

# The Genre of the Mood Memoir and the *Ethos* of Psychiatric Disability

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*Recent rhetorical accounts of mental illness tend to suggest that psychiatric disability limits rhetorical participation. This article extends that research by examining how one group of the psychiatrically disabled—those diagnosed with mood disorders—is using a particular narrative genre to engender participation, what I call the mood memoir. I argue here that mood memoirs can be read as narrative-based responses to the rhetorical exclusion suffered by the psychiatrically disabled. This study employs narrative and genre theory to reveal mood memoirists' tactics for generating ethos in the face of the stigma of mental illness.*

The psychiatrically disabled have long suffered exclusion from public life. Historically, doctors have isolated the psychiatrically disabled in asylums, because “doctors believed that between 70 and 90 percent of insanity cases were curable, but only if patients were treated in specially designed buildings” (Yanni 1); courts have imposed on them forced sterilization, believing that “heredity plays an important part in the transmission of insanity” (Buck 206). Today, the psychiatrically disabled continue to be denied civic participation: they are dismissed as criminals, committed patients, or simply unreliable observers of their world.<sup>1</sup> In short, the psychiatrically disabled are not trusted to exercise reason or judgment; as a consequence, civic exclusion often yields rhetorical exclusion as well. For

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<sup>1</sup>Courts continue to determine whether a mentally ill person is competent—reasonable enough—to stand trial, to testify, to be held responsible for past actions, or to be committed to an institution against her will. These determinations are largely based on the person’s ability to participate in judicial proceedings, taking into account factors such as “whether the defendant: (1) is oriented as to time and place; (2) is able to perceive, recall, and relate; (3) has an understanding of the process of the trial and the roles of judge, jury, prosecutor, and defense attorney” among other factors (Hermann 236). Given how few of the sane laypersons involved in the U.S. legal system could provide an adequate “understanding of the process of [a] trial” or other proceeding, this standard of mental competency seems quite high.

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example, the “character” portion of the professional licensing process for lawyers scrutinizes psychiatric treatment in order to determine whether a person is competent to advocate in court, despite showings that such scrutiny is both misdirected and harmful (Langford 1220). Doctors often bar psychiatric patients from speaking to the decision-making portion of their treatment, even when treatment has successfully rendered patients able-minded.

Psychiatric disabilities—even mild ones, or ones that respond well to treatment—mark a person as unreasonable or incapable of rational thought, producing an unreliable *ethos* for the mentally ill. Only recently have rhetorical scholars begun to address these rhetorical limitations. Cynthia Lewiecki-Wilson’s work investigates “the problem of granting rhetoricity to the mentally disabled: that is, rhetoric’s received tradition of emphasis on the individual rhetor who produces speech/writing, which in turn confirms the existence of a fixed, core self, imagined to be located in the mind” (157). As Catherine Prendergast aptly observes, “To be disabled mentally is to be disabled rhetorically” (202). These accounts suggest that psychiatric disability limits rhetorical participation. This essay extends these considerations of rhetorical disability by examining how one particular group of the psychiatrically disabled—those diagnosed with mood disorders<sup>2</sup>—seeks to overcome rhetorical exclusion by way of a narrative genre, what I call the *mood memoir*. I argue here that mood memoirs can be read as narrative-based responses to rhetorical exclusion suffered by the psychiatrically disabled. What is more, mood memoirs can be classified as a genre because their shared exigencies have given rise to shared rhetorical conventions, including an apologia, a moment of awakening, criticism of doctors, and certain techniques of *auxesis* (or rhetorical amplification). Using these shared conventions, mood memoirs have been successful in creating a reliable *ethos* for the mentally ill, at least in certain spheres. For example, the mood memoir genre has gained extraordinary popular appeal in recent years. Many mood memoirs have become best-sellers, such as journalist Elizabeth Wurtzel’s *Prozac Nation*; novelist William Styron’s *Darkness Visible*; and psychiatry professor Kay Redfield Jamison’s *An Unquiet Mind*. In 2002, MTV aired a documentary special titled “True Life: I’m Bipolar,” featuring Lizzie Simon, a mood memoirist whose narrative I examine herein.

This study employs narrative and genre theory to reveal mood memoirists’ tactics for generating *ethos* in the face of the stigma of mental illness. Mood memoirs employ narrative-based modes of persuasion, entering the rhetorical realm as “stories competing with other stories constituted by good reasons” (Fisher 2). The mood memoir competes with a variety of other stories: those produced by

<sup>2</sup>Mood disorders, a category of psychiatric disability recognized in the *Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association, include depression, bipolar disorder, and other illnesses whose primary symptoms are a disturbance of mood. For a discussion on the Mood Disorder group in the fifth edition of the DSM, see the Report of the Mood Disorders Work Group of the American Psychiatric Association (Fawcett).

doctors, by law-makers, and by popular media in its portrayals of the mentally ill. Furthermore, the mood memoir's "good reasons" can be studied as generic conventions, as I demonstrate below. In the end, then, this article suggests that narratology and genre theory are useful tools for examining the rhetoric of psychiatric disability, and neurorhetorics more broadly, for narrative is an important form through which lay populations come to understand disability. Narratives, that is, serve a rhetorical purpose (not just a literary or aesthetic one), in that they constitute mental illness.

To this end, this article will focus on mood memoirs published by major publishing houses.<sup>3</sup> I further limit my study to the writings by those diagnosed with what the *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM) calls "mood disorders":<sup>4</sup> depression and bipolar disorder (manic-depression) and all of the sub-categories of these diagnoses.<sup>5</sup> After a review of relevant current rhetorical scholarship, I examine the interaction between narrative and the rhetorical exclusion of the mentally ill, tracing the exigencies in which mood memoirs arise. Next, I highlight some of the generic conventions of the mood memoir as demonstrated by the texts I have examined. Lastly, I point out some implications of the rhetorical space claimed by mood memoirists and discuss the possible limitations of the *ethos* they create.

## Recent Rhetorical Examinations of Disability and Psychiatry

Scholars have recently turned to the rhetorical construction of psychiatric disability. Rhetoric of science scholars, for example, have examined this construction through the documents generated by medical professionals—most notably, by the DSM. Stuart Kirk and Herb Kutchins, in their book-length study of the manual, highlight the DSM's role in constructing mental illness through its categorization of symptoms, or its nosology. These scholars reveal just how much psychiatric diagnoses rely on discursive constructions of illness. The rhetoric of the DSM is central to the mood memoir genre, as nearly all memoirists I consider here draw from the book's authoritative force (Jamison *Unquiet Mind* 87; Hornbacher

<sup>3</sup>For a closer study of mental illness narratives published in nontraditional, and perhaps more democratic, fora, see Jones.

