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Opium, Cocaine, and the Fall of an Empire: Drug Addiction and Medical Outcry in Sir Arthur Conan Doyle’s Sherlock Holmes

Cassarah Blackstock

INTRODUCTION

Readers of Sir Arthur Conan Doyle’s Sherlock Holmes are hardly clueless to the detective’s somewhat odd behavior and almost aloof way of speaking to others, particularly his roommate and friend, Dr. John Watson. The stories are mostly written from Watson’s point of view, with four or five exceptions. In “A Study in Scarlet,” we are given a lengthy view of Watson’s background as a doctor, which includes graduating from the University of London in 1878. Watson, having just returned from the Afghans, is searching for lodgings and, when an old friend says he might know someone, becomes intrigued. The friend, known only as Stamford, tells Watson that Holmes is “a little queer in his ideas” and that “His studies are very desultory and eccentric, but he has amassed a lot of out-of-the-way knowledge” (Doyle 16). Sherlock’s personality, however, is not his only flaw—the brilliant detective is also addicted to cocaine and morphine, which Britain was importing from Turkey. Watson, being both friend and doctor to Holmes, sees the effect that these drugs have on the detective and makes it obvious that he does not approve. If Holmes’s mind and intellect are his strengths, the drug addiction is Holmes’s weakness—one that he almost overcomes, but ultimately doesn’t.

We are first introduced to the detective’s weakness in The Sign of the Four. Holmes’s “vice” is not explicitly stated, but it is shown through Watson’s observation of him as he “[takes] his bottle from the corner of the mantelpiece, and his hypodermic syringe from its neat morocco case.” Disgusted, Watson attempts to make Sherlock see reason, “not only as one comrade to
another, but as a medical man to one for whose constitution he is to some extent answerable.” Watson sees Holmes as both a friend and a patient, someone for whom he feels responsible. In a time when British colonialism was at the start of its decline, it was not uncommon for men of a certain social standing to partake of drugs such as cocaine and opium. During the mid-1880s, cocaine was considered a medicinal miracle, and in his essay “Addiction, Empire, and Narrative in Arthur Conan Doyle’s The Sign of Four,” Christopher Keep states that “Cocaine’s medical popularity had its corollary in the commercial sector: the alkaloid was added to wines, sherries, ports, teas, lozenges, and soda drinks—Coca Cola included cocaine as an active ingredient until 1903.” Keep goes on to note that “British medical journals were overflowing in their praise of cocaine’s medicinal properties, and Conan Doyle, himself a practicing physician at the time, is also known to have experimented with the drug” (Keep 209). Doyle’s own experience with cocaine is perhaps what fueled his desire to write about a detective who also enjoys the narcotic for the effects on his mind and nervous system—which is not only euphoric but also offers a reprieve from the constant barrage of thoughts that plague him. The drug, in Holmes’s view, prevents him from stagnating. It is clear that The Sign of the Four is not the first time that Watson has witnessed Holmes use the drug, though it is the first time for readers of the series. While Holmes does not see an issue with taking the drug, Watson sees it as an addiction and sets out to keep Holmes from damaging his mind.

Addiction, however, was not something that the Victorians considered for several decades. In her essay “Victorian Opium Eating: Responses to Opiate Use in Nineteen-Century England,” Virginia Berridge opens with the statement that “Addiction was not seen as a pressing social problem in England, nor did it become a matter of public policy until 1916” (437)—right at the height of Sherlock Holmes’s popularity and publication. Even so, as England’s colonization of India grew, so too did the number of opiates being exported primarily to the Orient, specifically China. In his essay, Christopher Keep states that “opium was a major export commodity for Britain’s largest colony, India, and the British government was very sensitive to the profits that could be realized through the sale of the drug. The single largest market for opium and its derivatives was China” (Keep 207). According to Keep, China, which distrusted Britain, attempted to limit the number of opiates entering its country, which lead to the Opium Wars, the first of which lasted from 1839 to 1842 and the second of which ran from 1856-58.

Keep argues that there is also a homology between Britain and the Indian Mutiny of 1857 and Sherlock’s dependence on cocaine and morphine. He states that “Just as the nation struggles with a foreign conspiracy that has
been belatedly released into its blood stream by the events of 1857, so too Holmes is represented as dangerously ‘occupied’ by a drug with distinct orientalist overtones, one which threatens his physical health as surely as the Mutiny threatened the health of the empire” (Keep 208). After the Mutiny, Britain’s hold became tenuous and, after WWII, it faltered altogether, with lack of funds to keep what remaining colonies it had. During Britain’s colonization of Africa and India, however, there was a fear of the “other,” which Susan Canon Harris discusses in her essay “Pathological Possibilities: Contagion and Empire in Doyle’s Sherlock Holmes,” which focuses on Holmes’s poisoning in “The Dying Detective.” Harris states that when “Watson visits Holmes’s sickroom he finds the tool Culverton Smith intended to use to infect Holmes—an ivory box concealing a spring like ‘a viper’s tooth,’ and the disease becomes both a poison and a weapon, transmitted by this device identified with Africa (ivory) and Asia (home of the Indian swamp adder)” (448).

Perhaps then, this is the true crux of Sherlock’s addiction. If Sherlock represents a “sick” England—an England afraid of stagnation yet unwilling to accept any other means of stimulation—then Dr. Watson is the means to restore health by rehabilitating his friend, weaning him off the very substance that—while euphoric—offers nothing but ill effects down the line. This is the focus of this essay: to observe not just Holmes’s addiction but how Watson, as a doctor, responds to it, and what Doyle hopes to convey with this doctor-patient relationship.

THE ADDICTION
Sherlock’s addiction is one that causes consternation in his friend. Yet Sherlock doesn’t seem to care at all about the ill effects that the drug has on him. On the opening page of The Sign of Four, Watson asks Holmes to consider the long-term effects of his drug use, and while he expects Holmes to be angry with him, Holmes is not. Holmes’s answer is that “[His] mind rebels against stagnation. [He] can dispense then with artificial stimulants. But [he abhors] the dull routine of existence. [He craves] mental exaltation” (Doyle 89-90). Sherlock’s mind, which he takes great pride in, is the equivalency of the British Empire, in that the Empire was interested in bringing in the exotic spices and drugs to stimulate Britain’s subjects. Like Sherlock’s craving for puzzles which is abated only with a foreign substance, so too did the Empire long to expand its outside horizons and settled for exotic drugs and spices from India, Africa, and Turkey. While they had these colonies—before the mutinies and Britain’s loss of control and funds for them—Britain sought total control over them, just as Sherlock seeks control over the drugs he puts into his body. Despite his brilliance, however, Sherlock’s personality seems detrimental, often described as “eccentric” and
Bohemian, which the University of Glasgow’s Douglas Small, in his essay titled “Sherlock Holmes and Cocaine: A 7% Solution for Modern Professionalism” argues “demonstrates his ‘counter-culture’ status [. . .] Holmes’s cocaine use is uniquely framed, not as an addiction, but as a defiance of addiction—Holmes masters the drug as he masters the demands of his work” (Small 341-2). The cocaine he injects into his system is a “seven-percent solution” which Sherlock finds “transcendentally stimulating and clarifying to the mind” (89). Yet, as we learn in “The Man with the Twisted Lip” (which occurs after Watson attempts to cure Holmes), as well as in the opening scene in The Sign of Four, cocaine is not Sherlock’s only “weakness”. Morphine, an opiate, is also on the list, as well as a variety of other things that aren’t explicitly mentioned.

In “The Man with the Twisted Lip,” we see Watson go into an opium den with a friend of his, looking for another man whose wife fears is dead. As he walks through the rows of glassy-eyed men, one stops him and tells him to turn around. When he does so, he realizes that it is Sherlock. The detective quips, “I suppose, Watson, that you imagine that I have added opium-smoking to cocaine injections, and all the other little weaknesses on which you have favored me with your medical views” (Doyle 232). Opium dens at the time were not uncommon outside of London—the docks there importing opium, cocaine, and other exotic imports, and Doyle was certainly not the only writer to broach the subject. Oscar Wilde mentions them in The Picture of Dorian Gray, and nonfiction publications such as Figaro—a French journal at the time—describes the opium den in Whitechapel. Many literary Brits used laudanum: Percy Bryce Shelley suffered hallucinations from the drug, Robert Clive used it to ease gallstones and depression, and even Charles Dickens is said to have used it. The opium dens, however, primarily catered to seamen who had become addicted to opium, though it was easy to buy opiates over the counter, even after the 1868 Pharmacy Act, which (like Watson’s attempt to rehabilitate Holmes) was largely ineffective.

