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“Frailty, thy name is woman”:  
Depictions of Female Madness

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Fine Arts in  
Theatre Pedagogy at Virginia Commonwealth University.

By

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Master of Fine Arts in Theatre Pedagogy

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## ABSTRACT

### “FRAILTY, THY NAME IS WOMAN”: DEPICTIONS OF FEMALE MADNESS

Julianna Little, Master of Fine Arts in Theatre Pedagogy

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Fine Arts in Theatre Pedagogy at Virginia Commonwealth University.

Virginia Commonwealth University, 2015

Director: Noreen C. Barnes, Director of Graduate Studies, Department of Theatre

Concepts of mental health and normality cannot be understood apart from cultural norms and values. The most significant of cultural constructions that shape our view of madness is gender. Madness has been perceived for centuries metaphorically and symbolically as a feminine illness and continues to be gendered into the twenty-first century. Works of art and literature and psychiatric medicine influence each other as well as our understanding and perception of mental illness. Throughout history, images of mental illness in women send the message that women are weak, dangerous, and require containment. What are the cultural links between femininity and insanity, and how are they represented? Through the lenses of disciplines such as theatre criticism, feminist theory, and psychiatry, this thesis examines the history of madness as a gendered concept and its depictions in art and literature. Additionally, it will explore the representation of female madness in contemporary dramatic literature as compared to the medical model used during the era in which it was written as well as the social and cultural conditions and expectations of the period. The three plays under consideration are: *Long Day's Journey Into Night*, written in 1941 by Eugene O'Neill; *Fefu and Her Friends*, written in 1977 by Maria Irene Fornés; and

*Next to Normal*, produced on Broadway in its current form in 2009 and written and scored by Brian Yorkey and Tom Kitts. None of these plays tell a tidy story with a straightforward ending. In none do treatment facilities offer refuge or health professionals offer answers. Struggling characters resort to drug abuse, fall prey to internalization, or leave treatment all together, having been subjected to enough victimization. The relationship between patient and physician is depicted to be, at best, ambivalent. The themes in these plays illuminate women's mental illness as an extensive problem with many contributing factors, and the origins of which are quite complex.

## INTRODUCTION

How is one to define madness? There is no one description that can capture all the variants of what might be considered deviant behavior and thought over time. It is a concept that has been characterized by centuries of religious, political, social, medical, and aesthetic dynamics. Lillian Feder, author of *Madness in Literature*, writes that certain symptoms are characteristic of different periods in history, and the definition also depends on what lens is used: religiously, madness was used to persecute; politically and socially, it has been used to designate discrimination and oppression; medically, madness is an illness of the mind; and aesthetically, it is used as self-expression and as a reflection of society (xii). Concepts of mental health and normality cannot be understood apart from cultural norms and values; the most significant of cultural constructions that shape our view of madness is gender. In *Women and Madness*, Phyllis Chesler claims that madness in any form is a breakaway from traditional roles. She writes, “What we consider ‘madness,’ whether it appears in women or in men, is either the acting out of the devalued female role or the total or partial rejection of one’s sex role stereotype” (93). For the purposes of this paper, we will look at madness through all of the above lenses as they pertain to women, given that the depiction of madness closely intersects with discourses of female gender ideologies.

Madness has been perceived for centuries metaphorically and symbolically as a feminine illness and continues to be gendered into the twenty-first century. Works of art and literature and psychiatric medicine influence each other as well as our understanding and perception of mental illness. Throughout history, images of mental illness in women send the message that women are weak, dangerous, and require containment because we must control what we perceive to be uncontrollable. As early as the

fourteenth century, women were persecuted as witches. By the sixteenth century, women were shut away in madhouses by their husbands. Physicians began to argue that some women accused of witchcraft were suffering from mental illness and it is this reassessment that began the shift toward gendering madness as female. By the seventeenth century, special wards were reserved for prostitutes, pregnant and poor women in France's first mental asylum, the Salpêtrière. In the Victorian era, the model image of woman emphasized the virtues of delicacy, purity, and domesticity and rejection of that ideal resulted in psychological and physical problems. By the end of the nineteenth century, images of madness culturally executed and enforced were primarily of women (Chesler, 74). Feminists in the twentieth century began to understand female madness as an historical label applied to female protest. Labeled "deviant," Victorian women subverted the linear logic of male science by expressing their opposition against the traditional feminine role with physical symptoms (Showalter, *Malady*, 5). So too could women of the twentieth century. Just as social conditions changed and shaped the nature of female mental illness, theories about the nature of the disease also evolved. Medieval ideas of madness and melancholia were centered in humoral theory. Nineteenth-century discourse still based mental illness on a biological model, but to the extent that women's mental problems stemmed directly from their reproductive organs, a belief that reflected morally charged assumptions about women's nature and roles. The biological model was replaced by a psychological framework in the early twentieth century, largely through Freud's influence. Changes in gender roles, in the social relations of power, and in the understanding of sexuality beginning in the mid-twentieth century, replaced traditional psychiatric discourse. Today we use a combination of biological and psychological models to determine madness.

The mad woman does not exist alone; she influences and is a reflection of society. Because of this, theatre has always found great fascination in portraying madness. What are the cultural links between femininity and insanity, and how are they represented? Through the lenses of disciplines such as



theatre criticism, feminist theory, and psychiatry, this paper examines the history of madness as a gendered concept and its depictions in art and literature. Additionally, it will explore the representation of female madness in contemporary dramatic literature as compared to the medical model used during the era in which it was written as well as the social and cultural conditions and expectations of the period. The three plays under consideration are: *Long Day's Journey Into Night*, written in 1941 by Eugene O'Neill; *Fefu and Her Friends*, written in 1977 by Maria Irene Fornés; and *Next to Normal*, produced on Broadway in its current form in 2009 and written and scored by Brian Yorkey and Tom Kitts. None of these plays tell a tidy story with a straightforward ending. In none do treatment facilities offer refuge or health professionals offer answers. Struggling characters resort to drug abuse, fall prey to internalization, or leave treatment all together, having been subjected to enough victimization. The relationship between patient and physician is depicted to be, at best, ambivalent. The themes in these plays illuminate women's mental illness as a pervasive problem with many contributing factors, the origins of which are quite complex.

## THE HISTORY of FEMALE MADNESS

As early as the dramas of ancient Greece and Rome, the theme of madness was used as a device to comment on the human condition. Insanity metaphorically connoted cultural dysfunction, breakdown, or upheaval; the society's ills were mirrored in the madness of the individual. It was most often represented as a condition divinely influenced and offered an explanation for ill fate, such as disease, or as a punishment for sin. Classical tragedies such as *Orestes*, *The Bacchae*, and *Thyestes* depict characters with symptoms such as fever, writhing, eye rolling, frothing at the mouth, hallucinations, and murderous rage or wild abandon. The art of rhetoric was a highly valued trait of a strong and clear-minded individual, therefore those who exhibited irrational speech and confused thought processes were also considered mad. The earliest extant example of dramatic madness is the depiction of the soothsayer, Cassandra, in Aeschylus's *Agamemnon*. Cassandra was so loved by Apollo that he gave her the gift of divination, but when she refused the god's advances, he cursed her prophecies, condemning them never to be believed. She is clearly characterized by her mad visions, as witnessed by Clytemnestra when Cassandra descends into a prophetic trance.

Ancient Greek scholars Aristotle and Hippocrates speculated on the origins of melancholia and madness. Disorders of the mind were believed to be an excess of black melancholy humor and could be cured by making corrections. Humoral theory has a long history, from Hippocratic treatises in the fourth century BCE to Galen's work in the second century AD. It was rediscovered and employed during the Renaissance. The body was thought to be traversed by canals that circulated the four humors: black bile (melancholy), yellow bile, phlegm, and blood (Deans). During the late Middle Ages, at a time when war,

plague, and religious upheaval were rife and scientific discourse was in its infancy, the unexplained, under the auspices of the clergy, was assumed to be the result of evil spirits. In 1484, Pope Innocent VIII claimed that heretics in Germany were meeting with demons, casting spells that destroyed crops, and aborting infants. He commissioned the *Malleus maleficarum*, a treatise that helped define the crime of witchcraft and urged Christians to hunt down and kill them.

Witch trials were commonplace in Europe and North America from the late fourteenth century until the seventeenth century, resulting in the torture and death of primarily women. Estimates vary between hundreds of thousands to many millions (Ussher, 43). From 1500 to 1660, Europe saw between 50,000 and 80,000 suspected witches executed (Linder). Witches were said to be able to kill with a look, ruin crops and destroy livestock, and cause illness or famine. As second class citizens, women became a convenient source of evil and were used as scapegoats, accused of witchcraft for many reasons. Some women may have been melancholic, mad, or exhibiting psychotic symptoms; others could have been those who deviated in some way from societal norms. In many cases however, the accused was simply a susceptible lonely spinster, or in the case of revenge, someone's enemy. Reginald Scot in his 1584 treatise, *Discoverie of Witchcraft* wrote, "... [T]he cause why women are oftener found to be witches than men: they have such an unbridled force of fury and concupiscence naturally that by no means is it possible for them to temper or to moderate the same" (qtd. in Ussher, 49). Women branded as witches were subjected to horrible tortures, including rape, beating, thumbscrews, bloodletting, stripping, and other public shaming. Tests were brutal: trial by water, where women were bound and tossed into the water to see if they would sink or float; and prick tests, which hunted for areas on the body that were insensitive to pain. In the end, witches were generally found guilty and suffered death by burning or hanging.

By the mid-sixteenth century, physicians began to argue that some women accused of witchcraft were suffering from mental illness rather than corrupted by evil spirits. This reevaluation began the shift toward gendering madness as female. Physician Johann Weyer and Reginald Scot, who was a justice, were among the first to denounce the persecution of witchcraft, suggesting that rather than be subject to trials, victims should be under a physician's care being treated for psychiatric or pathological disease. As medical advances were made in the late sixteenth and early seventeenth centuries and the profession itself gained prestige, medical treatises in the vernacular were popular and circulated widely. Diagnoses of madness then led to more secular perceptions of insanity. Three doctors were largely responsible for documenting madness in the late sixteenth century: Richard Napier, Timothy Bright, and Edward Jorden. Napier was a physician, minister, and astrologer from 1597 to 1634. He treated about 60,000 patients from all social classes in Great Linford, England, including those with disorders of the mind and those accused of witchcraft. Symptoms of such were reported as: having visions, feeling haunted or suicidal, suffering fits, swooning, or trembling. Napier prescribed a variety of medical, astrological, and spiritual treatments, including purges, cordials, bloodletting, amulets, and prayer. Timothy Bright was a physician and parson who wrote the *Treatise of Melancholie* in 1586 and claimed that the causes of melancholia were bad diet, bad air, a sedentary life, worry, and a guilty conscience, factors that affected the physical humors. Edward Jorden, a London physician who attended witchcraft trials as an expert witness, wrote *A briefe discourse of a Disease Called the Suffocation of the Mother* in 1603. In this treatise, Jorden distinguished "Suffocation of the Mother" (the term "mother" being an antiquated usage of uterus) or *strangulatus uteri*, as different from bewitchment and asserted that there were natural causes for insanity and placed the cause of physical and mental distraction in the uterus (Neely, 47-48, 79-81).

As a result of this documentation, skepticism of witchcraft grew, though prosecutions continued to take place in England until 1680 and well after in the United States. As women were the majority of

patients during this period, the re-diagnosing of madness as a female illness shifted the source of distraction to origin in women's reproductive bodies. This established what Carol Thomas Neely, author of *Distracted Subjects: Madness and Gender in Shakespeare and Early Modern Culture*, calls the "regendering of madness" (6). Eventually "mad" or "hysteric" came to replace the label of "witch."

## DEPICTIONS of MADNESS on the SIXTEENTH-CENTURY STAGE

Elizabethans were inured to the public spectacle of madness. Every English village had its idiot or lunatic. Many vagrants looking for charity pretended to be ex-inmates of Bedlam (Hattori, 285), the colloquial term used for London's Bethlem Hospital for the insane. The word Bedlam eventually came to signify a state of madness or chaos. The hospital allowed public and casual visits for those not related to inmates, an idle entertainment for sightseers, to be sure. In *The History of Psychiatry*, authors Alexander and Selesnick write:

Bedlam... was a favorite Sunday excursion spot for Londoners, who came to stare at the madman through the iron gates. Should they survive the filthy conditions, the abominable food, isolation and darkness, and the brutality of their keepers, the patients of bedlam were entitled to treatment – emetics, purgatives, bloodletting, and various so-called harmless tortures provided by various paraphernalia. (qtd. in Ussher, 64-5)

Patients were considered nothing more than animals, and the mad were, by and large, treated inhumanely until the nineteenth century. Michel Foucault, in *Madness and Civilization* describes women at the Salpêtrière Hospital in Paris (a noted asylum for thousands of insane and incurable women) at the end of the eighteenth century, being crammed into cells, enduring cold, wet, and wholly unsanitary conditions as well as endless attacks by rat swarms. These were the quiet maddened. Of the more violent inmates, he writes, "...[M]adwomen seized with fits of violence are chained like dogs at their cell doors, and separated from keepers and visitors alike by a long corridor protected by an iron grille; through this grille is passed their food and the straw on which they sleep; by means of rakes, part of the filth that surrounds

them is cleaned out” (7). Some inmates at Bethlem “performed” to elicit donations of food or money. It was a common dramatic device during this period to include a scene set in Bedlam; actors and actresses were encouraged to visit the asylum as background for creating their characters. Because madness in this period was defined legally and medically by how mad people were assumed to look and behave in terms of facial features, speech, gait, and overall demeanor, distraction became inextricably linked to performance and theatricality. Society was conditioned to see the mad as behaving oddly or with violent mood swings; speech ranged from babbling nonsense to furious raving to dead, withdrawn silence (Hattori 285-6). What constituted madness resulted from outward appearance and performance.

The depiction and enactment of madness became an extremely popular and familiar stage device in the English theatre in the sixteenth century. Stage representations of madness in Elizabethan and Jacobean drama depicted larger than life characters that represented not only derangement, but distraction as love-sickness, as well as feigned madness. These presentations established a new way of looking at different representations of the mad. According to Neely, sixteenth-century dramas such as *Gammer Gurton’s Needle* (1550s) and Thomas Kyd’s *A Spanish Tragedy* (1585-87), both adapted from early Roman plays and redeveloped for the English stage, became influential in new representations of maddened characters in later drama, such as Antipholus and Dromio in *The Comedy of Errors*, Falstaff in *The Merry Wives of Windsor*, Feste in *Twelfth Night*, and Poor Tom in *King Lear* (32). The protagonist of *Gammer Gurton’s Needle*, Diccon the Bedlam, isn’t truly mad, but by being a trickster, his character disrupts social order by creating madness and mayhem within the community.

*The Spanish Tragedy* established the revenge tragedy on the English stage and was immediately popular in its theatricality. The protagonist, Hieronimo, is a dynamic character whose grief over the murder of his son, Horatio, gradually yet methodically manifests itself into a mad revenge. By the end of

the play, he bites out his own tongue. His wife, Isabella also becomes insane, but her madness has an abrupt onset and quickly leads to suicide. She exclaims in Act III, scene viii:

So that, you say, this herb, will purge the eye,

And this, the head?

Ah!—but none of them will purge the heart!

No, there's no medicine left for my disease,

Nor any physic to recure the dead. [*She runs lunatic*]

O Horatio, where's Horatio? (1-6)

Like Cassandra in *Agamemnon*, Isabella's language then devolves into incoherent nonsense language. Additionally, both Hieronimo and Isabella hallucinate journeys to supernatural places. Success of *The Spanish Tragedy* fueled many successor plays in the 1580s and '90s. It introduced gender differentiation and associations with madness that would later become influential; we begin to see distinctions in portrayals of madness between male and female characters that contemplate inwardly of their own distraction. Shakespeare's tragedies, such as *King Lear*, *Macbeth*, and *Hamlet* represent a new way of seeing the mad which differentiates them from previous depictions and make distinctions between natural and supernatural and actual and feigned madness (Neely, 39, 46).