<sup>4</sup>This limitation fits this study because most psychiatric memoirs on the market today are written by authors with depression and manic-depression, and because authors often use the strong correlation between mood disorders and creativity to justify the writing of a memoir in the first place. There are, however, some well-known memoirs of mental illness whose authors fall outside of the mood disorder category, such as Susanna Kaysen's *Girl Interrupted* (1994) and Elyn R. Saks's *The Center Cannot Hold: My Journey Through Madness* (2007). Kaysen's diagnosis was borderline personality disorder, and Saks's was schizophrenia.

<sup>5</sup>The DSM currently lists five diagnoses under the category of Mood Disorder: Major Depressive Disorder, Dysthymic Disorder, Bipolar I Disorder, Bipolar II Disorder, and Cyclothymic Disorder.

*Madness* 7; Styron *Darkness Visible* 53–54). Like Kirk and Kutchins, Berkenkotter illustrates how diagnostic criteria, alongside patient narratives, create a means of interpreting symptoms of psychiatric disability—and of billing for treatment. Disability scholars take as their focus the rhetorical disability that often attends mental or psychiatric disability. Following the work of Foucault, Lewiecki-Wilson highlights the rhetorical double bind of mental disability.<sup>6</sup> To achieve rhetorical participation, one's disability must be made invisible, which has the effect of "diluting the transformative potential of their participation in the public forum" (159).

Recently, other scholars have noted the rhetorical power of narrative—and of memoir in particular—in constructing disability. In "Conflicting Paradigms: The Rhetorics of Disability Memoir," disability theorist G. Thomas Couser notes, "Most literary scholars would agree that autobiography has served historically as a sort of threshold genre for other marginalized groups"; however, "disability may disqualify people from living the sorts of lives that have traditionally been considered worthy of autobiography" (78). The disabled lives that often yield published memoirs hardly represent the norm: rather, they are often narratives of the exceptional cases who have overcome disability, of the "Supercrip, who is by definition atypical" (80). The rhetoric of these memoirs "tends to remove the stigma of disability from the author, leaving it in place for other individuals with the condition in question" (80). The mood memoir should be read as a memoir with a different purpose than the typical disability memoir, as it does not track the narrative conventions described by Couser. For example, the mood memoirist rarely seeks to remove stigma through a Supercrip narrative; rather, the memoirist tends to embrace her illness as not just a disability, but also a gift, building an *ethos* based on links between mood disorders and creativity drawn by recent scientific research, as well as upon the historical conception of the mad genius that dates back to Plato.<sup>7</sup>

Mood memoirs can be read as narrative-based responses to rhetorical exclusion suffered by the psychiatrically and mentally disabled. Mood memoirists seize the rhetorical authority provided by the DSM (as described by Kirk and Kutchins)

<sup>6</sup>Foucault points out the connection between language and exclusion of the insane: "From the depths of the Middle Ages, a man was mad if his speech could not be said to form part of the common discourse of men. His words were considered null and void, without truth or significance, worthless as evidence, inadmissible in the authentication of acts or contracts" (*Archaeology* 217). The "mad" were thus considered to be utterly without reason; the words of the insane lacked *ethos*, because they could not be relied on to reflect reality.

<sup>7</sup>Plato, in the *Phaedrus*, outlines the divisions of "divine madness" through the voice of Socrates: "The divine madness was subdivided into four kinds, prophetic, initiatory, poetic, erotic, having four gods presiding over them" (140). In the *Ion*, he argues that poets compose from within a trance of madness: "For the poet is a light and winged and holy thing, and there is no invention in him until he has been inspired and is out of his senses, and the mind is no longer in him" (11).

and combine it with the authority provided by autobiography as a genre (as described by Couser). They use narrative to describe their illnesses, often echoing the descriptions of illness that doctors provide in their patient files, seizing the authority inherent in the act of describing for themselves—implying that patients, not just doctors, are capable of describing symptoms and their attendant suffering. Much of the rhetorical authority generated by the mood memoir relies on narrative and the generic conventions of memoir itself.

The narrative nature of the texts mood memoirists produce are ideally suited for their rhetorical purposes of removing taboo from mood disorders, of talking back to the medical profession, and of generating a stronger *ethos* for the psychiatrically disabled. Rhetoricians have often pointed out that narrative has a persuasive purpose. As Donald Phillip Verene writes, “What holds a philosophy together is its narrative aspect. The narrative it expresses is its life blood that animates its arguments and gives them interest” (143). Indeed, for Cicero and Quintilian, the *narratio* of a speech was required before the rhetorician could put forward any arguments. The *narratio* created a shared tale that bound the audience to the speaker, a framework within which the audience might be persuaded. Because it functions to bind audiences and speakers, narrative is central to the “mad movement,” the activist movement that seeks to gain acceptance for the mentally ill. MindFreedom International (MFI), a large organization in the movement, features on its web site many stories of “psychiatric survivors,” such as that of Leah Harris, “a second generation psychiatric survivor, [who] discovered MindFreedom in 2000 when she was 25 years old. Her first act in the mad movement was to tell her story of oppression and resistance, and to help edit stories for MindFreedom’s Oral History Project” (MindFreedom.org). That storytelling was Harris’s first “act” in the “movement” implies that narrating one’s experience with psychiatry is a form of political activism. The narratives written by mood memoirists should also be read as such: they are political counter-narratives to the dominant psychiatric narratives about mental illness.

Despite efforts of organization such as MFI, the mentally ill continue to be excluded from rhetorical participation on a variety of fronts. These exclusions create the exigencies which give rise to the mood memoir as a genre, a narrative form that, in Fisher’s terms, functions as “a dialectical synthesis” of persuasion and literature (2). Narratives, and memoirs in particular, can intercede rhetorically on behalf of people such as the mentally ill who are traditionally excluded from rhetorical participation. Narrative authority—authority grounded in *stories supported by reasons*—provides a way to speak back to experts. In this way, as Fisher observes, narrative can have a democratizing force, albeit one that is still dependent on hierarchies of knowledge and power (9). The mood memoir should be seen as a counter-narrative to a dominant narrative of mental illness put forward by the psychiatric profession. As a group of counter-narratives grows, the narratives tend to adhere to a particular generic form. Judy Z. Segal observes, “People do not fashion their narratives out of just the events of their lives; narratives are

structured using available narrative knowledge” (6). Narratives are deeply embedded in the context in which they arise—a context full of other memoirs—such that dominant narratives can easily take hold, often to the exclusion of other, alternative narratives.<sup>8</sup> In fact, as Brett Smith and Andrew Sparkes point out, our cultural context “has a ready stock of narratives from which [storytellers] draw” (18). Authors of counter-narratives constantly contribute to this stock, modifying the rhetorical choices that are available to future authors. These “stock narratives” might best be examined using a theory of genres, to examine the conventions shared across different sets of narratives (say, mood memoirs or cancer narratives) and by narratives within a certain set.