THE FAILED CURE
Watson makes no attempt to hide from Holmes his disdain for the detective’s vice. He states in The Sign of Four that he had initially lacked courage to say anything to Holmes, yet on this occasion, “whether it was the Beaune which I had taken with my lunch or the additional exasperation produced by the extreme deliberation of his manner, I suddenly felt that I could hold out no longer” and viciously asks if it is “the morphine or cocaine” (Doyle 89). What follows is the conversation discussed in the previous section, in which Holmes states that he takes the drug as a means of stimulating his brain. When Watson asks him if he presently has a case (this after Watson
feels insulted by Holmes’s deduction of his father’s life), Holmes says he
doesn’t and that is why he is using the cocaine. In his essay, Keep states that
“Watson’s pairing of cocaine with morphine, the idea that the addict might
use the one as easily as the other, was part and parcel of the ‘orientalization’
of the coca plant” (Keep 210). While the drugs are bio-chemically differ-
ent—a fact that Watson, being a medical professional, would know—there
is a sense that addicts use them interchangeably, even if that is not the case,
and it certainly doesn’t seem to be the case for Sherlock, who doesn’t seem to
partake of opiates after his experience in “The Man with the Twisted Lip.”

What is interesting here is that Watson doesn’t care about distinction
between one addictive substance to the other: Sherlock’s weakness is destroy-
ing him in the long run, despite the short-term euphoria and stimulation
that he is seeking out. Much like Britain’s short-term desires to expand their
empire and control several colonies, the long-term ramifications were either
not planned out or not considered. Britain’s importation of these drugs
and the fact that they were used liberally—and even given to children as a
means of keeping them from being too rowdy—only further exemplifies
this idea. Watson then, becomes the personification of the 1868 Pharmacy
Act. He sets out to wean Holmes off the drug and almost succeeds, though
ultimately failing. Holmes seems amused by his attempts and humors him,
though as we see in “The Man with the Twisted Lip,” Holmes is still using
cocaine, even if it is a milder dose than a 7% solution. Despite this flaw,
however, it is interesting to note that Sherlock doesn’t seem to partake of
opium; he displays, when he is under disguise as an old man, the symptoms
of being under the influence (glassy eyes, for example), but then imme-
diately, he is the same man that he normally is and even scoffs at the idea
that he would take opium.

DOYLE’S INTENTIONS
While it is believed that Doyle based Holmes on a professor of his from
medical school, it is fascinating to see the parallels between Holmes and the
decline of the British Empire. The rise of opium and cocaine use in Britain
corresponds to Holmes’s euphoric state when he injects himself between
cases and, likewise, Watson’s outcry and attempt to help Holmes end his
addiction corresponds to the 1868 Pharmacy Act. Armed with this, we
can see how Doyle uses his most popular character (despite having written
several non-fiction works and other fictional short stories) to display the
fall of the Empire due to its own need for external stimulation, injecting
foreign toxins into the body of the public and the Empire’s subjects, and
how he uses Watson in order to give voice to the idea that there are other,
safer ways to gain stimulation that have less long-term harm to the body
and the Empire. Doyle himself was a doctor and practiced medicine when
not writing, giving him ample time to not only see the adverse effects of long-term opiate and cocaine use, but also to research ways to stop it. By writing a flawed hero, he gives Sherlock not only an intriguing story but also a way for Doyle to show his own ideas on the fall of British rule and society.

What Doyle did, however, was show that it would take much more that Pharmacy Acts to put an end to the disease of cocaine and opioid addiction, as it was much worse than that. Instead, he was able to use Watson to exemplify that best intentions do not always work unless there is a more thorough follow-through. This came later when, in the late 1890s, aspirin as we currently know it was introduced, and doctors were able to prescribe something safer to the public. This in turn sparked an anti-opium movement and smoking it for pleasure was a vice that any self-respecting Brit wouldn't participate in. It wasn't until 1910 that the opium trade was finally abolished but it still took nearly five years to tighten the reigns on drug supplying and eradicate any traces of recreational drug use. By 1915, opium and cocaine were highly regulated, and anyone found selling the substance was arrested (though it was mostly purchased from Chinese, which fueled paranoia about the Chinese).

Doyle, aware of the politics and medical research at the time, would have known all of this, and it is no surprise that he makes little mention of Holmes’s vice after 1910. Instead, he changes to poisons as a method of killing, though poisoning was a rare occurrence in Britain at the time. Doyle knew the impact of his writing and knew the ramifications if he continued to show Holmes’s injecting himself with cocaine.

CONCLUSION
During a time of mutinies, distrust of the Orient, and the decline of Britain's empire, Doyle wrote about a detective that was not only the first of his kind (that is, a private consultant), but also a flawed and sick hero, who dismisses the medical advice of his friend and doctor. When he initially wrote about the now-famous detective, he had no expectations of Holmes’s success and even seemed frustrated that the detective’s popularity was above that of Doyle’s nonfiction works. Yet Sherlock’s popularity gave rise to other great “sick” detectives. In television, we have House (a specialty diagnostician with a Vicodin addiction), Monk (who not only has OCD but a wide variety of phobias, including milk), and Psych (which parodies the great detective).

Not only has Sir Arthur Conan Doyle’s character influenced other fictional characters, but Holmes has also been one of the most adapted characters, with the Guinness Book of World Records awarding the character (who has been portrayed by over 75 actors since his creation in 1887) the most portrayed human literary character in film and television. The most notable early adaptation is the 14 movie film series starring Basil Rathbone, which
BBC released between 1939 and 1946. Since then, there have been countless other adaptations including movies such as Disney’s *The Great Mouse Detective* (1986), *Sherlock Holmes* starring Robert Downey, Jr. (2009), and television shows including BBC’s *Sherlock*, starring Benedict Cumberbatch (2010-present); *Elementary* which features Johnny Lee Miller (2012-present), *Wishbone* (both the book and movie, which starred a terrier as the role of Sherlock in the 1990s), and most recently *Sherlock Gnomes* (2018).

With such a wide variety of detectives that were inspired by the famous detective, as well as the numerous portrayals, it is easy to see how significant Sherlock Holmes is, not just to the Victorians and the literature of the time, but also to literature and even television and movies today. Sherlock Holmes’s popularity, despite his addiction and Watson’s own failed rehabilitation method, is still just as significant now as it was then, and not just in England, but the United States, as well.

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Living and Dy(lar)ing Under the “Poisoned Sky” in Don DeLillo’s *White Noise*

Sydney Bollinger

**CHEMICALS IN THE AIR / CHEMICALS IN THE BODY**

Chemical threat looms above the characters in *White Noise* after the Airborne Toxic Event, during which “a dark black breathing thing of smoke” threatens normalcy for the middle-class Gladney family (109). Don DeLillo’s careful construction of this world mirrors our own, and as Jayne Anne Phillips states in a 1985 *The New York Times* review of the novel, “DeLillo has dealt not so much with character as with culture, survival and the subtle, ever-increasing interdependence between the self and the national and world community.” Truly, as Phillips describes, this novel studies a culture inundated with chemicals, both in the air and the body. In essence, the Airborne Toxic Event changes the lives of the Gladneys: Jack, a professor of Hitler Studies at the local college; his wife Babette, a busybody who may have a drug addiction; and their children. DeLillo, whose novel acts as a warning for future chemical destruction, “never set out to write an apocalyptic novel. It’s about death on the individual level” (DeLillo qtd. in Phillips). The chemical panic created in the novel does represent a type of apocalypse, though—one where misinformation and lack of information run rampant, thus forming a culture where medical chemical dependency becomes normalized in the throes of the chemical age.

The novel, published in 1985, exists within a framework of new medical advancement, particularly in the pharmaceutical industry, and a history of chemical disaster. In *The American Economy, Energy and Environment in the Eighties*, the writing centers on a specific environmental concern: “environmental problems of unforeseen hazards that are the legacy of the
chemical age” (President Jimmy Carter’s Commission for a National Agenda for the Eighties 119). In fact, DeLillo’s novel contextualizes many chemical disasters, both accidental and with reason, throughout the advancement of chemistry: the use of DDT, chemical warfare such as mustard gas or Agent Orange, the Union Carbide disaster, and Chernobyl. These disasters often cause medical crises that include “blindness, extreme difficulty in breathing and gynaecological disorders [. . .] Cancer, brain-damage and [birth defects]” (“Union Carbide’s Disaster”). Though misinformation surrounding the Airborne Toxic Event runs rampant and the cause of the disaster is unknown, the implications of this chemical fallout are seen in these past events, allowing the Gladney family to serve as the launchpad to navigate the intersection of chemical outbreak and chemical intake.