In *King Lear*, Shakespeare neatly distinguishes between two types of madness. The first is the king's plunge into insanity from indignity and grief, which mirrors the chaos of the kingdom. To depict his disrupted state of mind, Lear's language devolves from iambic pentameter to prose as he moves toward insanity. By Act III, scene i, Lear is described as beginning to lose his mind. When the Fool realizes what is happening to Lear, he begs the king to find his grip on reality. By Act III, scene ii, Lear finally admits, "My wits begin to turn" (66) and he is completely shattered by Act III, scene vi. In Act IV, scene iv, Cordelia reports that her father is deranged:



As mad as the vexed sea, singing aloud,  
Crowned with rank fumiter and furrow-weeds,  
With burdocks, hemlock, nettles, cuckoo-flowers,  
Darnel, and all the idle weeds that grow  
In our sustaining corn. (2-6)

This lunacy will be treated and to some extent overcome not by supplication to the gods, but by medical intervention in Act IV, scene iv. Lear's madness can be remedied, however temporarily, through bodily rest and simples, "whose power will close the eye of anguish" (IV.iv.14-15). By contrast, the feigned madness of Gloucester's son Edgar, disguised as mad Poor Tom, is depicted by irrational logic and nonsense language. Edgar describes in Act II, scene iii how he will behave as a "Bedlam beggar" and will smear his body with filth, make his hair matted, and begin to speak like a lunatic. As Edgar, he speaks in verse. As Poor Tom he speaks in prose, in third person, and devolves into babbling, feigning hallucinations and claiming persecutions by the devil. Edgar reemerges as he witnesses real madness in Lear losing his mind in grief. The representations of madness in *King Lear* then, are more secular, more medicalized than previous representations of madness (Neely, 59). While gods are invoked in the play, it is to solicit punishment for crimes against the king, not as lamenting possible causes for his madness.

In *Macbeth*, Shakespeare distinguishes the supernatural madness of the witches from the morally diseased Macbeths, which is depicted in their descent into dementia: his by way of losing his moral center, hers by way of realizing the depth of her crimes. Their deteriorating mental health, corrupted by anxiety and paranoia, is depicted in various acts and scenes of the play through hallucinations and incoherent language, but most famously in her speech in Act V, scene i:

Out, damned spot! out, I say!--One: two: why,  
then, 'tis time to do't.--Hell is murky!--Fie, my

lord, fie! a soldier, and afeard? What need we  
fear who knows it, when none can call our power to  
account?--Yet who would have thought the old man  
to have had so much blood in him. (25-30)

Lady Macbeth's lunacy disturbs her Gentlewoman sufficiently that she consults with a medical practitioner. The Doctor is summoned but proclaims in Act V, scene i that, "This disease is beyond my practice" (40), and presents the argument that Lady Macbeth's troubles are psychological in nature rather than a supernaturally influenced:

Foul whisp'rings are abroad. Unnatural deeds  
Do breed unnatural troubles. Infected minds  
To their deaf pillows will discharge their secrets.  
More needs she the divine than the physician.  
God, God forgive us all! Look after her,  
Remove from her the means of all annoyance,  
And still keep eyes upon her. So, good night.  
My mind she has mated, and amazed my sight.  
I think, but dare not speak. (49-57)

This is another clear example of more secularized, medicalized representation of insanity.

In *Hamlet*, we find another example of feigned madness as being distinguished from natural madness as in *King Lear*, but Hamlet's contrivances are depicted differently than Ophelia's distraction. Hamlet uses illogical language when speaking to Polonius in Act II, scene ii. Ophelia's gendered madness in Act IV, scene iv is innovative and unlike depictions previously seen. Unlike characters in *The Spanish Tragedy*, *King Lear*, and *Macbeth*, Ophelia does not hallucinate. She remains tied into her own fantastical

mind. In Act IV, scene v, she recites verses, proverbs, tales, and songs that express her losses of chastity, love, and security. Ophelia's disordered language is indicative of mental illness, but she, nor does anyone else refer to humoral disorders or supernatural afflictions to explain her madness. Derek Russell Davis, in *Scenes of Madness: A Psychiatrist at the Theatre*, writes, "Her distracted behavior and the veiled allusions in what she says, with loose associations and excessive use of metaphor, may be seen as evidence of mental illness, as does her bawdiness and overt sensuality and, especially the unsuitable, out-of-character display of sexual preoccupations" (40). It is with *Hamlet* and the portrayal of Ophelia that we begin to associate her madness with a depiction that is overtly female and feminine. Iconographically, Ophelia most often appears as young and beautiful, with a wan and frail look. Her long, disheveled hair is often strewn with flowers, twigs, or straw. She carries and distributes symbolic flowers and wears a long flowing white dress as a sign of purity and innocence. She fluctuates between singing wistfully and bawdily; she frequently speaks in metaphors. Ophelia's beauty, passive demeanor, and vulnerable femininity translate to sexual innocence and sexual appeal (Kiefer, 12). Neely writes, "Ophelia's madness, as the play presents it, begins to be gender-specific...that later stage representations of Ophelia will exaggerate by associating her with the condition of female hysterics" (52).

Though Gertrude did not witness Ophelia's death (or if she did, she is complicit in her death), she narrates it as natural, romantic, and beautiful, and also eroticized, by referring to orchids being phallic in shape:

There is a willow grows aslant a brook,  
That shows his hoar leaves in the glassy stream;  
There with fantastic garlands did she come  
Of crow-flowers, nettles, daisies, and long purples  
That liberal shepherds give a grosser name,  
But our cold maids do dead men's fingers call them:  
There, on the pendent boughs her coronet weeds  
Clambering to hang, an envious sliver broke;  
When down her weedy trophies and herself  
Fell in the weeping brook. Her clothes spread wide;

And, mermaid-like, awhile they bore her up:  
Which time she chanted snatches of old tunes;  
As one incapable of her own distress,  
Or like a creature native and indued  
Unto that element: but long it could not be  
Till that her garments, heavy with their drink,  
Pull'd the poor wretch from her melodious lay  
To muddy death. (162-180)

The cause and method of Ophelia's madness and death is unclear. Her madness may be the result of unrequited love, the death of her father, an assertion of self in a rebellion against patriarchal control, or a combination of all of these. Her death may have been an accident or she may have committed suicide. Possibly she was murdered. The Elizabethans would likely have seen Ophelia as suffering from love sick melancholy, or even erotomania. Oomen and Gianotten, in "Lovesickness: In Search of a Discarded Disease," distinguish the difference between the two maladies: Lovesickness is melancholy as a result of excessive *unrequited love for another*; erotomania is the *delusion of being loved by another* (70).

Thus, this is the period in which we see, in large part due to Shakespeare's works, a new way to represent the distracted mind. Shakespeare varied his representations, and made distinctions between feigned and real madness and then, male and female madness. The stage conventions for playing Ophelia carried subtextual messages about femininity and insanity and her representation as a beautiful but mad woman begins an iconographically gendered understanding of madness as a female illness.

A passionate portrayal by Harriet Smithson in Paris in 1827 brought significant attention to the previously under recognized, minor role. The Parisian audience presumably did not understand much of the language and previous to Smithson's portrayal, Ophelia's madness was expressed primarily through non-sequiturs and metaphors. Composer Hector Berlioz felt that Smithson's exceptionally expressive gestures, facial expressions, and modulation of voice were more persuasive and convincing to transfer meaning than any translation could have been. Smithson wore the traditional white dress, with a black veil and straw in her disheveled hair, but her originality lay in the iconography of her evocative and

distracted portrayal. Alexandre Dumas claimed that Smithson's portrayal was the first time he'd seen real passion in the theatre. Victor Hugo commented that hers was the realistic madness reminiscent of the asylum (Wechsler, 202-6). Smithson became an instant celebrity; her image was widely copied in popular lithographs and she influenced French fashion.

Under the sway of Romanticism, the visual or aural representation of Ophelia's madness became a fascination for artists. Authors, poets, painters, and composers all were influenced by the tale of the beautiful but mad woman, but Smithson's performance in particular evoked a remarkably sympathetic emotional response. Eugène Delacroix's *The Death of Ophelia*, lithographed in 1843, (he subsequently painted versions in 1844 and 1859), was initially inspired by the emotionally charged scenes in Smithson's stylization. His Ophelia is therefore quite dramatic. She is collapsed into the stream, straining to hold on to the willow branch as her dress swells out around her, gathering water. The pathos evoked indicates that Ophelia is clearly in torment. A sensual quality is created by the transparent clothing and bared breast. Peter Raby, in *Fair Ophelia: A Life of Harriet Smithson Berlioz*, writes: "Delacroix's works at the least testify to the potency of Ophelia as an image for the Romantic period, a symbol both of wounded, self-absorbed sexuality and of the destruction of innocence by an indifferent world" (182). John Everett Millais' painting *Ophelia Drowning*, 1851-52, is the quintessential image of Ophelia and exceptional in its botanical symbolism: the willow tree mentioned in the text, forget-me-nots (remembrance), poppies (death) and a wreath of violets around her neck (faithfulness). Millais perfectly captures what Elaine Showalter in "Representing Ophelia: Women, Madness, and the Responsibilities of Feminist Criticism" asserts is the dual messages that the role conveys: "Her flowers suggest the discordant double images of female sexuality as both innocent blossoming and whorish contamination; she is the "green girl" of pastoral, the virginal "Rose of May" and the sexually explicit madwoman who, in giving away her wild flowers and herbs, is symbolically deflowering herself" (79). Countless other

artists from the nineteenth century to the present have been inspired to create the aesthetic of the beautiful madwoman. Paintings of the Romantic period featured the beautiful invalid with a melancholic gaze. Literature emphasized themes of pathos, illness, and death and popular women's magazines featured such stories as "The Grave of My Friend" and "Song of Dying" (Ehrenreich and English, 99).

Ophelia became the archetype for a madwoman in art and literature but also for the insane woman in the asylum. Victorians were Shakespeare enthusiasts and psychiatrists used the Bard's plays as diagnostic guides for mental derangement. Ophelia set the standard for female insanity; medical textbooks even contained illustrations of Ophelia-like maidens. In 1863, English psychiatrist, John Connelly described hysteria as the "Ophelia Syndrome." Ophelia, too, became the model for the first photographic documentation of female insanity in 1848. Dr. Hugh Diamond, medical superintendent of the female ward at the Surrey County asylum in England photographed many of his patients with the intent to document correlations between physiognomic characteristics and various types of mental illness. Rather than the representing the compelling image of Ophelia, Diamond's photographs show poignantly how depressed these women look. Their clothes do not fit and patients have bald patches or lank and dirty or strangely knotted hair. However, when the patients did not willingly strike Ophelia-like poses, costumes, props, and gestures were imposed upon them (Showalter, *Malady*, 87-92). Thus reflections of Ophelia as the prototype for female insanity permeate nineteenth century culture—in and out of the insane asylum. Performance, art, and illness begin to intersect and madness looks to art for diagnosis.

## MELANCHOLIA and LOVESICKNESS

Melancholy as a specifically female disease gained traction during this period and linked women's madness with disordered female wombs and genitals (Neely 69). English noblewoman, Lady Grace Mildmay, diarist and medical practitioner, practiced medicine on her family and others, and had a large repertoire of cures. She wrote that melancholy, "doth arise from the putrifications of the stomach, liver, and matrix" and that remedies may be found by "working upon the spirits of the senses" (qtd. in Neely, 72). Physical remedies were routinely prescribed for mind diseases; treatments consisted of bloodletting, purges, emetics, and cordials. Recipes and regimens varied widely and practitioners shared recipes when treatments seemed to work. Since Galen in the second century, lovesickness has been associated with disequilibrium in the melancholy humor and thereby associated with the condition of female melancholy. It has been characterized as a disease of the head, heart, and imagination, with inflamed or congested genitals leading to disordered fantasy (Neely, 99). Lovesickness or erotic melancholy begins to be newly diagnosed during this period, with particular focus on women. This is largely evident in the pervasive medical discourse on melancholy as being associated with uterine disorder as well as the stage representations of this period and then later in seventeenth-century Dutch art. Physician to King Henry IV of France, André du Laurens wrote *A discourse of the preservation of the sight: of melancholicke disease, of rheumes, and of old age*, in which he defined lovesickness as "melancholie which commeth by the extremitie of love" (qtd. in Neely, 101). Jacques Ferrand, famous for his early psychological treatises on melancholia, including his *Treatise of Lovesickness* in 1623, claimed that women were the majority of the love sick and that the two major causes of erotic melancholy

were uterine fury (madness that comes from an excessive burning desire in the womb) and itching or tickling of the genitals, known as satyriasis (Neely, 109). He described the symptoms of the malady as being, “a pale and wan complexion. . . slow fever. . . palpitations of the heart, swelling of the face, depraved appetite, a sense of grief, sighing, causeless tears, insatiable hunger, raging thirst, fainting, oppressions, supplications, insomnia, headaches, melancholy, epilepsy, madness, uterine fury. . . without mitigation or cure” (qtd. in Neely, 101). Reasoning that the primary symptom of lovesickness was unsatisfied desire, Du Laurens advocated immediate intercourse--with the beloved if possible, but if not, any substitute would do. If intercourse could not happen, the lovesick would be exposed to the physical or moral defects of the beloved. In 1597, Du Laurens attempted to treat both body and mind by lulling the imagination to cure its disorder. He proposed that by catering to the delusions of the deranged person, the disease of the mind would be pacified and he could then treat the secondary problem of desire (Neely, 102).

The lovesick illness in women was apparently so widespread during this period that in the Netherlands, it became a central theme in seventeenth-century Dutch genre painting. Jan Steen in particular, paints *The Doctor's Visit* at least eighteen times in the 1660s. Each scene depicts a doctor visiting a distracted and feverish, lovesick lady with a self-involved, melancholic gaze. The paintings are satirical in nature with visual hints at interpretation in the positioning of the characters and background signifiers. The “afflicted womb” is represented by similarly shaped baskets, bowls, musical instruments, and various apparatus of the medical trade. Heterosexual intercourse was the treatment for such a malady, therefore phallic symbols, such as the enema syringe, are prevalent in the scenes as well. Steen seems to be mocking the medical establishment of the period and the heavy-handedness of the ubiquitous dissertations on the subject such as *Medicine in Relation to Lovesickness*. The lady-sufferer is also a target of criticism in her dramatic poses and self-absorption. Women were clearly under intense scrutiny during



this period; male dominance of the disorder resulted in doctors and painters becoming misogynist participants in the creation of *furor uterinus* (Oomen and Gianotten, 75-77).

Female lovesickness is well represented in the character of the Jailer's Daughter in *The Two Noble Kinsmen*, by William Shakespeare and John Fletcher, published in 1634. Like Ophelia before her, the Jailer's Daughter is distracted from unrequited love. She refers to the death of her father and the gathering of flowers, sings ditties but forgets the words, and frequently speaks in a bawdy fashion. The Doctor is summoned and diagnoses her illness as love melancholy. In Act II, scene iv, the Daughter expresses her desperate desire, despite class distinction, for Prince Palamon by crying, "To marry him is hopeless; To be his whore is witless. Out upon 't!" (4-5). She then conjures a plan to set Palamon free from prison in hopes that he will love her. In Act II, scene vi, the Daughter has released the prince and is waiting for him in a nearby wood:

I love him beyond love and beyond reason  
Or wit or safety. I have made him know it;  
I care not, I am desperate. If the law  
Find me and then condemn me for 't, some wenches,  
Some honest-hearted maids, will sing my dirge  
And tell to memory my death was noble,  
Dying almost a martyr. (11-17)

The Jailer's Daughter alludes to dying for the love of Palamon. Her soliloquies become increasingly fragmented and anxious. She stops eating and considers death as an option in Act III, scene ii:

Food took I none these two days;  
Sipped some water. I have not closed mine eyes  
Save when my lids scoured off their brine. Alas,  
Dissolve, my life! Let not my sense unsettle,  
Lest I should drown, or stab, or hang myself.  
O state of nature, fail together in me,

Since thy best props are warped! So, which way now?  
The best way is the next way to a grave;  
Each errant step beside is torment. Lo,  
The moon is down, the crickets chirp, the screech owl  
Calls in the dawn. All offices are done  
Save what I fail in. But the point is this—  
An end, and that is all. (26-38)

By her fourth speech, her language is quite altered, which as we have seen is now commonplace for representing distraction. She has not eaten or slept and is now quite unbalanced. The Wooer reports that she is mad in Act IV, scene i, and he recites the tale of his saving her from an accidental drowning. Not unlike Du Laurens' actual treatment of feeding the deluded mind and "disordered uterus" with intercourse, in an effort to comfort the maddened Daughter, the course of treatment suggested by the Doctor is that the Wooer pretend to be Palamon and eat with and sing to her, and to "commune of love" (IV.iii.80). Once the delusion is satisfied, intercourse will presumably cure the body's demands. This new disease would later be called neurasthenia, a mild form of hysteria.

