinking: 'I wondered what I thought I was burying'. At the end of the service she says, 'I took a deep breath and listened to the old brag of my heart. I am, I am, I am.' (ibid., p. 256.) This is the same sound of her heart that she listened to while attempting to kill herself by drowning (ibid., p. 167), thus completing the circle: she is alive, while Joan is not anymore; she has a life before her, even though she must come to terms with her identity as a young, gifted woman who has suffered a mental breakdown. However hard this is for her, in the end she seems to integrate the experiences of her madness into her self-image: 'But they were part of me. They were my landscape'. (ibid., p. 250.)

Her internal self-diagnoses are the core of her tale, and they start already on the second page ('I knew something was wrong with me…') marking the narrating-I's awareness of her own condition as the central theme of her story. Esther offers the audience both outright statements of her own illness ('Only my case was incurable. I had bought a few paperbacks on abnormal psychology at the drug store and compared my symptoms with the symptoms in the books, and sure enough, my symptoms tallied with the most hopeless cases.' (ibid., p. 168-169)) and, in greater and increasing frequency, descriptions of her behaviour and thinking that can be seen by the audience as symptoms of her illness. For example, she cannot sleep, eat, read, and that everything seems 'silly' (ibid., p. 136) and meaningless. Her most poignant symptom of all is her repeated and vigorous wishes and actions to end

her life. Thus, one can see that the internal diagnostic moments are the spine of her tale, they form the Labovian point of her story, explaining why it is told – a strong indication of Esther's narrative power. The diagnostic 'what', or the contents of her self-diagnosis, interconnect with her rhetorical 'why', or the purpose of her story. She uses both the external and internal diagnoses to convey her own point of view of what is told, thus tying together the narrative power of convincing the audience with these moments of diagnostic power. The external and internal diagnostic moments Esther gives her audience form a structure of interconnected situations in which madness and everything related to it is encountered and evaluated. For example, even the fleeting reference to the mad nun joke can be seen to have significance as a very brief depiction of madness. The nun in the joke ending up in an asylum is situated in the story just before the almost successful suicide attempt. This serves as a reminder for Esther that mad people end up in asylums, of which she has only the negative experience of Dr Gordon's private clinic. As such, she has no place to go for solace, as the nunneries do not accept mad nuns. (During this episode, Esther fantasises about becoming a nun.) The asylum has only negative connotations for her, thus she ends up trying to kill herself instead. The meaning of madness for Esther at this point is thus at the same time inescapable and predetermined: it is inescapable in its horror (the state is so painful that Esther seeks death to end it) and predetermined to cause only more horror (in the only destination a mad person can have in the society – the asylum) if one chooses to stay alive.

I argue that a crucial difference between *The Bell Jar* and *Asylum* or *The Killer Mine* is the way Esther presents her gradual slide into madness rather than a definite, easily perceivable, clearly stated break with sanity. Jim and the community around Mr Manack, or Peter with his sure psychiatric diagnostic gaze could see madness clearly in those they diagnosed. They knew who was mad and who was not, and they knew that they themselves were not mad. With Esther, these ruptures or breaks between sanity and madness are far more delicate. For example, Esther does eccentric things while still in New York. She eats chicken with caviar with her fingers at the Ladies' Day banquet, remarking: 'I'd discovered, after a lot of extreme apprehension about what spoons to use, that if you do something incorrect at table with a certain arrogance, as if you knew perfectly well you were doing it properly, you can get away with it and nobody will think you are bad-mannered or poorly brought up. They will think you are original and witty.' (ibid., p. 28.), or, more clearly still, before leaving the city, she throws her expensive clothes off the sunroof of her hotel (ibid., p. 117). I argue that these acts are neither 'normal' nor 'not-normal' when trying

to make a strict madness diagnosis; they are 'eccentric' and fall somewhere between 'witty', 'symbolic' and 'mad'. (E.g. Perloff (1972) sees the throwing of the clothes as a symbolic killing of the false self; and Wagner (1986) sees this act as tantamount to rejecting the traditional image of a pretty, smart girl; whereas Ferreter sees in it both the symbolic act and the beginning of her illness (2010, p. 45).)

At the same time, Esther is painfully aware of her tendency to think and perform through the idea of the 'appropriate', (cf. Smith 2010, p. 10). For example, she agonises over how much to tip in taxis. She searches in vain for the definite borderline between appropriate and inappropriate, which, during the gradual build-up of her symptoms, also becomes the borderline between sanity and madness. This gradual slide towards madness in Esther's narration is, I argue, a conscious choice by Esther as the narrator to emphasise her experience with madness as one not easily contained or described by concepts that presuppose the clearer rupture we encountered in McGrath and Innes. In Esther's case, we are not easily led to see the line at which she ceases to be sane and becomes mad (cf. Perloff 1972), like Jim could say of Mr Manack's murderous obsession with the mine or Peter of Stella's sexual obsession with Edgar. On the other hand, Esther's strategy of narrating through the gradual slide also accentuates the social and societal side of her experience: if madness is this gradual, is it right to enact strict, possibly stigmatic diagnostic borderlines to confine those who are seen as 'mad'? This question is raised by Esther explicitly, as she finally asks it by using the central metaphor for her madness, being under the bell jar: 'What was there about us, in Belsize [hospital], so different from the girls playing bridge and gossiping and studying in the college to which I would soon return? Those girls, too, sat under bell jars of a sort.' (*TBJ*, p.251.) The difference, Esther implies, is artificial: everybody is under the bell jar of a potentially meaningless life. Her boyfriend, Buddy Willard, whose proposal she rejected, turns up at the hospital to taunt her by asking: '"I wonder who you'll marry now, Esther. Now you've been […] here."' (ibid., p. 254). Buddy's question further highlights Esther's situation: her surroundings see and socially define her as a mental patient, a stigmatised mad person, against whom they define themselves as sane (Fabrega 1991, p. 109), whereas her own experience of her madness is contextualised in the surrounding society's (male) ideological and power structures which are largely to blame for her illness. This is one of the central tensions in diagnosing Esther: the societal power relations materialise in her closest human relationships and in those who treat her for her madness – a madness that she herself is at pains to describe as a gradual rather than an all-or-nothing experience.

4.3.3 The Search for Identity: Groupings

This theme of gradual madness is elementally connected to the theme of Esther's search for identity: the borderlines between madness and sanity are artificially drawn, and this drawing is done by a society that also sets (impossible) rules for women trying to find their place in it. We can also see Esther's identity hunt when we take a look at the way her narrative engages the thematic tool of grouping: Esther skilfully uses the grouping tool to convey the desperate nature of her search for an identity that she could accept and thrive in. This is well captured in the often quoted fig tree episode:

> I saw my life branching out before me like the green fig-tree in the story.
>
> From the tip of every branch, like a fat purple fig, a wonderful future beckoned and winked. One fig was a husband and a happy home and children, and another fig was a famous poet and another fig was a brilliant professor, and another fig was Ee Gee, the amazing editor, and another fig was Europe and Africa and South America, and another fig was Constantin and Socrates and Attila and a pack of other lovers with queer names and off-beat professions, and another fig was Olympic lady crew champion, and beyond and above these figs were many more figs I couldn't quite make out.
>
> I saw myself sitting in the crotch of this fig-tree, starving to death, just because I couldn't make up my mind which of the figs I would choose. I wanted each and every one of them, but choosing meant losing all the rest, and, as I sat there, unable to decide, the figs began to wrinkle and go black, and, one by one, they plopped to the ground at my feet. (*TBJ*, p.80.)

Even though Esther clearly sees these figs as kinds of 'individual performances' of herself, I argue that one can also perceive them as group identities: there are, after all, a number of poets forming a group of poets, which in its own manner defines what being a poet is. Therefore, one can say that Esther is searching for a suitable in-group identity: some group that could welcome her with all the gifts and ambitions she has, the way she is. She describes groups or individuals representing groups that are offered to her as role models: her mother and Mrs Willard (representing the oppressive societal female ideal of submitting to the male order of society), Dodo Conway (a young mother of six children, seventh on the way), the editor of the fashion magazine, Jay Cee (a successful woman who, however, has no family and is

ugly), Philomena Guinea (a successful author of nonsensical bestsellers), and so on (cf. Smith 2010, p. 4, p. 18; Wagner 1986). However, she cannot pick any of these role models; she wants all the 'figs' instead – and is, temporarily at least, left with one that is bitter and marginal: madness.

Esther's search for an identity and a permanent, acceptable in-group identity may make the reader's empathetic endeavour more difficult: if the reader empathises according to Esther's in-group status (Keen 2007, p. 94), she may be as baffled as Esther is in her search. On the other hand, the reader may see Esther as an in-group member of youth in general (or the mad in general). However, the in-group status Esther has as a young person and a mad person is perhaps an easily unsettling one for the general (sane) audience, moreover as Esther reveals the extreme nature of her youthfulness: she ends up in a mental asylum having first found out that youth for her is an absolutely intolerable state.

The intolerable state of youth is further exacerbated by finding out how socially stigmatic madness and the in-group membership in the group of mad people can be, as the 'dead end state' of Esther's youth. She even evokes the Foucauldian notion (Foucault 2006, p. 6) of madness being like leprosy (*TBJ*, p.249). For an excellent performer like Esther, the stigma formed in and given by society and those nearest to her (also as the representatives of society), her mother first and foremost, can be surmised to be an even more distressing experience. The guilt of being mad is, again, given and formed by the social environment of the mad person (Salo 1996, p. 88). She has not succeeded, not in finding a suitable place in society, nor in pleasing her nearest and dearest. Even the stay in the hospital is a performance to Esther: she constantly frets over how people around her in the hospital see her and her mental state, afraid that they might find out how 'really bad' she is (*TBJ*, p.201). Esther's mother is the most constant wellspring of this stigmatic notion of Esther's madness. From the very beginning of Esther's 'career' as a mad person, in the clinic of Dr Gordon, her mother states her dislike of mad people ('those awful dead people'), and as Esther sinks deeper into madness, she does not change her opinion, but makes Esther feel distressed about being mad: 'My mother's face floated to mind, a pale, reproachful moon, at her last visit to the asylum since my twentieth birthday. A daughter in an asylum! I had done that to her. Still, she had obviously decided to forgive me.' (ibid., p. 250.) This paints a deeply selfish picture of Esther's mother: instead of worrying over Esther's state and her distress as an ill person, her mother worries about her own state, and what this daughter-in-an-asylum does to *her*. This socially constructed stigmatic nature of madness, the way it feels in Esther's experi-

ence, makes a strong plea for empathy from the audience: Esther seems to use the broadcast empathetic strategy (Keen 2007, p. 142) to get the message through to the largest possible out-group: the in-group membership with the mad is excruciating for her because of the stigma formed and given to her by her social surroundings. She does, however, integrate it somehow into her own personality in the end ('my landscape'), which can be seen as a brave and mature deed by the audience.

4.3.4 Good and Bad Psycho-Science

The picture of psycho-sciences in Esther's tale, like the stigma, is formed and given in the personal, clinical treatment relationships between Esther and those who take care of her. The relationships Esther has with her doctors (first Dr Gordon and later a female psychiatrist in the private hospital, Dr Nolan) show certain predetermined tensions: the doctor's (rather Foucauldian) power position vis-à-vis her patient (e.g. his/her will to subject the patient to unpleasant treatments) and the patient's dependence on the doctor (e.g. her position offering only the possibility of asking for help, to be changed somehow) These tensions do not completely predetermine the outcome of these two doctors' treatment; one must juxtapose Dr Gordon and Dr Nolan. Even if they are both 'as much' psychiatrists having the power position of any psychiatrist, one is incapable of helping, listening and understanding Esther, the other is genuinely able to help her. Dr Nolan, a real mother figure for Esther, who herself has a very complicated love-hate relationship to her own mother, uses the assistant empowering power (Karlberg 2005, p. 10) on Esther, to coax her back to sanity.

It is important to note that the viewpoint is constantly Esther's, that is, the patient's. Esther lets us see what it feels like to be a psychiatric patient, at the mercy of those taking care of her and their ability to understand her predicament. Esther states very clearly what she first expected from her doctor: 'I had imagined a kind, ugly, intuitive man looking up and saying 'Ah!' in an encouraging way, as if he could see something I couldn't, and then I would find words to tell him how I was so scared, as if I were being stuffed farther and farther into a black, airless sack with no way out. Then he would lean back in his chair and match the tips of his fingers together in a little steeple and tell me why I couldn't eat and why everything people did seemed so silly, because they only died in the end. And then, I thought, he would help me, step by step, to be myself again.' (*TBJ*, pp. 135–136.) Of course,

one can note how naïve it is of Esther to think that someone could do the job of 'becoming herself again' for her, but this little vignette of a 'perfect psychiatrist' offers us a stark comparison with what Esther gets instead from Dr Gordon. She does not receive the understanding wisdom capable of changing her from mad to sane again, instead she receives a torturous, botched ECT treatment that makes her loathe the only institution in society designed to help mental patients, the psycho-scientific establishment.

Esther finally finds a wise, understanding doctor in Dr Nolan. She has a wide and modern enough range of vision to suggest that Esther gets a diaphragm to help her to come to terms with her sexuality (Esther is bombarded by chastity propaganda by her mother and Mrs Willard and agonises over the societal hypocrisy which demands chastity before marriage from women but allows men like Buddy Willard to fool around as much as they wish because they cannot get pregnant); and Dr Nolan, like a proper psychoanalyst, gives space for Esther's hatred of her mother, which is also hatred of the whole community's and the society's picture of women.

Ferreter has emphasised the patriarchal nature of medicine and psychiatry in the novel (Ferreter 2010, p. 128), stating that in the America of the 1950s, clinical ideology meant that 'only men can be mentally healthy' (ibid., p. 129). Therefore, the female condition is doubly hopeless: society drives women to the edge by placing them in distressingly narrow niches, but when they search for help from the psychiatric establishment, they are only further reminded of these patriarchal niches. This feminine state reminds me of the Laingian social double bind (Laing & Esterson 1990), which further supports Esther's perception of her societally caused madness. The social double bind as a cause for madness is an example of seeing madness predominantly as a social construct, and this is the one rhetorical purpose of Esther's narrative (Phelan 2005b, p. 323) – to reveal this societal trap that labels and makes women mad. Another point of reference is the Foucauldian notion that scientific knowledge is interconnected with societal power (Kusch 1993, p. 170–171): (patriarchal) society has its (patriarchal) forms of psychiatry that maintain society's power structures.

However, I argue that the picture of psychiatry in Plath's novel is not only dark and sinister; in the figure of Dr Nolan, we are given a possibility of mental liberation through correct and wise psychiatric intervention, and the real use of assistant empowerment. Thus, there is more of a kind of 'good doctor'/'bad doctor' and 'good psychiatry'/'bad psychiatry' pattern in *The Bell Jar*.

Esther vividly describes the experience of psychiatric treatment from the patient's point of view. She details how the insulin treatment makes her fat, and how scary the 1950s type of ECT can be (only later, after anti-psychiatric protests, was the treatment changed considerably so that the patient was anesthetised before treatment). The 'talking cure' of Esther's is not depicted in detail, only the outcome is stated ('after all, I had been "analyzed"' (*TBJ*, p.257)), making Esther's recovery somewhat enigmatic: what have they talked about (and how?) that has helped her so? The end sees Esther on the verge of being released from the hospital, but instead of being sure of herself and her recovery, she can only see question marks. Scholars of Plath's novel have not agreed on the novel's ending and its meaning: does Esther learn enough in the hospital not to succumb to madness again? Is it even possible to steer clear of madness if it is a societal phenomenon caused by patriarchal restrictions on womanhood?[8]

4.3.5 Differential Diagnosis?

Making a strict differential diagnosis of Esther is perhaps even more difficult than it was in the case of Jim's lay depiction of Manack Sr. Esther's story is largely situated in the clinical context of mental hospitals, a context that strongly suggests that a differential diagnosis of Esther must have been made; without a diagnosis, the hospital could not prescribe the right treatment for her. Esther, however, never once uses clinical terminology about herself or others. Is it possible, feasible, or justifiable for the audience to try to make a strict nosographical diagnosis?

Many scholars have diagnosed Esther with schizophrenia or psychosis (Hunt & Carter 2012, p. 35; Perloff 1972; Martin 1981; Patterson 1979, p. 47; Showalter 1985, p. 216). Another diagnostic category offered by scholars is depression (Hunt & Carter 2012, p. 29; Smith 2010, pp. 16–17; Wagner 1986; Barnard 1978, p. 26; Ferreter 2010, pp. 86–87). To support the psychosis diagnosis, Perloff (1972), Martin (1981) and Patterson (1979 pp. 56–57) refer to R. D. Laing's notion of psychosis as a condition of the false-self system or a mind-body split in which a person develops two distinct ranges of self-hood, an inner self which must be protected from the environment by a false, outer self (Laing 1990, p. 161). Those Plath scholars who

8. Cf. e.g. Wagner (1986), who claims that Esther has gained momentarily at least coherence; Basnett (1987, p. 123) also states that Esther has learned enough, but Hunt & Carter (2012, p. 33) state that the patterns of psychological distress continue, and Barnard (1978, p. 33) says there is a note of warning in the end that the bell jar may descend upon Esther again.

refer to Laing in their conceptualisation of Esther's condition as psychosis build their case rather strongly by analysing Esther's recurring split into an observing and acting self, like Laing's psychotics. However, it must be remembered, that Laing was an anti-psychiatrist – a critic of mainstream psychiatry – and that his conception of psychosis was not and is not mainstream psychiatry, no matter how intuitive it was. He attempted to existentially understand the patient with psychosis, not scientifically explain her condition. DSM-psychiatry, however, functions diagnostically under different kinds of guidelines, namely those of differential diagnosis realised on the basis of symptom lists. If looked at from the perspective of these lists, I argue that the best fit is in the clinical pattern of classical depression (its major features are suicidal tendencies, fatigue, markedly diminished interest or pleasure, depressed mood, etc. as is delineated in DSM-5, pp. 160–161).

The psychosis diagnosis seems to be prevalent in some of the most feminist views, e.g. Showalter argues that *The Bell Jar* 'offers the most complex account of schizophrenia as a protest against the feminine mystique of the 1950s' (Showalter 2004, p. 216). Ferreter points out that the anti-psychiatric notion of Esther is connected to the 1970s feminist movement which chose to use Laing and other anti-psychiatrists 'to develop a specifically gendered critique of the institution of psychiatry' (Ferreter 2010, p. 129).

To add another viewpoint, we may remember that in Freud's opinion (whose successors in the 1950s still reigned the world of psychiatry, including Esther's America), depression – or melancholia – is a subgenre of psychosis. Freud claims that when a person suffers a specific type of early trauma, such as the loss of a loved one, it can serve as a precipitant trigger for melancholia later on in life when the person meets other losses. The loss in melancholia is more unconscious than conscious, and what is more, melancholia is formed when lost objects are 'intrajected' and made part of the individual's intrapsychic system. The self-attacks typical of melancholia are really directed at the lost object. (Fisher and Greenberg 1996, pp. 21–22.) Freud sums it up thus: 'From this [the fact of self-reproaches] we can conclude that the melancholic has, it is true, withdrawn his libido from the object, but that, by a process which we must call "narcissistic identification", the object has been set up in the ego itself, has been, as it were, projected on to the ego' (Freud 1978a, p. 427). What makes melancholia a form of psychosis is the process of narcissistic regression present in the formation of melancholia. In this, as in psychosis in general, the patient loses interest in the outer world. (Freud 1993a, p. 32.) Freud writes:

> The narcissistic identification with the object […] becomes a substitute for the erotic cathexis, the result of which is that in spite of the conflict with the loved person the love-relation need not be given up. This substitution of identification for object-love is an important mechanism in the narcissistic affections; Karl Landauer (1914) has lately been able to point to it in process of recovery in a case of schizophrenia. It represents, of course, a regression from one type of object-choice to original narcissism. (1978c, p. 249.)

In another work, Freud sums up the phenomenon of psychotic regression: the libidinal energy liberated by frustration does not connect to fantasy objects, but regresses back to the ego (Freud 1993a, p. 43). As a result, in the case of melancholia, the patient treats herself with the same anger and aggression that she would treat the abandoning object. Esther does have an early trauma: her father died when she was nine, after which she lost her childhood happiness. She goes to mourn her loss at the graveyard before trying to kill herself (*TBJ*, p.177). Therefore, one would be able to call Esther melancholic: both psychotic and depressed.

However, one can ask whether this hunt for the right differential diagnosis is splitting hairs: what difference would it make to the audience to whom she is telling her story, or the authorial audience whether Esther is suffering from psychosis, depression, or both? Is not it possible to say, like in the case of Innes's Jim, that there is 'literary' madness, madness that operates with simple, inexplicit lay diagnostics. Can one say that Esther is simply 'mad'?

One difference for our understanding of Esther might come from the nature of psychosis in contrast to depression: psychosis is characterised as a diminished sense of reality, that is, a certain relinquishment of reality. Depression, on the other hand, may border on psychosis in its most extreme cases, but otherwise it is characterised by concentrating on the darker side of reality, that is, not relinquishing the reality altogether. If we go back to Keen's empathetic strategies (2007, p. 142) available in my model to narrators, could one argue that if Esther were psychotic rather than depressed, her vision of reality would be more 'at fault' from the viewpoint of the sane audience than if she were depressed? Would her out-group status be more cut off from the general, sane public? Would her task of convincing them of her own experientially based notion of her illness and its nature become more difficult, since its experience would be the most extreme mental transgression of psychosis? (E.g. Evelyne Keitel, 1989, has argued that psychosis as a severely autistic phenomenon

effectively cuts the psychotic person off from normal communicative possibilities: psychotics cannot communicate their experience to the sane community.[9])

Esther's control of her narrative power is convincing, she handles her story and its knowledge-power streams in a sovereign manner. She is much more a reliable than an unreliable witness of her own journey to madness and back (if she ever was mad), thus implying the author's backing for her notions of herself and others. The narrator/implied author relationship is therefore one of endorsement, of the implied author in a way giving her blessing to Esther's narrative and her interpretations, and the authorial audience's judgements follow Esther's lead without much questioning. (Phelan 2005b.)

If she is psychotic, her feat of telling her story, of building her metaphors and similes, or interlinking her diagnostic moments shows no signs of the extreme autism's incapacity to convey her experience and message. This may, however, be the result of her narrating from the position of regained sanity, after the phase of her madness. Nevertheless, her command of her depiction of madness is markedly intuitive and clear, without the pressing characteristic typical to psychosis: an uncanny bizarreness.

In my perception, Esther, like Peter and Jim above, applies Keen's broadcast empathetic strategy (Keen 2007, p. 142): she wants to spread her message to the larger community, not to just some chosen group. I support my supposition by, for example, noting Esther's choice of vocabulary; it is her decision not to mention clinical psychiatric terms in connection to her own illness. By keeping her tone in the lay register and not using any expert diagnostic terminology, she is not grouped into only one diagnostic population, as a member of this or that subgenre of mental illness. Instead, she can speak from a broader register of madness in general, as a social, societal, psychological – and extreme – experience. In her analogy of all college girls and those that end up under bell jars, she keeps on insisting that she is talking about something much more general than just a private ailment of one or two persons. It is instead about something that has broader societal significance.

Unlike Innes's Jim – another lay diagnostician – Esther concentrates heavily on the theme of madness. For Jim, madness was more like one of his literary devices used to tighten the adventure plot and to explain certain aspects in his relationships to others. For Esther, madness is a societally significant factor and a metaphor for something of broader significance – the female condition in particular. Of course, in

9. However, one can note that the phenomenon of autism is more of a spectrum or gradation rather than an all or nothing phenomenon. There are, for example authors who have been diagnosed autistic (e.g Corinne Duyvis). This should alert us to notice that autism does not necessarily rule out the autistic person's capability to communicate with her environment.

a marked fashion, madness is a question of human relationships for Esther, too. For her, society exerts its pressures through human relationships in a concrete manner.

When compared to McGrath's Peter, Esther's unwillingness to even mention her differential diagnosis is emphasised. Her silence seems like a conscious statement, directed at the segregating power of the psychiatric gaze – all the more so, since she most probably has got a diagnosis from her doctors. I argue that Esther does not want to be the object of Peterian-like psychiatric gaze. In the end, she mentions Joan's doctor, who is much more theoretical in her approach: 'Doctor Quinn was Joan's psychiatrist, a bright, shrewd, single lady, and I often thought if I had been assigned to Doctor Quinn I would still be in Caplan or, more probably Wymark [incoming or chronic wards of the hospital]. Doctor Quinn had an abstract quality that appealed to Joan, but it gave me the polar chills. […] I never talked about Egos and Ids with Doctor Nolan.' (*TBJ*, p.236.) Thus, Esther seems to prefer Freud's notion of every patient being unique, (Millon 2004, p. 258) than his overarching theoretical tour de forces.

4.3.6 Power Patterns

In relation to the Foucauldian paradigm of subjectifying power (Foucault 1982), one can apply his formulation of the notion of power to *The Bell Jar's* pattern of societal and human relationships. Even though Foucault can hardly be called a radical feminist,[10] I argue that his notion of subjectifying power can be used to clarify the patriarchal power structures of Plath's novel. As society is structured to suit men's needs, it causes Esther's illness through its contradictory and repressive ideals of femininity (cf. Smith 2010, pp. 6–7; Martin 1981). All the points of my

10. Seppä has studied the application of Foucault to feminist analysis, and she remarks: 'In this study, the connecting of Foucault's aesthetics with contemporary feminist theory is primarily meant to demonstrate how his insights are compatible with theories of female aesthetic subjectivity, be the discussion focused on the subject or the self, the body, gender, or sexuality. Moreover, given that he is one of the major figures in recent discussions of the aesthetics of the self, all considerations of Foucault's work almost necessarily have to take into account contemporary feminist questions concerning the subject. What makes the connection between these two discourses even stronger is the fact that Foucault's work has inspired a large number of feminists to rethink their conceptions of the subject and the self, as well as their views of the body, power, and language. Yet, at the same time, feminist debate has brought to the light some serious problems in Foucault's thinking. In discussing this, I intend to show how Foucault offers a set of adequate tools for reconstructing feminist views on the aesthetic construction of the subject and the self, on the one hand, and how, on the other hand, his work requires critique and reformulation when brought together with feminist insights.' (Seppä 2003, pp. 27–28.)

Foucauldian list of power aspects are in action in this relationship between Esther and the patriarchal society and those implementing its ideals (Esther's mother or Mrs Willard, Dr Gordon's psychiatry and Buddy Willard for example). Esther is placed in a dependent subject position and is tied to her own identity by self-knowledge, first as a woman, then as a madwoman. (Remember that Foucault himself in the 1982 essay remarked that the power relationship between men and women could be compared to that between the sane and insane (Foucault 1982, p. 780). Thus his analysis can also be used to support the feminist analysis that Esther's condition as doubly subjectivised – as a mad person and as a woman.) What is remarkable and important to notice is that Dr Nolan, with her Karlbergian, psychiatric assistant empowering use of power, attempts to intervene and correct this pathological patriarchal pattern. This can be seen as the resistance inherent in all Foucauldian use of power (there is power only if it can be resisted by the free subject, the target of power). The ending, as we saw above, is, however, open and ambiguous on the point of the success of this endeavour.

One can also note a very Phelanian (2005) ethical pattern in this subjectifying power relation between Esther and society's representatives: Esther's mother uses this subjectifying societal power on her daughter (Martin 1981) which is then judged unethical by Esther (with the approval of Dr Nolan: she only smiles and says 'I suppose you do.' when Esther announces that she hates her mother (*TBJ*, p.215)) and her audience whose empathy and approval Esther looks for – and finally by the authorial audience who may side with Esther on the issue of the fairness of these repressive societal ideals placed on her by her mother and others, and her desperate search for a suitable in-group membership. The audience is thus made to make an ethical interpretation on the lines offered by Esther's managing of the knowledge streams of her narrative, which is an example of her using of narrative power.

4.3.7 Comparing Diagnostics

I end this analysis with a comparative note on the diagnostic and narrative powers of Esther's narration: these two forms of power intertwine in a different manner in *The Bell Jar* than in *The Killer Mine* or *Asylum*.

In McGrath's and Innes's novels, their characters and narrators make only external diagnoses by which they attempt to explain the mad persons' destructive behaviour, and protect the sane community from them (Jim and Peter) or change

them to better fit the sane society again (Peter). Esther, then, makes both external and internal diagnoses and also explains her own madness and gives it causes, but she does so in order to direct her audience to see that these causes implicate the whole society around her. Her story implies (feministically and ethically) that instead of trying primarily to change the mad (women), to define them and 'cure' them by (patriarchal), punitive psychiatry epitomised by Dr Gordon, we should first change the societal ideals that effect this madness (in women) (cf. Perloff 1972; Martin 1981; Ferreter 2010, p. 148). Esther's narrative statement also points to the Foucauldian notion of madness being constituted by different social and scientific actors (Kusch 1993, p. 161): society at large is to blame for both the experience and label of madness being given to Esther. Esther presents her notion of madness as a gradual continuum, at one end there are all those people/women, seen as sane, and at the other end, there are those who are utterly mad: the 'shop dummies'. Nowhere does she give a clear rupture that would definitely sever these two ends from each other: everyone is under a bell jar of some kind.

I thus argue that in the light of my Foucauldian-Phelanian model, and in the pattern of her internal and external diagnostic moments Esther offers us, the narrative and diagnostic powers interlink. Thus, on the one hand, Esther's narrative power aims to direct the diagnostic power at the whole of society and its pathological structures, to question its right to use diagnostic power on people like Esther; on the other hand her narrative power aims to explain her experience as a madwoman, and why she ended up under the bell jar. Esther gives these experiential details of her qualia as a madwoman and of the reasons why she became mad, whereas Innes's Jim refuses to give his audience this information about Mr Manack, and Peter claims to offer it to his audience, even if the audience cannot be completely sure of the validity of his testimony, as he uses partly illicit narrative situations to convey his messages.

Esther's diagnostic power is also directed at herself, as she must make self-diagnoses to direct the potentially and actually stigmatic diagnostic power at herself. She opposes this social, stigmatic move, however, by her narrative power: by her choice of focusing on her own point of view as the narrator and patient; by her narrative progression of diagnostic moments that open up the pattern of diagnoses in the story; by her thematic tool of focusing and explaining her own experientiality; and by the relentless use of the thematic tool of grouping in clarifying the desperate search for a suitable in-group. Thus, she opens up her feminine experience which is the root of her suffering, and implicates the whole society in causing her illness. She gives social and societal reasons for her breakdown and therefore makes her

madness understandable to her audience, thus engaging its empathy and avoiding the Innesian insulting stigma or the McGrathian psychiatric objectification (in fact she reveals that clinical psychiatry, in the form of Dr Gordon, is rather part of the problem, not its cure). Esther's story is the antidote to Innes's Jim's insulting diagnostics or McGrath's Peter's domineering psychiatric targeting. It opens up the patient's experience in a way that questions and problematises the sharp definitions of psycho-scientific differential diagnostics and the justification of the distress caused by stigma often placed by their social surroundings on mad people because of their madness.

4.4 Susanna Kaysen's Girl, Interrupted: Autobiographical Madness

Susanna Kaysen (born 1948) is an American author who has written two novels: *Asa, As I Knew Him* (1987), and *Far Afield* (1990), and two memoirs: *Girl, Interrupted* (1993), and *The Camera My Mother Gave Me* (2001). All her works are related to her own life in some manner. *Girl, Interrupted* was made into a Hollywood film in 1999, and the film and the memoir together have made Kaysen famous. There is some existing research on *Girl, Interrupted*, and I will refer to some of it that is relevant to my study of the book.

The memoir tells the story of her almost two-year stay in a mental hospital as an adolescent in the late 1960s. It is the only factual narrative in my study; its importance comes from the juxtaposition it offers to the other, fictional texts. I ask: what kinds of differences result from the aspect of factuality when one compares the empathetic strategies and narrative and diagnostic power patterns of Kaysen's autobiography to those of the fictional texts? At the same time, *Girl, Interrupted* further offers us a pointed critique of the psycho-sciences: Kaysen debates with and about them directly and uncompromisingly, and she also targets the power aspect of psychiatric treatment, emphasising the issue of social stigma. Marshall (2006) and White (2008) consider *Girl, Interrupted* from a feminist viewpoint; I will be referring to their studies but retain a more gender-neutral focus myself, since I consider Kaysen's message concerning the psycho-sciences not to be completely gender-bound. It is notable that Kaysen uses humour as one of her narrative devices, enabling me to touch upon the comically portrayable nature of the experience of psychiatric treatment.

4.4.1 Narrative Situation, Experientiality, and Diagnostic Moments

Kaysen's narrative situation is constant first-person narration, as is proper for an autobiography. Thus, her experiential sphere and her own qualia are entirely in the focus of her narrative, the way she perceives her world and her experiences. As the author-narrator, she controls the knowledge-power streams of her narrative in a sovereign manner. Marshall states: 'Kaysen invites the reader to side with her as the authority on her experience' (Marshall 2006). Like McGrath's Peter, Innes's Jim and Plath's Esther, Kaysen also 'owns' her story and shows her ownership and control of it right from the beginning: she opens her text by stating that 'People ask, How did you get in there? What they really want to know is if they are likely to end up in there as well. I can't answer the real question. All I can tell them is, It's easy. And it is easy to slip into a parallel universe.' (*Girl, Interrupted* (*GI*), p. 5.) This is a straight forward signal to her audience that she knows what she is talking about (it is her own experience, after all), and that she has recourse to such information that fascinates her audience. Her story's tellability is poignant, and her demand for her audience's attention is strong. This stressing of her story's tellability is one of the Fludernikian (2005, 2003; see also: Toolan 2001, pp. 151–152) signals of experientiality: Kaysen tells a story which is important for herself, too.

Like all the other works analysed thus far, Kaysen gives us a Phelanian (2005b) progression of narration and diagnostic moments. However, Kaysen's style of narration is much more fragmentary than those already discussed. She produces her story in small vignettes, whose exact temporal relations are not greatly elucidated. The main plot (how she ended up in the hospital, what happened inside) is dealt with in short episodes rather than in long developing plot lines. Unlike Jim and Peter, but like Esther, Kaysen makes several external diagnoses alongside with her own internal diagnoses: she lets us meet many of the other patients on her ward, for example Polly, who has attempted suicide by burning herself; Lisa, a hilarious sociopath; and Georgina, Kaysen's schizophrenic roommate. This is one of the strong links between Kaysen's and Esther's tale, which can be seen as kinds of 'sister narratives' (there are other links: e.g. the constant focus on the experience of a mental patient; even the exact locus of their madness is the same. Plath's autobiographical novel is partly set in the same hospital that Kaysen ended up in over a decade later than Plath, the McLean Hospital; Kaysen herself notes this connection (*GI* p.48)).

As in Esther's tale, a pattern forms of several diagnoses and those diagnosed. This diagnostic pattern functions in a different manner in Plath's novel than in

Kaysen's: Esther compared – or made the audience compare – all the other diagnoses with her own condition, more or less explicitly. Her pattern of diagnostic moments reverberated to uncover her status and state; the fictional structure of Plath's tale made it so. Kaysen, then, as an autobiographer, an author of her own factual story, must be more documentary than poetic. She lets us see the inhabitants of her ward and briefly glimpse the specific ways they are mad, but the narrative progression of diagnostic moments is not as tight-knit as with Esther, who always uses her diagnostic moments as a mirror; Kaysen even props up her documentary thrust by giving us excerpts of her patient records. (White sees this citing of the patient records as a 'bold move' to 'publicly [declare] her experience with mental illness' (White 2008, p.9).) The Phelanian narrative progression of depiction and interpretation is thus more episodic: the audience is invited to interlink the little vignettes and documentary excerpts into meaningful arrangements; Kaysen in a way gives us only the outlines of her reality in the hospital. I argue that this is one of the differences between fictional and factual autobiography: the factual autobiographer does not have the right and device of moulding the text into artificial poetic patterns like in fiction, or of creating new characters, for example, to suit the needs of poetic juxtaposition (like Plath did by creating Joan Gilling's character in *The Bell Jar*: Patterson 1979, p.67).

4.4.2 Groupings and Empathetic Strategies

The empathetic strategies of Kaysen's narration are heavily based on the groupings of her text: Kaysen's and the other patients' status as mad people is opposed to the group of those deemed sane – their keepers and other sane people they meet. White sees that Kaysen and other 'autobiographical manifesto writers' 'position themselves expressly as members of a community of those with mental illnesses, and also function as advocates for all those in this community' (White 2008, p. 10). (I will shortly note the ambiguities and contradictions I see in this initial grouping, made also by White; first I will analyse it as if it was unproblematic.) She emphasises this difference, for example, in the chapter called 'Applied Topography'. She describes the ward's spatial structure: 'Once you turned the corner past the living room, though, things changed. A long, long hallway: too long. Seven or eight double rooms on one side, the nursing station centered on the other, flanked by the conference room and hydrotherapy tub room. Lunatics to the left, staff to the right. The toilets and shower rooms were also to the right, as though the staff claimed oversight of our

most private acts.' (*GI*, p. 45.) At first sight, she seems to employ the ambassadorial empathetic strategy (Keen 2007, p. 142) in which she, as a (former) in-group member of the insane, attempts to get her message through to the chosen out-group of the sane. The stratification of groupings, is not, however, this simple (i.e. simply mad/sane); the group of the insane is further layered into madder and saner, and more popular patients and those avoided by others (e.g. 'Martian's girlfriend', whose first name Kaysen does not even give and with whom no one wants to share a room (*GI*, p. 31)). This reminds me of Esther's statement that the population of the mental hospital, with its gossip, can be likened to that of any college dorm.

Kaysen underlines the paradox of being a mental patient. As patients, they have been stripped of almost every right as persons (the patients are, e.g. denied the right of having sexual encounters while being under treatment), but still protected by the institution of hospital psychiatry:

> The hospital shielded us from all sorts of things. We'd tell the staff to refuse phone calls or visits from anyone we didn't want to talk to, including our parents.
>
> 'I'm too upset!' we'd wail, and we wouldn't have to talk to whoever it was.
>
> As long as we were willing to be upset, we didn't have to get jobs or go to school. We could weasel out of anything except eating and taking our medication.
>
> In a strange way we were free. We'd reached the end of the line. 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. (*GI*, p. 94.)

In this excerpt, we can detect the Foucauldian power structures (1982) of psychiatric care: the subjectifying power (point 8) of the institution is self-realising (first, it strips the patient bare, then it offers to protect her as a patient, to make her a subject of and through treatment), and the patient is left with the possibility of 'weaselling out', to clandestinely take advantage of the only power they are left with – that of appearing mad and in need of protection. This also reminds me of Szasz's notion of the mad taking advantage of those treating them using their feigned helplessness (Szasz 1975). However, Kaysen emphasises the conception that the institution of psychiatry 'started it': 'the hospital had stripped us naked in the first place', and, at least in her own case, she constantly states that she did not wish to be hospitalised

or treated, and that the institute is more of a prison than a funfair of indulgence (here, Kaysen seems to come close to Szasz's point that psychiatry is torture rather than treatment (Szasz 1975, p. 12 and p. 174)). Therefore, in Kaysen's narrative, the patient is under societal, institutional, psychiatric power, but has her (though rather meagre) opportunities to fight back as a Foucauldian free subject (Foucault 1982, point 6). This power struggle further emphasises the strict hierarchies Kaysen depicts on her ward, but Kaysen also handles these hierarchies with a delicious sense of humour, which further reveals the hierarchies' nature as power structures.

4.4.3 Comical Madness – Comical Psychiatry

To study the phenomenon of the comical in Kaysen's depiction of madness and psychiatry, I employ Simon Critchley's work *On Humour*, which emphasises the social side of humour: '[J]okes are a play upon form, where what is played with are the accepted practices of a given society. The incongruities of humour both speak out a massive congruence between joke structure and social structure, and speak against those structures by showing that they are no necessity. The anti-rite of the joke shows the sheer contingency or arbitrariness of the social rites.' (Critchley 2010, p. 10.) Critchley does, though, make a difference between 'reactionary' humour that does not laugh at power but at the powerless, which hurts and does not change the social power structures, and 'true' humour that is capable of changing the social order. However, even reactionary humour has its value: '[I]n its "untruth", as it were, reactionary humour tells us important truths about who we are. Jokes can therefore be read as symptoms of societal repression.' (ibid., p. 12.) 'True' humour, in Critchley's opinion, has the feature of both not hurting the specific victim and always containing self-mockery; it also has a therapeutic, even messianic side to it, besides a critical societal function. Therefore, I will follow Critchley's guide to try to see who laughs at what, and why. The social side of humour goes well with my notion of madness and diagnosis as power fields. It is worthwhile asking: Does Kaysen's madness narrative represent reactionary or messianic humour? Does she laugh at the powerless or at power? Is she supporting the *status quo* (of the psychiatric establishment) or subverting it? What kinds of communities are built around her comical madness?

Kaysen offers us a number of comical situations which highlight the social structures of the hospital life. For example, she describes the types of discussions she had with the head of the ward, Dr Wick:

Dr. Wick seemed utterly innocent about American culture, which made her an odd choice to head an adolescent girls' ward. And she was easily shocked about sexual matters. The word *fuck* made her pale horse face flush; it flushed a lot when she was around us.

A representative conversation with Dr. Wick:

'Good morning. It has been decided that you were compulsively promiscuous. Would you like to tell me about that?'

'No.' This is the best of several bad responses, I've decided.

'For instance, the attachment to your high school English teacher.' Dr. Wick always used words like *attachment*.

'Uh?'

'Would you like to tell me about that?'

'Um. Well. He drove me to New York.' That was when I realized he was interested. He brought along a wonderful vegetarian lunch for me. 'But that wasn't when it was.'

'What? When was what?'

'When we fucked.'

(Flush.) 'Go on.'

'We went to the Frick. I'd never been there. There was this Vermeer, see, this amazing painting of a girl having a music lesson – I just couldn't believe how amazing it was – '

'So when did you – ah – when was it?'

Doesn't she want to hear about the Vermeer? That's what I remember. 'What?'

'The – ah – attachment. How did it start?'

'Oh, later, back home.' Suddenly I know what she wants. 'I was at his house. We had poetry meetings at his house. And everybody had left, so we were just sitting there on the sofa alone. And he said, 'Do you want to fuck?"

(Flush.) 'He used that word?'

'Yup.' He didn't. He kissed me. And he'd kissed me in New York too. But why should I disappoint her?

This was called therapy. (*GI*, pp. 85–86.)

Here, Kaysen gives us one of those moments when the world of the keepers and that of the mad do not meet, even in the locus of the hospital, where one could expect this meeting to take place. This is especially remarkable because the treatment Dr Wick is expected to give Kaysen is of the broadly psychoanalytical kind – the 'talking

cure' – which is based on the verbal exchange between the doctor and her patient. Kaysen portrays the comical side of it: the doctor is inhibited sexually, and Kaysen, her patient, abuses that feature in her doctor, even to the degree that she seems to bully and tease her. The doctor herself is equally culpable; she opens her part of the conversation by placing Kaysen into a degrading pigeonhole of being 'compulsively promiscuous'. (Kaysen later challenges the notion of promiscuity as a 'symptom' of her 'illness' by noting that it is sexist, as there is a huge difference in the numbers of sexual partners deemed enough to call a boy or a girl promiscuous (*GI*, p. 158).) The comedy in this excerpt comes from the inward laugh the patient gets from opposing and subverting the psychiatric institution by revealing its representative's weakness: sexual matters (which is another odd, ridiculous thing, as psychoanalysis is driven to such a great degree precisely by the discussion on sexuality). Her end note: 'This was called therapy' intensifies the critique Kaysen directs at this kind of 'cure': the talk with Dr Wick is absurd, and does not help anyone as the patient only deliberately drives her doctor to blush in a private social game. (Kaysen here offers us a description of a mad-keeper relationship that comes close to the Szaszian madness-as-a-role-game notion (Szasz 1975), but from a comical rather than deadly serious point of view.) Kaysen is seen here to laugh at the power of psychiatry, with its strict hierarchies that allow the psychiatrists to communally (remember the 'it has been decided') label another person. By making the psychiatrist look ridiculous, she offers us the patient's viewpoint and her clandestine opposition to labelling and its psychiatric use of power. Thus, Kaysen laughs at this power by seeing the ridiculous in psychiatry.

Another representative of Kaysen's comical occurrence and the patients' way of opposing the psychiatric power is in her depiction of Lisa's (a patient diagnosed as a sociopath) clever stunt. Lisa is a patient who, as is proper for a sociopath, openly opposes the ward's nurses and doctors, and even escapes the institution at times. After being returned following one escape attempt, she seems to go 'blotto', as Georgina expresses it: unlike her usual self, Lisa becomes passive and silent, just watching the TV, and the other patients think she is being heavily medicated. However:

> One morning in May we were eating breakfast when we heard a door slam. Then Lisa appeared in the kitchen.
> 'Later for that TV,' she said. She poured herself a big cup of coffee, just as she used to do in the mornings, and sat down at the table. She smiled at us, and we smiled back. 'Wait,' she said.

> We heard feet running and voices saying things like 'What in the world…' and 'How in the world…' Then the head nurse came into the kitchen.
> 'You did this,' she said to Lisa.
> We went to see what it was.
> She had wrapped all the furniture, some of it holding catatonics, and the TV and the sprinkler system on the ceiling in toilet paper. Yards and yards of it floated and dangled, bunched and draped everything, everywhere. It was magnificent.
> 'She wasn't blotto,' I said to Georgina. 'She was plotting.'
> We had a good summer, and Lisa told us lots of stories about what she'd done those three days she was free. (Ibid., p. 24.)

Lisa here reminds me of a fictional sociopath pulling stunts to lighten up the other patients' life: Ken Kesey's McMurphy in *One Flew over the Cuckoo's Nest*. They both oppose the psychiatric establishment and draw the patients together as a group by doing hilarious, comical things against the rules of the ward. At the same time, Lisa's stunt is completely harmless, no one gets hurt, and the patients get a good laugh. ('It was magnificent.') The opposing of the psychiatric system, and laughing at it (it is directed at the keepers, who need to keep order on the ward and do the cleaning up) makes the patients tighten as a group ('We had a good summer'), thus forming a community of the mad in the face of the community of the keepers. Kaysen thus employs her almost messianic humour to bring into light the social structures of the hospital. Her humour also emphasises her critique of the psycho-sciences (better seen in the first comical representation of the 'therapy' session with Dr Wick), on which I will next concentrate.

4.4.4 Opposing the Psycho-Sciences

In *Girl, Interrupted*, one thematic thread comes from trying to (re)delineate the relationship between madness and the psycho-scientific paradigms. Marshall states that Kaysen 'underscores how psychological discourses are not neutral, but tied in specific ways to cultural lessons of femininity' (Marshall 2006). I see that besides offering a feminist account of her own illness, she also criticises the psycho-sciences in a vehement manner using skilful tactics. The depiction of madness and the psycho-sciences, the 'what' of her narrative, is strongly intertwined with the 'why', the rhetorical purpose of narrating (Phelan 2005b, p. 323). Kaysen directly questions

the application of psycho-scientific paradigms on the personal experience of the patient. She discusses the possibility of a 'brain theory' of madness:

> A lot of mind, though, is turning out to be brain. A memory is a particular pattern of cellular changes on particular spots in our heads. A mood is a compound of neurotransmitters: Too much acetylcholine, not enough serotonin, and you've got a depression.
>
> So, what's left of mind? (*GI*, p. 137.)

She is strongly against this theory, since it does not correspond to her sense of being: 'It's a long way from not having enough serotonin to thinking the world is "stale, flat, unprofitable"; even further to writing a play about a man driven by that thought. That leaves a lot of mind room. Something is interpreting the clatter of neurological activity.' (ibid., p. 137.) Here, she is making an analysis of her own mental status and that of all those who have been diagnosed and treated as patients, with drugs and other physical treatments (e.g. ECT), and with more psychological approaches. In addition, she seems to evoke the notion Horwitz takes up in connection to the change from psychodynamic to brain psychiatry: brain psychiatry makes 'scientific claims [...] in isolation from the personalities and social contexts in which they arise, an abstraction that would be unthinkable in the dynamic model' (Horwitz 2003, pp. 57–58). The patient is reduced to a brain; she is no longer a unique person showing unique symptoms (Freud emphasised the unique and untypical symptomatology; Millon 2004, p. 258; Freud 1978a, pp. 270–271) that are seen as symbols of deeper developments in her psyche.

Kaysen wonders how it is possible for a doctor to shuffle between the two interpretations: biological and psychological (the narrator discusses only the psychoanalytical aspect of psychological treatments, as it was the one used in the 1960s during her stay at the hospital).

> At that moment, when the doctor suggests Thorazine [an antipsychotic medication], instead of psychoanalysis,[11] what's happening to that doctor's mental map of mental illness? Earlier that day, the doctor had a map divided into superego, ego, and id, with all kinds of squiggly, perhaps broken, lines running among those

11. Freud's original view was that psychosis is not treatable by the means of psychoanalysis (Freud 1978a, pp. 438–439). Therefore, the doctor prescribing antipsychotic to her patient may be seen to follow her Freudian guidelines. However, by the 1960s – the time Kaysen is describing here – psychoanalysis had conquered the area of psychosis as well, and had started to develop psychoanalytical tools to treat it.

> three areas. The doctor was treating something he or she calls a psyche or a mind. All of a sudden the doctor is preparing to treat a brain. This brain does not have a psychelike arrangement, or if it does, that's not where the problem is. This brain has problems that are chemical and electrical. […]
>
> Something's wrong here. You can't call a piece of fruit an apple when you want to eat it and a dandelion when you don't want to eat it. It's the same sort of fruit no matter what your intentions toward it. (*GI*, pp. 141–142.)

Here, in order to denigrate the psycho-scientific paradox of having two opposing but simultaneously applied paradigms, she openly positions the rivalling paradigms against each other.

The thought that madness (or the mind in general) is biological, has different sides to it. The idea that the mind is something more than just neuro-chemical activity means that there is something debasing in the notion of the mind being just the brain. Paradoxically, it creates the chance of lessening the possible social stigma of mental illness, since it turns mental illness into a bodily, somatic disease (Kaysen states the doctor's side ironically: 'Take two Lithium and don't call me in the morning because there is nothing to say, it's innate.' (ibid., p. 142)), yet it contains the threat that, like some other somatic illnesses, madness is biologically hereditary. Kaysen discloses the difficulty of those being treated, and those who treat, to approach the issue without running into considerable notional trouble.

Is the mind and disease only in the brain? What would it mean for those suffering from madness? If it is simply biological, the mad might gain in their status as patients, as the possibly stigmatic nature of mental disease as something deeply injuring to the human condition lessens (cf. Laitinen 1996, p. 16) – 'it is not their own fault, after all, or that of their mothers!' – which is one claim the biological psychiatrists have on their side. (This echoes Basaglia's perception that the guilt of madness is defined socially; the mad person is not guilty of her own madness (Salo 1996, p. 88).) On the other hand, everyone would then lose as well: if the mind is only the brain, one must rethink one's concept of what the mind is, the essence – sometimes called the 'soul' – of a human being. This shows that madness is a test case for the mind vs brain debate.

On many levels, Kaysen's narration is a battlefield. As she herself has been a mental patient and thus an object of psychiatric labelling, she acts on the thought of having the right to diagnose herself and others in a way that suits her better than the label or theoretical framework of biological psychiatry, which seems to her de-

meaning or inappropriate. This is a weighty reminder of the Foucauldian paradigm: everyone is both an object of power and a subject exercising power (Kusch 1993, p. 178; Foucault 1982). Kaysen hits back with the same ammunition that she has been attacked with by the psychiatric establishment: (scientific-like) reasoning. The experience and meaning of being labelled through diagnosis is strongly felt by her; it would be enough to be called 'mad' in so many clinical names, but to be robbed of a mind in the bargain? That is too much. The Foucauldian perception of subjugated knowledge (Kusch 1993, p. 129) and psychiatry as a battlefield between patient and doctor (Foucault 2006b, p. 10) is present here as well: Kaysen's knowledge of her own mind is being suppressed by the biological psychiatric establishment, which tries to cling onto the diagnoses she attacks, but she retains her identity by holding onto her own perception of herself. (White emphasises this retaining of her own feminine identity in Kaysen's work: 'Autobiography can function as a form of discursive resistance against a world that does not want to hear the story of mental illness, and a medical community that depersonalizes the female subject' (White 2008, p. 4). I consider Kaysen's work to be not exclusively feminist; it gives possibilities for both sexes to identify themselves in Kaysen's experiences as a mental patient.) Kaysen as a lay person does her best to fight back against the psychiatric establishment – partly by using its own weapons and terminology.

The power relations in Kaysen's text point toward the power of the author-narrator. What Kaysen's text 'wants to do' with or to the audience is to try to persuade her of the troublesome nature of the biological, psycho-scientific thesis of psychiatry. She is a very forceful Stanzelian teller-character (Stanzel 1984, p. 145) who has a clear agenda and does not leave much room for counter-argument, even to the extent that White (2008) sees this agenda as political, and Kaysen's work as a feminist manifesto. Kaysen questions the basis of biological psychiatry's approach of trying to diagnose brains instead of minds, and this indirect diagnosis she makes of herself and all other mental patients ('it is the mind, not the brain that is affected') is one of her strong points. Her use of both simple, general and unprofessional sounding terms (like 'mind' and 'brain' – these, though, turn out to be far from simple) and strictly psychoanalytical terms ('superego', 'ego', 'id') only strengthens her position. Thus she can reach both the lay public, and attack the establishment biological paradigm with its own psycho-scientific nemesis: psychoanalysis. She uses these terms skilfully and intentionally to defend her own position as a former mental patient. Thus, she welds together her narrative power of exposing her and other patients'

experiences and her fight against the professional diagnostics of the establishment. She also does this by making her inexplicit lay diagnoses.

Kaysen most surely problematises psycho-scientific diagnosis-making by bringing it into the sphere of experience; she can take the position of a former patient, which lends authority to her attempt to counter the establishment. Thus, she contests the diagnostic power (of the psycho-sciences, especially the biological branch) by narrative power – the power of revealing her and other patients' experiences. (Cf. White 2008.) The (fragmentary) narrative progression she offers us gives us the accumulation of testimonies from the patients' viewpoint; they often accuse 'the other side' (psychiatry) of being power thirsty, ridiculous, unhelping, labelling, etc. The narrative's world – the revealing of the reality inside the mental institute – directs the reader's ethical stance towards Kaysen's narrative (the 'double change' of narrative progression (Phelan 2005b, p. 323)): the reader is made to consider the justification and supportability of psychiatric treatment. The (experiential) knowledge Kaysen offers as her grounds for challenging psychiatry is thus strongly of the type of Foucauldian-inspired knowledge-power that Kaysen controls as the author.

The relationship between the two streams of psycho-science she comments on, namely psychoanalysis and biological psychiatry, can be seen to be uneasy, as it historically has been and continues to be. This can be seen, for example, in the way the psychoanalyst Roudinesco defends psychoanalysis against biological brain psychiatry. Roudinesco maintains, firstly, that psychoanalysis is the only psycho-scientific branch that truly can cure the patient, and not just alleviate the behavioural symptoms she has (like the psychoactive drugs do (Roudinesco 2000, p. 13 and p. 24)). Secondly she claims that the subjectivity psychoanalysis acknowledges, studies and treats is not measurable or computable (like the brain psychiatry claims), but at the same time it is visible and invisible, conscious and unconscious, precisely in the form in which the essence of human experience is shown (ibid., p. 51). Brain psychiatry, then, accuses psychoanalysis of being, for example, a mere *Weltanschaaung* (Shorter 2005, pp. 178–179); it is unscientific and ineffective. Kaysen acknowledges this rivalry and uses it against the establishment by showing how incompatible they are. She seems to ask: If the establishment cannot decide whether madness is biological or psychoanalytical, how can we entrust our minds into its hands? She also asks: with what right does it label us, when its claim to be scientific can so easily be undermined? The Foucauldian theme of psychiatric knowledge being intertwined with social power (Kusch 1993, pp. 170–171) rings in the background: as psychiatry is a forceful societal actor, it has social power, and this constellation of psychiatric

power and social power is one of the core issues of psychiatric stigma, the labelling Kaysen so strongly opposes and questions (cf. White 2008, p. 5).

The questions she asks are: when psychiatry uses its biological methods – its drugs, ECT, or surgery – does not it brush aside the patients' experience as patients, human beings – the objects of these biological interventions? This experiential aspect is emphasised in her narrative, and it is the most central weapon she uses to counter the establishment: the ethical issue of the psycho-sciences pivots on this question of the patients' experiences. For the patient and her psychiatrist, the battle is fought on the plane of the patient's body, but the significance given to this battleground differs: for the psychiatrist it means a treasured highway into a malfunctioning psyche, or even more restrictedly a malfunctioning brain; for the patient it may mean side-stepping what the real issue is: her existential and experiential well-being, a discrepancy that may make the intervention through her body possibly monstrous, not beneficial. This is the claim Sass makes most poignantly against biologically reductionist psychiatry:

> A common assumption is that the discovery of biological correlates for psychopathology, or at least for psychotic illnesses, is likely to diminish the importance of the experiential dimension (and also that of cultural factors) and in particular to undermine any conception that – like mine – would attribute a significant degree of meaningfulness, intentionality, or rationality to the patient's experience. Such an assumption is not, in fact, supported by a careful analysis of recent [that is: the late 1990s] neurobiological research on schizophrenia[.] (Sass 1998, pp. 374–375.)

Sass makes the point that 'psychological phenomena must logically precede a physiological investigation of them' (ibid., p. 374); that 'often there is no reason […] to assume that it is always the physiological changes that bring about the mental events rather than the reverse' (ibid., p. 385); and that therefore: 'it is only by detaching oneself from such an approach [the biological reductionism] that one can appreciate the potential complexity of the possible interactions or interweavings that can exist between the psychological and biological planes' (ibid., p. 383). Thus, Sass fortifies the position Kaysen takes: it is a narrowing of perception for the mental patient to be perceived as a merely dysfunctional brain.

Kaysen's autobiography can be placed into the context of the social construct theory of madness as well. A central part of Kaysen's narrative thrust is in her

questioning of the notional border between sanity and madness, thus making the bridge between the (unsteady diagnostic) contents of her narrative and the rhetorical purpose for her narrating. On the one hand, she sees her own position clearly; on the other hand, she cannot make a clear distinction between the two worlds of madness and sanity. In the end, she poses the question of diagnosing everyone. She says about her 'misperceptions':

> I never 'believed' anything I saw or thought I saw. Not only that, I correctly understood each new weird activity. […] This clarity made me able to behave normally, which posed some interesting questions. Was everybody seeing this stuff and acting as though they weren't? Was insanity just a matter of dropping the act? If some people didn't see these things, what was the matter with them? (*GI*, pp. 41–42.)

Kaysen's rhetoric is poised towards posing these unnerving questions: Where does one draw the line between madness and sanity? Why are some of us locked behind hospital bars and others not, even if the perceptual difference between these two groups seems to be questionable? She also undermines the psychiatric reading of her own status by using the very same terms as those who direct them at her. She is a consonant narrator (Cohn 1981), so she was aware of these peculiar questions already at the time of the narrated occurrences. This makes the reader appreciate her testimony perhaps even more, making her rhetorical thrust a successful one.