Running concurrently with the development of “chemicals in the air” during the 1970s and 1980s, America also saw a rise in “chemicals in the body,” not only as a drug for mental health, but also as a new lifestyle. In his book *Happy Pills in America*, David Herzberg states,

> Drug companies now routinely sold antibiotics and the era’s other new wonder drugs as brand-name products, marketing them with unprecedented intensity not just to physicians but also to the general public through a variety of creative means. [. . .] Commercial dynamics, in other words, shaped American notions of medicine from the earliest days of modern miracle drugs, beginning with Miltown, the first true blockbuster (6).

Thus, the marketing push for drugs such as Miltown and other antidepressants, normalized chemical dependency, because the drugs became readily available to a greater number of consumers. So, how can we mitigate this chemical crisis when we have to navigate two distinctly different spheres? Although these medications have a purposeful use, their existence, specifically the popularization and commercialization of these chemicals, correlates with the toxins released into the air due to industrial disasters or chemical warfare. In DeLillo’s novel, these spheres collide: the Gladney family lives in a world where the chemicals in the air and the chemicals in the body exist simultaneously following the Airborne Toxic Event.

Inside DeLillo’s constructed environment, and in our real, physical world, we cannot escape the intake of toxic substances. By breaking down the barriers between these two chemical realms, DeLillo posits that no one can escape these chemicals, even though the characters of the novel believe they can separate these two spheres, “other”ing the idea of chemical toxicity. One of Jack’s colleagues, Murray Jay Siskind, affirms this privileged desire for separation when describing his love for small-town life against
“the poisoned sky” of cities: “The eventual heat death of the universe that scientists love to talk about is already well underway and you can feel it happening all around you in any large or medium-sized city” (10). Unfortunately for Murray, this small town will become a burgeoning landscape for the very toxic living he intends to escape. As an inescapable force, the cloud of Nyodene D. serves as a constant reminder of the polluted environment, and the continuous poisoning faced by the characters, Jack included. This intersection of the chemical and then the medical, especially after Jack’s “diagnosis” and treatment, confirm that these chemicals harm human health, but are also required to prolong human life. This paradox remains present throughout the novel, even though characters such as Murray may take comfort in thinking that he will remain unaffected. However, Rachel Carson challenges notions about containing the toxic in her 1962 expose *Silent Spring*: “Man, however much he may like to pretend the contrary, is part of nature. Can he escape a pollution that is now so thoroughly distributed throughout his world?”

The metastatic pollution Carson speaks of causes a shift in the priorities of the characters, as they navigate their own crises following their exposure to Nyodene D. DeLillo’s larger study of the chemical age marries the fallout of small-town toxic disaster and desire for psychotropic medication, particularly Babette’s use of Dylar, a fictional drug used to reduce the patient’s fear of death. This drug, though fictional, lends itself to comparison with other psychiatric medications of the time. For example, after the 1970s, “Prozac became a blockbuster because the drug’s supporters successfully portrayed it as a nonaddictive, commercially available self-enhancement technology that helped women become ‘supermoms’ with careers and loving families” (Herzberg 8). Thus, Babette’s choice to seek out a cure to her fear of death, cements the tensions and overlaps between the chemicals in the air and the chemicals in the body, allowing her experience of the Airborne Toxic Event to provide a beginning for the analysis of the rest of the family’s experience during and after the event.

These chemical spheres integrate themselves fully within a medical framework, particularly in the instances of Babette’s need for psychotropic medication and Jack’s diagnosis following his exposure to Nyodene D. However, in both of these cases, the characters either lack the information they need to understand the medical implications of their actions, or they are given misinformation about the situation. The officials monitoring the Airborne Toxic Event, SIMUVAC, also lack information about the event and are using the Airborne Toxic Event as a simulation, thus crafting it as a serious health and environmental emergency, as well as a learning experience. When talking with Jack, one of the men tells him, “we thought we could use it as a model” (134). In essence, this opaque missing link between crisis
and care allows for the novel to accurately portray the chemical age as an age that also led to medical misinformation, particularly due to the lack of knowledge about the ways these chemical disasters will affect human health in the future.

As the novel progresses, Jack begins to believe that his previous diagnosis negatively affects his health; however, he never receives a “true” diagnosis that explains his medical condition or that can give him clarity on how exposure to Nyodene D. will affect him. This lack of information highlights how DeLillo intersects the chemicals in the air and the chemicals in the body to critique our own trust of the chemical age when we do not know how these current actions will continue to affect human life. This novel, then, studies the beginning of the inevitable post-human landscape of chemical disaster and medical repercussions. Medicine and chemical disaster link together because of their simultaneous development. Without a clear diagnosis, Jack cannot pursue a medical care that can treat his ailment; without access to an adequate psychiatric practice, Babette acquires Dylar from a questionable source. On their quest for medical knowledge, both Jack and Babette either fail to find what they need or are let down by their own misconceptions of the availability of medical care. Thus, the novel studies on the chemicals we ingest, their effect on our bodies, and the ways we must navigate a world where we do not have access to scientific information or medical expertise that can save us.

**COLLEGE-TOWN CHEMICAL CRISIS**

In the first chapter of *White Noise*, Jack describes the ritualistic events that begin the college academic year, which creates a landscape marked by overt middle-class American normalcy. For Jack, this tradition represents a communal identity: “This assembly of station wagons [. . .] tells the parents they are a collection of the like-minded and the spiritually akin, a people, a nation” (4). The absence of chemical discussion at the start of the novel works to establish Jack’s community as an “every-community.” Within this setting, nothing abnormal should take place and so, the coming events, specifically the future toxification of the environment will become a surprise to Jack, as well as his community. However, as David B. Morris says, the coming event “was predetermined by the inherently unstable relations among humans, technology, and the natural world. Toxic black clouds will continue to arrive simply because all the conditions for their arrival already exist” (5). By setting up a world where the characters possess no known understanding of the conditions that could potentially house their college-town chemical disaster, DeLillo, through Jack’s narration in this first paragraph, creates an ironic dissonance, portraying Jack’s world as a world that thrives on perceptions and misinformation.
Furthermore, this cult of misinformation lays the groundwork for the tensions found between chemicals in the air and chemicals in the body, specifically beginning with the existence of Babette’s Dylar prescription in the Gladney household, which Babette’s daughter Denise finds before the Airborne Toxic Event. Instead of asking Babette about the drug, Denise turns to Jack after finding the medication, and with concern for her mother, tells Jack about the drug: “Dylar. One every three days. Which sounds like it’s dangerous or habit-forming or whatever” (62). Though “one every three days” likely does not form addictive habits, Denise’s instant conclusion that Dylar endangers her mother highlights these characters’ inability to understand the use of these chemicals, specifically the use of psychotropic drugs by women. Without access to reliable medical expertise, Jack and Denise assume that Babette must be an addict. In fact, the commercialization of medication plays into Jack and Denise’s perception of Dylar, which, as a non-commercial drug, was not a household name for these characters, which also meant that the characters lacked easy access to information about this drug. Herzberg comments on the perception of psychotropic drugs in middle-class families such as the Gladneys, when he says, “tranquilizers and antidepressants served as icons in the inner lives of the white middle classes, defined in part through contrast with illegal ‘street’ drugs, and praised or vilified for what they revealed about the nature and fate of white middle-class culture” (3). Not only does Babette take an unknown drug, her choice of chemical assistance rejects her own class-standing, making this not only a personal chemical crisis, but a choice that affects her family, and more specifically, her family’s identity in their community. Further, the fact that Babette appears to hide her drug use from her family, points to her own anxiety at outwardly expressing her own mental instability, as if her place as the matriarch of the family would not allow this behavior. Her chemical dependency has now changed her own family’s perceptions of her character and her actions as the inch toward the Airborne Toxic Event; her own dabbling in “toxic” chemicals instills fear, as if nothing should be wrong.