### The Mood Memoir as Genre

Using narrative to convey their experiential knowledge, mood memoirists overcome rhetorical exclusion by creating a narrative space in which their voices can be heard, generating a rhetorical capital grounded in narrative logic rather than scientific logic. Mood memoirs, when viewed as a set of narratives, share common features which allow them to be classified as a genre. As Northrop Frye has observed, “The purpose of criticism by genres is not so much to classify as to clarify . . . traditions and affinities, thereby bringing out a large number of literary relationships that would not be noticed as long as there were no context established for them” (247–248). The mood memoir, then, shares traditions and affinities with other narrative genres that have been developed in response to different sorts of rhetorical exclusions. As Tzvetan Todorov observes, genres come “[q]uite simply from other genres. A new genre is always the transformation of an earlier one, or of several: by inversion, by displacement, by combination” (15). In keeping with Carolyn R. Miller’s assertion that genre should be viewed “as social action,” as “a complex of formal and substantive features that create a particular effect in a given situation” (153), the mood memoir fits within a tradition of other narrative genres designed to generate rhetorical authority for their authors.

For Miller, a genre consists of conventions that have rhetorical consequences; it is “a point of connection between intention and effect, an aspect of social action” (153). A genre arises in response to the exigencies of a situation; motivated by those exigencies, a genre can in turn transform the situation. At other points in U.S. history, memoir genres have arisen to generate rhetorical authority for their authors. For example, during the era of American slavery, the slave-narrative genre served the cause of abolition by giving authority the previously enslaved to speak

<sup>8</sup>Ellen Barton points out that, when personal storytelling meets disability activism, the “preferred counter-narrative is not always the narrative told by many individuals with disabilities” (96).

about their experiences. The slave narrative—a genre itself built upon the early-American captivity-narrative genre, as literary scholar John Sekora notes (486)—shares many qualities with the mood memoir. For example, both slave narratives and mood memoirs usually begin with an *apologia*, in which the author strikes a tone of humility, apologizing for sharing a story of suffering and stating a desire to help others. Mood memoirs and slave narratives also share the convention of awakening. As Sekora explains, antebellum slave narratives tend to describe the autobiographer's escape from slavery and a coming to political consciousness (493). This coming-to-consciousness is reflected in the mood memoir at the moments when the authors experience an awakening to the fact that they are, in fact, mentally ill, and realize that they most likely need psychiatric treatment. The awakening to the reality of illness and treatment represents a move toward metaphorical freedom (from illness) and enlightenment (to a mind that is reasonable, no longer insane).

The awakening moment of the mood memoir also reflects another historical, transatlantic memoir genre: the spiritual autobiography. This genre was often employed by those who experienced religious persecution to gain authority for themselves and for their faith. As noted by literary scholars such as Robert Bell, the conventions of the spiritual autobiography often include a narration of “youthful transgressions” followed by a narrative of religious conversion (112). A distinct parallel exists in the mood memoir, when the memoirist recounts the horrors of life before the moment of awakening to the illness, followed by the attendant diagnosis and effective treatment that occurs post-awakening.

That the mood memoir shares features with these earlier memoir genres suggests that the mood memoir has grown out of familiar autobiographical genres of the past. Recognizing that a “genre, whether literary or not, is nothing other than the codification of discursive properties” (Todorov 15), and recognizing further that a genre is never a “closed set,” but rather “an open class, with new members evolving, old ones decaying” (Miller 153), I posit the mood memoir as a new autobiographical genre. The mood memoir genre is motivated by the rhetorical exclusion of the psychiatrically disabled based on their supposed lack of reason. This exigency creates the prime intention—and effect—of the mood memoir: the creation of an authoritative and reliable *ethos* for the author and for others that suffer from mood disorders for the purpose of overcoming this rhetorical exclusion. Mood memoirs move toward this goal through a number of shared conventions. Each mood memoirist considered here

1. discusses in an *apologia* the motivations for writing the memoir, to justify the project and defend it from detractors;
2. experiences a *moment of awakening* to the existence of the illness;
3. criticizes “bad” doctors;
4. lays claim to other sufferers of mood disorders in order to normalize the illness and amplify (via *auxesis*) the memoirist's authority.

The next section will consider how these four conventions are shared across mood memoirs, and what rhetorical purposes they serve.

### Convention 1: Apologia

Most mood memoirs contain an apologia, usually in the introduction or afterword, justifying or defending their project. In delivering apologies, “rhetors respond to threats against their ‘moral nature, motives, or reputation’ by adopting defensive postures of absolution, vindication, explanation, or justification” (Downey 42). Memoirists of all stripes have defended their work from the charge of self-absorption: critics suggest that writing an entire book about oneself is bold, crass, arrogant, or selfish. For example, the apologia was a “stock device” in slave narratives (DeCosta-Willis 8). In the preface to *Incidents in the Life of a Slave Girl*, Harriet Jacobs declares, “I have not written my experiences in order to attract attention to myself” (5). Instead, she hopes “to arouse the women of the North to a realizing sense of the condition of two millions of women at the South, still in bondage” (5). Jacobs thus claims humility by stating that her purpose is to help others, rather than to aggrandize herself. Olaudah Equiano makes a similar apologia at the opening of his slave narrative, *The Interesting Narrative of the Life of Olaudah Equiano*: “Permit me, with the greatest deference and respect, to lay at your feet the following genuine narrative; the chief design of which is to excite in your august assemblies a sense of compassion for the miseries which the Slave-Trade has entailed on my unfortunate countrymen” (192). The apologies of these slave narratives defend the authorship of former slaves and justify their autobiographical projects by casting the authors’ purposes as selfless.

Similarly, many mood memoirists draw on the apologia to depict their work as selfless, driven by a desire to break down taboos, which will help other sufferers of mental illness. Kay Redfield Jamison presents an exemplary apologia in the introduction to her book, drawing authority from her scientific background. It would seem that Jamison, Professor of Psychiatry at Johns Hopkins University, would not need to include an apologia. Her ethos is already well-established through her other publications, which include the respected medical text *Manic-Depressive Illness* in 1990 (as co-author with Frederick K. Goodwin), and the groundbreaking *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* in 1993. Her mood memoir, *An Unquiet Mind: A Memoir of Moods and Madness* (1995), is unique among mood memoirs in that it is written by a psychiatric professional. Even so, Jamison’s apologia first notes how, in her clinical work, she has tried to break down taboos surrounding bipolar disorder: “Through writing and teaching I have hoped to persuade my colleagues of the paradoxical core of this quicksilver illness that can both kill and create; and, along with many others, have tried to change public attitudes about psychiatric illnesses in general and manic-depressive illness in particular” (7). In this passage, she makes reference



to her earlier work on creativity and manic-depression.<sup>9</sup> Jamison also identifies two audiences she has sought to persuade. Her earlier “writing and teaching” were written primarily for her “colleagues”; in saying so, she implies that the audience of her mood memoir is the lay public. That the mood memoir is written for a broader audience is confirmed when Jamison states that her mood memoir is meant to demystify bipolar disorder and “change public attitudes.” By identifying a specific purpose—demystification—and specific audiences, Jamison comes across as a thoughtful and generous person who seeks to help others with both her scientific research and memoir writing. Jamison here cultivates the virtue of *eunoia*, or goodwill, with her audience.