Her diagnosis is borderline personality disorder, which she finds out years later when investigating her old patient records. This diagnosis is seen by her to be the 'charges' against her, charges that make her status so different from other people:

> What does *borderline personality disorder* mean, anyhow? It appears to be a way station between neurosis and psychosis: a fractured but not disassembled psyche. Though to quote my post-Melvin psychiatrist: 'It's what they call people whose lifestyles bother them.' He can say it because he's a doctor. If I say it, nobody would believe me. (ibid., p. 151.)

Here, Kaysen approaches the perception that madness is not a biologically or even psychoanalytically configured, universally applicable dysfunction, but an essential social construct, not far from being a Laingian socially produced one (Laing & Esterson 1990). This means that the border is drawn more for the safety

of those claiming to be 'sane' than because of a real ontological difference between those deemed mad and those making the diagnosis. Here, the line between the two worlds of sanity and madness is seen to be very weak. The eye of the beholder and the mouth of the utterer makes all the difference: if the person stating this diagnosis is a doctor, she has the right to make the statement, but if the person is a patient, her statement would only add up to the 'charges', as 'defensiveness' or 'resistance': further evidence of insanity.

The excerpt above is an interesting meeting point of Foucauldian subjugated knowledge and psychiatric hegemonic knowledge: the exact same statement receives two completely different readings depending on the person making the statement. This emphasises the Foucauldian paradigm that the psychiatric power position is not exclusively dependent on the 'better knowledge' the psychiatrists have of the conditions of madness; the therapeutic operation takes place outside of nosographies or medical diagnosis and does not require medical knowledge to be successful. Instead of applying technical medical formula to something seen as a pathological process of behaviour, what actually takes place is a battle of wills, a relationship of power. (Foucault 2006b, pp. 10–11.) It must be noted that Kaysen's statement is somewhat unorthodox when heard from the mouth of her 'post-Melvin psychiatrist', but this does not refute the above analysis of it as both hegemonic and subjugated knowledge: psychiatric power seems not to be dependent on the content of this diagnosis no matter how unorthodox it seems, but on the power position of the psychiatrist vis-à-vis her patient. This is well embodied in Kaysen's statement; the power position is not shattered even when the person occupying it adopts the very statement that may be seen to oppose it. Kaysen's psychiatrist is still her psychiatrist even when he adopts this subversive stance. This also emphasises that the field of psychiatry is so diverse that the persons acting under its umbrella may maintain completely opposing positions (e.g. that madness is biological or that it is psychological in its causation).

Thus, Kaysen shows that the border between madness and sanity is virtually non-existent – or at least very random. In Kaysen's eyes, (cf. *GI*, p 124, quoted below) this clearly threatens (supposedly) sane people's sense of security; they need to use these tags – for example, Kaysen's 'borderline personality disorder' – in order to feel safer by confining the (supposedly) mad person, if not physically, then at least notionally. As Kaysen so vividly demonstrates, these borderline cases are the toughest to delineate. Whereas a 'thoroughly', 'visibly', 'inescapably' mad person does not ignite as much fear in those who surround her, because her madness is so far away from the sane persons' life, a 'borderline' case is just that: a drawing of a

border around the sane community, a border that must be re-evaluated separately for each case – and this line is a random thing, not something objective. This also is a reminder of Fabrega's notion that the sane forcibly define their identity against the marginal group of mad people (Fabrega 1991, p. 109).

The narrator asks when she goes through the DSM-III definition of her condition: '"[I]nstability of self-image, interpersonal relationships, and mood… uncertainty about… long-term goals or career choice…" Isn't this a good description of adolescence?' (*GI*, p. 152.) Kaysen uses her narratorial power to demolish psychiatric diagnostic power by questioning its basis through its right to use these tags. In her perception, her condition as a patient with 'borderline personality disorder' is not to suffer from madness but from something that is completely normal: the difficulties of adolescence. (For a good analysis of Kaysen's depiction of BPD and particularly female adolescence, see Marshall 2006.) Madness may be socio-psychological in being a condition based on the social and psychological patterns of the patient, and those between people making the diagnosis and those being diagnosed, but these patterns are not, as Kaysen here demonstrates, necessarily indications of illness or abnormality (mad that is), but more of a random affair. She suffered from mental growing pains, not something that she has ever recognised as 'proper' madness, but for some reason she got locked up for it. The lack of sense of illness in the patient is not, however, a definitive reason not to make a psychiatric diagnosis, as we have seen (Lönnqvist 1999, p. 30), which only heightens the theme of Kaysen's opposition against the psychiatric diagnostics. The 'charges' against the patient are often watertight, and they liken to the Laingian social double bind (Laing & Esterson 1990): the patient is declared mad both if she sees herself as mad and if she does not. The nature of Kaysen's 'madness' as a social construct is also apparent in the randomness of diagnosis (as we saw in the above excerpt): it is in the eye of the beholder, but it is not constant even then – the psychiatrists do not agree inside their own camp.

The narrative power that Kaysen uses here is rather aggressive: she openly and strongly argues her cause, turning the 'charges' of her diagnosis against the diagnosing establishment by showing that the tags it uses are invalid and poorly grounded. She attacks psychiatry directly, even by employing the self-diagnosis, which is her experiential basis for saying: 'I know this because I have been a patient myself' (a move natural for an autobiography). Thus, the employment of tags even in self-diagnosis is a thoroughly considered strategy: Kaysen uses these tags to undermine them and to question them in the strongest possible manner, by attacking them from the inside ('they do not fit into my self-image') as well as from the outside ('they

are poorly grounded anyway'). The two forces of narrative and psychiatric power can be seen to form patterns: Kaysen uses subversive diagnostic power to demolish establishment diagnostic power through employing narrative power (depicting the experiential contents of these diagnoses).

Kaysen also ponders the fact of the 'taint' of mental illness, namely the stigmatic nature of being diagnosed. She discusses the possibility of having a 'normal' life after her hospital years:

> Could we get up every morning and take showers and put on clothes and go to work? Could we think straight? Could we not say crazy things when they occurred to us?
>
> Some of us could, some of us couldn't. In the world's eyes, though, all of us were tainted.
>
> There is always a touch of fascination in revulsion: Could that happen to me? The less likely the terrible thing is to happen, the less frightening it is to look at or imagine. A person who doesn't talk to herself or stare off into nothingness is therefore more alarming than a person who does. Someone who acts 'normal' raises the uncomfortable question, What's the difference between that person and me? which leads to the question What's keeping me out of the loony bin? This explains why the general taint is useful. (p.124.)

Again Kaysen employs a clear grouping, a division of 'them' from 'us', 'them' meaning all those claiming to be sane (not just the psychiatric establishment), and 'us' being those confined in a 'loony bin', and the taint is the others' ('their') tool for dealing with the insane 'us'. However, as Kaysen makes clear, this clarity is not completely based on the clear or essential difference between 'them' and 'us': the general taint covers all loony bin occupants, present and former, even those who can take showers and put on clothes and go to work despite the crazy things sometimes inhabiting their minds. This excerpt's self-diagnosis and 'peer' diagnosis of other mad people on her ward, with its ironical taste, gives the narrator an advantage over those who otherwise might look down upon her: 'I know it better myself'. The diagnosis is a pre-emptive move; it is the appropriation of the possibility of stigma, and the explanation of it by the needs of the 'us and them' relation. Here, Kaysen does not use special scientific-psychiatric terminology, but strips the mad-sane relationship to its barest bones: it is as separation of two camps, the border of which is guarded by the psycho-sciences.

4.4.5 Turning the Kaleidoscope

Finally, one must directly tackle a curious aspect in Kaysen's narration precisely in connection to her in- and out-groupings – the blurring of her own position as an author-narrator making these groupings. Even though above she makes a strong case for guarding the rights of the mad, one must ask again: Who is her audience? How is she related to it? Unlike Innes's Jim, McGrath's Peter, or Plath's Esther, Kaysen *addresses her audience directly*; she speaks of the revulsion she now feels for madness and mad people, years after her stay in the hospital, and asks: 'If I who was previously revolting am now this far from my crazy self, how much further are you who were never revolting, and how much deeper your revulsion?' (*GI*, p. 125). Thus, her audience is the sane community, and the (Labovian) point of her tale is to depict to them the 'parallel universe' of the madness with which she opened her narrative (ibid., p. 5).

As I remarked above, Kaysen's empathetic strategy can be seen as ambassadorial, her chosen out-group being the community of the sane and the in-group the community of the mad. She appears to be asking for empathy for her mad characters along with herself, but the pattern is not that simple: Kaysen moves across the borders of sanity and madness in her narrative, and thus she does not definitively indicate her own position. This gives her the opportunity to tell the sane community about madness: she is sufficiently sane to control her narrative and structure her experience in a manner that is understandable for a sane community that has not had the traumatic experiences that may, by their traumatic nature, be inexpressible (for an analysis of the difficulties autobiographers may have with verbalising their traumatic experiences, see Stone 2004). On the other hand, her narrative is governed by a central contradiction: she at the same time affirms and negates her own madness, and thus also her own belonging to the in-group of the mad. The audience therefore cannot know for sure from which exact empathetic position Kaysen argues: is it from the sane or the mad? Furthermore, one must ask whether it is possible for her to employ the ambassadorial strategy – to speak for the mad – if she sees madness as revolting.

Here, we come close to Kaysen's fictional 'sister narrative', Plath's Esther's tale. Esther, too, had the experience of the gradual slide into mental illness, the borders of which were difficult or impossible to delineate. Kaysen asks the same kinds of questions (but perhaps even more pointedly) about the societal right to stigmatise persons whose madness can be disputed. However, in Kaysen's memoir, this pattern of questioning is different from Plath's: Esther was in her own perception mad

(e.g. she thought of herself as an 'incurable case'), she just did not perceive a clear rupture in the scale between madness and sanity, and, conversely, saw everybody (at least every college girl) as mad – under a bell jar of some kind. Kaysen, then, clearly refutes her own madness: 'I have to admit, though, that I knew I wasn't mad' (ibid., p. 42). She only flirted with madness, with its huge negation of the way of life (her parents', teachers', etc.) she could not accept as her own. From this follows perhaps the greatest difference between Esther and Kaysen – their evaluation of hospital treatment. Esther experienced her stay at the hospital as one of recovery (she was 'retreaded', after all); Kaysen derides her stay at the hospital as incarceration, and she remains fairly bitter about it. However, on the other hand, Kaysen does expertly depict her own 'madness' (e.g. its 'viscosity' or 'velocity', and she says: 'Luckily, I never had to choose [between viscosity and velocity of thoughts]. One or the other would assert itself, rush or dribble through me, and pass on.' (ibid., p. 78.) Thus, she seems to claim that she was both mad *and* sane.

The contradiction of affirming and negating her own madness could be seen as a flaw in her narrative. After all, the narrative is, in its narrative power structuring, heavily based on the groupings, delineations and border drawings between 'us' and 'them', or mad and sane; these groupings also direct her position vis-à-vis her audience. As the readers, we can ask: If she denies ever having been 'properly' mad, by what right does she depict the world of madness as its citizen? If she, on the other hand, was mad, why does she deny it?

This contradiction could be seen as one of her main messages, though: she could be arguing that madness is entirely ambiguous. Her ambivalent depiction of her own madness interlinks elementally with her narrative power position and her critique of the psycho-sciences: on the one hand, she aims to give a better depiction of madness than psychiatry could. (She states that experientially madness is not, as psychiatry claims, infinitely complex with dozens of diagnostic categories, but capable of being depicted simply by two notions of 'velocity' vs 'viscosity'.) On the other hand, she denies having been mad, despite the fact that she was diagnosed as such by psychiatrists. Kaysen employs her diagnostic power on herself and others in order to support her struggle against the psychiatric establishment. She denies psychiatry its object ('I was not mad') and thus also its justification as a societal force, and/or stating that there is something that can be seen as madness, but that something is wrongly perceived in psychiatry. In either case, we are left with sharp critique of the psycho-sciences, even if the devices on which this critique is based are contradictory.

It is notable, though, that Kaysen does not seem to claim that *every* form of madness is as prone to interpretative difficulties as her own diagnosis of BPD. She does say, attempting to anticipate her audience's reactions: 'If my diagnosis had been bipolar illness, for instance, the reaction to me and to this story would be slightly different. That's a chemical problem, you'd say to yourself, manic-depression, Lithium, all that. I would be blameless, somehow. And what about schizophrenia – that would send a chill up your spine. After all, that's real insanity. People do not "recover" from schizophrenia.' (ibid., p. 151.) She does not claim to speak for all mad people, with all the diversity of mad experiences, even if she many times seems to group herself with them.

If the audience cannot know for sure the in-group basis or the exact position Kaysen speaks from, how can they relate to her groupings, her empathetic strategies, and all the aspects of her story? Here, we can emphasise Keen's hypothesis that the factual narrators have a more difficult job of getting the sought-for empathetic response from their audience than fictional ones (Keen 2007, p. 4): the reader easily feels aversion if the text seems to require some 'this-worldly' – even political – reaction from her. If we see Kaysen's text, like White (2008), as a manifesto, it would strongly require an immediate reaction from the reader. This possible aversion from the reader seems to explain certain narrative devices Kaysen employs: her self-ironic humour (which seduces the reader into seeing things like Kaysen); her documentary exhibition of her patient records; and her straight-forward pleas for the reader to affirm her way of thinking (e.g. she has a chapter titled 'Do You Believe Him [the psychiatrist who sent Kaysen to the hospital after only a minimal – Kaysen claims – discussion with her] or Me?' (*GI*, p. 71)). We did not encounter these devices in McGrath's or Innes's novels, or even in Plath's, whose message comes closest to Kaysen's. They seem to be closely tied to or even inherent in the factuality of Kaysen's text.

Finally, one must ask, like in the case of all the other texts in my study: what is madness in *Girl, Interrupted*? Unlike in the novels of McGrath, Innes or Plath, in *Girl, Interrupted* madness does *not* sufficiently explain the behaviour of those deemed mad (Kaysen says of her own diagnosis that it is 'accurate but it's not profound'(ibid., p. 150)). On the one hand, madness is an identity for Kaysen, but an identity she disliked more than liked then and definitely abhors now, as she does the more or less arbitrary manner in which she became to be called mad by the psychiatric establishment. Unlike Plath's Esther, she feels no debt of gratitude to the psychiatric establishment for her treatment, emphasising the stigma and the

societal power structures that – in the form of psychiatric care – confine and label people, even those, like Kaysen, who did not recognise 'proper' madness in herself.

My model elucidates this narrative's way of using the narrative power techniques of narrative situations and progression of diagnostic moments, and the thematic tools of grouping and experientiality in manners that emphasise the patient's point of view over that of the psycho-sciences. The narrative power Kaysen employs is pointedly directed against the psycho-scientific establishments' power moves that she describes in her narrative. As a factual testimony of one person's encounter with the psychiatric establishment, *Girl, Interrupted* is a tapestry of negative attitudes towards the psycho-sciences seen through Kaysen's own experiential sphere. My reading through the lens of narrative power tools reveals how richly Kaysen especially employs the empathetic strategies inherent in the (sometimes contradictory) groupings she gives to the mad and the sane, the stigmatised and those stigmatising; and she enlivens the groupings by depicting the experiential contents of being (called) mad and being subjected to the Foucauldian subjectifying power of psychiatry.

4.5 Pat Barker's Regeneration: Heterodiegetic Diagnostics

Pat Barker (born 1943) is a British novelist who has published 12 novels and won the Man Booker Prize and Guardian First Book Award. Her themes include memory, trauma, survival and recovery, and she has also concentrated on the World War I, which is the theme of the *Regeneration Trilogy. Regeneration* is the first part of this trilogy; the other parts are *The Eye in the Door* (1993) and *The Ghost Road* (1995). Although a part of the trilogy, *Regeneration* functions well also as an independent novel. *Regeneration* has been studied to some degree, and I will be referring to a number of scholarly articles.

Regeneration (1991) is the first of my target texts narrated in the third-person. It thus gives me an opportunity to compare homodiegetic and heterodiegetic narration, and especially the different kinds of strategies of empathy and intertwinings of narrative and diagnostic power. It further offers me the opportunity to expand my handling of the depiction of the psycho-sciences and the theme of madness depiction.

4.5.1 War and Madness

Regeneration is a historical novel depicting a WWI British military mental hospital, Craiglockhart, where cases of officers' shell shock are treated. Shell shock was a much-debated issue at the time of the war, but it is retrospectively regarded as a mental reaction to the pressures of warfare on the front line. It mainly caused neurasthenia in officers; its symptoms were nightmares, insomnia, heart palpitations, dizziness, depression, or disorientation. Among the rank and file, the symptoms were more physical and hysterical in nature: blindness, deafness, contracture of a limb, mutism, paralysis, or limping. (Showalter 1985, p. 174.) In the novel, the phenomenon of shell shock is explicated through the focus of Dr W. H. R. Rivers on his patients, especially Siegfried Sassoon, Billy Prior, and David Burns (both Rivers and Sassoon, and their encounter at Craiglockhart are factually based; Prior and Burns are Barker's invention). The factual Rivers was a psychoanalytically oriented psychiatrist who applied Freud's theories on repression of harmful or difficult memories to the treatment of his patients' war neuroses. He was also a renowned anthropologist and neurologist before the war.

A strong theme of this novel is the madness of war, which Barker's narrator depicts through the characters who have been broken mentally by war, and through Rivers, who treats them. I argue that one cannot separate questions of what madness is and how the psycho-sciences are depicted in this novel – the 'what' and 'how' of the madness narration or its diagnostic contents – from questions of the realities of the First World War and how the societal power patterns function during wartime and affect the perception of madness (in soldiers) and the psycho-sciences (treating soldiers). The 'why' or the rhetorical purpose of the narrative (Phelan 2005b, p. 323) is the ethical questioning of these power patterns. The phenomenon of shell shock was new at the time of WWI[12] it came about because of the horrors of trench warfare and the newly invented modern artillery, and it was elementally tied to the realities of the front (Shephard 1999, pp. 33–40) and wartime societal power patterns.

This theme of military power intertwining with psychiatric power is personified in the main encounter in the novel, that of Dr Rivers and Siegfried Sassoon, an exemplary, decorated officer turned pacifist by the mindless slaughter that he witnessed on the front. Sassoon publishes a pacifist anti-war declaration, but being such a prominent, famous figure, he is sent to Craiglockhart to Rivers to be 'cured'

12. Nowadays, the disease category has evolved into the notion of Post-Traumatic Stress Disorder, PTSD, but the perception that the cause of the disorder is prolonged stress, such as living in combat conditions for an extended period of time, has not been changed.

instead of being court-martialled. Sassoon is to be convinced not to go on protesting but to return to support the war effort again. It is seen by the military establishment as the best way to handle his protest; by declaring it insane, Sassoon himself is considered irresponsible for his actions. As a military psychiatrist, Rivers has the duty to do this convincing, even though he clearly sees that Sassoon is not a usual case of war neurosis, but suffers instead from 'an anti-war neurosis' (*Regeneration*, p. 15), a half-ironical notion that Rivers uses to express the situation of having Sassoon sent to a psychiatric institution for mainly political reasons. Sassoon does have battle nightmares and has had hallucinations, but he does not consider himself to be a war neurotic, as he is still able to carry on his passion for poetry writing. (Sassoon is one of the most important poets of the WWI Britain). When Rivers asks him directly: 'do *you* think you were 'shell-shocked'?' Sassoon replies: 'I don't know. Somebody who came to see me told my uncle he thought I was. As against that, I wrote one or two good poems while I was in there[…]' When Rivers asks further: 'You don't think it's possible to write a good poem in a state of shock?' Sassoon replies: 'No, I don't.' (ibid., p. 13.) Shortly afterwards, Rivers himself makes an emphatic counter-diagnosis: 'I'm quite sure you're not [mad]. As a matter of fact I don't even think you've got a war neurosis' (ibid., p. 15).

This encounter between a prominent military psychiatrist and an equally prominent soldier-turned-pacifist who has been confined to his institution for holding unpatriotic political opinions, is, however, a process that changes *both* the doctor and the patient: Sassoon returns to the front, even though he refuses to give up his opinions (he does promise to the Medical Board not to sabotage the war effort while on the front; he goes back for the love of his men – and to please Rivers); but Rivers finds himself changed too – he notices that, although previously an unrelenting supporter of the war, he now starts to think more pacifistically.

4.5.2 Deciphering Empathy

The empathetic strategy (Keen 2007, p. 142) of Barker's narrator is more difficult to perceive than that of a first-person narrator. The starting point in perceiving the empathetic strategy in my model – the in-group membership of the narrator – is not easy to decipher if the narrator is a Stanzelian covert, or 'invisible' one (Stanzel 1984, p. 47). It can be asked whether a third-person narrator even could be mad (which is crucial to know from the focus of this study), since it would easily make

her an unreliable narrator (in the traditional sense of the term) – a notion that has not gained much support from narratologists.[13] This is in stark contrast to Plath's Esther, a self-proclaimed mad person, or Kaysen, who directly announces her in-group memberships. (Although in both Esther's and Kaysen's cases, the membership is not a simple or straightforward issue, as we have seen. They do, however, make an announcement, and it is at least possible for them to be mad in some sense of the word.) This is the first of the major differences between the empathetic strategies of first- and third-person narration. Another difference is that for a narrator like Barker's, there is an absence of one central consciousness concentrating solely on a single focaliser. Plath's Esther, Innes's Jim, and Kaysen all offered us the focus of a personalised 'I'. Through this 'I', everything narrated in the fictional world was tied to a person who chose what was narrated and how, and who (especially in the case of Esther) related everything said to her own persona. McGrath's Peter, even though a first-person narrator, is slightly more difficult to pigeonhole in this sense, as he hid behind his focalisation through Stella's viewpoint (quite a bit like a heterodiegetic narrator), but his hold of the narrative, in the end, was as strong as the other first-person narrators'. He too chose his viewpoints, he could be positioned in the mad/sane spectrum, and – at the end at least – related the told to his own character as well. I do not claim that a heterodiegetic narrator has a weaker hold of her narrative than a homodiegetic narrator, or that she cannot choose her narrated phenomena; I am only stating that the personality traits of the heterodiegetic narrator are often more hidden, and as she is not a part of the fictional world she narrates, she is an 'outsider' whose opinions (and group memberships) have a different kind of relation to the fictional world's inhabitants.

Barker's narrator is of the Stanzelian covert variety: she does not express her own opinions directly by stating them, or 'advertise' her story's tellability, point and evaluation, like the first four of my target texts. This does not mean that she cannot control her text and its reception by the audience all the same: she develops narrative and thematic patterns from which one can attempt to decipher her viewpoints on what is told, primarily her anti-war attitude, which is the most important theme of the novel. Even though we have little tangible material from which to extrapolate her possible in-group memberships, the attitudes of the narrator to the groups involved in the narration can be perceived by following the ways she depicts and narrates her characters. In this novel, this means following the ways the characters meet with the tribulations of war and insanity, which are strongly considered to be psycho-social in

13. For arguments about the possibility of third-person unreliability, see Cohn (2000, chapter 8) and Martens (2008).

causation. For one, Barker's narrator makes juxtapositions from which her audience can deduce her attitudes towards the characters. For example, the character of Billy Prior's father, who is depicted as a rude man with no real compassion for his son, is juxtaposed with Rivers (in an encounter with him), who is both polite to everyone and compassionate.[14] After visiting his son, the Billy's father pays an unexpected visit to Dr Rivers:

> He [Mr Prior] seemed to have no feeling for his son at all, except contempt. 'You must be proud of his being an officer?' [asks Rivers]
> 'Must I? *I*'m not proud. He should've stuck with his own. Except he can't, can he? That's what she's [the mother] done to him. He's neither fish nor fowl, and she's too bloody daft to see it. But I tell you one person who *does* see it.' He pointed to the ceiling. 'Oh, it's all very lovey-dovey on the surface but underneath he doesn't thank her for it.' He stood up. 'Anyway I'd be getting back. His nibs'll have a fit, when he knows I've seen you. Wheezing badly, isn't he?' He caught Rivers's expression. 'Oh, I see, he wasn't wheezing either? Not what you could call a successful visit.'
> 'I'm sure it's done him a lot of good. We often find they don't settle till they've seen their families.'
> Mr Prior nodded, accepting the reassurance without believing it. 'Any idea how long he'll be here?'
> 'Twelve weeks. Initially.'
> 'Hmm. He'd get a damn sight more sympathy from me if he had a bullet up his arse[…]' (*Regeneration*, p. 57.)

The first sentence in the excerpt is Rivers's focalisation (not the narrator's direct authorial statement) as the encounter is seen mostly through Rivers's focus: he observes the father's rudeness, his impoliteness, and the lack of compassion for his badly broken son. Rivers's focus is unrelentingly sympathetic to his patients, Prior included, even if Prior makes Rivers somewhat uneasy by his attitude. Rivers sees first-hand the

14. Some background information to the following excerpt: Billy Prior is an officer who comes from a lower class background. The war killed officers in such great numbers that the war leaders were forced to grant commissions to the lower classes to meet the demand. Prior's father is angry about his son's ambitions, which he sees as the influence of Billy's mother. Billy is also asthmatic; this should have disqualified him from taking part in front-line battle, but as said, officers were needed badly. Briefly before his father's visit, Billy had recovered from his mutism, but he has a sudden relapse because he must meet his father. His father's response to Billy's mutism is dismissive: 'Comes when it's convenient and goes when it isn't.' (*Regeneration*, p.55.)

suffering war causes to those who do not have the luck of having a 'Blighty wound'[15] (Duckworth 2004, p. 66) but succumb to war neurosis instead. As we will see, war neurosis is a complicated mixture of at least the following: mental vulnerability, an inability to match the impossible masculine ideals that are heightened during the war, a wish to survive physically by going mad, and socialy constructed stigmatisation. Rivers sees this mixture clearly, and acutely feels the burden his patients carry. He attempts to help them, and his point of view, conveyed to the audience through his focalisation, is altruistic: he is the archetypal 'good psychiatrist', a professional doing his best to use the assistant empowering power (Karlberg 2005) of healing. His and his patients' focalisations bring the suffering of war close to the surface of the narrative for the audience to see – and to empathise with. I argue that this is the major empathetic pattern the narrator uses to convey her messages.

4.5.3 Narrative Progressions and Third-Person Diagnostic Power

Like Plath's Esther or Kaysen, Barker's narrator brings in a Phelanian narrative progression (2005b), a cavalcade of mad people to the stage, whose task is to open up the nature of shell shock and to represent the sheer magnitude of the phenomenon.[16] In the novel, we are therefore introduced to a number of Craiglockhart residents; their diagnoses are made in diagnostic moments that are structured as dialogues, focalisations, and, though more rarely, in authorial narration. The diagnoses are mainly external, made by the characters or narrator explicitly, or only hinted at for the audience to make, but there are a few self-diagnoses as well.

During the first five pages, we are given a number of diagnostic moments that are either quotations: '("I suppose [Sassoon] is – 'shell-shocked'?" "According to the Board, yes."' or: '"And the minister will say that no disciplinary action has been taken, because Mr Sassoon is suffering from a severe mental breakdown, and therefore is not responsible for his actions."' (*Regeneration*, p. 4)) or focalisations: ('The whistle [of the train] blew. Immediately, [Sassoon] saw lines of men with grey muttering faces clambering up the ladders to face the guns. He blinked them away. […] For a moment, looking up to find that khaki-clad figure standing just inside the door,

15. A Blighty wound was a physical wound bad enough to justify being sent home, but slight enough not to cause much real trouble, e.g. the 'bullet up his arse'.
16. Showalter gives us one statistic: by 1916, 40% of casualties in the fighting zones were shell shock cases; and by the end of the war 80,000 cases of shell shock had passed through army facilities (Showalter 1985, p. 168).

he thought he was hallucinating again.' (ibid., p. 5.) Some twenty pages later, there is an example of authorial diagnostic moment:

> The typical patient, arriving at Craiglockhart, had usually been devoting considerable energy to the task of *forgetting* whatever traumatic events had precipitated his neurosis. Even if the patient recognized that the attempt was hopeless, he had usually been encouraged to persist in it by friends, relatives, even by his previous medical advisers. The horrors he'd experienced, only partially repressed even by day, returned with redoubled force to haunt the nights, giving rise to that most characteristic symptom of war neurosis: the battle nightmare. (ibid., pp. 25–26.)

Thus, one can see how the narrator employs both the more easily 'relativised' (Stanzel 1984, p. 134) focalisation through a character's focus, and the most reliable type of narration – authorial narration – to bolster her own and Dr Rivers's diagnostic moments. The focalisations bring the characters' (both the mad and those treating madness) experiences, their qualia, vividly to life, whereas the authorial narration supports Rivers's diagnoses, confirming that they are indeed correct.

The two types of diagnosis, that of the focalising character and that of the narrator, are, however, on different ontological levels. Dr Rivers's diagnoses in particular are effective in the fictional world itself; they are, inside that world, 'proper' diagnostic power moves with all the characteristics of Foucauldian power (Foucault 1982). (The other characters' diagnoses are of the lay variety, and thus lack the institutional aspects of professional psychiatric diagnosis. Nevertheless, they still have many of the Foucauldian power characteristics inside the fictional world.) Whereas the narrator's direct diagnoses serve as a narrative power move of convincing the audience of Dr Rivers's diagnostic accuracy, they lack the subjectifying (ibid., point 8) aspect in regard to the characters the narrator diagnoses. This is because the characters are on a different ontological level from the narrator, and they are thus examples of *communicative* power – *narrative* power using diagnosis as a narrative power tool – not 'proper' Foucauldian diagnostic power. Here, we have a clear juxtaposition between homodiegetic, embodied narration and heterodiegetic, disembodied narration. When the Stanzelian 'Olympian' narrator (Stanzel 1984, p. 126) in her disembodied nature has *narrative* power (which also directs the audience's reactions towards these characters by using third-person narration with its crossing of the borders of her characters' minds) she does not have 'proper' Foucauldian diagnostic power over her characters, as they are (in a non-metafictional text) completely unaware of the

narrator's existence and narrating, and thus incapable of reciprocating or resisting the power move of the narrator's diagnosis-making. Furthermore, Barker's narrator uses both reflector-mode and teller-character-mode narration in exhibiting the diagnoses made in the narrative. The focalisers are not in any narrative power relation with the narratee/authorial audience, whereas the teller-character-narrator is: she is conscious of narrating and of having an influence on the narratee.

The narrator directs the streams of narrative knowledge the audience(s) try to interpret and judge, and the implied author gives her backing to her narrative moves by not questioning them, making the multi-layered narrative communication (Phelan 2009, p. 310) and the dual interpretive effort of the narrative and authorial audience (Phelan 2005b, p. 323 & 336) work in unison. The narrator is, as said, reliable, so the relationship between her and the implied Barker is harmonious and unmarked in her directing of the ethical, aesthetic and interpretive judgements of the audience.

Barker's narrator, like the homodiegetic narrators studied thus far, accumulates dozens of diagnostic moments, which emphasises the gravity of the phenomenon of shell shock. They tie together the narrator's drive to convince her audience of the madness of war and the diagnostic moves themselves. In its own way, *Regeneration* takes part in the discussion on shell shock. During the war, shell shock was hotly debated, and Showalter reminds us of this: 'When they realised that shell shock did not have an organic cause, many military authorities refused to treat victims as disabled and maintained that they should not be given pension or honourable discharges' (Showalter 1985, p. 170). *Regeneration* shows the gravity of the victimisation through shell shock, the utter destruction of the men's minds by war. It also reminds us, the audiences of early 21st century, that shell shock was a real and vastly widespread phenomenon. Thus, this is one way for the narrator to use narrative power: by making diagnoses (though these diagnoses are not, as said above, 'full-blooded' Foucauldian power moves), or by quoting and focalising others' diagnosis-making, she supports her narrative effort to convince her audience of the depth and magnitude of the suffering caused by shell shock – and simultaneously, the insanity of war.

As stated, the narrative situations in this novel are varied. There is much focalisation and dialogue, and rare moments of authorial narration. The narration centres on the focalisations of, and discussions between, Rivers, Burns, Prior and Sassoon. (There are moments of other focalisations, such as Prior's girlfriend, Sarah, and other parties of discussions, but these moments are not as extensive.) The amount of two-person scenes often given in dialogue is vast, as is proper for a novel also depicting the psychoanalytical process, which is, after all, the 'talking cure' (Pellow 2001, p.

131). The structuring of the novel as a string of encounters between different pairs of people emphasises the confrontational nature of the narration: persons embodying different kinds of groups analyse and discuss the war and its essence. The thematic tool of grouping is thus elementally tied to the narrative technique of structuring narrative situations. Barker's narrator groups her characters into different kinds of encounters, in which they represent, I argue, both themselves and their in-groups. (Here I am reminded of Esther's fig tree and the 'figs' of female roles: like them, Barker's narrator's characters are both individuals and members of their in-groups.)

Barker's narrator, therefore, groups her characters into a great variety of in-group/out-group positions. The variety of centrally relevant groupings is far larger than in the novels discussed so far, and I regard the thematic tool of grouping as perhaps the most important tool of narrative power for Barker's narrator (as is also emphasised by Pellow (2001), who diligently maps the different encounters between some of these groupings and their analogies). Among the groupings there are: officer/rank and file; superior/subordinate; mad/sane; patient/doctor; soldier/civilian; good psychiatrist/bad psychiatrist; heterosexual/homosexual; old man/young man; war supporter/pacifist; and father (figure)/son. These groupings form the backbone of the novel, as they provide the basis for the encounters between the characters. By following them, the audience may decode the messages of the narrator (and the implied author behind her). Many of these groupings touch or are touched upon by the category of madness or its treatment: in Barker's novel, madness and its treatment are phenomena which in a way heighten the other encounters of the war society by putting them into a new light.

The encounter between Rivers and Sassoon, for example, groups them to opposite sides of a multiple divide. Rivers is older than Sassoon, a doctor, heterosexual, a war supporter, a superior officer (Rivers is a captain, Sassoon a second-lieutenant), and an apparent father figure to Sassoon, who was orphaned at young age. Sassoon, then, is a younger man, a patient, a homosexual, a pacifist, a subordinate, and a fatherless son. The question of whether Sassoon is also insane in a way intensifies many of these groupings; it is the basic question when one considers the grouping doctor/patient, but also his sexual orientation: homosexuality was considered during WWI to be a mental illness as well as a criminal offense that disqualified men from military service. Therefore, Sassoon can be seen to be 'disguised' as a sane man, with Rivers's co-operation (Rivers does not use Sassoon's homosexuality against him in their arguments – even if he could have used it as a denigrating force, or a lever to manipulate Sassoon's position as a pacifist), since he hides his homosexuality in a

society that sees it as both a form of insanity and – most of all – an offense to its masculine ideals, as something 'unbecoming to men' (Harris 1998, p. 292). The question of pacifism is not only tied to the question of homosexuality, but also affected by the essence of shell shock as insanity: Sassoon's declaration is hushed up by using shell shock as a political tool to denigrate the pacifist position as insanity and the declaration as an irresponsible deed. This can be seen to connect with the Foucauldian notion of silencing the mad (Foucault 2006, p. xxvii and p. 103–104): Sassoon is silenced by declaring him mad. The superior officer/subordinate officer grouping can also be seen to reverberate with madness in Rivers's and Sassoon's encounter. Both must realise and take into consideration their respective positions as military personnel: captain Rivers has the duty of convincing his patient, a subordinate officer, to support the war effort and do his duty as an officer in war; their curative relationship is condensed into the notion of 'curing' Sassoon's 'anti-war neurosis'. The young man/older man grouping is also heightened by the situation of war neurosis (i.e. shell shock): thousands of younger men are being slaughtered and crippled physically as well as mentally in a war led by older men. Rivers is perceptive enough to realise the injustice of this pattern:

> The bargain, Rivers thought, looking at Abraham and Isaac [in the stained glass windows of the church]. The one on which all patriarchal societies are founded. If you, who are young and strong, will obey me, who am old and weak, even to the extent of being prepared to sacrifice your life, then in the course of time you will peacefully inherit, and be able to exact the same obedience from your sons. Only we're breaking the bargain, Rivers thought. All over northern France, at this very moment, in trenches and dugouts and flooded shell-holes, the inheritors were dying, not one by one, while the old men, and women of all ages, gathered together and sang hymns. (*Regeneration*, p. 149.)

Rivers here is on the side of his patients, whom he sees as victims of a broken bargain between older men like he himself, and younger men, like Sassoon. Finally, the grouping father (figure)/son also is brought about by the psychoanalytical transference between Rivers and Sassoon: again, this grouping is put forth by the aspect of madness and its treatment.

Barker's narrator thus skilfully operates with the groupings of her characters. What is more, there is a narrative progression of some of these groupings. The central grouping of mad/sane evolves in the characters of Sassoon and Rivers: Rivers, under

the huge stress of his work load, starts to diagnose himself with the symptoms of shell shock (ibid., p. 140). Conversely, Sassoon is a 'political patient' to start with, who in the end gives in to the treatment of his 'anti-war neurosis' and joins the military way of acting (if not perfectly thinking) again. As opposed to Rivers's other cases, there is no question of really 'curing' Sassoon, but of convincing him, of *arguing* for the case of war against his pacifism. Rivers discusses Sassoon with his colleagues:

> 'No, there's no case [for letting him just be],' Rivers said. 'He's a mentally and physically healthy man. It's *his* duty to go back, and it's *my* duty to see he does.'
> 'And you've no doubts about that at all?'
> 'I don't see the problem. I'm not going to give him electric shocks, or subcutaneous injections of ether. I'm simply asking him to defend his position.' (ibid., p. 73.)

Thus, in this encounter, from the start of sending Sassoon to Rivers in the first place, madness is seen as, on the one hand, a political pawn that can be used as a tool to disparage one's opponents, revealing the essence of madness as a societal force and a possibly stigmatic phenomenon, and on the other hand, madness is seen as a psycho-scientifically perceivable illness, but it is also 'contagious' (not unlike in McGrath's Peter's tale connecting the madness of Edgar and Stella, or Innes's Jim's seeing madness as kind of contagion between Manack Sr. and Jim's mother). Rivers gets symptoms of shell shock as well, and he must take them as seriously as those of his patients.

In the end, there also is a turn of the kaleidoscope in the grouping of the doctor/patient, which is elementally tied to the opposition of sanity/madness. Rivers sees that he suffers from the same, more or less insane, problem of the British social and gender roles that he started to see as arbitrary after one of his anthropological trips to Melanesia. His patients have done to him what he couldn't do for himself: 'You see healing *does* go on, even if not in the expected direction' (ibid., p. 242). Thus, the categories of madness and sanity can be seen to shift in the narrative progression, as do the categories of patient and doctor. Together with the change in the characters, a change in the audience's reactions comes (Phelan 2005b, p. 323): the audience is convinced of the madness of war, which is the most important ethical judgement the narrative aims at by directing its streams of knowledge and its soliciting of the authorial audience.

4.5.4 Madness, Power and Masculinity in Wartime

Even though Barker's novel is a depiction of shell shock, and thus one form of insanity, it is nevertheless, primarily a novel about war. It is possible to argue that madness as a theme is a narrative device that the narrator (and the implied author) uses to heighten the theme of war and to highlight its mindlessness. The diagnostic power used by the narrator is a tool of narrative power, as the depiction of diagnostics and madness serves the end of the anti-war theme. This does not make the depiction of madness any less perceptive, though. Compared to Innes's Jim's 'behaviourist' depiction of madness, Barker's narrator uses much more space to outline the effects of being shell-shocked, thus giving a lot of experiential information about the illness. Though it can be argued that both narrators use madness as a subordinate theme to serve another narrative device or structure (in Innes's case, the device of creating suspense, in Barker's, the anti-war theme), Barker's narrator's depiction of madness is much more extensive and illuminating regarding the contents and perceptions of madness than that of Innes's Jim .

One such content in Barker's novel is the socially and societally constructed stigmatic nature of madness and its uses in the wartime military power structures. It is used not only to denigrate Sassoon's pacifism; it is inbuilt in the structures of the military hospital and the patients' position as broken cogs of a military machine. By wearing a blue badge, psychiatric patients are forced to advertise to the world that they are not 'proper' soldiers, but mad patients under treatment. This public humiliation is part of the masculine ideology of wartime England, which emphasises the notion of the need of the majority to define themselves against the marginal, like the mad (Fabrega 1991, p. 109). Taking off the badge is an offense, and when Billy Prior removes his, he is reprimanded by Rivers:

> [Rivers:] Matron says she saw you in town, and you were not wearing your hospital badge.
> [Prior:] I wasn't wearing the badge because I was looking for a girl. Which – *as you may or may not know* – is not made easier by going around with a badge stuck on your chest saying I AM A LOONY. (*Regeneration*, p. 95.)

This badge affair emphasises Foucault's notion of disciplinary power systems. Like the modern army, it does not just require a part of the subjects' time or service, it

takes hold of the subject completely (even affecting the possibility of his success in sexual relations in the excerpt above):

> It seems to me that disciplinary power can be characterized first of all by the fact that it does not involve imposing a levy on the product or on a part of time, or on this or that category of service, but that it is a total hold, or, at any rate, tends to be an exhaustive capture of the individual's body, actions, time, and behavior. It is a seizure of the body, and not of the product; it is a seizure of time in its totality, and not the time of service. (Foucault 2006b, p. 46.)

The army, especially during wartime, when its role takes centre stage in society, subjectifies its personnel in the manner Foucault highlighted in his 1982 essay (point 8). By being the object of military power, the soldier becomes a subject to someone else (the military command) by control and dependence (in everything starting from being fed by the army and ending in being supplied the ammunition for fighting – for his own life as well as for his comrades), and is tied to his own identity as a soldier by the self-knowledge of the ideals and expectations of what it means to be a soldier. When this is coupled with another total, subjectifying power structure – psychiatry – one gets a war machine that is committed to keeping fighting. This includes treating those cogs of the machine that have broken down mentally in order to send them back to the front to do their jobs again. Thus, Dr Rivers has the military as well as psychiatric *duty* to diagnose and treat mad officers and to heal them enough for them to be able to take part in the warfare again. This duty is heightened when Rivers meets Sassoon, whose case makes it impossible for Rivers to side-step the more gruesome part of his duty, namely the mindlessness of the war machine that devours the bodies and minds of thousands of young men. This is the most poignant way Barker's narrative problematises the psycho-sciences: it highlights their participation in this kind of cruel, all-engulfing war machine.

Even though an empathetic psychiatrist, the overall objective of Rivers's work is thus dictated by wartime societal power structures. The power structures direct the way he uses his diagnostic power, which affects the doctor and the patients: the war machine's subjectifying power is intertwined with the subjectifying power of psychiatry. Although Rivers sees shell shock as a purely psycho-social illness, capable of being depicted in psychoanalytical terms, and most basically madness caused by the conditions of war, he must, at last, admit that he has a double role in treating his patients: he must cure them, but cure them only enough to be sent back to the

front again, where their minds had been broken in the first place. As a good psychiatrist, he has to ask himself: what is the point in this all, what's the justification?

The madness of war is clearly visible in the madness it causes in the soldiers, and in the way society treats them after being broken down by the war. Some saw shell shock as malingering, as cowardice, and an excuse to avoid fighting (Harris 1998, p. 290). This is easily linked to Szaszian critical notion of madness being feigned in order to gain something from the surroundings; in this case it is security. The form of madness, 'male hysteria' (Showalter 1985, chapter 7) further emphasises the possibility of applying Szasz's ideas here, as his example came from hysteria being a form of language rather than a real illness (Szasz 1975). Like Szasz's hysterical women, who aimed at more or less specific gains by falling ill with hysteria, Barker's shell-shocked soldier tries to 'both [challenge] the power of command through an individualized symptom, and [evade] its disciplinary wrath' (Mukherjee 2001, p. 60). Thus, there is a gain, and a definite attempt to get a specific reaction from the surroundings of the patient, making the treatment relationship a charged Szaszian power struggle. However, Barker's Rivers sees to the bottom of the suffering of the soldiers and acknowledges it as real, not as feigned. He sees the Laingian double bind the war puts its men in (Laing & Esterson, 1990): like peacetime women, shell-shocked men are placed – partly by subjecting them to certain masculine ideals – into impossible positions: 'the neurotic soldier […] was helplessly divided between his instinct for survival and the social-moral imperatives that forced him to repeatedly risk it' (Mukherjee 2001, p. 50). They are at the same time bound by the demands of heroism and placed into states that cause prolonged extreme strain, immobility and helplessness that they cannot escape unless they die, are injured – or become mad. The masculine ideals of Edwardian Britain were culpable to a great degree for the impasse the soldiers found themselves in. Harris writes:

> One wonders why the onus of mental illness was placed on soldiers, as if their adverse reaction to brutal war experiences somehow resulted from their own inherent instabilities. Even the medical definitions of those psychological ailments emphasised the *neurotic* aspects of the illnesses as weighed against social expectations of how real men 'should' behave in the heat of battle. Social expectations, for example, are emphasised in Rivers's definition of war neuroses in his report published in *Mental Hygiene* (October 1918): '[War neuroses] depend upon a conflict between the instinct of self-preservation and certain social standards of

thought and conduct, according to which fear and its expression are regarded as reprehensible'. (Harris 1998, p. 290–291.)

Thus, the social gender role of masculinity drives the soldiers into forced bravery, and when that is impossible, into behaving 'like women': falling ill with hysteria – an illness basically feminine in essence, Showalter (2004) claims. Here, we have the woman/man grouping in action and in connection with madness: war makes men mad like women are in peacetime – even with the exactly same illness, hysteria. It is notable that Barker makes the same kind of connection between male gender roles and their impossibilities causing madness as Plath does with Esther and her feminine roles.

Showalter considers her notion of madness as always feminine, and that WWI shell shock cases prove her point by bringing into focus the 'feminisation' of shell-shocked patients. However, I am a little troubled by Showalter's feminist stance on the perception of madness. She claims that women were stigmatised by being labelled mad more often and more profoundly (as madness was considered to be a 'natural' feature for women) than men; and that madness (e.g. hysteria) was stigmatised by being labelled as a feminine sickness. I do not deny that certain forms of madness like hysteria were overwhelmingly diagnosed in and suffered by women, but her claim that, for example, schizophrenia is similarly a 'female malady' (Showalter 2004, p. 203) can be contested: DSM-5 states that the sex ratio 'differs across samples and populations' and that 'definitions allowing for the inclusion of more mood symptoms and brief presentations […] show equivalent risks for both sexes' (DSM-5 p. 102). Another point of trouble – and a larger one – is Showalter's viewpoint that gender and sex roles are always not just possible and relevant, but also *dominant* points of view. Her own study is a clear-sighted one, and she offers good bases for many of her arguments; as we have seen in Barker's and Plath's cases the issue of gender roles can truly be a relevant power issue, and their treatment represents a widening of scope. However, it can also be a narrowing of scope: Showalter leaves the male experience of madness almost completely out of the picture. Her handling of the shell shock is telling; she takes up this form of male madness only to bolster her view that it is an inversion of a gender role, a 'feminisation' of the male military patients through madness. I would say that this is a narrowing of scope, since madness cannot be termed singularly a female malady: there have always been and always will be mentally ill male people, and their experiences are as important as those of their female co-sufferers. (Another observation that also might even trouble the

feminists is that by claiming madness to be a 'female malady', Showalter seems to make an essentialist connection between the two: that females *are* somehow closer to the phenomenon of madness.)

Allen Thiher has also studied the gender issue in its connection to madness and power relations, and he argues in a similar vein to Showalter that the issue is very much in the foreground of our era, and that it cannot be ignored. He does, however, also point out that the feminist point of view may be partly misled:

> Feminist revisionists have argued this point of view with cogency, though this cogency springs from an a priori identification of femininity with insanity, or with whatever is other than reason – reason being identified with the masculine. However, I do not think that it is true that these a priori identifications reflect the complexities of historical reality, however much medicine may have contributed to the patriarchal ideology that, with reason, feminists wish to attack. Some women have experienced their madness as an intrinsic part of being woman – some but hardly all – just as some, but hardly all, doctors thought women are intrinsically insane. (Thiher 2002, p. 294.)

Showalter's study is on Barker's self-proclaimed source text (*Regeneration*, Author's Note, p. 252), and it shows in her treatment of Rivers and the notion of shell shock. Barker makes Rivers note for example: 'Any explanation of war neurosis must account for the fact that this apparently intensely masculine life of war and danger and hardship produced in men the same disorders that women suffered from in peace' (*Regeneration*, p. 222). The position of the gender roles in Barker's depiction of the causation of shell shock (and this is very clearly a statement having factual proof already in Rivers's writings, referred to by Harris (1998)) is definite. This does not, however, make madness a monolithic essence; it is neither a wholly feminine or masculine experience. The whole gamut and diversity of its realisations testify to the variation of the experience and causation of madness, not of a monolithic, purely gendered essence. This can be seen, for example, in the side-stepping of McGrath's Peter or Innes's Jim of the whole issue of gender in their version of madness depiction and causation.

4.5.5 Experientiality, Psycho-Sciences and the Essence of Madness

The issue of experientiality, of the experiential knowledge of madness and its treatment, is also elementally tied to the issue of narrative situations in *Regeneration*. Together with dialogues, the abundant focalisations of Rivers and his patients (which make up the bulk of the narration) bring the experience of the characters to the fore. The suffering of both the patients and their overworked doctor is easy to empathise with, which heightens Keen's notion that empathy for narrated negative emotions is more easily achievable than for positive emotions (Keen 2007, p. 41 and p. 71). Rivers is continuously portrayed as an empathetic, altruistic doctor on the side of his fractured soldier-patients. The narrator emphasises this portrayal by creating a juxtaposition between the 'good psychiatrist' – Rivers – and a 'bad psychiatrist' – Dr Yealland (a figure also having a real-life basis).

Dr Yealland was a representative of the 'disciplinary therapy' of curing shell shock, the other significant branch of British military psychiatry during WWI, which was in competition with Rivers's 'talking cure' (Showalter 2004, p. 176). Thus, in Barker's novel there is a depiction of a personified encounter between these branches of psycho-science. Mukherjee describes the disciplinary method: 'Disciplinary therapists sought to make the consequences of the symptom acutely painful for the patient, who was then persuaded of its detrimental nature and the absurdity of 'maintaining' it. The apparatus that tested the fixity of the symptom was usually electrical and succeeded in unremittingly asserting the demands of public duty over the defensive ruses of ignominious private survival. […] Disciplinary therapy treated the symptom as an expression of the will of the patient[…]' (Mukherjee 2001, p. 50.) Yealland's method is based on military hierarchies: he basically orders his patients to recover, or more accurately, to drop all psychosomatic symptoms. Barker depicts a scene in which Rivers joins Yealland in a session of his electrical method, during which Dr Yealland charges the tongue of the patient suffering from mutism and simultaneously orders him to speak. (*Regeneration*, pp. 229–234.) Even though Yealland uses biological-sounding methods, he is not a brain psychiatrist. His method is strictly disciplinary; he sees the patient-soldiers as degenerates who should pull themselves together and stop indulging in madness. It is significant that Rivers treats the officers, whereas Yealland treats the rank and file – the grouping officer/rank and file is active in the narrator's portrayal of Rivers's and Yealland's methods, and heightens WWI British societal hierarchies. Whereas Rivers invites Sassoon, his patient, to join his own Conservative Club in order to give him the opportunity of spending time in

a more pleasant surroundings than the officers' hospital (which itself offers, e.g. excellent opportunities to play golf) and where they can talk in private, Yealland's motto in curing his mutist regular soldier patient is: 'You must speak, but I shall not listen to anything you have to say' (ibid., p. 231) and his method is, as stated, to *order* the recovery. Dr Yealland's method is like an exaggeration of the Foucauldian notion of psychiatric relationship being battle of wills between the patient and the psychiatrist. There is nothing specifically medical in Dr Yealland's method, it is simple coercion (Foucault 2006b, pp. 10–11). It also illustrates the Szaszian claim that (this kind of) psychiatry is torture (Szasz 1975, p. 12).

Rivers comes to realise at the end of the novel, while analysing one of his dreams (depicting Rivers painfully applying a horse's bit to a patient's mouth in a similar setting as Yealland's electrical laboratory), that his and Yealland's objectives are terrifyingly similar:

> Just as Yealland silenced the unconscious protest of *his* patients by removing the paralysis, the deafness, the blindness, the muteness that stood between them and the war, so, in an infinitely more gentle way, *he* [Rivers] silenced *his* patients; for the stammerings, the nightmares, the tremors, the memory lapses, of officers were just as much unwitting protest as the grosser maladies of the men. (*Regeneration*, p. 238.)

Even though he moves on in his analysis from this 'general accusation' to the 'concrete, specific' – that the silenced patient is specifically Sassoon, whose protest he had stifled by curing his 'anti-war complex' – I argue that both the general accusation and the specific one point to Rivers operating in an analogical manner to Yealland in the military psychiatric machine they are both parts of.

As psychiatrists, one can also compare Rivers to Plath's Dr Nolan and McGrath's Peter. Like Dr Nolan, Rivers is capable of really helping his patients by listening to them. What is more, he supports them in extensive ways (e.g. he keeps in contact with many of them even after the hospital treatment has terminated, or goes to see them during his leave). Furthermore, like Dr Nolan, Rivers is a parent figure to his patients, as is proper for a transference-based psychoanalytical treatment. When compared to McGrath's Peter, Dr Rivers is far more capable of putting the phenomenon of madness into larger social frames, whereas Peter kept the depiction of Stella's and Edgar's madness in the closed circle of nearest family, colleagues, and friends. As a general view, Plath, Kaysen, and Barker on the one hand and

McGrath and Innes on the other can be juxtaposed in their relationship towards the societal causation and description of madness: the first three see madness as a larger, societal issue, the latter two keep the depiction to smaller human circles. This is also, rather naturally, reflected in the amount of mad characters depicted by the narrators: Plath, Kaysen and Barker show us a variety of mad characters in relation to their surroundings, whereas Innes and McGrath have only the two mad persons and their closest community. Barker, like Kaysen, places madness into a societal – and psychiatric-scientific – pattern, which emphasises the Foucauldian notion that madness is constituted by different social and scientific actors (Kusch 1993, p. 161).

Rivers's branch of psychoanalysis is not strictly Freudian: he has 'purged' it of its overt sexual themes, and specifically applies the simple method of recall to cure war neuroses caused by traumatic, repressed memories of war experiences:

> Rivers's treatment sometimes consisted simply of encouraging the patient to abandon his hopeless attempt to forget, and advising him instead to spend some part of every day remembering. Not brooding on the experience, nor trying to pretend it never happened. Usually, within a week or two of the patient's starting this treatment, the nightmares began to be less frequent and less terrifying. (*Regeneration*, p. 26.)

Rivers's purging of the psychoanalytical method of its sexual theoretical basis reminds us of the fact that 'psychoanalysis' is a notion that serves as an umbrella for a multifarious variety of theories and methods. Freud himself, in an essay in which he develops the notion of death instinct in connection to his speculations on war neurosis, connects war neurosis with his sexual libido theory. For example, a shell-shocked patient's battle dreams are manifestations of the repetition compulsion which is a manifestation of the death instinct that is in contradiction with the sexual instincts. (Freud 1993b, p. 88 and p. 99.) In the novel, however much Rivers de-emphasises the sexual undertones of psychoanalysis, the psychoanalytical method meets opposition from the part of Rivers's patient, Billy Prior, who has some kind of knowledge of Freudian theories. Prior protests the analyst's silence and lack of reciprocity in the analytical talking relationship by saying to Rivers: 'Well, all I can say is I'd rather talk to a real person than a strip of empathetic wallpaper.' (*Regeneration*, p. 51.) Another patient, Anderson, objects to the Freudian sexually driven theory, while he is interpreting one of his dreams (featuring snakes and corsets) at Rivers's request: 'That's what you Freudian Johnnies are on about all the time, isn't

it? Nudity, snakes, *corsets*. You might at least try to look *grateful*, Rivers. It's [the dream and Anderson's telling it to Rivers] a gift.' (ibid., p. 29.) Thus, the narrator lets the audience have a glimpse of criticism of Rivers's method (as supposed – partly incorrectly – by his patients), but when one juxtaposes this method with Yealland's, one cannot escape the gravity of the comparison. It is clear whose side the narrator – and the implied author with her – is on when one weighs up the human suffering caused by Yealland's 'treatment'. Rivers's method, even though far gentler, is effective: his patients, for example Willard, may recover considerably. Yealland also boasts of recoveries – and fast ones – as he usually produces a 'cure' in a single session of his electrical therapy. However, when 'Rivers asked [Yealland] questions about the relapse rate, the suicide rate, [he] received the expected reply. Nobody knew.' (ibid., p. 224.) Indeed, Rivers sees many patients with 'signs of depression' (ibid., p. 224) on Yealland's post-treatment ward – the ward for patients whose physical symptoms were 'cured' and who were waiting to be sent back to the front. Thus, one can again point to how Barker's narrator uses juxtapositions to emphasise her directing of the audience's empathies and interpretations.

Even though the novel's characters and narrator emphatically leave psycho-scientific jargon to one side, the novel is a weighty recommendation of the psychoanalytical cure over the disciplinary one. This choice not to use theoretical terms may be seen as the wish of both the narrator and Rivers to keep the tone informal. All in all, the portrayal of psychoanalytical method, as applied by Rivers, is seen in a positive light.

What does my Foucauldian-Phelanian model of narrative and diagnostic power bring forth from the narration of Barker's narrator? My model underlines the power patterns, the Foucauldian intertwinings of military and psychiatric powers in the novel, and the narrator's use of narrative power in order to direct the audience's empathetic and interpretative efforts in revealing and relating to the military-psychiatric power patterns depicted. The narrative power aims to relay the anti-war message in a pronounced way through experiential means. This is done by showing the audience what the numerous encounters between different groups' representatives feel like, what it feels like to be a patient, or a doctor, for example, in a wartime relationship of diagnosis and cure.

What is madness, then, in Barker's novel? Shell shock is for her narrator – and for the implied author, I argue – a phenomenon of wartime society. It is purely psycho-socially caused by the war and is elementally intertwined with its military values and hierarchies in its causation, symptoms, and societal repercussions. The psycho-sciences are seen through this lens as well: they are committed to the war

effort, to fix broken soldiers, which is the objective of doctors like Yealland and Rivers. They use their diagnostic and treating power for this end with their respectively different methods. That a war supporter, like Rivers, starts to see things more pacifistically in the narrative progression, only emphasises the narrator's and implied author's message that war is madness. The narrator uses all the narrative power devices – narrative situations, narrative progressions, the depiction of experientiality, groupings – to convey the message that war is madness, that shell shock is caused by the madness of warfare, and as a phenomenon, it brings forth this message acutely.

4.6 Marge Piercy's Woman on the Edge of Time: The Madness of a Focaliser

Marge Piercy (born 1936) is an American poet and novelist. She is author of seventeen volumes of poems, among them *The Moon is Always Female* (1980, considered a feminist classic), and *The Art of Blessing the Day* (1999). She has also published fifteen novels, one play (*The Last White Class,* co-authored with her third and current husband Ira Wood), one collection of essays (*Parti-colored Blocks for a Quilt*), one non-fiction book, and one memoir. Her work often focuses on feminist and social concerns.

Marge Piercy's novel *Woman on the Edge of Time* (1976) is appraised as a 'contemporary classic' (Booker 1994, p. 337; Afnan 1996, p. 332) of feminist science fiction, and it has been studied from different angles, most importantly from the standpoint of its feminism and the building of utopian and dystopian future worlds (e.g. Booker 1994; Levine 2009; Fancourt 2002; Afnan 1996; Maciunas 1992). My own, slightly differing viewpoint to this work comes from the perception of seeing it, like all of my target texts, from the focus of it being a madness narrative and a depiction of madness and psycho-sciences.