Before dubbed an Airborne Toxic Event, the black cloud of Nyodene D. garners many descriptions from the different characters, pointing to the newness of the phenomenon, especially as something not understood by the larger population of the Gladneys’s town. In a span of two pages, the characters refer to the cloud of Nyodene D. as “a lot of smoke,” “pretty toxic or pretty explosive stuff,” “a slightly larger accumulation, a towering mass in fact, maybe a little black now,” “a feathery plume,” “not a plume,” and “Nyodene Derivative or Nyodene D” (108-109). The conflicting terminology points to the lack of information available to people in this community, especially because this form of chemical crisis should not take place in their town. For Jack, this toxic cloud inconveniences his daily life and forces him to confront
both the chemicals in the air and the chemicals in the body. Coming from a place of privilege, Jack’s understanding of these toxic events extends only to chemical disasters such as the Union Carbide disaster or Chernobyl, both events which are foreign and would not affect a middle-class college town. After watching the cloud of Nyodene D, Jack asks his son Heinrich, “What if it blows this way?” to which Heinrich replies, “it won’t come this way” (109). In addition to Heinrich being no more informed on the event than anyone else, his adamance that his family should face no harm from the cloud of Nyodene D. is also misguided, because the very existence of this disaster near their home rejects the idea that they can remain safe from this event. Similar to the situation involving Babette and Dylar, the Gladney family draws their own conclusions about the toxic cloud, not only because they have their own perceptions about whether or not the toxic cloud will come their way, but also due to the fact that reliable information remains absent, forcing them to draw their own conclusions.

These conclusions often rely on Jack portraying himself and his family as victims of the Airborne Toxic Event, rather than perpetrators, another sign of their considerable misinformation about both their consumerist lifestyle and their own bodies. Now, the Gladneys have no choice but contamination. Unlike Babette’s Dylar use, the Gladneys cannot choose whether or not to face exposure to Nyodene D. While driving to their evacuation point, Jack gets out of the car to pump gas, which exposes him to “the enormous dark mass [which] moved like some death ship in a Norse legend” (124). He goes on to express fear of the toxic cloud, but cannot recall specifics about what exactly makes the cloud toxic: “It was a terrible thing to see, so close, so low, packed with chlorides, benzines, phenols, hydrocarbons, or whatever the precise toxic content” (124). Jack’s ignorance cannot remain overlooked, because, as Morris laments, “The new danger from environmental degradation is less alien than total nuclear war. […] The enemies are everywhere and include us, especially in our social rules as hapless, but far from innocent, consumers” (Morris 12-13). In this context, DeLillo offers an interesting look at American consumerism, particularly when that consumerism leads to our own toxicity, of which we choose to ignore. Furthermore, Jack expresses irritation, because he must evacuate: “I’m the head of a department. I don’t see myself fleeing an Airborne Toxic Event. That’s for people who live in mobile homes out in the scrubby parts of the county” (115). Jack can no longer remain separate from these chemicals, because his wife ingests a psychotropic drug, he exposed himself to Nyodene D., and the onset of these two events result from a culture of consumerism. The clouded information surrounding the Airborne Toxic Event itself points to the larger consequences of a community founded on misinformation and characterized by ignorance.
NYODENE D(YLAR)

Jack receives his diagnosis at the evacuation center, where these chemical spheres collide, because his exposure to Nyodene D. at the gas station leads to a medical condition, although that the details of his condition remain elusive. In regard to the effects of chemical exposure, the technician tells Jack, “we definitely have a situation […] If you’re still alive [in fifteen years], we’ll know much more than we do now. Nyodene D. has a life span of thirty years. You’ll have made it halfway through” (DeLillo 136). At this point, the technician admits both that the chemical exposure will adversely affect Jack’s health and that he himself does not know too much about the situation. The SIMUVAC worker’s vague statements frustrate Jack, who wants clear answers about the future of his health; however, even the SIMUVAC workers lack this information, and have decided to use the Airborne Toxic Event as practice for later chemical disasters: “we thought we could use it as a model” (134). Though, clearly, Nyodene D. could potentially harm Jack, the lack of communal knowledge shows, as described by Laura Barrett, how “the expected order of events has been inverted: event precedes rehearsal. The result is a life hopelessly circular and illogical” (98). The existence of Nyodene D. changes the landscape of Jack’s life, and rather than receiving a clear medical diagnosis, he, like his wife, is at the mercy of a greater force that better understands these medical repercussions. In fact, Jack finds out that even though the worker has access to his medical history, he still cannot receive a clear answer about his future health: “I punch in the name, the substance, the exposure time and then I tap into your computer history. … This doesn’t mean anything is going to happen to you as such, at least not today or tomorrow. It just means you are the sum total of your data. No man escapes that” (136). In this text, medical diagnosis and medical treatment do not act as a point of clarity, but rather play into the larger discussion of medical misinformation, which directly links Jack’s medical diagnosis with Babette’s use of Dylar. Thus, this propels Jack toward further anxiety, leading to his fear of death, because he cannot properly treat his ailment. The side effects of these dangerous toxins remains unknown, which both shows the newness of this environmental crisis, but also how environmental toxicity only became a serious threat following large-scale investigations into toxicity in exposes such as Rachel Carson’s Silent Spring.

Medical misinformation continues with Jack’s quest to better understand Dylar; however, he fails because not even Babette’s doctor has heard of Dylar, highlighting the human condition as one marked by chemical ignorance in the form of toxic clouds and psychotropic medication. Dr. Chakravarty tells Jack, who secretly seeks out information about his wife’s drug use, “I certainly never prescribed it [Dylar] to your wife. She’s a very
healthy woman so far as it’s within my ability to ascertain such things, being subject as I am to the same human failings as the next fellow” (172). This admission furthers the Gladneys’ inability to understand their own chemical and medical crisis, as well as perpetuates sexist notions of psychotropic medication, while also invalidating the authority of the doctor. Without an authoritative response, Babette’s apparent medical care appears to be a farce, and potentially ruinous, especially because now, her treatment must be illicit since her doctor has no recognition of the drug. Furthermore, her secret use of the drug points to a larger anxiety present within middle-class families, such as the Gladneys: psychotropic drugs, “prescribed for women at twice the rates of men, became symbols of how society limited affluent women’s self-fulfillment and kept them safely ensconced in the home” (Herzberg 8). Additionally, since Jack does not discuss his sleuthing with Babette, he undermines her authority over her own health and the expertise she likely has about this medication, turning instead to outside sources to gain information about this, because he believes that it must be harmful.

Unable to find any information about Dylar, Jack chooses to confront Babette in an attempt to come to some type of understanding of her chemical dependency, and by extension, the chemical crisis that plagues his community. Jack’s lack of information prompts him to place his own preconceived notions on Dylar, and thus, he also attempts to explain Babette’s illness away, discouraging her from needing these chemicals. As she describes her experience taking Dylar, Jack continually interrupts her until she finally tells him, “I’m afraid to die [. . .] I think about it all the time. It won’t go away” (DeLillo 186). Here, she both admits the reason for her chemical dependency and her failings as a wife and mother. This fear of death overwhelmed Babette to the point of experimental treatment, which she pursued irrespective of the fact that no research had been published on the drug and the effects were unknown. Although Jack expresses concern at Babette’s condition, his attempt to understand her need for Dylar fails because his chemical exposure has marred his worldview, causing him to question the validity of Babette’s condition: “How can you be sure it is death you fear? Death is so vague. [. . .] Maybe you just have a personal problem that surfaces in the form of a great universal subject” (DeLillo 187). By trivializing Babette’s condition, he marginalizes the chemical crisis that affects him, too, because he fails to understand how his own condition and his wife’s condition link together, specifically because they both have ingested chemicals and both of these events affect their bodily health. Furthermore, this logic allows Jack to situate his chemical experience as more serious than his wife’s fear of death, thus leading to his interest in Dylar as a possible solution to his inevitable death due to chemical exposure. At this point in the text, the chemicals in the air and the chemicals in the body collide,
because now Jack seeks treatment for his misinformed chemical by using an illicit psychotropic drug.

Though Jack sees usefulness in Dylar, especially to cure his own chemical ailment, as the couple continues their conversation, Jack realizes that the drug has not cured Babette of her depression, and thus, the novel critiques this chemical dependency, especially as Babette’s drug use, though a hot topic for the Gladney family, ends as a failed experiment. Babette laments her use of Dylar and tells Jack, “I’ve now taken twenty-five from that bottle. That’s fifty-five all told. Five left. [. . .] The very beginning was the most hopeful time. Since then no improvement. I’ve grown more and more discouraged” (DeLillo 191). Without any success, her chemical dependency yielding no results, Babette’s discouragement runs parallel with many women’s experience with these type of psychotropic drugs. Drugs like the Miltown or the fictional Dylar, as Jonathan Metzl states,

thanks to pharmacology, [could cure] ‘emotional’ problems [. . .] simply by visiting a doctor, obtaining a prescription and taking a pill [. . .] psychopharmaceuticals came of age in a post-war consumer culture intimately concerned with the role of mothers in maintaining individual and communal peace of mind (242).