## HYSTERIA

Hysteria, a characteristically female condition, (from the Greek, meaning “of the womb”), was one of the classic diseases in the United States, England, and Europe of the eighteenth and nineteenth centuries. By the second half of the nineteenth century, the syndrome was so widespread as to become a way of life. Illness once thought of as having supernatural origins was now determined to have a physical source—the uterus and ovaries, considered the controlling organs in the female body. A woman’s personality was thus naturally derived by these organs and disease or abnormality could cause anything from irritability to insanity (Ehrenreich and English, 109). Hysteria was most frequent among middle and upper class women between the ages of fifteen and forty and commonly followed an emotional or financial setback. Characteristics of the complaint were never fatal but never curable, vast and ever changeable: weakness, headaches, nervousness, depression, crying, fatigue, or disabling pain. As a result, women would take to their beds as invalids, sometimes for years, sacrificing all familial duties and being cared for by a relative (Smith-Rosenberg, *Hysterical*, 663). The most dramatic and frightening symptom of the condition however, was the hysterical “fit.” Carroll Smith-Rosenberg describes a typical attack in her essay, “The Hysterical Woman: Sex Roles and the Role Conflict in 19<sup>th</sup> Century America”:

Mimicking an epileptic seizure, these fits often occurred with shocking suddenness. At other times they “came on” gradually, announcing their approach with a general feeling of depression, nervousness, crying or lassitude. . . It began with pain and tension, most frequently in the “uterine area.” The sufferer alternately sobbed and laughed violently, complained of palpitations of the heart, clawed her throat as if strangling and, at times, abruptly lost the power of hearing and

speech. A death-like trance might follow, lasting hours, even days. At other times violent convulsions - sometimes accompanied by hallucinations - seized her body. (661)

By the end of the nineteenth century, hysteria included virtually any symptom imaginable, such as fainting, heart palpitations, vomiting, laughing then sobbing, as well as some rather alarmingly extreme: loss of sensation or paralysis in areas of the body, sensation of choking, inability to swallow or loss of taste, smell, hearing, or vision (Smith-Rosenberg, *Hysterical*, 662). Attacks of this nature would be followed by extreme exhaustion. Equally frustrating and medically unexplainable was the rapid change in the hysteric's symptoms. Anything was possible; paralysis could shift from one limb to another, or contracture of a limb would shift to loss of voice, or the inability to taste. Predictably, hysteria was deemed related to a woman's reproductive cycle and any disordered uterus could "cause" hysteria; the condition was also thought to be a result of excessive sexual relations. Treatments could be short or long term, some as extreme as the symptoms: shock treatment, blistering, operations, and amputations (Smith-Rosenberg, *Hysterical*, 660, 669). Caring for the hysteric completely disrupted the household when a female, excused from her ordinary duties, took to her bed for an extended period. The hysterical patient dominated the household and often the finances, with exorbitant medical bills, drugs, and operations. Hysterics were labeled morally weak and lacking in willpower for not being able to cope and willful, indolent, and self-absorbed for avoiding their duties.

The reaction of the medical profession to this defiant behavior was scathing and often punitive. The physician who treated the hysterical woman felt threatened by the elusive nature of the disease and individualized symptoms that initially did not seem to have a physical source. In 1897, George Preston wrote, in his study entitled, *Hysteria and Certain Allied Conditions*:

In studying the...disturbances of hysteria, a very formidable difficulty presents itself in the fact that the symptoms are purely subjective. The patient declares that sensation is perverted or lost

and the statement must be accepted, since there are no means of proving or disproving such a statement. . . there is only the bald statement of the patient. No symptoms present themselves to confirm. . . that paralysis exists. . . and the appearance of the affected parts stands as contradictory evidence against the patient's word. (96-97)

The rapid passage of one symptom to another suggested to the medical profession of the period a certain capriciousness which is traditionally associated with a feminine nature (Showalter, *Malady*, 129). Always threatened by and self-conscious of not having a quick remedy and not able to establish any sort of authoritarian control over their patients, physicians struck out at the invalids and began to generally assume they were faking their illnesses. Victorian psychiatrist Henry Maudsley claimed that those suffering from hysteria were simply young women who, "believing or pretending that they cannot stand or walk, lie in bed. . . all day. . . [become] objects of attentive sympathy on the part of their anxious relatives, when all the while their only paralysis is a paralysis of will" (qtd. in Showalter, *Malady*, 133). The assumption of fakery led to a psychiatric treatment of hysteria that reestablished the authority of the physician: indifference and neglect. Such treatments included a showering with cold water, stopping the patient's breathing, physical abuse, shaving the head, and ridiculing and exposing them in front of family and friends. (Smith-Rosenberg, *Hysterical*, 675). The diagnosis for a more accommodating form of hysteria was neurasthenia, but the quality of the patient's submissiveness led to a differential diagnosis. These women had many of the same symptoms, but were thought to be cooperative where the hysteric was defiant; ladylike, where the hysteric was unmanageable. Physician Silas Weir Mitchell in a lecture in 1875 declared, that the neurasthenic was, "just the kind of women one likes to meet with. . . sensible, not over sensitive or emotional, exhibiting a proper amount of illness. . . and a willingness to perform their share of work quietly into the best of their ability" (Showalter, *Malady*, 134-5). Gentle invalidism was permissible; hysteria and violent "fits" were not. Certainly there was a constant power struggle between

the hysterical patient and physician. Doctors were expected to cure. Patients were expected to get well and they, stubbornly, did not. Determining the fraudulent cases from the real cases was difficult, if not impossible. Bullying and neglect, drugging, and operating did not seem to curb the growing number of cases.

As a response (and, presumably, reestablishment of power for the physician), the rest cure became the standard treatment for hysteria. Mitchell is credited for its creation after he had success treating soldiers during the Civil War, for what today we would call post-traumatic stress syndrome (Kaplan 159). For six weeks, the patient was removed from society and isolated from her family and friends. She was then confined to bed, forbidden to sit up, sew, read, write, or do any intellectual work. She was visited daily by the physician, and fed and massaged by a nurse. Mitchell operated on the assumption that psychological punishment by way of sensory deprivation and sheer boredom would increase his influence and decrease the negative behavior. Showalter quoted him in *The Female Malady*:

When they are bidden to stay a month in bed, and neither to read, write, nor sew, have one nurse-- who is not a relative--then rest becomes for some women a rather bitter medicine, and they are glad enough to accept the order to rise go about when the doctor issues a mandate which has become pleasantly welcome and eagerly looked for. (139)

When the patient succumbed to normative and traditional behaviors, such as being obedient and compliant to her physician's suggestions, she was "cured" (Smith-Rosenberg, *Hysterical*, 676). Anything that placidly restored the invalid to her domestic functions was considered a cure. W.S. Playfair, professor of obstetric medicine at King's College in London, introduced Mitchell's rest cure to England in the 1880s. Playfair preferred to treat refined and cultured neurasthenic invalids, those that fit the model of the Ophelia-like, beautiful, pure, and feminine "wasting beauty" that was becoming a popular aesthetic during the Victorian era. He was, by and large, successful (Showalter, *Malady*, 140).

In the period 1870 to 1900, a specific organic malfunction was sought for hysteria. Neurology was just becoming accepted as a specialty. French neurologist Jean-Martin Charcot began his work on hysteria in 1870 at the Salpêtrière Hospital under the assumption that hysteria was a genuine malady and that it had psychological origins. He was able to reproduce hysterical symptoms through hypnosis, electroshock therapy, and genital manipulation. Inmates of the Salpêtrière were methodically photographed with the intention of providing skeptics with visual proof of the existence of the illness. For many years, he published *Charcot and the Photographic Iconography of the Salpêtrière*, a multi-volume journal of photographs that cataloged these patients and their stages of hysterical “fits.” Georges Didi-Huberman, author of *Invention of Hysteria*, scathingly criticizes Charcot’s techniques, claiming that through hypnosis the patients’ “performances” were rehearsed and staged. He writes that Charcot was accused of experimenting on his patients rather than treating them (181). Showalter writes that many of Charcot’s contemporaries suspected that the performances were made according to suggestion, or were outright frauds (150). Sigmund Freud pointed out that Charcot’s techniques allowed him to intercede on the patients’ psyche by way of hypnotic suggestion (Didi-Huberman, 186). Charcot lectured regularly on the subject, including an exhibition of patients’ “fits.” *A Clinical Lesson at the Salpêtrière*, painted by André Brouillet in 1887, depicts Charcot delivering a lecture on hysteria, complete with a collapsed female patient as a demonstration. Thus the Salpêtrière became a voyeuristic environment in which female hysteria was, for a decade or more, displayed, reproduced, and reinforced (Showalter, *Malady*, 150).

Since the beginning of the twentieth century, hysteria has been defined in terms of psychodynamics. Freud shifted the malady from gynecology to psychology, believing that, whether or not hysteria was feigned, the issue remained that it was a serious mental illness. He proposed that women became hysterics because they, fearful of their sexual impulses, converted that energy into psychosomatic

illness. He named the problem “conversion hysteria” and psychoanalysis, rather than hypnosis was his cure. Physicians and psychologists have since seen hysterical symptoms as a neurosis or anxiety disorder (Smith-Rosenberg, *Hysterical*, 653). Freud published a case study about a woman, (pseudonym Dora), entitled “Fragments of an Analysis of a Case of Hysteria” which documented the situation of a young woman diagnosed with hysteria and loss of voice. Dora had been sexually confronted by a friend of her father’s, in what she felt was an exchange of favors, due to the relationship Dora’s father had with the attacker’s wife. Eager to explore the sexual nature of the case and ignoring its relevant social conditions, Freud concluded that Dora’s story was a case of her own suppressed desire for nearly everyone involved. Dora walked out on Freud after eleven weeks of treatment, discerning that Freud was using his authority to bring her to “reason” and he deemed the case a failure. The case was initially heavily criticized, but later gained traction as psychoanalysis became popularized and Dora was assumed to have, in some fashion, welcomed the attention. Dora was treated like a pawn by all concerned.



## THE NINETEENTH-CENTURY WOMAN

One wonders how Elizabethan lovesickness and erotomania manifested and solidified into hysteria. The answer lies in the framing of expectations of the female during this period. The ideal role of the female in nineteenth century was one of total submission, where individualism was devalued. She managed the burdens and responsibilities of the entire household alone; this included the demands of child rearing and schooling, making all the food and herbals, sewing clothes and linens, and nursing any illnesses. She frequently managed these demands while pregnant, which in all ways required stamina and energetic health. In every sense the woman was to be passive, dependent, and obedient to her husband or father and never allowed any autonomy in thought or action. The ideal woman wanted a home and family; she was to be a gentle, giving nurturer. Carroll Smith-Rosenberg writes that the model woman was, “expected to be gentle and refined, sensitive and loving. She was the guardian of religion and spokeswoman for morality. Hers was the task of guiding the more worldly and more frequently tempted male past the maelstroms of atheism and uncontrolled sexuality. Her sphere was the hearth and the nursery; within it she was to bestow care and love, peace and joy” (*Hysterical*, 655-6). When women became ill, they were afforded the privileges of the sick by being relieved of emotional and physical demands of these traditional roles, familial duties and sex lives. Hysteria, then, became a socially accepted, even stylish sick role for women. Though it came at a cost of pain, disability, and at times disfigurement for many, hysteria became a way that women could express (in most cases unconsciously) dissatisfaction with one or several aspects of their lives. Not surprisingly, this woman exhibited a significant level of hostility and aggression which may have led to depression and a pattern of punishing

herself with psychosomatic or psychiatrically induced illnesses. She was both product and indictment of society's expectations (Smith-Rosenberg, *Hysterical*, 672, 678). It was permissible for a hysterical woman to exhibit a deviant role with aggressive behavior because she was "sick." Many women, overwhelmed with domestic demands, did not wish to "get well." Hysteria became an alternate role option for those unable to accept their life situation.

The sick woman's countenance was not that far from what was considered the ideal woman of the nineteenth century. The melancholic aesthetic that developed, where female beauty and illness were linked, was actually a source of real illness and generally poor health. Society ladies drank vinegar or arsenic to give them a pallid look. Victorian fashion to a great degree cultivated the frail and ornamental look; corsets were used simply to enhance the figure and were debilitating to the extreme. Ehrenreich and English, in *For Her Own Good: Two Centuries of the Experts' Advice to Women*, equate the wearing of corsets with the Chinese practice of footbinding for its crippling effects on the female body. Of women's fashions, they write:

The style of wearing tight-laced corsets... was de rigueur throughout the last half of the century... A fashionable woman's corsets exerted, on the average, twenty-one pounds of pressure on her internal organs, and extremes of up to eighty-eight pounds had been measured... Some of the short-term results of tight-lacing were shortness of breath, constipation, weakness, and a tendency to violent indigestion. Among the long-term effects were bent or fractured ribs, displacement of the liver, and uterine prolapsed. (99)

Added to this suffering would be, according to Ehrenreich and English, the thirty-seven pounds of clothing a society woman would wear in the winter months, of which nineteen pounds were suspended from her waist (99). Society women often succumbed to fainting, sunstroke, or asphyxia due to all the

clothing they had to wear. Women in the nineteenth century were put on a pedestal but they were not worshipped.

The nineteenth century was a formative one for medical reform and psychiatry with the establishment of The Association of Medical Superintendents of American Institutions for the Insane in the U.S. in 1844 and the Medico-Psychological Association in Britain in 1865. Still, the hysterical female emerged from the essentially male-dominated culture as what Caroll Smith-Rosenberg, in *Disorderly Conduct: Visions of Gender in Victorian America*, terms a “child-woman.” This patient was described in medical discourse of the era as highly dependent, filled with self-doubt, attention-seeking, impressionable, unpredictable, uninhibited, and given to masochistic or self-punishing behavior, and weakness of ego (212). The Victorian woman was socialized to reflect only feminine behaviors to avoid threatening the patriarchy. She was not simply discouraged from all “manly” pursuits, but punished in some manner for them. Smith-Rosenberg writes:

Women were sharply discouraged from expressing competitive inclinations or asserting mastery in such "masculine" areas as physical skill, strength, and courage, or in academic, scientific, or commercial pursuits. Rather they were encouraged to be coquettish, entertaining, nonthreatening, and nurturing. Male religious writers and educators forbade overt anger and violence as unfeminine and vulgar and they did not reward curiosity, intrusiveness, exploratory behavior, in women. Indeed, when such characteristics conflicted with the higher feminine values of cleanliness, deportment, unobtrusiveness, or obedience, they were criticized or punished.

(*Disorderly*, 213)

Those who desired a life that did not include marriage, child-bearing, or other self sacrifice were deemed “other” and treated as such. It is therefore, not surprising that the consequence of this type of socialization was many women with low self-esteem or those who suppressed their own needs to support the male

figures in their lives. Some of these women may have chosen to feign hysterical behavior. Others, who may have felt rage against systems in which they were powerless, may have had legitimate illness arise from the stress and anxiety of living under such oppression. Women's suffrage at the turn of the century reflected years of fighting this social and political struggle. The patriarchal culture was under attack by women demanding change; a natural defense was to claim that because women were ruled by their bodies and therefore unfit for anything other than a domestic role, deviance from this was associated with hysteria and mental disorder. Anti-suffrage propagandist cartoons declare the mental instability and criminality of these women, since it was deemed much easier to tolerate hysteria than to allow changes to the social order such as legal rights for women.