Piercy's novel gives me the opportunity to analyse a heterodiegetic text that has only one focaliser. The novel depicts internal and external diagnosis, and takes a strong view on the psycho-sciences, especially biological psychiatry. Therefore, it will help me to deepen my study of the use of narrative and diagnostic powers, and the depiction of madness and the psycho-sciences.

As a feminist, Piercy highlights messages that we have already encountered in the above analyses of Kaysen's, Barker's and Plath's works: madness and gender, especially

in womanhood, are interlinked in specific ways; madness is a societal issue, as is the position of women, and madness or being declared mad is connected to gender issues through causal chains. However, Piercy provides an even more forceful lesson: in her work, the protagonist is not a disoriented but well-to-do, white, middle-class young woman having troubles with choosing a fitting career (as one might caricature Plath, or to some degree, Kaysen), instead, Connie, the protagonist of Piercy's novel, is marginalised in multiple ways: she is a member of the 'wrong' class (she is very poor); 'wrong' race (she is a Chicana woman); 'wrong' gender (she is a woman in a man's world); and she fights an outright war against American society and its brutal social oppression – and the casualties of this war have the real possibility of ending up as corpses.

The question of madness and its role in this pattern is my central emphasis: how is madness perceived against this kind of background? What kind of a picture does Piercy's narrator paint of the psycho-sciences? These questions cannot be severed from the societal themes of the novel, or from the utopian and dystopian worlds the work builds. The theme of madness, I argue, clarifies and heightens these societal themes. Even though madness has not always been an emphasis in the analyses of Piercy's novel, in my opinion, it can help to see the meanings of the other central themes. Of course, from the point of view of this study, the theme of madness is central as well, and thus worthy of an independent analysis.

4.6.1 Plot Summary

The novel starts as the protagonist, 37–year-old Connie, a multiply marginalised Chicana woman, is forcibly confined to a mental institution after attacking Geraldo, Dolly's (Connie's niece's) pimp, who threatened to coerce Dolly into an abortion carried out by an illegal doctor. The reason for Connie's confinement is her 'irrational violence' (the pimp claims that Connie attacked him without any provocation. He also claims that she hit Dolly as well, even though it was he who hit Dolly). Connie has been in a mental institution once before, after the death of her black, blind pickpocket boyfriend, Claud. While grieving over him, she drank heavily, used drugs, and, finally, hit her small daughter, Angelina, breaking some of her bones. This is the first 'irrational act of violence' that tainted Connie as a madwoman in the eyes of society. Angelina was duly taken from Connie, an 'abusive' mother, and was permanently adopted by an Anglo family. Thus, after Claud's death, Connie lost

both her lover and her daughter, and when she was hospitalised, she came in eagerly, seeking help and a cure. However, the state hospital, Rockover, is very different from Plath's and Kaysen's expensive McLean, or even McGrath's Peter's forensic hospital. Connie's hospital is for poor people, a place where one must be afraid, not only of the other patients, but also, or especially, of the staff. No one gets genuinely cured or helped at Rockover; a 'cure' means only submitting to the subjugated roles of poor people some of the patients, like Connie, would like to rebel against. If one rebels against the system, the patient is only further tainted as a mad person, who 'resists treatment'. The encounters between the staff and the patients are driven by mutual resentment and fear, and psycho-medication and seclusion are heavily used to curb the 'wrong' kind of behaviour. The notion of the empowering use of power is unknown at Connie's hospital; it knows only the brutal institutional use of power against the patients that begins from the staff having the right to refuse the most simple demands of the patients (toilet paper for example) and ends in the most final deprivation of freedom (by seclusion, forced ECT treatment or the administering of heavy tranquillizers). This is the place Connie must return to, against her will and without knowledge of when or how she will get out again.

Already before her second hospitalisation, Connie has begun to experience something unusual: a person named Luciente, who claims to come from the town of Mattapoisett in the year 2137, has entered her dreams. Eventually, Connie meets this person in the street and at her own home as well. Luciente is actually present, in another room, when Dolly comes to seek safety from her pimp's attack. In the hospital, Connie starts to have more and more contact with Luciente, to visit her future world, and to learn about Luciente's utopian society, which does not have sexism, racism, or poverty. The issue of mothering, for example, is like everything else divested of the biological gender issues: babies are produced in tanks and are mothered by three people, who may be men or women, both genders being able to breast feed the baby. The notion of private property is almost extinct, and the population of Mattapoisett is completely mixed-raced. These circumstances mean that the society of Mattapoisett is not obsessed with the inequalities of our own time. Little by little, Connie becomes fascinated by this utopian future society, which heightens the sense of her own time's oppression. This oppression reaches its peak when Connie (with the agreement of her brother) is used as a guinea pig in a psychosurgical experiment. The patients' brains are implanted with an electrical device which 'switches off' their anger whenever they feel it, and thus 'cures' them of their 'irrational violence' (in the eyes of the society). Of course, this also gives

society the means to control their emotions and actions. Through her access to the future world, Connie slowly learns that the utopian future will not take place without her participation in the effort to make it happen. Thus, after one unsuccessful attempt at escape, she chooses to wage her own outright war on the society and the psychiatrists serving its needs; she poisons the psychiatric personnel responsible for the surgical experiment. The novel ends with excerpts of Connie's patient records, which briefly follow her course back to Rockover: she becomes an institutionalised chronic mental patient.

4.6.2 Is Connie Mad?

My central questions are: Is Connie mad? If she is, how is she mad? How are the (clinical) psycho-sciences represented in the context of Connie's madness? How does Piercy's narrator build, through her narrative use of power, the picture of Connie and her mental status – also in relation to the dimensions of the novel's societal and utopian themes?

There has been discussion whether Connie is mad because of her encounters with Luciente and her future world (Fancourt 2002, p. 111, fn. 9; Booker 1994, p. 341; Seabury 2001, p. 133). In her analysis of the altered states of consciousness offering access to utopia in her three target feminist novels, Fancourt brushes the question of Connie's madness aside by saying that she prefers to 'leave the boundaries between sanity and madness blurred', because the case is inconclusive. In an interview, Piercy stated that Connie's encounter with Luciente is neither a hallucination nor real, but something in between (Fancourt 2002). Cramer also states that 'whether this future time and place are supposed to be fictionally real or are hallucinations in Connie's mind, does not matter' (1986, p. 230). However, I would like to engage with the question of Connie's madness – and also her assumed 'irrational violence' – because I see it has an importance of its own: it heightens, clarifies, and underlines the perception of the novel's central themes, plus is an independent thematic thread as well. Thus, again, the diagnostic content the 'what' of her madness is elementally tied to the rhetorical purpose of narrating (Phelan 2005b, p. 323) – the 'why' of her madness.

One of the central themes – Connie's position as a multiply oppressed individual: a woman, a Chicana, and a poor person – is escalated in her becoming a forcibly treated mental patient. The surgical experiment divesting her of the last remnants

of freedom to even feel her own emotions is possible only on mental patients in a mental institution. Their consent is not needed for the experiment to be carried out; it is only cosmetic, seen as the patient's will to be 'cured'. In fact, the doctors, after using 5000 chimpanzees, started their experiment with prisoners – but this caused too much commotion in society (*Woman on the Edge of Time* (*WET*) pp. 220–221), so they took up violent mental patients instead, since no one rises to their defence. Thus, the status of madness is the final seal of Connie's marginalisation and subjugation. This is a blatant example of Foucauldian subjectifying power (Foucault 1982, point 8): it locks her into an almost totally helpless position vis-à-vis society, which has, through the surgical implantation, direct access to her brain states, behaviour and emotions. These it attempts to direct towards the course most appropriate from the society's viewpoint. The psychiatric experiment is thus the peak point of the clash between Connie and her environment, which at the same time tells about psychiatry's role as a societal power actor. I will return to the issue of psychiatric power, for now it suffices to say that in Piercy's narrator's world, psychiatry is far from neutral in its societal ramifications.

The question of Connie's madness is placed elementally through the use of narrative power: the narrator uses the depiction of experientiality, the progression of diagnostic moments, instances of grouping and socially formed stigmatisation, and the narrative situations as her messages to the audience of Connie's state of mind in relation to the diagnoses made about her (especially in the patient record excerpts at end of the novel).

4.6.3 Diagnostic Moments and the Aspects of Diagnosis-Making

In contrast to the works discussed above, the diagnostic moments in Connie's tale point perhaps even more emphatically to the problematisation of the psycho-sciences and diagnosis-making.

The dozens of diagnostic moments of Connie's tale can be divided roughly into four groups: 1) diagnoses made by psychiatrists that tend to trap their target ('You don't want to hurt someone close to you again, do you, Connie? You have a recurrent disease, like someone who has a recurrent malaria' (*WET*, pp. 372–372)); 2) lay diagnoses and also self-diagnoses that can be seen as, or almost as, insults and that can be crystallised in the interpretation that the mad person cannot/does not have to be trusted; that she cannot/does not have to be understood ([Lewis of his

sister, Connie:] ’Keep an eye on her. She’s crazy as a bedbug[…]’ (ibid., p. 360); ’Skip shook his head. ‘“They did a kind of operation. They stuck needles in her brain.” “Are you kidding?” [asks Connie] Maybe Skip was crazy.’ (ibid., p. 193.)); 3) diagnoses of the patients on Connie’s ward that are made on the basis of their behaviour seen through the focalisation of Connie (‘For months Mrs Martinez had not spoken.’ (ibid., p. 82)); and 4) the diagnoses made in the utopian future that are seen as opportunities to grow rather than as being socially stigmatic (‘The second time I was mad, Diana helped me. […]’ [Jackrabbit says.] ‘Do you tell everyone you meet that you’ve been mad twice?’ [asks Connie…] ‘Why not? Why keep that from you any more than studying with Marika?’ (ibid., p. 124)). None of the diagnoses are made by the authorial narrator, thus juxtaposing with Barker’s narrator above. In Piercy’s novel, all the diagnoses function at the level of the characters, and they are therefore, within the fictional world, ‘full-blooded’ Foucauldian power moves (Foucault 1982).

In this way, a partly different pattern is built than in Plath’s, Kaysen’s, McGrath’s or Barker’s novels; the Phelanian narrative progression (2005b) of diagnostic moments was also related to the patients’ more or less rightful psychiatric perception in those works: they each placed the patient under psychiatric diagnosis and asked questions about the justification of psychiatric diagnosis and/or use of diagnostic power. In Piercy’s novel, on the other hand, the question of whether Connie is mad at all, is, I argue, in all its complexity even more heightened than in Kaysen’s or Plath’s works, which also posed the question of the justification of psychiatric categorisation in relation to Esther and Kaysen herself. In Plath’s and Kaysen’s works, ‘madness’ is a notion or a factor that explains a person’s mental state and social status in society, and that relates to the societal issues of the position of women. However, in *The Bell Jar* especially, ‘madness’ is a deeply felt inner state of the patient; Esther sees herself as incurably mad; she suffers from extreme, life-limiting and even -threatening symptoms, which the established psycho-sceinces have also emphasised in their definitions of mental illness (therefore, in this framework, the established psychiatry was not completely seen as dubious). Kaysen questioned the justification and bases of her DSM diagnosis of borderline personality disorder, and the rationality and contents of the (psychoanalytical and biological) treatment, but Piercy takes the escalation of this theme to the extreme: she shows what kind of use of power (biological) psychiatry can have when it is practiced on the poorest and most marginalised patients against their will.

In *Woman on the Edge of Time*, it is defensible in the light of the diversity of diagnostic moments to maintain that Connie is not mad in any 'real' meaning of the word, which makes the way Connie is treated completely unjustified. Booker writes accordingly: '[S]he is wrongly diagnosed as a violent paranoid schizophrenic' (Booker 1994, p. 339). Fancourt argues similarly: 'Piercy disrupts constructed notions of sanity and insanity, arguing that madness is a gendered construct in patriarchal society, exploited by those in power and used as a means of oppression' (Fancourt 2002, p. 105). Like Kaysen, Connie makes a counter-diagnosis of herself: 'I don't think there's a thing wrong with me' (*WET*, p. 65), and this counter-diagnosis is thus placed against those diagnoses made by the psychiatrists to justify treating her against her will. The narrative power used by Piercy's narrator, by opening up Connie's experience, makes it clear that the diagnostic moments which taint Connie are false. Thus, the narrative and diagnostic powers of this novel intertwine in a somewhat different manner than in the narratives analysed thus far. Connie's lay internal counter-diagnosis is thus forcefully positioned to oppose the professional external diagnoses of her – even if it lacks the professional institutional backing of a psychiatric, professional diagnosis (Foucault 1982, points 12 and 14).

The theme of going against the patients' will is one of Piercy's narrator's strongest in the representations of madness and the psycho-sciences. The forces of psychiatric diagnosis (related to the lay, insult-like diagnoses in their power contents) that trap the target in a position of helpless and their (very Foucauldian (Foucault 1982)) subjectification of the patients as dependent, irresponsible, untrustworthy, mute objects of psychiatric and social definitions are emphasised as the patients have no effective ways of resisting. Of course, they can respond with outright violence, but even this recourse is doomed since the patients are less powerful than their opponents (Connie must also receive the revenge of the system after the poisoning incident: she is made a chronic mental patient for the rest of her life).

In Connie's tale, however, there is also the notion of 'real' madness: she sees madness in her co-patients, for example: 'Oh, Sybil [Connie's closest friend on the ward] was crazy, but Connie had no trouble talking to her' (*WET*, p. 84) or 'Captain Cream was a light-skinned numbers runner born in Trinidad, who believed he was a comic book hero' (ibid., p. 259). The narrator makes it clear though that even this 'real' madness does not justify the treatment of Connie and her co-patients: each patient, like Skip, after the surgical operation of implantation, 'would return to them [the other patients on the ward] violated' (ibid., p. 259). The interpretation that their surgical treatment (and the whole notion of mental illness in Connie's society)

is simply misguided and wrong is further supported by Luciente's world's way of seeing madness (in their diagnostic moments) in a rather late-Laingian manner – as a possibility of mental growth rather than as a stigmatic phenomenon (Laing 1967; Fancourt 2002, p. 100). Thus, we are given a rich picture of what madness can be, what the meaning of the word may be, and what it should not mean to those subjected to it and those doing the subjecting.

By seeing Connie's status and the way it is perceived psychiatrically in a Foucauldian manner, one can argue that in *Woman on the Edge of Time*, there is a heavy relation between soci(et)al control and psychiatry: what the psychiatric establishment defines as the meaning of the word 'mad' is not true mental aberration (i.e. some kind of clear, universalisable psychological dysfunction and causing suffering in the patient) but what the societal establishment sees as a threat to itself: the social undercurrents of crime, poverty, racial and gender friction. Some of these already function in Foucault's depiction of the classical, undifferentiated conglomerate '*unreason*' which Foucault argues preceded the modern notion of mental illness and left its imprint in this modern notion of madness as well. (Foucault 2006, p. 82.) Connie is called mad because she is a social misfit. That she is dealt with as a mental patient means that the establishment does not have to take into consideration her socially inferior position. By defining Connie's resistance to society as the resistance of a violent mad person to being treated (remember the Foucauldian battle between psychiatric *pouvoir* and its objects (Foucault 2006b)), society moves the problem of how to deal with Connie's demands into a whole new context; it washes its hands of her penury. One is also reminded of Salo's notion of the moral aspect of treatment given against the patient's will: this type of treatment is for those who break the social rules and roles (Salo 1996, p. 80). Connie does break these rules: even though as a woman she is supposed to be docile and obedient towards men, she hits Geraldo. That the society labels her a madwoman because of this can be seen to tie in to Foucault's conception of morality haunting madness (Foucault 2006, p. 159): Connie's deed can be deemed immoral from the point of view of the patriarchal society which demands her obedience; labelling her a madwoman is thus the society's way of punishing her unfeminine disobedience.

It is telling that the psychiatric establishment (and thus society) uses brain operations to bring violent patients under control: in the Foucauldian perception, the control of bodies makes it possible to control the mind as well – at least to a degree (cf. Foucault 2006b, p. 46.) The body of the patient is palpable and concrete, psychiatry seizes the possibility of controlling the person by controlling her brain

functions. It also means that it does not have to deal with the subjective reality of the patient: if the perception of her 'illness' were psychological, they would have to take into consideration her experience, her way of being in the world, but when they see her status only as biological and bodily, they can shut her experience out. As Horwitz pointed out, brain psychiatry separates madness from the social context and personality of the patient (Horwitz 2003, pp. 57–58). On the other hand, this pattern of relationships is more of the order of Foucauldian *violence*, not genuine power relations (between free subjects): the establishment sees only the body of Connie and the other patients. It does not see them as human beings with the option of surrendering or resisting, thus they are subjected to outright violence. (Kusch 1993, p. 103.)

I also see in Connie's psychiatric diagnoses a rather gruesome example of how the Laingian common consent definition of madness can be used, in a very contrary way to anti-psychiatry, as a tool of control and hegemony over the mad rather than as a tool of making the definition of madness more healthily justified. Laing formulated his definition of psychosis thus (Connie too is defined as a schizophrenic by the psychiatrists in the final excerpts of the novel):

> I suggest, therefore, that sanity or psychosis is tested by degree of conjunction or disjunction between two persons where the one is sane by common consent. The critical test of whether or not a patient is psychotic is a lack of congruity, an incongruity, a clash, between him and me. (Laing 1990, p. 36.)

Connie's doctors use the leverage of this definition: they define themselves as sane and thus define themselves as having the right to diagnose Connie as 'insane' in her violent incongruence. Connie's case is thus a clear example of how the Laingian definition can go badly wrong as the reader is led to see the possibility of Connie not being mad at all. Her own counter-diagnosis is strengthened by the reader's access to the world of Luciente, in which Connie would even be considered an admired 'catcher' (a person capable of time travelling) rather than a second-class citizen because of her madness. Luciente tells Connie that many of their time-travelling guests from the past are mental patients (*WET*, p. 196).

Thus, the picture painted from the diagnostic moments of Connie's tale is a rich one, and it has antagonistic forces. The effect is such that the audience must face the difficulty of psychiatric diagnosis per se, something that is further strengthened by the narrator's use of narrative situations and the theme of experientiality.

4.6.4 Narrative Situations and Experientiality

In Piercy's narrator's tale, the technique of narrative situations and the thematic tool of experientiality are intimately related: save for short segments of authorial narration and dialogue, the narrator keeps the narration almost exclusively in the focus of Connie's focalisation. Thus, one also gets clear access to Connie's qualia and experience, and also through her dialogues with other people. The audience gets a completely different picture of her and her mental status from this direct access (remember the Stanzelian appearance of immediacy in reflector-mode narration; Stanzel 1984) than the one given to her by the psychiatric establishment: her 'irrational acts of violence' are far from irrational, when seen from Connie's perspective. There is thus a definite clash between Connie's own perception of her status and that of the psychiatrists as scientists (as Maciunas writes: 'Piercy shows a parallel between violent crimes against women and the practices of science-as-usual' (Maciunas 1992, p. 254)). She bitterly regrets hitting Angelina, the first and catastrophic act of violence caused by Connie's depression and heavy drinking and drug use, but the narrator notes (through Connie's focus) that act of violence, though unacceptable, was not *unexplainable* (as in the case of it being 'true' *irrational* violence):

> 'They were wrong to take my daughter!' [Connie] saw Miss Ferguson [a social worker] frown. 'Imagine – your daughter. I hurt her once. That was a terrible thing to do, I know it. But to punish me for it the rest of my life!'
>
> The social worker was giving her that human-to-cockroach look. Most people hit kids. But if you were on welfare and probation and the whole social-pigeonholing establishment had the right to trek regularly through your kitchen looking in the closets and under the bed, counting the bedbugs and your shoes, you had better not hit your kid once. The abused and neglected child, they had called Angelina officially. She had been mean to Angie, she had spent those months after she got the news about Claud's death gulping downs, drinking bad red wine. A couple of times she had shot speed. She had thought nothing could hurt her anymore – until she lost Angelina. Maybe you always have more to lose until, like Claud, they took your life too. (*WET*, p. 26.)

Thus, the audience can hardly see the act of violence as irrational, humanly unexplainable in other terms than insanity: the fundamental perception of madness-as-irrationality (Sass 1998, p. 2), but it is deeply chained to the causations of

poverty and misfortune. Connie regrets her act sincerely, which further emphasises the notion of her being not irresponsible and mad, but deeply responsible for her wrong deed – and accepting that responsibility.

The second act of violence for which Connie is made to pay dearly is her attack on Geraldo, Dolly's pimp. This act of violence, when seen from Connie's focus, is even less irrational: it was simply self-defence and the defence of Dolly and her unborn child. The fact that Geraldo is capable of making it seem irrational is testimony of value placed on Connie's patient record: as she has been a mental patient before, and has a record of irrational violence, it is easy for Geraldo to add to those charges and claim that Connie's attacking of him and Dolly (which she never did) is a relapse into her old madness.

Finally, Connie's 'resistance' to treatment, which the psychiatric establishment also sees through the lens of irrationality as a sign of her madness, is hardly irrational from Connie's point of view. She resists treatment because it is far from a cure, it is rather a powerful device of (Foucauldian) subjectification to the society's will to keep her in her soci(et)al pigeon hole. Thus, one can see how Connie is being made a madwoman, not so much by the altering of her psyche, but by making her position that of a madwoman: she is a subordinate, muted, subjectified – a person who is not and cannot be 'a master of herself' (Jaspers 1997, p. 789). Her own self-knowledge is subjugated by the same move (Kusch 1993, p. 129) that makes her madness a soci(et)al fact, as constructed by societal actors (ibid., p. 161) such as psychiatrists, social workers, parole officers, etc. The psychiatric knowledge that defines Connie as mad is forcefully connected to social power (ibid., pp. 170–171).

Through the lens of Connie's experience the audience can clearly see that Connie's forcible treatment as a 'violent' patient is an injustice that offers a juxtaposition to her societal portrait. The narrator makes this juxtaposition clear; her control of the narrative knowledge streams (with the backing of the implied author who does not create questioning gaps or incongruities in the narrator's narrative, making the multi-layered communication work in unison (Phelan 2009, p. 310)) heightens Connie's point of view. This is also emphasised in the future utopian connection; Jackrabbit, one of the future inhabitants, says to Connie: 'We'd be stupid not to sense you're confined wrongly. That you hurt and sadden there and no one seems to want to help you heal. That you've fed drugs that wound your body. Enjoy us. Don't fade from old pain and return to present pain. Guest here awhile.' (*WET*, p. 127.)

Is Connie mad, then? She is in the eyes of society. In the eyes of Connie herself, and of the people of Luciente's time, she is not. Connie's experientiality and the

narrative power used by the narrator in underlining this experientiality are used to override the psychiatric, diagnostic power wielded by the authorities over Connie. The narratee, narrative and authorial audiences are given, by the narrator's directing of the knowledge needed for the audiences' interpretations, a sound testimony for Connie's sanity – pointing towards the ethical judgement that she is *not* mad but oppressed. Whereas madness in Plath's, Kaysen's, McGrath's, Innes's and Barker's novels was also a true state of psychological abnormality, Connie's 'madness' can be seen as a pure societal category: the 'irrational violence' for which she is being confined and treated is completely in the eye of society. The irrationality aspect is dependent on the person looking, and the way one is being looked at. The authorities see in Connie only an object that does not need to be listened to: 'It was as if she spoke another language, that language Claud's buddy had been learning that nobody else knew: Yoruba. They acted as if they couldn't hear you. If you complained, they took it as a sign of sickness. "The authority of the physician is undermined if the patient presumes to make a diagnostic statement." She had heard a doctor say that to a resident, teaching him not to listen to patients.' (ibid., p. 19.) This, of course, is a blatant example of the famous Foucauldian 'silencing of the mad' (Foucault 2006, p. xxviii, pp. 103–104). It reminds us also of the way the position of madness is seen as elementally inferior and incorrect according to some universal standard (Sass 1998, p. 2), thus adding to the Foucauldian subjugated position of the madwoman forced on Connie.

The question of whether Luciente is a psychotic hallucination or not is irrelevant in this connection: Connie does not tell anyone about Luciente or her time-travelling. She is not being treated in the hospital because of her contact with the future, but because of her 'paranoid schizophrenia' (*WET*, p. 379) – so the official, psychiatric diagnosis of her does not touch upon Luciente or her ontological status. However, the fact that Connie is depicted as a psychiatric patient creates an 'alert mode' of interpretation, which also includes the authorial audience: the reader. The reader must look for reasons for Connie's confinement: Is she really mad? What would justify her being treated as a patient? The contact with Luciente is then obviously relevant in the reader's quest for reasons in this debate: Is Luciente 'real'? What kind of genre we are dealing with – science fiction or realism? (For a handling of Piercy's novel's genres, see Booker 1994.) My own position in this debate on Luciente's and her world's ontological status is that we are dealing with science fiction; time travel is 'real' (meaning not breeching the category of 'sanity'), and Connie truly is a 'catcher', and thus not mad in this regard.

I ground this interpretation on one small detail, which may seem minor, but is strategically important: at the beginning of the novel, when Dolly flees Geraldo to Connie's place, she sits on the same chair as Luciente had sat on a moment before and says: 'The chair is warm' (ibid., p. 9). Later, Dolly also claims to have heard someone (Luciente?) talking with Connie right before Connie opened the door to Dolly. So, I argue that Luciente is 'real', since her body's warmth and her voice can be detected by others besides Connie.

On the other hand, the fact that Connie is the only character-focaliser makes her focalisations vulnerable to the (Stanzelian) perception that her point of view can be more easily relativised than that of the authorial narrator (Stanzel 1984, p. 134). The fact that Connie is also a psychiatric patient makes her even more vulnerable to the relativisation of her viewpoint: these two relativities may join in the audience's eyes and make her see Connie as mad even when she, in her own opinion, is not. (Again, we are reminded of the fact that the psychiatric patient's own sense of illness is not needed for a psychiatric illness to be diagnosed (Lönnqvist 1999, p. 30).) As Booker notes: 'Piercy runs the risk of subtly reinforcing the ideology of rationalism [supported by her choice of narrating through the 'transparent' and 'rational' realist mode] that makes it possible safely to contain [Connie's] potentially subversive energies simply by declaring her mad.' (Booker 1994, p. 340). This viewpoint is partly supported by Connie herself: she too starts from the interpretation that Luciente is a hallucination, a symptom of genuine madness: 'Either I saw [Luciente] or I didn't and I'm crazy for real this time, she thought' (*WET*, p. 9). Only slowly does she come to the conclusion that Luciente is real, but the reader must choose whether or not to believe in the reality of Luciente's world.

But what would it mean if Mattapoisett, Luciente's utopian village, were a psychotic hallucination – seen from the focus of madness? It could represent either the romanticisation of madness – that madness creates something very fascinating, admirable (for is not a powerful utopia just that: fascinating and admirable?) – or it could mean that it is only delirium. I argue that the effect of Mattapoisett being a hallucination could not be neutral: madness is a loaded phenomenon. Part of Piercy's narrator's message to the audience is surely that we should reconsider our understanding and approach to madness; this is one reason why the narrator juxtaposes Luciente's world with Connie's. However, we cannot completely detach ourselves from our own world's notions of madness and its non-neutrality.

Another point of focus in the discussion on the possible madness of Mattapoisett is the fact that Connie learns so much from this vision: a new way of perceiving

herself, her society, her notion of change, and even practical skills. When she attempts to escape the hospital, Luciente teaches her to alter her state of consciousness wilfully in order to feign concussion. As Fancourt writes: 'Connie's dreams enable her to imagine a life different from her own, providing her not only with the desire, but also the drive and perseverance, necessary for political change. Her dreams and hallucinations, therefore, are not experiences that lock Connie into a private solitary world[…]' (Fancourt 2002, p. 106.) This does not sound like the regular DSM paranoid schizophrenia that emphasises the debilitating side of mental illness. Usually, it is observed that the patient's capacities and capabilities are impaired by the illness, but Connie learns and is empowered by her vision of Mattapoisett; she even starts her own war against the psychiatric and societal authorities. If Luciente and Mattapoisett were the only symptom of Connie's madness, her madness would be very literary, and it would not follow the rules of real world diagnostic criteria of DSM psychiatry. Piercy may, like Fancourt above argued, leave the boundary between Connie's possible madness open – but I still consider the question of Connie's madness important for the interpretation of the ontological status of Mattapoisett and the ensuing discussion of its contents. If Mattapoisett is a hallucination, it is surely different from being a 'real thing'.

The narrative situations, the focalisation through Connie's focus, direct the reader towards taking Connie's position. Even though we are dealing with heterodiegetic narration, Connie's central consciousness is an important point of empathetic orientation for the audience: the audience follows her suffering and tribulations (here we can, again, argue for the Keenian notion of empathy for negative emotions being more easily engendered in the audience than for positive emotions; Keen 2007, p. 41 and p. 71). The audience gets an almost novel-length depiction of Connie's inner world seen through her focalisation, which (even though it is, again, impossible to tell the exact in-groups of Piercy's narrator) makes it possible to argue that the narrator emphasises Connie's experiential sphere over the psychiatric perception of her. This pattern is further heightened by Connie's contact with the future and the environmentalist, socialist and feminist utopia of Mattapoisett (Booker 1994, p. 340; Fancourt 2002, p. 95) with its socially equal and just society. From the standpoint of Connie's suffering in her own world, she internalises the utopian society and its values. Connie's possible madness or her being declared mad by society underlines the juxtaposition between Connie's reality and Mattapoisett, which heightens the audience's capability of seeing the contrast perhaps more clearly than if Connie were better placed societally: her madness makes her definitively marginalised and

socially stigmatised (Fabrega 1991, p. 109), and she is easily persuaded to endorse the utopia, as the narrator (through Connie's focalisation) notes:

> Everybody outside had freedom and power by contrast. The poorest most strung out fucked up worked over brought down junkie in Harlem had more freedom, more place, richer choices, sweeter dignity than the most privileged patient in the whole bughouse. (*WET*, p. 170.)

It is easy to see why the utopia appeals to Connie (and perhaps to the audience, too): it offers societal equality – and a better way to relate to madness as well.

There is a narrative progression of narrative situations directing the audience response (Phelan 2005b, p. 323) as well: the ending shows us direct excerpts of Connie's patient records, giving us the opportunity of seeing her through the psychiatric eye. Thus, the novel offers at least two perceptions of Connie that are antagonistic: the authoritative one and Connie's own. The novel challenges the reader to choose between them and I believe that because of the great sympathetic coverage (of seeing her unnecessary and unjustifiable suffering, for instance) of Connie's experiential sphere as opposed to the psychiatrist's much more delimited one, the reader chooses Connie's side.[17] As Piercy notes herself: '[the novelist can] seduce the reader into identifying with characters whom the reader would refuse to know in ordinary life' (cited in Seabury 2001, p. 133). Finally, the groupings of the novel also support this empathetic direction of the audience.

4.6.5 Groupings

In my study's view, the most important grouping in the novel is that between Connie, the chief representative of the group of patients, and those treating her:

17. Even to the extremity of seeing the psychiatrists through the murderous focus of the novel's ending, although there has been debate on the ending and its justification. Is Connie justified in murdering six people? Is it a just war? Do the people of Mattapoisett really endorse Connie's actions? For example, Booker writes that '[Connie's] eventual violent reaction to the violence that has been done to her might be taken as a comment on the way violence in our society triggers more violence […] But one could also read this ending simply as a demonstration that the diagnosis of [Connie] was in fact right all along.' (Booker 1994, p. 341.) Seabury also notes: 'Many critics have seen the violence at the end of *Woman on the Edge of Time* as a liberation' but in her own view, 'Connie's acts are monstrous. And society has *created* its monsters.' (Seabury 2001, pp. 136–137.) Afnan points out a similar fact: 'The ending of the novel has, understandably, been controversial, since Connie's solution seems hardly utopian' (Afnan 1996, p. 334).

Connie is under medical control, poor, of the 'wrong' race, and a woman. Her doctors are powerful, rich, white men. Psychiatric use of power is the chief channel of communication between these groups: the doctors have almost complete control over their patients, they can use them as guinea pigs in a highly speculative, morally suspicious (in the eyes of those subjected to it – and, I argue, those of the authorial audience) surgical experiment. In Connie's world, like in that of Barker's, there is some stratification among those giving psychiatric treatment: there are 'bad' nurses and 'better' ones (like Mrs Yoshiko ('she smiled sometimes and sometimes she looked at them when they spoke' (*WET*, p. 190)) or Mrs Valente ('But Valente actually saw them as people' (ibid., p. 201)) who see the patients more as human beings with human emotions, rather than as animals or objects. However, the contrast to Barker's representation of care givers is huge: in Connie's world, the most likable of nurses 'couldn't be relied on' (ibid., p. 162); and the place of asylum, cure and help, 'offered none' (ibid., p. 31). The care givers of Connie's reality offer no real cures, but soci(et)al control in a world that is deeply stratified in terms of basic human rights and privileges.

Another important grouping is between Connie's world and the future utopia, which also is central to the understanding of madness in Piercy's novel. For example, Jackrabbit is not ashamed of his past madnesses, which is a stark contrast between Luciente's world and Connie's. Luciente directly criticises the surgical experiment: 'Sticking a log in somebody's eye to dig out an eyelash! They had not even a theory of memory! Their arrogance… amazes me.' (ibid., p. 223.) Thus, the future world also opposes the psychiatric practices of Connie's time, connecting the theme of madness and the groupings based on the divide between mad and sane. The phenomenon of stigmatisation through madness is also an issue in these groupings: madness is highly stigmatic in the social patterns of Connie's world, and not at all in Luciente's. In Connie's world, the socially given stigma is real: 'She lugged that radioactive fact around New York like a hidden sore. To find out that she had been in an institution scared people – how it scared them. Not a good risk for a job. They feared madness might prove contagious.' (ibid., p. 124.) The stigma is given, like Basaglia noted of the guilt of madness (Salo 1996, p. 88), by the social environment of the patients and reinforced by the psychiatric treatment that more or less reduces the patients to objects of raw institutional power. This marks a sharp polarisation between the sane and the mad; this is resolved in the future utopia where madness is more of a transitory state of mind that can lead to greater self-knowledge. One can see how there is a narrative progression of groupings as well: Connie, with the audience,

slowly starts to see how the future utopia offers improvement on the issues of all of the central groupings of the novel – those between mad and sane, and, finally, between all the 'haves' and the 'have-nots'.

4.6.6 Depiction of the Psycho-Sciences

The doctors of Connie's world represent brain-biological psychiatry which was, in the 1970s (the time of the writing of this novel), regaining the upper hand in the psychiatric sciences. Piercy depicts a biologically oriented psychiatry which can be considered, however, to escalate to the extreme its reductionism: it sees human beings as only as brains that can be controlled by affecting the neurobiological function. There is a psychologist character in the novel as well, Mr Acker, but he is only a 'fifth wheel' in the surgical experiment entourage; when Connie is returned to the hospital after the unsuccessful attempt at escape, she is pestered by the psychologist:

> Ever since she had run away, she had been of particular interest to Acker. She had the feeling he was an uneasy fifth wheel to the project, the psychologist added for some kind of show. He made up reasons for what the others did in terms of not exclusively medical. […]
> 'So, Connie, perhaps you can see we're working for your benefit. After all, why should society care? You've proved you can't live with others. They locked you away where you can't harm others or yourself. Isn't that so?' […] 'We want you to function again, but without danger of committing those out-of-control acts. Without danger of your attacking some child again, or some other person near and dear you.'
> Connie ground her teeth. 'Any person not in a wheel-chair can hurt somebody. Haven't you ever hit anybody? Ever?'
> 'Connie, you're resisting. You're the patient. You know why you're here. The more you resist, the more you punish yourself. Because when you fight us, we can't help you.' (*WET*, p. 261–262.)

Here, Mr Acker crystallises the clash between Connie and the doctors. Connie is placed in the position of the patient who has no real choice other than being treated like a resisting, irrational and violent person who must be controlled by the society which she has harmed. It is a Laingian double bind (Laing & Esterson 1990): either

one resists and is treated like a subjugated person – a patient – or one does not resist, and one is still treated like a subjugated person – a patient.

The surgical experiment that the doctors and Mr Acker above championed as a help and cure for the patients is seen by the patients as an act of rape and destruction that turns them into controllable machines (cf. Seabury 2001): when Skip, Connie's homosexual suicidal co-patient, returns from the operation, the narrator focalising through Connie says: 'Something beautiful and quick was burned out. It hurt to watch him. Because he was too beautiful and tempted them, they had fixed him.' (*WET*, p. 270.) Thus, the depiction of biological psycho-science is profoundly dark: it is seen as a power lusting to control people who have scarcely no choice or effective way to resist. (Skip kills himself after operation, which annoys the experiment team as he did not prove to be a success. Connie murders the six experiment team members by poisoning them. These acts of violence are the only effective ways Piercy's narrator gives as methods of resistance. Nevertheless, it leaves the insurgent either dead or confined for life.) Piercy's narrator's focalisation through Connie emphasises that the biological method of 'cure' brushes the patient's emotions and experience aside. As they are operating on Connie, she muses: 'Suddenly she thought that these men believed feeling itself a disease, something to be cut out like a rotten appendix' (ibid., p. 282). This viewpoint is further emphasised by one patient, the delirious Captain Cream, who after the operation says: 'I don't dream no more. […] How come I can't dream? Something missing.' (ibid., p. 339.) What is missing is (in Piercy's portrait) psycho-science's ability to listen to its patients and their experiences.

Thus, the picture Piercy's narrator paints of the psycho-science of biological psychiatry is very negative, even in comparison to the treatment-giving institutes in the works of Barker, Plath, Kaysen, and McGrath. Part of this contrast comes from the fact that Piercy's hospital gives mainly biological treatment whereas the hospitals in the works of Barker, Kaysen, Plath and McGrath all used mainly psychoanalytical socio-psychologically oriented psychiatry. Plath and Kaysen offer more glimpses of biological treatment: Kaysen is given psychoactive drugs, including a strong antipsychotic, Thorazine; Plath's Esther is also given ECT[18]. Yet it is Piercy's intra-brain machinery beats them for grimness. When Plath's Esther actually saw positive sides to being treated with biological means (after all, she was 'retreaded' by the treatment, ready to encounter the world again), in Piercy, the face of biological psychiatry is only fierce and controlling. The intra-brain machinery was not, however, in the 1970s,

18. This emphasises the fact that both branches of psychiatry, psychoanalytical and brain oriented, have co-existed for a considerable amount of time and have also been applied simultaneously in the treatment of individual patients.

still a real possibility but more science fiction. Piercy is writing science fiction, for sure, but still her depiction of Connie's world is closer to realism than the science fiction (cf. Booker 1994, p. 340) offered as a contrast to the utopia of future. That Piercy's narrator chooses to depict intra-brain machinery as a viable, real possibility of treatment can be seen as an exaggeration of the biological method, aimed at the polarisation of the theme of societal-control-through-brain-psychiatry, a dystopian move. As Booker writes: 'Piercy's contemporary America [is] a society that is already a dystopia for marginal members of society like her protagonist Connie Ramos' (ibid., p. 339).) Whether this is an accurate depiction of actual, modern biological psychiatry, one can also argue that it is not: there are surely real gains in biological psychiatry, drugs, for example, that bring real relief in many cases. However, Piercy, like Kaysen, rings the warning bells of giving too much room for extreme biological reductionism: to treat the patient only as a brain is to brush aside something that still is important, for the patient at least – her experience.

What my Foucauldian-Phelanian model highlights in Piercy's novel is the way the narrator uses all the tools of narrative power – narrative progressions, diagnostic moments, experientiality, narrative situations, and groupings – in order to direct the audiences empathy for Connie and her co-patients, and to see the world through her focus. The narrator also uses them to counter the psychiatric use of diagnostic power depicted in the novel. The narrator's way of narrating makes the audience see through the use of raw psychiatric power directly into its being at its core a societal, (Foucauldian-like) subjectifying power actor. Accordingly, madness in Piercy's novel is also a societal category, a way of categorising social misfits, the examples of Foucauldian 'unreason'. Even if there are 'real', perhaps universally recognisable mad people on Connie's ward as well (like Captain Cream), who are truly psychically abnormal, Piercy's narrator makes it clear that they should not be treated as mere controllable brains by their doctors. The lesson Piercy's narrator wishes to convey is of the same vein as Kaysen's but in an extreme form: biological psychiatry at its grimmest removes the person and her experiences from of the picture.

4.7 Patrick McCabe's The Butcher Boy – The Reader's Solo Diagnostics: A Mad Narrator

Patrick McCabe (born 1955) is an Irish author who has published novels, radio plays, short stories and a children's book. His novels *The Butcher Boy* and *Breakfast*

on Pluto have been adapted for film by Neil Jordan, and both were also shortlisted for the Booker Prize. McCabe's themes often include Irish small-town life, the deconstruction of the ideologies at work in Ireland between the early 1960s and the late 1970s, and their relationship with recent Irish history. McCabe has been studied by literary scholars, and I will refer to some of these analyses.

I have chosen Patrick McCabe's novel *The Butcher Boy* (1992) as one of my target texts because it is an example of mad homodiegetic narration, the narrator of which does not seem to acknowledge his own madness. Thus, it is an example of narration in which the reader (following the implied author's lead) must act (almost) alone in making a diagnosis. This gives me the opportunity to consider the reader's right and/or duty to make a (psychiatric) diagnosis in this kind of situation, and to ask how the narrator's lack of awareness of his own madness affects the diagnostic and narrative power patterns of this work.

4.7.1 Plot Summary

McCabe's novel is set in an Irish small town in the 1960s. Its protagonist and teller-character, Francie Brady, and his best friend, Joe Purcell, are in their early teens, when an intruder comes to ruin Francie's life: the Nugent family returns back from England to take their place in the upper echelons of the town hierarchy. The Bradys are of a lower social caste: Francie's father is an alcoholic, his mother is mentally fragile (she spends a while in a mental hospital), and when Joe and Francie steal Philip Nugent's comics, Mrs Nugent, his mother, demands punishment from Francie's mother, calling Francie's family pigs. Being called a pig by Mrs Nugent becomes an obsession for Francie, not the least because it blends with his envious hatred of the Nugent family: he would like to lead their kind of life, rather than the one of his own dysfunctional family – an emotion for which he feels intense guilt. He harasses the Nugents in different ways to get revenge, but his guilt is only intensified as, after running away from the town for a long time, he comes back to hear that his mother has committed suicide. He returns to harass the Nugents: he attacks Philip and threatens to hit him with a chain, which horrifies Joe, who begs Francie to leave Philip alone. Even after promising Joe that he'll leave the Nugents alone, Francie goes on to vandalise the Nugents' house, breaks in and defecates on the floor. For this he is sent to an industrial school, a juvenile delinquent reformatory institute run by priests. There he is sexually abused by one priest. After being sent

back home, he stops going to school (because he would have had to go to a class for those younger than himself; Philip and Joe have moved on to a higher class and have become friends), and takes a job at the local butcher's. He seems to become increasingly psychotic when his father also dies, and after his father's death, Francie is admitted for a while to a mental hospital. When he returns home, he hears that Joe has gone to boarding school. In a last attempt to regain his trust and friendship, Francie goes to a trip to Bundoran, the town Joe is living in. This trip is also an attempt to recover the story of his parents' honeymoon there. The trip goes horribly wrong: he does find the boarding house his parents stayed in, but hears from the landlady that his father behaved 'like a pig' already on their honeymoon. Finally, he visits the boarding school in the middle of the night, only to find out that Joe can no longer forgive Francie for his vendetta against the Nugents. Joe is friends with Philip, who is a fellow boarder, and Joe finally and definitively disowns Francie for good. From then on, Francie has only one thought: revenge on Mrs Nugent, who has done 'two bad things': making Francie turn against his own mother, and taking Joe away from him. He murders Mrs Nugent with a butcher's tool, gets caught and is sent to a forensic mental hospital for the rest of his life. As he tells his story many years later, he is still a patient in the hospital.

4.7.2 Narrative Situations, Experientiality and Unreliability

Francie is a first-person narrator, whose qualia and experiences are at the centre of his narration: we get lively access to his mental world and (like the other homodiegetic narrators studied so far) he makes his point very early on in his narrative, tying the whole story to his own focus. His very first sentence is: 'When I was a young lad twenty or thirty or forty years ago I lived in a small town where they were all after me on account of what I had done on Mrs Nugent.' (*Butcher Boy*, p.1.) A while later he says (reminiscing about the moment before the murder, as the audience will learn at the end of the tale): 'I was thinking about Mrs Nugent standing there crying her eyes out. I said sure what's the use in crying now Nugent it was you caused all the trouble if you hadn't poked your nose in everything would have been all right. And it was true.' (ibid., p. 2.) In a nutshell, this gives Francie's point of view to his audience: Mrs Nugent is to blame for everything bad happening – including what happened to her – and their schism is the crux of the tale. The tellability of his tale is thus emphasised as the tension between him and Mrs Nugent forms the inter-

esting content of his narrative. This is also tied to Francie's own subject position and experientiality. However, as the story evolves, the audience must take a stand in relation to something which Francie himself does not seem to acknowledge: his madness.

As a narrator, Francie differs markedly from Plath's Esther and Kaysen, the already analysed homodiegetic, self-diagnosing narrators: Esther and Kaysen both narrated from the position of being cured of madness (if they were ever mad), thus from the position of sanity. Francie cannot claim to have been healed thus, he is still a patient 'twenty or thirty or forty years' after, and the specific position of madness from which Francie narrates makes him unable to see his own state. The reader learns as the story unfolds that he has never had any apparent sense of being ill. (We are, again, reminded of the fact that a sense of illness does not preclude a psychiatric diagnosis (Lönnqvist 1999, p. 30).) This makes his narration elementally different from Esther's and Kaysen's: the reader must face a narrator whose madness seems apparent but whose accurate diagnosis is very difficult. His narration also constantly blends childish imagination and psychosis – play and madness – recalling Sass's observation that madness has for centuries been seen to be close to childhood, a kind of 'eternal childhood' (Sass 1998, p. 4). The reader has a hard time in trying to perceive how serious Francie is, when he seems to constantly only play, even with very serious matters (like calling his mother's mental hospital a 'garage', seeing his sexual abuse as a mere joke, or, finally, seeing the murder of Mrs Nugent only as a play act). His not being serious about serious matters can be seen either as a manifestation of his extreme childishness and/or as a symptom of his madness: an example of 'inappropriate affect' (DSM-5, p. 817). He does show more or less clear signs of psychotic hallucinations very often (though again, it is often difficult to delineate them from childish playing), claiming to hear voices and see things that to the audience seem unreal. For example, in the industrial school he starts to claim to the priests that he speaks with the Virgin Mary. His manner of narrating this blends joking with religious mystery and possible hallucination:

> I knelt on the soggy turf for penance. I looked up and there she was over by the handball alley. I wasn't sure what to say to her ah its yourself or did you have a nice trip or something like that. I didn't know so I said nothing at all. She had some voice, that Blessed Virgin Mary. You could listen to it all night. It was like all the softest women in the world mixed up in a huge big bowl and there you have Our Lady at the end of it.

[…] I told Father Sullivan [the paedophile priest] all about it and he said I had unlocked something very precious.

The next day I got talking to a few more, St Joseph and the Angel Gabriel and a few others I don't know the name of. The more the merrier. I went through Father Sullivan's books and found dozens of the fuckers. St Barnabas, St Philomena. We could have had six matches going at once in the low field there was that many. (*Butcher Boy*, pp. 77–78.)

He says later that he (on another occasion) 'told him [Father Sullivan] a heap of lies and true stuff mixed in. That was a good laugh.' (ibid., p. 90.) Thus, on the basis of the quotation's joking tone, the audience is justified in seeing that Francie may have told both lies ('a good laugh') and truth (the visions being religious mystery for real or psychosis – the two being intertwined in this mockery of a visionary) about the saints. All the while, he is unaware of the possibility of being a mad person.

Thus, he seems to exhibit a gross lack of self-consciousness in the apparent symptoms of his madness (inappropriate affect and hallucinations). For the authorial audience, this lack of self-consciousness makes visible and underlines the multi-layered communication (Phelan 2009, p. 310) between the implied author and his authorial audience in the central issue of this study, namely the making of a diagnosis of Francie, the narrator. The reader must go against the current of the narrator's narration, to diagnose him, even though he cannot or does not want to do so himself. Thus, the authorial audience departs from the interpretation the narrator wishes for his audience. The reader, in making the diagnosis, uses what could be termed the power of diagnostic interpretation, of making a readerly solo-diagnosis; the implied author's supreme power over his narrative is emphasised. The implied author obviously uses this supreme power any time he creates a story and a narrator to tell that story (being the Phelanian story-creating, external agent (Phelan 2005, p. 45)), but this supreme power wielded by the implied author is underlined in the pattern in which he hints 'between the lines' that the narrator cannot be trusted for one reason or other to give the factual truth in the fictive universe – in Francie's case most notably about his own mental status.[19]

I argue that the narrative power used by the implied author is not 'proper' Foucauldian power as Foucault maintains in his 1982 article, because it does not subjectify the target like the use of (e.g. real life diagnostic) power does, it only ex-

19. At the end of the next part of my study, I will reconsider the terminology used to describe unreliable narration. In my terminology, Francie is 'intra-mentally reliable' but 'inter-personally unreliable'.

hibits certain features of this power (primarily the means and intentions of directing the reader's reactions). I argue further that this implied author's narrative power is directed at the authorial audience, not Francie-the-narrator, whom he has created to relay his messages to the authorial audience. That Francie is unreliable as a narrator means only that the message the implied McCabe needs to relay to his audience must make a detour: it is stratified in Francie's narration, and there are ruptures, discrepancies and gaps the implied McCabe has created in Francie's narration in order to get his message about Francie's madness (and its repercussions) through to the reader. This pattern is markedly different from the cases where the narrator is reliable, like Innes's Jim, or Barker's narrator, where the implied author seems much more hidden, in a way 'behind' the reliable narrator – most notably in the focus of my central issue of supporting the narrator's diagnosis-making. Innes's or Barker's implied authors do not 'booby-trap' the narrator's attempts at diagnosis, but leave the narrator's messages concerning their diagnosis intact.

The power the reader wields, then, is yet another issue. It is directed at making an interpretation about the work, its narrators, characters and implied author, and their values and norms. This interpretative power is limited, as it can only try to gather 'what the work means', and what to think about that (it is thus no more Foucauldian, subjectifying power than the implied author's or heterodiegetic narrator's narrative power). In a way, it is a response to the narrator's, and finally, the implied author's messages – it is thus a counterpart to the implied author's use of narrative power, and, as said, as a power limited. The readerly power of interpretation seems to me to underline point 7 on my list of Foucauldian power features: it consists in putting in order the possible outcome – the readerly interpretation – sought for by the narrator and implied author, but it is not totally capable of being dictated by them. Thus, the reader acts upon the authorial action of building a specific storyworld, giving her own interpretation of it. Of course, this readerly interpretation does not change the storyworld itself, only the reader's interpretation of it. One could argue that in the light of Francie's unreliable narration, the interpretative power can be seen as 'proper' power because in an unreliably narrated madness narrative, the reader is left with the duty and opportunity to make a diagnosis alone, that is, to wield the diagnostic power (which is very much Foucauldian 'proper' power). However, in Francie's case, this diagnostic power, wielded by the reader alone, is *not* subjectifying the narrator: the reader *cannot* force Francie into a dependent subject position, she can only change her own perception of Francie's subject. Francie himself remains on a different ontological level from the reader and he is completely unaware of

the reader's existence or wielding of any powers. (As Francie is not a meta-fictional narrator.) Thus, one can see that the reader's power of interpretation of the diagnostic possibilities of Francie's narration is of the same kind of power as the narrative powers of the narrator and implied author: it features certain aspects of 'proper' Foucauldian power, but not the most important: subjectification.

This pattern of the narrator's narrative power being undermined by the implied author's and authorial audience's communication makes Francie's tale different from those analysed thus far; and the unreliability of Francie's narration affects all the narrative power tools used by him in his (partially vain) efforts to convince the reader to completely adopt his perceptions.

4.7.3 Narrative Progressions and Diagnostic Moments

Unlike in the works studied thus far, in the case of McCabe's novel it is difficult to perceive the chain of diagnostic moments, largely because of the fact that Francie is an unreliable narrator, whose unreliability is caused by and massively intertwined with madness. Thus, the delineation of the points of his unreliability becomes a diagnostic issue. The interconnection between the narrative and diagnostic powers that would be realised in diagnostic moments in his narration are tangled in a different manner from the cases studied thus far.

There is a handful of clear, outspoken diagnostic moments. There are examples for Francie's mother, most importantly: 'it was her nerves' (*Butcher Boy*, p. 4), 'he [the father] said she was mad like all the Magees' (ibid., p. 6); for Mrs Nugent – her brother accuses Francie of wrecking her nerves: 'What you done to my sister, Buttsy says. Her nerves have never been the same since.' (ibid., p. 110.); and, finally, for Father Sullivan (or Father Tiddly, in Francie's own idiom), who Francie suspects has been sent into a mental hospital, or the garage, as Francie calls it: 'Poor old Tiddly was probably climbing the walls of the garage by now shouting *I love you bogman!* to some young farmer lad' (ibid., p. 94). Thus, one can say that these explicit diagnostic moments of Francie's mother, Mrs Nugent and Father Sullivan create a backdrop for Francie's own, more difficultly delineable madness: there is definite madness in his surroundings, even though Francie himself does not seem to notice it in himself.

The most definitive diagnostic task – diagnosing of Francie himself – is much more difficult and less easily defined: his speech is so childishly idiosyncratic that it is hard to delineate madness from childishness. As a reader, I would still like to

maintain a line between childishness and psychosis, no matter how fragile it is in Francie's case; otherwise we would have to diagnose every child playing role games. It is often very difficult to draw that line, for sure, since knowing whether Francie is hallucinating or playing is not easy. In the episode in which Francie breaks into the empty Nugent house, he seems to first play, then to hallucinate (the difference being marked by the change in affective tone: from feeling good to being smothered by Mrs Nugent's breast):

> Then I went round the house like Philip. I walked like him and everything. Mrs Nugent called up the stairs to me are you up there Philip? I said I was and she told me to come down for my tea. Down I came and she had made me a big feed of rashers and eggs and tea and the whole lot. […] I felt good about all this. When I was finished I said I was going back upstairs to finish my experiments but I didn't, I waltzed around the landing singing one of the *Emerald Gems* to myself O the days of Kerry Dances O the ring of the piper's tune! And then into Mr and Mrs Nugent's room. I lay on the bed and sighed. Then I hear Philip Nugent's voice. But it was different now, all soft and calm. He said: You know what he's doing here don't you mother? He wants to be one of us. He wants his name to be Francis Nugent. That's what he's wanted all along! We know that – don't we mother?
>
> Mrs Nugent was standing over me. Yes, Philip, she said. I know that. I've known it for a long time.
>
> Then slowly she unbuttoned her blouse and took out her breast.
>
> Then she said: This is for you Francis.
>
> She put her hand behind my head and firmly pressed my face forward. Philip was still at the bottom of the bed smiling. I cried out: *Ma! It's not true!* (*Butcher Boy*, pp. 59–60.)

In this episode, play seems to blend with psychosis, as Francie moves from controlling the situation and his own emotions into being subjected to the guilt-triggering, out-of-control emotion of envy of the Nugent's life style. The limit at which play becomes psychosis is not easy to see, though. Does he hear Mrs Nugent's voice from downstairs, or see the food 'for real', rather than imagining them and knowing he is imagining, or is it already a possibly psychotic hallucination?

Sometimes it is easier to make the diagnostic move on Francie, even though the audience may have to do some detective work to get there. For example, when Francie's father dies at home, Francie does not notice the difference in his father (he

only remarks passingly that 'I felt his forehead it was cold as ice' (ibid., p. 118), which marks for the reader the point when Francie's father is definitely dead), but goes on to buy him beer and make him sandwiches and, finally, to imagine a Christmas party in which he is still very much alive, even though the 'party' ends when Francie wakes up to see that the 'guests' are really Dr Roche and the police who come to house and see Francie's father covered in maggots. That Francie cannot understand his father being dead is thus a strong diagnostic moment, a sign of his psychosis. After this episode, Francie is sent into a mental hospital in which he hallucinates continuously. The mental hospital setting of course makes it easy for the reader to see Francie's idiosyncrasies as psychosis. But it must be remembered that Francie himself does not seem to notice his own madness at all. He never explicitly says that he feels mentally ill.

What is Francie's madness then, in the eyes of the diagnosing reader? The reader's trying of different psychiatric diagnoses on Francie reveals a complex picture. He could be seen suffering from conduct disorder and/or schizophrenia. Both these diagnoses receive some validation in his behaviour. The conditions of conduct disorder, as DSM-5 and ICD-10 define it, are met: Francie shows aggression towards people, destroys property, steals, runs away from home, and blames others for his own misdeeds (Mrs Nugent 'doing bad things' so he must murder her), (see DSM-5 pp. 469–472; ICD-10 pp. 266–271). The familial pattern is an additional feature: it is noted in DSM-5 (p. 473) that parental neglect and sexual abuse[20] may cause this type of disorder in the child. This diagnosis would, thus, seem to wrap his condition up quite neatly. On the other hand, as we have glimpsed, Francie time and again reports hearing things he could not have heard, people and even animals speaking to him and saints appearing to him. Is he psychotic? (DSM-5 p. 473 does corroborate this possibility by remarking that 'individuals with conduct disorder are at risk for later […] psychotic disorders.')

However, things are not made that easy for the psychiatrically minded reader, thus emphasising the difficulties of an authorial reading. If Francie was simply suffering from conduct disorder, the reader would be tempted to look down on him and his conduct: it is only pathological. His narration would be seen from the point of view of inferiority, incorrectness (Sass 1998, p. 2) and of Foucauldian subjugated knowledge (Kusch 1993, p. 129). He is very violent, inconsiderate of others' (especially the Nugents') feelings and rights, but he has his 'soft spot' as well: he yearns for

20. However, one can note that Francie already displays symptoms of conduct disorder *before* being sexually abused. One can argue, still, that his being abused sexually does not improve his situation.

the closeness offered by his mother and Joe. These are the 'beautiful things', family and friends, he is looking for in his life, and repeatedly losing. (The 'soft spot' does not, however, rule out conduct disorder, as the patient may have normal relationships with other people as well. ICD-10 describes socialised conduct disorder as a disorder in which the patient is capable of having normal peer relationships, like Francie with Joe. (p. 269)) In addition, the class dispute, Mrs Nugent calling his family pigs and having contempt for them, is real. There is true hatred between them, even if Francie has (as goes well with the overall picture of conduct disorder) a tendency of exaggerating grievances and accusations. The first-person narration keeps Francie's point of view constant, and the reader is led to follow his thoughts and make the diagnosis on her own. The reader sees that the blame on others – a move Francie makes time and again – is at the same time a misperception (Mrs Nugent does not deserve to be murdered) and an acceptable point of view (Mrs Nugent should not have insulted Francie and his family).