Babette’s need for Dylar stems from her own feelings of inadequacy, and the failing of the medication itself again references the lack of information available to their community for both Babette’s ailment and chemical effects. The experiences of Jack and Babette highlight the relationship between chemicals in the air and chemicals in the body. In particular, Babette’s experience with psychotropic medication and Jack’s experience with chemical contamination both center on the need for adequate and informed medical care. Although during the chemical age the science behind these medical developments advanced, this information was often withheld from the public. At this point, Nyodene D. and Dylar become one in the same, both resulting from a cultural landscape marked by medical and scientific progression.

**FINDING CHEMICALS / CURING FEAR**

Babette’s acquisition of Dylar points to thematic undertones, which relate directly to unavailable information and misinformed medical care. Instead of receiving a prescription from her doctor, Babette meets with Mr. Gray, a man who sets up these drug transactions in a motel and gives his customers Dylar in exchange for sex (185). Furthermore, throughout this conversation, Babette insists on treating her relationship with Mr. Gray as a transaction: “I did what I had to do. I was remote. I was operating outside myself. It
was a capitalist transaction” (185). By framing her relationship with Mr. Gray in this way, DeLillo points to the abysmal state of mental healthcare for Americans, particularly women, which DeLillo often displays through Jack’s belief that Babette does not need to pursue a chemical solution to her fear of death. However, again, Jack sees his situation as different than his wife’s leading him to pursue Mr. Gray in search of both information and revenge. His anger at this man’s violation of his wife propels him toward destruction. The chemical dependencies referenced throughout the novel, heighten our understanding of these characters’ chemical fear. Now, Jack must look critically at his own involvement with chemicals, especially as the health of his family remains at stake, and he must pursue medical treatment for his chemical exposure.

Upon hearing about Babette’s Dylar acquisition process, Jack begins to contextualize his own chemical experience and diagnosis, within this new medical framework his wife has made available to him. His diagnosis led Jack to ponder not only fearing death, but the inevitability of his own death, potentially due to chemical exposure. He tells Babette, “I’m tentatively scheduled to die. It won’t happen tomorrow or the next day. But it is in the works” (192). In essence, his own concern for impending death and the Nyodene D.-caused environmental health crisis factor into the natural progression of life. Jack’s cluelessness resonates with a deep human need to understand and conquer death; he knows that death comes for him. However, the discussion of death should not overshadow the chemical crisis at hand. For Jack, as discussed by Greg Garrard,

[his] exposure to the toxic cloud leaves him adrift in uncertainty [. . .] Such a projected or simulated death seems somehow superior to the subject’s own living reality. [. . .] Death and environmental disaster, which might seem to exemplify the real, are subordinated to the order of simulation in which every narrative of threat and resolution is hackneyed and insincere (171).

Thus, his musing on death leads him to pursue the mysterious Mr. Gray to better understand Dylar and his wife’s interest in the drug. Additionally, the chemical ambiguity surrounding Dylar plays into DeLillo’s satire: Jack intends to cure himself of death, but death cannot be cured.

As Jack continues living after the Airborne Toxic Event, he searches for cures and tests in order to better his own life, an effort that often fails because Nyodene D., though a known chemical danger, has unknown long-term effects on the human body. In order to better understand his future health, Jack goes to Autumn Harvest Farms for medical testing. While reading a printout of Jack’s testing results, the examiner asks Jack, “Have you ever
heard of Nyodene Derivative? [. . .] There are traces in your bloodstream’’ (265-266). However, Jack pushes back against this claim, saying that he has not heard of Nyodene D., even though he has been exposed to the chemical and the SIMUVAC worker told him that this chemical exposure could adversely affect his life. Here, again, we see the problematic notion of chemical knowledge come into play. Although the Airborne Toxic Event changed the landscape of Jack’s community, the content of the black cloud had been forgotten. In this context, especially, chemical misinformation leads to a medical crisis: “‘We have some conflicting data that says exposure to this substance can definitely lead to a mass [. . .] A possible growth in the body [. . .] It’s called a nebulous mass because it has no definite shape, form or limits,’” the doctor tells Jack (266). However, this medical crisis also exists in the throes of missing information, because the examiner, while they know that a mass could potentially develop, has no way of predicting the seriousness of said mass, or even if Jack will develop a fatal nebulous mass.

“AM I GOING TO DIE?”
Jack’s medical panic about the nebulous mass leads him to seek out Dylar, even though he knows of its potential failure, which points to the novel’s larger critique of chemical panic and the resulting fear of death. Upon gathering information about Dylar and Mr. Gray, also known as Mink, Jack forms a plan: “shoot him [Mink] three times [. . .] scrawl a cryptic suicide note on the full-length mirror, [and] take the victim’s supply of Dylar tablets” (DeLillo 290). Here, Jack purposefully inserts himself into the chemical crisis, transcending the idea that these spheres should be separated, which leads him to “imagine other modes of experiencing [his] relation to the earth. We [Jack] may even come to see the earth anew, as if awake for the first time to its mute, impenetrable resistances to thought” (Morris 5). Jack’s quest to escape death in the face of a medical disaster for his own body, means that he also seeks to escape the human species, because death is inescapable. By reading this study of death through a chemical panic, we can come to better understand the fragility of human life in the face of our own chemical creations.

Jack’s interest in death did not begin after his experience with Nyodene D., but rather these thoughts consumed him throughout the novel. At the onset of the novel, Jack ponders on the idea of death: “I wonder if the thought itself is part of the nature of physical love, a reverse Darwinism that awards sadness and fear to the survivor” (15). However, his seemingly simple musings on death become serious through the lens of chemical crisis and Dylar, especially because Jack seeks Dylar in order to refrain his own mind from mulling over its eventual chemical demise at the hands of Nyodene D. While talking to Mink about Dylar, Jack suggests that an effective medica-
tion will be created, but Mink pushes back against Jack’s hope for a better medication, because it would be “Followed by a greater death. More effective, productwise” (294). At this answer, Jack questions Mink, asking, “Are you saying death adapts? It eludes our attempts to reason with it?” (DeLillo 294). Thus, Jack’s search for a cure-all, not only for his fear of death, but also his chemical exposure fails because death remains inescapable. In an effort to gain the upper hand, Jack shoots Mink. While looking at Mink’s body, Jack “felt large and selfless, above resentment,” showing him as both a witness to death and become death in a dying body (299).

Throughout DeLillo’s novel, the longevity and availability of toxic chemicals exist in a black cloud hovering over Jack Gladney’s college-town, a testament to missing information and medical crisis. Though the community remains confused about Nyodene D and Dylar, Jack understands the danger of these toxic chemicals:

That little breath of Nyodene has planted a death in my body. … It has a life span of its own. Thirty years. Even if it doesn’t kill me in a direct way, it will probably outlive me in my own body. I could die in a plane crash and the Nyodene D. would be thriving as my remains were laid to rest” (144).

The chemical age of the twentieth century created a surge in chemical development. However, we continue to lack information about these chemicals and chemical disasters run rampant, both in the air and in the body. American chemical dependency speaks volumes about our relationship with death, particularly in a culture filled with misinformation and poor medical care. The Gladneys, and Jack in particular, highlight how DeLillo’s novel about the chemical age becomes a study of human death and the inevitable posthuman landscape. We need chemicals for the body to survive, but chemistry can kill us just as easily. Chemical apocalypse seems insignificant in the face of inescapable death, because current chemical disaster may not adversely affect a large population. Unfortunately, though, the adverse health effects of Nyodene D or DDT last well into the future, and as the world continues to modernize and globalize, the risk of a global health crisis becomes increasingly greater as the effects of these chemical disasters and our chemical dependencies are slowly discovered.

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Depression and the Fairer Sex: “The Yellow Wallpaper” as a Reaction to Gendered Psychiatry

Kati Bowden

PSYCHIATRY AND WOMEN

Since the formal coining of the term “psychiatry” in 1808, a fascination with what ails the mind and causes victims to suffer has driven research to understand the human brain in all of its complexity. Depression, in particular, deeply interested the new doctors, serving as a potential key to many problems and afflictions which were before believed impossible to solve or cure. In his chronicle of the disease titled *From Melancholia to Prozac: A History of Depression*, Clark Lawlor studies the evolution of the human understanding of that state of mind which has rendered so many helpless and despondent. Once the diagnosis was identified, precursors to modern depression were blamed for nearly every negative reaction or emotion that a person could have. Through the years, the definition of the disease was refined, and the name changed multiple times. In the late nineteenth century, the morose malady of the mind was slowly transitioning between being called “melancholia” and “neurasthenia.” The two terms were often treated as separate diseases, despite their similarities. Maurice De Fleury of France explained that both were “affective or emotional conditions related to physiological states of over- or under-excitability: depletion of energy or nerve force versus an unhealthy lack of expenditure” (Lawlor 131). Later, in the twentieth century, the two diseases would merge into what we now classify as clinical depression, which would in turn become one of the most studied illnesses in modern psychiatry.