In her apology Jamison expresses fear of exposing her own experiences with a taboo illness, and works to justify this exposure: “I have had many concerns about writing a book that so explicitly describes my own attacks of mania, depression, and psychosis, as well as my problems acknowledging the need for ongoing medication. Clinicians have been, for obvious reasons of licensing and hospital privileges, reluctant to make their psychiatric problems known to others” (7). She acknowledges the complexity of practicing psychiatry and suffering from psychiatric illness: “It has been difficult at times to weave together the scientific discipline of my intellectual field with the more compelling realities of my own emotional experiences” (7). Here, Jamison invokes a dichotomy between scientific knowledge (*logos*) and emotional knowledge (*pathos*): she points to her “scientific disciplines” as one source of knowledge, and her “emotional experiences” as another. Jamison purports to unite these two types of knowledge in her memoir: “And yet it has been from this binding of raw emotion to the more distanced eye of clinical science that I feel I have obtained the freedom to live the kind of life I want, and the human experiences necessary to try and make a difference in public awareness and clinical practice” (7). Her authority as a mood memoirist stems from her status as both a doctor and a sufferer; by invoking these roles, she frames herself as ideally suited for demystifying mental illness, “mak[ing] a difference in public awareness and clinical practice” (7), the primary project of her memoir as established in her apology.

Novelist William Styron’s apology justifies his use of memoir—a deviation from his typical fictional mode—as a selfless project meant to help others. He states that he wishes to break down taboos with his memoir, *Darkness Visible: A Memoir of Madness*.<sup>10</sup> He writes that “prevention of many suicides will continue to be hindered until there is a general awareness of the nature of this pain,” that

<sup>9</sup>The DSM uses the term *bipolar disorder* to refer to illnesses that cause both depression and mania. Jamison uses the term *manic-depressive illness*. The term *manic-depression* also refers to the same illness. I use these terms interchangeably. Referring to a person as a “manic-depressive” (or simply a “depressive”), however, seems unnecessarily limiting of a person’s identity, so I avoid such nomenclature.

<sup>10</sup>Styron is the author of many award-winning novels, including *The Confessions of Nat Turner* (1967) and *Sophie’s Choice* (1979).

is, the pain of depression (33). Styron tells readers that he first spoke out publicly about his own depression in a *New York Times* Op-Ed piece regarding the suicide of Italian author Primo Levi. After Levi died, many “worldly writers and scholars, seemed mystified by Levi’s suicide, mystified and disappointed” (32). For these scholars, Levi’s suicide “demonstrated a frailty, a crumbling of character” (32–33). Angered by what he perceived to be a grave misunderstanding of the nature of depression and suicide, Styron wrote his column: “The argument I put forth was fairly straightforward: the pain of severe depression is quite unimaginable to those who have not suffered it, and it kills in many instances because its anguish can no longer be borne” (33). The large number of positive responses to this piece surprised Styron, he writes: “I had apparently underestimated the number of people for whom the subject had been taboo, a matter of secrecy and shame” (33–34). He claims to have written *Darkness Visible* in part because of this response. His apologia thus justifies the otherwise self-centered memoir mode by arguing that the goals of the book are generous and selfless. In this way, Styron, too, cultivates *eunoia*.

A nearly identical story lies behind *Prozac Nation* by Elizabeth Wurtzel, as she describes in her apologia (located in the afterword of the paperback edition). In her apologia, Wurtzel explains that she decided to write the book, in part, because of the responses to an article she published on depression in *Mademoiselle* a few years before (354). After the article was published, she “received a ton of letters . . . which led [her] to believe this was a worthy topic, one that could have widespread resonance in book form” (354). Thus, after breaking the taboo with smaller articles, Wurtzel and Styron write that they were convinced—by reader response—of the worthiness of book-length projects. The responses of other sufferers ostensibly created the exigency that drove their mood memoirs. By including these statements in their memoirs, Wurtzel and Styron present themselves as selfless, countering any presumptions a reader may have held that the authors of memoirs are self-absorbed.

In their apologias both Wurtzel and Styron use the metaphor of the closet in order to better describe their goals of breaking down taboos. Wurtzel writes: “In effect, if *Prozac Nation* has any particular purpose, it would be to come out and say that clinical depression is a real problem, that it ruins lives, that it ends lives, that it very nearly ended *my* life; that it afflicts many, many people, many very bright and worthy and thoughtful and caring people” (356). Here, Wurtzel invokes the metaphor of the closet when she employs the term *come out*. Styron writes, regarding his *Times* piece, “The overwhelming reaction made me feel that inadvertently I had helped unlock a closet from which many souls were eager to come out and proclaim that they, too, had experienced the feelings I had described” (34). Fear of exposure has forced other sufferers to hide their illnesses, and the authors of mood memoirs claim a desire to help others to stop hiding. In fact, for Styron, the motivation of helping others is the only one he describes: “I thought that . . . it would be useful to try to chronicle some of my own experiences

with the illness and in the process perhaps establish a frame of reference out of which one or more valuable conclusions might be drawn” (34). Similarly, mood memoirist Lizzie Simon writes, “I want to produce a new image for bipolar people. I want to present new voices of bipolar people” (41). This justification based on selflessness is pervasive throughout the mood memoir apologies.

Another common justification that arises in the apologies comes in the form of a comparison. Memoirists often compare their illnesses to more socially acceptable diseases in order to convince readers of the seriousness of mood disorders, usually diabetes (Hornbacher 71; Styron 9) and cancer (Jamison 102; Styron 9, 33; Wurtzel 21). By proving that their disease is serious and deadly, the authors further justify writing memoirs about their experiences with the disease.

Other motivations besides justification manifest in the apologies, such as a compulsion to write and a desire for therapeutic release, for catharsis. For example, Wurtzel describes a compulsion to write her memoir, as though the story of her madness was itself driving her mad: “I had tried very hard to get away from thinking or feeling depression in all of my professional endeavors, but it just kept creeping up, over and over again, like a palimpsest, a text hiding beneath whatever else I was working on that refused to remain submerged” (355). In order to gain release from her thoughts about depression, Wurtzel explains, “I gave in to the obsessive hold that my experiences with depression seemed to have on me, and decided to just write a whole book” (355). Wurtzel thus suggests that the creative drive overcame her own wants and desires. Wurtzel uses the justification of catharsis to counter the charge of self-absorption by suggesting that she did not have the option to *not* write the memoir.