The same applies to the diagnosis of psychosis: it can be validated and partly refuted at the same time. Validation comes from the viewpoint that Francie must be imagining much of the discussions he is having with inanimate objects, animals, saints, even people – he is a very unreliable witness and narrator. On the other hand, some of these discussions (with saints and other holy characters) can be placed in the context of Irish Catholicism. It is not 'sick' to talk to Jesus, Mary or the saints in the society Francie lives in, it is even encouraged. When Francie himself claims that he is talking to the Virgin Mary, the priests at the industrial school start to think he might be fit to become a priest. The reader, as we have seen, gets a rather strange picture of these discussions between Francie and the saints – he talks to them as lewdly and funnily as to all other persons or things. However, as stated, there is a curious feature to these talks as Francie describes them to the priests: he says that sometimes he makes up discussions in order to please the priests (*Butcher Boy*, p. 78) – but only sometimes: there are then real – or psychotic – discussions with the saints as well?

Thus, the application of these DSM diagnoses reveals the blurriness of the picture of Francie's condition. The reader does see that there is something badly wrong with this murderer-child: the reader makes the diagnosis of his madness and its nature, and is backed by Francie's community in this move when it locks him up in the mental hospital rather than the prison. The ultimate narrative control (and diagnostic power) is in that sense taken from Francie, he is seen to be put under scrutiny of the reader's eye strained to catch the nature of his madness. The narrator

offers ample evidence of his mental status, trying to control his narrative and the audience's picture of him, but the reader, by making her readerly diagnosis, moves against the flow of his narrative power and diagnoses him. Thus, it can be seen how Francie's rhetorical purpose for narrating (Phelan 2005b, p. 323) is thwarted by the reader's interpretative thrust. The narrator tries to control the knowledge streams and through them the audience's interpretations, but fails because of the implied author's hinting that the narrator, in his madness, is not trustworthy in this directing of the knowledge streams. However, the nature of the madness is not simple or singular. The applied DSM psycho-scientific paradigm can be seen to be on infirm ground, since the diagnoses the reader may try to apply to him at least partly fail: Mrs Nugent is at least partly culpable for Francie's animosity towards her, and Francie's talks with saints are culturally valued in the Irish Catholic society.

One can further study Francie's mental state by considering the psychoanalytical notion of psychosis. Jones writes:

> [N]euroses come about when the id impulses rebel, a compromise is reached and impairment of a certain section of reality takes place. With the psychoses, on the other hand, it is the id impulses that are victorious, and there is a flight from a piece of reality which is denied. In the second phase of psychotic development a false reality is invented (delusions, etc.) as a substitute for the true one. So one may say that neurosis does not deny the existence of reality, it merely tries to ignore it; psychosis denies it and tries to substitute something else for it. (Jones 1957, p. 272)

What would be Francie's substitute psychotic reality as opposed to the real? Francie becomes obsessed with Mrs Nugent's calling him a pig, and he can be seen to develop a paranoid delusion about Mrs Nugent 'doing bad things' in Francie's life. This intertwines with his guilt for feeling envious of the Nugents and their life and for turning his back on his own mother. This only intensifies Francie's delusions concerning Mrs Nugent and her persecution of Francie. The psychotic, substitute reality can thus be seen to be an improved world – Francie is able to live like Philip – and a persecuting image – Francie turns his back on his own mother. It is worth quoting the lengthy description Jones gives about Freud's detailed analysis, which also gives us the central psychoanalytically perceived symptoms of paranoia:

> Starting with the simple formula (in the case of a man) 'I love him', [Freud] pointed out that each of the three words could be denied separately, producing a consequence three of the most typical paranoid delusional ideas. If the verb of the sentence be denied, we have 'I do not *love* him – I *hate* him'. Even this attitude, however, is not admitted directly to the consciousness. By the mechanism of projection so common in paranoia it is exteriorized in the form 'He hates (and persecutes) me', after which the patient feels justified in his own hatred. There we have the most frequent delusion of paranoia, that of persecution. If the object of the sentence is denied, we have 'I do not love *him* – I love *her*'. The projection turns this into 'She loves me', where we get the well-known delusion of erotomania [...] If now the subject of the sentence is denied, we get 'It is not *I* who loves him – it is *she* who does': in other words, the distressing delusion of jealousy. [...] There is still another possibility, that all three words are denied, which signifies 'I don't love at all; I don't love anyone'. Since, however, the erotic instinct must find some expression it falls back on the subject and invests it with libido. The result is megalomania that in some degree or other is present in all cases of paranoia. (Jones 1974, pp. 303–304, Jones's emphasis.)

The relationship of Francie and Mrs Nugent is not a straightforward Freudian homosexual relationship, but one can still surmise the tangled emotional web of relations: Mrs Nugent is both hated and loved by Francie in his delusion of her. The substitute reality Francie composes of his envy-hatred-love of the Nugents is fraught with tensions that ultimately cause him to crack and resort to ultimate violence.

Clare Wallace has diagnosed Francie as a schizophrenic (Wallace 1998, p. 157) and Tim Gauthier sees in him both sociopathic and schizophrenic features (Gauthier 2003, p. 198 and p. 205). Thus, my suggestions of the child Francie's DSM diagnoses being conduct disorder (sociopathy or antisocial personality disorder is, according to DSM-5, 'closely connected to the spectrum of 'externalizing' conduct disorders' (p. 476)) and (also psychoanalytically perceivable) psychosis get support from these scholars. Gauthier goes further and gives a societal analysis of Francie's madness as symptomatic of the neo-colonial Irish situation:

> The Bradys become all-too-easy target for Mrs. Nugent who needs a contrast to validate her position in the community. The Nugents are not English but are Irish striving to be English, and becoming more imperial than the colonizer. A sense of inferiority, fostered by years of living in the shadow of the colonizer, needs to be

> constantly assuaged by the subjugation of another. For the community, that Other is the Bradys, who must be ostracized for the new conception of the community to be established. (Gauthier 2003, p. 201–202.)

In Gauthier's analysis, the community fails to give its support for Francie's dysfunctional stereotypically Irish family (see McWilliams 2010 for an analysis of Francie's mother as an Irish stereotypical mother dismantled) which only heightens Francie's suffering, and finally, drives him into madness. Gauthier explains:

> Mrs. Nugent's labelling of the Bradys as 'pigs' is the trauma that unleashes Francie's self-loathing. […] Because Francie cannot define an identity of his own and has no past on which to construct it, he must assimilate Mrs. Nugent's attributions – but only to the degree that they are no longer hers but his own. […] Bhabha notes the propensity of the colonial to adopt a dual role, wishing to maintain his original identity while appropriating that of the oppressor: 'The fantasy of the native is precisely to occupy the master's place while keeping his place in the slave's avenging anger.' The danger, of course, lies in the schizophrenic state that can arise from not actually inhabiting either space. (ibid., pp. 204–205.)

Thus, one can see how Francie, even in his apparent unconsciousness of his and his country's history (for example, he does not recognise the historical value of Daniel O'Connell, the famous Irish freedom fighter), exhibits societal patterns in his falling mentally ill, with his delusions of Mrs Nugent's persecution of him and his family.

What do these diagnoses, DSM psychiatric, psychoanalytical, and societal, tell us about Francie and his community? They emphasise his special position as a pathological – or made pathological – individual, whom, as the audience pieces together all the possible points of mad unreliability in his narration, is begun to be seen as an individual who is pushed outside his community in his dysfunctional behaviour. This is the case whether his communal disowning is seen as the cause (societal viewpoint) or consequence (communal and pathological viewpoint) of his madness. The confinement instigated by the community can be seen in the Foucauldian tradition of exclusion-by-inclusion (Foucault 2006): Francie is confined in reformatory and mental institutions because of his inadequate social behaviour, finally seen by his community – and the reader – as pathological. Francie breaks the social roles and rules, thus he is treated against his will (cf. Salo 1996, p. 80). The reader can only follow this narrative progression of permanently confining Francie

in the forensic mental hospital, which gives the audience the backdrop for making her own diagnoses against the current of Francie's narration. (This emphasises the Phelanian point that the narrative progression is dual: there is the narrative progression of the characters and the narrative progression of the audience's response (Phelan 2005b, p. 323).) The reader in a sense takes Francie's tale 'into custody', in order to place it into the frame of what happened 'really' inside Francie's psyche and between Francie and his community, which are the testing points of his sanity as well: the diagnostic moments centring on them.

The narrative progression of the plot structure towards the point of Francie committing the murder of Mrs Nugent is the most important development in the novel. The character of Francie, however, cannot be seen to develop: when Joe, for example, is seen to mature and find a girlfriend, Francie is still the same small child inside after years of confinement in the mental hospital. Perhaps the most important feature of his character is his nostalgia. It seems to be the only mental basis for Francie to build on. After losing his mother and father, he still clings onto Joe's friendship and the memories of them playing together, but when Joe also disowns him, Francie attacks the person he sees as culpable for all his losses: Mrs Nugent. The progression towards this point is what Francie wants the audience to follow: to see how Mrs Nugent gets what she deserves. However, the authorial audience is led to see, by following the implied author's cues, that Francie's world breaks apart, piece by piece leading to the full mental illness after he drops through the last social safety nets. What we have, in the end, is the trope of the dangerous madman, which we have already encountered in McGrath's Edgar and Innes's Mr Manack Sr. McCabe, however, gives us the full mental development of this trope's fulfilment, which we did not have in the case of McGrath or Innes. We understand Francie's personality much better because we get his mental landscape by seeing through his own focus – and that of the implied author which is given us in the gaps and discrepancies of Francie's narration. Thus, the audience finds itself in the place of feeling empathy for Francie for reasons that he himself has not asked for or that he himself cannot perceive due to his blindness to his own mental condition. The reader's imposition of the diagnostic content, the 'what' of the diagnosis is severed from Francie's rhetorical purpose, the 'why' of his narration – and in a way turned against it by the reader's diagnostic effort.

4.7.4 Groupings and Empathetic Strategy

The empathetic strategies that Francie employs are based on steep differences between 'us' (the Bradys) and 'them' (the Nugents). As we have seen, it is possible to argue, like Gauthier (2003), that this grouping is even the cause of Francie's mental breakdown in the neo-colonial society where Francie lives. This societal streak is, however, almost completely based on the implied author–authorial audience communication, as Francie himself is almost completely unaware of the societal dimension of his condition – or of his own 'condition' at all.

From this blindness to his own condition also follows the difficulty of perceiving his empathetic strategy: because of the busy communication between the implied author and his audience, Francie's own interpretations of his tale become questioned and reframed by the authorial audience. Thus Francie's main agenda, to make the audience see that Mrs Nugent is to blame for everything and that Francie is justified in murdering her, is overruled by the audience seeing it as a symptom of his madness, and the main crux of his unreliable narration. This is the most important ethical interpretation the authorial audience makes on the basis of the redirecting of streams of knowledge that are also the currents of narrative power. Accordingly, one cannot make Francie's empathetic strategy the pure Keenian broadcast strategy (Keen 2007, p. 142) of 'a mad person telling to a wide audience about madness'; as he does not acknowledge his own madness, he cannot see that he is narrating from the position of madness. He does not seek empathy for his madness, like Plath's Esther and (to certain degree) Kaysen did. This makes the reader capable of feeling empathy for Francie for matters that he is not conscious of: his madness and the way his community fails him just when he most needed it. McCabe paints a picture of Francie as a character who seeks the audience's empathetic commitment to his cause of seeing Mrs Nugent as a character culpable for everything – and who instead gets empathy for his falling ill with psychosis, the main symptom of which is the delirious love-hate relationship with the Nugents.

How perceptive is Francie when he makes his groupings? As with the case of diagnostic moments, the reader is often uncertain of Francie's social perception, as Gauthier writes: 'The reader is constantly reassessing Francie Brady's psychological (in)stability and is never quite sure to what extent Francie's perceptions are delusions or are incisive commentary on the narrow community in which he lives' (Gauthier 2003, p. 197). Thus, the groupings he makes are at the centre of the reader's focus of trying to fathom his madness and its symptoms: the groupings *are* one of the

symptoms of his madness, as he seems to be unaware of these groupings being part of his delirium.

The social forming of stigma of madness is present in Francie's groupings as well. This can be seen in the fate of his mother's only partially hidden social ostracism by her community. Francie's father is the first to form and highlight the social stigma of her madness: 'He [the father] said at least he never had to be took off to a madhouse to disgrace the whole family' (*Butcher Boy*, p. 35). This only intensifies Francie's groupings, as he continues:

> I knew then ma was never in any garage but I knew all along anyway, I knew it was a madhouse I just didn't want Nugent or anyone to hear so I said it was a garage. But then I knew too that Nugent knew all about it Mrs Connolly and the women would have told her. So I don't know what I bothered saying anything about a garage for at all. I could hear Nugent saying: Imagine him thinking he could pull the wool over my eyes! (ibid., p. 35.)

Thus, the stigma of madness is built into Francie's tense relationship to Mrs Nugent: he is aware of the social stigma of his mother's madness, it heightens his wish to hide his family's condition from the upper class Nugents, and may also participate in his envy of the Nugents – at least they are not tainted by madness by the community they live in (epitomised by 'Mrs Connolly and the women'). His talking and joking about a garage is thus a vain effort to hide the stigmatisation of his mother by the community, which is eager to place the Bradys into the position of the Other (Gauthier 2003, p. 197; Fabrega 1991, p. 109) and will readily use a diagnosis of madness to this end. The stigma of madness is given by the community to the Brady family (in a Basaglian manner they define the guilt of madness socially (Salo 1996, p. 88)), and this is the current against which Francie fights – perhaps also in his refusal to see his own madness. Even when they are carting him away to the forensic mental hospital, he shouts: 'You don't fool me! I shouted. You're trying to trick me! You're going to put into a mental hospital! He [the policeman] got a bit red under the eyes and I could see him clenching the fist. Then I laughed: Its all right I said, its only a joke, for fuck's sake!' (*Butcher Boy*, pp. 213–214.) Again, we cannot easily distinguish between inappropriate affect, childish play or psychotic unawareness of reality.

4.7.5 The Picture of Madness, the Psycho-Sciences, and the Reader's Involvement

The picture McCabe's Francie gives us of the psycho-sciences is as childishly and psychotically distorted as everything else in his narration. During the hospital episode, he constantly blends his knowledge of popular culture and psychiatric treatment procedures:

> Some days I went off with the doctors to this room with two pictures in it John F. Kennedy and Our Lady. Well well we meet again I says and gave her the wink. You're a long way now from the low field in the old school for pigs I say and she started laughing. They were all interested to hear about this. And who else did you see? Oh the whole shooting match I says. St Theresa of the Roses the lot. […] They couldn't get enough of all these saints. […] Then they asked me about dreams. Did you have any dreams they said. O I did I says, I did indeed. […] The worse it was the better they liked it so I put in a whole lot about Bubble [the head priest in the industrial school] stinging me and biting my head off Father Alien says you must die earthling dog! And then he laughed and all this. It was a good laugh. […]
> Other days they took me off to other garages and stuck me in a big chair with this helmet on my head and wires coming out all over the place. I liked that. That was the best of the lot sitting in that chair. And all these starchy bastards of students with clipboards gawking at you *I hope he doesn't leap up out of the chair and chop us up!*
> But I paid no heed to them I was too busy being Adam Eterno The Time Lord in that big chair. (*Butcher Boy*, pp. 146–147.)

The psycho-sciences are given a testimony that makes them seem ridiculous: they do not help Francie because he treats everything flippantly, embellishing his life's story for the dream-hungry (apparently psychoanalytically oriented) psychiatrists. Francie refers to some kind of biological treatment as well, as another patient tells him: 'They're going to give you the treatment. There won't be so much lip out of you when they take you off and put the holes in your head. Know what they do then? They take your brains out. […] I had a good laugh at that. Taking your brains out, for fuck's sake.' (ibid., p. 148-149) It remains a bit uncertain whether Francie receives 'the treatment' or not (there is a long apparently psychotic passage where

he thinks he is being operated on, but when he leaves the hospital, he presumes that the doctor releasing him is trying to make up his mind whether to cancel the release and give him 'maybe the drill this time' (ibid., p. 156)). The operation scares Francie and he tries to avoid it. It might be an embellished version of a lobotomy, but the description is so hazy that it is not easy to be sure. All in all, what is certain is that Francie does not consider that he has received any help from this psycho-scientific interference in his life; he travels through the hospital apparently untouched by it all. The psycho-scientific tests and treatments – be they ridiculous or frightening – do not change him at all. Francie in his madness thus seems to pass through the last safety net as the hospital releases him into the community where it all started – and still goes on. We are left with an image of the psycho-sciences as laughable and a failure of the empowering use of power (Karlberg 2005). Whether this is because of Francie's countering of their efforts with his Teflon-like untouchable manner of relating to them (as to almost everything), or their inadequacy, or both, is left for the audience to surmise.

Francie's madness can be seen as psycho-soci(et)al, caused by his community's and environment's pressures on him. It is also highly idiosyncratic; it intertwines with childish imaginativeness, which makes it very hard to delineate strictly. DSM psychiatry or psychoanalytical theories seem to help partially with their theorising, but the psycho-sciences are only one thematic thread, touched upon more directly only in the rather short psychotically driven passages on Francie's first hospitalisation. The psycho-sciences also are problematised when the reader searches for the right psychiatric diagnosis or its justification. Against Francie's telling of his own experientiality, it seems partly wrong to diagnose him as thoroughly pathological, since he is seen as a very childish and playful character, innovative and entertaining in his imaginativeness. (Of course, over the years, his unchanged childish condition can be seen as a further symptom of madness, of arrested mental development.) Another point of emphasis against too total a view of his madness is in the manner in which he more or less consciously reveals his community's shortcomings. It could be said, at least, that his madness is of the same kind of visionary-in-blindness as Kesey's Chief Bromden's paranoia.

My Foucauldian-Phelanian method structures the patterns of narrative and diagnostic power of McCabe's work in a way that uncovers the special ways in which an unreliable narrator changes these power patterns. Much more is occurring on the axis between the implied author and authorial audience than in, for example, Plath's case, where Esther, narrating from the position of her regained sanity, uses

narrative power and empathetic strategy in (successfully) convincing her audience of her diagnostic patterns. Francie, then, attempts to gain his audience's backing in his war against Mrs Nugent, but instead gets the audience's empathy for being obsessed with her. He is, after all, declared irresponsible for her murder, and thus, his act is seen in the light of irrationality; it is not rationally understandable as he himself sees it. For example, he begins his tale by arguing for his own interpretation of the Nugent affair (reminding us of the irrationality thesis of madness (Sass 1998, p. 2) and the notion that the madman is not quite 'master of himself' (Jaspers 1997, p. 789)). The reader must thus go against the current of his narration in making her interpretations of him and his mental status.

In my reading experience, Francie is – even when he murders – a sympathetic and funny figure. I am supported here by Gauthier (2003), who sees Francie as a victim of his community, and by Wallace (1998, p. 157), who sees Francie as a teller-character employing black humour. This is a strong reminder, I argue, of the notion Keen took up: fiction can engender empathy for such characters that the reader would not necessarily empathise with in real life (Keen 2007, pp. 28–29). Francie succeeds in being seen by the audience in a sympathetic light due to the opening up of his own experientiality and idiosyncratic mental landscape, and, I argue, the implied author supports him. This is the case even if he does not always back Francie on, for example, the factual plane, or on the plane of his groupings and cause-effect ideation. This backing can be seen in the way the implied McCabe hints at the societal issues behind Francie's condition, the suffering caused by his dysfunctional family and his losing of all his loved ones – even if Francie himself does seem to wander through his tribulations in an amazingly hilarious manner.

McCabe's work also makes the audience ponder the justification of readerly solo diagnosis-making: on what grounds can the reader move alone in the psychiatric field and diagnose a teller-character who is apparently unaware of his own madness? What would it mean to the ethics (a very Phelanian theme) and power politics (a very Foucauldian theme) of reading?

When the reader diagnoses Francie, she consciously positions herself 'above' Francie's own narration. She uses interpretative power, the counterpart to the implied author's narrative power, a kind of power that cannot subjectify Francie (and is thus not 'proper' Foucauldian power as established in the 1982 essay), but affects the communication between the implied author and the audience, and the interpretation the reader makes of the work's message. It is like the diagnostic, 'proper' Foucauldian power in its placing of Francie into a certain informative niche apart

from sane characters, which affects the ways the audience handles the information Francie gives in his narration: it is received on the interpretative level with a pinch of salt. Of course, the diagnosis of Francie is justified if it captures his mental condition and explains something that otherwise would remain unexplained (here we encounter the same interpretation of madness as an explanatory fact as in Innes's and McGrath's novels). However, it also 'captures' Francie in another manner: the readerly diagnosis creates a certain disjuncture between the narrator and authorial audience, as the implied author hints to the authorial audience (who has joined the observing position of the narrative audience) that the narrator is not completely trustworthy. The authorial audience, as we have seen (also in the case of Piercy's Connie) may start to doubt, in a kind of high alert mode, everything Francie says because of his apparent psychosis – even those parts of his narration that are in their modality more of the kind of childish imagination and naiveté than sheer psychosis. The interpretative power of the reader is seen to override Francie's interpretative and narrative attempts to control his own message.

The reader's task, obviously, is to make interpretations as she reads, and the diagnosis is (potentially a highly valid) interpretative option in Francie's case, but his case is still a very ill-defined one and thus reminds us of the difficulties of making an authorial, strict, clean psychiatric diagnosis, even when we can see that he *is* mentally highly disturbed. The imaginative factor on the one hand, and the very emphatic issue of the possibility of stigmatisation through diagnosis (which figures in Francie's tale in the fate of his mother) should keep the audience alert to the pitfalls of diagnosis-making. The ethics of reading Francie's tale is, thus, a very loaded issue.

I will return to the issues of ethics and power intertwining in telling and reading madness narratives in the next part of my study. Here, it suffices to say that Francie's unreliability as a narrator makes visible the axis of implied author–authorial audience in the making of diagnoses, which gives the reader much more responsibility for her diagnoses, as she must act against the currents of narrator's narrative power. McCabe's depiction of madness reveals societal and narrative issues which further enrich our analysis of the picture of madness narration and, especially, the narrative power used by the implied author and the interpretative powers used by the reader.

4.8 Jane Urquhart: Away – A Reader's Solo Diagnostics: A Mad Focaliser

Jane Urquhart (born in 1949) is a Canadian author who has published several novels, a collection of short stories, and three collections of poems. She has been awarded, among other prizes, the French Prix du Meilleur livre etranger for her novel *The Whirlpool* and the 1997 Governor General's Award for the novel *The Underpainter*. Her work has been studied and I will be referring to a number of scholarly articles.

Jane Urquhart's novel *Away* (1993) is my last target text in this part, a heterodiegetic narrative which enables me to discuss (potentially) unreliable focalisation, and especially the effect of culture on psycho-scientific diagnosis, which highlights the relationship between the psycho-sciences and mythical dimensions (this theme also serves as a bridge to the second part of my study in which I will delve deeper into, among other things, the dichotomies of madness narration). With this text I ask questions like: Does the authorial audience have a right to make a differential diagnosis of a member of another culture, as an 'outside observer' (DSM-5, p. 14)? How does the psycho-scientific diagnosis function with a literary text that is strongly related to myth and folklore? In asking these questions, I trace a delineation between psycho-scientific and cultural explanations of deviant behaviour.

4.8.1 Plot Summary

Away tells the dynastic story of an Irish family. The story spans a period of 140 years, and begins with the depiction of the Irish potato famine and the forced emigration of the family to Canada in the middle of the 19th century. The narrative is told through the last living member of that family, Esther, whose telling of the story of her family to herself on the last night of her life is narrated by the heterodiegetic narrator. The story is the same as the one Esther was told by her grandmother Eileen when Esther was a child, and it begins with the depiction of Mary, Esther's great grandmother and Eileen's mother. I will focus chiefly on Mary's character, who is described in the first half of the work, as she is the one character who could be considered mad (I will, thus, concentrate less on the younger generation: Eileen, Liam and their offspring).

At the beginning of the narrative, Mary meets a shipwrecked sailor on the beach of her Irish home island, Rathlin. She immediately falls in love with him, and he whispers the name 'Moira' before dying in her arms. Mary interprets his words as

her own renaming, and the sailor as a faery-daemon lover who has come to 'take her away', to the other world. The community around Mary sees the occurrence the same way: Mary is 'away', possessed by her otherworldly lover. After this incident, Mary stops speaking, but sings instead to her lover; her housework seems to be blessed to the extreme, which the community interprets as a gift from the other world. She communicates with her lover by swimming naked, by seeing him, even making love to him. During these encounters, the sailor teaches Mary by showing her visions of faraway places. Almost the whole community, even the priest, Father Quinn, believes that Mary is 'away'. The male villagers, the priest included, become haunted by Mary, and have disturbing dreams about her. This disturbance makes the priest ill at ease, and he decides to bring Mary 'back', first by praying, but then by pairing her with the school teacher Brian, who does not believe in faeries or folklore any more. By relating to the myth of faery lovers with indifference and removing her from the island, Brian makes Mary come back little by little: she starts to speak again, marries Brian and has a child with him, whom they name Liam. For a while, Mary seems to lose contact with her faery lover, but finds him again near her new home on the mainland.

During the famine, Mary and Brian's British landlords send the family to Canada, where Mary has another child, Eileen, with Brian. However, Mary finds her faery lover again by the side of Moira lake, and she leaves her children and husband in order to live on the shore of the lake. She receives support from Ojibway Indians who connect with Mary's description of her faery myths and see in her the same qualities as their notion of Manitou. When Mary dies seven years later, an Ojibway named Exodus Crow brings her body back to Brian and the children to be buried and to tell her story to her family. In this encounter, Brian seems to understand his wife's need to be 'away', as an expression of the Irish culture, which to his sorrow, is being weakened. But Liam, her son, accuses his father of being mad for believing in the stories and for not forcing Mary back to her family. The rest of the narrative describes Eileen's and Liam's adult life in Canada.

My reading of the novel concentrates on Mary's fate, and my crucial question is: is Mary mad? In this, I trace the intertwinings of (the reader's interpretive) diagnostic and (the narrator's) narrative power, the use of tools of narrative power in directing the audience's interpretations, and the narrative's relation to the psycho-sciences and the (possible) portrait of madness.

4.8.2 Narrative Situations, Experientiality and Grouping

The narrative is focalised by a number of characters, including Mary, and all of these focalisations are of equal importance in the narrative's structure. Thus, it concentrates on all these characters' experientiality – their qualia – and because there are multiple focalisations, the narrative is 'cross-referenced', particularly regarding Mary's state of being. The work, a heterodiegetic text, does not give us the kind of direct Labovian evaluation and point, like the homodiegetic texts encountered previously in which the narrators 'advertised' their text's importance and personal value to them, but the multiple focalisations give the audience a more complex structure of narrative situations (cf. Toolan 2001, p. 171), not unlike that encountered in Barker's narrator's multiple focalisations of her shell-shocked soldiers. The empathetic strategy of the narrator (Keen 2007, p. 142) also is more difficult to fathom, like in the other heterodiegetic texts we have encountered thus far (i.e. Barker's and Piercy's). In Urquhart's case, the empathetic directing of the audience is subtle and relies on the complex kaleidoscopic narrative situation structure of the text: the streams of knowledge directed by the narrator (and implied author) give the audiences multiple perceptions on the same issue, most importantly in the face of this study: the possible madness of Mary.

The groupings that are encountered in the first half of the story, which traces Mary's fate in Ireland, concentrate on the most important societal power division, which is between the oppressed Catholic Irish tenants and the oppressing Protestant British landowners. The tale's British characters, the brothers Sedgewick, are scientifically interested enough in Irish folklore to collect it from their tenants, and Mary's case therefore enchants them. They are depicted as benign but misguided in their relationship with the Irish population. The Irish, then, see Mary through their own mythology and religion. Being 'away', she is a special character in her community after the incident at the beach, but this specialness does not result in the kind of socially given stigma of madness we have encountered thus far. Mary is dreaded because she is considered to be an otherworldly creature: 'They feared Mary, but did not wish to offend her, fearing the retribution of "the others" more. They wondered if she would bring a changeling into the world and, if so, what dark powers it would have. Some of them secretly hoped that the girl had been given the ability to do cures, particularly for the complaints of women and the diseases of children.' (*Away*, p. 22.) In the eyes of the Irish community around her, Mary is considered an exact replica of her former self, a mere shelf of a human; the priest explains to

Mary's mother: '"Consider this," the priest replied. '"They" leave an exact replica of that which they've taken, in its place. This girl is an exact replica. She is here but she is not. […] There is nothing about her would have changed except that she is changed. […]' (ibid., p. 26.) The Irish community believes it is dealing with the supernatural[21] rather than madness. (I will return to the dichotomies of madness, the supernatural, and real in the second part of my study.)

Brian, Mary's husband-to-be, does not believe in the folklore myths at the beginning of the narrative. In the eyes of Father Quinn, this makes him a suitable suitor to Mary: he could bring her 'back' in his disbelief. Thus, he also brings to the narrative a third point of view (alongside the British folklorist study of the myths and the Irish belief in myths) on Mary's condition, namely that of a down-to-earth sceptical Irishman. He sees the mythical tales as mere superstition, but he does not conceptualise them or Mary's condition as madness, either. He advises his friend, the priest: 'When you convince yourself and her that it's all nonsense… that and your congregation… that will end it.' (ibid., p. 49.)

Mary's condition is seen as a kind of distress to the community after the male members, including Father Quinn, become haunted by her figure and have disturbing dreams about her. Mary herself does not consider her new state of being as bad, but feels intense love for her faery lover.

Later, in Canada, when Mary is dead and Exodus Crow returns her body to her family, her son, Liam, interprets the Irish myths (that his father Brian has once again started to believe, after hearing Mary's story from the lips of Exodus) as mere madness:

> [Liam says to his father:] 'She was your wife. She belonged to you-'
> 'She was my wife, but she did not belong to me.'
> 'Who did she belong to then? Do you believe in this spirit?'
> Liam had risen to his feet to ask the question. 'Do you?' he demanded. 'Do you believe in this fairy tale?'
> 'I didn't use to.'
> 'So, do you believe it now? Have you gone mad?' (ibid., p. 190.)

Exodus Crow's viewpoint also joins with the Irish community's viewpoint of Mary's condition: he sees great amounts of Manitou in her and her devotion to her faery

21. Cf. Wyile 1999, p. 31, who considers *Away* an example of magical realism in which (he quotes Chanady) 'the supernatural is not presented as problematic.'

lover. Thus, there is also a narrative progression of focalisations and viewpoints to Mary's being – and the reader's reactions to them (Phelan 2005b, p. 323). Liam is the first and only character in the narrative to conceptualise Mary's condition – the condition of believing in Irish tales – as madness. As the focalisation structure of the work gives access to each focalising character's experientiality equally, the effect is to create a kaleidoscope of viewpoints on Mary's condition. It is difficult if not even impossible to answer the question of Mary's possible madness in simple terms. Does the audience, then, have the right to grasp Liam's demanding words and see Mary simply as a madwoman?

4.8.3 Diagnostic Moments

The case for Mary's madness gets support from the possibility of interpreting her experiences and encounters with her daemon lover as psychotic hallucinations. There are never witnesses to the reality – nor to the unreality – of these encounters, as Mary is always alone when she is told to meet her lover. If scrutinised from the focus of reality or unreality, however, the encounters do have unreal elements. For example, shortly after marrying Brian, Mary is once again in contact with her lover at the shore of a nearby lake:

> Twenty minutes later, by the small lake with the island – the water closest to her cottage – she saw him standing in the reeds near the shore.
>
> As she moved through the grass, bent under her load that smelled of the sea, the word 'Moira' moved with her, its two syllables becoming clearer as she lifted her face to the lake. She saw that he who called her swayed like the reeds and shimmered in the early-morning sun, and she slid the straps from her shoulders and walked towards him with her spine straight and her throat open to the air. In her arms he was as cool and as smooth as beach stones, and behind him the water trembled and shone.
>
> When he entered her she was filled with aching sorrow. His cool flesh passed through her body and became the skin she would wear inside her skin. [...]
>
> Dancers, poets, swimmers. Their distant blood ran in Mary's veins until he who lay in her mind slipped back into the water. (*Away*, pp. 83–84.)

How should one interpret this passage? Is she experiencing delirium? Mary's physical and mental boundaries seem to give way to psychotic hallucinations when she feels her lover's presence. DSM-5 defines hallucination as 'A perception-like experience with the clarity and impact of a true perception but without the external stimulation of the relevant sensory organ' (DSM-5, p. 822). If we assume that Mary's lover is invisible to others, she is definitely hallucinating.

This interpretation would make Mary's focalisations unreliable, and result in a series of diagnostic moments that the reader would interpret as signs of her madness. The narrative power relations between the narrator and narratee, and implied author and authorial audience, would be active in this part of the tale, tying together narrative power and diagnostic power of placing Mary into a category of madness. This would mean that the heterodiegetic narrator would narrate through Mary's focalisations, but build them and the whole of her narrative in a way that would place them in a different light from those of the other characters, who would not be seen as mad. Mary's focalisations would be doubted at the level of Phelanian misreporting (Phelan 2005, p. 51). In this reading, I would be applying his notions of unreliable narration to focalisation: Mary would not 'really' see her lover, like she is reported to see through her focalisation. Instead, she experiences hallucinations that the heterodiegetic narrator would then report (because she is focalising through Mary) falsely, and the authorial audience together with the narrative audience and the narratee would make the diagnosis alone – in a way behind Mary's back – thus making the multi-layered communication (Phelan 2009, p. 310) work in unison.

The interpretation that Mary is hallucinating when encountering her lover is supported by the other focalisations. For example, it is supported by the focalisations of the Sedgewicks and (in this early phase of the narrative) Brian; and, later on, by Liam's interpretation of his father and (by extension) his mother. All of these focalisations and interpretations are by persons who do not believe in the materiality or mythical reality of Mary's lover. Mary being a reflector-character (Stanzel 1984, p. 145 and p. 151) is not herself in any kind of narrative power relation with any kind of audience, which means that Urquhart's narrator and her audience, together with the implied Urquhart and her authorial audience, are the chief diagnosis-makers when deciding if Mary's exact encounters with her lover are hallucinatory. Liam, or any other character, does not have access to these depictions as he is not a witness to them; however, his interpretation of Mary's story as madness gives additional grounds and support to the authorial audience's possible madness diagnosis, like that of the community surrounding Francie in McCabe's tale – making the reader's task easier.

Like in the cases of Piercy and Barker, my other heterodiegetic target narratives, the narrative power exercised by the heterodiegetic narrator, when suggesting a diagnosis of a character, is not 'proper' Foucauldian power. Diagnostic power would have all the features Foucault expects of a true power relation, including, for example, the subjectification of the object of power. (Foucault 1982, point 8.) Instead, the narrative power, even when suggesting a diagnosis, is 'only' communicative power. It is a power that attempts to direct the knowledge streams and, along them, the audience's reactions and interpretations, including their diagnosis-making, which is here considered to be an interpretation made of a character on a different ontological level from that of the audience as the diagnosis maker. As the character has no way of opposing the diagnostic moves of the reader, the implied author, or even the narrator – a part of Foucault's 1982 formulation of real power relations – the diagnosis-making is not full-blooded, and thus it is only a communicative move: it is an answer to the narrator's and implied author's communicative acts.

Is seeing Mary as a madwoman, then, or making a differential diagnosis of psychosis, justified?

4.8.4 DSM Psychiatry and Culture

To answer the question above, one must address DSM psychiatry's relationship with the cultural differences affecting the diagnosis and treatment of mental disorders. In DSM-5, a 'cultural syndrome' is defined as:

> a cluster or group of co-occurring, relatively invariant symptoms found in a specific cultural group, community, or context […]. The syndrome may or may not be recognized as an illness within the culture (e.g. it might be labeled in various ways), but such cultural patterns of distress and features of illness may nevertheless be recognizable by an outside observer. (DSM-5, p. 14.)

This would strongly suggest that DSM psychiatry imposes its own psychiatric categories and understandings upon other cultures' notions of experiences: it can offer an 'outside observer' position from which a diagnosis is possible, even when the cultural context itself cannot or does not want to make that same diagnosis, or any kind of madness diagnosis.

On the other hand, there is a genuine attempt at cultural sensitivity in DSM-5, as it supplies a number of semi-structured Cultural Formulation Interviews meant to help diagnosticians take cultural differences into account when diagnosing members of differing cultural groups (ibid., pp. 752–757). Furthermore, there is a telling formulation in the manual which 'acknowledges that *all* forms of distress are locally shaped, including the DSM disorders. From this perspective, many DSM diagnoses can be understood as operationalized prototypes that started out as cultural syndromes, and became widely accepted as a result of their clinical and research utility.' (ibid., p. 758.) These two positions: outside observer making a DSM diagnosis of another culture and DSM diagnoses also being cultural syndromes seem somewhat contradictory. How do they affect the perception of Mary's condition?

Mary can be diagnosed, even without her or her cultural community's acceptance as a psychotic on the grounds that her condition fulfils the DSM definition of mental disorder: 'A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.' (ibid., p. 20.) She can be seen to hallucinate, and to withdraw (as she stops speaking) from her environment into her own psychotic world of encounters with a daemon lover that presumably no one else can see (a clinically significant disturbance in her cognition and behaviour), and this causes considerable distress to her environment (remember the dreams and fears of her closest community). That she does not consider her own condition to be an illness or in any way harmful to herself can be ignored in this diagnosis (cf. Lönnqvist 1999, p. 30), since even the distress caused to the surroundings is enough to fulfil the definition's emphasis on a 'distress in social activities' (as in the cases of, e.g. paedophilia, where the disorder causes significant harm to the patient's surroundings, even though the patient may experience none). This is the position offered by the 'outside observer' option in the DSM-5 definition of cultural syndromes.

Therefore, to diagnose Mary, one must draw social borders and build groupings in order to see who is distressed by her condition. As already stated, Mary is seen in four different ways: as a charming and interesting specimen of Irish folklore (the British Sedgewick brothers); as a victim of nonsensical superstition (early Brian); as a supernatural creature (her Irish community and Exodus Crow); and as a madwoman whose belief in faery daemon lovers is sheer madness (Liam).

Thus, the work itself does offer a 'psychiatric position', namely Liam's. Like clinical psychiatry, he wishes to change Mary, to get her back from her faery land to be his mother again to stop his distress of being without his mother. As we have seen, there are also other characters, like Father Quinn, who want to change Mary because they are distressed by her. However, Father Quinn acted 'inside the myth' (Father Quinn, when haunted by the dreams of Mary prayed 'that she would be taken completely by "the others," and that nothing disturbing would be left in her place' (*Away*, p. 24)), he did not try or wish to overthrow the notional structure supporting the interpretation that Mary really is 'away'. Liam, on the other hand, wishes to do just that – to repudiate the Irish mythology behind his mother's affliction and shatter the necessities that underlie her need to be with her daemon faery lover instead of her children. Liam takes the 'outside observer' status provided by DSM psychiatry, too, even though he (obviously) is not a psychiatrist of any branch. Thus he places, in a single gesture, his father and his mother into the out-group of madness for believing in daemon lovers. Liam's diagnosis of Mary is an inexplicit lay diagnosis, but it differs from Innes's Jim's lay diagnosis of Mr Manack Sr., for example: Jim did not show any wish to change Mr Manack Sr., he only wanted to steer clear of him. Liam, then, even if he is a lay diagnostician, shows marked signs of having wanted to have his mother back to something he seems to perceive as sanity. Liam can be further placed in the psychiatric position by emphasising that he seems to place Mary's knowledge of her faery lover into the Foucauldian position of subjugated knowledge (Kusch 1993, p. 129). Thus, he builds an opposition of proper knowledge (the interpretation of Mary being mad) vs subjugated knowledge (the interpretation that Mary and her lover are supernatural).

Here, one can trace a double Phelanian narrative progression (Phelan 2005b) of characters and the audience's reaction to their change: first the audience is given the Irish interpretation of the myths as causing the affliction of Mary being supernatural or 'away'; then, the British folklorist interpretation of the same thing, which makes Mary a folklorist specimen; then Brian's (early) interpretation of Mary as a victim of superstition; and finally, both Exodus Crow's supernatural interpretation and Liam's interpretation of his mother and father being mad for believing in faeries. These groupings are elementally tied to the narrative situations (multiple focalisations and dialogues) which carry the complex experiential structure of the work (following each focaliser's experiences and interpretations of Mary's condition). The end product is a myriad of viewpoints of the same issue of Mary's condition, which is the chief effect of Urquhart's narrator's use of her tools of narrative power.

In his move of rejecting the Irish mythology, Liam's 'psychiatric' conceptualisation can be juxtaposed with the British Sedgewicks' sampling of Irish folklore and natural exhibits. Like the British brothers, psychiatry aims at rigorous scientific depiction and classification. (Osbert comes to seek his former tenants in Canada. Liam, on encountering him, starts to emulate Osbert's gestures, and later starts to amass land property like the British landowners in Ireland. This is a further support for my comparison between Liam's and Sedgewicks' interpretations of Mary, which both echo in some way the scientific, clinical DSM psychiatry.) In Ireland Osbert Sedgewick collects sea molluscs:

> When he was engaged in this activity Osbert paid little heed to the gorgeous small world he was disturbing. His specimens would gain significance and reality only when he got them home, put them under microscope, and accurately reproduced them on paper. But by then, of course, they would be dead. (*Away*, p. 85.)

This is a *misé-en-abyme* of the entire way the benign but misguided British Sedgewick brothers treat their Irish tenants: they claim to adore them and their culture but cannot see that the Irish and their culture are dying at their hands. This is also a vignette in my juxtaposition of DSM cultural psychiatry and Urquhart's narrator's characters: like the Sedgewick brothers, DSM psychiatry claims to respect cultural differences, but tellingly leaves the back door open with its formulation of an 'outside observer' who can diagnose cultural syndromes where the culture itself cannot. Like Osbert with his molluscs and collections of Irish cultural objects, DSM psychiatry places cultural concepts under the microscope of its own psychiatric perception. The outcome is that when Mary is seen as mad, Irish folklore and mythology are, by extension, seen to be mad as well. Connected to this dismissal of Mary's cultural context as something producing madness is the move that completely side-steps Mary's own experiences with her lover. She sincerely believes in him (thus strengthening my terminology of seeing her focalisations as intra-mentally reliable, see the last chapter in this study), and so do many of the other members of her community. Are they all mad in believing in faeries? How far can one stretch the mandate of the 'outside observer'? What is the ethical position the authorial audience should take in regard to Mary's condition as the consequence of the directing of the narrative's knowledge streams?

4.8.5 The Literary Point of View and the Freudian Option

The mandate of the 'outside observer' is restricted in the DSM-5 definition of 'delusion':

> A false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not ordinarily accepted by other members of the person's culture or sub-culture (i.e. it is not an article of religious faith). (DSM-5, p. 819.)

Here, again, the DSM definition seems to acknowledge cultural diversity: Mary's belief in her faery lover is not a delusion, since it is an article of religious faith in her community. This opens the door for a 'cultural' interpretation of Mary's condition.

A Freudian – and cultural – reading of Mary's condition is offered by Cynthia Sugars, who sees Mary as a person mourning her own exile: 'The experience of exile, […] is comparable to Freud's account of profound mourning, a condition marked by the "loss of capacity to adopt any new object of love [man or country]" […] From the beginning of the novel, the psychic state of being "away" functions as a metaphor for the migrant's state of mourning.' (Sugars 2003, p. 11.) She continues:

> The psychoanalytic sense of the internalization of lost and loved object is important here, for Mary's haunting is figured as a constitutive transformation of the self. Such pathological states of mourning occur through an imagined merging of self and ghostly object, as is clear when Mary later encounters her ghost lover near a lake on the Irish mainland. […] She thus assimilates the evanescence of Irish legend into her own identity only to become its embodiment[…] (ibid., p. 13.)

Sugars here demonstrates the psychoanalytic reading's capacity to interlink the cultural with the original psychoanalytical preoccupation with the pathological, the great flexibility of psychoanalytical theory to encounter and explain all that is human through psychoanalytical categories. Psychoanalysis seems to be more flexibly attuned to cultural contexts than DSM psychiatry. It can explain cultural phenomena, like an Irish exile's psychic state that is caused by her weakening relationship to her country and cultural background, through psychoanalytical theory formation. This is not surprising, as psychoanalysis has become a branch of cultural

studies, especially after being displaced as the dominant clinical psychiatric theory by brain psychiatry. Here, one can also detect traces of what Horwitz saw as the psychoanalytical blurring the border between sanity and madness by pathologising everyday life (Horwitz 2003, pp. 50–51). In the above interpretation by Sugars, is Mary a clinical case of mental disorder? Should or could she have been treated for her exile mourning?

Tellingly, Sugars does not explicitly call Mary a madwoman, and other analysts of *Away* have side-stepped the issue completely (Birch 1997; Kulberger 2007; Wyile 1999) or referred to the possibility of a readerly madness diagnosis only to note that Mary's 'engagement with alterity [...] exceeds the possibility of representation' (Goldman 2002).[22] Like Sugars did above, (and, e.g. Birch 1997 does as well) it is possible to see Mary as an embodiment of her culture. This means that if Mary is seen as a madwoman, the interpretative pattern of *Away* becomes impoverished, because then the domain of the cultural and mythical, and the supernatural and religious possibilities of interpretation, become stigmatised as sheer madness – a move that DSM psychiatry also attempts to steer clear of. This is the ethical position possible for an authorial audience: to see that by diagnosing Mary as mad is a move of diminishing the interpretative scale by leaving the cultural and mythical aside.

However, the psychiatric scene is fraught with tensions in regard to cultural differences: if seen in a Foucauldian light, psychiatry is power thirsty in its acquisition of new realms of experience to be considered its target (i.e. the mad). In the Foucauldian scheme, modern psychiatry as a science came to be only after it could demonstrate that there was something that could be considered to be solely its own territory – madness as a clinical phenomenon, a mental disease. (Foucault 2006.) And as Shorter also shows, psychiatry is still expanding its territory by creating ever new diagnostic categories and drugs to treat these new disorders (Shorter 2005). Against this background, the perception that Mary is mad can be seen, on the one hand, as a typical move made by modern psychiatry, and on the other hand, as a reminder of the psychiatrification of realms of life that are not perhaps always straightforwardly capable of being seen as mad. (Here, we again encounter the same theme as in the case of Piercy and Kaysen: the psychiatrification and pathologisation of realms of life that can be seen to be sane from another perspective (cf. also Horwitz 2003).) Mary's madness is a point of testing psychiatry's relating to cultural difference, and the outcome is contradictory: DSM psychiatry claims to respect cultural difference by not defining cultural deviance on the basis of modern Western ways of seeing

22. Goldman's formulation echoes Foucault's notion of madness being muted and impossible to 'say' directly. (Foucault 2006.)

them as psychiatric entities, but leaves the back door open for just this kind of activity, because it is 'widely accepted as a result of [its] clinical and research utility' (DSM-5 p. 758).

Would it be useful to diagnose Mary, then? As a literary character, she cannot be clinically treated. What about at the level of readerly interpretation, then? If Mary is seen as mad, one is blinded to the strong mythical-cultural dimension of her state, and this dimension risks being tainted by the stigma of madness. However, if one places the possible diagnosis at the same level as all the other possibilities of interpretation in the work, one could position it with Liam's viewpoint of his mother. Liam has been seen to turn his back on his Irish heritage (Wyile 1999, p. 35) and he also seizes the opportunity to become a landowner. Both of these features strengthen the juxtaposition with his mother, Mary, who is the embodiment of the Irish culture and the oppressed, landless tenants. This juxtaposition is further supported by Mary's relation to the native Ojibways, who also face the prospect of losing their land and culture at the hands of the invader-settlers like Liam. The opposition of Liam/Mary, or 'practical, oppressing and realist'/'mythical, oppressed and non-realist' (seen as mad by the practical Liam) is thus reinforced by the groupings and narrative progression, so the narrator can, by using these tools, direct the audience's reactions and interpretations of both Liam and Mary and the themes they embody and carry. One rhetorical purpose (Phelan 2005b, p. 323) of the narrative would thus be the juxtaposition of these two thematic bundles embodied by Liam and Mary.

One further approach that a psychiatric reading of Mary's condition can elicit is the late Laingian position: Mary is – in her psychosis – a shamanist visionary (Laing 1967). The daemon lover teaches her things she otherwise would never have learnt:

> She heard the rocks of lakes and oceans rattle in the cavity of his skull and then in the cavity of her own skull. A battalion of young men, their bright jackets burst open by battle, their perfect ribs shattered, their hearts broken apart, marched in his mind and then in her mind, and so she came to know all the sorrows of young men as she lay on the earth; their angry grief, their bright weapons, their spilled blood. Then across his forehead and hers sailed a pageant of all the ships, proud and humble, rough and fine, in which young men departed for the violence of the sea.
>
> There were any number of ways for young men to die. Some had been flung by vicious currents against the granite, some had watched the ocean's ceiling close over them while the fish they had caught swam free of the nets, some had died

> violently outside taverns after singing songs of love. Some took up arms against injustice and had been killed publicly on scaffolds or privately in ditches at the hands of the oppressors, the poetry of politics still hot on their lips. (*Away*, p. 84.)

This Laingian reading, too, is positioned against DSM psychiatry and its will to forcibly change the psychotic patient and stop the visions.[23]

So, which grouping does the reader engage with to see Mary? This question is partly caused by the complex and multiple focalisation structure of the text, which does not favour any of the focalisers over the others. The audience is left to choose; this emphasises the opportunity the reader always has to use her interpretative power to make interpretative, ethical and aesthetic preferences. Of course, the narrator and the implied author behind her do their best to control and direct the audiences' reactions, as we have seen over and over again in these pages. In Urquhart's text, however, the narrative structure is more kaleidoscopic than in, for example, Piercy's novel or in the homodiegetic, one-narrator narratives we have encountered thus far. It depends both on the narrative and the reader, and the unique dynamisms of reading. In my reading, seeing Mary as a madwoman would side-step real cultural and religious issues. With this in mind, Liam's defining his father and mother as mad, because of the cultural-supernatural interpretation, seems unjust. On the other hand, Liam's reaction is understandable as well: he loses his mother at a very young age to something he cannot ever understand, and therefore considers it, in his practical mind, as madness. Thus, Liam gives a 'this-worldly' definition of something weird (as we will further see in the next part of this study).

The narrator of *Away* uses her tools of narrative power to create a polyvalent text full of prisms – a true kaleidoscope of meanings. The founding motto of the narrative is Mary's daughter's (Eileen, who is Esther's grandmother) remark to Esther, when she tells the narrative the first time: '"Try to understand, but try not to interpret." "Any interpretation is a misinterpretation," Eileen had told Esther. "Remember that."' (ibid., p. 12.) This is a caution to the audience as well: the danger of misinterpretation is real when the narrative is full of perceptive focuses. The psychiatric perception is only one possibility among others. It is a rather imperialist perception, though: it is pregnant with the attempt to overwrite other perceptions that do not see madness where it does, even when it attempts to steer clear of this imperialist tendency.

23. It is, though, possible to argue that Laing's late formulation of psychosis as an even desirable state is a romanticisation of madness that ignores its truly painful aspects.

What is madness then, in Urquhart's novel? It seems to be a category of understanding offered by an 'outsider' viewpoint to a cultural condition. It is thus, ultimately, a product of seeing through the psycho-scientific framework, of practical and scientific rationality as opposed to the mythical and religious. The novel does not directly depict any branch of psycho-sciences, but I argue that it offers Liam's practical and rationalist perception as a kind of crude template for a psycho-scientific explanation of Mary's condition. It is possible though to see this psycho-scientific explanation, through the Foucauldian and Laingian points of view, as having cultural imperialistic tendencies. My Foucauldian-Phelanian model shows us how the narrative structures of the novel, with its specific ways of using the narrative power tools of narrative situations, progressions, experientiality and groupings, make a kaleidoscopic perception to Mary's condition possible, which weakens the possibility of a unilaterally dominant psycho-scientific viewpoint.

Madness and cultural difference is a very vexed issue, which I hope my reading of *Away* has made visible. With a text like Urquhart's, the reader must be careful in her reading when attempting to untangle the knotted perceptions of madness and culture. The text offers a position in which the madness diagnosis is plausible and understandable (Liam's perception), but it is not the only possible way of seeing Mary, and it is juxtaposed with other viewpoints. The reader can choose, or choose not to choose, between these viewpoints. My choice is to remain cautious of the cultural imperialist side of DSM psychiatry: I see Mary's condition as a cross-roads of culture, myth, and truly deviant behaviour, which can be interpreted in multifarious manners. This is the message I receive from Urquhart's narrator, whose structuring of her text and use of her tools of narrative power, in my reading at least, favour a multi-perceptive approach over any one perception or focus.

4.9 Summing Up: My Findings and on the Art of Literary Diagnosis–Making

In this summary, I will explore some of my central findings on the three interconnected themes I have considered in the previous pages: the way my interpretive tools of narrative and diagnostic power can be seen to work in these texts; the way my target texts depict madness; and the way this madness depiction is related to the depiction of the psycho-sciences. I will also touch upon certain problems, as well

as the benefits and limits, of my analytical model. Finally, I will consider the justification of literary diagnosis-making, which serves as a coda for the whole chapter of my target text analyses.

4.9.1 Narrative and Diagnostic Power: Intertwinings

In these pages, we have seen time and again how the theoretical tools of narrative power I defined in the previous chapter can be used to interpret the narrative strategies and agendas – the Phelanian rhetorical purposes – of different kinds of narrators. The rhetorical purposes of using the tools of narrative power in my target madness narratives are often intertwined with diagnostic purposes of various kinds. In this way, I have practised my vein of psychiatric literature research by studying the nexus of narrative and diagnostic power in order to elucidate the different ways these narratives use the madness depictions and psycho-scientific frameworks with their possibilities and limits as narrative strategies and structures. I have concentrated on the power relational side of madness narratives, namely the power of narration intertwining with the diagnostic power. This focus emphasises the dynamism of madness narratives, and that these narratives are power fields of both narration and diagnosis.

The thematic tools of experientiality and grouping were seen to be used to direct the audience's reactions and its empathies regarding the storyworld occupants. The groupings formed by the narrators are elementally tied to the revealed experiential contents of these groupings, and they are equally elementally tied to the narrators' chosen narrative technique of narrative situations: I argue that the amount and quality of exposure given to different characters' experiential spheres through different kinds of narrative situations are at least an attempt to guide the audiences' reactions to these characters. (As Keen pointed out, the actual empathies of the audience are difficult to pre-direct or predict; I will return to the problems of empathetic strategies shortly.) The homodiegetic narrators were seen to use the empathetic strategies directly by handling their own in-group/out-group memberships; the heterodiegetic narrators operated more covertly (as they themselves could not be grouped as easily as the homodiegetic narrators) by, for example, juxtaposing different groupings and by rationing the amount and quality of different groups' experiential exposure. The texts' narrative technique of narrative progressions further directs the streams of information, hence the knowledge/power of narratives. The narrative technique

of narrative progression of diagnostic moments is a tool of narrative power especially used by the narrators in building up the specific storyworld representations of madness and the psycho-sciences. In most of the texts, the progressions build a cumulative mass of moments of diagnosis which is then used to direct the audiences' perception of specific diagnosed characters – either directly by declaring them mad (e.g. Innes's Jim or McGrath's Peter's accumulation of diagnostic evidence) or (also) indirectly by creating a backdrop of perceived-insanity-in-others for their madness (e.g. Plath, in whose text all the diagnostic moments are connected to diagnosing Esther, even those that are about other characters). In those texts where the aspect of madness is less clearly marked out (in McCabe and Urquhart), the narrative progression of diagnostic moments is more difficult to display, due to the problematic nature of how to delineate madness from seemingly closely related phenomena like play, myth, folklore, or religious vision.

These tools of narrative power, then, can be seen to connect to the diagnostic power used by characters, narrators, implied authors, and readers: the narrative power tools were seen to direct and use diagnosis, both psycho-scientific and lay variations, to tell of madness in specific manners for specific purposes, both narrative and diagnostic. I asked: what do the narrators and implied authors *do to/with* these diagnoses and psycho-science depictions in their narratives? How do the fictional narratives at the same time position themselves in the diagnostic power field of clinical psycho-sciences and their counter-forces, debating with and commenting on them?

4.9.2 Madness and the Problematisation of the Psycho-Sciences

There are three general ways in which the narratives relate to diagnosis through psycho-scientific frameworks:

1) The narratives may strive to support the psycho-scientific diagnosis directly by referring to specific diagnostic categories and by, for example, showing – through the use of the thematic tool of experientiality and the qualia – the nature of how it feels to be a doctor or a patient in a given psycho-scientific framework, in order to support this specific psycho-scientific framework. I argue that this happens, or is meant to happen, in the novels of McGrath, Barker, and partly in Plath (in Esther's experience with Dr Nolan).

2) The narratives may strive to challenge, question and even accuse the psycho-scientific frameworks – again, for example, by showing the qualia of the patient or doctor. This happens in my view in the novels of Piercy, Kaysen, McCabe, and partly Plath (in Esther's first experience with the psycho-sciences) and Barker (with Dr Yealland).
3) The narratives may be completely ignorant of the psycho-scientific frameworks and function on the basis of lay notions of madness (Innes's novel) or offer completely different kinds of explanatory frameworks (as in Urquhart's novel, where Mary's condition was seen from the point of view of myth and folklore as well as – or even more forcibly than – through the focus of madness).

The narratives thus have very different ways of operating with the psycho-scientific diagnosis, and the way the narratives depict the psycho-sciences obviously affects the way they represent madness.

When the psycho-sciences are seen (at least partly) favourably, as in McGrath, Plath, or Barker, the depiction of madness acknowledges madness as a mental dysfunction: that there is something truly wrong (that it is possible to more or less universally see as a malfunction) in the psychic functioning of the patient which justifies the patient being categorised and treated psycho-scientifically like the psycho-sciences maintain. McGrath's Peter wanted to establish Stella's infatuation with Edgar as sexual obsession, a psycho-scientific, psychoanalytically perceived dysfunction; Plath's Esther saw herself (also) from the viewpoint of having a psycho-scientifically perceivable mental dysfunction (she for example studied a book on abnormal psychology and found in it connections to her own condition); and Barker's shell-shocked officers all suffered from a psycho-scientifically perceivable mental dysfunction. The categories are used to explain the deviant psychic functioning and behaviour of the mad persons. In all these depictions, the psycho-sciences are (also) seen from the viewpoint of using assistant empowerment, and capable of offering real cures and helping the suffering patients.

When the narratives want to directly question or problematise the psycho-sciences (along the lines of Foucauldian and critical psychiatric frameworks), the phenomenon of madness more prominently takes up different guises: it is seen as a stigmatic societal category, and/or essentially a social construct which has much less clearly defined borders than the psycho-sciences making diagnoses would wish to acknowledge. The narratives may also criticise the scientific basis of the psycho-sciences. In Piercy's and Kaysen's novels the social and societal aspects of madness and the

psycho-sciences are used to accuse the psycho-sciences of social and societal stigmatisation (Kaysen), or of extreme biological reductionism, and of being a power tool of social and societal control and coercion (Piercy). Kaysen also takes up the scientific problems and challenges the psycho-sciences by remarking on their inconsistency, self-contradictoriness, and arbitrariness. In McCabe's novel, the ridiculousness and ineffectuality of psycho-scientific intervention in the mad character's world underlines its failed societal and social mission.