As psychiatry spread through the educated world, there was a noticeable focus on men, which meant that women and their psychology were largely
ignored, unless their infirmities could be related to theories centered on and created by men. Perhaps most notable for his male-centric understanding of the world and the mind was Sigmund Freud (1856-1939). His “phallic-centered thinking” was most recognized in his penis-envy theory, which debased the value of women's sexuality and mental development by claiming that women and their development advanced based on their jealousy of male genitalia and what societal importance accompanied the possession of that phallus (Moynihan 195). Although these theories are now recognized as largely invalid, Freud did manage to attract a large following and inspire studies based on men and their social superiority to women. Truly, Freud flourished in man-built field, with little regard or understanding of women incorporated. This can be partially blamed on the significant lack of women in the field who were not mere disciples or assistants. Those whose work was their own, no matter what it studied, found themselves ignored and shunned from the practice by the overwhelming sexism present.

While an understanding of the brain and its many illnesses spread and eventually bled into the popular culture, other fields began to take hold of these newly introduced concepts. Literature was one of the major playgrounds of popularized psychiatry: a wave of representation of those disorders now recognizable by name engulfed the new works being produced, and there were many retroactive examinations of works already accepted into the canon for any sign of mental trouble. Specifically, critics and audiences alike analyzed female characters whose motives and responses had previously been questioned or blamed as merely hysterical or irrational. According to Marilyn Maxwell in “Socialization of Women: A View from Literature,” “the hypothesis that depression may be a symptomatic response to an unequal distribution of power that affects those who are most vulnerable [provided] the literary critic with a new interpretive lens through which to ‘re-view’ most, but not all, fictional women” (222). These new interpretations of well-known female characters led to representation for women who had previously felt isolated from others due to their own internal conflicts. An application of psychiatry to literature illuminated the problems that women faced by encouraging them to recognize or even speak up about their own problems that would have remained neglected and in the shadows otherwise.

CHARLOTTE PERKINS GILMAN AND HER HEALTH
Physically, Gilman was a specimen of the ideally fit woman in the nineteenth century. She had always enjoyed exercise in school and her daily life, often finding herself to be in wonderful health. Mentally, Gilman was very sharp and found herself enamored with the arts. She seemed to be the picture of health for most of her life, until the birth of her only child,
Katharine Perkins Stetson, in 1885. During her pregnancy, Gilman noted in her journals bouts of what she calls “that increasing depression,” which made her unwilling to do simple tasks, like get food for herself or even write (Living 1586). As an inexperienced mother, Gilman assumed that this was just a part of pregnancy, and ignored her troubles for the duration of her gestation. However, once Gilman gave birth to Katharine and realized she experienced “an extreme of nervous exhaustion which no one observed or understood in the least,” her mental health became a priority (1606). Her husband Walter hired a maid and a nurse to help with the basic care of the baby, which Gilman found herself incapable of. Soon, the new family moved as if to escape the dreariness that Gilman felt, but, according to Gilman’s own writing, she merely “lay all day on the lounge and cried,” despite living a life that she simultaneously deemed ideal (1606).

What Gilman seemed to have experienced was postpartum depression, a form of the disorder particular to new mothers who could be reacting to any number of triggers. According to the studies of Ruth Nemtzow, C.S.W., Gilman seemed to suffer from Moderate to Severe Depression in this period. Symptoms listed include “feelings of inadequacy, an inability to cope, tearfulness [, . . .] despondency, listlessness, apathy, self-derogatory feelings, indecisiveness, inability to concentrate, and multiple somatic complaints,” most of which Gilman admits to experiencing in Chapter VIII of her autobiography, a section aptly titled “The Breakdown” (134). However, studies of depression at the time were broad, and there was essentially no professional assumption that a specific kind of depression could be linked to new mothers. Despite this lack of “real” evidence, there were plenty of tonics and easy fixes readily available to mothers like Gilman, such as the renowned “Rest Cure,” which Silas Weir Mitchell established in the late 1800s. While it was believed to help some patients, condemnation of the “cure” for doing more harm than good for patients who succumbed to their mental failure during their treatment was widespread. Under the advice of Mitchell, Gilman attempted to “lie down an hour after each meal; have but two hours’ intellectual life a day; and never touch pen, brush or pencil as long as [she lived]” (1697). This attempt at wellness by Gilman lasted perhaps three months before she “came perilously close to losing [her] mind” (1697). Clearly, this “cure” was not meant for a woman as intellectually busy as Gilman.

“THE YELLOW WALLPAPER”
Published in 1892, “The Yellow Wallpaper” reflects Gilman’s experience under Mitchell’s “Rest Cure.” Throughout the story, the treatment forces the unnamed female narrator into isolation from her newborn son, husband, and loved ones who come to visit, and it prescribes her nothing but
idleness to cure her distraught nerves. She is locked in a room that “was nursery first and then playroom and gymnasium [. . .] for the windows are barred for little children, and there are rings and things in the wall.” It is papered with “one of those sprawling flamboyant patterns committing every artistic sin” that haunts her in both sun- and moonlight (66). This room is isolated, taking up an entire floor of their summer home on its own, and despite its inclusion of “windows that look all ways, and air and sunshine galore,” it becomes the narrator’s constrictive prison, as she is not allowed to leave except by allowance of her physician, and eventually finds herself locked in the room, both by her keepers’ doing and then by her own will (66). Gradually, the narrator slips into insanity, finding her only company with a woman who seems to live trapped within the garish wallpaper. Eventually, the narrator slips into such mental disrepair that she and the woman in the walls become one, and she destroys the wallpaper for the sake of her own freedom. She is so far gone that she is no longer able to differentiate her reality from the shadows in the patterns of the paper. This is perhaps the destiny Gilman saw for herself, had she followed Mitchell’s advice and remained dormant.

Within the text, the only representation of a physician available is John, the narrator’s husband, who prescribes this rest to her. The narrator describes John as “practical in the extreme” and having “no patience with faith, an intense horror of superstition, and he scoffs openly at any talk of things not to be felt and seen and put down in figures” (42). He seems to be a man of strict science, and he proves to lack any overly sentimental affection for his wife throughout the story. His adamant dismissal of his wife’s concerns mirror the disregard for the female voice in the world of psychiatry and the denial of complaints based on feminine experience. This neglect eventually leads to the heroine’s isolation and consequential insanity. Critics have argued that her eventual succumbing to insanity “should finally be viewed not as a final catastrophe but as a terrifying, necessary stage in her progress toward self-identity and personal achievement” in response to her oppression under her husband’s care (Johnson 523). How cruel it is, then, of male-based science and psychiatric medicine to only free a female patient from its grip once she has lost her mind.

Postpartum depression, the source of the narrator’s suffering and cause of her incarceration, was not considered an illness at the time, despite its overwhelming presence in the lives of young women across America, at least. When the tale was published in magazines across the country, Gilman received letters from both physicians and female patients sympathizing with the heroine and finding themselves relieved that Gilman replicated their experiences in literature. One response that Gilman received asked if the story was based on truth, and when she confirmed that it was, in
fact, based on Gilman’s own case, he shared that “he had a friend who was in similar trouble, even to hallucinations about her wallpaper, and whose family were treating her as in the tale” (Living 2001). Upon their reading of the story, their reaction to the woman’s complaints became much more proactive, resulting in their “[changing] her wallpaper and the treatment of the case,” and in her successful recovery from her depressive state (2001). The fear that their loved one could fall into the same insanity as the narrator drove them to listen to her and to try to adjust to her needs, as opposed to suppressing her in the hopes that idleness and calm would heal her. When medical professionals prioritize the mental health of the patient, the dire end results are often curtailed, and in the case of this young lady, the potential of insanity is avoided.