In nineteenth-century literature, madness became an important theme as an expression of suppressed rebellion; the image of the "madwoman" has mirrored the oppression of feminine potential, her symptoms seeming to critique the society that oppresses her. The madwoman rebelling against the patriarchy, referenced in *The Madwoman in the Attic*, by Sandra Gilbert and Susan Gubar, appears throughout literature of the nineteenth century and is best illustrated by the violently insane Bertha Mason, in Charlotte Bronte's *Jane Eyre*. Bertha is kept locked in the attic by her husband, Edward Rochester. The madwoman with the disheveled hair and violent and destructive tendencies speaks toward gender politics merged with madness. Miss Havisham of Charles Dickens' *Great Expectations* depicts a heartbroken spinster who remains shut up in her rooms still wearing the torn and tattered wedding dress from the day in her youth that she was jilted, leaving the mouse-eaten wedding cake on the table. Though non-violent, Miss Havisham is mentally unstable and devises ways for mad revenge. Charlotte Perkins Gilman's gothic short story *The Yellow Wallpaper*, written in 1892 and based on her actual experiences, expresses a Victorian woman's condition coping with mental instability within a controlling, male-

dominated medical profession. Having been subdued and conditioned to obey, the woman in the story follows her doctor's prescribed treatment of rest and isolation, but eventually descends into psychosis.

The move toward depictions of female madness in literature continues into twentieth-century drama. French feminist theorist, Hélène Cixous penned *A Portrait of Dora*, concerning Freud's famous case. Cixous also saw hysteria as a rebellion against the patriarchal order and writes in *Castration or Decapitation*, "Silence: silence is the mark of hysteria. The great hysterics have lost speech. . .their tongues are cut off and what talks isn't heard because it's the body that talks and man doesn't hear the body" (qtd. in Showalter, *Malady*, 160-1). In his many plays, Eugene O'Neill often represented mental disturbances from a psychoanalytical perspective, with importance attached to the causes of the illness. Many of his characters are neurotic, depressed, or mentally unstable and attempt to cope with emotional damage from a dysfunctional family environment. Charlotte Perkins Gilman described the home in a 1903 treatise entitled, *The Home: Its Work and Influence* as "something perfect, holy, quite above discussion" (8). This concept seems to dominate the lives of the Tyrone family in O'Neill's classic *Long Day's Journey Into Night*.

## LONG DAY'S JOURNEY INTO NIGHT

Set in New London, Connecticut in 1912, O'Neill masterfully conveys a family's complex history, as *Long Day's Journey Into Night* unfolds through the course of one full day. The Tyrone family is mired in a convoluted cycle of addiction, blame, and guilt and as the action builds, Mary, the linchpin of this tenuous family structure, resumes her drug habit and the men turn to their drug of choice, alcohol. Mary's addiction, although not a mental illness, per se, develops from pathological influences upon her environment and causes neurosis with bouts of deluded thought and related drug-induced hallucinations. Her inability to face the realities of life and fulfill her obligations as wife and mother causes her loneliness, isolation, and addiction to morphine. The play dramatizes a family that is impacted by gender, class, and ethnic conflicts. James Tyrone is an actor from the Romantic stage; his origins are working class Irish and he is by nature tightfisted with money. His wife, Mary has just returned from a "cure" after many such efforts of more than twenty years of morphine addiction. This addiction stems from the difficult birth of her son Edmund. Her family is aware of her fragile condition but expects her to renew her place in the home as a nurturing mother and wife. Older brother Jamie is an alcoholic "ne'er-do-well" and younger brother Edmund is sick with consumption. Each is a victim of their lives and inadequacies and they blame each other for real and imagined wrongs. The most strenuous efforts to preserve the family happiness come from Mary as she will not accept any disturbance of her tenuous grip on reality.

*Long Day's Journey Into Night*, though written in 1941, is set one day in the summer of 1912. The turn of the twentieth century marks a period of changing familial dynamics, such as waning patriarchal authority and the home now seen as a purely feminine space. In particular, fathers as the

successful and sole providers of the immigrant family did not come easily. These men were in a precarious position in an uncertain marketplace and, as immigrants, were explicitly pressured to quickly convert any opportunities into success. The heavy pressure to make good in the world affected the father's traditional role within the home as his success or failure reflected directly on the family (Pfister, 24). John Putnam Demos, author of *Past, Present, and Personal: The Family and the Life Course in American History* writes:

Popular formulas stressed "self making" but in fact, opportunity was limited by race, class, ethnicity, race, and blind luck. Failure exacted a heavy price in self and social esteem. To make matters worse, that price was shared with the families involved. A man who could not find his way in the world was likely to seem failed father – in his own eyes, and in the eyes of those who mattered most to him. (53)

Any failure to succeed resulted in bitter reproach from self and family. It is therefore not surprising that James Tyrone, in order to be the successful breadwinner, chooses the lucrative, long playing role of Monte Cristo to support his family and is consequently bitter about forsaking the coveted Shakespearean roles he desires. The scathing reproaches that his family heaps upon him for not being a good provider throughout the text are emasculating.

As the father's importance waned, the mother's power increased within the domestic sphere. There were new ideas about gender and sex-role stereotyping and women and men began to occupy different fields considered appropriate to their diverse natures. The female sphere was only of the home. She was qualified for this due to her "femininity" and "purity"—a moral judgment that seemingly equipped her for motherhood, but little else. The father was still expected to set the standard for morality, but by the mid-nineteenth century, the child rearing responsibility had shifted solely to the mother (Pfister, 24). It was her duty to keep firm control over her children by instilling a conscience that would not allow

rebellion in any form. To ensure proper socialization including engendering traits such as honesty, industry, frugality, temperance, and self-control, a mother could rely on a host of writings on domestic life and child rearing. Books such as *The Mother at Home*, *The Mother's Book*, and *The Young Mother's Companion*, were ubiquitous (Demos, 49). In the colonial period, a son's failure was blamed on the father, but during the Victorian era, failure was attributed to the negligence of the mother (Pfister, 25). The mother as a selfless ruler of the domestic domain was given an impossible task--to achieve the perfect home, which was to be cheerful, tranquil, and pure. Her function was to be of service to all others, sacrifice her own needs, and deny her own ambitions, while transferring her own wishes and abilities onto the men in her life. As we have seen, this was a volatile situation for many. Smith-Rosenberg describes the role of woman as it was envisioned in nineteenth-century America:

Society provided but one socially respectable, non-deviant role for women -- that of loving wife and mother. Thus women who presumably came in assorted psychological and intellectual shapes and sizes, had to find adjustment in one prescribed role, one that demanded continual self abnegation and a desire to please others. (qtd. in Mandl)

Like women in the nineteenth and beginning of the twentieth centuries, Mary Tyrone has sacrificed her personal goals for a domestic life, a choice made after meeting James for whom she had an adolescent infatuation. Throughout the play, she regrets this decision.

For Mary, a home is one where she can feel respectable and where she is not lonely. She feels abandoned and blames the family's problems on Tyrone's miserliness and failure to build a solid and stable home for her. Of the Monte Cristo cottage, she complains bitterly, "I've never felt it was my home. It was wrong from the start. Everything was done in the cheapest way. Your father would never spend the money to make it right. It's just as well we haven't any friends here. I'd be ashamed" (948). None of the Tyrones feels truly at home and, in fact, the concept of home and comfort is completely absent from the



play. There is no stable identification or connection to home or family at all. Mary is not equal to the task of maintaining the perfect façade demanded of her. She is trapped psychologically in this social construct, where women are pathologically squeezed, patterned, and molded by an artificial perfection, and in her case, a role that includes sobriety. Her inability to cope with the unrealistic expectations of the traditional mother role lead Mary to escape from this private sphere to which women had been regulated; she retreats into chronic illness and lashes out to cast blame on others. The demand that she take up this nurturing role is too much for Mary. She cannot live with the torment and guilt of her traumatic past. She also cannot let go of her youthful aspirations of being a concert pianist or a nun, dreams that would have led to life experiences that would have conflicted with being a wife and mother. Had she taken a different path and remained pious and virginal, she would not be battling addiction. Throughout the play, Mary identifies with Mother Elizabeth, the Reverend Mother at the convent where she went to school. In her last speech, Mary, hallucinating from an overdose of morphine says of the nun, “She is so sweet and good. A saint on earth. I love her dearly. It may be sinful of me but I love her better than my own mother” (1012). Nothing in all her fond recollections of the past throughout the play suggests a desire for anything maternal. This implies a reluctance in Mary to follow in the footsteps of her own mother, to have a home and raise a family. Disassociating herself from her mother also implies a struggle to find her own identity (Black, *Beyond*, 10-11).

Anger underscores the dysfunctional and pathological family dynamic. The Tyrone family are dependent upon each other and require Mary to be a stabilizing foundation upon which they may build their own identities. Each member of the family reacts to others with blame and hostility and the relationships in the family are superficial unless explosive and blaming. Unpleasantness is swept under the carpet or traumatic experiences are repeatedly dredged up. Each member of the Tyrone family is narcissistic. None can hear the pain and suffering which underlies the hostility, nor be empathic to it or

take responsibility for it. Each misunderstands affection and hears it as an accusation; each refuses the others' psychological agony. Old wrongs distract attention from what is dangerous ground in the present. The flow of emotions in the family is checked again and again, conversations are deflected to a different, less painful quarrel. Negative feelings are intolerable but at the same time remain inexpressible. The use of intoxicants by every member of the family indicates their withdrawal from serious familial interactions. As Mary increasingly uses morphine to withdraw from her reality, the three men use more and more alcohol to escape from the reality of her drug use (Miliora, 39, 46). The four are united in an effort to remain a family in spite of their collective destructiveness. With such a dynamic, loving feelings are replaced by cynicism and resignation (Sjödin, 81-3). Mary cannot express her anger because it is an ugly emotion that contradicts the image of motherhood. She has no protection against pain except addiction and denial.

Though the family knows that Mary's detached manner is indicative of her morphine use, she consistently denies their insinuations throughout the play. The Tyrone men are content to allow her to hide her addiction. Mary denies her usage of morphine, but she acts with an air of detachment and uses euphemisms to hide it which only confirms their suspicions. They never ransack the spare bedroom looking for needles or drugs. They never refuse the use of the car for trips to the pharmacy and they allow her time alone to inject the morphine. Instead of interfering with her habit, each of the Tyrone men is satisfied to blame her for not having enough willpower. As a consequence, she isolates and insulates herself from her family. In Act IV, Edmund, in despair, says:

Yes. It's pretty horrible to see her the way she must be now. The hardest thing to take is the blank wall she builds around herself. Or it's more like a bank of fog in which she hides and loses herself. Deliberately, that's the hell of it! You know something in her does it deliberately – to get

beyond our reach, to be rid of us, to forget we're alive! It's as if, in spite of loving us, she hated us! (992).

In her isolation and safety net of denial, Mary completely refuses to acknowledge Edmond's consumption, the disease that killed her father. Having been clean for two months, it is this news that causes Mary to relapse. Mary does not hear Edmond when he tells her that he is going to the sanatorium. Instead, she begs him not to listen to Doctor Hardy and reels off reasons. She calls Hardy an ignorant fool and claims he is just another "cheap quack" who addicts his patients to build repeat business. Considering Mary's serious anguish and suffering with the death of baby Eugene, a difficult pregnancy with Edmond which results in her morphine addiction, an attempted suicide, and the threat of Edmond's illness, it is not surprising that she chooses the instant relief of morphine to battle her demons. In addition, the highly volatile family environment causes her emotional distress. Finally, she is acutely aware of the contempt and disgust that her husband and sons feel toward her because of her drug habit (Miliora, 42 ). Mary's references to her nerves or rheumatism have become a code for addiction and are met with derision by the family. As she attempts to mask the real reason for her most recent trip to the drug store, she tells the maid Cathleen, "It's a special kind of medicine. I have to take it because there is no other that can stop the pain—all the pain—I mean in my hands" (974). The stigma of addict radically destabilizes the image of motherhood for Mary's sons. Jamie sobs, "Christ, I'd never dreamed before that any woman but whores took dope!" (1005). For these reasons, she chooses morphine rather than engagement with her family or harsh realities. She presumes that the family will never have faith in her, will never forget her earlier habit, and will always be suspicious. She will never overcome the stigma. How much easier it is to give in to the overwhelming impulse and solace of morphine (Barlow, 79-80).

Mary craves morphine because it allows her immediate transportation to a world where she can revert to a time before her marriage when she felt safe at the convent, and where she dreamed of a celibate

life as a nun. She clearly blames Tyrone and her marriage for her wrecked life when she says, “You should have remained a bachelor and lived in second rate hotels and entertain your friends and bar rooms. Then nothing would’ve ever happened” (958). Presumably she charges Tyrone for all her broken dreams, the death of the baby, as well as her addiction. However, physical addiction is not Mary’s primary problem. Morphine injection is a means to relieve anguish associated with conflicts and anxieties. Addiction experts Dr. Marie Nyswander and Dr. Abraham Wikler agree that:

[O]pioids suppress the source of certain conflicts and anxieties, permitting the addict to make a passive adaptation to his inner tensions. Addicts seem to take advantage of the powerful action of the drug to mute and extinguish their emotions and to solve, at least in the short run, problems associated with interpersonal questions. (Black, “*Ella*”)

Mary Tyrone accurately represents the nineteenth-century morphine addict. Most were female, white, middle-upper class housewives (Courtwright, 36, 40). Morphine was used to treat a variety of illness and maladies, including insomnia, anxiety, and fatigue resulting from stress or overwork. Those afflicted with neuralgia seemed especially prone to addiction. Women suffering from most gynecological complaints were dosed with morphine, including morning sickness, difficult or protracted labor, and dysmenorrhea. This telling comment was written in lecture notes from 1830 and illustrates Mary’s position: “Uterine and ovarian complications cause more ladies to fall into the habit, than all other diseases combined” (qtd. in Courtwright, 48). Mary was not inaccurate when she described the “cheap quacks” who purposely addict their patients for financial reasons, as greed was a reason for continued abuse in the nineteenth century. Physicians’ laziness and incompetence were other reasons that patients became addicted to morphine. By 1910, the rate of addiction finally slowed due to the introduction of newer, milder analgesics, alternative treatments to illnesses, and general public health improvements, as well as greater diagnostic precision (Courtwright, 52).

The psychological family dynamics of hostility, resentment, blame, and narcissistic rage cause intense emotional injury in *Long Day's Journey Into Night* (Miliora, 39-40). Mary's neurosis is demonstrated by the anxiety caused by all of these emotions as well as her intense narcissism. She does not have any psychological capacity for empathy toward her family because she is mired in a self-centered view of reality. Mary led a sheltered childhood in the convent and she admits her father indulged her. Because of this, she never matured. Mary quotes her "pious and strict" mother, "You've spoiled that girl so, I pity her husband if she ever marries. She'll expect him to give her the moon. She'll never make a good wife" (980). Without her father or the convent for support, she continually needs someone to turn to for protection, to relieve her loneliness and feelings of isolation. She continues to perceive life through the eyes of a child, living in a world of dreams which now are enhanced by morphine. She will remain forever disappointed (Sjödin, 84). Mary never considers herself fortunate to have a summer house, maid, cook, and automobile with chauffeur. Each of these comforts are considered second rate compared to her child life home. She had a schoolgirl fantasy about the actor James:

[H]e was handsomer than my wildest dream, in his makeup and nobleman's costume that was so becoming to him. He was different from all ordinary men, like someone from another world. At the same time he was simple, and kind, and unassuming, not a bit stuck up or vain. I fell in love right then. . . I forgot all about becoming a nun or a concert pianist. All I wanted was to be his wife. (975-6)

These dreams of a starry-eyed romance were shattered by the reality of life as a theatre artist, with constant drinking, traveling, and never having a permanent home. When the two-year old Eugene died while she was away on tour with James, the trauma and guilt became too much for Mary and her mental instability began in earnest.