Jamison, too, describes an emotional drive to write her memoir, but hers is less of a compulsion or desire for therapeutic release, and more of a desire for honesty. Despite fears of negative ramifications on her career, Jamison decides to tell her story, suggesting that “the consequences . . . are bound to be better than continuing to be silent” (7). She is “tired of hiding, tired of misspent and knotted energies, tired of the hypocrisy, and tired of acting as though I have something to hide. One is what one is, and the dishonesty of hiding behind a degree, or a title, or any manner and collection of words, is still exactly that: dishonest” (7). Jamison wishes to step out of the closet described by Wurtzel and Styron.

For Marya Hornbacher,<sup>11</sup> author of *Madness: A Bipolar Life* (2008), writing her mood memoir allows her to reclaim power over her life, a therapeutic goal:

How do we know who we are or what we can become? We tell ourselves stories. The stories we tell are what we know of ourselves. We are a creation,

<sup>11</sup>Hornbacher is also the author of *Wasted: A Memoir of Anorexia and Bulimia* (1998) and a novel, *The Center of Winter* (2005).

a product of our own minds, a pastiche of memory, dream, fear, desire. My memory looks like a child's collage, or a ransom note, incomplete and full of holes. All I have is today, this moment, to work with. I am writing my story as I go. (278)

Thus, Wurtzel, Jamison, and Hornbacher all describe writing as more of a need than a desire. They are fervid, engaged, and committed to their writing. In these passages, they construct their *ethos* not from reason but rather from emotional drive and creativity. They mark their invention as passionate, rather than reasoned. They claim to be driven by their creative or emotional urges. Further, they tap into the correlation between creative genius and mood disorders drawn by psychiatric researchers in order to gain authority as writers, invoking a dichotomy between rational and scientific sources of knowledge (*logos*) and emotional and creative sources of knowledge (*pathos*); it is the second that they claim to draw upon in their narratives.

## Convention 2: Awakening

A second convention of the mood memoir is the moment of awakening to the reality of the memoirist's illness. Mood memoirs often include an early denial of the illness and then an awakening, followed by the confession of the illness to others and the seeking of treatment, and treatment failures followed by a final success. These conventions share strong similarities to the conventions of older memoir genres, such as the spiritual autobiography (or conversion narrative), when the author comes to God; the slave narrative, when the former slave comes to political consciousness; and the breast cancer narrative, when the "survivor" discovers a lump (Segal 4). The similarities are so striking that, as I suggest above, the mood memoir can be thought of as a recent addition to a much older family.

During the awakening moment of the mood memoir, the memoirist points to a specific moment in which she first realizes she is mentally ill. The mood memoirist's awakening is unique among similar genres in that the narrator is recounting *the awareness of a mental illness*; an illness which, in a paradoxical fashion, does not impede the author's self-awareness. This apparent paradox renders the awakening moment as particularly rhetorically powerful: the precision of the descriptions of awakening establishes the author's reliability as narrator, despite the author's mood disorder. By describing the awakening with ostensible clarity, precision, honesty, and self awareness, the memoirist tacitly invites the audience to trust her narration of events. In short, although the mood memoir is a story of mental illness, the awakening implies that the illness does not impede the narrator's ability to tell the story.

The awakening is both the turning point of the author's life and the impetus for the narrative. Mood memoirs thus often commence with the moment of

awakening, and then “swoop”<sup>12</sup> back in time to tell of the period of sickness and denial which occurs before. For example, Styron’s memoir opens with this awakening: “In Paris on a chilly evening late in October of 1985 I first became fully aware that the struggle with the disorder in my mind—a struggle which had engaged me for several months—might have a fatal outcome” (3). By describing his awakening to the “disorder in [his] mind,” Styron implicitly declares that he is capable of describing this disorder accurately—after all, if he can become aware of the illness in the first place, he must be capable of recounting the illness for readers. After recounting how he came to realize the risk of suicide while driving down the Champs-Élysées, he writes, “Only days before I had concluded that I was suffering from a serious depressive illness, and was floundering helplessly in my efforts to deal with it” (5). Styron had come to Paris to accept a prestigious award for his writing. The moment of awakening is thus tied to what should have been a positive event in his life. Styron’s story suggests that the positive nature of the award highlighted his suffering, making it easier to perceive. The “self-loathing,” he writes, caused him to feel “persuaded that [he] could not be worthy of the prize, that [he] was in fact not worthy of any of the recognition that had come [his] way in the past few years” (19). After the award ceremony, he rushes home on the Concorde to seek psychiatric treatment. At this point, the narrative swoops back in time to tell of how Styron grew sick and finally reached the nadir of his disease in Paris.

Lizzie Simon describes her awakening at the beginning of her memoir, *Detour: My Bipolar Trip in 4-D*: “What started the day after I found out I was accepted to college was an episode so horrific that it would become impossible for me to deny that I had a mental illness for the rest of my life. Though I had always known that something was wrong with me, what started that day was evidence, concrete evidence” (3). Simon uses the term “concrete evidence” to emphasize both the concrete nature of the illness (an illness that many still consider to be merely a character flaw) and the concrete nature of her recollection—a recollection that readers can rely upon to be accurate. Like Styron, Simon’s awareness comes on the heels of a positive life event, her acceptance to Columbia University, which throws her illness into high contrast. And like Styron’s memoir, the next chapter swoops back in time, to Simon’s birth in 1976, and wends its way forward to the moment of awakening.

Like Styron and Simon, Jamison begins her book with an awakening tied with an otherwise positive life event: “Within a month of signing my appointment papers to become an assistant professor of psychiatry at the University of California, Los Angeles, I was well on my way to madness; it was 1974, and I was twenty-eight years

<sup>12</sup>The “swoop” is a common narrative structure in short fiction. It entails commencing a story with the turning-point of the narrative, then going back in time to tell the relevant events leading up to the turning-point, and lastly moving forward in time to the climax of the story and the end.

old" (4). Jamison then reaches back in time to discuss life events that eventually led to her mental illness, beginning with her childhood. Sixty pages later, the narrative returns to the awakening: "I did not wake up one day to find myself mad. Life should be so simple. Rather, I gradually became aware that my life and mind were going at an ever faster and faster clip until finally, over the course of my first summer on the faculty, they both had spun wildly and absolutely out of control . . . In the beginning, everything seemed perfectly normal" (68). She then pinpoints a precise moment when she realized she was ill: "Although I had been building up to it for weeks, and certainly knew something was seriously wrong, there was a definite point when I knew I was insane" (82–83). Like Simon's "concrete evidence," Jamison describes a "definite point," emphasizing not only the reality of the illness but the reliability of her recollection of it.