As a classic piece of feminist literature, scholars often analyze “The Yellow Wallpaper” as an example of the frustrations of the embattled woman within her oppressive patriarchal world. According to Jürgen Wolter, whose study of the text appeared in the 2009 edition of Amerikastudien, “feminist readings have seen the wallpaper as representing either the narrator (her individual unconscious and the dependence of women in general) or her husband (and a society that victimizes women),” and have primarily stuck to examining the relationship between the two (200). Few scholars, however, have studied the relationship between the narrator and the author of the story, despite the significance of that connection for women. After all, both women are victims of depression as a result of their recent delivery of a child, as well as the shortcomings of the contemporary field of psychiatry, and both are prescribed the Rest Cure. Their primary difference is their individual end results in the process of that treatment: Where Gilman broke away from the Cure and healed herself through what ministrations she believed would best benefit her, her narrator falls into complete insanity as a result of being forced to comply with the restrictive instructions of her husband. These results define the two women while also reflecting the failures of psychiatry in helping female patients with cases particular to their societal struggles and station.

FEMALE FRUSTRATION
Within “The Yellow Wallpaper,” the language in the narrator’s diary entries stress the frustration the woman feels to escape her room and her husband’s condescending professional opinions, and reflects the same frustrations that women like Gilman felt under the thumb of psychiatrists unwilling to pay attention to their needs. John, her husband and physician, places the heroine under a strict regimen of “phosphates or phosphites - whichever it is, and tonics, and journeys, and air and exercise” while simultaneously being “forbidden to ‘work’ until [she is] well again” (52). The idea behind this
treatment was to coddle the patient’s mind into health again and relieve it of any stressors that may overwhelm her fragile female psyche. In the cases of both Gilman and her character, psychiatry ignored their actual needs in favor of what was determined, by men, to be the most useful means of treatment for their sex-specific condition: postpartum depression. Gilman used her narrator as a conduit for her own grievances with the experience, and confesses the entrapment she felt in the process of her treatment.

As a patient, the narrator seems to want desperately to trust her physician and his clinical analysis of her condition. But does she respect him because she respects his conclusions, or because, as a woman, she has to respect his position as a medical professional? Early in her telling of her story, the narrator confesses that perhaps John’s being a physician is to blame for her deterioration. John does not listen to her complaints or her expression of her feelings, but instead insists that he knows what is best for her and that she just is not aware of her own health in the same way he is. This makes the narrator wonder what one is to do “if a physician of high standing, and one’s own husband, assures friends and relatives that there is really nothing the matter with one but temporary nervous depression” and question how she is meant to assure her loved ones that she is fine, or that she would be, if she were allowed to pursue her own theory that “congenial work, with excitement and change, would do [her] good” (42, 52). Her writing the diary entries that comprise the short story is her own form of therapy, but she keeps it a secret because she knows that it would count as a form of work that John condemns. According to Greg Johnson, the narrator “understands the healing power which inheres in the act of writing and recognizes intuitively that her physician husband’s rest cure can lead only to her psychic degeneration,” but she is not able to follow through on her own theoretical healing because John is an established power over her in terms of medical expertise (527). Despite her recognition of the flaws in John’s psychiatric methods, the narrator is unable to assert her voice in her own healthcare, leaving her locked in a constrictive pattern of being displeased with her treatment, but unable to change it in any way.

John’s dual role as both the physician and the husband of the narrator traps her even further in her despondent situation. As Harriet Goldhor Lerner puts it in her study titled “Female Depression: Self-Sacrifice and Self-Betrayal in Relationships,” “it is not women’s ‘affiliative needs’ or ‘relationship-orientation’ that predisposes females to depression [. . .] rather, it is what happens to women in relationships that deserves our attention” (218). The case of the narrator and her husband stands as a representative of the harm that can happen in marital relationships, and then in turn contribute to depression in the wife. In her attempt to remain a good and loving spouse, the narrator makes personal sacrifices in an effort to please
her husband and, ironically, to soothe his nerves as he works to heal hers. One of her greatest concerns in the first half of the story is avoidance of worrying John that her condition is atrophying, despite clear evidence in her writing that that is precisely what is happening to her mind. Many times, the narrator relates a desire to bypass concerning John with her condition, which perhaps, in turn, makes him believe that his methodology is working for her. As her energy wanes, she literally cries to John multiple times about the changes she would like to see made in her treatment, and undeterred by his constant dismissal of her wants, she still manages to admire his affection for her. In an instance of her insistence that John allow her to see her loved ones, she notes that John “loves [her] very dearly, and hates to have [her] sick,” and goes further to depict his love by describing his tender care of her after her bout of emotions with admiration (“The Yellow Wallpaper” 159). Her love for John and for the kindness he treats her imbue a sense of helplessness within the wife: If the pair love each other so, why does John ignore her pleas for help, and why does she feel as if her expression of her problems would anger him or in any way disturb their relationship? Simply put, this is a reflection of the subservience that late nineteenth century American society demanded of wives, and that was demanded of, and yet not yielded by, Gilman.

As a wife to her first husband, Walter Stetson, Gilman was treated as an equal in her relationship. This can be attributed to the mutual respect that the duo felt for one another, as Gilman had established herself as an accomplished writer before their meeting, and Stetson was an admired artist. The two never demanded inequality from one another in their marriage due to any mundane gender expectations, which perhaps further frustrated Gilman when she found herself judged and diminished by the psychiatric world due to her sex.. Finding her drive and accomplishments damned as a cause for her breakdown, and then hearing that she was forbidden from performing them in an effort to mend was a shock: As she says in her autobiography:

To step so suddenly from proud strength to contemptible feebleness, from cheerful stoicism to a whimpering avoidance of any strain or irritation for fear of the collapse ensuing, is not pleasant [. . .] To lose books out of one’s life, certainly more than ninety per cent of one’s normal reading capacity, is no light misfortune (Living 1748).

Gilman, much like her narrator in “The Yellow Wallpaper,” found herself circumvented by modern medicine, and was frustrated that her wellness hinged on her sacrifice of what she loved. The creation of the narrator and
her ensnarement demonstrated the feeling of being stuck in a process of being cared for, yet simultaneously ignored, by male-centric psychiatry, and illustrated Gilman’s need for a greater understanding of women in the field, or, to gain that understanding, the inclusion of more women who were able to apply experiential knowledge to the handling of similar cases.

**MASCUINE MANAGEMENT**

In the household Gilman creates in “The Yellow Wallpaper,” John’s dual roles as the husband and the family physician enable him to make decisions about what is best for his wife without considering her input, mimicking the control that male-centric psychiatry extended over female patients without cogitation of the female voice. In a field led and developed by men, where could women find themselves represented? How were women expected to heal from disorders specific to their physiology or psychology if no one in the field could apply realistic insight attained through study or experience on what exactly those disorders were, or their causes and effects? Put under the care of men who either didn’t have the knowledge to treat women in a fashion that would best serve them, or who frankly did not care to attempt to understand the differences in gender-specific treatment, female convalescents were left with little hope. Stereotyped as reliant on their ability to give birth, they were popularly believed to be “controlled by the reproductive system,” and it was thought that they “derived their mental ailments from that cliched source,” which served as a reason not to invest time and effort into studying their mental ailments (Lawlor 108). After all, if the functioning of a uterus caused these problems while also ensuring the furthering of lineage, why try to stop what was believed to be a natural side effect of having that organ? John exemplifies this disregard for the exploration of female study by ignoring his wife’s concerns or her own theories that may have halted her sanity’s decay. His taking on the responsibilities of both offices to determine what is best for the family unit as a whole leaves his wife helpless to his supposed remedies. John essentially lives with unchecked power in his summer home, similar to male psychiatrists in Gilman’s contemporary world, and dictates the life and health of his wife, despite not understanding what she wants and what she deems her stressors to be.

John hopes to coax his wife’s mind back into working order not only for her own good, but also to restore her position as the mother of their child, so that his life and success as a physician may go on uninterrupted. This involves giving her examples of maternity perhaps meant either to shame her back into her role or to encourage her by making motherhood appealing. However, he does this in a manner that echoes the idea of isolation prevalent in Victorian treatments of depression and mania. Though his wife craves more socialization than she gets from the company of her immediate
family and her sister-in-law Jane, John vehemently denies her request to host her own family members, stating that he would “as soon put fireworks in [his wife’s] pillow-case as to let...those stimulating people about now” (“The Yellow Wallpaper” 97). This violent imagery perhaps indicates the extremism that her husband is willing to resort to in order to see her well again. However, the idea that people with whom she wishes to speak would overwhelm her, even after she proves she is perfectly capable of interacting with those John chooses to bring into their home, implies that his decisions, and not hers, should be what alleviate her struggle. Later, John allows her company on the Fourth of July—this time, a much more appropriate context for fireworks—but he still denies her those family members she asked for by name in favor of “Mother and Nellie and the children,” a group that “suggests conventional domesticity” (“The Yellow Wallpaper” 130, Johnson 526). John only allows what he thinks will influence his wife’s return to her job in the domestic sphere, which, in this instance, is motherhood. While there is no evidence that the presence of her other family members would have cured her depressed state, it is clear that her meeting with this group does little to help the narrator, who claims that even the lighthearted week together “tired [her] all the same” (130). According to Maxwell, a separation from family and their approval “proves to be a psychologically devastating occurrence, leading to alienation, loneliness, and depression” (233). By isolating his patient unless there is an opportunity for her to see what she could have should she return to motherhood, John disregards her right to treatment outside of her role in his household.