Mary has no demonstrable empathy for Edmund when he tells her of his illness. She can only seem to react from her sense of injury and loss rather than how sick he is. In Act I, she resentfully responds to his concern that he feels so rotten: “Oh, I’m sure you don’t feel half as badly as you make out. You’re such a baby. You like us to get worried so we’ll make a fuss over you” (947). By Act III, however, Mary is using morphine regularly to cope with the reality of Edmund’s illness. When he complains that she will not listen to him about how sick he truly is, Mary still cannot relate to her son. She inappropriately feigns a teasing demeanor when she says with a belittling laugh, “You’re so like your father, dear. You love to make a scene out of nothing so you can be dramatic and tragic” (983). She becomes delusional at one point, accusing James of being jealous of her and her babies. Mary cannot stand pain in any form, be it physical or mental. Neither can the men in her family. Their concern for Mary is genuine, but only to the extent that it is coupled with narcissistic motives. They clearly want her to be healthy and happy, but they are more interested in how that health and happiness will benefit them. The Tyrone men continue to pretend that she is sober to enhance the fantasy that they have a stable home life. They will do all they can to preserve this illusion because it is useful to them, though eventually Tyrone and Jamie attempt to halt the game of denial in order to position her to take some responsibility for her actions. Ultimately, however, just as Mary cannot engage with her problems, neither can the men cope with Mary’s addiction. For them, the failed image of the mother is too painful (Maley, 49-53).

Delusion and blaming as a cycle of recrimination are large parts of Mary’s neurosis. The cycle of blame is illustrated best by her speech about the death of Eugene. Initially she blames herself for the child’s death, then, she blames James for asking her to leave the baby and Jamie, sick with measles, to join him on the road. Finally, she blames Jamie for transmitting measles to the baby. Deluded, she intensifies her blame to accuse Jamie of intentional fratricide and tells him she has never forgiven him for that. She blames Edmund’s birth for her addiction. No doubt the sons as children perceived their mother’s

accusations and this contributed to their self-destructive behaviors as adults (Miliora, 43). Mary also reinvents an idealized past and the morphine allows her to immerse herself in this delusion. She remembers her childhood home as respectable and her father as the model parent. He was generous, supportive, and most especially sober, qualities that she claims James lacks. Mary sees her true self as modest and virginal and with great potential--a young woman who knows nothing of James Tyrone. She tells Cathleen, "I had two dreams. To be a nun, that was the more beautiful one. To become a concert pianist, that was the other" (975). James believes that Mary never had any real musical talent and that her delusion is created by her neurosis and addiction. She asks James if she hasn't "been such a bad wife," to which James answers with what she wants to hear to avoid hurting her feelings, but Mary disassociates herself from any unpleasantness and lives in a world where she can pretend that her addiction isn't ruining the family. Mary has a powerful motive for escaping into a narcotic haze. It allows her access to her lost fantasy world of adolescent happiness, a time before her dreams were shattered by reality (Eisen, 93).

There is no question that O'Neill has portrayed a psychologically complex character in Mary Tyrone. O'Neill claimed that he was "no great student of psycho-analysis" and attributed his psychological insight in creating characters to the discernment of authorship (qtd. in Pfister, 98). He declared there was "no conscious use of psychoanalytic material in any of my plays" (Sheaffer, 244). However, O'Neill not only knew but was on good terms with some of the leading psychoanalysts and pop psychologists of his day. It is suggested by Dr. Ann-Louise Silver that O'Neill's finest play owes enormously to the direct and personal influence of two American psychoanalysts: Smith Eli Jelliffe and Gilbert VanTassel Hamilton. Silver writes in "*American Psychoanalysts Who Influenced Eugene O'Neill's Long Day's Journey Into Night*," that in addition to treating O'Neill for severe alcoholism, both

of these gentlemen independently shared psychoanalytic theory with him through the writings of Freud, Jung, Edward Kempf, and Adolf Meyer (305).

Psychoanalysis, which flourished in America in the early part of the twentieth century, became a cultural force due to the tremendous growth in the fields of science and psychology (Pfister, 54). Freud wrote *Mourning and Melancholia* in 1915 and it signaled a significant shift from nineteenth-century thought in both psychoanalytic theory and in our understanding of how people react to various kinds of loss (Bradbury, 212). Its principles can be applied to *Long Day's Journey into Night*. Mary is in a state of perpetual mourning, first for her broken childhood dreams, and secondly for the loss of her baby, Eugene. Freud defines mourning:

[T]he reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such one's country, liberty, and ideal, and so on. In some people the same influences produce melancholia instead of mourning and we consequently suspect them of a pathological disposition. It is also well worth notice that although mourning involves grave departures from the normal attitude to life, it never occurs to us to regard it as a pathological condition and to refer it to medical treatment. We rely on its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful. (243-4)

According to Freud, many of the characteristics of normal mourning appear the same as those of melancholia, though he stipulates there is no identification with the deceased or loss of self-regard. The distinguishing features of psychogenic melancholia are cessation of interest in the outside world, self recriminations, expectation of punishment, loss of the capacity to love, and painful dejection (244). Mary won't leave the house, won't make friends; she blames herself for the death of Eugene and believes that the Virgin Mary is punishing her for being a "lying dope fiend." Her seeming incapacity to love and dejectedness lead directly to her injection of morphine for solace. Freud suggests that melancholics identify with a "lost" object. Upon losing the object, rather than directing to a new object, which is the healthy response, melancholics withdraw into themselves and establish a narcissistic identification with the abandoned object (Bradbury, 216). Frequently throughout the play, Mary is looking for a lost object: "What is it I came looking for? I know it's something I lost" (1010). This turn of phrase is conceivably



O'Neill's way of symbolizing the ideals and family members that Mary feels are lost to her. By focusing on her losses, she can punish herself again and again. Mary's grief has become pathological in the sense that she has become obsessed with her losses and can never heal.

Various treatments and cures for Mary have been alluded to throughout the play. Treatment for morphine addiction in the nineteenth century was a course of nine weeks in a sanatorium, where the patient received a combination of sodium bromide and a diminishing number of injections of morphine. Three days into treatment, the patient was comatose or nearly so. Mental confusion, hallucinations, and delusions of persecution were common when the effects of bromide wore off. As soon as the patient seemed sufficiently sensible, he or she was hypnotized with suitable suggestions (Miller, 1597). While this method may have been sufficient for reducing Mary's craving for morphine, it did nothing to resolve her melancholic issues, which were obviously hoped to be resolved simply with time and willpower.

By her entrance at the end of Act IV, Mary has descended into derangement due to her extensive morphine use. She is delusional and hallucinating and all together different from the woman that exited at the end of Act III, supposedly six hours earlier. O'Neill describes her in the stage directions: "The uncanny thing is that her face now appears so youthful. Experience seems ironed out of it. It is a marble mask of girlish innocence, the mouth caught in a shy smile" (1009). Mary has become the woman from her past. Steven Bloom, in "The Mad Scene: Enter Ophelia!" writes, "Transformed by the morphine, as promised, into a ghost hunting the past, she has become a ghostly image of her former youthful self, now existing in a realm of her own making, beyond the reach of the world in which she actually lives, and which she now enters (235). Jamie bitterly announces Mary's entrance with a reference to mad Ophelia, for which he receives a slap in the mouth from Edmund. Mary enters, completely oblivious to her family's commotion. O'Neill writes that they are "simply a part of the familiar atmosphere of the room, a background which does not touch her preoccupation" (1009). In a desperate attempt to reach her,

Edmund impulsively grabs her arm and cries, “Mama! It isn’t a summer cold! I’ve got consumption!” (1011). For an instant, she seems to come to her senses, but then retreats back into her morphine-induced delusion. She regards Edmund as some stranger and herself as a girl from the convent. “You must not try to touch me. You must not try to hold me. It isn’t right when I am hoping to be a nun” (1011). Edmund is devastated; he is very ill and needs the support of his mother, but she remains unavailable to him. Mary carries a wedding gown that represents the day that her dreams were broken and the beginning of her suffering as the future Mrs. James Tyrone. The gown her father bought for her symbolizes her idealized youth as well as her difficult adult life (Eisen, 107). The play ends with Mary having regressed into her idealized, virginal adolescence in an attempt to free herself from the oppressive present. In her distracted state, Mary speaks in present tense at the beginning of her monologue, but by its conclusion, she is speaking in past tense. This indicates that even in her deepest morphine-induced stupor she cannot quite escape from the present, but yet cannot wholly return to the past (Barlow, 82).

The allusion to the character in *Hamlet* is apt first because James idolizes and often quotes Shakespeare and secondly because Mary is, at this point, as deranged as Ophelia. Mary is also a fragile woman at center stage who often talks of loss and death and of a past that will never come again. There are many descriptors that suggest O’Neill may have consciously written the character of Mary to signify Ophelia in this last scene: Mary enters after playing the piano with her hair in braids and Ophelia, according to Quarto I, enters Act IV, scene v “playing on a lute, her hair down, singing” (qtd. in Berlin, 313). Mary’s outward appearance is that of a young girl, just as Ophelia is; both talk distractedly and make religious references; both Tyrone and Claudius make references to poison; Ophelia’s flowers are distributed for remembrance, just as Mary’s wedding dress commemorates the day her life changed (Berlin 313-4). Mary, dressed in blue like the Virgin Mary, has transformed into a distracted, aging Ophelia and O’Neill’s choice to use this iconography is fitting. Both Mary and Ophelia are bound by the

societal restrictions of women in a patriarchal society; what has happened in each of their lives has been determined by the men who control them. While adhering to societal expectations and obedience, these women have no voice, but through extremity they find a way to express themselves in madness. However, finding a voice does not permit them to change their fates, nor is either to be taken seriously in their madness.

The character of Mary Tyrone is an excellent example of how our early twentieth century understanding of mental illness was reflected on the stage. O'Neill was very knowledgeable about psychology and he used his knowledge and experience to write the story of the Tyrone family. Mary can be viewed as a melancholic in Freudian terms which are psychological rather than gynecological as previously understood. Nineteenth-century female expectations of total submission by the woman and where individualism was devalued frames Mary's life. Unfortunately anyone who did not fit the intellectual or psychological mold of these expectations had to find a way to adapt. Mary has failed in her first "duty" as a traditional mother. She has neglected the domestic demands of raising children and instilling in them the virtues of honesty, industry, frugality, and temperance and as a consequence, neither of her sons has any of these qualities. The selflessness expected of a mother in the early twentieth century also required Mary to sacrifice all her dreams. Though Tyrone claims that her dreams were unrealistic, he may have been simply diminishing her due to his expectations of the female role. Mary is too narcissistic to be of service to others; she was pampered as a vain, young girl and having moved immediately from the convent to married life, she never had the opportunity to mature into an empathetic adult. Having disassociated herself from her own mother in her early life, and sacrificed her personal goals, Mary was never able to find her own identity. She is now trapped psychologically in the artificial perfection of a social construct of mother-nurturer, distracted by her losses in life. Her inability to cope with the unrealistic expectations of the traditional mother role leads her to escape through a drug induced haze.

There, she is able to revisit her life as a young child, where there is no pressure to conform, be dutiful, or be responsible for her own life. She retreats into illness and uses morphine to immediately transport to a time and place of safety and withdraw from her present reality. She cannot heal. Time and willpower are no match for Mary's ills.

## MID-TWENTIETH CENTURY MADNESS

In the years after World War II, renewed attention was given to mental health, spurred in part by the growing need for mental accommodations for returning veterans. The disturbed mind was then considered incurable and many of those afflicted were institutionalized. Major reforms began when *The Shame of the States* was published in 1947 by researcher Albert Deutsch. It revealed the appalling state of asylums: no single state mental hospital in the U.S. met the minimum standards established twenty years previously by the American Psychiatric Association. The exposé drew on images of the Holocaust to establish that mental hospitals rivaled the Nazi concentration camps in standards of care and treatment for their patients. Interest in psychology grew and was not limited to mental health reform. The science of psychiatry turned into popular discourse; psychiatry and psychology were the new religion and psychiatrists were the new gods (Caminero-Santangelo, 5-6). Freudian psychoanalysis was well-accepted and answers were frequently found within the confines of this discourse until the 1960s.

Predictably, in the ongoing pursuit of an association between madness, femininity, and social arrangement of gender roles, the industry looked in the post war years to family structures where women, those primarily responsible for home and family, would receive the brunt of the shifting emphasis. As noted by Betty Friedan in *The Feminine Mystique*: “All of us went back into the warm brightness of home...[We] shrugged off the bomb, forgot the concentration camps...[and] avoided the complex larger problems of the postwar world... in a catch-all commitment to ‘home’ and ‘family’ ” (qtd. in Caminero-Santangelo, 53). As veterans came home to seek stability in the idealized image of domesticity, women’s wartime efforts were curtailed in order to service male employment or reemployment. This

reconfiguration did not sit well with women who had established work place positions outside the home. In an effort to keep women from exploring ranges beyond the domestic, women's angst was pacified by the suggestion that women in their traditional roles were already many things at once, (such as chef, nurse, chauffeur, maid) and they were not required to fill the male role as well. Women were encouraged to be content with the roles they were most "suited" toward (Caminero-Santangelo, 96). Just as it had been at the turn of the century with women's suffrage, the patriarchy was once again threatened mid-century by changes to socially constructed ideas of femininity and order.

Perhaps it not surprising then, that when several women such as Eudora Welty, Jean Stafford, and Hortense Calisher wrote about madness in the 1940s, '50s and '60s, their discourse was associated with female protagonists who were widowed, divorced, or simply decided not to marry. Other popular novels appropriated madness themes and stereotypes which constituted variations on the genre: *The Snakepit*, (1946); Sylvia Plath's *The Bell Jar*, (1963); and *I never promised you a Rose Garden*, (1964); as well as autobiographical accounts of psychotic experiences such as Lara Jefferson's *These Are My Sisters* (1952). Interestingly, just as the idea of multiple feminine roles, such as wife, mother, and professional had become socially threatening, a new form of madwoman took shape in American popular culture in the mid-1950s: that of the female multiple personality. This disorder was the subject of fiction, film, and a nonfiction case study; in all of them the patient was a woman. *The Three Faces of Eve* is the most memorable of this trend (Caminero-Santangelo, 10, 95). Doris Lessing's fiction in the 1960s used madness as an interpretation of schizophrenia, a response to conflicting social demands and a form of rebellion. In her book, *The Golden Notebook*, published in 1962, Lessing experiments with a literary form that replicates the split quality of the schizophrenic psyche, representing a view of the female experience (Showalter, *Malady*, 238).

The 1960s brought many revolutionary cultural and political movements, including changes to mainstream psychiatry, where the very basis of psychiatric practice was characterized as repressive and controlling. The anti-psychiatry movement's argument was that psychiatric illness was not necessarily medical in nature, but social, and the focus shifted to social contexts that determined madness, such as the emotional dynamics of the family. An international trend developed of renewed interest in madness, its history and social dynamics. Its advocates were Michel Foucault in France, R.D. Laing in England, and Thomas Szasz and Erving Goffman in the United States, leaders who brought forth a host of new, radical theories of madness as a social construct. Foucault, (1926-1984), became a leading figure in this movement. He argued that the social construct of madness was separate from mental illness and that madness in its many forms such as mania, melancholia, hysteria, and hypochondria have served varying purposes in different periods in history. Foucault gave form to the complexities of the social dynamics of mental illness and argued that anything that attacked the institution of the family came to be a sure sign of madness (Caminero-Santangelo, 52). R. D. Laing, (1927-1989), was also a key authority figure within the movement. He argued that madness was not the result of an inherited weakness, as evolutionists had claimed, or incomplete development, as Freud had suggested, but rather a strategy that a person invents in order to survive in an untenable position (Caminero-Santangelo, 8). A diagnosis of mental illness was simply one possible response to behaviors that violated social expectations. Laing worked with chronic female schizophrenics in the 1950s. He experimented with twelve hopeless patients, creating a special environment for them and attempting to reach them through personalized therapy. All the patients improved dramatically and this experience made him aware of the importance of the human bond, a kinship between therapist and patient versus a relationship based on power relations (Showalter, *Malady*, 226). Thus, Laing became a leader of the anti-psychiatry movement by introducing humanism into the practice. With his concepts of madness, sanity, and the importance of self, he became the mentor of the

psychiatric counterculture in all its political, psychedelic, and mystical manifestations. His books provided discourse for leftist thought, the drug culture, the eastern religious revival, and the new women's movement (Showalter, *Malady*, 223).