However, in those of my target texts that depict the psycho-sciences in more favourable ways, it is important to note that the social and societal problematisation (through seeing the coercive societal power aspect of psychiatry and the social construct aspect of madness) is also present and can be taken up by the audience. Barker's Dr Rivers must wake up to the madness of the war machine he is serving (the military-societal power aspect of psychiatry becomes glaringly clear to him). Plath's Esther reminds the audience of the societal causation of her madness, in which the patriarchal psychiatric power has its own share, and its widespread nature and ill-defined borders (which opens up the question of the justification of diagnosis as it has also socially and societally formed stigmatic characteristics). McGrath's Peter (in my reading at least) can be accused of being blind in his diagnostics; his narration can be argued to be unreliable and an instance of psychiatry's power hungry appropriation of Stella's viewpoint to the extent that her own viewpoint vanishes from the view. The mental dysfunction or aberration of madness is not, even in these more favourable texts, a socially neutral, but potentially stigmatic category, and psychiatry is seen as being at least partially and potentially power hungry and coercive.

Other points of problematisation of the psycho-sciences are the troubles of readerly diagnosis and representations of treatment: when the diagnostic categories available to the audience at least partly fail (as in the cases of Innes, McCabe, and Urquhart), or when the narratives paint a grim picture of psycho-scientific treatments (in Piercy's, and partly in Plath's and Barker's novels), the psycho-scientific frameworks are questioned, either epistemologically (how to delineate the borders of specific literary madness) or ethically (how to accept the way the patient characters are treated). These troubles further emphasise specific problems of the psycho-scientific frameworks as interpretative and reading strategies – the first at the level of the reader and the reading through the psycho-scientific frameworks, the second at the level of the storyworld and the ethics of the representations of the psycho-sciences.

Thus, we can see how the narratives connect to the psycho-scientific frameworks, debating with and commenting on, submitting to and challenging, or ignoring and

supplementing them. The reading through these frameworks has opened up the works in specific ways, throwing light on their psycho-science and madness depiction. (I will shortly return to the problems and possibilities of reading through the psycho-scientific frameworks in detail.) The narrators and implied authors can be seen to use the depiction of the psycho-sciences and madness in their own ways: to submit to the psycho-scientific agendas in order to further their diagnostic agendas (as in McGrath's exposition of Stella's madness as a psychiatric case); to use diagnostic power to further their narrative agendas (as when the theme of madness bolstered the adventure plot of Innes, or in Barker's novel, where the evolving of the theme of madness was an elemental part of the narratorial agenda of showing the madness of war); or more a mixture of both diagnostic and narrative agendas in challenging the psycho-scientific paradigms (as in, e.g. the works of Plath, Kaysen and Piercy, were the theme of madness was central to the development of Esther's, Kaysen's, and Connie's tales and the narrators' critique of the society and the psycho-sciences). The option of side-stepping the whole issue of the psycho-sciences or perceiving even madness itself as a relevant reading of the narrative strategies were encountered as well in the case of Urquhart's novel; in *Away*, the theme of madness and the possibility of reading through the psycho-scientific paradigms faced grave difficulties when they were assessed as viewpoints on Mary's mental landscape.

4.9.3 Internal and External Diagnoses: Madness as a Literary Device

One can further note certain differences between self-diagnosing homodiegetic narrators and homodiegetic narrators making external diagnoses. In Innes's and McGrath's novels, the external diagnoses were (at least meant to be) unproblematic, whereas Plath's and Kaysen's novels both questioned the bases of their self-diagnoses by taking up the soci(et)al aspect of diagnosis. The latter could be seen as a narrative power move made in order to counter the socially formed stigmatic nature of madness and diagnosis: the narrator questions the basis of the self-diagnosis she must make to support her narrative power, which we might surmise to be undermined by the aspect of her madness, a feature possibly seen as causing aversion from the part of the (sane) audience. The external diagnosticians (Jim and Peter) could be seen to use the unproblematically meant diagnosis to bolster their narrative power: Jim's use of the diagnosis of Mr Manack Sr. was a narrative power move meant to further support his efforts to convince the audience of Mr Manack Sr.'s dangerous-

ness; Peter's diagnostic power gave support to his narrative efforts (and vice versa, as his tale was a psychiatric tale). Thus, the narrative and diagnostic powers can be seen to make different kinds of patterns in different narratives. In Plath's and Kaysen's novels, the diagnosis was at least partially questioned by the narrative power moves (of opening up the self-diagnosticians' experientiality and own viewpoint); in Innes's, the diagnosis elementally supports the narrative power; and in McGrath's, an inter-supportive power pattern of both narrative and diagnostic powers is built.

The heterodiegetic narrators, then, did not have in their diagnosis the aspect of self-diagnosis or diagnosis of another character on the same ontological level as the narrator. Through focalisation and dialogues, the heterodiegetic narrators depicted the characters' self- and external diagnoses, and made their own diagnoses as well – which were at the level of the narrator–audience communication, and thus not 'full-blooded' Foucauldian power moves. The heterodiegetic narratives could be seen to use the characters' diagnostic power moves as thematic structures in building their storyworlds and their statements on madness.

The reader's solo diagnosis-making is a special case of literary diagnostics: in McCabe's or Urquhart's novel, the reader had to work (almost) alone when the narrator (McCabe) or the focalising character and her social environment (Urquhart) were (almost completely) unaware of the possibility of madness as an explanatory category applicable to them. The solo diagnostics further emphasised the problems of the psycho-scientific reading of these literary texts. In McCabe's case, the DSM or psychoanalytical categories at least partly failed; in Urquhart's case, the folklorist, cultural, and religious modes of explanation made it difficult to perceive the borders of Mary's possible madness. The reader could attempt a psycho-scientific reading, but her efforts were made difficult by the narrator's and other storyworld occupants' differing perceptions on the possibility of seeing madness in them. The implied author's way of acting behind the scenes was most pronounced in McCabe's novel, due to Francie's unreliability on the issue of perceiving his own madness. The implied author–authorial audience communication made the diagnosis of Francie a central act of readerly interpretation, and the outcome was such that Francie received the reader's empathy for something he was unaware of: his own madness, its depth and its causation. Thus, his attempts at controlling his own tales' narrative power streams was thwarted, and the diagnostic (narrative/interpretative, not 'full-blooded') power used by the readers against the current of his narration took the upper hand.

The aspect of madness depiction used as a literary device is a relevant viewpoint as well: Innes and Barker both used madness depiction forcibly as a literary device:

Jim uses it to bolster the thickening of his adventure plot, and Barker's narrator to convince the audience of the correct way to perceive the central theme, the madness of war. The way these narrators handled the theme and depth of madness depiction does, however, differ markedly: Jim gave only rudimentary outlines of the mad character's inner being, whereas Barker's narrator delved deeply into the experiential beings of her mad characters, which intertwined elementally with her main theme of the madness of war. Thus, I argue, that the 'literary device' may also be thematically central and a well-developed component of the depiction of the phenomena in question. (I will return to the issue of madness as a literary device in the second part of my study, where I consider Robin Downie's development of the theme.)

4.9.4 What Is Madness, Then?

Madness in these eight target texts can be seen through the psycho-scientific and lay diagnosis, both readerly and intra-textual. Against this background, madness is at least the following: an explanatory category, used to clarify other's or one's own odd behaviour (in the novels of Innes, Barker, McGrath, Plath, and Urquhart); a social category in which mad people are placed in order to confine them notionally and to enable the sane population to define their own identity against the mad (in the novels of Barker, Plath, McGrath, McCabe, Piercy, Kaysen, and Innes); and a societal category, which is defined by the psycho-sciences as societal actors guarding their own scientific and societal territory, that of the realm of madness as their object of study and intervention (in the novels of Plath, Piercy, Kaysen, and Barker). Thus, one can see that madness is not a stable or monolithic phenomenon. It has protean faces, depending on the eye of the beholder, i.e. the position of the beholder in relation to the psycho-sciences, on the one hand, and the in-group/out-group memberships of madness or sanity on the other.

These characterisations of madness can be seen to be in contact with the real world characterisations of madness partly through their connection to the psycho-scientific frameworks: madness as an explanatory category harks back to the psycho-scientific paradigm of classifying and treating different forms of madness. The social and societal categories of madness, then, point towards the critical viewpoints of the psycho-sciences and their societal power position. Thus, one can note that the psycho-scientific paradigms and their counter-forces are relevant frameworks to the study of madness narratives: they shed light on the way literary madnesses

are connected to the real world ones. I argue that they thus have certain poetical, interpretative relevance.

The lay diagnoses of Innes and Urquhart, the two narratives featuring no explicit connection to the psycho-sciences, form a distinct case. Their resistance to psycho-scientific reading came in part from a counter-theoretical perception of the mad person. For instance, in Innes's novel, we saw how Mr Manack Sr. was handled like a representative of classical 'unreason', and also by the moral gesture of exclusion-by-inclusion that Foucault studied in his thesis, thus emphasising the way modern psychiatry was absent from the narrative. This gesture dates back to pre-psychiatric practices, and the community around Mr Manack Sr. simply ignored psycho-scientific reasoning. The resistance also came from seeing the inappropriateness of the psychiatric gaze to capture the mental landscape of the person deemed possibly 'mad'. In Urquhart's novel, Liam's position resembled that of modern psychiatry facing madness connected to a different cultural environment. Yet his 'psychiatry-like gaze' faced opposition from the viewpoints on Mary, that of Brian, for example, and this gaze could be seen as inappropriate in itself to cover the whole spectrum of Irish myth and belief present in Mary's 'condition'. The Laingian reading, another counter-force reading of Mary's 'condition', only strengthens the viewpoint that psychiatry is not the most useful framework in her case.

Thus, it seems often – but not always – feasible to read madness narratives through psycho-scientific paradigms: this reading strategy at times gives us the opportunity to study the representations of madness in connection with the real world madness theories and, through that connection, to gain insights into both the representations of madness and the psycho-sciences. However, there are certain problems with this approach, and I shall tackle these forthwith.

4.9.5 The Problems, Benefits and Limits of My Model

My Foucauldian-Phelanian model of narrative and diagnostic power can be seen to offer certain benefits in interpreting madness narratives. It concentrates on the ways the meanings of madness are constituted as an interplay of both the psycho-scientific, and by extension lay, diagnostics (the diagnostic, Foucauldian/Karlbergian power), and narrative power. In other words, it concentrates on the ways narrators, and implied authors in the final instance, use these diagnostic powers to build storyworlds to further their communicative goals (the Foucauldian communicative power, and

Phelanian rhetoric direction of interpretation). Thus, the model is dynamic and tuned to the contingencies of narration: the analysis of literary diagnosis cannot sidestep the literary quality of the text. It also offers opportunities to examine different layers of diagnosis-making (intra-textual, readerly, homodiegetic, heterodiegetic). My rendition of Foucauldian narrative theory solves the problems of the earlier Foucauldian narratologists by insisting on the ontological layers of diagnostic and narrative powers; and by acknowledging the fact that narrative power is not 'proper' Foucauldian, full-blooded power, since it lacks certain aspects of this subjectifying power. It also heightens the Phelanian model's power aspects, and supplements it by noting that the cognitivist experientiality is the content of the rhetorical 'what', and by emphasising the empathetic strategies of the narrators.

Clinical psycho-scientific diagnosis-making is one central basis for my model, as it directs the perception towards the (Foucauldian) use of power, namely diagnostic power and narrative power (as its co- and counter-force in madness narratives). My model is thus especially attuned to the significance of the clinical psycho-sciences as guardians of the knowledge of madness. I have not given much space for more 'cultural' explanations of madness (e.g. the later psychoanalytical developments of cultural theories), because I have seen the clinical psycho-sciences as real societal actors in the field of the study of madness, and that the power aspects emphasised in the clinical encounters are a valid and little-studied basis of interpretation for literary representations of madness and its treatment. The Foucauldian power aspect also brings forth another social and societal phenomenon: the possible stigma of madness. The subjectifying Foucauldian power of diagnosis-making places the object of power into a dependent position, tied to self-knowledge, which she (in the context of madness narratives) may find difficult to assimilate or accept, since it is often seen as socially inferior.

However, as we have noticed along the way, there are certain problems in the details of my model, namely my using of the Keenian analytical tool of empathetic strategies. I have had to ask: How do I decipher the group statuses of both the (homodiegetic) narrator and her audience? Most of my homodiegetic narrators could be placed on the axis of sanity/insanity, but knowing the in-group features of their narratees was more problematic: only Kaysen, my sole factual author, names her audience specifically – the others did not specify their narratees. In Kaysen's case, I had the problem of not knowing for certain *her own* in-group status. This makes the deciphering of the Keenian empathetic strategies problematical: if we do not know for certain to what kind of audience the narrator is directing her narrative,

or the in-group statuses of the narrator herself, it is difficult to suppose anything about their empathetic strategies, since knowledge of the in-group statuses of *both* the narrator and the audience is needed to specify the empathetic strategy in use.

This problem of knowing the in-group statuses of the relevant actors is an elemental feature of the Keenian tool in general: even if we try to apply this tool to *authorial* empathetic strategies, as Keen originally formulated it, we still have problems with the possibility of often not knowing enough (extra-textually) about the authorial intention or her in-group statuses. The counterparts of the authorial strategy, the authorial audience and its in-group statuses, also prove to be as difficult to probe. Rabinowitz, with his 'corrupted' authorial reader (Rabinowitz 1998, p. 26), and Phelan, with his notion of ideal reading (Phelan 2005, p. 213) by the authorial audience, both point to the possibility of the authorial audience encompassing the point of view of the mental patient: the reading meant by the author may well include taking into consideration the mad character's point of view if it is elemental to the understanding of the work. However, knowing the authorial audience's preferred in-group statuses is as difficult as that of the narratees, since in all reading 'like the authorial audience', we tend to have only suppositions and interpretations that can never be definitively verified.

A further problem comes from the nature of the notion of 'in-group' in the first place: how homogeneous are they, after all? The grouping of 'mad' or 'mentally ill' people, for instance, is hardly monolithic. In these pages we have already encountered a large number of very different kinds of people – all capable of being called 'mad' in one way or another. Thus, the question of 'reading like' an insane or sane person is fraught with tensions. Do schizophrenic persons 'read like' depressed persons? Do all depressed persons 'read like' all the other depressed persons in their empathetic reactions to the portraits of various literary mad characters? Lacking reader response laboratory tests, I can only assume, and my assumption is that they do not. The in-group status of mentally ill people is a very loose category, and anyone trying to 'read like' a mentally ill person can hardly ever claim to cover all the possible human responses to the same text that can be engendered by all mentally ill people; it is surely universally impossible in all cases to try to 'read like' a large group of people.

The questions to ask, then, are whether there is the true opposition of in-group memberships between the mad and the sane, how clear it is, and how the people on either side of the line really experience their memberships. In my target text analyses, I have tried to study this intra-textual positioning. For example, I have looked at how Plath's Esther and Kaysen experience their (possible) madness as an

in-group status, that is, how clearly delimited the representations of group memberships are in these texts. Kaysen and Plath both poignantly take up the theme of the blurred borders between the groups. Innes's Jim and McGrath's Peter, then, take another kind of position in regard to these groupings: for them, the line is more pronounced. The way these intra-textual positionings affect the reader in her own group statuses is more controversial, or at least often more difficultly established. As Keen herself pointed out in connection to character identification, predetermining the empathetic responses of the audience is rather hard (Keen 2007, p. 72). The group memberships can be a thematised part of the text in question, and the text itself then pronouncedly takes part in the discussion on these memberships: they are certainly part of the narrative agendas to which the audiences must respond. The supposition that the memberships of the audience may have an effect on the way it perceives these themes is, still, a defensible starting point. The derivation from a loose in-group membership to a monolithic and certain reading is the risky step to take, yet one can ask, as I have: how does the narrator control her groupings, what does she seem to aim at while doing so? The reading reached is, however, only one approximation: it is one interpretation of the narratorial aim and control. However, is this not true of any reading? Is it not always just one interpretation?

Keen's empathetic strategy tools therefore have their limitations and problems. Are they of any use, then? As a presupposition, they do, I argue, have importance: they help us to remember that the authorial and narratorial agendas have, as a partial goal, the drive to affect our emotions, our empathetic reactions, and our ensuing interpretations of the texts, by touching upon our group memberships. They also serve to remind us that narrators and implied authors have specific agendas in the first place – they have narrative aims and wishes to affect the audience – why else narrate? Even though the empathetic strategies may often be difficult to establish for certain, to assume that many a narrator and author – if not everyone – has them, is important to keep in mind.

Finally, there is the question of the general applicability of my Foucauldian-Phelanian model: can it be applied universally, to any kinds of narrative, not just madness narratives? This is a question that demands a series of new studies, but something preliminary can be stated already. The narrative power tools of narrative techniques and thematic tools may have different kinds of applicability. The narrative techniques of narrative progression and narrative situations are to my perception universal and applicable to all narratives. The thematic tools, then, may have more restrictions. The theme of experientiality has been argued by the cognitivists to

be a universal feature of narratives, but the grouping tool seems to me to be more tied to specific features of madness narratives. The groupings considering mental status – and even more the specific grouping considering possible stigmatisation through madness – is rather naturally more applicable to madness narratives than to stories not featuring mad characters. The grouping tool may have importance in other ways in these other stories: there may be, even must be, other groupings that are elemental to these stories. So, it should be possible to apply, with modifications, this model to other narratives as well.

I do not claim, however, to have covered the field of narrative power tools in its entirety. I have only formulated tools that I have found important and useful in reading my target madness narratives, in following the questions of diagnostic power being intertwined with narrative power, which connects to the psycho-science and madness depiction of these narratives. There are surely other tools of narrative power that I have not touched upon – even in case of madness narratives, for example, in their specific aesthetic persuasion – but my intention has been to open up the discussion to include the notion of narrative power in the first place. This study has posed the question: What kind of a power is narrative power? To end this chapter on the diagnosis of madness in narratives, I will examine some of the issues of literary diagnosis-making, including the justification and utility of it all.

4.9.6 Coda: On Literary Diagnosis-Making

In madness narratives, as we have seen, sometimes only the reader may make the strict differential diagnosis, and often only between the lines of narration, using hints given by the implied author. This was the case with Plath's Esther, Innes's Jim, McCabe's, Francie and Urquhart's Mary.

Here, Fludernik's 'narrativisation' becomes a handy tool. Fludernik formulates her concept by stating: 'Narrativization is that process of naturalization which enables readers to re-cognize as narrative those kinds of texts that appear to be non-narrative' (Fludernik 2005, p. 46). She formulates naturalisation by stating: 'Naturalization processes are reading strategies which familiarize the unfamiliar, and they therefore reduce the unexpected to more manageable proportions, aligning with the familiar' (ibid.). Fludernik's narrativisation and naturalisation are processes that lie on the basis of 'natural parameters' of story-telling as understood in the cognitive theoretical vein. Fludernik builds a four-layered model. On the first level, there are the axiomatic

natural parameters of real-life experience (core schemata from frame theory) which accommodate presupposed understandings of agency, goals, intellection, emotions, motivation, and so on. On the second level, there are four basic viewpoints (telling, viewing, experiencing and acting) available as explanatory schemas of access to the story. All four relate to narrative mediation – to narrativity. On the third level, she locates well-known naturally recurring story-telling situations that provide individuals with culturally discrete patterns of storytelling (storytelling situations, understanding of different types of stories, narratological concepts such as narrator etc.). On the fourth level, readers use conceptual categories from levels one to three in order to grasp textual irregularities and oddities (the 'narrativisation' – the interpretation of literary texts – happens on this level). (ibid., pp.43–46.)

Jan Alber has introduced some additional perceptions on the theme of naturalization. He sees that even the most bizarre narrative structure is 'still part of a purposeful communicative act' (Alber 2009, p. 82) that can be naturalised, that is, understood from the basis of the assumption that it is about human concerns. He proposes five reading strategies, the first of which directly concerns madness narratives and their interpretation – reading through the assumption that 'some impossible elements can simply be explained as dreams, fantasies, or hallucinations ("reading events as internal states")' (ibid.).

Naturalisation and narrativisation are thus processes which the reader uses to make sense of strange narrative phenomena. The diagnosis of madness, making the interpretation that certain oddly behaving/narrating character/narrator is mad, is one possible move for the reader when confronting a narrative. Fludernik's and Alber's conceptions of naturalisation and narrativisation are thus valuable tools in tracing the reader's diagnosis-making.

In the first part of my study, I have studied the power relations present in making diagnoses and narrating about them. In the process, I have attempted to apply my psycho-scientific frameworks to these narratives in order to see the limits and possibilities of reading through psycho-scientific frameworks. My target texts (e.g. Kaysen, Barker, and McGrath) have sometimes themselves given me the tags to make these diagnostic moves. However, as a reader, I have also had to use Fludernik and Alber's naturalisation process alone to make diagnoses without the help of diagnostic name-giving by the narrative.

This process of naturalisation can be illustrated by the analogy of the psychiatrist's consultation room: how would a psychiatrist diagnose the character/narrator if she entered the space of her consultation room? The context of the consultation

room gives a (rather natural?) framework for the possibility of detecting madness. As a reader (who has had to try to enter the authorial audience's position by first joining the narrative audience) I have used this naturalising framework, detecting madnesses, symptoms, diagnostic categories and idiosyncrasies. These processes of naturalisation have opened up a channel between the narratives and the real, shared world; this is how the context of naturalising through the concept of madness gives a certain tinge to the interpretation of these texts. The literary phenomena gain an extra dimension through being diagnosed as representations of madness. As we saw above already, the viewpoint of psycho-scientific reading makes it possible to connect the narratives to the real, shared world by noting the ways these works seem to comment, ignore, supplement, use, submit to and debate the psycho-scientific and counter-force theories. The psycho-scientific diagnosing of literary madnesses seems from this viewpoint poetically relevant, giving a new and significant focus to the study of literary madness.

On the other hand, can this process of naturalisation through the concepts of madness and the psycho-sciences also mean that the diagnosis narrows down the perception of narrative? Is it possible that a diagnosis of madness somehow impoverishes the perception of the narrative through seeing something as mad instead of seeing it as, for example, a generic, literary phenomenon (seeing the genre of nonsense only as schizophrenic, for example, or Jane Urquhart's Mary only as a madwoman)? This question could also be suggested by Fludernik's four levels: the narratological level is on a lower level (level three) when compared to the ultimate naturalisation on level four. Does Fludernik favour naturalisation (in my case through the concepts of madness and the psycho-sciences) to narratological considerations of the same text by making the narratological level serve the naturalisation level?

Here, one can ask: is madness 'just' madness? Is madness not a valuable dimension of interpretation that can be – and must be – detected in narratives when warranted? The emphasis is on the word 'just': if literature is perceived through the viewpoint of being 'just' madness, one can lose track of the 'literariness' of literature – its value as having its own, artful dimensions. If madness, then, is seen as 'just' madness, one can lose track of the value of madness as a phenomenon in its own right, as a category of interpretation, a horizon of its own. What is the important factor that the horizon of madness can give to the reader? Madness is many things, as we have seen in the previous chapters: the fitting of a diagnosis has complex facets, which I have tried to delineate in this part of my study. For one, reading through the notion of madness, (and also the psycho-scientific or counter-force reading) can

offer the reader a possibility of understanding something that often seems strange: this is the crux of both the Fludernikian naturalisation and the Keenian broadcast empathetic strategy I saw many of the homodiegetic narrators used in their handling of the theme of madness. On the other hand, this 'domestication' of the strangeness of madness narratives may, through diagnosing narrators and characters, open the way to oversimplifications and the flattening of the perception of the strange literary experiences. Surely this happens sometimes, as was in the case of Urquhart's Mary. The making of literary madness diagnoses is clearly a fine balancing act.

What happens, then, when the diagnosis is made in the context of literary characters and narrators? The literary phenomenon interpreted is placed into a new category by making a distinction between what is 'sane' and what is 'mad'. At the same time, these categories are strengthened, or are at least attempted to be strengthened, by exclusion, delineation and/or confinement of the concept of 'madness' from that of 'sanity'. This is part of the power of clinical diagnosis. On the other hand, the phenomenon confined, delineated, or excluded is given a clear tag: 'madness'. This tag, though, has no stable meaning, it is given to various phenomena by various theoretical or non-theoretical concerns (psychiatric, psychoanalytic, madness philosophical, anti-psychiatric theory formation; lay diagnoses), creating a multi-faceted picture of the different things people see as 'mad'.

Thus, I claim that literature problematises the non-contradictory and easy application of the diagnostic words, and the unity of the concept of madness. This has been seen in the previous chapter, especially in those madness narratives, like Kaysen's, Piercy's or Plath's, that more or less directly tackle questions of endemic and/or the unclearly bordered nature of madness. Thus, madness narratives often do raise the issue of the difficulty of making the interpretation of madness, which illustrates and debates the madness theories. As seen in the framework chapter, the issue of the ill-defined boundaries of the concept of madness is present in all of my theoretical bases: in the problem of defining disease units in DSM psychiatry; in the difficulty of delineating neurotic from normalcy in psychoanalysis; in the disclosing of the protean faces of madness by Foucault's madness philosophy; and in schizophrenia's social causation by double-binds (Laing's formulation of schizophrenia as socially caused type of behaviour destabilises the concept of schizophrenia as a psychiatric disease entity).

Still, the diagnoses are made, as I continually did in the previous pages – but with what right did I do this? One can argue that reading like I have, through the psycho-scientific lenses, one coerces the phenomenon of madness into answering

yes-or-no questions, allowing no gradation in the perception of madness; and that this contributes to the marginalisation of the mad characters.

Jaspers (1997, pp. 779–780) states that everyone uses categories like 'mentally ill' and 'healthy'; psychiatry and psychoanalysis are not alone in this field of definitions. In my perception, which is strongly supported by the data of madness narratives, the distinction between 'mad' and 'healthy'/'normal'/'sane' with its multiple facets is one of the basic ones made when one meets a person who seems to be mentally bizarre or strange somehow. Clinical psychiatry and psychoanalysis have only tried to stabilise, classify, and analyse the concepts of this mental bizarreness. The yes-or-no questions, then, arise form the clinical setting I have concentrated on: the clinical pyscho-sciences demand somewhat clear answers to the question: is the person mentally ill or not? In order to be able to treat a person in an efficient way the psycho-sciences have to categorise her first, as stably as possible. Thus, the yes-or-no asnwers and the possible marginalisation of the mad characters, is perhaps elementally tied to the psycho-scientific reading, if one takes, like I have done, the *clinical* psycho-sciences as a reading strategy.

Diagnosis-making in the real world context of clinical psycho-sciences creates at least two power fields: 1) the wish to help (Karlbergian empowering use of power); – when one makes the right diagnosis, one can also find the right form of treatment; and 2) the wish to guard, through an act of demarcation, the border between the identities of sanity and insanity; – by diagnosing another person as mad, one can defend one's own identity as a sane person. The first wish is the *raison d'être* of clinical psychiatry and psychoanalysis, and the second one can be seen as a more or less covert aspiration of (at least many) sane people when encountering madness. The two can be seen to intertwine as well. Is number one a form of number two? Is treating the madness of a person the best way to guard the border between madness and sanity?[24] Furthermore, is number two a form of number one? Does one, by guarding or defining the border between sanity and madness, make the best treatment solutions?[25]

Again, one can see that the diagnosis is a tool of power. When in a piece of literature this tool is used explicitly, or when one applies this tool to analyse literature even when there is no explicit diagnosis made, that piece of literature unavoidably

24. This claim is strongly supported by Foucault's conception of psychiatric *pouvoir* and the struggle nature of psychiatric treatment. A literary example – and a rather gruesome one – is Piercy's novel; the patients are treated in order to be controlled.
25. This thematic can be seen to be in action when Lönnqvist and Lehtonen (1999, p. 15) acknowledge the difficulty of defining mental health while at the same time admitting that this border drawing is demanded by clinical practice, i.e. the making of the best treatment solutions.

becomes a field of power. Naturally, the reader uses the most supreme interpretative power in the narratives, and this also applies to making diagnoses (even though these readerly diagnoses are not 'proper' Foucauldian diagnostic power moves). However, the diagnosis of the reader may be unsound, as well: the information given by the narrator may not offer enough evidence for a stable diagnosis, the narration may be self-contradictory, etc. This difficulty of making a diagnosis is thus often manifest even at the level of the reader. There is a wide scale of diagnosis-making by the reader: from the most uncertain, merest hints of a possibility of a diagnosis to the explicit diagnoses given directly by the narratives.

When the implied author creates a narrator whom she does not question and who explicitly names the form of madness of the narrator/character, like in Barker's case, the diagnosis is easily stabilised and stopped. Does it also become an illustration of a kind, by this process? The other extreme is the most unstable diagnosis: the reader is left in a state of aporia in which she cannot know for sure whether a diagnosis is warranted or not. This can be seen in, for example, Urquhart's Mary's case.

The 'illustrative' diagnosis has its strengths: by familiarising something strange, it makes the experience of madness felt by the reader. In this act, one can detect traces both of Fludernik's and Alber's naturalisation and Laing's anti-psychiatry. Both stress the factor of familiarisation of/through the concept of madness, of making sense of something that is easily seen as bizarre. The unstable diagnosis, then, has as the strength the questioning of the excessively monolithic, clear picture of the possibilities and justifications of making a diagnosis. The diagnosis is unstable because the phenomenon of madness is unstable.

I have used the diagnostic manuals (DSM-5 and ICD-10) and psychoanalytical disease categories in making the diagnoses of narrative agents to try to find correlations between narrated phenomena and the frameworks of madness theories. When doing so, I have attached a *general* diagnosis (a diagnostic category or group of symptoms) to a *unique* manifestation that a literary representation of madness always is. This is the *recognition* of a madness described by a diagnostic manual. Without the diagnostic category or group of symptoms, there is no psychiatrically defined madness; the category or group of symptoms is the face of psychiatrically delineated madness. This does not, however, tell much about the causes of madness behind the group of symptoms. Freudian psychoanalysis, then, does give causes, but it offers a fraction of diagnostic categories, meaning that they are even more general than those of DSM psychiatry – and their borders are not safe from the blurriness factor either; Freud had considerable trouble in drawing the border between normal

and neurotic. Therefore, madness is recognised as a fulfilment of a category or a group of symptoms which justifies its being called 'madness' in the first place. At the same time, one applies a general term to a unique manifestation of that term, which is then elucidated through the description of the *experience* of being mad and encountering madness. Thus, madness narratives depict and may warrant the recognition of madness through diagnostic categories while at the same time often posing questions about the justification, possibilities and definitive nature of that process of diagnosis.

I must ask: *how warranted* is it to use psychiatric tags about *literary* personae? For example, Plath's Esther can be summarised and diagnosed with clear psychiatric labels. Esther is either depressed or schizophrenically psychotic, or both (as Freud would maintain, melancholia was a form of psychosis for him). Esther does not use these tags herself. She is a teller-character and a narrator of great lengths; she is hospitalised. Yet her example can pose the question of the meaningfulness of the psychiatric labels applied to her: *as a literary character*, does she need to be labelled? Can the reader not understand her condition even without these tags? After all, does the qualia-nature of literature not carry the experiential meanings of her illness even without tags and labels? What kind of surplus value is given by these psychiatric tags if applied to her?

There are layers of diagnosis: when the character/narrator makes the diagnosis herself, its content may differ from that made by the reader. For example, does Esther make a *medical, differential* diagnosis of herself, as a depressed or psychotic person? If not, what does it mean if the reader makes such a diagnosis? Furthermore, what does it mean if the flesh-and-blood readers' diagnoses differ? Is either of the readers simply wrong, or does the *authorial audience* have a multiplicity of choices?[26] Even further, when a character/narrator does not perceive her own status *strictly medically*, has the reader the right to make a differential diagnosis and to label the person with the possibly stigmatic, specific mental illness? It is thus a question of readerly ethics as well; it concerns how we treat the literary personae in our reading.

Here, I will make a brief detour through Gadamer's hermeneutic model, which dispenses with theory as a method maker, because theory is one way to force the

26. Beaugrande writes about the relations of madness and art's multi-perspectivism: 'Evidently, we can empathize through literature with values we do not endorse in life, without becoming – as simple-minded moralists assert – "immoral" persons. This multiplicity enables art to reveal many versions of life and our ability to understand them frees us from the inevitable limitations of any one version.' (Beaugrande 1994, p. 27.) This assertion would point to the perception that multiple possibilities of interpretation are intrinsic to literature (of madness as well): authorial audiences can have more likely a multiplicity of choices instead of one – and that flesh-and-blood readers can have sound bases to argue for their own different interpretations.

other into the mould of the interpreter (Saariluoma 2000, p. 18). Gadamer writes: 'Modern theory is a tool of construction by means of which we gather experiences together in a unified way and make it possible to dominate them' (Gadamer 1989, p. 454). In this view, my making of strictly psychiatric, theoretical analyses of my target texts and their characters lets the theories come between me as the reader and the other, even to marginalise her, even though, according to Gadamer, there is no space for theory in humanist research, because a humanist's task is to genuinely face the other. (Saariluoma 2000, p. 18.) Of course, psychiatry as a branch of medicine is also a natural science, but it is also a science that should be sensitive to the other's otherness and meanings. Seen in this Gadamerian manner, psychiatric theoretical diagnosis can be seen to show its inhuman, unethical, stigmatising face.

How does one answer this critique? One answer to the question of the justification of a differential diagnosis of literary personae would be in the sheer necessity of *recognition*: in my example, Plath's Esther – like any real person – is seen to be mad in a certain way and for certain reasons. As soon as the reader/observer makes the inference of the person's madness, she also makes some kind of inference about the nature of her madness. Does not even the vaguest lay delineation of madness, when scratched, reveal some kind of differentiation, even some kind of nosology or aetiology, no matter how crude or rudimentary? Esther sees her madness in the context of taxing choices between different female roles; madness is the madness of making decisions in a world that teeters on the verge of absurdity. The madness of Innes's Mr Manack Sr. is seen by Jim to be a kind of murderous obsession, even if the tag 'monomania' is not explicitly attached to him. Both of these diagnoses are hardly the only possible ones in the worlds of those making them: there surely exist other kinds of madnesses besides those elucidated by and through the situations the characters and narrators are in. Thus, one can see that even the most undifferentiated lay diagnoses reveal layers of meanings – *kinds* of madness. Therefore, are not the finely tuned psychiatric and psychoanalytical webs of notions justified, since they offer detailed analyses of the layers of meanings of different mental illnesses? Thus, even though the situations and experiences of Esther *can* be understood without specific labels (to talk about the madness of taxing choices), using these psychiatric labels to describe her mental status is justified because they are intrinsic to the interpretations of that status anyhow (to talk about depression as being confused by the choices so badly that one becomes psychotic/clinically depressed) – even when they are left unannounced. The case of Innes's Mr Manack Sr. is a little different, though: his madness can be seen to be even more 'literary' than Plath's Esther's,

as the DSM and psychoanalytic disease categories fail. He is mad, monomaniac even – but no modern disease category covers his symptoms properly. Thus, one must add the category of 'literary madness' to one's repertoire of diagnoses when interpreting literary madmen. This does not, however, in this argument, make the psychiatric, differential diagnosis less possible or desirable in those cases where its application is an option.

This argument does not solve the problem of letting psychiatric theory come between the reader and her literary Other in the ethical encounter. If differential diagnosis in its theoretical guise is seen as a stigmatising, marginalising, dominating, power-hungry force, how can its application ever be justified? This is also the core question of psychiatric diagnosis in general, the problem of the psychiatric label, which has followed us from the first step to the last on our path of psychiatric diagnosis of the target texts: all of them could be placed on the power field of stigmatisation through diagnosis. The problem cannot be solved until our society finds new ways to relate to mental illness and mental patients. This is the reason I have coupled my reading of the texts through the focus of differential diagnostic categories with the question of in-group statuses and stigmatisation: I did so in order to see to the bottom of psychiatric diagnosis in this regard as well. For example, in Plath's, Kaysen's, Barker's or Piercy's cases, I noted the narratives raise the issue of the social and societal power structures that keep up the stigmatising pattern of being diagnosed. One cannot easily disperse the question of stigmatic psychiatric labelling, but one can also study it through literature. This is what I have tried to do, too – to see how using these strict labels affects our interpretations of the intra-textual worlds, the reader's positioning to them, and how warranted these labels are in each unique literary case. I have used psychiatric theory, true, but I have also questioned the very bases, scientific and power political, of that theory, together and in line with my target texts.

Nonetheless, one can still raise questions of the usefulness of psychiatric and psychoanalytical tags in the context of literature: how useful is it to make a differential diagnosis, when one cannot treat a literary persona, when one cannot justify the possible stigma with the altruism of treatment? The question of mimesis becomes relevant, too: I have treated my target texts' narrators and characters as 'real' human beings, but how about their nature as literary, synthetic artefacts? Why make specific diagnoses of literary artefacts in the first place?

The differential diagnosis is so finely tuned, because it serves the psychiatric machinery of treatment choices. Depression requires a different treatment from

psychosis. This differentiation would be a highly necessary act on the part of a real doctor treating a real Esther, and the success of that treatment would also mean (at least a partial) confirmation of a diagnosis. Does the psychiatric and psychoanalytical diagnosis give us anything else than a suggestion for further treatment? They sometimes give aetiologies; they give statistics of those fallen ill or carrying the gene or some other measurable matter; they interlink different conditions by giving guidelines on how to delineate, for instance, schizophrenia from depressive psychosis, all of which is important data in the context of treating a person. Yet from the viewpoint of literary personae and their ailments, it is not as interesting, since the literary persona cannot be torn away from her story to be treated and cured by these features.

What about mimesis, then? I have treated narrators and characters as 'real' people because of my project of testing out clinical psycho-sciences as reading strategies, and the clinical psycho-sciences have as their objcets real people, not artefacts. This does not give much opportunities to take into consideration the aesthetic, synthetic characteristics of narrators and characters. It is a fairly traditional way of looking at literary personae – and a true narrowing down of reading options: one weakness of my vein of psychiatric research of literature.

And further: the stigma of madness is often hard to lose. For example, in the case of Urquhart's Mary, the diagnosis of her 'condition' would mean the denigration of a whole culture. Her 'condition' is more than a mere mental aberration; it is expression of religion, of belief, myth, and folklore. Calling her a madwoman does not acknowledge the wealth of other aspects in her and her community's mental landscape. The forcing of her 'condition' into DSM diagnostic categories ignores the highly literary in her portrait. It overlooks how, for example, she learns shamanistically from her faery demon lover those things she could not have discovered alone. Thus, one must limit the application of the psycho-scientific diagnosis in relation to such examples of madness literature, like Urquhart's novel, where the phenomenon of possible madness is connected more forcibly to cultural aspects, for instance, than to clinical psycho-scientific considerations.

One can, however, turn the whole question upside-down to see some, limited, importance in literary psycho-scientific differential diagnoses: the differential diagnosis can be seen as a skeleton to which literary representation of the 'what's-it-like', qualia, offers flesh and substance. Literature truly has something to offer for those looking for the experiential substance of what it feels like to be mad or to encounter madness. In his study *Mental Health in Literature, Literary Lunacy and Lucidity*

(2005), Glenn Rohrer analyses a variety of literary sources in the light of the current DSM categories in order to use literature instead of real case studies. He writes:

> Using literature to examine human behavior has many advantages over using case studies. One of the major problems with case studies is that they are often written to illustrate a diagnostic point. They lack the vitality of writings designed to develop characters without the limitations of a predescribed set of behaviors. (Rohrer 2005, xi.)

Literature can thus be of use to those studying mental illness in providing vivid descriptions of various mental problems, and this is Rohrer's book's main intention – to offer 'students of both literature and human behavior' (ibid., xii) insight into madness through literature (the book is structured as a textbook, and includes discussion questions in the end of each chapter). By making a differential diagnosis, one can thus study that diagnosis – its representation in literature – and its experiential meaning for those mad under that label and those encountering them. The differential diagnoses of literary personae can thus be seen as windows opened into those conditions. This is especially true in the cases of those literary characters and narrators who are explicitly and unquestioningly diagnosed in the narratives. In the cases where the explicit diagnosis is absent, however, the process becomes more risky. Is Rohrer right in diagnosing Hamlet as an example of 'disorganised schizophrenia'? (Rohrer 2005, p. 90). The diagnostic category is emphatically modern, and the argument has been made that categories of mental illnesses are connected to specific eras (Foucault 2006), and are therefore anachronistic if used for different eras. Even if the diagnostic category were of the same period, the readerly solo diagnostics of personae who receive no explicit, unquestioned diagnoses from their narrative surroundings is always risky business: the argument that Hamlet is mad, even in Shakespeare's time's terminology, and not *feigning* madness, is far from settled. The role of interpretation is emphasised: in these cases, one cannot easily reach a unanimous diagnosis.

I argue that the issue of literary diagnosis-making in madness narratives is a balancing act between psycho-scientific theory application and the artfulness of literary representation of the characters' and narrators' mental landscapes. The stress on the usefulness of literary diagnoses in the study of different conditions also demands a stress on the unique nature of literature as representation. This is one reason why I have insisted on the two powers: the diagnostic and narrative.

If madness narratives were only illustrations of various conditions, there would be no narrative agendas besides diagnostic ones; the narrative power in itself points further though, towards the artfulness of literature, to the unique ways narrators and implied authors use madness and the psycho-sciences as thematic structures in furthering their own narrative agendas.

Thus far, I have mostly concentrated on the interpretive side of the Phelanian tripartite readerly judgement (Phelan 2005b, p. 324), the ways narrative power directs the readerly interpretations of 'the nature of actions or other elements of the narrative' (ibid.), or, more specifically, the depiction of the psycho-sciences and madness itself. However, I have also referred to the ethical side (though I have ignored more or less completely the aesthetic side) of this judgement-forming. I have concentrated on the interpretive direction of the audience concerning the representations of the psycho-sciences and madness, because I see it as the most fundamental one when considering the interplay of diagnostic and narrative power in madness narratives. Without this foundation, one cannot understand the dynamism of diagnosis-making in madness narratives. The diagnostic power used by narrative agents requires, in my perception, the counterpart of narrative power that concentrates on psycho-science and madness depiction: these are the very themes that pertain to diagnosis-making most directly. The ethical readings I have given are elementally based on the interpretative readings: I see that it is necessary to first consider what the nature of actions or other elements of the narrative are before one can build an ethical reading of those actions or elements.

Of course, these three elements – interpretation, ethics and aesthetics – cannot be completely severed from each other, and my delimitation is partly artificial, and I have also pointed out the ethical questions connected to the interpretive ones. I tackle the ethics and aesthetics of madness narration in more detail in the second part of my study. I do not, however, approach them strictly from the narrative power political viewpoint, but as examples of other literary theoretical questions which reading through the concept of madness elucidates. I do this because I also see that questions of ethics and aesthetics interlink to the ways madness narratives can be used as a case that has significance for the perception of literary narrative, for example, in fictitiousness and world-building. I wish to ask questions like: How do readerly ethics connect to fictional world-building and literary structures? What kinds of special questions of ethics and aesthetics do madness narratives raise? Now, it is time to ask: what do madness narratives tell us about (madness) literature and literary theory?

PART II

TELLING MADNESS
– MADNESS AND LITERARY THEORY

5 MEANING, MADNESS, FICTION, AND UNRELIABILITY

5.1 Madness and Fiction: Studying Fictitiousness and the Literary Device of Madness

> 'But it's the truth even if it didn't happen.' Chief Bromden (*One Flew over the Cuckoo's Nest*, Kesey 1973, p. 8.)

> 'And it is easy to slip into a parallel universe. There are so many of them: worlds of the insane, the dying, perhaps the dead as well. These worlds exist alongside this world and resemble it, but are not in it.' Susanna Kaysen (*Girl, Interrupted*, Kaysen 2000, p. 5.)

> 'Mark's lie had departed from ordinary lying because it required the careful maintenance of a full-blown fiction.' Leo (*What I Loved*, Hustvedt 2003, p. 218.)

In order to investigate the relationship that madness has with fiction and fictitiousness, one must first have an understanding of what fiction or fictitiousness means. The subject is not an easy one, since the drawing of the border between what is 'real' and what is 'fictional' in any given literary work is a difficult task.

Dorrit Cohn has summed up the different meanings that have been given to the word 'fiction': '[F]iction as untruth, fiction as conceptual abstraction, fiction as (all) literature, and fiction as (all) narrative' (Cohn 2000, p. 2). The first option presents a difficulty; the meaning of the word 'fiction' as an untruth may 'imbue the word *fiction* with a degree of covert negativity and frivolity' (ibid., p.3). The second option is from the world of philosophy, where the word 'fiction' means 'concept' or

'idea'. This viewpoint has a disadvantage for the study of literature because 'fiction, in the *literary* sense of the word, is conspicuous for its absence' (ibid., p. 5). The third option includes in 'fiction' everything inside 'literature', which includes historical and essayistic works as well as lyric poetry (ibid., p. 7). The problem with this viewpoint is that it indicates that 'fiction' is not 'primarily *narrative* in nature. When [...] they [theorists endorsing this viewpoint] do include such genres as autobiography, narrative poetry, or the novel, they tend to regard them as expressive, ideological, or visionary genres and to deemphasize their narrative structure or language.' (ibid., p. 8.) The fourth option Cohn calls 'the most pervasive and prominently problematic application of the word *fiction*' (ibid.). This viewpoint includes in 'fiction' everything narrative: histories, journalism, autobiographical texts, and also imaginative discourse. This conception has been endorsed most prominently by Hayden White, for whom, Cohn writes, 'historical narratives are no less "verbal fictions" than their purely imaginative counterparts in literature' (ibid.). However, Cohn argues, literary narrative can achieve what is entirely alien to historical narrative: it creates for the reader an imaginative world, which can make the reader 'share in a character's rich and vital experience of time' (ibid., p. 9). All in all, Cohn finds problems with all four conceptions, and therefore she proclaims her own distinction of the word 'fiction': 'fiction as nonreferential narrative' (ibid.).

She explicates her choice of words in the following manner: 'First and foremost [the term nonreferential] signifies that a work of fiction itself creates the world to which it refers by referring to it' (ibid., p. 13). This, however, does not mean that the world of fiction is independent of the actual world we know (or even can be independent, I might say, because if it was completely independent, we would have no way of understanding it). Cohn writes: 'If the adjective nonreferential is to be meaningful, it must not be understood to signify that fiction never refers to the real world outside the text' (ibid., p. 14). The work of fiction can refer to the outside world, but it does not need to do so. '[F]iction is subject to two closely interrelated distinguishing features: (1) its references to the world outside the text are not bound to accuracy; and (2) it does not refer *exclusively* to the real world outside the text' (ibid., p. 15). Cohn sums up her thesis by stating that 'the referential narratives [such as historical studies, journalism, autobiographies etc.] are verifiable and incomplete [that is, their accuracy can be contested], whereas nonreferential narratives are unverifiable and complete' (ibid., p. 16): one cannot claim that there are 'missing parts' in a novel, its world is complete and whole as it is.

Cohn's distinctions are a useful reminder of the complexity of the meaning of the word 'fiction'. Her proposal makes a fine distinction between any other narrative

and the ones that are fictitious in the literary sense. However, her scheme does not readily lend itself to such narratives that contain different levels of fictitiousness, such as stories within stories, character's daydreams, imaginings, or mad, delirious, psychotic experiences. To clarify the matter of embedded fictions inside fictions, Marie-Laure Ryan's possible worlds theory is a useful tool.

Like Dorrit Cohn, Ryan's model also states that a work of fiction itself creates the world to which it refers by referring to it, but she makes a more subtle refinement to this thesis: there can be multiple layers of worlds which have different relationships with each other, and the reader's position in relation to them may vary accordingly.

Ryan begins with the notion of the 'alternative possible world', a philosophical notion that gives Ryan great flexibility in her attempt to conceptualise vastly differing types of texts. An alternative possible world is a world that exists in a modal relationship with the actual world, that is, the alternative possible world has a relationship with the actual world that involves necessity or probability, or has a relationship that is based on knowledge, belief, and obligation. For example, an alternative possible world can be believed in in the actual world or not. What is the actual world then, and how does one differentiate it from its satellite alternative possible worlds? Ryan starts by distinguishing what she calls the system of reality: '[It is a] set of distinct worlds. The system has a modal structure, and forms a modal system, if it comprises a central world surrounded by satellite worlds. The center of a modal system is its actual world, the satellites are alternative possible worlds.' (Ryan 1991, p. vii.) Then she goes on to conceptualise the actual world: 'The actual world, [is the] center of our system of reality. [It] is the world where I am located. Absolutely speaking, there is only one [actual world].' (ibid.) An alternative world exists then as a satellite, an alternative world to the actual world, and it can have a plethora of disguises: it can be a world of daydreaming or one with opposing rules of nature, or anything that differs from the actual world we live in.

This notion is interesting when one moves from describing different kinds of worlds to describing their relationships to each other. Since there are certain movements – shifts between different worlds – they cause the centre of the system of reality to be recentred. While reading literature, for example, the reader's mental world is momentarily recentred to the text's world. Ryan writes: 'For the duration of our immersion in a work of fiction, the realm of possibilities is thus recentered around the sphere which the narrator presents as the actual world. This recentering pushes the reader into a new system of actuality and possibility.' (ibid., p. 22.) The narrator's actual world (in fiction), is necessarily different from the actual world

in which we, the flesh-and-blood readers, are situated, and this is also the root of Cohn's nonreferentiality. Ryan goes further and distinguishes fiction from other kinds of narratives by stating:

> Fiction is characterized by the open gesture of recentering, through which an APW [Alternative Possible World] is placed at the center of the conceptual universe. This APW becomes the world of reference. The world-image produced by the text differs from AW [Actual World], but it reflects accurately its own world of reference TRW [Textual Reference World = the world of which the text claims facts], since TRW does not exist independently of its representation. TAW [Textual Actual World = the image of TRW proposed by the text] thus becomes indistinguishable from its own referent. This phenomenon – which makes the concepts of TAW and TRW largely interchangeable when discussing fiction – explains the fashionable doctrine of the self-referentiality of the literary text. (ibid., p. 26.)

Thus, the reader's mind becomes recentred when reading. Since fiction itself may contain embedded fictions (dreams, tales etc.), this means that the centre of the textual universe shifts again: there can be any number of re-shiftings of the textual universe, giving us multiple layers of fictitiousness. Ryan has built a solid foundation for analysing madness literature; in her system, there is the concept of an 'F-universe': '[This] private sphere involved in narrative semantics is formed by the mind's creations: dreams, hallucinations, fantasies, and fictional stories told to or composed by the characters. These constructs are not simply satellites of the TAW, but complete universes, and they are reached by the characters through a recentering.' (ibid., p. 119.) Furthermore, this recentring, brought about by the character's fantasies (or, e.g. psychosis), is reached by the very same movement (recentring of the system of reality) that one must make when starting to read a novel. Madness, as an F-universe, reflects the contours of fictitiousness itself: the description of madness inside a literary text means that it is a secondary level of fictitiousness (from the reader's point of view), that is, it is an embedded fiction, and thus it can echo the very structures and borders of fictitiousness, of what fiction is, what reality is, and how these two intertwine in a given work. Already Ryan's grouping of possible F-universes speaks the same: hallucinations are on the same level as fictional stories told by the characters.

5.1.1 Madness and Fictitiousness: What Is Real and What Is Normal?

5.1.1.1 When Madness Is Normal

There is therefore a curious relationship between madness and fiction: madness narratives as often multiple-layered fictions can be seen to reflect the very nature of becoming-fictitious in their narrative structures. Madness fictions often study the essence of fictitiousness by playing with it, making the border between what is fictitiously 'real' and 'mad' hazy. For example, in Timothy Findley's *Pilgrim,* it is an open question for the other characters whether the main character, Pilgrim, is truly what he says he is – a person unable to die – or a lunatic. (For the reader, the same question may be put in a slightly different manner, which I will address below.) In Fitzgerald's *Tender is the Night*, Nicole's sister, in a conversation with Nicole's husband, Dick, a psychiatrist, expresses her exasperation at not being able to delineate madness from sanity in a clear and precise manner:

> 'I knew the Marmoras were up here so I asked Tino to meet us at the funicular. And you see what happens – the very first thing Nicole has him crawling over the sides of the car as if they both were insane –'
> 'That was absolutely normal,' Dick laughed. 'I'd call it a good sign. They were showing off for each other.'
> 'But how can *I* tell? Before I knew it, almost in front of my eyes, she had her hair cut off, in Zürich, because of a picture in *Vanity Fair*.'
> 'That's all right. She is a schizoid – a permanent eccentric. You can't change that.'
> 'What is it?'
> 'Just what I said – an eccentric.'
> 'Well, how can any one tell what's eccentric and what's crazy?' (*Tender is the Night*, p. 48.)

Not all madness narratives are centred on the haziness of the border between real/normal and mad, though. In Bessie Head's *A Question of Power*, the protagonist Elizabeth's psychosis is usually clearly delimited from her sane life in the surrounding community; the reader knows where Elizabeth's psychosis ends and everyday life begins. The worlds of madness and real life are kept well apart; only on a couple of occasions does the novel suggest another type of relation between the two: for example, when one of the characters of her psychosis, Medusa, is killed, the remnants

of her being are also seen by Elizabeth's son. Thus, the borders between madness and reality become porous for a while:

> 'What was you burning last night?' he asked, pointing to her room. 'The floor is full of burnt things.'
> She jumped up alarmed. Why, anything could happen in her nightmare. She might have left a cigarette lit. She walked to the door of her bedroom, then froze. There was the drama of a death-throe on the floor. Charcoal-like foot-prints dragged into each other across the floor and in the centre of the room was a heap of charcoal dust. She half muttered aloud to herself:
> 'Is this the last of Medusa?'
> From the room behind her Sello [another psychosis character] said: 'Yes.' (*A Question of Power*, p. 93.)

Keeping the worlds of reality and madness apart seems to be rarer than the scenario where the two are divided by a very hazy, ill-defined border.

The bond between madness narrative and fiction in general can also be seen on the level of the characters' and reader's way of analysing the phenomena that seem to intrude in the fictitiously real level of narrative. In Findley's *Pilgrim*, the available options of 'naturalising' (in Culler's, Fludernik's and Alber's meaning of the word) 'otherworldly' phenomena can be seen to gravitate towards two possibilities: the phenomenon is either supernatural or it is madness. In *Pilgrim*, the protagonist states that he is unable to die regardless of his numerous suicide attempts, two of which are described in the novel. He also claims that because of this he has lived for centuries. He is admitted to Burghölzli hospital as a patient of Carl Gustav Jung, who does not believe in Pilgrim's claim to be immortal and treats him as a mad patient. For Jung, his framework of interpretation is strongly tinted by his psychiatric theories and common sense attitude, which means that he cannot accept his patient's claims, even if he has access to supporting evidence (Pilgrim's diaries, in which he describes his encounters with historical personae like Leonardo da Vinci and Saint Theresa; Pilgrim also attempts suicide in vain in the hospital). The two options of interpretation, the supernatural or madness, compete in the novel for the reader's and characters' acceptance, and the juxtaposition of the two options is central to the thematic of the novel.

In Miller's *Ingenious Pain*, the pattern is different, but it still revolves partly around the interpretative balance between madness and the supernatural. In the novel, the protagonist, James Dyer, has the supernatural trait of being unable to feel

pain; he also recovers from any injury with amazing speed. This trait means that he is unable to feel compassion or love for anyone. The atmosphere of the novel is tinted with the supernatural: for example, Dyer encounters a real mermaid in the house of his protector. Later in the novel, Dyer is miraculously cured of his inability to feel pain by a witch during his trip to Russia, after which he is admitted to Bedlam hospital for being mad. His madness is caused by the overwhelming flow of past pains and injuries that Dyer must suffer now that he has recovered from his state of painlessness. Madness is thus like a passage rite to normalcy, away from the supernatural, and towards a common way of living. In this novel, the options of madness versus the supernatural settle in a slightly different manner than in *Pilgrim*, but still they can be seen as poles: Dyer is not *both* mad and supernatural, but cured of his supernatural trait *by* a spell of madness. Thus, madness can be seen as the anchor for a normal life, an interpretation and state that ties Dyer back to normalcy; it makes him an ordinary man instead of a freak of nature.

Perhaps the most famous example of fiction that has aroused strong opinions about whether its interpretative framework is that of supernatural or madness is Henry James's *The Turn of the Screw* (1898). This famous literary quarrel was fought between those that took the story 'at its face value' as a tragic ghost story in which a governess battles in vain with the evil supernatural forces that threaten her protégés; and the 'Freudians', headed by Edmund Wilson, who claimed that the tale told by the governess is that of neurosis and madness caused by the governess's frustrated sexuality. In their view, the governess has hallucinations, not true encounters with supernatural forces. The story itself is cleverly constructed to not answer to the question of whether its main interpretative framework is madness or the supernatural. In my view, the work, like *Pilgrim*, clearly studies and plays with these two interpretative frameworks, and also with its readers. There is no 'true' or 'final' answer to these thematic riddles, and I would say this makes the works all the more interesting. (About the famous schism on James's novel, see Booth 1983, pp. 311–316.)

In Pat Barker's *Regeneration*, we see the drawing of borders between supernatural and madness as well: Siegfried Sassoon, a patient in an army mental hospital during the WWI, sees something that he himself interprets as a ghost. He is afraid that his psychiatrist, W. H. Rivers, will see the phenomenon as a symptom of war neurosis, a diagnosis Sassoon strongly resists. When he finally talks to his psychiatrist, Rivers responds by telling him a memory of his own, when he could not explain a similar phenomenon during an anthropological trip to Solomon Islands. This was during

a wake in which the natives were expecting an auditory sign of spirits that were supposed to take the deceased's soul away. In this situation the whole party expected to hear the swish of paddles, but instead they heard whistling. Rivers recalls:

> Nobody was making those sounds, and yet we all heard them. You see, the *rational* explanation for that is that we'd allowed ourselves to be dragged into an experience of mass hypnosis, […] But what we'd been told to expect was the swish of paddles. Nobody's said anything about whistling. That doesn't mean there *isn't* rational explanation. Only I don't think that particular rational explanation fits all the facts. (*Regeneration*, p. 188.)

So, even an experienced psychiatrist admits that there are situations in which the border between the supernatural and madness is sometimes blurred.

The opposition between madness and the supernatural is thus evident in these works. They can be seen as interpretative poles, either as complete opposites (as in Jung's analysis of Pilgrim or the reader's attempt to unravel the mystery of Henry James's governess's tale) or in a curious relation (as in Dyer's miraculous passage from being a freak into being an ordinary man capable of feeling pain and love). In all of these stories, the juxtaposition is that between what is considered supernatural, and what is considered 'real', but mad. This is the case even in Dyer's tale, as the character passes from being supernatural to 'normal', but mad. It is as if the two interpretative poles, madness and the supernatural, cannot exist in these fictional worlds at the same time; they exclude each other as two possibilities of interpretation – one offering an 'otherworldly' (supernatural) explanation, and the other offering a 'this-worldly', 'normal' (mad) explanation. There is the recentring in both options, but the nature of the F-universe differs: it is either a mythical or supernatural world, or it is madness.

5.1.1.2 When Madness Is of a Mythical Genre

The reader can sometimes see the possibility of the strange phenomena of possibly supernatural traits (that can be interpreted as madness by the other characters) in the light of genres of fiction. The reader interprets the supernatural/mad phenomena as pockets of a secondary level of fictitiousness that have been imported into the TAW from other genres of fiction: from fairy tales, fantasy, or myth. This may

seem an uneasy interpretation, as the frameworks of madness and supernatural phenomena can be said to be more commanding ones because they can be shared by the characters and narrators as well as the authorial audience, but I would still argue that sometimes the interpretation of the 'visiting' genres of fiction can be supported by analysis.