Hornbacher first awakens to her bipolar disorder during a visit with an insightful psychiatrist. After the psychiatrist delivers the diagnosis, Hornbacher writes, "My chest floods with a mixture of horror and relief. The relief comes first: something in me sits up and says, *It's true*. He's right, he has to be right. This is it. All the years I've felt tossed and spit up by the force of chaos, all that time I've felt as if I am spinning away from the real world, the known world, off in my own aimless orbit—all of it, over . . . I have a word. *Bipolar*" (66–67). Hornbacher emphasizes the "rightness" of the diagnosis; she depicts the diagnosis as a lodestar, a precise point that will guide her out of her "aimless orbit." For the reader of her memoir, the medical term arises out of the chaos of her disjunctive narrative, providing a clear framework to interpret the chaotic behavior Hornbacher describes. Hornbacher's description of awakening is a moment of sublime clarity, one that the reader can share as well.

Whether they are describing a moment of awakening or criticizing doctors (as I describe below), mood memoirists rely on experiential knowledge—transmitted via narrative—to provide an alternative source of knowledge about mood disorders for their readers. This alternative source of knowledge, often rhetorically opposed to more traditional medical or scientific knowledge, creates a space in which memoirists can speak with authority, despite their diagnoses and (in most cases) lack of medical training.

### Convention 3: Criticizing Doctors

A third convention of the mood memoir is criticism of doctors and other psychiatric care providers. Nearly all mood memoirists write about interactions with doctors who ignore patient stories in favor of other forms of knowledge, such as observations and diagnostic criteria. When they criticize doctors, mood memoirists pass judgment on the failures of the medical system, relying upon their experiential knowledge to talk back to traditional medical knowledge. This "talking back" gives rhetorical power to the memoirists; they deliberately oppose their experiential, narrative-based knowledge as patients to the empirical, scientific knowledge of

the medical profession. Doctors, like lawyers and other experts, can be blinded to the different types of knowledge possessed by the lay. For example, in the debates over “regressive” autism, the experiential, narrative-based knowledge of parents slam against the nearly united scientific front of the medical community.<sup>13</sup> For the mood memoirist, casting the psychiatric establishment as monolithic gives their position—their opposition—more power. When memoirists talk back to the medical profession to regain authority, contrasting the narrative of experiences with the lack of insight demonstrated by health care providers, the source-of-knowledge dichotomy employed by mood memoirists—*pathos* versus *logos*—is particularly striking. Mood memoirists claim to rely upon emotional, experiential knowledge, transmitted through an artistic, nonlinear narrative, in order to speak against the *logos* of the medical profession.

Marya Hornbacher presents a striking example of the medical profession’s failure: she suffered from a life-threatening eating disorder throughout her childhood and, as a consequence, was often misdiagnosed with depression and prescribed anti-depressants. Psychiatrists agree that anti-depressants are generally thought to cause mania in persons with bipolar disorder (Cipriani and Geddes para. 6). Hornbacher writes: “No one even thinks *bipolar*—not me, not any of the many doctors, therapists, psychiatrists, and counselors I’ve seen over the years—because no one knows enough. Later, this will seem almost incredible, given what a glaring case of the disorder I actually have and have had nearly all my life” (7). Here, she suggests that because her case was “glaring,” a typical presentation of bipolar disorder, the medical professionals who treated her failed in their treatment. Implied in her language is that, even Hornbacher, a non-specialist, can see that her symptoms constitute a diagnosis of bipolar. This criticism, then, points to weaknesses in the presumption of expertise and strengthens the position of the non-expert. Later in her life, after she attempts suicide by cutting open a vein in her forearm, the psychiatrist releases her from the hospital because “Hospital policy is to impose the least level of restriction possible” (5). Hornbacher states that she is “very convincing” when she promises she will not injure herself again. The suicide attempt occurred in 1994. It is not until 1997 that she met the doctor who diagnoses her with bipolar disorder. This narrative forms the basis of Hornbacher’s argument that current treatment of bipolar disorder is seriously flawed.

Jamison, too, roundly criticizes medical professionals involved in her case, recounting an interaction with a doctor who asked her whether she planned to have children (*Unquiet Mind* 190). She responded in the affirmative, and, “At that point, in an icy and imperious voice that I can hear to this day, he [the doctor] stated—as though it were God’s truth—which he no doubt felt it was—‘You shouldn’t have children. You have manic-depressive illness’” (191). She reflects

<sup>13</sup>For more on the autism debates and the diverse forms of proof employed by the parties, see “A Broken Trust: Lessons from the Vaccine-Autism Wars” by biologist Liza Gross.

further, “Brutality takes many forms, and what he had done was not only brutal but unprofessional and uninformed. It did the kind of lasting damage that only something that cuts so quick and deep to the heart can do” (191). From her position of authority as a clinical scientist, Jamison criticizes the doctor’s knowledge and professionalism. From her position as a mood memoirist, she criticizes his behavior using emotional appeals grounded in metaphorical terms: “brutality,” “cuts,” and “heart.” These emotional appeals help pinpoint the weaknesses of medical treatment of bipolar disorder, lending more authority to Jamison as a mood memoirist—and, in a unique fashion—as an insider (in that she is a psychologist) stepping outside (as a patient) to critique standard practices of psychiatry.

Styron describes many bad doctors in his narrative. One, Dr. Gold, failed to “say much of value” (*Darkness Visible* 53). Instead, “His platitudes were not Christian but, almost as ineffective, dicta drawn straight from the pages of the *Diagnostic and Statistical Manual of the American Psychiatric Association* (much of which, as I mentioned earlier, I’d already read), and the solace he offered me was an antidepressant medication called Ludiomil” (53–54). In this passage, Styron tries to generate *ethos* by relying on a medical text—the DSM. He strikes at the authority of the doctor by suggesting that the doctor did nothing more than what he, Styron, could have done—read the DSM and applied the diagnostic criteria. This argument attempts to demystify (and thereby disempower) the psychiatric profession.

Styron later describes a moment when the same doctor gave Styron the anti-depressant: “Dr. Gold said with a straight face, the pill at optimum dosage could have the side effect of impotence” (*Darkness Visible* 60). Here, Styron presents a doctor performing ostensibly correct medical treatment: warning a patient of side effects of a new drug. But Styron argues that the correct treatment is actually flawed: “Until that moment . . . I had not thought him totally lack in perspicacity; now I was not at all sure . . . I wondered if he seriously thought this juiceless and ravaged semi-invalid with the shuffle and the ancient wheeze woke up each morning from his Halcion sleep eager for carnal fun” (*Darkness Visible* 60). Styron’s narrative, placed in opposition to the correct treatment provided by Dr. Gold, seeks to reveal weaknesses inherent in what the profession accepts as correct treatment. Dr. Gold, Styron argues, was a very poor observer and listener; implied in this claim is that doctors should improve these skills. In this scene, Styron, the patient, was shocked that the doctor could so misperceive his physical symptoms. Styron illustrates the disjuncture that can grow between the narratives patients tell doctors, the doctors’ interpretations of these narratives, and the treatments doctors prescribe based on these interpretations.