Anti-psychiatry attacked the hierarchical authority structure of the doctor-patient relationship, institutional environments, and treatments such as psychosurgery and electroconvulsive therapy. It replaced compulsory institutionalization with attentive noninterference and opened up the psychiatric experience to new avenues of thought. In theory, anti-psychiatry was responsive to the needs of women: it offered opportunities to relook at the relationship between madness and femininity and female madness as the product of women's repression and oppression within a patriarchal society (Showalter, *Malady*, 221-2). In practice, anti-psychiatry was male-dominated and unaware of its own sexism. However, the theorists of the anti-psychiatry movement were important for their political impact on the humanization of psychiatry and for creating discourse about the complex problems and purposes of mental health. Laing later came to believe that mental disease was merely a societal label that was applied to anyone that had not adapted sufficiently; schizophrenia was found to have a chemical causation and Laing, wasted by drug use, lost his reputation. The movement died in the 1980s (Showalter, *Malady*, 246-7). During this period, Freudian psychoanalytic theory, (the basic premise that both conscious and unconscious forces are working together), had been found to enforce gender stereotypes, maintain women's powerlessness, and pathologize women's anger, which simply reinforced the social oppression of women. Thus, traditional psychoanalysis was rejected by many feminists in the 1960s and '70s as being misogynistic. They looked instead toward a woman-centered, nonsexist, non-blaming perspective, encouraging cooperation and solidarity rather than isolation (Ussher, 201). Feminist Therapy was developed as a means of understanding women's response to subjugation to the patriarchy. Its early adherents were psychotherapists, primarily women, who transformed their protests against sexism in the mental health



professions into the development of a viable alternative for women seeking psychotherapy. Today, Feminist Therapy theory offers an understanding of how a subordinate position in the world due to gender, sex, age, race, ethnicity, etc., can be so internalized as to cause mental illness. Feminist Therapy places the marginalized person and her power (or lack of it) at the center of the debate. The patient is encouraged to consider her oppression and own her true feelings and express them (Ussher, 194).

## REEMERGENCE OF HYSTERIA

Hysteria reemerged as a mental disorder in the 1960s. It was renamed hysterical personality disorder, though it carried the same negative connotations. The renewed interest was related to the emergence of the feminist movement and changes in gender roles, the understanding of sexuality, and in the social relations of power. The reintroduction of hysteria signaled an effort to return to a more traditional conception of women's roles (Jimenez, 157). Symptoms were remarkably similar to those of nineteenth-century hysteria: uterine complaints and difficulties with the role of wife and mother were most often cited. In the Diagnostic and Statistical Manual of Mental Disorders (DSM), second edition, the childlike qualities of the nineteenth-century hysteric continued to characterize the disorder: "excitability, emotional instability, over reactivity and self dramatization" (qtd. in Jimenez, 158). In both centuries, we find the hysteric to be characterized as attention-seeking, manipulative, seductive, immature, self-centered, and dependent on others. Hospitalized hysterical patients were demanding, flamboyant, riotous, and calculating. Twentieth-century hysteria was found to be psychologically, rather than reproductively based (Jimenez, 158). Psychiatrist Paul Chodoff argued that women's powerlessness led patients to find control through hysterical behaviors. Further, he argued that the root of the condition was of a patriarchal derivation. He wrote, "Women suffer these afflictions or behave in this fashion not because of anything inherent in their nature. Rather, they are prone to hysteria because of cultural and environmental forces. A major component of these forces is male domination as through the ages men have produced, or rather have invented, the myth of a unique femininity" (546).

Concerns about women deviating from prescribed gender roles led to the introduction of borderline personality disorder which replaced hysteria as a diagnosis in the 1980s. The fourth edition of the DSM describes the disorder as: “A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts” (qtd. in Jimenez, 162). Further characteristics include: fear of abandonment; unstable mood, relationships, and sense of self; impulsivity; damaging behaviors; paranoia; and anger. Similarities between the borderline personality disorder and hysteria are striking: both reflect women’s roles and choices and both attempt to determine appropriate or normative behavior for women. What distinguishes borderline personality disorder is the inclusion of nontraditional female behaviors: anger, being argumentative, irritable, and sarcastic as well as a tendency toward risky behaviors such as shoplifting, reckless driving, and substance abuse. Hospital records from the nineteenth and early twentieth centuries show that sexuality outside traditional venues has been pathologized. Sexual promiscuity is also frequently mentioned as a sign of borderline personality in women. Thus, women that display behaviors that are seen as masculine or aggressive are now current indicators of mental disorder for women. Dependent personality disorder first appeared in the psychiatric classification system in 1980. Its criteria embody the qualities associated with the traditionally feminine gender: the patient lacks self confidence, is unable to make decisions, needs reassurance, and has difficulty disagreeing with others. Where once, these qualities were accepted as traditional, they are now deemed inappropriate in a post-feminist society. Worse, they are seen as signs of a psychiatric disorder. These revisions of psychiatric “norms” offer a moral and psychological guideline for what is acceptable behavior for women, just as hysteria classified women of earlier eras. According to Mary Ann Jimenez, Professor of Social Work at California State University at Long Beach, the introduction of these new diagnoses was not accidental. She writes:

It was related to the social and cultural gains women achieved in the 1970s, when many middle-class women moved into the public sphere, increasing their independence and reshuffling gender roles. These personality disorders define the mentally healthy woman as one who is renewed and energized by social change and no longer dependent on men, but neither angry nor aggressive. According to the criteria, a woman who is mentally healthy restrains her sexuality and does not use her new powers to manipulate men. (166-7)

Together, the classifications for borderline personality disorder and dependent personality disorder demonstrate psychiatry's ability not only to quickly respond to societal changes in gender roles but to define and limit behaviors for women through medical diagnoses. Psychiatry has bracketed normative behaviors for women: behaviors deemed too masculine are pathologized and so too are once traditional behaviors. The medical profession continues to dictate what constitutes mentally healthy behavior for women.

## FEFU AND HER FRIENDS

Written in 1977 by Maria Irene Fornés, *Fefu and Her Friends* explores the lives of contemporary women and feminist issues of the period. The structure of the play, the topic, and the tone are clearly feminist, but the play is a social analysis rather than a critique. Says Fornés, “The play is not fighting anything. My intention has not been to confront anything” (Pevitts, 319). Fefu has invited seven of her friends to her home to rehearse for an upcoming charity event for education. Through various conversations and encounters throughout the play, each woman's individual character and voice comes into focus; none are cloaked by roles of mother, wife, or daughter. This is the portrayal of characters searching for identity, depicting the variety of women's responses to violence, fear, and pervasive sexism. Fefu and Julia are the most multifaceted of the characters, but each of the other women has her own specific differences, attitudes, and desires as well.

Maria Irene Fornés claims that she set *Fefu and Her Friends* in 1935 because of an affection she has for a time in the world, before Freud, where people accepted each other at face value and did not try to constantly reinterpret meaning (Marranca, 109). There are some historical parallels between the state of feminism in 1930 and 1970. Both were periods of re-entrenchment after organized feminist activism; both periods encountered a feminism backlash supporting a return to domesticity and family values. Fornés also makes reference to early feminists in the text: Voltairine De Cleyre, Isadora Duncan, and Emma Sheridan Fry, who all struggled against conditioning by social forces. With their inclusion, Fornés asks us to view the play in relation to the social change movements and strategies of both the 1930s and 1970s (Kent, 141-3).

Most prominent in the play is that society places value on men and but denies women. “Women are inferior beings,” wrote Nobel Prize winner Octavio Paz, in *The Labyrinth of Solitude* in 1950. “Their inferiority is constitutional and resides in their sex... which is a wound that never heals” (qtd. in Fuchs, 87). And indeed, this is the ingrained perception that Fefu and her friends rebel against; this is the “wound” that has been bandaged. Fefu finds women bitter and erratic, with little natural strength. She declares, “Women are restless with each other. They are like live wires... either chattering to keep themselves from making contact, or else, if they don't chatter, they avert their eyes... like Orpheus... as if a god once said ‘and if they shall recognize each other, the world will be blown apart’ ” (631). The men in this play never enter the scene, but still have a dominant presence, just as men hold the power in society. Fefu uses a stone metaphor to describe how she understands the male/female dynamic. The stone is society; the men live on the outer most surface, possessing the smooth, clean side, taking advantage of a world brought by privilege. Women live on the same stone world, but underneath, where it is dark and dank, where women are not given the same rights as men, Fefu describes:

You see, that which is exposed to the exterior... is smooth and dry and clean. That which is not... underneath, is slimy and filled with fungus and crawling with worms. It is another life that is parallel to the one we manifest. It's there. The way worms are underneath the stone. If you don't recognize it... (Whispering)... it eats you. (629)

Fefu's vivid description of the stone represents how women feel about the “loathsome” reality that has been created for them. If women do not realize and recognize this victimization, their identities will rot with the fungus and worms found there. Fefu's house is a symbolic venue for the play. Its “dark,” domestic spaces can be construed as female body parts and inner organs. Its rooms are tied to the needs of the body: the kitchen--the stomach; the bedroom--sleep and sex. The outside, that is, “the fresh air and sun,” is the male domain (Fuchs, 89).

All the characters are either victims of the patriarchy, or have witnessed the consequences to others who do not conform. Throughout the play, we are introduced to each character's battle through intimate scenes. Fefu confesses to Emma that she is frightened by a constant pain that is not physical and not emotional, which suggests Betty Friedan's depiction of women's widespread unhappiness, identified as "the problem that has no name" in *The Feminine Mystique* (Kent, 122). Cindy relays a terrible dream about being molested by a doctor and policemen as she tries to demand respect; Sue reminds her classmates that smart women at their college who did not conform to traditional stereotypes were persecuted and labeled deviant, but Emma and Christina rely on standard tropes, describing them "crazy" or "nymphomaniac." Paula relates that she had always envied the advantageous rich until she "started noticing the waste" and how they were making "such a mess of it" (643). Later she describes the pain of breaking up with Cecelia, trying to make sense of their failed relationship. Cecelia discusses how women need to band together to survive: "We cannot live in a vacuum. We must be part of a community, perhaps 10, 100, 1000" (639). Julia, possibly the most complex character in the play, struggles with madness. Paralyzed and in a wheelchair, she suffers realistic hallucinations of being beaten and tortured. She shares with Cindy, "I feel we are constantly threatened by death, every second, every instant, it's there" (642). These scenes represent a wide spectrum of contexts and individual experiences in which the characters cope with and respond to oppression and interpersonal problems.

Among the friends, Fefu at least seems to find a way to deal with the challenges involved with living in a society which denies the validity of femaleness. Fefu has re-appropriated male activities which, presumably, guarantees her a greater degree of self-sufficiency, even if this male identification is a coping mechanism (Farfan, 445). Although she is married to a man who finds her "loathsome," she claims to like being and thinking like a man; she fixes toilets, hunts, and plays at shooting her husband as if he were a target at the fair. Just before she exits to check on her handyman job upstairs, she asserts to Christina and

Cindy, "Plumbing is more important than you think" (631). In addition to being able to do "man's work," the plumbing refers to the interworkings of the female body. Fefu suggests that women as a group have been taught to undervalue their femaleness (Geis, 297-8). Despite the light banter she uses throughout the play, Fefu admits to Julia the reality of her marriage: "He's left me. His body is here but the rest is gone. I exhaust him. I torment him and I torment myself. I need him, Julia. . . . I need his touch. I need his kiss. I need the person he is. I can't give him up" (644) Fefu confesses that she cannot survive without Phillip and realizes the extent to which she is emotionally dependent on a man.

Fefu is one feminist protesting the patriarchy in the ways available to her. On the other end of the spectrum is her friend Julia, whose sufferings in her hallucinations are more visceral than Fefu's desire to be more like a man. Elaine Showalter in *The Female Malady* writes:

[H]ysteria and feminism do exist on a kind of continuum. . . . if we see the hysterical woman as one end of the spectrum of a female avant-garde struggling to redefine women's place in the social order, then we can also see feminism as the other end of the spectrum, the alternative to hysterical silence, and the determination to speak and act for women in the public world. (161)

Julia suffers from an apparently psychosomatic illness that became evident a year earlier when a hunter's shot at a deer caused her to collapse. Both Julia and the animal convulsed; it died, but Julia did not. The deer (a purifier of venom and poison) symbolizes the power that Julia has lost (Fuchs, 88). She has not walked since the accident and still occasionally blacks out, having converted her internal pain into a debilitating physical ailment. The same social isolation and rejection that Fefu and the other friends experience cause severe and dramatic consequences for Julia. Fefu describes how Julia used to be: "She was afraid of nothing. . . . She knew so much. She was so young and yet she knew so much" (632). Julia has been diminished by the fight; she is weary and feels constantly threatened by death. She is Showalter's and Cixous' hysterical woman: she internalizes the pain and is silenced, unable to speak for



herself. Julia reveals during her hallucination in Part Two that the onset of her madness was a punishment for having gotten “too smart.” For Julia, life as a woman is empty and meaningless. She describes her torture:

They clubbed me. They broke my head. They broke my will. They broke my hands. They tore my eyes out. They took my voice away. They didn't do anything to my heart because I didn't bring my heart with me. They clubbed me again, but my head did not fall off in pieces....I was good and quiet. I never dropped my smile. I smiled to everyone. If I stopped smiling I would get clubbed....I repented. I told them exactly what they wanted to hear. They killed me. I was dead.  
(636)

The conditions of her “survival” are now to live, live crippled, but only if she is to remain silent about what she knows of patriarchal authority. She attempts to appease her “judges” by reciting a “prayer” that denigrates women. The judges tell her that she must believe the prayer as all other women have done. If she does not, the judges will beat her. Julia, in her paralysis and fragile mental state, conveys the theme of the repression of women. Until the end of the play, Julia remains covertly defiant, refusing indoctrination in an attempt to save her friend Fefu, whom the judges seem to be pursuing next (Farfan 443).

This scene in the bedroom coincides with three other scenes that occur simultaneously in separate spaces: on the lawn, in the study, and in the kitchen. The audience is divided into four groups, each of which is guided to a different space to witness the scenes. By moving the spectator from his or her single, unified perspective, Fornés has created a dramatic, multiple points-of-view narration without destroying the theatricality of the piece (Keyssar, 99-100). During Julia's hallucination, she lies on a mattress in a medical gown; the audience gathers around her, reminiscent of the medical students surrounding the hysterical patient at Charcot's lecture demonstrations at the Salpêtrière in 1870. The boundaries between

actor and spectator, and character and judges blur into meta-theatricality. The audience becomes unclear whether Julia is implicating them in the crimes against women (Fuchs, 95).