In *Pilgrim*, this is quite a tempting interpretation, as the reader is aware of the historical Jung's theories on the collective unconscious (which the fictitious Jung is led to discover at the end of the novel after encountering Pilgrim as a patient). One of the main themes of the novel can be seen to be an illustration of these particular Jungian theories, and Pilgrim as a character can be seen as an epitome of Jung's thoughts: he is what a human being would be like if he truly lived in the reality of having a collective unconscious – he would have lived forever, throughout the centuries collecting experiences that other people can only read in books. Pilgrim is a thoroughly mythical character: he explains that he is Tiresias, and that he had, as Tiresias, offended the gods and been condemned to live forever as a punishment (*Pilgrim*, p. 402). Thus, there is strong support in the novel itself for my thesis that Pilgrim is a character that has been imported into the novel and Jung's 'normal world' from the world of myth and tales.

Which frameworks of interpretation are available to each narrative level (character/narrator/reader) are therefore of central relevance; the reader can have access to such frameworks that are unavailable to the other levels, for example, to the theories of Jung formulated in detail only after the era described in the novel *Pilgrim*. That Pilgrim as a character is mythical and visiting from the world of myth (and thus more supernatural than mad but in a curiously 'theoretical' or 'literary' way as an embodiment of Jung's theories) is more readily available as an interpretation to the reader, since she is not restricted to the character Jung's perception of the laws of nature. Jung in the novel is a 'normal' human being in a 'normal' world into which Pilgrim – as an 'abnormal' or 'supernatural' creature – intrudes with his inability to die, forcing Jung's world to meet foreign phenomena. In this context, Jung represents a rational, natural scientific perception of reality that excludes the type of supernatural creature that Pilgrim appears to be. 'Normal' here means mostly 'rational' and 'scientific'. The reaction Pilgrim gets from Jung is conditioned by the restrictions of the world Jung lives in – a psychiatric hospital in which there are no miracles, only madness: '*No*, Jung thought. *This cannot be. It's a story. An intricate, bedeviled, clever story.* Dementia.' (*Pilgrim*, p. 402.)

Of course, the meaning of the word 'normal' is extremely loaded: even if we located the meaning of the word 'normal' to the flesh-and-blood readers' experience of the real, shared world, the Actual World of Ryan's theory, the flesh-and-blood readers may have very differing perceptions of that shared world. This makes the delineation of the words 'normal', 'real', and 'shared' cumbersome. However, this is hardly surprising, as we have already travelled through some terrains of perceptions of madness – which is one of the optional antonyms of 'normal' – and found that the word's meanings differ greatly depending on the viewpoint of the observer. There are clearly as many 'normalities' as there are 'madnesses'.

5.1.1.3 What Are the Borders of Normal?

The tension between the two poles of the supernatural and madness can also be seen in operation in works where the characters or narrators do not describe the strange phenomena with the word 'madness'. In such works, the reader is in the position of making the judgement. As seen in the first part, Jane Urquhart's novel *Away* depicts an incident in which Mary becomes 'possessed' by a drowned seaman, as is explained in the myths and fairy tales of 19th century Ireland. Almost all the characters, even the village priest, treat her as she really was 'away' (i.e. possessed by a spirit). At the time of the incident, no one uses the word 'madness'. However, if a person acting like Mary were among us today, she would very likely be committed to a hospital or treated for mental health problems.

The Foucauldian theorem of madness as a social construct warns us against the temptation of treating the madnesses of past centuries as if they were exactly the same as those of our own era. So, do we, the readers, have a right to diagnose Mary as a madwoman? This is a question of anthropology as well: do we have the right to assess other cultures by the standards of our own alone? Is the shaman's trance a drug related psychosis? I would like to say no, at least, not completely, in order to combat cultural colonialism and overstretched diagnoses, but the question is not simple: we cannot leave our own cultural background and baggage altogether and understand an alien one 'as it is', like my discussion in Chapter 4 on DSM psychiatry's relating to cultural differences attempted to show.

Another interesting borderline case is MacFarland's novel, *A Face at the Window*, which seems to bring to focus the border between the literary genre of the ghost story and a story of madness. In this novel, the protagonist and narrator Cookson starts

to have encounters with ghosts, which no one else can see, at the holiday hotel he is visiting with his wife. His wife starts to have doubts about her husband's mental health, but she finds herself to be in minority, as their new friends, the Sho-Pans, are discovered to believe in ghosts as well. The ghost interpretation gains support from other incidents at the hotel: for example, other guests have complained of ghosts before, and one character, Pascal, is killed in an elevator accident whose details would be most completely explained by the interference of one of the ghosts (who is an expert on elevator technology). Thus, again, the poles of the supernatural and the mad are engaged in the interpretation of strange phenomena. However, in this novel, the pole of the supernatural as the main framework of interpretation seems to take the upper hand. The narrator believes in ghosts, his friends believe in ghosts, as do other guests; his wife is the only one who favours the psychological explanation.

What is the position of the reader in this pattern? I believe that the reader may choose between the two poles – or choose not to choose. In my own reading of this novel, like the majority of the characters, I favoured the side of the supernatural. I chose the genre of the ghost story as my framework of reading because I felt that the doubting of Cookson's mental health might border on psychiatric colonialism, that is, reading through madness when other frameworks are at least as possible or even more pronounced. This is partly because I as a reader hover between the literary (a ghost story in this case) and the psychiatric (reading through diagnostic categories), and feel very strongly that the possibly stigmatic nature of psychiatric diagnostics must always be kept in mind, even when diagnosing 'only' literary characters. This case thus reminds us of the importance of the 'eye-of-the-beholder phenomenon' that has such gravity in any reading of a (possible) madness narrative.

Thus, another crucial aspect of madness fictions is their capacity to make the reader sensitive to the question: 'What is normal?' As we have already seen, madness fictions often play with the borders of (fictitious) reality, or those of the Textual Actual World. The reader must contemplate her own conception of what is possible and real on one hand, and what is mad – or supernatural – on the other. Ryan writes: 'Fictional universes always differ through at least one property from our own system of reality' (Ryan 1991 p. 33), but what is the 'normal world' or '*our own* system of reality' from which the mad world is recentred into its own F-universe? Perceptions of what is 'real' or 'possible' may vary enormously from person to person, especially if one person is considered mad and another sane. So, who defines the 'real' world? The mad or sane characters? The mad or sane narrator? The mad or sane reader? Or all of these? From which building blocks are the foundations of

'reality' built in madness narratives? Here, one can see the similarity between Ryan's formulation of the Actual World and Laing's formulation of the border between 'insanity' and 'normal' as the common consent of sane people: both seem to rely on an unproblematic-sounding consent of the majority. Yet the basis of this consent by majority is more precarious than it seems, because the sanity of the majority is at the same time the basis and the outcome of that same perception: 'because we are sane we can draw the border between sanity and madness in such manner that we are included in the sane'.

As an example, one can consider David Markson's *Wittgenstein's Mistress*. In this work, the question of the breadth of the narrator's madness is a central tension: is the narrator madder than she claims to be? She does say that she has been mad before, but is she 'totally mad' because she constantly claims that she is the last person on Earth? The book's blurb says the narrator is 'Presumably [...] mad', so the question is fairly well grounded. My own reading experience did not catch this 'presumed' or 'greater' madness, though. I had no problem with agreeing to the fictitious world-building that she *is* sane and all alone. There are no such visible contradictions in the inner logic of the work that would *unarguably* signal the madness of the narrator and that could not be explained away precisely because she *is* the last person alive. By contradictions, I mean the peculiar structure of the work in which the narrator repeats the same pieces of story again and again, with slightly different details; for example, certain events take place first in the Metropolitan Museum of Art, and then in the Hermitage, and then in the Tate Gallery. However, I would argue, this could also be explained by her being the last person alive: she is writing completely to herself, so there is no one to care about the contradictions or to remind her of them. It is therefore not that dangerous if she 'stretches' the truth a little. In addition, her status is such that she is completely dependent on her own memory: there is no one she can ask. To me at least, the possibility that she is alone gives the impression that the reader cannot claim without hesitation that the narrator is unreliable in the sense that she is mad, or mad because she is unreliable. She is obviously self-contradictory, but the reason behind this contradiction can be explained in a way that leaves the inner logic of the narrator's speech intact.

Markson clearly plays with the reader's capacity to diagnose the narrator, but does the reader have the right to diagnose the narrator on the basis of her own world configuration? It is a question of what the authorial audience makes the comparison with, which is the 'real world' – the TAW – that the authorial audience places at the centre of the told universe. It is thus also a question of preferences: when there

are multiple ways of interpreting the same text, the flesh-and-blood reader can take sides, or alternatively maintain that the case is inconclusive and that there are multiple ways of interpreting the text. In interpreting madness narratives, however, there is always the question of stigma that may come with the diagnosis. As I will show later, even if the diagnosed person is fictitious, the label of madness can attach firmly and affect the reader's ethical position vis-à-vis the text and its characters. The question of the reader alone making a diagnosis (when no one else in the text does so) is thus a very delicate issue and must be decided case by case.

As the case of *The Turn of the Screw* shows, the viewpoints of the (flesh-and-blood) readers of madness fictions can differ vastly, and in this battle between competing interpretations, there may not be a true resolution; instead, the differing viewpoints may remain in eternal juxtaposition. This is partly due to the thematic structures of many madness fictions: they may not give a definitive explanation of what is (fictitiously) 'real' – what is the 'normal' – against which the 'abnormal' can be seen; they may instead tend to play with the expectations and different viewpoints of the readers.

Nabokov's *Lolita*, for example, is an infamous case of the narratorial stretching of the notion of 'normal'. The 'normal' is stretched in the face of the reader's disgust, hesitation and attempts of resistance to Humbert Humbert's agenda of justifying his sexual relationship with a child. Consider the famous excerpt in which Humbert defines the basis of the paedophilic relation: 'Now I wish to introduce the following idea. Between the age limits of nine and fourteen there occur maidens who, to certain bewitched travelers, twice or many times older than they, reveal their true nature which is not human, but nymphic (that is, demonic); and these chosen creatures I propose to designate as "nymphets".' (*Lolita*, p. 15.) Humbert, by placing the emphasis on the demonic, washes his hands of the ethical condemnation of his own deeds as a paedophile: his definition of 'normal' (here meaning most forcibly 'ethically non-condemnable') sexual relations include those with 'nymphets', who, by their 'demonic' nature, are the real initiators of these relations in which the paedophile ends up through being 'bewitched', not because of his own immorality or ethical irresponsibility. I will return to Humbert Humbert and ethics shortly. Here, it suffices to say that Humbert at first (at least) seriously tries to shift the narratees' 'normal' to include himself and his fascination with 'nymphets' (as he calls his victims), even if his attempts may not succeed completely.

Thus far, I have not made any distinctions about the different phenomena that are all included under the term 'mad'. In the cases of Findley's Pilgrim, James's gov-

erness, or Miller's Dyer, they all could be classified as types of psychotics – if they are to be considered mad at all. They all may have hallucinations or severe distortions in their perceptions of reality. Does this mean that all that is said so far in this chapter applies only to psychosis? Other mental diseases found in the diagnostic manuals, such as depression (as one diagnostic option in Plath's *The Bell Jar*), eating disorders (as in Shute's *Life-Size*) or panic attacks (as in Minette Walters's *Devil's Feather*), may not build a 'world of their own' as efficiently and thoroughly as psychosis (which, according to Freud, does just that: it *replaces reality* with something altogether new – a psychosis world (Jones 1957, p. 272)), but still, the border between 'mad' and 'normal' is somehow affected in them too. The depressed person perceives the worth of life differently from a sane person, to the extent that she is ready to give up living altogether in her search for relief from the psychic pain she is experiencing – pain that others around her may not consider well-grounded enough to justify suicide. The anorexic perceives her own body in a dramatically different manner from the sane persons around her. The person suffering from panic attacks perceives the possible threat posed by the reality around her as markedly greater than those who do not have panic attacks. These are all departures from something that is deemed 'sane'. Otherwise, what would qualify these conditions as madness if they did not depart from 'normal' in some way or another?

However, these departures are not the *deictic shifts* that Ryan states to take place when a recentring to an F-universe takes place: 'This type of recursive embedding [as in F-universe] differs from the one we have observed in K-worlds [possible worlds that consist of what the character holds true] in that it does not propose ever new points of view on the same system, but transports the experience to ever new realities. Whereas K-recursion is like putting a new mirror in a room to reflect it from another angle, F-recursion is like crashing through the wall to enter another room.' (Ryan 1991, p. 121.) So, other mental illnesses, not as severe as psychosis, can be seen to build differing K-worlds for the characters, but not an F-universe with a deictic shift.

5.1.1.4 When Madness Is Not-Normal and Not-Real

Can the departure from the sphere of 'normal' be seen at the same time as a departure from the 'real', as opposed to the 'fictitious' (at least when this departure is narrated in a piece of literature)? Is the movement away from 'normality' also a

movement away from 'reality'? Is the real/fictitious dichotomy intrinsically related to the dichotomy of normal/mad?

In the case of Will Self's *Great Apes*, it can be seen clearly that the psychosis builds an F-universe inside the TAW most forcibly. In this novel, the main thematic tension is created by playing with the borders of psychotic and normal worlds: one day the protagonist wakes up in a world where chimpanzees are the most evolved species on Earth. Human beings are only barely existent on the fringes of the chimpanzee world. The protagonist, who considers himself human in this strange chimp world, is admitted to the chimp mental hospital for being psychotic – for believing himself to be human, whereas the chimps around him see him as a fellow chimp. The novel ends with the protagonist's re-appropriation of chimp identity, which is further sealed by the framing narrative of a chimp psychiatrist who presents the novel's case as one of curious psychosis. Thus, one can see how the novel plays with the interconnections of real/normal and fictitious/mad: when the protagonist departs from the real and normal, he enters the world of madness, the world of which is, when narrated, the world of (a secondary level) fiction.

Does this happen also in a depiction of panic attacks or paedophilia? In these cases, the mentally ill characters seem to retain a stronger relation to the TAW, thus it could be said that their illness does not build an F-universe in the way psychosis does, but still, something strange happens in this relation, and this strangeness is called madness. There seems to be a strong link between reality and the normal on the one hand, and fictitious and the mad on the other. When a madwoman builds a world of her own by departing from the consensus of what is real and normal, these terms become fused together; they are intertwined in their usage, and madness fictions play with these distinctions in different ways in order to make them visible and to study them.

Thus, it is common to many madness fictions that madness becomes 'endemic', by which I mean that the phenomenon of somebody being mad is not restricted to those characters that are most easily regarded as mad (psychiatric patients for example, or in general characters that are by – rather Laingian – 'common consent' diagnosed as mad, or who diagnose themselves as mad). In Kesey's *One Flew over the Cuckoo's Nest*, the whole system of the mental hospital – and further the surrounding society of which the hospital is a microcosm – is described as being mad. Madness is not restricted to the patients; those who treat and confine them are seen as mad if looked at from the right angle. This angle is offered as soon as there is a deviation from the 'normal' way of living in the hospital, which is caused by the new patient,

McMurphy. Thus, when this interruption by McMurphy materialises in the patients' wish to break the rules of the hospital by watching the Super Bowl even when the Big Nurse refuses permission to have the TV on, the scene reveals the hidden madness of the entire system embodied in the figure of the Big Nurse: 'If somebody of come in and took a look, men watching a blank TV, a fifty-year-old woman hollering and squealing at the back of their heads about discipline and order and recrimination, they'd of thought the whole bunch was crazy as loons' (*One Flew over the Cuckoo's Nest*, p. 136). What is normal or real when the system which forcibly defines these terms is seen as mad?

When Cohn makes the distinction between 'nonreferential' fiction and referential texts, she makes the relationship with reality the central issue: nonreferential texts can, but need not, refer to the real world (Cohn 2000, p.15). In my opinion, this distinction is a somewhat problematic, for can anyone imagine a text that did not refer to the real world in any way? Is not the distinction of fiction, or madness, or the real always a matter of comparison and contrast? Surely there is no 'absolute' reality or normalcy? Madness is madness in comparison to something that is declared normal by someone in some place and time. All phenomena considered 'mad' have in common this departure from 'normal', but the 'normal' varies, and so does 'madness'.

This variance can also be seen in the oppositions normal/mad/supernatural discussed above. In the discussion it was seen that in *Pilgrim, Ingenious Pain*, and *The Turn of the Screw*, the dichotomy was rather clearly between madness and the supernatural. In this opposition, 'madness' was grouped with 'real' since it was the option of those characters (or readers) who could not accept the possibility of the supernatural being the interpretative framework. Madness was the more 'normal' or 'real' way to naturalise the strange phenomenon. In the following discussion, then, it could be seen that madness vs real and madness vs normal also form oppositions. Thus, it can be seen that it is a question of choice of viewpoint. When the option was between what is real and what is supernatural, madness could be seen as a phenomenon of 'this world' and the delimitation was that between what is real or normal and what is supernatural, or, if put in another way, the borders of 'this world'. When it became a question of what is normal or real *within* 'this world', the dichotomies mad/normal or mad/real became effective. Thus, the ground under the feet of those making the distinctions of what is real or normal in contrast to madness can be seen to shift according to the viewpoint of the observer.

5.1.2 Madness as a Literary Device?

What role, then, does the depiction of madness play in a work of fiction? It has been seen that it can be a method of reflecting on the process of becoming fictitious, and that it can also be seen as a method of questioning the very foundations of what is 'real' and 'normal' in a piece of literature – or in the Actual World itself, as the piece gives its own reflection of the Actual World (without this connection to the AW there could be no way for us to understand the TAW). Another way of considering this question is by analysing madness as a literary device, that is, by asking whether literature uses madness only as a literary device, or whether it offers true insights into the essence of madness.

Robin Downie (2005) has studied this question in his article 'Madness in Literature: Device and Understanding'. Downie asks if literature can offer anything comparable to scientific knowledge about madness, and he perceives certain differences (as well as similarities) between the two forms of insight. He writes: 'In many works of creative writing madness is used simply as a literary device, which provides no understanding of the phenomenon but has other literary functions. [However,] some creative writers have succeeded in providing an understanding of madness which complements that of the scientific psychiatrist.' (Downie 2005, p. 49.) Thus, he makes a distinction between madness being used as a literary device only, and madness being studied and understood as a phenomenon of its own right. When madness is used as a literary device only, he claims 'it can have the unfortunate side-effect of encouraging stereotypical views of madness' (ibid, p. 50). This means that madness is exploited as a thematic and structural device that only furthers literary goals such as offering dramatic incidents, elements of fear, insights into character's traits, etc. (ibid.).

He also analyses the similarities and differences between the nature of psychiatric knowledge and the insight into madness provided by literature. He sums the psychiatric side of the question in the following manner: '[T]he scientific understanding of madness has five (perhaps overlapping) characteristics: it requires the discovery of patterns, underlying causality, and it is reductivist; and it requires professional detachment and value neutrality.' (ibid., p. 56.) He contrasts this with literary insight into madness:

> By means of that story [Woolf's *Mrs Dalloway*] of developing madness we come to understand a total social context. It points beyond itself and becomes a symbol

> of something much deeper. It enriches our human perceptions of ourselves and of a historical period. Even more than that, it reaches what is universal in the human condition through the exploration of the particular case. [...] I wish to make a plea for the kind of understanding which comes from literature, an understanding in which the reader can move from a total involvement with an individual case in its full context to something universal. (ibid., p. 61.)

Thus, Downie sees a role for both scientific and literary understanding of madness. The latter he explains to cover such spaces left intact by the psychiatric point of view, namely the uniquely sequential features of life, and the serial, individual and emotional identity of human beings. (ibid., pp. 56–57.)

This reminds me of Herman's formulation of qualia, the 'what-it's-like' dimension of narratives that he places at the centre of interest in the study of narratives. Is Downie's understanding through literature not close to Herman's understanding through narrative? Of course, Herman's and Downie's viewpoints differ in that Downie talks about the whole of literature (poetry and plays included), and Herman, on the other hand, talks about the whole of narratives (non-fiction included); this should not, however, blur the similarities of their viewpoints in highlighting the importance of literature/narrative in building and understanding human realities. However, I would like to state the question of the understanding of the what-it's-like in connection to Downie's criticism of the use of madness as a 'device only' to further 'insight into a character's traits'. Is not this what literature does best – analysing different characters' traits, to fathom how they perceive and experience the storyworld (which is in some kind of connection to the AW) – as Herman emphasises in his notion of qualia? Is this really a case of 'device only' to see how madness is experienced and perceived in the storyworld – even if it was done in a 'lay' manner, without defining the concepts psychiatrically?

Another matter is Downie's unproblematic perception of psychiatry as a form of knowledge: he does not elaborate at all on the hazy nature of psychiatric knowledge, the endless schisms between different schools of thought, or mention that the missing links of causation and objective testing of psychiatric illnesses causes troubles for the definition and treatment of these illnesses. Neither does he highlight the fact that the field of psychiatry has not been able to formulate the concept of 'mental disorder' in a definitive manner; or address the issue of the stigmatic nature of psychiatric diagnostics that is an existing possibility every time a diagnosis is made. Of course, every discipline has its pitfalls and tensions, but it must be kept in mind that psy-

chiatry as a school of knowledge has issues with definitions and ethics. Seen in this manner, literature may sometimes offer *an even deeper* perception of the experience of madness than the science of psychiatry, because it highlights the uniqueness of human experience that psychiatry places in parentheses in its search for something objective and scientific, as Downie states.

An interesting test case of its own is the question of building of suspense in such genres as the detective story, thriller, or courtroom drama by using madness as a device. Novels such as Chandler's *The Big Sleep,* Dibdin's *The Last Sherlock Holmes Story*, Innes's *The Killer Mine*, Sheldon's *Tell Me Your Dreams* and Appignanesi's *Paris Requiem* all use madness as a way of building suspense in the hunt for the perpetrator of a crime. In all of these novels, the role of madness is to offer an element of shock and/or surprise, as it is a phenomenon 'from another world' – it is something that intrudes in the sane world and catches it unaware.

In *Paris Requiem*, the murderer is the person least suspected because of her hysterical paralysis. This condition otherwise prevents her from walking but enables her, when movement is required, to kill a young actress. In *The Last Sherlock Holmes Story*, the element of surprise is perfect, as Sherlock Holmes is revealed to have split into two personas, the other being Jack the Ripper, the criminal Holmes himself is hunting for; the twist in plot works even without definite psychiatric tags. In *The Killer Mine*, the murderer is discovered at the same time as his madness is revealed to the narrator: Mr Manack senior's monomania (a tag given by me, a reader) explains the murders he has committed and is willing to continue committing if not hindered; murder is madness and vice versa, as these two phenomena are closely related in this thriller. In *Tell Me Your Dreams*, the whole work is about the nature of a form of madness (multiple personality disorder) and its legal life-or-death implications in the courtroom for the protagonist. In *The Big Sleep*, there is again the element of the least suspected person being the mad perpetrator, as the wealthy and decadent Carmen is discovered to have killed her brother-in-law in a bout of indefinite madness. In all of these novels, one can see the madness-as-a-device in action, but does this mean that the depiction of madness is automatically – and only – stereotypical?

Paris Requiem describes the phenomenon of hysteria in Charcot's Paris, considers the causation of madness (the focaliser, the brother of hysterical Ellie, sees poverty as the causal factor instead of degeneration, the contemporary mainstream explanation of madness). Most likely because of the detective story's structural demands, Ellie's personality is not opened 'too much' to make sure that the reader does not find out

that she is the killer 'too early'. The madness-as-a-device can be seen in action and as a restricting factor.

The Last Sherlock Holmes Story uses Holmes's madness as a clever and unexpected plot twist as well. Holmes's madness is seen through Dr Watson's eyes and, although the doctor is Holmes's friend, for all intents and purposes he ends up being his executioner: he is the person who (emotionally, though not physically) forces Holmes to commit suicide. Holmes does this at the moment he recognises himself as the Ripper, thus bringing together the two opposing parts of the same mind – that of the cleverest detective and that of the darkest fiend. Holmes's experience of being mad is approached only through hints and incremental evidence: Watson follows his friend's succumbing to the exhaustion of split personality and paranoia, but the viewpoint is nonetheless external to Holmes's experience of madness. The surprise effect of Holmes/Jack the Ripper is paramount and commanding: the doctor's narrative, although it claims not to be like Arthur Conan Doyle's Sherlock Holmes stories, is still (as the work of the implied Dibdin) an example of highly effective detective story. However, if one examines Dibdin's Holmes, one can see that he is very human; this is Downie's 'insight into character's traits', not the 'scientific-kind', 'psychiatry-approaching', 'not-a-device-only' form of madness narration. I would claim, however, that Dibdin's picture of Holmes's disintegrating mind offers not only a satisfactory detective story, but a convincing (and rather provocative, I must admit) case of madness narration, even if it is one that approaches the subject from without. So, is this a case of 'device only'? I would say yes and no; Dibdin's Holmes's madness is both a literary device, because it is a plot-turner, but it is not a 'device only', because it offers a convincing picture of the derangement of a mind.

Tell Me Your Dreams is definitely the most sensational of the works I have mentioned. It is eager to shock the reader by describing a psychological state that is both rare and extreme in its cause and content: it recalls childhood sexual abuse that causes the creation of a multiplicity of potentially murderous personalities inside one body. The novel aims at the disclosure of an extravagant twist of the human mind, and this phenomenon of madness is the shock factor, as the worlds of madness and sanity meet and the reader gets to take a peek of a reality so different (very probably – excluding those readers who do suffer from multiple personality disorder) from their own. Is madness stereotypical in Sheldon's novel? Yes and no: the form of madness is represented and studied (though rather superficially) in its features and meanings for those affected, but the shock factor looms so large that it becomes all-engulfing. Looking at Sheldon's portrait of multiple personality disorder

feels like looking at social or psychiatric pornography: it may be accurate, but devoid of the real bond between the described phenomenon and its reader, because the five castrations-cum-murders offer more tabloid value than a truly profound analysis of what kind of experience it is to have been abused sexually by one's father and then, consequentially, to have murdered and castrated five men. Madness is something so utterly disconnected from the worlds of the (average) readers that they can enjoy the sensation of shock without having to realise – or care – that this portrayal of madness is a freak show that exploits the tragic features of madness without really connecting the reader to the mad person's deepest realities. This is the case even though Sheldon provides the reader with extra information about the disorder in the appendix of the novel.

The Killer Mine and *The Big Sleep* are perhaps most on the side of 'device only', as the narrators of these novels do not disclose the inner reality of the mad person at all: Chandler's Carmen and Innes's Mr Manack senior are only identified as mad, and that is the fullest extent of the diagnosis. The narrators' choice not to tell the mad persons' realities of madness emphasises the narratorial agenda of portraying the mad murderer as a person who deserves neither pity nor understanding. It is therefore most strongly a narrative device as well.

The one stereotype all these novels exploit most prominently is that of madness as a danger: the mad, murderous person is a cause of risk and harm to the surrounding sane community. The mad murderer gets different kinds of hearings from these authors, ranging from Sheldon's sympathetic-sounding but pornographic-feeling immersion into multiple personality disorder to Chandler's and Innes's cool detachment from the inner experience of the mad person herself. Either way, the stereotype is kept constant. Do these works offer any other viewpoints to madness besides the stereotype of dangerousness? Are they only bound by their generic structures that demand the use of this stereotype as a literary device? The generic demands seem to guide and direct the use of madness as a device most strongly, though some of the works (try to) offer a more fleshed-out perspective by elaborating on madness as a phenomenon situated in a specific historical era (Appignanesi), or as a personal experience (Sheldon, Dibdin). In my opinion, Downie's criteria for a non-stereotypical representation of madness – if they are supplemented with my insistence on the qualia-nature, or the experiential analysis of madness – are thus approached, but not reached. Thus, it can be said, as Downie does, that some works of creative writing do use madness as a stereotypical device without offering thorough analyses of its experiential (or serial, though unique) depths.

There remain certain questions to be asked: How does this relate to the above analysis of the shifting borders between the real, the normal, the fictitious and the mad in madness narratives? Where are the borders between madness as a literary device and madness as a phenomenon of its own right? I think that it is somewhat harder to delimit 'device only' from 'phenomenon of its own right' when it comes to madness depictions. After all, is it not possible that a depiction of madness can be at the same time *both* a useful functioning literary device *and* a true exploration of the phenomenon of madness (as in my reading of Barker's *Regeneration* in the previous part)? Downie does not strictly claim the opposite, but does not closely explore this possibility either. I think it necessary to study this possibility more carefully.

In the case of metafiction, for example, when a work builds a metafictional structure by using a madness depiction, it can be said to use madness as a literary device in order to create a truly literary structure, but this is not necessarily the only reason. Cannot it also be said that madness as a phenomenon lends itself easily for such use? Is it not part of the nature of madness that it easily reflects the 'becoming fictional' when narrated? In the case of the shifting borders between real, normal, fictitious and mad, it can also be claimed that madness is used as a device to create such a shift; but again, the nature of madness, among other things, often makes these borders rather hazy. These examples may not be what Downie meant by those devices that exploit madness as a stereotype to expand the literary space with exciting new plot turns, but in my opinion, they cut through the apparent dichotomy of 'device only'/'phenomenon in its own right'. The phenomena of metafiction or shifting thematics of the real, normal and fictitious can be seen as truly literary in their nature: they can make a work of literature more interesting and still retain their connection to the 'true nature' of madness.

Another issue in this discussion is the strict 'diagnosis' of madness literature: is it necessary – or even possible – to make clear psychiatric diagnoses of literary madnesses? In the previous chapters, I have tried to do precisely that: I have recognised madness partly by seeing it through the diagnostic manuals. I have also tried to remain sensitive to this relationship's uneasy side: literature must have the 'right' to be literary – it is an art form with its own dynamics. I have tackled one side of these dynamics by addressing the question of narrative power/knowledge relations and by giving a hearing to those literary, narrative structures that are valid in literary fictions. Thus, it is important, from the viewpoint of a literature scholar, to see that madness narratives as an area of literature have the 'right' to be literary: it is not always possible – or even necessary – to name the illness a character is suffering

from. It may be enough to acknowledge that the character is mad somehow. For example, in Paul Auster's *New York Trilogy,* it is very difficult to strictly perceive some of the characters' type of madness, but it is clear that they are suffering from some form of madness that could be perhaps best described as the loss of one's identity. Under what diagnostic category does this illness belong? A psychiatrist might name it, but what new information would that offer to our analysis? The phenomenon of madness may sometimes be perceived even without naming it. Another side to this is that literary scholars have the advantage of not having to make one interpretation of a (literary) madness like a clinical psychiatrist must if she is going to be able to treat her (real) patient. The possibility – even necessity – of entertaining multiple interpretations is perhaps something that most clearly separates the interpretation of literary madness from that of real-life madness.

One final question remains: what is the nature of the information or knowledge that fiction can offer about madness? In the light of Cohn's term 'nonreferential narrative', fiction may take the opportunity to create its own worlds regardless of the Actual World we live in. However, as I stated earlier, this may not be quite so simple: fiction is bound with many ties to the reality of the Actual World, as Ryan points out: 'On all points other than its own existence as fiction, however, a fictional text may offer an exact reproduction of reality' (Ryan 1991, p. 33). In Downie's and Glen Rohrer's (2005) views, literature offers superb access to the worlds of madness, allowing one to gain from literature open and direct insights into how people think about, live through, and experience their madness. Still, Cohn's theorem is at least partly valid; in Ryan's terms, the TAW is a satellite of the AW – it is independent but accessible. One can learn by reading fiction about the real world – and the madness within it.

One detail that is connected to the discussion on the relationship between fiction and madness is the use of appendices. In many works, there are appendices that give more information about the mental illness they describe (e.g. *Tell Me Your Dreams, Devil's Feather*). This underlines the works' relationship to the Actual World: the works decide to refer to the Actual World and claim something about it instead of just building a fantasy world that would fulfil the requirements of a 'nonreferential' narrative, as Cohn might put it. As I stated above, I find the term 'nonreferential' somewhat problematic, and this difficulty also materialises here. As the writer points out when adding an appendix of this sort, the work, even if it is a work of fiction, still establishes a relationship with the Actual World by describing situations and phenomena that are common to the Actual World. The work of fiction may even

claim an educative function in this: *Tell Me Your Dreams, Devil's Feather* and their appendices make it clear that the books are not only intended as entertainment but also as sources of information about multiple personality disorder and panic attacks respectively. That works of fiction can do this (i.e. give true information and insights into the 'real madnesses') is clear from the viewpoints of Robin Downie and Glenn Rorher, but I still would steer clear from the two polar extremes of total nonreferentiality suggested as a possibility by Cohn's term and clear one-to-one relationship suggested by Rohrer. The literary phenomenon of narrated madness is a phenomenon in its own right that *both* can – and even must – retain a relationship with the real madnesses (in order to be identified, *recognised* as a case of madness at all, as I pointed out in Chapter 4) *and* preserve some sort of literary, fictitious nature in building its own interpretation of madness, which may be impossible to diagnose strictly using the 'real world standards' of diagnosis (ICD or DSM classification, for example). The narrated madness has a subtle relationship with the Actual World and its madnesses, and this must be kept in mind when analysing the relationship.

5.2 Ethics and Madness – Two Case Studies: Patrick McGrath's Spider and Vladimir Nabokov's Lolita

The issue of the ethics of madness narratives springs forth from the notion of the difference between the worlds of madness and sanity. When these two worlds meet and are juxtaposed, the question of ethics is unavoidable: how do the worlds of sanity relate to such a foreign world as that of madness?

My first case study on the ethics of madness narration is Patrick McGrath's *Spider*, an example of unreliable narration,[1] which gives us the world-building force of madness in an extreme form. This novel gives me the opportunity to study the way unreliable madness narration builds a fiction inside fiction, and how the two worlds of fictitious madness and sanity relate to each other ethically.

1. I will reconsider the term 'unreliable' at the end of this part. In the meantime, I will be using the term in its traditional manner.

5.2.1 Case study I: The Ethics of Narrative Structure – Patrick McGrath's *Spider*

5.2.1.1 *Spider*'s Narrative Structure

McGrath's *Spider* is a madness narrative that reflects the illness of the protagonist and narrator deeply in its narrative structure. The narrative has a kind of 'double code': it tells two stories at once. First, it tells the story the protagonist, Spider, constructs and tells about his own life, which he firmly believes; this story is the one the reader is tempted to follow and accept, but must abandon if searching for the fictional truth. The reader, in realising that Spider's story is not the one that contains and builds the Textual Actual World (TAW), seals Spider's fate as a narrator who cannot keep the force of narrative power in his own hands. Instead, Spider's narrative builds an F-universe, a whole universe of fantasy and hallucination, another world inside the Textual Actual World, which becomes for him the centre of his consciousness and thus replaces the Textual Actual World for him as the true world. The other story told in *Spider* is the story of 'what really happened', the story of the TAW. This other story is pieced together by the reader from scraps of evidence given in the F-universe story. Spider himself is completely unaware of the other story that tells 'what really happened' and the layering of his narrative worlds. This double structure is due to the unreliability of Spider's narration, which means that he unwittingly tells two stories and builds two worlds at once. This creates ontological and epistemological ambiguity, because the borders between the two worlds remain hazy.

Spider is a schizophrenic who has lived for twenty years in Ganderhill mental hospital. The narrative opens with a scene in which Spider is released from the hospital as an outpatient, and he returns to the part of London where he had lived as a boy before being committed to the hospital. He starts to keep a notebook or journal in order to remember more clearly what happened in his childhood, and he begins to tell his childhood story, very skilfully and consciously, to an audience – to a 'you'. The reader of his narrative is from the very start aware of his illness – he describes his present hallucinations vividly without trying to hide them – but the story of his childhood progresses seemingly without signs of illness for a long time, and the reader is tempted to believe in the lucid story that Spider tells.

In this story, Spider gives an account of how his father starts an affair with a prostitute called Hilda and how his father ends up killing Spider's mother in order to

be able to continue the affair. The end of the story sees Spider trying to kill his father, but instead he accidentally kills Hilda, after which he is committed to Ganderhill.

Without knowing it himself, Spider leads the reader to the point where the F-universe story hints at the TAW story, and the two codes of an F-universe and a Textual Actual World are seen to join together. From an outsider, a pub landlord, we learn that Spider's mother's name was Hilda and that she was killed by her son. (Before this moment, very late in the novel, the reader is not given the name of Spider's mother.) From that moment onward, the reader must rearrange the whole story Spider has told her, and thus go against the current of Spider's narrative power.

In this TAW story, the story told by Spider is seen throughout as a narrative infested with illness: what seemed at first a comparatively delirium-free story of childhood must be rethought as a story of psychosis. His is a story of a very sick son whose delirium makes him think that his mother has been killed and replaced by a prostitute. It is Spider himself who eventually kills his own mother, who had not changed at all, except in Spider's mind, before her death. The novel hints at reasons behind Spider's psychotic transformation of reality, and I will return to these hints later.

5.2.1.2 The Ethical Plane: Irresponsibility and Unreliability

Why does the implied author choose to build such a layered world, a world whose structure is unknown to the narrator himself? This is obviously a question of unreliability and its 'uses', and a question of ethics. On the ethical plane, one must ask, among other things: What does it mean for the reader to know more than the narrator? What does it mean for the reader to have to go against the current of narrative power of the unreliable narrator?

Phelan formulates four planes of ethical relations in narratives: that of the characters within the storyworld; that of the narrator in relation to the telling, to the told, and to the audience; that of the implied author in relation to the telling, told, and the authorial audience; and that of the flesh-and-blood reader in relation to the other three planes (Phelan 2005, p. 23). On all of these planes I would argue that the question of ethics must encounter the phenomenon of Spider's irresponsibility. One must ask: is Spider capable of following moral codes correctly? Jorma Laitinen has studied the moral philosophical perspective of the issue of the compulsory treatment of psychiatric patients. These patients, claims Laitinen, lose

their capability to act as moral beings because they start acting irrationally; they lose their ability to register the nuances of social interaction; their language is torn apart from shared meanings (Laitinen 1996, p. 35); they are incapable of understanding the meaning of different alternatives of action, which means that they are no longer free to make meaningful choices (ibid., p. 58); their actions are in conflict with the social expectations of their environment (ibid., p. 80); and the patients are, if psychotic, unable to distinguish between the realities of the outer world and their own psychic world (ibid., p. 60). All of these qualities mean that certain psychiatric patients are non-moral agents, that is, they are irresponsible in the eyes of the law and their community. By 'non-moral' I mean someone who is incapable of following the moral codes of his surrounding community, in a way he is then outside of the shared moral code, even if he did not choose to be so. Spider's case is most strongly that of the psychotic who loses his sense of reality and with it also the ability to act morally and responsibly. This emphasises Bernaerts's argument that 'the delirium affects the textual actual world and can even determine the course of the events. In other words, the delirium is not only a reaction to reality. It also alters reality.' (Bernaerts 2009, p. 378.)[2] Spider's irresponsibility due to his psychosis is real and affects the fictional reality in the most serious manner.

This irresponsibility marks Spider's actions and narration apart from other types of unreliable narrators. For example, even though he does, in Phelan's terms (Phelan 2005, p. 50), misread and misreport on a massive scale, he does not lie: behind his actions there is tragic sincerity. He acts in the belief that he *does* perceive the world around him correctly, while the reader comes to understand that he does not. This means that the reader is capable of feeling sympathy for Spider, even though he has planned and executed a murder, because she sees that Spider cannot be held responsible for his actions and because she also sees that Spider suffers horribly because of his illness, even if he does not suffer for the 'right reason'. Thus, Spider's case can be seen as an example of 'bonding unreliability', as Phelan has formulated it. Phelan writes: '[By] bonding unreliability [...] I mean unreliable narration that reduces the distance between the narrator and the authorial audience' (Phelan 2007, pp. 223–224). Instead of distancing the narrator from the authorial audience, his unreliable narration contains elements that the implied author and the authorial audience endorse (ibid., p. 225). Phelan also formulates six types of bonding un-

2. *Spider* fits comfortably into Bernaerts's category of 'narrative delirium'. Spider's story shows the defining elements of 'an alternative relation to reality, an alternative coherence, a strong belief, a psychological motivation, and a pathological background' (Bernaerts 2009, p. 376).

reliability,[3] but in my opinion *Spider* does not fit neatly in any of them. Thus, I propose the notion 'unreliability due to irresponsibility' for narratives, like *Spider*, where a mad narrator is pardoned for his unreliability due to being irresponsible and outside of the shared moral codes.

On the level of the characters, Spider's irresponsibility is perceived in his environment, and acted upon: he is sent to Ganderhill, not prison. This also means that the other characters perceive the layering of the worlds, or at least the clouding of the (fictitiously) real (Textual Actual World) for Spider by the monstrous psychosis (F-universe) that makes him kill his own mother. It becomes clear though that at least according to Spider's own account of his story, no one in his environment understands him or his thought worlds correctly: only the reader can make all the inferences and connect all the dots. Those closest to Spider seem only to understand that he is insane, not the quality or contents of his delirium, not to mention its meaning. Spider describes his state when he was admitted to Ganderhill:

> Oh, this was the low point; I shudder, now, to think of what I must have been going through to do the things I did. Such was my despair, my pain, the sheer bloody wretchedness and misery of my isolation that I flung off my gown and used my own feces to write my name on the wall – my real name, that is *Spider*, I mean, daubed and smeared in damp brown clots across the plaster – and *now* see me, hunkered naked on my hams and grinning at the wall where my own name drips in shit in letters two feet high, and for a few brief minutes I am my own creature, not theirs. But then see how I'm marched ungently down to the bathroom while my cell is scrubbed down with hot water and coarse bleach, confirmed, *in their eyes*, as a lunatic, by this dirty deed, though *in my own eyes* the reverse! (*Spider*, pp. 169–170.)

Spider's irresponsibility means also that he is stripped of his equal status as a human being. The reader is not presented with anyone who would make the real attempt to understand what goes on inside his mind. Of course, we are completely dependent

3. These subtypes are: 1) 'literally unreliable but metaphorically reliable' (as in Chief Bromden's narration in Kesey's *One Flew over the Cuckoo's Nest:* although the Chief is a paranoid schizophrenic, he interprets his surroundings metaphorically correctly. This is the closest subtype *Spider* could fall into as both examples are madness narratives. However, I do not see what the story of *Spider* could be a metaphor for; I consider the bonding effect to come from a wholly different source in Spider's case, namely his irresponsibility and suffering); 2) 'playful comparison between the implied author and narrator; 3) 'naïve defamiliarisation'; 4) 'sincere but misguided self-deprecation'; 5) 'partial progress toward the norm'; 6) and 'bonding through optimistic comparison.' (Phelan 2007, 226–232.) Phelan does not claim that his list is exhaustive, and that is why I propose my own heuristic tool to analyse Spider's narration.

on Spider himself for this information, and the implied author uses all kinds of tools to make it clear that Spider is an unreliable narrator (he makes him describe his hallucinations, he makes the pub landlord testify against him, he makes Spider himself confess that he makes up much of the story himself, as we will learn below) but still, I would argue that the issue of unreliability as a narrator is beside the point here: what is at stake is Spider's own experience of being left alone – and almost completely so. He did get emotional support from his mother when she still lived, and he did eventually find a kind of niche for himself in Ganderhill working in the hospital's vegetable garden, but even in the hospital he does not find a soul who would be interested in his mental world or in him as a partner in an equal discussion. As soon as he is defined insane, it seems to mean that Spider's status as an equal partner in any discussion vanishes. He is treated by the staff as a lunatic whose speech is almost incomprehensible, and the other patients, though they share the same misery of mental disease and being interned in a hospital, do not much share their experiences by talking about them. Thus, by writing his narrative, Spider tries to regain access to the world of shared words, to make his own life understandable to himself and to the 'you' of his narrative.

This makes the position of the narratee of Spider's narrative all the more important. The 'you' of Spider's narration has a special status as a person who is the receiver of his confessions. Brooks writes about the 'contract' between the narrator and the narratee:

> Each act of narration in the novel implies a certain bond or contract: listen to me because… The structure calls attention to the motives of telling; it makes each listener – and the reader – ask: Why are you telling me this? What am I supposed to do with it? As in the psychoanalytic context of storytelling, the listener is placed in a transferential relation to the narrative. As a 'subject supposed to know,' the listener is called upon to 'supplement' the story, […] to articulate and even enact the meaning of the desire it expresses in ways that may be foreclosed to the speaker. (Brooks 1993, p. 200.)

What is expected from the 'you' of Spider's narration? Spider obviously wants (in what could be termed in my terminology, as a narrative power move) the reader to believe him. But who is the 'you'? Is it a separate person or some part of Spider's divided mind? As Meredith Anne Skura points out: 'The psychotic has retreated not into total isolation but into a stage in which the other is part of himself, or a

projection of his own hostile wishes' (Skura 1981, pp. 182–183). In this perception, the psychotic is incapable of communicative connection with other people. He could be writing purely to himself. (Of course, it must be stated that normal healthy people sometimes write to themselves, but Spider's psychosis could be seen as a strong reason to believe that this is the case in his narration.) Still, I would say that Spider has a separate audience in mind when writing; otherwise the need to write would not be so strong. What else other than the ordering of his thoughts can the telling offer him if the audience is purely inside his own head? I believe that Spider needs the confirmation from a real 'you' who is separate from himself. What Spider wants from his 'you' is belief and the endorsement of the version of events he confides. This is the ethical relation between Spider and his 'you': it is a relationship of dependence on the 'you's' belief, and it is full of wishes that Spider hopes the narratee will fulfil.

What can the audience do? Like in the madly unreliable narrative of McCabe's *The Butcher Boy*, the narratee Spider wishes for is not the authorial audience he gets. At the latest, when the Textual Actual World and the F-universe are torn apart by the reader's realisation that Spider has in fact killed his mother himself, the flesh-and-blood reader must leave the narrative position Spider wishes her to fulfil, and the flesh-and-blood reader enters (or tries to enter) the position of the authorial audience, the position of better knowledge. This does not mean, however, that the narratee, the authorial audience, or the flesh-and-blood reader cannot feel sympathy for Spider. She can see how carefully and honestly Spider weaves[4] the threads of his story, how much he would like the narratee to believe in it, and when the reader is forced to part ways with him because of his irresponsibility and the ensuing disfigurement of his story, she is still convinced of the only kind of truth that Spider's story has: the fact that it is true to him. This is the core of the bonding unreliability in Spider's case, and I will return to this aspect of mad unreliability at the end of this part of my study.

4. There is a whole gamut of meanings that centre on the symbolism of spiders and the weaving of webs and stories in *Spider:* in a way *Spider* can be seen even as a metafictional narrative. I have no space here to go into this symbolism any deeper, but I only want to note that Spider is a very conscious teller, and in an ironic way: he tells his story in the hope of controlling it, but it breaks loose from his hands and starts to live a life of its own. In one of his hallucinations, he becomes an egg-bag from which tiny new spiders (perhaps new stories or interpretations) spring forth uncontrollably. This irony and metafictionality is of course possible even in the case of stories told by sane persons, but Spider's madness only works to emphasise this phenomenon. It is precisely his madness that creates the metafictional effect: the telling of his mad story (the F-universe) mirrors the making of fiction in the flesh-and-blood world; in both, a re-centring of the narrative's focus occurs in a fictional sphere.

On the level of implied author and authorial audience, larger questions on the nature of the narrative structure come to fore. One answer could lie in mimesis: the implied author wants to create a narrative structure that efficiently reflects Spider's psychosis. The building of an F-universe inside the Textual Actual World, a structure so large that only small hints of the TAW story are left for the reader to interpret and piece together, is definitely an efficient way of doing it. The layering of the worlds also reflect the irresponsibility of Spider: because there are two worlds, of which one is true only to Spider (F-universe), and the other cannot be properly reached by him (Textual Actual World), it is easy to see that this pattern does not make it possible for Spider to act fully as a moral being in the Textual Actual World. By using such a narrative structure, the implied author can display the whole tragedy of Spider's life and the core issue: Spider is not capable of perceiving his life correctly. His madness is seen as a massive error of interpretation, and the error is so massive that it creates a world of its own.

On the other hand, the implied author's decision to leave Spider outside this crucial knowledge can be seen as an ethical deed: the implied author can be seen to protect Spider from an even more painful experience than he already has gone through – that of facing his own culpability for murdering the only person he has ever truly loved. The work as a whole, as a product of the implied author's choices, also aims at the reader's understanding of the phenomenon it depicts: madness. The double code of narration can be opened up by using the psychoanalytical theory of psychoses, and the novel seems to use this theory abundantly.

Spider's psychosis can be decoded through the theory of a young boy's sexual awakening. The prostitute Hilda can be seen as an extreme interpretation of his mother's sexuality, which interests Spider and arouses his desire. Spider is on the threshold of puberty, which means that all the unresolved issues from earlier phases of development become activated. The double role of Hilda/mother is explained by Melanie Klein's term 'splitting', where the object towards which a person directs both erotic and destructive instincts is split in two: the 'bad' object (Hilda) and the 'good' object (mother). Splitting is a primitive defence reaction against anxiety (Laplanche & Pontalis 1974, p. 430). The psychoanalytical fantasy theory explains the nature and birth of Spider's psychosis. Spider's oedipal fantasy – his attempt to murder his father and his sexual interest for his mother – is brought into reality because he is unable to sublimate it. Skura writes: 'In the adult, these infantile confusions can be transformed into psychosis, if they take control, or into poetry, if they are self-consciously shaped and placed' (Skura 1981, p. 79). As Bernaerts

also remarks: 'twentieth-century literary representations of madness often activate Freudian scripts as feasible ways of naturalizing textual inconsistencies' (Bernaerts 2009, p. 381). The psychoanalytical theory explains the cause of Spider's psychosis (he cannot resolve his oedipal fantasies), and the nature of his psychosis (it is the oedipal triangle brought to life).

Even if psychoanalytical theory helps to explain many issues in the novel, it cannot completely bridge the TAW story with the F-universe story. As we only have Spider's account of what happened, even when the reader can collect the bits and pieces of evidence of the TAW story, she cannot build the whole story underneath the F-universe. We cannot know for sure what happened. For example, we do not know what kind of a person Spider's father truly was, as the pub landlord states that he loved his wife dearly, and Spider's account of him is completely different. Even the existence of the pub landlord can be doubted (like everything in the story) since, like everything else in the novel, he is presented to us only through Spider's sick mind. However, I would argue that the pub scene is real, because the thrust of the novel is built on the tension between Spider's story and the hard evidence given by the pub landlord that tears the story web that Spider has woven together. We can only suppose what did not happen: Spider's father did not kill his wife. This supposition – the best we can do in a fictitious, unreliably told, layered storyworld with partially hazy borders – is the reason why there is epistemological and ontological ambiguity surrounding our interpretations of Spider's story.

Aiming to understand the phenomenon of psychosis is, furthermore, an ethical position, as can be easily seen when the reader compares the level of understanding she has of Spider's madness and its meanings and the level of understanding of the other characters in the novel. In order to be able to encounter the other and treat him fairly, one must have some kind of understanding of how this other being feels and thinks.

Can the reader and implied author avoid feeling superior to Spider, then? This is, according to Phelan (2005, p. 24), the risk when one knows more than the narrator/character. If Foucault is right, the progress of psychiatry has meant the silencing of the mad. The concept of irresponsibility is also a part of this alleged silencing: as noted already above, Spider's madness makes him unequal to the other characters; he is not an equal partner even in discussions on his own fate. As soon as he is defined mad, no one but the reader seems to care what he perceives or how he perceives it; the central question that bothers people is how to deal with this madman. This silencing has meant that Spider has had to fight in order to piece together his own

coherent story, and the reader of this story can sense Spider's need for recognition and endorsement. The reader can feel sympathy, but does she feel superiority as well? After all, we, the readers, know something crucial that he does not.

Edward Said has studied the unequal power and knowledge relations in the Western societies concerning substantial minorities, such as racial minorities, delinquents, women, the poor and the insane. He considers them all to be 'lamentably alien' (Said 1995, p. 207). Each of these minorities has been controlled through knowledge. Knowledge is a double-edged sword: it can be used to encounter the other ethically, when knowledge gives information on how to treat the other well, but it can be used to oppress and patronise as well, as Foucault also pointed out in his own theories of knowledge. In any case, if one knows more than the other, it is an unavoidably unbalanced relationship.

From another point of view, that of the ontological difference between storyworld occupants and the authorial audience and implied author, one can ask: does this difference affect the ethical dimensions of reading? In the previous part, I emphasised this ontological difference and the way it affected the narrative power patterns of madness narratives: the reader – even when making diagnoses – could not use 'proper' Foucauldian power over the diagnosed character/narrator, most pressingly for the fact that this narrative-interpretative power was not capable of being resisted by the diagnosed character/narrator, and that the character/narrator was not capable of being subjectified by the authorial audience. Phelan seems to ignore this ontological difference in his formulation of readerly ethics.

So can there be readerly ethics, if one looks at reading as a 'non-proper' Foucauldian power relation? As I have emphasised, ethics is needed whenever one uses any kind of power. What kind of ethics do we need in reading, then, when we seem to cross the border of ontological difference? The character in a book cannot be really harmed or helped by the reader; she is (in a non-metafictional work) completely unaware of any readers. The narrative-interpretative power the reader uses when making a diagnosis of a character, for example, is a move in the power relation between the implied author and the audience: the (flesh-and-blood) reader may interpret the work in unison with the implied author or attempt a resistant reading. The character/narrator in this perception is only a tool used by the implied author to convey her messages to the audience. This perception could be seen to lessen the human bond between storyworld occupants and readers – Phelanian strong ethical bonds. However, I would still maintain that this perception is in its own way valid: if one looks at the issue from the viewpoint of Foucauldian ideas on power, one cannot

escape the ontological difference between storyworld occupants and readers, and its effect on readerly ethics and the processes of what I have termed narrative power.

Readerly ethics, in this perception, could be seen to come from the way reading may ultimately affect us, the flesh-and-blood readers in the real world. Sklar remarks: 'Whether or not we, as readers, would care to admit, we respond to characters on some level as *people* and invest them with human feelings and thoughts' (Sklar 2013c). Keen argues that it is held by some commentators on readerly empathy (like Hakemulder and Hoffman) that reading is a means to affect our real-world capacity of empathy (Keen 2007, pp. 89–92) and has such effects as inducing empathy for members of stigmatised groups (Hakemulder) or participating in the transmutation of (readerly) empathetic guilt into prosocial action (Hoffman). I would consider this capacity of reading to consciously direct our real world empathy as an ethical move on the part of the authors (creating implied authors creating narrators), as it enlarges our (i.e. the readers') capacity to understand other people's predicaments, and therefore make it easier for us to treat them more fairly and to take them into consideration as persons in their own right. Hakemulder has, however, questioned the automatic application of this formula (ibid., p. 90), arguing that there is simply too little evidence on the ways reading (certain kinds of) fiction may – or may not – produce empathetic reactions in readers to claim that readers would then altruistically apply their reading experience to real-life persons having similar kinds of features as the fictional characters they read about. In Keen's perception, the readerly empathetic reaction is also much more volatile and difficult to master than an automaton. I would argue, like Keen, that even if this empathetic reaction may be difficult to direct (by the author), one of the factors in writing fiction is to try to create empathetic reactions in readers (cf. ibid., p. 170). This has been one basis of my notion of narrative power: the narrators and implied authors creating narrators wish to affect the empathies of the narratees/readers – and thus also direct their ethical responses concerning the storyworld by, for example, applying certain kinds of empathetic strategies in order to nudge the audiences to seeing the in- and out-groups of the narrative in specific ways. The empathy-seeking narrative agendas function on all the levels: that of narrator/narratee; that of implied author/authorial audience; and that of flesh-and-blood author/flesh-and-blood reader. Thus, the power relation on all of these levels has, as its uniting force, the empathetic and ethical response to the told, which might sometimes, in flesh-and-blood readers, even be enlarged to cover the real-life counterparts for those characters empathised with.

As the actual audience of McGrath's tale, in Spider's case we might see him with empathy and take on the implied author's message that his tragic and mad irresponsibility makes him a sympathetic character – a pitiable mental patient rather than a repellent murderer. As readers, we cannot harm or help him in any way; we cannot prevent his suicide, for one, but we can respond empathetically and ethically to his tale. Fundamentally, we can see him – and perhaps even others that share his fate – through sympathetic eyes and take on board the causalities and interpretative patterns of his tale. We can know more than him, but we can also understand him. This, in my reading, is what the implied McGrath aims for.

Spider offers us the possibility of studying the ethical encounter between a sane world and a mad one which is accessed by the reader through the process of Ryanian recentring – the same process that is always taken in the move of becoming fictitious. Spider's F-universe is like fiction in this regard, since it is hallucinatory and as such not true for the other TAW residents. Through recognising this similarity between Spider's F-universe and fiction in general, one can start to ask questions about the role and value of this mad fiction-inside-a-fiction, both for the characters and for the reader. The formation of the F-universe inside Spider's mind makes him irresponsible in the eyes of his community and the reader; and also an example of Phelanian bonding unreliability. Therefore, the value of his mad fiction is multifaceted. It is first of all also ethically less valuable as the fictitiously true, as it is only hallucination and results in a murder. On the other hand, it makes Spider, who firmly believes in his own fiction, irresponsible for this murder and unreliable in the bonding manner: the very fictitiousness of his world, his F-universe, protects him from the moral condemnation of his community and the reader – even if he is himself totally unaware of all these ethical ponderings. Thus, one can see how the role of mad fiction-inside-fiction can have many values. In the discussion on Lessing, Kesey and Head and their psychosis narratives below, we will encounter a further development of the theme of the value of mad fiction-inside-a-fiction: this is the viewpoint that madness or psychosis might be even more valuable than the real in its metaphorical truth and visionary capacity.

Reading through Ryan's possible worlds theory gives us an opportunity to emphasise the perception of the different ethical values of unreliable mad narration. I see this way of relating different kinds of worlds to each other as one important focus that madness narratives give to the reader: it asks, what can a mad world give or tell to the sane world, and how do the F-universes of psychosis and the TAW relate to each other, ethically and otherwise?

Thus, one can see how Spider's story through its very narrative structure raises questions of how to ethically encounter a psychotic character-narrator. Spider is ethically and legally irresponsible, which is mirrored in the narrative structure of Spider's F-universe eclipsing the TAW in the manner that he cannot perceive the TAW clearly, making him, among other things, ethically handicapped in the TAW. The reader, in possession of the details of the F-universe told by Spider, and the rudiments of the TAW unwittingly hinted at in his tale, is also in a position in which ethical reading demands the delineation of the borders of these two worlds, and that of the AW, the world of the reader. What does it mean for the reader to know more than the narrator? What does it mean for the reader to encounter a mad world? Spider commands our sympathies with his honest but blinkered voyage through the tragedy of his own insanity – even when he is seen to kill the kindest character in the story, and the only person who Spider loved dearly. An ethical reading might be a negotiation between the reader's sympathy for Spider in his blind suffering and the reader's knowledge of details of the utter tragedy of Spider's deeds.

5.2.2 Case study II: A Few Words on the Ethics of Nabokov's Lolita

On the question of ethics, I have thus far concentrated solely on the issue of how the sane world should relate ethically to the insane one. The opposite ethical move – how the world of madness should relate ethically to the world of sanity – has not been considered. This is because madness is usually considered to be an affliction, making the mad person the underdog in the process of diagnosis, a creature who is defined and possibly treated by other people against her will. On the other hand, madness is in its most serious of variants (psychosis) also a source of (legal) irresponsibility and thus a phenomenon that is acquitted from the ethical and juridical condemnation (as in the case of *Spider* above). There are certain madnesses, however – conditions defined in the diagnostic manuals – which raise just this question of legal and ethical condemnation, and in the most fervent of ways. Such madnesses pose a real threat to the surrounding community, without having the side of the mad persons being legally or ethically irresponsible, thus making the stereotype of madness-as-dangerous a pressing fact and reality. These diagnoses include, for example, antisocial personality disorder which may lead to crimes (as in Hustvedt's Mark, and Teddy Giles in the novel *What I Loved*) and paedophilia (as in Nabokov's *Lolita*). Here, I will briefly concentrate on Nabokov's novel and its ethical interpretation.