Later, Styron criticizes Dr. Gold once more for advising against hospitalization (67–68). Styron writes, “Many psychiatrists, who simply do not seem to be able to comprehend the nature and depth of the anguish their patients are undergoing, maintain their stubborn allegiance to pharmaceuticals in the belief that eventually the pills will kick in, the patient will respond, and the somber surroundings of the



hospital will be avoided” (68). Styron relies on his experiential knowledge—that a hospital did indeed cure his depression in the end—to speak against the theoretical knowledge of doctors. His narrative provides the evidence needed to support these claims.

#### Convention 4: Laying Claim

The fourth convention that I examine here I call *laying claim*: every mood memoirist I have studied lays claim to other sufferers of mental illness as a means to create rhetorical authority. By “laying claim” I mean, on one level, simple name- or statistics-dropping. Memoirists seek to normalize their illnesses; until quite recently—and many would argue, still—patients were advised to hide their diagnoses. Memoirists can break this taboo by pointing out the large number of people who are also diagnosed with mental illness (statistics-dropping) or by invoking famous persons with mental illness (name-dropping). The rhetorical function of name-dropping, then, looks something like this: Here is another person who suffers from mental illness like me; this person is respected, so I should be respected too. A greater number of sufferers suggest that although mental illness can be horrible, it is not unusual.

Laying claim has deep roots in the history of rhetoric. In the *Rhetoric*, Aristotle makes suggestions for amplifying the reputations of those praised in epideictic rhetoric. He writes, “[I]f you cannot find enough to say of a man himself, you may pit him against others” (*I Rhetoric* 9, Trans. Roberts, 33). The rhetor should compare the object of praise “with famous men; that will strengthen [the rhetor’s] case; it is a noble thing to surpass men who are themselves great” (*I Rhetoric* 9, Trans. Roberts, 33). Aristotle calls this practice of comparison “amplification,”<sup>14</sup> or *auxesis* in Greek. Since mental illness is often taboo, it is not surprising that laying claim—comparing oneself to a famous person who has a similar illness—would take central importance in establishing authority.

Laying claim becomes complicated, however, when a claimed famous person is long dead and never actually diagnosed with a mood disorder. In order to lay claim to such a person, the memoirist must perform a retroactive diagnosis of the famous person’s supposed mental illness. Often, the memoirist is not the first to speculate about the person’s illness. If the famous person committed suicide, or kept a diary recording mental suffering, or produced fiction or art portraying it, scholars and biographers have often already pointed to mental illness as a root cause. Such retroactive diagnoses place the memoirist in a tradition of others with mood disorders; laying claim to great artists, such as Van Gogh, Plath, and Woolf, populates this tradition with creative geniuses. In summary, laying claim has two

<sup>14</sup>The Roberts translation, whose text I quote, uses the phrase “heightening the effect”; Kennedy’s translation uses the term “amplification.”

purposes: it can either normalize the author—a great step in establishing authority—or, through retroactive diagnosis of creative geniuses, push the author's *ethos* into the realm of genius, which seems like an even stronger rhetorical position, particularly in the context of creative nonfiction.

In Lizzie Simon's memoir, unique among the ones I studied, laying claim is the central project. Simon was diagnosed with bipolar disorder shortly before starting college. She was compliant as a patient, accepting medication and psychiatric care and living a life of full civic participation. After graduating from Columbia, she worked as an assistant producer in a successful theater. She conceived of a project to travel the country to interview other young people with bipolar disorder. These people are not famous—except through Simon's project—and like Simon participate fully in society. In her afterword, she explains the reasons for her project: "Everybody I interviewed for this book is diagnosed with bipolar affective disorder, between the ages of sixteen and thirty-five, on medicine, and highly functional in society. We do not share the same illness, for we each experience it differently. But we do share the same diagnosis" (210). Here, Simon's words assert that bipolar disorder is prevalent, given the large cross-section of people she interviewed. She also asserts that the disorder is not monolithic, because "each [person] experience[s] it differently." But they do share a diagnosis of bipolar, and furthermore, she writes, they "share the same nagging inner voice that wonders: how much of me is me, and how much of me is the illness?" (210). Emphasizing the experiences that they *do* share helps Simon lay claim to the experiences of the people she interviewed. They do, as Simon points out, share the same experience of alienation: "This is our interior, private response to the exterior, public noise of stigma" (210). By emphasizing the commonness of the disorder and the commonality of the experiences of the people diagnosed with it, Simon attempts to break down this stigma. Simon's project was eventually produced as a television special on MTV, titled "True Life: I'm Bipolar," one more step in the process of normalization.

Another form laying claim takes in a memoir is that of simple numbers, or statistics-dropping. For example, Marya Hornbacher has a list of "Bipolar Facts" at the end of her book, which starts with this statistic: "American adults who have bipolar disorder: 5.8 million (2.8% of the U.S. population)" (*Madness* 281). The list of statistics emphasizes the prevalence of bipolar disorder and suicide, normalizing them. In the prologue to her book, Jamison writes: "The disease that has, on several occasions, nearly killed me does kill tens of thousands of people every year: most are young, most die unnecessarily, and many are among the most imaginative and gifted that we as a society have" (*Unquiet Mind* 5). Here, Jamison attempts to remove the stigma from her suicide attempts and diagnosis by highlighting that both bipolar disorder and suicide are far more common than most people suspect.

Jamison's use of the adjectives "imaginative and gifted" point to the second function of laying claim: locating oneself within a tradition of creative geniuses. The creative genius trope is a powerful source of authority, one that most mood

memoirists employ. In order to invoke the creative genius trope, mood memoirists perform retroactive diagnoses of famous artists and writers. Early in her memoir, Wurtzel writes, "I'm starting to wonder if I might not be one of those people like Anne Sexton and Sylvia Plath who are just better off dead, who may live in that bare, minimal sort of way for a certain number of years, may even marry, have kids, create an artistic legacy of sorts, may even be beautiful and enchanting at moments" (*Prozac Nation* 8). Although her tone is one of depressed self-deprecation ("better off dead"), she associates herself with two towering geniuses of poetry. Later in the narrative she lays claim again, noting how, when she first suffered from mental illness, "The idea that a girl in private school in Manhattan could have problems worth this kind of trouble seemed impossible to me. The concept of white, middle-class, educated despair just never occurred to me . . . . I didn't know about Joni Mitchell or Djuna Barnes or Virginia Woolf or Frida Kahlo yet. I didn't know there was a proud legacy of women who'd turned overwhelming depression into prodigious art" (50). With these words, Wurtzel places herself firmly within that proud legacy of artistic genius.