In the final scene of the play, Fefu divulges her dependence on her husband and asks Julia for advice, but she can see in Julia's eyes something of her constant struggle that has now become overwhelming. Julia is prepared for death. Panicked, she shakes Julia violently and tells her to fight against her persecutors; she begs her to walk. Julia is too exhausted to battle any longer and proceeds to "bless" her friend, wishing her protection from what she herself has suffered in such a way as to echo the hallucination monologue: "May no harm come to your head...may no harm come to your will...may no harm come to your hands...may no harm come to your eyes...may no harm come to your voice...may no harm come to your heart" (644-5). Unable to accept what she perceives as Julia's passive surrender, Fefu takes action herself, exiting to the lawn with a loaded rifle. A shot is heard and immediately Julia puts her hand to her forehead. As her hand drops, we see blood on Julia's forehead and her head drops back. Fefu re-enters with a dead rabbit. Once more Julia suffers an indirect wound; this time, however, it is fatal. Julia's association with the deer and the rabbit, peaceful herbivores that are hunted by man, represents her victimization. Julia's position is clear: feminism is hopeless, no matter how much women struggle against the establishment (Chen, 5). The play ends in a final gathering of women. Julia's death signifies what women could do if they could acknowledge their own and each other's worth, in Fefu's words: "...if they shall recognize each other, the world will be blown apart" (631). Julia's identity created by the dominant culture is sacrificed so that a new self-determined female identity may emerge. The old world view must be abandoned in order for women to recognize their own and other women's strength. Fefu's shot can symbolically free the women from self-representations as victims and unite, as Cecelia saw it, into a community.

The concerns about women straying from feminine behavior and prescribed gender roles during the twentieth century are portrayed in *Fefu and Her Friends*. Each of the characters conveys a battle for identity while coping with and reacting to pervasive sexism; Julia, at one time outgoing and smart, is now punished for her behavior and battles for sanity. Fefu is still the woman that Julia once was and the play ends with her fate yet to be determined. Had these characters been real, several would likely have been diagnosed with a mental disorder. Fefu might have been determined to have borderline personality disorder for her “aggressive” nature. Julia would most certainly have been diagnosed as psychotic. Feminist Therapy, developed as a means of understanding women’s response to patriarchy, would have allowed Julia the ability to speak out through the pain, enabling her to find her voice, and nullifying her judges’ condemnations. This play does not presume to overthrow the patriarchy; it is a call for solidarity among women who struggle despite various kinds and degrees of internalized oppression. Maria Irene Fornés’s thought provoking play causes us to question our own assumptions about women and genders as well our own position in a misogynist society. Where do we fall on the feminist spectrum and how do we battle the conditioning? How will we work toward social change? It is a wakeup call. In Fefu’s words, “If you don’t recognize it, it eats you” (629).

## MODERN MADNESS and its DEPICTIONS

Recent research in genetics, neurochemistry, brain imaging, and psychopharmacology has caused a paradigmatic shift in psychiatry in the past thirty years, moving from the Freudian psychodynamic model where the damaged psyche is the cause of mental illness to a neurological and biomedical model, and likens it to physical disease. As the leading cause of disability in the United States, mental illness has become a major concern and unfortunately the biomedical model does nothing to include aspects of social injustice and discrimination that cause distress in this area (Wallin). Today, an estimated 43.7 million adults in this country have a psychosocial disability—anywhere on the spectrum from generalized anxiety to schizophrenia. Ten million more are women than men. One in seventeen—over thirteen million Americans live with a serious mental illness, (defined as one that substantially interferes with life activities), and approximately six million people cope with bipolar disorder (“Statistics”). Many of these persons are jailed, homeless, or otherwise indigent and are receiving no care whatsoever. Increased publicity regarding high profile sufferers as well as psychosocial disability as it relates to violence has brought the topic of mood disorders into the public sphere. Realistic portrayals of mental illness are increasingly prominent in television and film. Awareness-raising shows such as *Homeland*, *Shameless*, and *Girls* depict protagonists with bipolar disorder who experience a variety of symptoms including impulsivity, paranoia, risk taking, and having trouble distinguishing reality from delusion. These shows portray realistic manic and depressive episodic behavior while living reasonably well-adjusted lives. Dr. Vasilis Pozios, forensic psychiatrist and member of the American Psychiatric Association, believes that accurately portraying more characters with mental disorders in starring roles is quite encouraging:

It's becoming less rare to have accurate portrayals of mental illness. . . There are plenty of people who live and work and raise families and have mental illnesses like bipolar disorder. It's good to show this break in stigma to show people with mental illness are not outcasts or violent, but it also breaks the tropes of portrayals of mental illness in entertainment" (Sifferlin).

Shows and films of this type may focus on symptoms and side effects that can be extreme to provide dramatic entertainment, but generally they are shifting toward more normalizing, realistic portrayals and away from those that feature the mentally ill as dangerously psychotic. These shows may help those that struggle with mental illness and identify and with realistic characters. By increasing public awareness, normalizing in this way helps keep psychosocial disorders from being further stigmatized (Sifferlin).

These recent representations are a welcome change from the stigmatization of mental illness by decades of inaccurate portrayals in Hollywood. These depictions have a hugely negative effect on the perception of people with mental disorders by the general public, legislators, families, and the patients themselves (Hylar). Unfortunately, society perceives its understanding of mental illness from movies more than from any other type of media ("Mental Health"). The stereotype of the mentally ill as dangerously violent and deranged can be found in genre horror films from the 1960s, '70s, and '80s in films such as *Psycho*, *Halloween*, and *Friday the 13th*. Mainstream films are also guilty of reinforcing the stereotype in films such as *Silence of the Lambs*, *American Psycho*, and *Batman: The Dark Knight*. In fact, movie characters with mental health problems are now depicted as more demonic and cruel than at any time in film history, according to a 2009 report from *Time to Change*, an anti-stigma mental health campaign. Not only are we bombarded with violent films, but our pop culture is saturated with aggressive crimes perpetrated by the mentally ill; distorted images that emphasize dangerousness and criminality are widespread in entertainment and news. The media also model and reinforce negative behavioral reactions to the mentally ill, including fear, rejection, derision, and ridicule (Stuart, 99). An academic study by

Donald Diefenbach and Mark D. West, published in 2007, found mentally ill characters portrayed on several major television networks were ten times more likely to be violent criminals than those who weren't ill (Berson). Heather Stuart in her essay, "Media Portrayal of Mental Illness and its Treatments," argues:

In the U.S., one-fifth of prime time programs depict some aspect of mental illness and two to three percent of the adult characters are portrayed as having mental health problems. One in four mentally ill characters kill someone, and half are portrayed as hurting others, making the mentally ill the group most likely to be involved in violence. Overall mentally ill characters are portrayed as significantly more violent than other characters and significantly more violent than real people with mental illness. (100)

The clear and consistent message that pop culture sends is that mental illness is something to be feared. It remains true that people with severe mental illnesses are relatively more violent than members of control groups, though the percentage is small. However, this link between mental illness and violence is casual, not causal (Harper, 471). Overall, studies show that individuals with mental disorders are not more likely to commit violent crimes than the general population; indeed, these individuals are more likely to be victims rather than perpetrators of violence. Despite this, the public significantly overestimates the frequency of violence committed by people with mental disorders (Stuart, 102). We are bombarded by criminalizing stereotypes that reflect a very small percentage of persons with mental illness which the media sensationalizes and exploits for dramatic effect. Other stereotypes of the mentally ill in the media include self-centered attention-seekers, obsessive-compulsives, and the especially gifted in films such as *One Flew Over the Cuckoo's Nest*, *As Good as It Gets*, *Rain Man*, *A Beautiful Mind*, and *Shine*. These stereotypes only serve to stigmatize actual patients by ridiculing them and trivializing their problems or romanticizing them (Hylar). Oppressive tropes of madness are ubiquitous; they strengthen narrative, but

do so in ways that have little or nothing to do with actual psychosocial disabilities. Rather than illuminate and educate, such tropes invalidate and engender intolerance. The consequence of this misrepresentation and stigmatization is emotional and psychological distress which influences how the mentally ill view themselves (Wallin). Often sufferers have low self-esteem, avoid seeking help, refuse drugs, or stop taking prescribed medication. Overall recovery is seriously impaired. Media portrayals do little to convince the viewing public that people with a mental illness can recover or become productive members of society when characters are so frequently portrayed as disenfranchised. The media have also overdramatized the reputation of mental health professionals and side effects of psychiatric treatments. The horrifying images reflected in films and television have cast such a large shadow on the psychiatric profession that our opinions and prejudices are developed long before we meet someone with a mental illness (Stuart, 99-100). Stigmatization and stereotyping of mental disorders continues to reinforce feelings of shame and prevent people from seeking the treatment they need.

## NEXT TO NORMAL

Winner of three 2009 Tony Awards and the 2010 Pulitzer Prize, (becoming the eighth musical in history to receive this honor), *Next To Normal* is a contemporary rock musical with book and lyrics by Brian Yorkey and music by Tom Kitt. Like recent television programs that portray relatively realistic characters with mental illness rather than using old madness stereotypes, *Next to Normal* focuses on a woman's struggle with bipolar disorder and the effects of her illness on her modern suburban family. Diana is plagued with manic and depressive behaviors as well as hallucinations that trace back sixteen years to the tragic death of her baby boy. Though the family strives to establish some sort of normality and each character seeks coping mechanisms through delusions, denial, or drug abuse, relationships begin to break down. Diana seeks comfort through her delusions and re-creation of a happier past. In an effort to help her, Diana's husband Dan confronts his own confusion and denial; her daughter Natalie deals with isolation and feelings of abandonment and eventually resorts to drug use. Throughout the course of the show, Diana and her family try a number of strategies to cope with her instability, including talk therapy, pharmacological drugs, hypnosis, and culminating with electroconvulsive therapy (ECT).

Bipolar disorder, commonly known as manic depression, is a recurrent personality disorder that causes massive shifts in a person's behavior, mood, energy, and judgment, from feeling high and on top of the world, or uncomfortably irritable, to sad and hopeless. Bipolar cycles may last for a few days, weeks, or even months, and these mood swings can be so intense that the changes interfere with sufferers' ability to function well. Manic phases may also incorporate grandiose delusions, hyperactivity in thoughts and actions, less need for sleep, and excessively risky behavior. The depressed phase may include intense



sadness or despair, thoughts of suicide, trouble concentrating, and sleeping difficulties. Bipolar disorder may be misdiagnosed as depression since sufferers often seek help in the depressed phase. Occasionally, as in Diana's case, severe episodes of mania or depression include psychotic symptoms, such as hallucinations and delusions. Scientists generally agree that, rather than one single cause, there are many issues, including genetic and social factors that contribute to trigger episodes. Currently, the recommended treatment for bipolar disorder is a combination of long-term psychotherapy and mood stabilizing medication. Like all serious illnesses, bipolar disorder can disrupt a person's life and relationships with others, particularly with spouses and family members ("Bipolar Disorder").

*Next to Normal* has been enthusiastically welcomed by audiences and theater critics. Ben Brantley of *The New York Times* writes:

This brave, breathtaking musical focuses squarely on the pain that cripples the members of a suburban family, and never for a minute does it let you escape the anguish at the core of their lives. *Next to Normal* does not, in other words, qualify as your standard feel-good musical. Instead this portrait of a manic-depressive mother and the people she loves and damages is something much more: a feel-everything musical, which asks you, with operatic force, to discover the liberation in knowing where it hurts.

The nonprofit advocacy group National Alliance on Mental Illness (NAMI) have co-sponsored awareness nights in conjunction with performances of the play. Nancy Tobin, the executive editor of NAMI's magazine *bp*, claims that the show has become "a powerful ally in educating audiences" (qtd. in Wallin). Audience members have personally thanked Brian Yorkey and Tom Kitts for re-creating their personal stories of frustration with the psychiatry industry. Says Yorkey:

We picked the subject of bipolar disorder for the project because it was different and challenging and very compelling to us. We thought people would hate it, but they responded to it positively

from the very first. Really, at every step along the way, we kept hearing that same strong response and that's what kept it and us moving. (Tobin)

This six-actor rock musical is compelling not only for the unrelentingly intense, brutally honest story, but due in large part because of Tom Kitt's score, which earned him a Tony for Best Original Score and another for Orchestration (*Playbill*). The language of any musical is the music and the score of *Next to Normal* is not the standard Broadway pop, but hard driving rock and roll offset by passionate ballads, all emotionally authentic. Moreover, Kitts skillfully mirrors the fractured and erratic manic and depressive psyche of a bipolar mind, evoking in the music the tension and conflicts of the action. Critic Scott Miller writes that often instruments play in a "very dissonant harmony, telling us musically that there is something 'wrong' happening in the scene, even if only subtextually" (*Inside*). The musical also uses cinematic devices to further evoke the distracted state of Diana's mind; scenes dissolve into or interrupt each other. Thus, the musical is expertly written and scored to keep the audience off kilter and to force them to experience events just as Diana does. Miller asserts:

The audience is on this roller coaster ride with Diana, strapped in right beside her. And that ties into the central point of the story, that a person's illness affects not just them, but everyone in their orbit. And because of the way Kitt and Yorkey have told this story, we the audience are among those in Diana's orbit. We have to live in her illness, her delusions, her twisted world, with her for two hours. (*Inside*)

*Next to Normal* is one of the first major theater productions in the United States to present mental illness through a contemporary biomedical model, one that pronounces the disorder to be a product of genetic disposition and neurochemistry and excludes social influences. Diana's madness is depicted as genetic, inherited from her mother who exhibited dysfunctional behaviors. She shares with her psychiatrist, Dr. Madden, "When I was young, my mother called me 'high-spirited.' She would know.

She was so high-spirited, they banned her from the PTA” (39). Critics applaud Yorkey and Kitts for bringing to the forefront such a difficult topic and see *Next to Normal* as a positive step forward for representation of people with psychosocial disabilities. Though the musical attempts to destigmatize mental illness and thus help eliminate moral judgments, the biomedical approach to Diana’s illness essentially labels her brain “defective” and ignores all the individual social issues that actually affect this disability (Wallin). Thus, we tend to see Diana, not as a whole person (with friends and outside interests) living with a disease, we only see her *as* her disease.

To their credit, Yorkey and Kitts present Diana without resorting to familiar madness tropes used by the entertainment industry. While some critics take exception to the normative and non-marginalized values which markedly contrast with actual experience of the disease, the playwright sought to bring relatable characters to the show. Yorkey reports, “There were people who suggested that we make Diana an artist, a creative person, but we chose to make her an ordinary woman. Not everybody who becomes a great artist has this disorder and not everybody who has bipolar is creative” (Tobin). Several empathetic musical numbers describe the trials of dealing with a mental illness: “I Miss the Mountains,” “You Don’t Know,” and “I am the One” are a few. Nonetheless, normalizing the characters in the musical certainly sidesteps many of the stigmatizing aspects of an actual psychosocial disability. Diana’s symptoms are sanitized, a strategy that elicits empathy from the audience. Her manic behavior is limited to making too many sandwiches on the floor and a birthday cake for her dead son, Gabe. All other deviant behaviors are referred to in past tense. Diana's most extreme experiences take the form of hallucinations of Gabe, who she sees as the teenager he never became. But because we see him as a handsome young actor and singer behaving in a “normal” way, even Diana’s hallucinations are sanitized (Wallin). One critic notes, “One reason we like Diana so much and feel for her is that she never tries to hurt anybody or act indulgently,

she remains the innocent and confused victim who only tries to hurt herself to escape. I would dare say real bipolar sufferers get much scarier” (Warner).