James Phelan has analysed Nabokov's novel from the viewpoint of its ethics in an incisive manner. He separates the focalisers 'Humbert-the-narrator' from 'Humbert-the-experiencing-character' in order to study the ethical process of the novel. In his opinion, Humbert-the-narrator slowly, over the course of the narrative, begins to see the horror of Humbert-the-character's previous deeds and even to admit his own guilt in abusing Dolores. Phelan sums this up: 'He loves her, however imperfectly, and he has admitted to himself and articulated to his audience how deeply and irredeemably he has hurt her. Furthermore, he recognizes that he cannot do anything to ameliorate his situation or Dolores's; all he can do is to tell the story. The primary agents of Humbert's transformation are his genuine feeling for Dolores and the act of telling itself.' (Phelan 2005, p. 129.) The perpetrator thus comes to see the horrific nature of his crime.

How do the ethical relationships between Humbert, Dolores and Humbert's audience tally with paedophilia as a mental illness? Paedophilia is a 'paraphilia', as DSM-5 states (pp. 685–686; in ICD-10, paedophilia comes under diagnostic category 65.4), a term used to describe 'any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners' (DSM-5, p. 685) including, besides paedophilia, such conditions as sadism, or having sexual fantasies involving non-human objects. DSM-5 states the sickness side of paraphilic disorders thus: '*A paraphilic disorder* is a paraphilia that is currently causing distress or impairment to the individual or a paraphilia whose satisfaction has entailed personal harm, or risk of harm, to others' (ibid., pp. 685–686). This emphasis on clinically significant distress is what justifies paraphilic disorders being included in the diagnostic manuals in the first place. The stress on clinically significant distress can be illustrated in the case of homosexuality as a paraphilia being first included, and then, excluded from DSM in 1973, as the result of active campaigning and lobbying by gay rights activists. Homosexuality, after all, does not cause distress to the homosexual person or harm to the consenting homosexual partner.

DSM-5 does take into consideration the other party's side as well: the 'personal harm, or risk of harm, to others' (ibid.). So, the ethics of paedophilia as a mental illness has two sides: clinical distress *for the patient* suffering from paraphilia and *injuries caused* by the paraphilic behaviour *for the non-consenting others*. The distress for the patient may be in the form of being incarcerated for sexual offenses, of damaging social or sexual relationships because the surrounding community finds the unusual sexual behaviour repugnant, or because the individual's sexual partner refuses

to co-operate in the unusual sexual preferences. This is the side of the suffering of the patient. His 'noxious' deeds (ibid., p. 685), then, may cause suffering for others.

Humbert, as depicted by Nabokov, surely plays the suffering card:

> No wonder, then, that my adult life during the European period of my existence proved monstrously twofold. Overtly, I had so-called normal relationships with a number of terrestrial women having pumpkins or pears for breasts; inly, I was consumed by a hell furnace of localized lust for every passing nymphet whom as a law-abiding poltroon I never dared to approach. (*Lolita*, p. 17.)

Humbert tells the reader that he has been hospitalised a number of times for melancholia, suffering clinically significant distress for not being able to satisfy his sexual preferences because of the surrounding community's repugnance at paedophilia. But is Humbert really capable of regarding paedophilia as a mental illness? He does not seek treatment for it, only for its effect, namely his melancholia for not being able to live in his dream-world of abusing young girls. (He gets pleasure for deceiving his psychiatrists about his real sexual preferences.) On the other hand, he does refer to himself as a 'madman' a number of times, for example: 'You will have to be an artist and a madman, a creature of infinite melancholy, with a bubble of hot poison in your loins and a super-voluptuous flame permanently aglow in your subtle spine […] in order to discern at once, by ineffable signs […] the little deadly demon among the wholesome children […]' (ibid., p. 16.) However, at the beginning of his narrative, Humbert attempts to redraw the line between 'normal' and 'forbidden' most forcibly, even if this redrawing is often a difficult task for him, too:

> One moment I was ashamed and frightened, another recklessly optimistic. Taboos strangulated me. Psychoanalysts wooed me with pseudoliberations of pseudolibidoes. The fact that to me the only objects of amorous tremor were sisters of Annabel's [Humbert's first girl-love], her handmaids and girl-pages, appeared to me at times as a forerunner of insanity. At other times I would tell myself that it was all a question of attitude, that there was really nothing wrong in being moved to distraction by girl-children. (ibid., p. 18.)

Thus, he considers his predilection a forerunner of insanity, not insanity itself. It seems to me that instead of really recognising paedophilia as a mental illness, Humbert has troubles with the notion of it being a mental illness *for others*, because it

is part of the taboo that strangulates him, part of the surrounding society's ban on having sexual relations with a child. The insanity he refers to a number of times is the insanity of any lover: it is the insanity of passion in general.

In many, if not even the majority, of cases, when madness is seen as an affliction or source of distress for the mad person, the sympathies of the sane community (and readers of madness narratives) are engaged. In the case of Nabokov's Humbert Humbert, he must work hard to convince the audience of his sufferings, which are justified as empathy-worthy sufferings only if he also succeeds in convincing the audience of paedophilia's ethically non-condemnable nature and that he suffers more than his victims. Even so, he fails in his attempt of justification. Humbert attempts to justify his abuse of Dolores partly by playing the suffering card, and partly by claiming that the 'nymphets' are demonic, that is, they are more responsible for the paedophilic relationship than the 'bewitched travelers' (paedophiles) (ibid., p. 15). Thus, he tries to stretch his audience's notion of 'normal'.[5] This is the crux of the ethical core of the text as seen by Phelan and other readers, including myself. The very act of searching for the audience's sympathy for his paedophilic (seen as mentally ill, as well as criminal and sinful, by the surrounding community) urges has been seen as unethical; his (at least partial, as Phelan analyses it) admittance of his deeds' monstrosity at the end of his tale has been seen as a turn towards the ethical. Consider Phelan's summary:

> On the one hand, Nabokov is doing something extraordinary, however distasteful: occupying the perspective of a pedophile, asking us to take that perspective seriously, and, indeed [...] asking us, at least to some extent, to sympathize with him. In this respect, the ethics of the novel involves performing one of the best functions of art: extending our perceptions and feelings of its dominant audience,

5. Paedophilia is, if seen psychoanalytically, a perversion. Freud defined perversions in the following manner: 'We divide them into those in whom, like the homosexuals, the sexual *object* has been changed, and others in whom the sexual *aim* is what has primarily been altered' (Freud 1978a, p. 303, Freud's emphasis). Freud gives examples of perversion: people deriving sexual pleasure from anal-eroticism, fetishism, sadism, voyeurism, exhibitionism, masochism, etc. (Freud 1978a, pp. 305–306). One can see how Freud's distinctions are, at least partly, similar to the DSM's. The causation though, in the psycho-sexual regression to previous stages of development, is most poignantly stressed in the Freudian perception – and absent from the DSM. What is interesting, in this context of Humbert's stretching of the 'normal', is that Freud maintained that these forms of sexuality, though perverse, are in some degree present in almost every 'normal' person (ibid., p. 322). The psychoanalytical vision of human beings is, again, more blurry in its borders between deviant and 'normal' than DSM-5, and in the psychoanalytical perception (which is rather ironic, given that Humbert so vehemently despises psychoanalysts) he might have had an easier task in convincing his audience that paedophilia is perfectly normal.

> doing so in ways that challenge preconceptions even if the challenge makes us uncomfortable and even likely to turn against the artist. (Phelan 2005, p. 130.)

Humbert, and the implied Nabokov with him, attempt the most forcible narrative power move of extending the audience's sympathy to a person they very probably would not sympathise with in real life. However, even at best, at the peak of its formidable artistry, Nabokov's work is admirable but also distasteful. Thus, Nabokov's artistry has its dark side:

> At the same time, my sense of Nabokov's success with his project does not obliterate my sense of distance from and distrust of his ethics. In writing this book, Nabokov, like Dolores, enters umber and black Humberland, but unlike her, he does not survey it with a shrug of amused distaste, but rather lives there with a kind of perverse relish. That, to my vision, is the inescapable ethical dark side of this book. (ibid., p. 131.)

The depiction of Humbert's paedophilia is unethical because it concentrates only on Humbert's own perception (as a suffering 'bewitched traveler') and leaves aside Dolores's suffering: 'Because the attention Nabokov and the authorial audience give to Humbert's perspective comes at the expense of Dolores's, Nabokov's very construction of the novel mirrors Humbert's dominance of Dolores at the level of action' (ibid., p. 130–131). The non-consenting partner's viewpoint is left almost totally out of the focus of narration.

The case of Nabokov's *Lolita* brings to fore the other side of ethics in relations between the mad and the sane. Humbert is inescapably mad in his crimes, however, not legally irresponsible, or capable of being acquitted ethically. However, he is unethical precisely at the point at which other madnesses may find acquittal for their dangerous, injuring deeds: he tries to play the suffering card, and find sympathy for his own suffering *in the face of his madness*. Madness makes him a monster, but in a way that does not allow him to plead not guilty because of insanity, in the way that Spider could if he were to acknowledge the depth of his own psychosis. Humbert is not psychotic, therefore he cannot get away with his building of 'Humberland', a fantasy land in which young children seduce reluctant adult men. Is the world-building of 'Humberland' essentially different from that of 'Spiderland'? Humbert is seen to use rhetoric to convince his audience, to win its approval for deeds he knows (deep down) and admits (finally, at the end of his

narrative) are condemnable. Spider, then, is utterly incapable of controlling his narrative or the diagnosis readers make of his story and mental condition. If he were capable of lifting his own psychosis and seeing that he were himself responsible for his mother's death, he would undoubtedly be the first to condemn his own deed. Madness protects him both from legal repercussions and from deadly remorse. (He does kill himself in the end, but what is his motivation? Does he do it because he knows that he murdered his own mother, or because of the dreadfulness of the life he is forced to live outside the asylum? Could it be for both reasons? The reader will never know.) Thus, the form of dangerous madness is plural, and the reader, when encountering the abyss of criminal madness, must face a phenomenon which may profoundly assault her sense of ethics.

One can bridge Humbert's condition to Ryan's possible worlds theory to start to see the root of this difference between Spider's and Humbert's ethical conditions. With the help of this narrative theory, one can answer questions touching upon the difference between psychosis and paedophilia: why is Spider seen as legally and ethically irresponsible for the murder and thus a sympathetic figure even though he murders his own mother, whereas Humbert must bear the full guilt for his paedophilic deeds?

The answer can be seen in the difference between Spider's narrative world structure compared to Humbert's: Spider's psychosis builds a whole F-universe of psychosis, the access to which goes through a recentring; whereas Humbert's 'Humberland' is only a system of private worlds of knowledge (K-world; the modality of knowledge, belief and ignorance), obligation (O-world; a system of commitments and prohibitions) and wishes (W-world; propositions involving the laws of desire of the character, what is 'good' and 'bad' for him) that are not accessed by a recentring, but are satellites of the TAW, not F-universes in their own right. Ryan writes: 'Whereas K-recursion [recursion to a K-world from the TAW] is like putting a new mirror in a room to reflect it from another angle, F-recursion is like crashing through the wall to enter another room' (Ryan 1991, p. 119). Humbert's K-world, O-world and W-world are only aspects of the TAW, reflecting it from different angles and producing his statements of knowledge (e.g. that nymphets seduce men), obligations (that he has the disquieting obligation of a 'law-abiding poltroon' not to touch nymphets); and wishes (that it is good for a paedophile to have sexual relations with young girls.) These worlds, as said, are still in direct contact with the shared centre of the TAW: therefore, Humbert cannot be seen to *be blind* to the TAW and its rules of knowledge, obligation and desires, like Spider, as Spider's recentring to

the F-universe blocked his view of the TAW. This is also reflected in the way Humbert is in such a trouble for his trying to convince the audience of the justification of his redrawing of knowledge, moral obligations and acceptable wishes: he *knows* that his knowledge, morality and wishes are in conflict with those of the TAW and the narratee. This again is something Spider did not know, because he inhabits the F-universe instead of the TAW. Furthermore, one can see the ethical conflict of Humbert's treatment of Dolores in the terms of possible worlds; Ryan states: 'Narrative conflict occurs between domains whenever the realization of a private world requires the nonsatisfaction of some world (usually the corresponding one) in the domain of another character' (ibid., p. 122). The satisfaction of Humbert's Wish-world of having a sexual relation with Dolores means the nonsatisfaction of Dolores's Wish-world of not to be molested by him. Thus, Humbert can be seen in the light which he finally must be seen: he is a character who seeks his own pleasure to the cost of Dolores's well-being, no matter how much he argues for the redrawing of the borders of knowledge, obligation and wishes. The narrative structure can, thus, be seen to directly contribute to the ethical structures of both *Spider* and *Lolita*.

Following these detours through some of the ethical questions that arise from reading madness narratives, I will now concentrate more on the aesthetic plane: how does madness relate to the art of fiction? How can one draw the border between madness and art (if such an act is possible) in a text that seems to be both artistic and mad at the same time? Can artistry and madness occur at the same time and in the same mind?

5.3 Madness and Art: Vladimir Nabokov's Pale Fire

Case Study: Pale Fire – Art (of Fiction) and (the Artistry of) Madness

Pale Fire (1962) is considered one of Vladimir Nabokov's masterpieces. It has a curious structure: it is a 999-line, unfinished autobiographic poem enveloped by a foreword, commentary and index. The poem is attributed to an American poet, John Shade, and the commentary, index and foreword to a scholar named Charles Kinbote, who claims to have been not only Shade's neighbour and dedicated fan, but also his closest friend during Kinbote's stay in the poet's neighbourhood (the duration of which is given as only a couple of months). However, when the reader

starts her journey through the novel's convoluted tale (with constant inter-references from the poem to one part of the commentary to another part etc., as is customary for the reading of an annotated edition of literature) the reader must deal with surprises: the editor seems to be more keen on writing about his own life and person – and an unknown Northern kingdom of Zembla and its king – than doing 'real' research with the aim of shedding light on the poem and the poet (whom Kinbote in his tellingly possessive way calls 'my poet'). He even claims in the foreword that without his commentary, Shade's poem has 'no human reality at all' (*Pale Fire*, p. 25). The commentator engulfs and seizes the poem in order to tell his own life story (during the reading, Kinbote reveals that *he* is the dethroned king of Zembla), which, in Kinbote's opinion, should have been the 'proper subject' of Shade's poem, since he spent a considerable amount of effort telling Shade stories about himself.

Kinbote is far from a humble, learned and diligent commentator; in fact, he is insufferably egoistic. His egoism results in the commentary swelling into a novel about the king Kinbote thinks he is. Furthermore, the reader gets to the point where it seems more than likely that Kinbote is paranoid and mad. There is no Zembla, which is simply Kinbote's delirious hallucination, and the person who shoots Shade at the end of the novel is not the regicide 'Jakob Gradus' Kinbote thinks is hunting him, but only Jack Grey, a lunatic who has escaped from the local institution for criminally insane and who shoots Shade only because he resembles the judge who sent him to the institution. The novel's web of meanings is extremely tangled, with constant refined literary echoes of motifs, resemblances, mirror images, doubles, pseudonyms, anagrams, etc. The curious thing is that both the commentary and the poem seem to reflect each other (the commentary, of course *should* do that, but this is not as obvious in a work whose commentator is Kinbote – and the fact that the poem does so as well only adds up to the puzzlement of the reader).

Bernaerts, Herman and Vervaeck state how the central themes of my following analysis tie together: 'In the context of literary history, madness has turned out to be a rich and many-layered concept. Insanity not only affects (mental) action and communication in the fictional world; it also brings in fundamental concepts such as the creative imagination, genius, and the binary pair blindness/insight. Madness is therefore always connected with considerations of artistic and literary production.' (Bernaerts, Herman & Vervaeck 2009, p. 285.) Thus, in my own reading of this strange novel, I concentrate on the issue of art versus madness. Is Kinbote's commentary, with its splendid prose style, art? Can it be art, despite the fact that he is

mad, or a bad scholar, or both? How should one compare Kinbote's text with that of Shade's on the issue of artistry, control, and aesthetic effect?

Before I tackle these issues, I must make a detour through the issue of authorship, for it is not obvious, either, who in the fictional world has in fact written the texts that together make *Pale Fire*.

5.3.1. Authorship

Who has written the poem and its commentary? This is a burning question because of the 'echoes' that penetrate the work, creating links between the poem and the commentary, which Boyd has termed as being otherwise 'preposterously disjunct' (Boyd 1999, p. 208). There is (Boyd enumerates on pp. 112–113), for example: the 'pale fire' of the title of the poem, and all the 'pale fires' of the commentary (the King's friends, Oleg's ghost's 'dim light', etc.), 'the recurrence of either the phrase or its echoes of the source of Shade's "pale fire" in the Commentary, some clearly deliberate [...] some uncertain [...] some impossible for Kinbote to have fully intended, since they echo the source passage[...]' (in Shakespeare's *Timon of Athens*, which Kinbote does not bother to confirm); 'the weird presence of Shakespeare'; the mirror reflections and crystalline imagery common to both source texts; the shadows of waxwings and Kinbote's regicides being 'the Shadows'; the poet gives, in a mise-en-abyme, Kinbote's situation in relation to the poem (*Man's life as commentary to abstruse/Unfinished poem.* Note for further use.' (*Pale Fire*, p. 57)), etc.

These links have driven critics of the work to find various solutions to the problem of authorship. Tammi has summed up this debate. According to him, there have been three principal positions: 1) Kinbote or Kinbote's anagrammatic alter ego, the Russian professor Botkin (briefly mentioned in Kinbote's commentary and index) has authored the work; 2) Shade is behind the texts; 3) 'both of the above solutions are valid to a degree, but the novel retains a basic ambiguity between them.' (Tammi 1995, pp. 575–576.) Tammi gives the reason for this complexity as well: 'When fictional characters in a novel go on producing new fictions, it becomes difficult for the reader to decide which of the embedding levels should be chosen as the primary one' (ibid., p. 575.) I take Tammi's position in a somewhat different framework – that of the relationship of madness and art: the question of authorship in *Pale Fire* derives from the capability of both art of fiction and madness to create new worlds, to imagine things that do not exist in the real world. Thiher

states this in the following manner: 'Madness and literature spring from the same imaginative capacity to entertain present worlds that do not (really) exist' (Thiher 2002, p. 162). Thus, they create Ryanian alternative possible worlds and F-universes through recentring. I proceed, in the following short discussion on the authorship, to analyse the relationships between different worlds on *Pale Fire's* narrative planes.

5.3.1.1 Shade as the Only Author

If Kinbote was imagined by Shade, the texts attributed to Kinbote would be clearly literary, and thus fiction. A double recentring would occur: 1) Shade (occupying the Textual Actual World) makes up Kinbote (Alternative Possible World); and 2) Kinbote then makes up the delirious Zembla (an F-universe *par excellence*). This would compare Kinbote's madness with Shade's artistry. Kinbote would be Shade's mad double, and the world created by madness would be contrasted with a world created by sane imagination. The Shadean hypothesis has been hinted at or supported by, for example, Alter (1993, p. 139), Field (cited in Tammi 1995, p. 576: '"a sane man may invent an insane character" while the reverse is not possible.') and Boyd (previous to his newer interpretation, which I will tackle below (Boyd 1999, p. 125)).

However, there are problems with this line of thought. Boyd notes that an otherwise humble poet writing a fiction celebrating his figure and work does not tally with the information we are given about Shade (e.g. fictional Kinbote repeatedly states that Main Hall of the university they work for is renamed Shade Hall after Shade's fictional death; this goes against the grain of Shade's character (ibid.)). Shade would, moreover, have a very ironical relationship with his own poetry: Kinbote's mad commentary kills the poem almost as completely as Jakob Gradus's/Jack Grey's bullet kills Shade. On the other hand, Kinbote's endless worshipping of Shade would make Shade especially narcissistic. So, one must look for other options.

5.3.1.2 Kinbote Is Responsible for All Texts

If Shade were Kinbote's creation, the whole of *Pale Fire* would be saturated by madness, creating once again a double recentring: 1) Kinbote (occupying the TAW?) makes up Shade (an APW), together with his fantasies of Zembla (an F-universe); and 2) Shade makes up Appalachia and his own life story (another APW) in his

poem together with Kinbote's commentary (for Kinbote writes copious amounts of text to describe the Appalachian reality as well).

However, there are a number of difficulties for the reader with this interpretation as well: the Appalachian dimension can be disclosed to be a false bottom, part of the invention of Kinbote's fancy. When the basic level narrator (Kinbote) is seen to be mad, the TAW is left without definite borders, and the reader cannot know what is true in the TAW because the narrator and creator is unreliable (the Narratorial Actual World is not, after all, the TAW). It may happen that there are only embedded F-universes, Kinbote's Zembla being on the same level of reliability or fictional truth as Shade's Appalachia. This would strengthen the picture of *Pale Fire* being a masterpiece of postmodern ambiguity and undecidable world-building. However, Boyd has stated some of the weaknesses of this Kinbote-hypothesis: Kinbote is a self-claimed 'miserable rhymester' (*Pale Fire*, p. 227) illustrated by the few clumsy 'variants' he confesses to have written himself. He therefore does not – and cannot – take the honour for creating Shade and his poetic world. This does not tally with what we know of Kinbote's egoism; if he had written the poem, it would most certainly contain more of his Zembla – *all* of his Zembla – plus, he knows too little of America, being a European exile, to have created Appalachia, etc. Boyd sums this up: 'Kinbote lacks the restraint, the modesty, and the motive to establish the silent signals connecting poem and commentary that trouble and tantalize the good reader' (Boyd 1999, pp. 116–121). (I do have, though, some trouble in concurring with Boyd's verdict that Kinbote lacks 'the motive'; I will return to this below.) In addition, as Field suggested already above, a madman (Kinbote) cannot invent a sane man (Shade), only the reverse is possible.

5.3.1.3 Kinbote and Shade Are Separate Characters

If there are two persons, Kinbote (or Botkin) and Shade, who both create their respective texts, only one recentring occurs: Kinbote creating his F-universe of the fabulous Zembla, for which the TAW is the Shadean – and to a certain degree also Kinbotean – Appalachia. The borders between the two are still somewhat indefinite, due to Kinbote's all-encompassing paranoia regarding Kinbote's perception of his Appalachian surroundings and their relationship with him and his fantasies of Zemblan kinghood. Some critics find this interpretation most appealing. For example, Tammi writes: 'This [Kinbote being the editor and thus occupying the uppermost

narrative level in the work] need not mean that the editor (or any other narrative agent) goes about "inventing" everything else in the text[...] But Kinbote's position does grant him a unique opportunity to verbally adjust his discourse to the embedded texts in the novel.' (Tammi 1995, pp. 582–583.) Welsen states: 'However, the "family resemblance" [...] between the poem and the commentary probably results from Kinbote's admiration for the poet' (Welsen 1989, p. 392). I for one find this solution to be a simple (though not simplistic) and elegant interpretation, which allows us to delve deeper into the mysteries of artistry and madness and all their convoluted interconnections. If Kinbote is both mad and the author of his own texts, the comparison between his and Shade's character, mental state, and artistry is a true one, not an illusion created by a sane, but untouched (by true madness) imagination.

Before concentrating on the question whether Kinbote's writing – his prose – is art, I take a brief detour through bad scholarship and bad poetry.

5.3.2 Kinbote: A Bad Scholar

One obstacle between Kinbote and his being a true artist is in the perception that he is a scholar – and a bad one, at that. The viewpoint that Kinbote should be read (also – or first and foremost) as a scholar has been adopted by a number of critics. For example, Haegert highlights the fact that Kinbote's commentary is above anything else, a mad, bad, uncontrolled piece of research, and thus it cannot be seen as real art (Haegert 1984, p. 413); Hennard states that Kinbote's commentary is a 'hyperbolic and humoristic treatment of the syndrome of the critic' (Hennard 1994, p. 302); Pellerdi points out that Kinbote may have great examples of dedicated scholarship, but due to his insanity, he cannot follow them (Pellerdi 1996, p. 113); and Tammi sums up by stating: '*Pale Fire* functions as a not overly subtle satire of 'academic' literary criticism' (Tammi 1995, p. 577).

This viewpoint rests on the firm basis that Kinbote conquers space for his descriptions of the imaginary Zembla in something he himself claims to be a proper study, a critical edition of a literary piece of writing that apparently does not have much to say about or to do with Kinbote's Zembla. This, of course, reflects Kinbote's madness, his egoism and the delusions which have made him create a completely new world instead of the one in which he must live (the TAW being replaced by an F-universe for him, a rather Freudian perception of psychosis – even if Nabokov, in

Pale Fire and elsewhere, mocks the Freudian 'quacks' with considerate amount of pleasure). As Boyd states, '[...]Kinbote himself has immortalized Zembla, the refuge of his imagination, in the only way left him, by attaching it to the immortality he expects of Shade's poem' (Boyd 1999, p. 103). Of course, from the perspective of scholarship, a commentary on Shade's poem is not the place to immortalise anything other than Shade's poem.

Felman has studied another classic tale of madness and interpretation, James's *The Turn of the Screw*, by making an analogy between the reading process and murder: 'For it is by the very act of forcing her suspect [the 'possessed' child] to confess [that they, the children, have been in contact with the ghosts] that the governess ends up committing the crime she is investigating, it is nothing other than the very *process of detection* that *constitutes the crime*. The detection process, or reading process, turns out to be, in other words, nothing less than a peculiar and uncannily effective *murder weapon*.' (Felman 1987, pp. 218–219.) When compared to *Pale Fire*, one can see how here the interpreter/killer is mad himself. Kinbote is not pushed to the margins; indeed, he refuses to allow himself to be pushed to the margins (on this most overt plane, Kinbote's madness is not marginalised or 'blocked' in the text, like Felman supposes madness usually is (ibid., p. 16). Of course, Kinbote does not acknowledge his own madness, so there one can already see one 'block' or denial of madness). However, reader responses to *Pale Fire* have often seemed to bypass Kinbote's reality the way *he* sees it – just because it is only his mad reality, not a shared one. Therefore, it is perhaps not far-fetched to claim that in the readings of and in *Pale Fire*, there is a two-fold movement that mirrors itself: the reader kills Kinbote's story by confining it into an imaginary madhouse; and Kinbote kills Shade's poem by forcing it to be about its 'proper subject' – Zembla – rather than what it really is, a rather touching piece of autobiographic poetry. There is a forcible dynamism between these two movements. The reader repeats Kinbote's way of reading or Kinbote repeats the reader's reading – a 'killer reading' – either because the reader is mad (Kinbote cannot see his own reading's madness) or because she is sane (the average reader does not value Kinbote's story as highly as Shade's poem because it is mad). Here, one can say that the Felmanian rhetoric of madness (the average reader's bypassing the truth value of Kinbote's tale) repeats the gesture of the madness of rhetoric (Kinbote's mad reading of Shade's poem) – and is questioned by it at the same time (ibid., p. 252). In a manner that combines Foucault and Lacan, Felman sums up the violence of interpretation:

> The comprehension [...] of the meaning the Other is presumed to know, which constitutes the ultimate aim of an act of reading, is thus conceived as a violent gesture of appropriation, a gesture of domination of the Other. Reading, in other words, establishes itself as a relation not only to *knowledge* but equally to *power*; it consists not only of a search for meaning but also of a struggle to control it. Meaning itself thus unavoidably becomes the outcome of an act of violence[...] (ibid., p. 207.)

This also means that to try to master literature – and madness – is to find oneself in the traps of literature and madness, to be always inside them even when one thinks one is outside them. One occupies a blind spot: one is blind to one's own blindness (more of this in a moment). (ibid., p. 239.)

Kinbote is a notoriously bad scholar, which is impossible to deny. His interpretation is a tool of illegal appropriation, of the wilful mis- and displacement of meaning (of Shade's poem), of killing the poet's poem. There is no consensus about the artistic value of a bad commentary, however. I will return to Kinbote's artistry, but before that, I must ask: is *Shade's poem itself even* art in the meaning of good poetry? If it is not – where does it leave Kinbote?

5.3.3 Shade: A Bad Poet?

Not all of *Pale Fire's* critics are as convinced as Kinbote that Shade's poem is an immortal masterpiece. Even Boyd, who otherwise highly values Shade's poem, says of it: 'When we come from the tantalizing promise of Kinbote's character in the Foreword, the hints of mysteries not quite stated but perhaps soon to be solved, Shade's world can seem drab and flat' (Boyd 1999, p. 27).[6] This does not necessarily mean that Shade's poem is bad, but in comparison to Kinbote's flamboyant prose, its effect is most certainly more subdued. Others have gone further: O'Donnell states about Shade's poem that '[m]uch of this is hilariously bad poetry' (O'Donnell 1983, p. 387), and Abraham adds: '"Pale Fire" is a bad poem. It is a *clever* "bad" poem, it is true, with Nabokov executing his balancing act of writing a knowingly incompetent poem with a certain amount of grace and panache – and even sympathy. [...] So the single artefact "Pale Fire" is simultaneously two poems: a funny knowing poem

6. However, Boyd, in a separate article dedicated solely to Shade's poem (2011), analyses the poem with admiration and adoration.

by Nabokov and an appalling, embarrassing poem by Shade.' (Abraham 1983, pp. 245–246.)

If Shade's poem is embarrassing, where does it leave Kinbote, the poem's most dedicated fan? He *is* dedicated to it: he does not discard it even if it is a huge disappointment for him. In fact, quite the opposite is true: he is willing to work on it, and with it, to be able to say amidst its voice what he wants to say, by forging variants and forcing the commented lines to speak Zemblan. Nevertheless, he does confess his forgery and does not destroy the poem in a fit of anger he feels he is entitled to, even if he had ample opportunity to do otherwise. Even in his twisted, paranoid, stalking manner (for Kinbote also confesses that he actively spied on the Shades), he is the poet's admirer, come what may.

Kinbote's possible artistry is *artistry compared to* Shade's poetry and artistry. The two form a polar opposite almost in every way: Shade is down-to-earth, American and Appalachian, Kinbote is an exiled cosmopolitan from Europe; Shade is stability itself, Kinbote is mad; Shade is old, Kinbote younger; Shade is omnivorous, Kinbote vegetarian; Shade is heterosexual, Kinbote homosexual; Shade is a distinguished poet, Kinbote a not-so-famous scholar of poetry... Kinbote is unavoidably compared to Shade; their union is strengthened by the literary links between their texts, the resemblances and the mirror images that abound their writings. If Shade's poetry is bad, Kinbote's commentary of it gets another twist – it is doubly mad, both in its forcing of the Zemblan theme *and* in seeing immortality in a hilariously bad poetry. However, the appraisal of Shade's poem, the value given to it, is in the eye of the beholder. The matter cannot be solved in any real manner. In my own opinion, Boyd's and others' readings of Shade's poem as a richly textured rather than a drab embarrassment is more just – both for Nabokov and Shade. Even the most strange, even self-contradictory passages of Shade's poem (e.g. Shade promising to 'speak of evil and despair / As no one has spoken...' (*Pale Fire*, p. 56) while shaving in the tub – and still failing to speak of evil and despair) could be read as Shade's ironising his own distinguished poet-hood. So, I will continue seeing Shade as the polar opposite of Kinbote in the opposition distinguished poet/mad commentator. I will now consider Kinbote's prose: is it art or not?

5.3.4 Control, Aesthetic Production and Madness

5.3.4.1 Kinbote, Fiction and Control: The Mystery of Artistic Creation

Kinbote creates, out of his madness, a very rich tapestry of an imaginary world, a veritable F-universe. His Zemblan lore is written in a touching and catching manner: it grasps the reader firmly, even after the realisation that Kinbote is mad, and that the story told is 'a mere madman's rant' – but is it? Is Kinbote in control of his narrative? Does he need to be in control of it in order to be an artist?

There are certain inner tensions in the novel that warrant these questions. Kinbote does seem to control his narrative; for example, he creatively links his fantasies to bits and pieces of the poem's material (e.g. when Shade mentions his parents on line 71, Kinbote first briefly sums up what he happens to know about Shade's parents, and then, for nearly five pages, he elaborates on his own (fictitious) parents (*Pale Fire*, pp. 82–88)). On the other hand, Kinbote seems to lose control of the text he is writing: already in the first pages of the novel, in the foreword, Kinbote lapses into what appears to be uncontrolled writing: 'A methodical man, John Shade usually copied out his daily quota of completed lines at midnight [...] he preserved the date of actual creation rather than that of second or third thoughts. There is a very loud amusement park right in front of my present lodgings.' (ibid., p. 13.) Moreover, near the end of his tale, he vents his exasperation on the narrative and spiritual world's end: 'Yes, better stop. My notes and myself are petering out' (ibid. p. 235). Kinbote controls and loses control. This can be seen perhaps most strongly in the Gradus-theme Kinbote adds to Shade's poem as a kind of inbuilt motif of destruction – of the poem, its poet, and commentator, all in a single stroke. At the beginning of the tale, Gradus is seen to comply with Kinbote's fascination and machination:

> We shall accompany Gradus in constant thought, as he makes his way from distant Zembla to green Appalachia, through the entire length of the poem, following the road of its rhythm, riding past in a rhyme, skidding around the corner of a run-on, breathing with the caesura, swinging down the foot of the page from line to line as from branch to branch, hiding between two words (see note to line 596), reappearing on the horizon of a new canto, steadily marching nearer in iambic motion, crossing streets, moving up with his valise on the escalator of the

> pentameter, stepping off, boarding a new train of thought, entering the hall of a hotel, putting out the bedlight, while Shade blots out a word, and falling asleep as the poet lays down his pen for the night. (ibid, p. 65.)

At the end of that tale, however, Kinbote must face the horror of his self-made murderer, his own paranoia that first produced Gradus as a mental object, and then made him irreplaceable, even after the death (by suicide in jail) of the above-imagined Gradus/Jack Grey: 'But whatever happens, wherever the scene is laid, somebody, somewhere, will quietly set out – somebody has already set out, somebody still rather far away is buying a ticket, is boarding a bus, a ship, a plane, has landed, is walking towards a million photographers, and presently he will ring at my door – a bigger, more respectable, more competent Gradus.' (ibid., p. 236.) Gradus is the death that no one can avoid or control, which the paranoiac dreams so noisily and violently, giving it colours like no one else can. Thus, one of the central themes of Kinbote's narration is this fluctuation of control and the effects it has on the possibility of Kinbote being an artist.

In the discussion about the matter of control over aesthetic production – over the techniques of creating meaning through art – there have been strong perceptions that a true artist controls her art, whereas, if a madwoman creates an artwork, it can never be true art. In this perception, Kinbote's prose is not – and cannot be – art, as it is produced from inside the locus of madness. Kinbote does not completely control his fictitious world, its fictitiousness, and its building of the F-universe (of which he seems to be little, or not at all, conscious of; there are hints, like 'I felt sure at last that he [Shade] would recreate in a poem the dazzling Zembla burning in my brain' (ibid. pp. 66–67). Is Kinbote aware that his Zembla exists only as the fevered machinations of his brain?)

Consider the following description by Sass: in his handling, the presuppositions of mainstream psychiatry, cognitive psychology and psychoanalysis that schizophrenics have less control over the process of speaking and understanding language is applied to the appraisal of the late poetry by Friedrich Hölderlin from the times he was confined in a mental hospital as a madman. Sass writes:

> The powerful influence such presuppositions can have is particularly well illustrated by the varying responses that literary scholars and other writers have had to the late poetry of Friedrich Hölderlin, poetry written during the long schizophrenic period of his life. Specialists given to more traditional literary and psychiatric

> assumptions have tended to see these works as consisting of 'odd words, lumped together without plan, and of an awful unintelligibility" – indeed, as signs of 'catatonic form of idiocy' that show 'failure of linguistic expression' and 'helpless banality,' and as filled with 'empty words' that cannot conceal a profound incapacity to grasp or to express abstract concepts. [...] Yet other critics have seen these very same poems as pregnant with meaning, and as constituting this great poet's finest work. 'Signs of apparent helplessness prove to be calculated operations, and apparent slips in the flow of [Hölderlin's] language [turn out] to be a deliberate control of the system[...]' (Sass 1998, p. 183.)

So, is the writing of Hölderlin – or Kinbote, in the storyworld of *Pale Fire* – madness and not art, or is it art, despite its madness? Can a madwoman, as such, as an *a priori* case, produce anything valued as (literary) art? Felman states the negative (sup)position: 'What is at stake in literature, is meaning; but madman's speech is *a priori* meaningless; at any rate, it is unreadable, incomprehensible' (Felman 1987, p. 104). However, as Sass puts it, the relationship between madness, volition and art is not simple:

> Such views [of the non-mastery of mad language] generally presuppose a rather simplistic version of the act/affliction distinction, and one consequence of this is a failure to capture the complexity of either madness or art. For, in reality, more than a few modern poets and other writers have felt unable to master language, and some have even made this experience into a central theme of their work. [... This] should cure us of certain overly simple dichotomies, such as the assumption that the unusual speech of schizophrenics must necessarily be either empty nonsense or utterly saturated with meaning, or the tendency to see such people either as Macchiavellian schemers or overwhelmed victims. (Sass 1998, pp. 184–185.)

Thus, it seems to be that neither pole of the affliction-versus-act dichotomy can really capture the whole truth about mad or schizophrenic language (ibid., p. 183), or mad fiction, for that matter. Hence, Sass sums up the opposite (sup)position:

> The assumption seems to be that, if there is real method in speech or action, then it is not truly madness; thus to *play* at madness, or within one's madness, is not to be truly mad – and only in such literary artists as Diderot and Pirandello do we have the suggestion (never taken seriously by the mental health establishment) that an authentic madness might, in some essential, way involve just such a playing. (ibid., p. 114.)

Playing is most strongly an act of volition, and thus, madness can produce art: madness can play at meanings, construe them, and create something meaningful, says Sass. The complex nature of both madness and art give ample possibilities to study the volition/non-volition of the use of language and the art of language (i.e. the literary). This can be seen in force in Kinbote's imagining of Gradus, of building a coherent picture (apparently out of nearly nothing: a face in judge Goldsworth's album of criminals he has sent to jail; and a feverish imagination of a paranoid person) that is both 'textual' (Gradus as the one moving and being moved by the poem's text) and 'real' (a person who is capable of killing, for instance). Kinbote both imagines, creates, construes, and plays with images, notions, words – and he is a victim of his own imagination: his imaginary killer is not killed even by real death (of Jack Grey), but is copied endlessly, until death finally reaches Kinbote (who contemplates a number of times the graciousness of suicide) for real.

Felman has characterised the convoluted perception of madness-versus-art-versus-philosophy from the viewpoint of the relationships between them. In her treatment of these themes, she presses the interconnections between them: madness is, first and foremost, 'blindness *blind to itself*' (Felman 1987, p. 36); and the relationship between philosophy (logos), and literature and madness (both seen as pathos) is defined through this blindness which is blind to itself. Felman describes an interesting French philosophical debate of the 20th century (which I briefly touched upon in Chapter 2), that of Derrida and Foucault arguing over the essence of Descartes's cogito, its 'malin génie', creating as a fiction the whole consciousness of the cogitating Descartes, and its repercussions on the perception of madness. In this debate, Derrida maintained that Descartes in his *cogito* takes on madness in order to protect himself against it, to exclude it in the act of speaking; literature, or intra-philosophic fiction itself becomes a metaphor of madness of philosophy. (ibid., 1987, pp. 48–49). Foucault maintained another position that centred on the idea that Descartes's fiction of the 'malin génie' is anything but true madness. Felman sums up the meaning of Foucault's position to the discussion on literature, madness and philosophy:

> The philosopher ends up getting his bearings, *orienting himself* in his fiction; he only enters it in order to abandon it. The madman, on the other hand, is engulfed by his own fiction. As opposed to the subject of logos, the subject of pathos is a subject whose position with respect to fiction (even when he is the author) is not one of mastery, of control, of sovereign affirmation of meaning, but of *vertige*,

> of *loss of meaning*. It could be said that madness (as well as pathos and perhaps, literature itself) is the non-mastery of its own fiction; it is a blindness to meaning. (ibid., p. 49.)

Thus, Kinbote, being blind to Zembla's fictitiousness, is a non-deliberate subject of pathos. It is interesting that this viewpoint, seen from the position of philosophy versus literature, makes madness seem literary in the philosophical, and philosophical in the literary ('the literary madman is most often a disguised philosopher' (ibid., 1987, p. 37)). *Both* madness *and* literature are seen as a blindness blind to its own blindness. As Sass also stated above, madness is not excluded from art (of fiction), but is intrinsically inside of it, or it is at least in a very complex relationship with it. The worlds of *Pale Fire* thus build a comparison between the sane art of Shade (seen as art in the TAW), who is equally blind to being as a character in a novel by Nabokov, and mad art of Kinbote (seen as others in the TAW as the dazzling F-universe, a figment of imagination) who, although incapable of seeing Zembla as a piece of art rather than a reality, in the end almost sees his own imaginary being as a character in a fiction: 'I may [...] cook up a stage play, an old-fashioned melodrama with three principles: a lunatic who intends to kill an imaginary king, another lunatic who imagines himself to be that king, and a distinguished old poet who stumbles by chance into the line of fire, and perishes in the clash between the two figments.' (*Pale Fire*, p. 236.) Both Shade and Kinbote are subjects of pathos, creating an interesting counterpoint: it presents the opportunity to ask what unites and what divides them as (possible) artists.

5.3.4.2 Ghosts, Artists and Webs

In his influential monograph on *Pale Fire*, Boyd puts forth the interpretation that behind Kinbote's imaginations of Zembla and Gradus, there are the ghosts of Shade's suicide daughter Hazel (about whom a large part of the poem is written) and Shade himself. He grounds his interpretation partly on the assumption that Kinbote needs Hazel's assistance to create Zembla and that by immersing his friend in his fantasies, Kinbote helps Shade to write about his daughter – one of the goals Hazel wants to achieve from behind the grave. Boyd bases this interpretation partly on the fact that there is a resemblance between Kinbote and Hazel – something that Kinbote

himself acknowledges: 'But then it is also true that Hazel Shade resembled me in certain respects' (*Pale Fire*., p. 154). Boyd writes:

> As we shall see, Zembla becomes more clearly than ever an escape, an indulgent dream, yet underneath it all we can now glimpse a new depth of human truth, as we see Hazel acknowledge her own past, bravely facing it, playfully transforming it, allowing Kinbote an escape within life that she never had, but at the same time reflecting her own past predicament and her present delight in her new freedom from the solitary confinement of her old self.' (Boyd 1999, p. 154.)

Behind the artistic creation of Gradus is Shade's ghost, who wants to allow his exiled friend a share of poethood: '[...W]e are invited to see here that Shade's shade, his ghost, influences Kinbote's paranoia in such a way that his developing fantasy about Jack Grey takes shape as the Gradus story, which is then through Shade's unrecognized guidance shaped into a complex narrative counterpoint to the composition of the poem.' (ibid., p. 211.) He continues: 'By developing Kinbote's Zembla in his own unique way, by setting up the elaborate counterpoint of Gradus and the composition of the poem, Shade also helps Kinbote – always in awe of him as an artist – to become as much of an artist as he can, to impose a much tighter form than he can manage elsewhere on the obsessions filling his mind.' (ibid., p. 219.)

'Always in awe of him as an artist', Shade indeed calls Kinbote 'a fellow poet' in a roundabout way. At a cocktail party, Kinbote interrupts the poet in the middle of discussion about the mad. Just before being interrupted, the poet says: 'That is the wrong word. [...] One should not apply it to a person who deliberately peels off a drab and unhappy past and replaces it with a brilliant invention. That's merely turning a new leaf with the left hand.' (*Pale Fire*, p. 188.) Even though Mrs H., his partner in conversation, refers to a railway station man who thought he was God and began to redirect trains, the quote is an embarrassingly apt description of Kinbote (and 'the poet looked at [him] with glazed eyes' as he interrupts the conversation (ibid.)) and the term 'fellow poet', given by Shade to the railway man, is taken up by Kinbote himself as he replies to Mrs H's question by saying 'We all are, in a sense, poets, Madam' (ibid.).

There are a number of counter-arguments to Boyd's ghostly interpretation that, in my opinion, show certain incongruences to his theory: 1) does Shade not have a good reason to write about his daughter, without any indirect help from a mad neighbour? 2) Does Boyd claim that Hazel drove Kinbote to madness in order

to achieve her goals? Boyd is contradictory here: on the one hand he claims that the ghosts only work on Kinbote's madness, that he was already insane before they started their work (Boyd 1999, p. 219), on the other hand he claims that Hazel 'induc[es] in him a degree of madness that offers him a gift [...] at some cost to his sanity, though not to his intelligence' (ibid., p. 155) (I will return to this shortly); and 3) the 'beyond' Boyd postulates is seen by him a little too clearly: even though he states that Nabokov does not give any details of the two ghosts' afterlife (ibid., p. 223), Boyd does invent a number of details about the dead Hazel's and Shade's psychological features, their goals, motives, wishes, etc.

What is most telling is what Boyd's interpretation of the help from somewhere beyond seems to infer, again, that a madman cannot have the integrity – the capacity for control – of an artist; instead, he needs the help of the two ghosts *who are sane* (at least after death – Hazel may have been mad while alive, but I would state that as Boyd sees her transforming from a drab butterfly to a flashing Red Admirable, she regains her sanity as well). Seen from another vantage point, Boyd's interpretation pivots on the statement that when Kinbote starts to unravel his Zemblan theme, the 'vividness, unpredictability, and beauty of its details allow Zembla to leap into life in our minds, no matter how convinced we are it is Kinbote's fantasy.' (ibid., p. 176). 'No matter how': does Boyd claim that Kinbote's story would be more artistic (for is not one of the possible goals of a piece of art to touch, to impress?) if it were not his fantasy, an F-universe within the fictitious truth, the TAW of Shade's Appalachia? Is not all fiction art, precisely because – not in spite of – it is fiction, fantasy, and representation? Attacking from both sides, stating that Kinbote cannot control his fiction and thus needs ghostly helpers, and that Kinbote's prose is, even at its best, a madman's fantasy and thus not (real) art, Boyd drives Kinbote into the most ultimate corner: a Solus Rex position *par excellence* (this being the name of a chess problem Kinbote offers Shade as the title of his poem about the Zemblan king Kinbote, which, of course, ended up being the very Appalachian poem 'Pale Fire').

If a man must be driven to madness in order to be used as *a tool for art* – not being able to produce art on his own devices – what does Boyd's postulation tell us about the relationship between art and madness? It seems to combine the best features of madness and sanity: the (postulated) endless capacity for imagination of madness, and the (postulated) restraint and control of sanity required for diligent artisanship. However, this is an artificial combination: it does not matter whether we believe or not in ghosts that control the uncontrollable, the mad poet's creative process is unnecessarily split into the mad poet's part of producing the imaginative

matter and the sane controller's influence that controls and shapes that imaginative matter. Both positions are, from the viewpoint of Sass's above discussion on the volition of art and madness, artificially severed from each other. Could Kinbote not be creative on his own?

Of course, mad artists have been with us for ages, to the degree that *all* artists have been seen as mad. For ages, artists have also been seen as supernaturally, divinely inspired (for a classic and one of the earliest developments of the theme, see Plato's *Phaedrus*) – and divinely induced into madness. So, Boyd's ghosts are in distinguished company. Yet one can discard the divine or supernatural inspiration and still keep the theme of madness creating art. Thiher states the modern corollary of this ancient theme: the Freudian clause that '[p]sychosis is an art form. [...] Freud places art and pathology together as comparable strategies of adaptation, for artists and neurotics – and a fortiori psychotics – find common strategies for the impossibility of satisfactory repression by turning to the imagination.' (Thiher 2002, p. 247.) Madness and art both mean a possibility to escape dreary reality into fantasies as dazzling as Kinbote's Zembla. Galef (1985, p. 427) and Oakley (2003, p. 485) have pointed out that Hazel and Kinbote are both escapists – and artists. Thus, there are critics who have seen a true artist in Kinbote: for example, Alter states: 'Kinbote the fantast, master of the novel's prose, really eclipses the neo-Popean Shade as poet[…]' (Alter 1993, p. 139); and Tammi writes: '[W]hile Shade remains in control of the artistic system of the poem, it is Kinbote who is responsible for the system of the comprehensive narrative text as a work of art' (Tammi 1995, p. 583). It is time to ask, then, what 'art' means in the context of *Pale Fire*? What are Shade's and Kinbote's own aesthetic frameworks?

Shade describes how he, in hot pursuit of a glimpse of afterlife, followed the lead of a misprint in a magazine that seemed to tell of a similar experience he had had during his heart attack (he claims to have seen a white fountain at the moment of near death, but the lady telling a similar story in the magazine had meant 'mountain', not 'fountain'). After this experience, Shade (re)formulates his life view – and aesthetics – in his poem:

> Life Everlasting – based on a misprint!
> I mused as I drove homeward: take the hint,
> And stop investigating my abyss?
> But all at once it dawned on me that *this*
> Was the real point, the contrapuntal theme;

> Just this: not text but texture; not the dream
> But topsy-turvical coincidence,
> Not flimsy nonsense, but a web of sense.
> Yes! It sufficed that I in life could find
> Some kind of link-and-bobolink, some kind
> Of correlated pattern in the game,
> Plexed artistry, and something of the same
> Pleasure in it as they who played it found. (*Pale Fire*, p. 53)

Kinbote answers by giving his own position on the game of art:

> Although I am capable, through long dabbling in blue magic, of imitating any prose in the world (but singularly enough not verse – I am a miserable rhymester), I do not consider myself a true artist, save in one matter: I can do what only a true artist can do – pounce upon the forgotten butterfly of revelation, wean myself abruptly from the habit of things, see the web of the world, and the warp and the weft of that web. (ibid., p. 227.)

Both talk about the web – of the sense – of the world. Like Shade, Kinbote weaves a rich web of his own perception of the world, and in the process he also both lights 'pale fires' of truth (of art) for, and captures them from, Shade's poem. Art is the pale fire of the world, of truth, of life, of sense – these are all grand words, but can you help it? These are the echoes Boyd wishes to explain away with his ghost theory. I give a somewhat more modest and perhaps more obvious explanation: the echoes could be explained by the fact that the implied Nabokov wishes to study, compare and contrast two possible artists, one mad, the other not, in the act of creating their art. The echoes only heighten their juxtapositions and interlinkages.

Can one really bypass Kinbote's story nonchalantly after realising its madness? Does it have any kind of representational relation to the TAW – or our AW? This question of the relationship between literary representations of madness (fiction inside fiction) and the TAW or further the AW must be asked, for is not the art of fiction always in some kind of relationship with the real – otherwise, would not it be incomprehensible for the reader in AW? If Kinbote's prose had some kind of representational relationship to the real of the TAW or AW, would it be, then, undeniably art – like Kesey's, Head's or Lessing's great societal allegories (which I will touch upon below)?

This relationship between fiction and reality has been accentuated by Walsh with his notion of incremental truths that are accumulated in a literary piece about the real world we all occupy (Walsh 2007, p. 30). Others, though, have different positions. Kinbote himself takes the position of denying this (more or less) direct link: '"[R]eality" is neither the subject nor the object of real art which creates its own special reality having nothing to do with the average "reality" perceived by the communal eye' (*Pale Fire*, p. 106). Is it only Kinbote's madness speaking, his own writing being just the sort that severs its connections (almost totally) to the real and the shared, by imagining a whole new different world – a Zembla – making his art the art of fantasy. Keitel states: 'Fictions, however, should never be subjected to the question of whether they are true or false; the only question adequate to fictions is that of their function' (Keitel 1989, p. 63). What is the function of Kinbote's text, then? It is escapism, say those who emphasise its essence as psychosis and a denial of the real world. It is (bad) scholarship, say others who emphasise its essence as a commentary, a scholarly writing. It is art, say those who compare his prose to the poetry of Shade and find a common aesthetic enterprise – the web of sense, of worlds. Kinbote's text has many functions; it is a matter of emphasis what to heighten in his writing. I would add my voice to those who claim that, apart from other things, Kinbote's prose has a certain artistic value – as a counterpoint to Shade's poem, for a start. Tammi concludes: 'For any reader who refuses to take Kinbote's invention in earnest poses a threat not only to his status as the ruler of Zembla; the incredulous reader is also a menace to the status of art and imagination as purveyors of meaning in human life' Tammi 1995, p. 584).

Finally, I will consider the links between the F-universe of Kinbote's fantasy and Shade's poem, the TAW. Autobiographical art as the combination of truth value and artistic value, will, I hope, bring to rest some central themes of mad art as seen in *Pale Fire*.

5.3.4.3 Autobiography, Artistic Value and Truth Value

Comparisons between the writings of Shade and Kinbote partly, and rather strongly, focus on the autobiographic. Shade's poem is both autobiographic (which means it has certain truth value in the TAW) and a piece of art (having aesthetic value in the TAW – and in the AW as well). Does Kinbote's writing have either of these values as autobiographical art?

Above we saw that both Kinbote and Shade see certain artistry in Kinbote's person. His text is tantalising, grasping, touching – and mad. Kinbote does not himself perceive the fictitiousness of the autobiography he offers as the truth of his self and his kinghood. It is 'fiction' in the sense of 'something imagined' inside the TAW, and the recentring takes place as the effect of a deranged mind. Kinbote, though in at least partial control over his text, does not totally control the *manner* of his tale's fictitiousness; he is blind to his own blindness as a subject of pathos. He may control the Gradus theme (which was above presented at least partly as a deliberate literary construct by Kinbote) and the interlinking of his commentary to the poem, but he does not see his own story's madness – that it is fictitious in that meaning and that it loses its truth value at the same time. This is something that would, no doubt, madden and sadden him if he were to acknowledge it. His writing's possible artistry, then, rests on the absolute value of the rich and well-formed prose style, which is hard to deny. However, the twist of (at least partly) uncontrolled madness in the creative act renders the relationship between the world from which it is recentred (the TAW, the world in which its truth value is weighed) and the F-universe complex. There are opposite forces at work in this relationship: Kinbote wishes to put forth his own version of reality, with its kings and regicides, while the community around him sees this madness – this Zemblan theme – as an obstacle to Shade's poem's commentary being a 'proper' study (Kinbote himself gives a lot of room in his commentary for the animosities he feels around him before and especially after the poet's death, and his more-or-less theft of the poem). There are thus opposing truth claims and opinions about what is true in the TAW and what is true in Kinbote's commentary on Shade's poem and life.

However, is Shade's text, as the text with which Kinbote's prose is compared, any simpler as autobiography than Kinbote's? What is the role of imagination in an autobiographical work of art? One of the focuses is precisely the possible similarity between Shade's autobiographical (poetic) invention and Kinbote's autobiographical (literary) madness.

The notion of literary madness is with the reader from the first pages of any madness fiction. Can a piece of art capture the ephemeral madness that in Foucault's terms is silence itself? Keitel has pointed out that psychosis is an autistic state in which communication is impossible (Keitel 1989, p. 5), meaning both that authors cannot be psychotic at the moment of writing and that literary descriptions of psychosis are always dependent on literary strategies: they are literary constructs. Feder has also asserted the literary in literary madness: 'The madman of literature is, to some

extent, modeled on the actual one, but his differences from such a model are at least as important as are his resemblances to it: he is rooted in a mythical or literary tradition in which distortion is a generally accepted mode of expression; furthermore, the inherent aesthetic order by which his existence is limited also gives his madness intrinsic value and meaning.' (Feder 1980, p. 9). A schizophrenic's language can be utterly incomprehensible – but the literary representations of it may not be (as we will see later in connection to Kesey, Lessing and Head). Literature makes the language of schizophrenia ('schizophrenese', if you will) meaningful. Kinbote is a literary madman in two senses: he is (rather obviously) a mad character in a book *and* a madman producing a highly complex literary text about his own madness, a mad autobiography that impresses (perhaps too much to be an 'authentic' depiction of DSM psychosis) with its coherence and detail. It is an autobiography that, through being one written by a madman, turns out to be a construct, a representation of something that there may be no real counterpart for: a literary piece of a madness story; an autistic state made communicative; a silence speaking.

In counterpoint, then, one can ask: how much does Shade build his own poem as a literary construction, as art, not a document? It has been noted that *both* Shade's poem *and* Kinbote's commentary are, as autobiographical texts, literary, fictitious constructs, and that *both* Shade *and* Kinbote create a subjective reality in and through their using of language: *all* subjects, all self-images, are fictitious. Haegert states that '[...] as Shade's interpretation of the misprint [in the magazine; the 'mountain' not 'fountain'] suggests, both men [Shade and Kinbote] are embarked on an effort of assimilation that is clearly in excess of the facts alone' (Haegert 1984, p. 418), and: 'No less than Kinbote, then, Shade struggles valiantly to maintain the supremacy of a personal fiction over the felt illusion of human circumstance. [...] In their common pursuit of a sustaining fiction, each character is conspicuously engaged in ad hoc responses to apparently objective facts; something I can only call, in a crudely impressionistic way, a creative revision of reality.' (ibid., p. 419.) This revision, is, moreover, not dependent on notions of accuracy and error (ibid.). O'Donnell writes about Kinbote's textual self: 'In this view, writing becomes a deformation of the "original" self as it passes into the time of narrative, exiled from the land of perfect identifications and exact mirror resemblances, into the realm of the sign, where the text is the texture of misreadings, translations, and noise that work to define the "self"' (O'Donnell 1983, p. 402). The 'self' is a literary construct produced in the realm of signs (which is also the realm of literary art), and I would argue that this is true of Shade's poem as well. What is the difference, then, between these

two autobiographers? The madness of Kinbote does make a difference for Oakley: she compares the 'games' Kinbote and Shade construct in their free will as artists and in the face of the question of afterlife and the existence of God: 'Shade realizes that although the concept of an all-solving religious structure may be doubtful, the important thing is that he should construct his own subjective game-designs, and impose a structure upon existence[...] Unlike Shade, Kinbote cannot accept the absence of an all-powerful creator[...] Kinbote responds to this fear by creating a game in which, unlike Shade's, the boundary between reality and fantasy is blurred.' (Oakley 2003, p. 489.)

The blurred boundary is constant, but still, one can argue that the very genre of autobiography also 'tend[s] to deceive and falsify facts intentionally or unintentionally' (Pellerdi 1996, p. 114). Keitel also states that the very narration makes the narrated reality a falsified reality: 'Every attempt to shape, structure and interpret life necessarily entails a reduction of complexity. Therefore, narrated reality is always, to a certain degree, falsified reality.' (Keitel 1989, p. 46.) This can, of course, be contrasted with Herman's proposition (Herman 2009, p. 157) that narrative is a useful tool for capturing what is central for an experiencing I: narrative is a form of *analysing* human experience, not of *falsifying* it – human life *is like* narrative.[7] However, the debate cannot be solved in any conclusive manner. (For a discussion on the notion of life intertwining with narrative, see also Hyvärinen 2007.) The self-image of the subject and human life can be seen as literary constructs. Are we making plausible, in any 'real' or 'true' meaning stories of ourselves in *a textual world* in an unavoidable manner because the human condition is a language-oriented condition, or are we *falsifying reality* by forcing it into language, into texts, because the human condition can only see through language? Is the world a textual thing or not? Can we even know, since we are a language-driven species?