Of the memoirs considered here, Styron's most prominently features retroactive diagnosis. First, he mentions Albert Camus and his disappointment at never meeting him. Styron, a writer located in the upper echelons of fame and prestige, actually had an appointment to meet Camus at a dinner party in Paris with a mutual friend named Romain Gary. But the meeting never occurred, because, Styron writes, "before I arrived in France came the appalling news: Camus had been in an automobile crash, and was dead at the cruelly young age of forty-six . . . . I pondered his death endlessly . . . there was an element of recklessness in the accident that bore overtones of the near-suicidal" (*Darkness Visible* 22). Styron bolsters his retroactive diagnosis of Camus's suicidal tendencies by pointing to suicide in Camus's writings and by citing information passed on to him from their mutual friend: "Camus, Romain told me, occasionally hinted at his own deep despondency and had spoken of suicide" (23). Styron acknowledges, however, that the car in which Camus died was driven by someone else.

Styron also lays claim to his friend, author Romain Gary, "twice winner of the Prix Goncourt" (28), a highly prestigious French literary award, who committed suicide after lunch one day. Gary "went home to his apartment on the rue du Bac and put a bullet in his brain" (28). In addition to Camus and Gary, Styron lays claim to Abbie Hoffman (29), Randall Jarrell (30–31), Primo Levi (32), John Dryden (44), Sir Walter Scott (44), the Brontës (44), Emily Dickenson (45), Baudelaire (46), and many others. But Styron is hardly the only memoirist to use retroactive diagnosis to borrow the authority of creative geniuses. Hornbacher lays claim to Byron, and attributes her "career and passions" to her illness (279); Jamison lays claim to composer Hugo Wolf (39), Virginia Woolf (68), and Edna St. Vincent Millay (73), among others. By locating themselves in a legacy of creative geniuses, mood memoirists—who are, after all, practicing a creative art in writing their memoirs in the first place—grant themselves greater authority

as writers. They can show that one can achieve great things even with, or because of, a mood disorder.

The convention of laying claim has been further complicated by the medical research of Jamison and other authors, who have shown correlations between mood disorders and the “artistic temperament” (Jamison, *Touched with Fire*). This research, combined with the fine creative work produced by many mood memoirists, has created a popular misconception that all mood disorders carry creative potential. For example, as Jonah Lehrer recently observed in the *New York Times Magazine*, depression may have an “upside.” Lehrer ponders the prevalence of depression in the human population, and suggests that “depression has a secret purpose and our medical interventions are making a bad situation even worse” (para. 7). He points to Aristotle and Keats (Lehrer para. 16), and to researchers who seek to show how rumination caused by depression “might lead to improved outcomes, especially when it comes to solving life’s most difficult dilemmas” (Lehrer para. 17). “For Darwin,” according to Lehrer, “depression was a clarifying force” (para. 4). This perceived connection between creative genius (such as Darwin’s) and mood disorder lends a rhetorical authority grounded in creativity to *all* who would write a mood memoir. However, this connection is highly controversial, as the furor over Lehrer’s article demonstrates.<sup>15</sup> Although research shows that there might be a correlation between creative genius and mood disorders, the causation—that is, the notion that mood disorders *cause* creativity—is not at all clear.

Thus, rhetorical authority based on the creativity trope (which itself is often built on weak historical and scientific evidence), seems to serve many mood memoirists’ stated purposes of removing the taboo from mental illness and helping other sufferers to be more open about their diagnosis. But this type of authority might have implications outside of the literary/artistic sphere in which the memoirists are claiming authority. After all, there are many people diagnosed with mood disorders who might not wish to relinquish an *ethos* grounded in reason or science. In many ways, the retroactive diagnosis of artists is a weakness of the mood memoir genre. Not only is the practice often medically unsound<sup>16</sup>—Styron’s presumption of Camus’s “suicide” is particularly striking in this regard—but it does little to break down the traditional rhetorical limitations of the mentally ill outside of literary or creative spheres. It is possible that a diagnosis

<sup>15</sup>Lehrer’s article prompted a spate of articles in response to his position; many authors were supportive of Lehrer, and many others were deeply troubled by his conclusions. See, for example, Eric Jaffe at *Psychology Today*, Ronald Pies at *PsychCentral.com*, and James Gordon at *The Huffington Post*.

<sup>16</sup>The problematic retroactive diagnosis of mental illness echoes Foucault’s work, especially on the retroactive labeling of the ancient Greeks as “homosexual.” Foucault historicizes the term—and concept—of homosexuality, pointing to “Westphal’s famous article of 1870 on ‘contrary sexual sensations,’” as the “date of birth” of the “medical category of homosexuality” (*History of Sexuality* 43). As homosexuality itself did not exist before 1870, it is logically unsound to discuss same-sex behavior as “homosexual” if it occurred in a historical location before Westphal’s rhetorical establishment of homosexuality.

of a mood disorder might not affect one's career as a writer or artist. After all, much scientific work has been produced drawing a correlation between artists and mood disorders. However, if you work in a field that does not prize artistic genius—if you are a judge or scientific researcher, for example—this authority grounded solely in the mystique of a creative genius does you little good.

## Conclusion

Rhetoric scholars have effectively illustrated how the mentally ill have been excluded from rhetorical participation. I suggest here that rhetoric scholars should start examining the ways that the mentally ill attempt to move past this exclusion, in particular, how they employ narrative to speak against dominant perceptions of mental illness. Narrative genres provide quasi-democratic fora in which oppressed groups—such as those with neurological difference—can gain rhetorical authority. This study of the generic conventions shared across sets of narratives, and within a particular set (such as the mood memoir), makes more apparent the rhetorical challenges faced by oppressed groups.

For example, in this study, I have shown that a mood memoirist gains rhetorical authority through a variety of methods: by declaring a selfless purpose for writing the memoir in an apologia; by describing the moment of awakening to an illness; by speaking back to bad doctors; and by laying claim to others with mood disorders in order to normalize a diagnosis. The declaration of selflessness in the apologia certainly fits within a tradition of apologies shared across various sets of narrative genres; but it also reveals that mood memoirists, as a set, are aware of the stigma attached to psychiatric disability and that they seem to desire to break down that stigma. The description of the moment of awakening reveals a memoirist's desire to establish an *ethos* of a reliable narrator—of a reliable observer of experiences. By speaking back to doctors, memoirists cast the medical profession as complicit in their rhetorical exclusion, and hope to counter this exclusion by revealing medicine's weaknesses. Lastly, the convention of laying claim serves to counter the isolation and weaken the stigma that often accompanies diagnoses. In summary, this study shows how a particular approach to neurorhetorics, one that examines narratives and the generic conventions they share, provides a new perspective on the rhetorical exclusion suffered by those with neurological differences.

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