Yorkey and Kitt consulted with both a psychiatrist and a psychologist who read drafts, revised, and gave recommendations for language and treatment. Yorkey says, “. . .[W]e wanted the doctors to behave as competent, well-meaning, helpful doctors would -- as, indeed, we believe most doctors do. Our goal was not to indict medicine in any way -- far from it. Our goal was to show how insidious the disease is, how challenging to diagnose and treat” (Read). Yet the musical seems to send a moral message about the evils of psychiatry and depict the failures of pharmacology and electroconvulsive therapy. Dr. Fine and Dr. Madden, (in the musical played by the same actor), represent psychiatry as a faceless industry. Dr. Fine, the pharmacologist, reduces Diana’s experiences and history into one psychiatric diagnosis: “Goodman, Diana. Bipolar depressive with delusional episodes. Sixteen-year history of medication. Adjustment after one week” (18). In several speeches and a musical number entitled, “My Psychopharmacologist and I,” Dr. Fine rattles off the directions for taking the litany of pharmaceuticals, not only making light of the frequent trial and error aspect of treatment but the vast number of pills dispensed: “The pink ones are taken with food but not with the white ones. The white ones are taken with the round yellow ones but not with the triangle yellow ones. The triangle yellow ones are taken with the oblong green ones with food but not with the pink ones. . .” (16). When Diana complains about the side effects of the drugs, Dr. Fine’s cavalier attitude about long term treatment is indicated when he says, “So we’ll try again, and eventually we’ll get it right.” She counters, “Not a very exact science, is it?” (18). He makes three adjustments to her medications in five weeks, but the list of side effects continues to grow. After seven weeks, Diana reveals that she feels emotionally empty: “I don’t feel like myself. I mean, I don’t feel anything” to which Dr. Fine responds, “Hmpf. Patient stable” (22). Once Diana rejects medications as a solution to her distraction, she agrees to see the psychiatrist, Dr. Madden. He tells her,

“Often the best we can do is put names on collections of symptoms,” (39) which is an accurate portrayal of the nature of psychiatric treatment. As if determination were enough to solve her complex illness, Dr. Madden counsels Diana on having the willpower to succeed with treatment:

Make up your mind that you’re strong enough.

Make up your mind-let the truth be revealed.

Admit what you’ve lost

And live with the cost...

At times it does hurt to be healed. (46)

As Diana sings about her sense of depersonalization during treatment, Dr. Madden remains silent, professional, and only indirectly responsible for any side effects she experiences. He shifts from one treatment to the next, to what ultimately ends up being ineffectual management of her illness. Yet, Yorkey and Kitts were interested in depicting doctors who struggle daily to find the right treatments. Says Brian Yorkey, “One thing we said early on—and it was tough to get it as right as we could—was that we were not interested in setting up a straw man of a doctor who was part of the problem” (Tobin).

By consulting with members of the psychiatric profession, Yorkey and Kitts were able to establish the language that suggests Freudian aspects to the text. Dr. Madden counsels Diana on the loss of her child: “Unresolved loss can lead to depression... Fear of loss, to anxiety... the more you hold on to something you lost... The more you fear losing it” (49-50). Though influenced by years of consuming multiple medications, Diana’s madness was originally triggered by the loss of her child. This points to Freud’s definition of melancholia, which assumes that the patient identifies with the “lost” object and withdraws into herself. Diana’s grief, like Mary’s in *Long Day’s Journey Into Night*, has become pathological. She cannot help herself heal. Others step in to “fix” her and she allows that to happen.

Diana abandons her medications and uncontrolled mania is the result. This slides into a suicide attempt. Dr. Madden suggests electroconvulsive therapy and paints a more optimistic picture than the media routinely depicts:

It's the standard in cases like this. She's got a long history of drug therapy and resistance, she's acutely suicidal—it's really our best option. . . . The electricity involved is barely enough to light a hundred-watt bulb. . . . It's safer than crossing the street and the short-term success rate is over eighty percent. . . . The aftereffects are minimal. You'll feel a bit like you have a hangover. . . . A minority of patients report some memory loss, but it's usually not much memory. . . . Patients have said it's like becoming a new person. . . . The modern procedure's clean and simple. Hundreds of thousands of patients receive it every year. (53, 56)

Diana's husband, Dan consents to the procedure in fear of lack of treatment options. Natalie, her daughter is appalled and incredulous at the suggestion of ECT: "My mom is in a hospital being electrocuted. . . . Seriously—she gets it like every day for two weeks. I can't even deal. I'd never let them fuck with my brain like that" (59). Diana sings "Didn't I See This Movie?" which makes several references to *One Flew Over the Cuckoo's Nest*, one of the most influential movies depicting stigmatized, negative images of electroconvulsive therapy. Even though she calls herself "nuts," Diana doesn't think of herself as unbalanced enough to warrant ECT. She relents, wondering how she ever came to this position in her life. As Diana receives a shock treatment, she sings "Wish I Were Here," which uses language to describe the cumulative physical and emotional side effects of bipolar treatment.

Electroconvulsive therapy, first used in 1938, is still firmly established as an important and effective treatment for certain severe forms of depression and especially for those patients, such as Diana, who do not respond well to medications. As ECT is currently being practiced, patients (after informed consent, which is *not* depicted in the musical) are injected with muscle relaxants, then put under brief

general anesthesia while being given oxygen. ECT consists of a burst of electricity (lasting 35 to 80 seconds) to the head to stimulate a grand mal seizure. The patient's body tenses and convulses. Consciousness is usually regained rapidly but patients typically experience a brief period of disorientation immediately after seizure induction and headaches are quite frequent. Varying degrees of amnesia is common and usually related to recent world events rather than personal long-term memory. After treatment, the memory usually returns in a few weeks or months, but may be worse in patients with unrelated pre-existing cognitive impairments such as dementia. Treatment for depression is usually a course of six to twelve sessions, with two or three per week. Medications and psychotherapy are commonly given after a course of ECT is completed. No one is sure why electroconvulsive therapy seems to work; certainly putting an electric current into the brain seems like a bizarre way to treat an illness. It is hypothesized that the seizure caused by ECT may be related to its ability to increase cerebral blood flow and metabolic activity in specific neural regions of the brain (Gomez, 476- 480).

Though electroconvulsive therapy has been shown to be effective and the mortality rate is comparable to or lower than accepted antidepressant medication (Dowman, 84), it remains a highly stigmatized, controversial treatment. Powerful and dramatic film portrayals of ECT that represent brutal oppression and abuse rather than clinical treatment, (such as that in *One Flew Over the Cuckoo's Nest*), negatively influence public attitudes toward the therapy. Of the twenty-two American films depicting ECT, few show any positive benefits and most portray negative consequences or even death as a result. Side effects depicted include everything from listlessness and confusion, to memory loss, aphasia, personality change, and zombification (McDonald, 200-202). These movies contribute to an erroneous view that ECT is punitive in nature. Patients legitimately fear the treatment; some associate it with execution by electrocution. They also have anxiety about being conscious during the shock or having a memory of it, or sustaining permanent brain damage. Many simply consider the treatment barbaric

(Dowman, 84). There was a period of inhumane abuse in the early twentieth century when the treatment was being performed without the use of anesthesia (Smith, 79). This ghastly reputation was reinforced by adverse effects such as bitten tongues and fractured bones and teeth (Glass, 1346). Lobbying groups against ECT began forming in the early 1970s, founded by survivors who claim to have been severely physically or emotionally damaged by their experience (Dowman, 86).

Electroconvulsive therapy is generally considered by the public to be an extreme form of treatment and used only as a radical, last resort option. It is therefore not surprising that Diana, Dan, and Natalie are shocked to find the treatment suggested by Dr. Madden. Yet for many people the treatment is a valid and preferred option with minimal side effects (Morrison, 164). Many clinicians believe that ECT should be considered a first-line treatment, especially for suicidal or other at risk patients. Statistically, patients seem to be satisfied despite side effects. Patients who recover from their illness claim they function better than they did during their illness, and this seems to compensate for negative side effects (Gomez, 473-4). Extreme memory loss is still a concern, as depicted in *Next to Normal*. Though Diana regains most of her memories, she initially loses nineteen years worth of personal memories, which is extremely rare and seems to be used in the musical for dramatic effect rather than realistic depiction. Some patients do claim that they have gaps in their recollection of personal history, or have otherwise developed devastating cognitive consequences from ECT. Such results are certainly less common, but are the basis for much of the anti-ECT sentiment (Fink, 6) and are measured by the profession against the majority of success stories in treating a debilitating illness that has a mortality rate as high as fifteen percent (Glass, 1348). A study by ECT.org resulted from repeated patient complaints that memory deficits and cognitive disturbances following electroshock were being dismissed by many practitioners. Doctors have maintained that patients do not understand true memory deficits, or claim that the memory problems result from underlying illness, and not as a direct result from ECT. One important finding in the



study is that patients who feel they have been damaged by electroshock do not return to the doctor who performed the treatment to discuss the problem. Instead, they simply move on to another doctor, or leave psychiatric treatment altogether. It appears that this patient feedback is not being captured which would clearly bias published success rates of ECT (Lawrence). Further research is indicated.

In the final scene of *Next to Normal*, Diana decides to abandon her immediate family network and therapies. Through a moving song entitled, “So Anyway,” she laments having to leave:

So anyway, I’m leaving.

I thought you’d like to know.

You’re faithful, come what may,

But clearly I can’t stay,

We’d both go mad that way—

So here I go.

And anyway, I’m leaving—

I guess that you can see.

I’ll try this on my own.

A life I’ve never known.

I’ll face the dread alone...

But I’ll be free. (97)

Diana decides she needs to face her demons alone. Her recovery is negatively impacted by her dysfunctional family unit. This scene represents the family support breakdown in the lives of many of the mentally ill and illuminates a greater need for support networks and counseling for family members.

Additionally, the scene seems to be an endorsement to abandon science in an attempt to “heal thyself.” In his review of the musical, theatre critic Chris Caggiano denounces the play’s message as uninformed and

dangerous: “Diana confronts her psychiatrist and says she doesn't want to take drugs, undergo ECT, or do any talk therapy any more. Which is bad enough, but then the show launches into a ‘You're Gonna Make It After All’ kind of vibe that seems to be sanctioning the fact that Diana has given psychiatry the middle finger. Effectively, Yorkey and company are saying that Diana is better off without the ‘interfering’ hand of science and medicine” (*Everything*). Many patients experience Diana’s frustrations with mood disorder treatment. The musical emphasizes all the downsides of treatment for bipolar disorder and portrays health professionals as anonymous, and psychiatric treatment, at best, as an experimental solution to a complex problem.

A true difficulty lies in attempting to render the emotional and cognitive chaos of psychotic illness without misrepresenting or trivializing the experience as simply a mass of symptoms or conform to decades-old stereotypical behaviors, but *Next to Normal* provides realism. Rather than reflect an oppressive society as we have seen thematically presented in the previous two plays, Yorkey and Kitt have written a show that helps us understand the fragmented and deconstructed world of one woman. Through lyrics, score, and staging we are helped to understand her mental state by experiencing her broken perception of reality. The musical uses a biomedical model of a psychosocial disability in a way that somewhat sanitizes the representation of people who have bipolar disorder, but ultimately tells the story of Diana’s long and complex struggle in a way that honestly represents many patients’ experiences and addresses the stigma attached to mental illness. *Next to Normal* does not present madness as a female gendered malady, nor does it present the message that women are weak, dangerous, and require containment. Initially Diana is depicted as a fragile and innocent victim of the system, but ultimately we see her refusing to be contained as she abandons traditional treatment and steps away from the systems that enable behaviors and trigger episodes. Rather, the musical highlights the fact that as a single solution to mental health problems, treatments provided by the psychiatric industry are inadequate. Brian Yorkey

and Tom Kitts present bipolar disorder from a contemporary understanding of mental illness, highlighting a previously taboo subject in an honest and empathic way. The play provides a solid framework for us to question the status, ethics, and efficacy of modern psychiatry and mental health care in our society.

## CONCLUSIONS

As early as the seventeenth century, the files of the Dr. Richard Napier showed nearly twice as many cases of mental disorder among his women patients as among men. Women continued to be predominantly the patients of public lunatic asylums in the nineteenth century. Today, women are the majority of patients in psychotherapy and at psychiatric hospitals and outpatient mental health clinics (Showalter, *Malady*, 3). According to the National Institute of Mental Health, ten million more women than men in the U.S. suffer from a mental illness. Reasons for this are extremely complex. Feminist discourse regarding the historical and political repression, social expectations, and resulting illness of women is revealing, disquieting, and speaks for itself. Women have been and continue to be positioned as “other” and labeled as deviant when they do not subscribe to socially constructed ideas of femininity within the social order. Additionally, it is clear that throughout history, female mental illness can be considered at some level an act of rebellion. Oppression and subjugation of women is, simply put, built into the fabric of our society. An attempt to understand women’s madness is to acknowledge that which has regulated women’s lives for centuries. But, as feminist critic Shoshana Felman notes, depressed and ill women are not about to seize the reigns of the patriarchy. Quite the opposite of an uprising, madness becomes a *call for help*, a manifestation both of political and societal impotence (21-22). It may be fruitless to ever attempt to separate femininity and mental illness, for the two are inextricably intertwined. Images of the female body have stood for irrationality throughout history. Women have been depicted in art and literature as beautiful, weak, and distracted, creating a cultural tradition that represents “woman as madness” (Showalter, *Malady*, 4).

Obviously it is not something in femaleness per se that makes women mad. We must look within the social construction of womanhood for answers. Mary, Julia, and Diana all experience certain extenuating conditions beyond femaleness that impact their illnesses. Mary Tyrone in *Long Day's Journey Into Night* finds herself trapped psychologically in nineteenth-century expectations of total submission. The framework that devalues her individualism shapes her married life. She fails in selfless traditional "duties" such as mothering the perfect children and keeping the perfect home. Mary's inability to cope leads her to escapism through drug use. The theme of straying from traditional roles is further explored in *Fefu and Her Friends*, written thirty-two years later during the second wave of feminism. Each of the characters conveys a battle for identity while coping with and reacting to pervasive sexism. Julia, in particular, battles for sanity and finally succumbs to the pressure of fighting the patriarchy. Produced thirty-two years later on Broadway, *Next to Normal* tells a realistic picture of one woman's battle with bi-polar disorder rather than using societal oppression tropes. Diana ultimately breaks away from what might be construed as a patriarchal psychiatric industry by leaving traditional treatment behind. Yorkey and Kitts suggest in the telling that there is no single solution to mental illness. Treatments provided only by the psychiatric industry are simply inadequate. The play provides a framework with which to question the ethics and efficacy of the mental health care in the U.S. today.

As we have seen represented in these plays, when analyzing what Showalter has called "the female malady," it is not sufficient to offer one individualized solution to a complex problem, whether it be biological, psychological, or sociological in nature, for no single analysis will suffice and each woman's experience is unique to her. Female madness may take many forms, may have many roots, be manifested through any number of symptoms, and be given different names depending on the period in question: melancholia, lovesickness, hysteria, neurasthenia, mania, depression, borderline personality disorder, or dependent personality disorder. All share a common history (Ussher, 246). Complications

with reproductive biology are a reality for some; for others not at all. Corrections to disordered brain chemistry may have great effect, some, or none. Improvement in social systems where women's voices are heard and where they are given positions of power most certainly will be impactful. Foucault, Laing, and the anti-psychiatry movement gave form to the complexities of the social dynamics of mental illness and began the deconstruction of the male dominated psychiatric industry. In the four decades since the inception of Feminist Therapy theory, it has evolved from a female response to psychiatry in the 1960s to an integrative model that gives the rights back to those who have been defined as "other" by those dominant in the society. Though views of femininity are slowly changing, women in the U.S. are still expected to be passive, emotionally expressive, cooperative, and subordinate. Traditionally "male" qualities seen in women, such as competitiveness, assertiveness, and anger, are often criticized, and in fact, are now being pathologized, as we have seen. The institution of psychiatry is a patriarchal one. The DSM is unparalleled in its power to categorize and stigmatize patients. Categories that appear and disappear such as hysteria, hysterical personality disorder, and borderline personality disorder are not based on medical knowledge, but on social and political factors of acceptable behavior for women (Jimenez, 171). Today, according to the criteria, a woman who is mentally healthy restrains her sexuality, is not aggressive, but also is not dependent on others. These classifications limit and define women's behavior through medical diagnoses today, just as they did centuries ago. As gender begins to be acknowledged as a social and cultural construct rather than of biological determination, social processes that shape the concepts of masculinity and femininity should become less structured. This will greatly affect how we view and treat women specifically and mental health overall. Depictions in popular culture that focus on normalizing, realistic portrayals will help in this effort. Rather than educate the public on this serious issue, madness tropes invalidate and engender intolerance and stigmatization.

In the end, there can be no simple answer to the question of women's madness, but her pain is very real and we must listen to what she has to say.

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