In the context of *Pale Fire* and its two autobiographers, the question of falsifying reality is central. Oakley stated above that Kinbote's text blurs the border between fantasy and reality – therefore, Kinbote's autobiography has less truth value than Shade's. This can hardly be denied, on the level of pure accuracy, but Shade's poem, as an autobiography, narrates (i.e. makes into narrative, makes into a representation) a life that must be bent a little to fit into the frame of the poem's portrait, with its neo-Popean metre and rhyme, its 999 verses, and its structure and web of sense. Kinbote can be used as a counterpoint here as well: for example, he denies the ex-

7. Hyvärinen cites Joan Scott, and states that experience is always 'both an interpretation and in need of interpretation', and he states like her that experience is always partly structured by subjectivity and also by narratives (Hyvärinen 2010, p. 143).

istence of 'big trucks' driving in the vicinity of the Shades', even though the poem refers to them (*Pale Fire*, p. 213), and states that Shade's heart attack was not as severe as he claims in his poem, which Kinbote brushes aside by saying 'All this of course cannot detract from the great epic beauty of the passage' (ibid., p. 197). So, Shade falsifies – or analyses life – and makes art at the same time. Kinbote's narrative may have a smaller truth value as an autobiography in the TAW, but does this interfere with its art value? I would say that like volition in the act-affliction debate, the truth value of an autobiographic text is not simply connected to its art value: Kinbote may falsify a little more than Shade, but they are both artistic in their own ways.

Kinbote can be seen as a mad caricature of Shade's autobiography. He is a humorous distortion of the distortion that autobiography always is: he invents a kinghood, a kingdom, and a complete world instead of the drab life of an exile, obscure scholar. What if Shade's life were completely different 'in reality' (in the TAW) from what he claims in the poem? Would it make his poem less of a poem, less of an artwork? Apart from the poem, we know of his life only through Kinbote – and he, for a start, is mad. This returns me to the problem of authorship, of control over the production of the texts of the novel. On this matter, we cannot know for sure who is/are behind the texts of *Pale Fire*. Nabokov has constructed his worlds – his game of worlds – so that we can never know for sure. The novel is held together by these tensions: how mad is Kinbote? Is there a Zembla? Should there be a Zembla? Why are the two texts so interlinked? Can we bypass Kinbote and his text because of his madness? Can we even read outside of his madness? How much do they both falsify their texts? Can any texts about any lives be made without falsifying?

In its totality, Nabokov's *Pale Fire* is a playground of interpretation. Its texture gives us an iridescent prism of worlds both mad and sane, which we must interpret by using frameworks or dichotomies that are subverted and questioned by the text, such as 'madness vs sanity', 'autobiographic verisimilitude vs artistic invention', 'truth value vs artistic value', 'control over aesthetic production vs uncontrolled production', 'logos vs pathos', 'scholarship vs art', 'madness vs art', and so on. Writers are here to help us see more clearly the webs of our world and our place in it, both Kinbote and Shade seem to say. Does it then matter if one of the writers is mad? Is the revelation given by a mad mind less of a treasure than one given by a sane mind? This, of course, is one more of those impossible questions to answer with any amount of certitude. Like Hölderlin's late poetry, Kinbote's prose is left to the mercy of the reader to decide whether his or anyone's 'web of the world' is valuably revealed in his writing or not.

5.4 Madness as Meaningless – Madness as Meaningful: Ken Kesey, Bessie Head and Doris Lessing

When literature depicts madness, does it get a special, 'literary' quality that cannot be found in theoretical formulations of madness? Does literature make significant something that madness theories leave outside signification? What does madness 'mean'? These are obviously very hard questions, but I endeavour to analyse them through concrete examples: I will examine how different works build meanings in madness depictions, and how these meanings converse with those of the theoretical frameworks. These questions bring forth the different viewpoints to madness that can be found in the different frameworks, as they cut through all of them. Every framework gives its own answers to the question: is madness meaningful and if so, how? Literary works give yet another viewpoint to this debate. In the following discussion, I aim to juxtapose two points of view perhaps most distant from each other, namely literary depictions of psychosis and the brain-oriented framework of psychoses.

5.4.1 Madness as Meaningless? The Brain-Psychiatric Viewpoint of Psychosis

What does the 'content' of madness mean? This seems first to be almost as protean a question as to ask: what is madness? These two questions can, further, seem somewhat synonymous, as the 'content' of madness comes close enough to 'essence' of madness. As is stressed over and over again, one must be sensitive to the different viewpoints on these phenomena, and not limit oneself to only one or two of them. In this chapter, the issue is not so much what the 'essence' of madness is, but how differently from the theoretical frameworks madness narratives operate with the theme of madness. I will examine how they may make the phenomenon of madness significant inside literary structures, whereas in theoretical frameworks, this process of signification is seen to be formed differently, or to be uninteresting or even meaningless. I will concentrate here on one central case, psychosis, and its configuration in modern (brain) psychiatry and madness narratives.

The current Western mainstream brain-oriented psychiatric viewpoint to the 'content' of psychosis is one of putting it inside brackets: psychiatry aims to cure psychosis, not to 'understand' it existentially. This may seem a bold statement, but I claim that it has a basis in brain psychiatric practice.

What is important for psychiatry's aim of cure is how the person suffering from psychosis can be most efficiently changed into a non-psychotic, well-functioning individual again. This aim can be seen from at least two ethical viewpoints: psychiatry can be seen to be well-meaning and caring as it combats the great suffering caused by madness to those suffering from it and those around them; on the other hand, psychiatry can be seen as oppressive as it forces the deviant person to adjust to society, often against her will and by the use of such methods that might be considered by some to border on torture. The different ethical viewpoints on psychiatry are highlighted when one considers the 'cure' as the aim of psychiatry and how it relates to the aim of 'understanding' psychosis as an existential phenomenon. Psychiatry is functional: it endeavours to change the patient. In this function, it does not necessarily need to understand her existential position. This pattern is seen in the current Finnish practical recommendations for those treating different psychoses (Salokangas et al., *Psykoosialttiuden arviointiopas*, Duodecim 2002): the recommendations do not so much tackle the phenomenon of the 'content' of madness (for example, what the patient sees, hears or experiences in her delusion) or the existential status of these delusions – the reasons why the patient has the delusions she experiences. The question of 'content' is dealt with briskly: the patient must be questioned about her symptoms, when and how they started, how intense they are, how often they come, how they are connected to stress factors (ibid., p. 35), but not why she believes what she believes. The overall 'form' of symptoms is more important than their specific 'content': it is important to notice the fact that the patient has delusions, for example, that she is paranoid, not what the content of the delusion is, for example, who persecutes her. This is due to the fact that the process of curing paranoia is the same no matter who the imaginary tormentor is.

The 'content' of madness is thus almost empty in the brain psychiatric viewpoint, and this can also be seen in the formulation of the 'why' of psychosis. For brain psychiatry, the cause of psychosis is stress to the central nervous system. This stress causes changes in the information given by the senses of the patient, resulting in misinformation (e.g. hallucinations) instead of reliable sensory information. The patient then must deal with sensory misinformation that does not correspond to the memories of what she has experienced before, causing her to interpret the misinformation in the new, best possible manner, but in a manner other people cannot understand because they do not have such experience of psychotic misinformation. (ibid., pp. 21–22.) The best possible manner of interpretation can be seen to be

almost random here, or at least unimportant: the patient's interpretation is simply erroneous and must be changed.

How does brain-oriented psychiatry define those that are suffering from psychosis, then? A diagnosis is made through a clinical interview with the patient and her relatives, and through direct observation of the patient. The psychiatrist looks for oddities in the patient: disordered thinking, delusional thoughts, paranoia, megalomania, hallucinations, disordered language, etc. (ibid., pp. 36–40.) The recommendations do not much question this process of observation: how can one define what is 'psychotic' and what is 'real'? (One symptom of megalomania is formulated as 'I [the patient] am famous and on TV and radio' (ibid., p. 38, my translation) – what if she really is a TV and radio star?) One yardstick is the patient's own experience that something is wrong with her. There are patients with low or non-existent experience of illness, as well: they do not perceive themselves to be ill or in need of treatment. The psychiatrist's interpretation is thus the final measure of illness: she decides what is psychotic and what is not with the help of the recommendations that offer a detailed clinical interview pattern for delineating the various symptoms of psychosis (ibid. pp. 36–40). But what is recurrent in this interview pattern is the emphasis on the 'form' (the patient is psychotic) and no stress on the 'content' (what the psychosis means to her and why).

Another problem is the definition of symptoms: what is regarded unusual, disoriented or strange? When the patient herself cannot draw the border around what is real and what is not, how can a formulation 'I hear at times voices that do not exist and that no one else hears' (ibid., p. 38, my translation) be helpful? Who defines the border between mad and real if the patient cannot do it herself? Of course, the recommendations rely on the common sense attitude towards psychotic symptoms: they are often so strange that 'anyone' can see that they are symptoms: for example, delusions of the form of influencing machines or hallucinations that can be verified by other people to be hallucinations (e.g. when a patient suffers from an olfactory hallucination that no one else can smell). Nevertheless, the borders are hazy and there is a real risk in over- or misinterpretation when all the diagnosis rests on the basis of clinical observation and interview, and there is no objective medical method (e.g. blood tests) that could independently verify the case of psychosis. The haziness of borders between what is real and what is mad is a very strong theme in madness narratives, and one of its targets is just these psychiatric diagnostics and their possible failures.

5.4.2 Meaning to Madness? Madness Narratives on Psychosis

> 'In our parallel world, things happened that had not yet happened in the world we'd come from. When they finally happened outside, we found them familiar because versions of them had been performed in front of us.' (*Girl, Interrupted*, Kaysen 2000, p. 28.)

When compared to the above description of the psychiatric viewpoint of psychosis, the viewpoint of madness narratives is very different: they give meaning to something the psychiatric process places little stress on. One reason for this could be seen in the literary process of making anything described in literature significant: by the sheer process of describing something in literature, this something gains in significance and meaning. Can anyone imagine a literary piece of work that had no meaning in it? Even a blank page, if published in a novel, for example, could be seen as a literary statement, and a form of artful making-something-significant even an apparent insignificance. Thus, it is no surprise that literary descriptions of the content of psychosis seem to carry more meaningful weight than the psychiatric-theoretical model outlined above would give. Already by describing psychotic processes, literature makes them visible and analysable by asking: why does the heroine suffer from this sort of psychosis? Why is the content of her psychosis the way it is? This happens automatically, and the reader is led to ponder the different aspects of madness – its causes, its content and its methods of cure. The process may go even further, however, and the piece of literature may give special literary importance to the phenomenon of madness. This means not only referring to the theoretical frameworks of madness theories, as in when delineating the diagnostics or methods of cure, or even forming idiosyncratic descriptions of madness, but making the process of psychosis a *literary* process in which it becomes a metaphor or allegory for something altogether different from the restricted view of madness being 'only' an illness. This happens in the three novels on which I will now concentrate: Doris Lessing's *Briefing for a Descent into Hell*, Bessie Head's *A Question of Power* and Ken Kesey's *One Flew over the Cuckoo's Nest*.

5.4.2.1 Case Studies: Metaphorical Madness – Kesey, Head and Lessing

In each of these novels, the first thing that the reader encounters is the lengthy description of psychotic symptoms. In all of the novels the illness of the protagonists is omnipresent, and (Lessing's) professor's, (Head's) Elizabeth's and (Kesey's) Chief Bromden's delusions are depicted in minute detail. The 'content' of their psychosis is very much present in the novels, and already this suggests that there is more to the content than the Western modern brain-oriented psychiatry would warrant. Why else would the author bother to describe the contents of various psychotic symptoms with such care? This alone alerts the reader to look for cues and clues to what 'lies behind' these symptoms: the literary hunt for meaning begins.

Tiffany Magnolia has studied Head's novel from the viewpoint of the concept 'national allegory', a term developed by Fredric Jameson to describe certain process of meaning-making in third-world texts. In Jameson's opinion, in third-world texts 'the story of private individual destiny is always an allegory of the embattled situation of the public third-world culture and society' (cited in Magnolia 2002, p. 1). Even though Magnolia rejects the thought of *every* third-world text being a national allegory (ibid.), she still uses the term to analyse Head's novel, since, in her opinion, even if the text is the most personal and autobiographic of Head's novels, it still has characteristics as a political and religious allegory. Elizabeth's madness – the way she experiences the different characters of her psychosis – leads the reader to search for the reasons behind this narrative structure: there must be a meaning to the detailed discussion of her psychosis. Elizabeth's madness consists of torturous battles between different characters of her psychosis, characters who appear over and over again in her delusions and who fight each other inside her head. These main characters are Sello of the Brown Suit, Sello of the White Robes, and Dan. The battles can be baffling to the reader, because she must struggle to understand the hidden meaning behind these patterns of fighting. The battles in Elizabeth's mind relate to religion, politics and history; the characters are allegorical symbols of certain political and religious ways of thinking. Magnolia has analysed these characters from the viewpoint of South African apartheid politics (Head's novel was published in 1974, and she wrote it after being exiled from South Africa to Botswana, where the novel is situated). In Magnolia's analysis, Sello is 'the culmination of all of Africa' (ibid., p. 3) and also the symbol of all Africans in South Africa. Both Sellos resist monolithic political ideology, thus they challenge the logic of apartheid (ibid.). They are also an embodiment of ANC's mainstream politics that emphasises unity (ibid., p. 5). Another side to the

battle is Dan, who believes in domination and brutal force and thus 'allegorises the underground Umkhonto we Sizwe (Spear of the Nation) movement [...], and the Poqo who were responsible for several bombing attacks' (ibid., p. 4). Magnolia also sees that Dan corresponds to the South African whites in his brutality. (ibid.) The struggle between these characters is religious in tone, as Sello of the White Robes, a Gandhi-like figure, promotes in Elizabeth a belief in that the only true God is in Man. When Elizabeth wins the battle against Dan and his power-seeking policy and efforts to stain Sello's reputation and the psychosis subsides, she is able to say: 'There is only one God and his name is Man. And Elizabeth is his prophet (*A Question of Power*, p. 206). The value of ordinary, everyday life is glorified in Head's novel, as the main way to cure Elizabeth's illness is through ordinary work and simple love of those around her, as embodied in the figure of Sello of the White Robes.

Already in this brief account one can see that there are many layers of meaning in Head's depiction of Elizabeth's madness: it is not just reaction to stress which causes random misinformation to take over the patient's mind, even though the novel does suggest that the onslaught of the illness is caused by stress of apartheid politics. When Elizabeth meets Eugene, he understands immediately that Elizabeth suffers from having lived in South Africa as a coloured person: '[H]e was working on the simple theory that South Africans usually suffered from some form of mental aberration' (ibid., p. 58). A whole F-universe of psychotic characters that have their own messages, political and religious is built on this layer of stress-factor. Elizabeth's madness is an allegory of grand scale. The content – the why and how and what of her madness – does count. Even if the method of her curing were the same as that of anyone else suffering from psychosis, still one could ask: does it not count how she experiences her existential status while being ill?

Another example of highly allegorical madness depiction is Chief Bromden's narration in *One Flew over the Cuckoo's Nest*. His psychosis is all-embracing, but it does not lack content. James Phelan has studied Kesey's novel from the viewpoint of unreliable narration, and sees it as an instance of his new formulation of 'bonding unreliability': it is unreliable narration that, though being unreliable, reduces the distance between the narrator and authorial audience (Phelan 2007, p. 225). Kesey's novel is, for Phelan, an example of 'literally unreliable but metaphorically reliable' bonding unreliability (ibid., p. 226). This means that even though the reader is very much aware of the discrepancies in the Chief's narration (e.g. the 'Combine' does not exist quite the way he says it does (i.e. physically, 'really')) she still sees the truth behind this mad Combine talk: the society does have such features that the Chief

attributes to the Combine – it can be seen to try to 'adjust' the citizens even against their will. The Chief's paranoia may be pervasive but it is not without its own tinge of truth. Semino and Swindlehurst sum up the juxtaposition between the Chief's literal use of machine metaphors (like the Big Nurse being a powerful machine) and the truth of those metaphors, seen by the reader as valid descriptions of his situation:

> The source domain of machinery enables him [the Chief] to use what he knows best to make sense of what he finds difficult. The machine images, moreover, express his constant fear and sense of helplessness in the face of a system that seems unbeatable and, when used in what appears to be their literal sense, reflect his view of reality distorted by paranoia. The reader also knows, however, that even at their most literal Bromden's machine images say something 'true' about the world they help to portray. They expose the mechanization of contemporary society, the dehumanization of psychiatric patients in Kesey's America, and the effects of electro-shock therapy. Bromden's account of himself as a casualty of a mechanical world is in this sense perfectly accurate. (Semino and Swindlehurst 1996.)

The metaphorical truth and value of the Chief's narration must be, though, appraised in total: what is his ethical standing? How far can the reader follow him in his narration, mad or not?

On the ethical side, one must note that it is perhaps central to the thematic and rhetoric of the whole of the Chief's text to 'cleanse' McMurphy of the alleged 'accusations' (read 'diagnoses') given to him by the system. They are refuted by McMurphy as misdiagnoses during the first therapeutic meeting, even those that might have also needed the other party's testimony to be properly judged (I here use the word 'judged' in a consciously juridical way, as McMurphy is sent to the ward straight from courthouse as a pathological criminal and as the community of fellow patients form a kind of court in this instance, judging his past deeds). McMurphy is accused, among other things, of raping a minor, to which his only comments are: 'She said she was *seven*teen, Doc, and she was *plenty* willing" (*One Flew over the Cuckoo's Nest,* p. 41). Would not the reader want a little bit more corroboration to refute this accusation? (I would, at least.) The Chief's text does not give this corroboration, but pictures McMurphy as the hero of the ward. His virtue is manliness, and this also is the real cure for the effeminate, weak (male) patients. Thus, it may be natural that his masculinity in the Chief's text is strengthened by leaving the other side of the story (i.e. that of the girl) without further comment.

McMurphy is very capable of lying for his own benefit as well as for that of his fellow patients, and the truth behind the accusation against him may not be relevant, at least to the Chief's rhetoric in his description of him. However, the existence of such an accusation and its being left unexamined underlines the narrative power relationship the Chief's text needs to establish with the narratee. He must convince her, among other things, of McMurphy's unjust diagnosis before he can ground the belief that what society calls 'mad' may be something altogether different: 'madness' is not the right word to describe the conditions the patients are in; and even if it were called 'madness', what 'madness' means and what causes and what cures it (if a cure was needed) should be redefined.

However, here Elaine Showalter's remark that 'Kesey's novel […] is a disquieting fantasy of sexual violence against women, a fantasy rationalized by the fiction that women push the buttons and call the shots' (Showalter 2004, p. 219) seems warranted: the Big Nurse – a woman – is the epitome of social control of the effeminate male patients who must be set free from her tyranny. The rape of a minor can be seen to be a minor detail in this context, something that can be pushed aside by a simple stroke of denial. At the end of the novel, McMurphy also attempts to rape and murder the Big Nurse. There is another caveat: the Chief's perception of the black attendants on the ward is highly racist. Booth sums up the ethical side of the Chief's narration:

> [T]hough *One Flew over the Cuckoo's Nest* has some genuine qualities of humor and imaginative vitality, too much of its appeal, for […] me and hundreds of thousands of other American males depended on a sentimentalized dream of male freedom from revenge against 'Big Nurse', 'who too crudely symbolizes not only 'female' domination of what 'should' be a man's world but also all civilized restraints. Morality is reduced to courage, wit, daring, physical toughness, and willingness to resist tyranny. […W]e were offered, and we bought, a glorious myth of vengeance – against women, against bureaucracy, against the law, and almost incidentally, against three comic, vicious, unredeemable black folks who get in our way. (Booth 1988, p. 75.)

However, Bernaerts has proposed another approach to the question of ethics in relation to the novel's sexism and racism: he argues for a speech-act analysis of this side of the novel:

> McMurphy's particular way of "emasculating" the nurse's speech belongs to what is often read as a broader strategy of sexism, which he uses to destabilize her social authority. The speech-act analysis shows that the misogyny displayed in the fictional world is functional in the narrative composition. [i.e. in the power struggle between the nurse and McMurphy. …] In my conviction, this approach to the presented misogyny is potentially more productive than some of the moralizing interpretations that involve the author. A narrative speech-act reading entails a functional split between the narrator's and the author's speech acts and can assign the fictional sexism and racism their place within the design of the narrative. (Bernaerts 2010, p. 287.)

So, it may be said that the implied Kesey is not sexist or racist, but McMurphy is. This, however, in my opinion does not lead to exculpation of either, as Kesey shows McMurphy through the lens of Chief's narration in completely positive light – including his relationship with women and black people. Bernaerts acknowledges the possibility of the reader digressing from the Chief's portrait of McMurphy: 'On balance, the narrator's [the Chief's] rhetoric highlights McMurphy's role as a positive figure – a savior – and that is why, despite the bitter taste of the ending, we are led to judge McMurphy's *ethical choices as superior*. In the end, however, it is up to the reader to judge whether Bromden's implicit act of excusing the 'collateral damage' [the deaths of Bibbit, Cheswicker and McMurphy himself], is acceptable or reprehensible.' (ibid., p. 293, my emphasis.) I would add that to this collateral damage one could include the minor McMurphy (may have) raped.

Thus, one can question the ethical basis of the Chief's narration, and the ethical meaning of this allegory, but one cannot question that it *is* an allegory. Its depiction of madness has more content to it than being just a depiction of a mental breakdown.

Head's novel can also be seen as a case of bonding unreliability of the type of metaphorically true. Both of these novels work on the reader's desire and need to see some meaning behind the apparently psychotic narration. In the process, even though the focalisation (as in Head's novel) or narration (as in Kesey's novel) can be seen to be grossly unreliable when it comes to palpable facts that should be shared by other people, the content of these reports of psychosis gains in weight, and the reader can grasp the meaning of these phenomena behind the apparent meaninglessness.

In Doris Lessing's *Briefing for a Descent into Hell*, there is the same pattern of reliability-in-unreliability: the professor's psychosis yields greater truths than the psychiatrists trying to cure him are capable of admitting. There is a strong clash

between the worlds of the patient and the psychiatrists, which is very much similar to the one described above – that between psychiatric and literary interpretations of psychosis. The doctors see only delirium and psychosis in their patient: when the patient himself feels he is trying to wake up to recall something important, his 'waking up' is regarded by the doctors as 'giving in to madness'. The professor's psychosis, and its content, is given as much room as in Head's and Kesey's novels: it is the main element of the thematic structure of the novel. The waking up that is so important to the mad professor is a waking up into the consciousness of perceiving the wholeness and identity of something that has been seen only as individual and dissimilar:

> Some sort of a divorce there has been somewhere along the path of this race of man between the 'I' and the 'We,' some sort of a terrible falling-away, and I (who am not I, but part of a whole composed of other human beings as they are of me) hovering here as if between the wings of a great white bird, feel as if I am spinning back (though it may be forwards, who knows?) yes, spinning back into a vortex of terror, like a birth in reverse, and it is towards a catastrophe, yes, that was when the microbes, the little broth that is humanity, was knocked senseless, hit for six, knocked out of their true understanding, so that ever since most have said, I, I, I, I, I, I, I, I, I, I, I, and cannot, save for a few, say, We. (*Briefing for a Descent into Hell,* p. 109.)

The professor, in his madness, perceives humanity, and indeed the whole universe with its stars and planets, as a working entity in which all the parts, no matter how minuscule, are connected to each other. It is this reality of 'wholes' and 'oneness' that the professor tries to wake up to, and his struggle to wake up is his spell of madness. In his mad narration, he gives one possible version of how the stars and gods they represent get together to discuss the Earth's situation, and decide to send a new group of people to Earth to help humans wake up to the reality of imminent destruction (the 'briefing' is just that: the messengers' last opportunity to get information about the tasks ahead before being sent to the 'hell' of Earth). The professor's account of the 'summit' of the stars and gods is a hypothetical one littered with phrases like 'perhaps', 'who knows', 'might have gone', 'we may suppose' (ibid., p. 114). Even in its double nature as hypothetical (being a reconstruction at best and pure fantasy in any case; and its being a form of experience that others call madness), it still yields metaphorical and allegorical truths as great as those of Kesey's and Head's narratives.

In Lessing's case especially, one must refer to Laing's later oeuvre, where he makes the comparison between psychosis and transcendental voyage. In his later work, Laing starts to verge on the glorification of the psychotic experience as having potentially religious meanings (and this, of course, can be seen to apply to Head's description of Elizabeth's psychosis, as well). Laing writes: '[The mad person] can often be to us, even through his profound wretchedness and disintegration, the heirophant of the sacred' (Laing 1967, p. 133). The psychosis, he explains, is a 'journey [...] going further "in", as going back through one's personal life, in and back and through and beyond into the experience of all mankind, of the primal man, of Adam and perhaps even further into the beings of animals, vegetables and minerals' (ibid., p. 126). This is an almost verbatim reproduction of one of the themes in the professor's experience of psychosis as a revelation. The professor is seen to be shipwrecked (a term that could be borrowed directly from Laing) and then makes a journey through the stages of human spiritual evolution. Laing calls this process 'perfectly natural and necessary' (ibid., p. 129) and calls for, instead of the usual psychiatric treatment that tries to 'cure' the mad person, an 'initiation ceremonial' in which the mad person would be helped by other, ex-mad persons to go mad and then come back again to sanity (ibid., p. 128). Lessing, in her novel, can be seen to illustrate the Laingian vision of psychosis as a transcendental voyage. The professor surely loses in insight as he is propelled back into 'sanity' by the 'cure' through electroshock treatment. (For an analysis of the links between Laing's and Lessing's texts, see Keitel 1989, pp. 90–106. Keitel considers that Lessing not only illustrates but also questions Laing's theories by instigating 'a sense of oppression by extrapolating emotional elements of psychotic phenomena into the reader's response' (Keitel 1989, p. 106).)

Another question to ask is whether this type of giving meaning to the content of madness applies to all forms of madness. The three examples quoted above are all descriptions of psychosis, and it can be said that the status of psychosis is one of the most prevalent ones in madness narratives: this is probably due in part to the great power of psychosis for creating whole new worlds of fiction-within-fiction. The other forms of madness do not play as clear a role in creating new worlds, but still the capacity is there even in such forms of mental disease as depression, dementia, anorexia, borderline personality disorder, etc. These other forms of madness may not build whole worlds of hallucination, the F-universes that could be seen to replace the shared ordinary world, but they still warp or change the world view of the patient in such manner that a new viewpoint to the world is created, different from the one that most sane people share. This new viewpoint can then be seen to offer

a new vantage point to the shared world, one that could, even if it were 'erroneous' from the viewpoint of shared meanings and facts, build a new vision of the world. Madness has something to say to us, the madness narratives point out, even when we are unwilling to listen.

Yet another point is the madness theoretical frameworks' attitude toward the meaningfulness of madness. In Foucault's madness philosophy, the content of madness is put in parentheses, as the essence of madness eludes the seer in its mutability as a social construct with protean faces. On the other hand, the force of madness to challenge remains: psychiatry needs to combat the force of madness, to alleviate its challenge to the norm and society. All in all, it has meaning as a counter-force to the norm building in the disciplinary society.

Psychoanalysis and (earlier Laingian) anti-psychiatry both give more stress to the content of madness than current mainstream brain psychiatry does. In the psychoanalytical viewpoint, the content of the symptoms is always connected to the nature of the disease – they point to the cause of the symptom and thus need to be analysed carefully in order to find the cause: the remembering and becoming conscious of the root of the symptom leads to the cure. The symptom is thus always pregnant with meaning, at least when deciphering the (psycho-sexual) origin of the symptom: the symptom is a symbol of the underlying cause; it is a trace of an imbalance in the mind that can be attempted to be cured by the psychoanalytical process.

In the (earlier Laingian) anti-psychiatric view, symptoms are understood as symptoms of abuse present in the social environment of the patient. Even apparently meaningless or confused/confusing symptoms have their meaning as markers of social pressures; this can be seen, for example, in the way Laing analyses the double binds behind strange schizophrenic phenomena. Again, as in psychoanalysis, the symptom points back to its cause and possible cure. The content of madness is meaningful and waits to be heard. However, when compared to the literary viewpoint, the allegorical use of madness, this pointing to the cause of the symptom, does not go as far. In the literary use of madness as an allegory, the phenomenon of madness is made to point far outward, away from the 'simple madness' and its causes and cures, to society as a whole, for example. (This meaningfulness is even more emphasised in Laing's later work after his most influential contribution in his first studies on schizophrenia, as was seen above, where he approaches the religious allegories of madness.) In these literary representations, madness is no longer only a disease, but it has a greater message to give, and the mad can play the part of the blind seer: even if the patient is blinded by her madness, and made to experience

things that do not exist for other people, she can at times see better than her sane companions because of her madness.

5.5 Unreliable Narration/Focalisation – Comparing and Contrasting

Finally, I must tackle an issue that has been frequently present in the background in the above discussion, namely the issue of the unreliability of mad narration and focalisation. It can be seen as natural that madness narratives often are cases of unreliable narration/focalisation, since the phenomenon of madness easily severs the world of the narrator/focaliser from that of the surrounding community, creating layered, internally contradictory narration.[8] In this layered narration, in Ryan's terms, the NAW (narratorial actual world, or what the narrator presents as facts of textual reference world) of the narrator/focaliser is seen to differ from that of the TAW. Thus, the narration/focalisation is seen as unreliable from the viewpoint of other narrators/characters and/or that of the reader. However, this pattern is not quite that simple (e.g. that the mad narration/focalisation is simply 'wrong' when compared to the 'true' or 'real' of the TAW), and I will study this phenomenon from the viewpoint of how to delimit the unreliable from reliable, and what kind of messages are borne by unreliable narration/focalisation.

5.5.1 Shifting Interpretations: What is 'Unreliable' and 'Compared to What'?

There has been a heated discussion on the phenomenon of unreliable narration for a long time. The debate has centred on the figure of the implied author, first formulated by Wayne C. Booth in his authoritative study *The Rhetoric of Fiction* (first published in 1961). I chose to use Ryan's terms above to describe the narrative structures of unreliable narration because her delineation of the narrative structures of madness narratives as F-universes inside the fiction proper is such a useful tool, but her description is far from being the only one[9]. The discussion, as was seen in Chapter 3, has been mostly between those who propose, like Ansgar F. Nünning,

8. There are naturally cases of madness narratives that do not contain unreliable focalisation or narration: *The Killer Mine* and *The Big Sleep,* for example.
9. For a clear depiction of this discussion, see Martens (2008).

to completely give up the position of the implied author because they see it as unnecessary and even confused, and those, like James Phelan, who want to retain the concept in one form or another. The question of unreliable narration has been a case study in this debate over the figure of the implied author because it underlines her position as the keeper of the overall aesthetic and ethical structures of the narrative. The fundamental question has been: if the narration is 'unreliable', then what are we comparing its unreliability against?

Ryan writes: 'In unreliable narration, the authority of the narrator is undermined by internal contradictions, and the reconstruction of the facts of TRW necessitates the rejection or correction of some narratorial declarations. [... U]nreliable narration is represented as the combination characteristic of lie or error *within the domain of the implied speaker's discourse*.' (Ryan 1991, p. 27.) Thus, there is dissonance between the Narratorial Actual World and the Textual Reference World, something brought about by the narrator's incapacity or unwillingness to accurately describe the TRW (or in fiction, TAW also, as they coincide because the text builds its own actual world by referring to it). In addition, Ryan formulates the position of the implied author (renamed by her as the 'implied speaker') by stating that unreliable narration occurs in her domain. So, Ryan sees a role for the implied author (/speaker) as her discourse is the domain in which unreliable narration takes place. Nünning has contested this, however, by claiming that the concept of the implied author is poorly defined, dysfunctional and unnecessary, and that the reader can do without it by 'naturalising' the inconsistencies of the text by using her own frameworks that vary from time to time and person to person (Nünning 1999).

James Phelan has responded to Nünning's statements by forming his own conceptualisation of the implied author: 'the implied author is a streamlined version of the real author, an actual or purported subset of the real author's capacities, traits, attitudes, beliefs, values, and other properties that play an active role in the construction of the particular text.' (Phelan 2005, p. 45). As already mentioned in Chapter 3, I take Phelan's side in this debate because I consider the role of the implied author to be invaluable in delineating the work's aesthetic and ethical structures. There must be in the work some kind of inbuilt notion of what the work wishes to express and how; and there is something in the work's narrative structure itself compared to which the reader can make an interpretation that the narrator/focaliser is unreliable. However, I would like to question Phelan's formulation by pointing out that the notion of 'streamlined version' is rather vague: what does it mean in this context? A 'better version' of the real author? Phelan obviously wants to steer clear

from simply claiming that the implied author is the real author (as Richard Walsh (2007) claims) and arguing that one should take into consideration the real, flesh-and-blood author in interpreting the worlds that she has created (which is such a bugbear for many a scholar of literature, and also a real problem, when, e.g. trying to analyse the text of unknown provenance, i.e. the 'purported' author). Hence the notion of 'streamlined': it differentiates the implied author from the flesh-and-blood one. Do we need the adjective, though, if we only keep in mind that there is a difference between a real author and an implied one, that they are not identical and should not be thought as being the same? What that difference is varies from work to work and from author to author, and must be delineated case by case, which is the job of those scholars who concentrate on the flesh-and-blood authors and their relations to their works. For other scholars (and for me at least), it suffices to remember that the relationship is complex and not one of straight forward identity.

5.5.2 Borders Hazy and Clear

As is seen in many cases throughout this study, madness narratives often play with the borders of madness and sanity by relying on the reader's (in)ability to perceive where the borders lie. This can also be seen in the case of unreliability: in many works, one cannot always know what the reader can believe in the narration and what they cannot. In other cases, of course, it is easier. In Head's *A Question of Power*, even though the third-person narrator states: 'She [Elizabeth] was not sure if she were awake or asleep, and often after that the dividing line between dream perceptions and waking reality was to become confused' (*A Question of Power,* p. 22), I would still maintain that the novel is more often than not very clear in its division of 'mad narrative' from 'sane narrative': the reader can in almost every case know what is true in the TAW and what is Elizabeth's hallucination; the border between sane ordinary everyday world of the community Elizabeth lives in and the world of torturing madness is kept clear. Even in this narrative, however, there are moments when the reader cannot know whether Elizabeth's mad focalisation is fused with the everyday life, whether what happens in her psychotic reality has direct implications to the real world that should be impossible. Elizabeth's friend Tom hears the voice of one of Elizabeth's psychosis characters that she alone should hear (ibid., p. 24), the demise of one of the psychosis characters leaves palpable evidence to Elizabeth's house (ibid., p. 93), and Elizabeth herself loses track of the border between her sane

world and insane world as she interprets one of the members of her community to be involved in her hallucinations (ibid., p. 171). The border of unreliable/reliable focalisation is thus porous in some cases, but this is more of an exception than a rule in Head's novel.

In Findley's *Pilgrim*, there is the question of whether the eponymous protagonist is unreliable in his focalisation. The question of his madness revolves around the balance between madness and the supernatural on the one hand and madness and reality on the other. The reader may perceive Pilgrim's condition in a different way from the characters due to her capability of using the kinds of frameworks of interpretation that are unavailable to the characters (such as Jung's later theories on the collective unconscious). Thus, the question of Pilgrim's madness is rather more complex than just stating whether Pilgrim 'tells/perceives the truth' (focalises correctly). The 'reliable compared to what' is an issue here: is Pilgrim's condition real/normal compared to the TAW? Who defines the TAW? Is it the narrator, the other characters, or just the reader? The question of unreliability is a thematic structure that pervades the whole work, and it is common to many madness narratives.

In Kesey's *One Flew over the Cuckoo's Nest*, the question is also posed: the fact that Chief Bromden's narration, due to his psychosis, is highly unreliable is obvious to anyone. The point of comparison to the Chief's evident hallucinations is given in the text itself in his description of the everyday life on the ward, by which the implied author hints at the internal contradiction of the Chief's narration. Compared to the routines of the mental hospital, his hallucinations about the robot butchers or fog machines are simply so bizarre that they have to be 'naturalised' as madness, to borrow, again, Fludernik's, Alber's and Culler's notion. This framing of everyday life by the Chief's own narration – and the inescapable fact of his being a mental patient in a mental asylum – are keys to the understanding the unreliability in the Chief's narration. Without them, there is at least the notional possibility that the Chief's narration could be interpreted in a completely different way, perhaps as science fiction, or pure allegory, as well as madness. There are other frames of even Fludernikian 'naturalisation', besides madness, that can be used to explain bizarre literary phenomena, for example, the possibility of a non-realist genre of literature. The framing, or the building of internal contradiction, can be seen to be the act of the implied author; it is her way of hinting that the narrator is unreliable. This act of framing by description of the everyday life is present in Head and Lessing as well, thus making it possible to see that there is a point of comparison in the

implied author's act of framing. There is an internal contradiction in the narrative that warrants the reader to make the inference of unreliability and madness.

Thus, the Chief has clearly hallucinations, but on another plane, his hallucinations are 'true', and he himself acknowledges the discrepancy and reality of his own narration: 'But it's the truth even if it didn't happen' (Kesey 1973, p. 8). Here the phenomenon of unreliability is completely intertwined with that of reliability. As Phelan has formulated in his valuable contribution to the discussion on unreliability, the Chief's narration may be factually highly unreliable, but metaphorically highly reliable. The Chief's viewpoints on the workings of the Big Nurse's ward and of society as a whole are not just the rantings of a madman, but clear-sighted and insightful; they must be dealt with on the plane of serious discussion between equals (even if one questioned his ethics, this questioning would have to take place on an equal footing). Thus, unreliable narration/focalisation is not simply about what is 'wrong' with these narratives, or how they stray from the 'real' and 'true'. The same statement in an unreliable narration/focalisation may be at the same time true and untrue, depending on the plane of interpretation, and whether one considers the factual side or the metaphorical side of the same statement.

The issue of unreliability must nevertheless face the question: what does 'unreliability' in fact *mean*? What does it signify when we call a piece of narration 'unreliable'? The target of this statement is obviously the discrepancy between the TAW and NAW as Ryan would put it, or the domains of the implied author and narrator. There are ideological differences as Booth would have it, or misreadings, misreportings, misevaluatings, underreportings, underreadings and underregardings as Phelan would put it (Phelan 2005, p. 51). This is all very well and accurate, but for one thing: it is well and accurate *from the viewpoint of the reader*. What about the viewpoint of the narrator/character, though, especially a mad one? Her experience as she narrates or focalises is labelled as unreliable by the reading community. What I seek here is the viewpoint that asks: is not a madness narrative with unreliable narration or focalisation an instance of giving highly *reliable* information about the mad person's state? A madman's hallucinations, delusions, obsessions, and so on can be most accurately described by what has been termed unreliable narration or focalisation. The unreliability means in such instances the most profound immersion in an unusual mental world that is reached through 'unreliable' narration/focalisation. One could perhaps also get this information from an authorial narrator, but not in so vividly and acutely as through 'unreliable' narration/focalisation.

As was already seen above, Lessing's, Kesey's and Head's novels all yield metaphorical truths in their unreliability, and are thus reliable on that plane. It must also be noted that Lessing's and Head's novels are instances in which the unreliable focaliser/narrator is on a higher normative and value level than most of those that are deemed sane: Lessing's professor surely loses on the level of values and norms as he is 'cured' and returns to the community of the sane; and Elizabeth wins in insight by going through the torment of insanity, and her insanity is perhaps the strongest way of depicting the system of apartheid and its mechanisms of oppression, which is the truly mad thematic element, not Elizabeth's illness. Thus, the classical Boothian definition of unreliability as also being a moral defect does not apply to these characters, even though they are highly unreliable on the factual plane.

One viewpoint to these themes is to consider again the Foucauldian notion of subjugated knowledge, that is, knowledge that has been pushed into the margins by scientific communities. According to Foucault, mad people's knowledge of their own condition, its causes, contents, and cures is one instance of subjugated knowledge that is of little or no interest to the psychiatric establishment (as was also seen above in the case of psychiatric treatment of psychosis). The mad person's own experiences, of course, gain in importance in different psychotherapeutic treatments where the patient talks about her own perceptions with a sympathetic listener (this being the domain of the psychotherapists, who may but need not be psychiatrists by training). If one considers the modern strictly brain psychiatric treatment of different mental diseases, the current approach is more biological than psycho-social with, for example, drug treatments, surgery, and ECT as methods of cure. These methods leave less space for the patient's own experience of her illness in comparison to when the psychiatric paradigm was more psychoanalytically oriented.

Has the community of literature scholars, then, pushed those madness narratives with 'unreliable' narration/focalisation into the margins with the value base of the notion 'unreliability'? The word itself is pregnant with condescension. If a person is unreliable, she is not to be trusted. This untrustworthiness of mad narrators is also emphasised by Olson, in her defining of narrators whom she calls untrustworthy '*dispositionally* unreliable' (Olson 2003, p. 102), and the paradigmatic examples of this kind of disposition are mad people (ibid., p. 104). Mad people as dispositionally untrustworthy narrators; they 'always misreport' and do not tell the tale 'straight' (ibid, p. 105).

The mad person is not unreliable deliberately: she does not lie or deceive intentionally. Why then call her untrustworthy and/or unreliable? Of course, her viewpoint differs from that of the shared community and the inter-personal domain: there are no

robot butchers (Kesey's Chief Bromden), Medusas (Head's Elizabeth) or crystal discs (Lessing's professor) – they are all manifestations of delirium – but there are oppressive sides to the society, apartheid systems, morally higher perceptions of human reality. Even when there is no 'higher' or metaphorical meaning to the madness described, the description is still valid as a picture of a particular world of experience.

What would be a better notion than 'unreliability', then? Phelan proposes the notion 'bonding unreliability', which is an improvement – but still its 'unreliability' remains. Could the notion of 'intra-mental reliability' be more fitting? After all, is it not a question of intra-mental, personal accuracy, the delineation of what is mad and what is not? As has been repeatedly stated in this study, madness is in the eye of the beholder more often than not. Madness theories (first and foremost psychiatry and psychoanalysis) attempt to delineate the contours of madness, but they do not even agree inside their own circles. The word 'intra-mental' would also point to the inner experience of the mad focaliser/narrator, showing that it is a question of her own inner realities and her own viewpoints to her own condition that count. I do not claim that these madness narratives would be reliable in the traditional, inter-personal manner – they are highly unreliable on the factual plane – but as representations of inner realities, they are as valuable as any other representation. Is this ultimately not what literature is about as well – the description of inner realities that otherwise would be left unvoiced and unheard? This viewpoint is even more emphatic in the case of madness narratives: they lend voice to those who would otherwise be easily left outside the listening communities. The words count; it is not without value judgement that one claims something to be 'unreliable', it is a stigmatic word.

Thus, I seek a reconsideration of the notion of 'unreliability'. Surely, as said, I do not claim that mad narrators and focalisers are not unreliable factually and inter-personally, in which case the implied author hints to the reader (behind the back of the narrator/focaliser in a sense) that the narrated instances are factually untrue. Martens expresses his worry that the recognition of the kind of intra-mental reliability would endanger our view of the real, factual unreliability (Martens 2008, p. 88 and p. 100). However, my formulation of 'intra-mental reliability' does not change *that* picture, it only attempts to redirect attention towards the mad narrator's/focaliser's *own experience* and perception of what is real and true. As Lars Beranerts remarks of one central form of insanity: 'Contrary to lies, mistakes, and to a certain extent, dreams, a delirium presupposes a person who believes in the truth and reality of the alternative version. As a consequence, the subject may be unreliable, but not insincere.' (Bernaerts 2009, p. 379.) The mad person may choose to lie about her own experience

as easily as a sane person, but this would fall under the 'traditional', inter-personal unreliability as a case of intentional deception. The *experience of madness*, as an experience and if narrated/focalised truthfully, departs from the TAW (what is real and true in the shared reality of the narrative) in a different manner: it is narrated/focalised *sincerely*, but still differs from the TAW, although unintentionally. These two notions of reliability (the 'traditional', 'inter-personal' unreliability and my 'intra-mental reliability') do not exclude each other, but work together to build a richer picture of these fictional occurrences. Precisely by retaining the concept of traditional, inter-personal un/reliability, I avoid the problem that worries Martens – the eradication of the line between unreliability and reliability – as the concept of inter-personal un/reliability would still be used, together with my new notion of intra-mental un/reliability.

On the ethical side, one must similarly distinguish the different aspects of narration/focalisation: as long as the person herself believes in her own judgement (e.g. Humbert Humbert in *Lolita*) she is intra-mentally reliable, even if she were ethically condemnable (as Phelan and Booth stress in their conception of unreliability). Only outright lying breaks the code of intra-mental reliability, which can also be seen in the case of naïve personae: they too are intra-mentally reliable, even if unreliable otherwise; their naïveté does not break the code of intra-mental reliability.

The tension between the two notions of inter-personal unreliability and intra-mental reliability can, in fact, be used as a diagnostic and interpretative tool: by considering these two aspects simultaneously, one can arrive at a scale of unreliability. This scale consists of the following levels: 1) reliable narration/focalisation (both inter-personally and intra-mentally reliable); 2) outright lying (inter-personally unreliable and insincere; intra-mentally unreliable), 3) self-conceit (inter-personally unreliable and on a 'grey zone' of intra-mentally reliable, i.e. not clearly reliable nor unreliable in the person's own sense); 4) naïveté (inter-personally unreliable and intra-mentally reliable, but differing in a lesser amount from the TAW than mad perception) and 5) madness (inter-personally unreliable and intra-mentally reliable in a way that differs in a gross amount from the TAW). The difference between naïve and mad narrators/focalisers is both qualitative (the mad person may in her psychosis e.g. create a whole new world, the naïve person just does not perceive the shared one in a mature manner) and quantitative (the error of interpretation a naïve person makes is lesser than the error a mad person makes: in naïve narration/focalisation there appears a different perception of the TAW, but not e.g. the 'praecox feeling' typical to encounters with schizophrenics, meaning an eerie feeling of complete non-understanding of the schizophrenic experience and ways of expression).

How does my notion improve on Phelan's notion of 'bonding unreliability'? One aspect that speaks for the propagation of the notion of intra-mental reliability is just in this possibility of finer diagnostics. The mutual illumination of the two aspects of (un)reliability – one's error and one's relating to that error – is at the core of diagnosing madness. One needs this tension in order to make a sound diagnosis: it does not suffice that one detects a gross unreliability or even 'bonding unreliability'; one must also detect intra-mental reliability in relation to the person's viewpoint to a diagnosis. The issue of the sense of one's illness demands a detailed analysis of the joining of inter-personal and intra-mental reliabilities: the mad person may feel ill and in a sense know that some of her notions are not shared by the sane community, but still be incapable of reversing her unshared notions: thus she is both intra-mentally reliable in her expression of her unshared notions, inter-personally reliable in her acknowledgement of the unshared nature of these notions – and inter-personally unreliable in still holding onto her notions.

Another important aspect is the reader's ethics. It does make a difference to grant value (also on the notional level) to the person's own experience of herself and the world. If the person is sincere in her narration/focalisation, a different kind of approach is required from the reader than to a person who lies or deceives intentionally. Intra-mental reliability does not change the fact of inter-personal unreliability, it only heightens the complementary viewpoint of it, namely, the subjective, personal aspect to the experience and expression of unreliability.

There is a dilemma at the core of a mad person's intra-mental reliability: a mad narrator/focaliser must, in one sense, lie in order to speak the truth. Her 'lie' appears at the level of the implied author and reader: she does not tell the truth about the TAW. Her truth, on the other hand, appears on the level of her own experience: even if it is not a *shared* truth, it is still *a* truth, a truth about her own perception, the NAW. Remember Kesey's Chief Bromden – he would have to lie in order to claim that there is no Combine or its robot butchers: 'But it's the truth even if it didn't happen.' On the other hand, the reader knows that there are no robot butchers 'for real'. What does this dilemma point to? Can the reader's position be such that it makes it possible to give value to intra-mental reliability?

It is a question of the position the implied author places the reader into in relation to the told, and a question of what the authorial audience – and we, as flesh-and-blood readers – value. The readerly position the implied author grants the authorial audience does of course vary from work to work. Some positions are less constrained on the question of valuing intra-mental reliability. Obvious examples

are Kesey's Chief Bromden, Head's Elizabeth, and Lessing's professor, all of whom appear in novels that *thematise* the problematic nature of the exclusively psychiatric interpretation, giving thus more room for the reader's interpretation of these personae as people who should not be summarised psychiatrically (or narratologically) simply as unreliable mad persons, but whose own experience and perception of themselves should be respected. The metaphorical and allegorical dimensions of their stories are impoverished if they are seen simply as unreliable. The case of the Chief is somewhat more complicated, perhaps, than the other two: in his case, the implied author is seen to be completely on his side, including in his and McMurphy's perception of women (first and foremost the Big Nurse) and black people (the attendants). It has been noted by Booth that this *implied author* is unethical in this respect, and I agree. This, however, does not change the picture of *the Chief's intra-mental reliability* – nor that of his Phelanian metaphorical, bonding unreliability in respect to the greater vision he has of the Combine and its significance to its citizens, which overrides the fact that the overt expression of his beliefs are clad in the paranoid schizophrenic's way of expressing his beliefs – delirium. As I have pointed out, his delirium sees more clearly than the psychiatry of those 'treating' him.

Another, different and telling example is Nabokov's Humbert Humbert. He is an example of a narrator in relation to whom the implied author makes the reader work hard in trying to steer her interpretations in the mine field of Humbert's complex, multi-faceted mad worldview and its grossly difficult ethical side. The difficulty with interpreting Humbert's nature (is he mad or not? ethical or not?) culminates partly in the interpretation of his intra-mental reliability: is he sincere? Does he perceive after all, how blatantly incongruous his perception of seductive nymphets is to the reality he imposes on his victim? Can he be *both* insincere *and* a madman? Humbert does raise the question of sincerity in a most forcible manner. He seems to challenge my notion that mad people are reliable and sincere in their perception of their own status, because they do not perceive its erroneousness, or because they cannot help but perceive or experience something the shared community does not endorse as a sensible thing, even if they are told that their experience is not well grounded or even if they can see the incongruence *themselves*. On the other hand, why should a madman not lie as much as a sane person, if he wishes to? Humbert can be both a liar (knowing that he hurt Dolores by his mad deeds, but claiming – at first, at the beginning of his tale – that his deeds did not hurt her) and a madman (holding onto his Humberland and his beliefs about seductive nymphets). He is perceptive enough to understand that his deeds are condemned in the sane community, since he tries

to escape this ethical condemnation. He may lie or deceive himself, at least, but he cannot escape his own mental state – his madness as a paedophile – and he tells the intra-mental truth about it: he cannot, and could not, behave otherwise with Dolores, *even if he had wished to*. He is seduced by nymphets, after all. His mental pattern is very complicated, but his condition as a person suffering from (and making others suffer because of his) paraphilia, cannot be questioned: his perception of sexuality is by general standards – legal and psychiatric – unusual, and the harm done to the non-consenting partner is huge. The implied Nabokov makes it hard for the reader to assess Humbert's overall sincerity – and his madness. He plays with these notions, which makes the case of Humbert an ambiguous example, somewhere between lying, self-deceit and madness, and forces the readers to choose their positions in relation to this complex issue. The flesh-and-blood reader may feel the position of the authorial audience's insecurity of interpretation as an unnerving one (at least I did), or on the other hand, marvel at Nabokov's artistry in creating this ambiguity. The question of perceiving Humbert's intra-mental reliability is at the core of his diagnostics and the ethical and aesthetical assessment by the reader.

A third example is in order to shed further light on the issue of a narrator/focaliser's unreliability and the perception of her intra-mental reliability: Shute's anorexic Josie in *Life-Size*. In her case, the reader must face an acute, rather Foucauldian, battle in the mind of the patient: it is a battle of intra-mental reliability (Josie's perception of herself as a hunger artist) and inter-personal unreliability (the psychiatric perception of Josie as mentally ill). This battle builds the novel's thematic backbone. Josie's tale is a tale of voyage towards recovery, of a new merging of the psychiatric viewpoint and the patient's personal one. In this process, the psychiatric viewpoint wins and Josie is led back to the community of normally eating people, which can be seen to emphasise the interpretation that her previous perception was unreliable over the interpretation that she still was intra-mentally reliable in her self-perception. The process of healing makes Josie's case different than those above. The whole novel is about healing and the redirecting of Josie's own perception of herself back to 'normal'. Her healing can be seen as a process by which her intra-mental reliability is wrenched from being in gross disharmony with the psychiatric viewpoint of it (which is also the TAW's way of seeing it) to being more in synchrony with it. In a way, her sincerity does not change in quantity, but is only redirected in quality: it becomes the sincerity of sanity rather than of madness.[10]

10. Phelan's interpretation that Humbert Humbert, through his narrative voyage, starts to perceive his own deeds' repercussions to Dolores can also be seen as a kind of process of healing, or at least a process of a better merging of Humbert's own vision of himself and his deeds and the

All of these examples point to the notion that intra-mental reliability can receive different kinds of hearings from different kinds of readerly positions. In Kesey's, Head's, and Lessing's novels, the authorial audience's position is strongly rooted in the viewpoint that the madness depicted cannot be interpreted only through the notion of inter-personal unreliability without the complementary emphasis on the value of the narrator's/focaliser's own intra-mental reliability. In *Lolita*, the readerly position is murkier, but still, the emphasis remains on the dynamics of inter-personal unreliability being related to intra-mental reliability. In Shute's novel, these dynamics are equally as pronounced, but in a different manner of being: they are in a continuum as well as a battle of the healing process. Thus, in all of these examples, the dynamics are present: one cannot side-step the significance of intra-mental reliability – neither as a tool of diagnostics, nor as an ethical stance towards the narrator/focaliser.

One must also ask: is the problematic of the reader's relating to the intra-mental reliability of the mad person inbuilt in *every* madness narrative with mad focalisers and narrators? I would claim that it is. When a narrator/focaliser is possibly mad, the reader must encounter that possibility of madness and make an interpretation of it as madness: she makes her interpretation partly on the basis of configuring the aspect of intra-mental reliability of the persona in question.

Finally, the issue of diagnostics must be raised as well: my notion of intra-mental reliability versus inter-personal reliability directs the attention towards the community of sane people determining (in their inter-personal reliability) the madness (the inter-personal unreliability) of mad characters and narrators. This is basically what Laing proposed as the basis of delineating the border between madness and sanity: it is defined by common consent (Laing 1990, p. 36). I have myself questioned the unquestioned basis Laing uses: how does one steer clear of the difficulty of defining madness or sanity through group memberships; what does one do if the insane revert to the same argument and say they are sane by *their* common consent? These questions must be kept in mind when analysing madness narratives, and I argue that my two tools of intra-mental un/reliability and inter-personal un/reliability can be used to weigh up these questions as well – they help to ask questions of why one sees madness in the character or narrator – and *who* forms the community of inter-personally reliable people that defines others as mad.

This explains why I propose these new notions to be tested and discussed in further analysis.

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psychiatric, legal or ethical way of seeing his paedophilia (meaning also the TAW's shared way of seeing it).

6 CLOSING WORDS: TELLING MADNESS

I have travelled a rather rough terrain, first through the diagnostics of madness, and then onwards to the wider literary scholarly repercussions of reading madness narratives. A few closing words are in order.

In the first part of my study, I highlighted the intricate way madness narratives combine diagnostic and narrative power when weaving their patterns. This viewpoint has made it possible for me to study the ways madness narratives may support, challenge or ignore psycho-scientific debates, and use them as a part of their narrative strategies and agendas. In this way, I have teased out the fine balance between narrative and diagnostic powers: madness narrating – telling about madness – is a power field of rhetoric and psycho-scientific or lay diagnosis, both in connection to the shared world's psycho-scientific debates, and in the unique, literary forces of signification. This focus has also given me the opportunity to analyse the madness narratives in the light of the psycho-sciences. I have examined how these narratives may or may not exemplify certain diagnostic categories, observed how the psycho-sciences are depicted in the narratives, and considered the ways these narratives comment on psycho-scientific debates. Finally, this focus has opened up the discussion on madness itself by examining how it is configured in the narrative and diagnostic power patterns of my novels' narratives.

I hope I have been able to convince the reader at least of the multifarious and heterogeneous nature of the psycho-scientific debates, madness narratives as a form of literature, and madness itself. There are often no easy or simple answers to the questions of seeing madness in a narrator or character: even in our era of sophisticated psycho-sciences, madness is, more often than not, in the eye of the beholder.

In the second part of my study, I addressed a wider number of issues of importance to the study of literature and madness narratives. Madness's relationship to fictitiousness, as a builder of fictional universes inside fiction proper, gives us the opportunity to examine the process of becoming fictitious through the lens of madness as one side of dichotomies such as mad/normal, mad/supernatural, and mad/real. This enables the reader to see the multiple natures of both madness and literature: madness narratives often play with the borders of these foundational dichotomies, making the borders of different worlds hazy.

I have also examined how madness functions as a literary device. Madness may from certain viewpoints be impoverished in the process of being used as a device, but from other focuses, it can be a valuable point of view in itself, broadening the reader's knowledge of madness through the process of reading madness narratives. I have found that these relations are not simple, but are instead mutable; madness can sometimes be used *both* as device *and* as a profound depiction of the phenomenon of insanity.

I have also examined the ethics of diagnosis-making by considering two cases that have shed light on the various aspects of this process: the ethics of irresponsibility (Patrick McGrath's *Spider*); and the possibility of unethical madness (Vladimir Nabokov's *Lolita*). I argued that when the worlds of sanity and madness meet, their ethical relationships can be difficult to unravel and fathom, making the ethical encounter between the madness narrative and its readers pronounced.

On the aesthetic side, I studied Nabokov's *Pale Fire* as an example of the (fictitious) product of madness, which crystallises the multifaceted relationship between art and madness. My discussion addresses the often contested capacity of the mad to create valuable, real art, and how the relationships between the worlds of sanity and madness affect the process of creating art. Is it possible for an unintentionally fictitious, autobiographically meant work to be art? I hope that I have shown that *Pale Fire*, a work that is notoriously difficult to interpret, does not answer this question definitively, but instead teases out its intricacies.

I also took up the issue of the meaning of madness (more specifically psychosis) given in madness narratives as opposed to the meaninglessness of the contents of madness given in brain psychiatric theories. I have argued that literature highlights something the theories side-step or ignore, namely the qualia and allegorical nature of madness; literary madness worlds have something larger to say than just to point to the aetiology of the illness.

Finally, I attempted a reconsideration of the term 'unreliability' in connection to madness narratives. I have argued that since mad narrators and focalisers are most often sincere in their mad narration/focalisation, the term 'unreliable' is misleading. I have proposed a supplementary notion of 'intra-mental un/reliability' which, together with the more traditionally-based notion of 'inter-personal un/reliability', gives literary scholars more finely tuned tools and spectrums to diagnose literary personae.

There are issues that might elicit further study that fall outside the scope of this study. These include e.g. the study of mad language in madness narration, analysis of patient-doctor relationships and the hospital as an environment of cure and struggle. The issue of the general nature of narrative power is also of interest, for example, in examining the kinds of patterns of narrative power found in different genres of narrative. I find these all intriguing subjects for further study; unfortunately I could not give them space inside this present volume.

All in all, I hope that I have given the reader a sufficiently multifaceted perception of madness to show how madness narratives have much to offer to us all: madness narratives have something intriguing to tell us about madness and madness literature.

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