Unable to fulfill her roles as a mother, the narrator loses her usefulness to John and to society, and is therefore stripped of her autonomy as an adult. As has been previously established, in her dependence on John for her health-care, the wife is forced to relinquish her ability to attend to herself to some extent. She assumes the role of John’s charge with needs to be taken care of as opposed to a fully developed adult, and is infantilized by her husband and his language. Many times in the story, John uses pet names as terms of endearment for his beloved, and while this is not an odd practice in itself, his tendency to use “little” in his monikers for the sick woman is telling. Aside from darling, John calls his wife a “blessed little goose” and a “little girl,” and then claims to “bless her little heart,” all in instances when the pair converse and disagree about her illness and treatment at length (96, 172, 186; emphasis mine). By diminishing her size multiple times, the physician is able to liken her to a child who relies on him, and therefore erase her agency as an adult. Similarly, he identifies her as a “goose” and a “girl,” which casually strips her of both humanity and classification as a grown woman. Here, he associates the sickness of his wife with a childlike existence and expresses that her role has been diminished in the household by her illness. He is able
to demote her from female head of house to a mere responsibility that the family must care for, with just his cosseting language. As a representative of the psychiatric movement, John negates any expertise that his patient and women like her may have on their own condition by establishing her as intellectually inferior, as a toddler may be to an adult, and therefore ruining her credibility with anyone who may otherwise sympathize with her. Here, he exerts his control by essentially shunning her to a lower position of power, ensuring that those who understand their relationship as he wants them to will accept his word as the truth and refute any claims that the narrator may make about her own health, simply because the dynamic between the two has shifted from loving husband and wife to doting parent and dependent child. This subversion of the traditional relationship between John and the narrator results in “the woman’s strategy for coping with her situation [turning] from childlike obedience and dissimulation to open confrontation” before the story’s end as the narrator finds herself in the woman in the walls and is able to reestablish her adult being without John’s help (Wolter 205). In this instance, the domineering tendencies of psychiatrists like John backfire when the patient is able to achieve independence by turning to another source.

Gilman, much like her narrator, was removed from the role of motherhood by her doctor. Instead of being punished or guilted for not being a greatly involved mother like her character, the author was told to put distance between herself and her family in hopes that a change in location could soothe her nerves. There was no pressure from either Gilman’s doctor or her husband to return to her child, as the mere presence of the infant caused “sheer continuous pain” for the new mother (Living 1632). Unable to relate entirely to her own creation, Gilman wrote the narrator as an example of extremes, showing an isolated woman under complete control of one man who viciously diminishes her value as a wife and a mother, when neither of those roles were taken from Gilman so much as they were turned away from by the woman. Despite being the hyperbolic illustration of potentially the worst possible situation for a woman like Gilman to be in, the narrator serves as a very real model for how psychiatrists treated women and prioritized their existence in relation to that of psychiatry itself. Gilman’s perhaps absurd caricature of her own situation illuminates the problems inherent in a male-coded profession that is meant to apply to both sexes, but which lacks genuine interest or care for the one not included in its foundation.

GILMAN’S GOALS
As a piece meant to illuminate the problems within a patriarchal medical system that personally affected her, Gilman’s “The Yellow Wallpaper” presents an argument for the application of steady work for women on the verge of a breakdown, as opposed to no work at all. The instruction to maintain
a lethargic state given to both Gilman and her sickly narrator has adverse effects on both women. The lead character in the short story restrains herself from any activity deemed extraneous by her physician-husband, and subsequently falls victim to the deterioration of her mind. Her condition changes from depression and exhaustion to insanity and mania due to her immobility and the denial of her pleasures and wants. Gilman never suffered a complete breakdown, as her narrator did, because she avoided the guidance of Mitchell and his peers and continued on with her work, though she had to remove herself from her setting to do so. The author reclaimed her agency as an adult and as a patient. Her recovery from her bout of depression established her case as a testament to the value of work in similar circumstances, and flew in the face of the Rest Cure and its popularity, despite its “effect of boring at least some women into lunacy” (Lawlor 133). Gilman’s successful self-treatment, while anecdotal and therefore not solid evidence in the scientific community, served as an advancement of the idea that female insight was needed in psychiatry. It also posed a threat to the masculinity inherent in the discipline, as Gilman’s goals in her self-medication “to become clearer, to act stronger, to be more separate, assertive, and self-directed were all equated with a castrating, destructive act” that would remove or at least challenge the status quo (Lerner 202). That threat was larger than just Gilman, though, as any women identified with her publication and related their similar self-treatment to her through letters; had some of these women, with this insight and experience, been able to apply themselves to mental healthcare without being shunned by gender, perhaps treatment of depression in new mothers would have been more practical. The man-led field stood to be shaken up with the introduction of new ideas and perspectives, as it was clearly failing women without them.

The short story also served as a rebuttal to the popularized idea that women and their nervous systems were weaker than their male counterparts, and therefore more susceptible to failure and illness. In fact, the story testifies that ill women may only be weakened by others who wish to control them through their sickness, and that, if left to their own treatment, can prove to be more useful to their health than other practitioners. Gilman’s narrator relinquishes control of her being to marriage and medicine, both established to be patriarchally driven, and suffers at the hands of both. The stripping of her person and decimation of her health by both institutions leaves her alone, fragile, and dependent on others. The only support available to the narrator comes in the form of her shadowy double who only exists because of the character’s insanity. Despite her nonexistence, the woman in the walls provides solidarity for the ill woman, due to their synchronic capture within the room and her eagerness to escape, shown in her “[taking] the bars and [shaking] them hard” from inside her yellow
prison (244). The woman in the wallpaper is a reflection of the narrator, exhibiting the strength that the main character, as well as other women, find in themselves when they are given the opportunity. As a statement on the stationing of women in Gilman’s society, this posits that independence strengthens the will of the women. With a stronger drive motivating them, there is potential for women to move without the strings of male-driven structures pulling them in line or in a manner counterintuitive to their recovery from illness. And perhaps this sentiment which stood in Gilman’s writing is still applicable to modern social constructs. The restraint of depending on male-built precedents may do little to help women and their health, but serves as a hindrance of female success. Though modern medicine has been broadened to include women and their contributions into the fold, perhaps there is more to be opened to the fairer sex. Where can women go, once there is no sexist control being exerted over them and their success? What can female experience further broaden? And how do women like Gilman, who saw potential for her sex unrecognized by men, fit into that narrative?

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Different Medicines, Different Results: Exploring Ways to Cure Racism in *A Raisin in the Sun*

Anya DeLaremore

A play that ran for more than 500 shows on Broadway, receiving enormous positive feedback from white audiences, Lorraine Hansberry’s *A Raisin in the Sun* depicts the daily life of the Younger family, an African-American working-class family residing in a Chicago ghetto. The hero of the story, Beneatha, lives in a cramped apartment not only with her mother, Lena, commonly called “Mama,” but also with her brother, Walter, his wife, Ruth, and their son, Travis. After the death of Beneatha’s father, the family eagerly waits for Lena to receive the payment on her husband’s life insurance policy. Tension between the siblings builds as the play progresses. Beneatha never withholds her opinions or retreats from her dream of becoming a doctor. Walter wants to invest in a liquor store so he may reclaim the breadwinner role of the home. Ruth holds on to her crumbling marriage and family. Each one has a separate plan for their share. Lena ultimately decides to invest in a new home in an all-white neighborhood, which distresses both Walter and their future white neighbors. The Youngers navigate the changing times, and tackle questions about personal and cultural identity, happiness and survival. Audiences raved over the play’s portrayal of African Americans as people who experience the same trials and tribulations as others. With its message that a person does not need to be black to understand the struggles of this family, *A Raisin in the Sun* made its mark on history as the first play written by an African American to be performed on Broadway.

Hansberry noted that in creating many of the characters and events, she took inspiration from her personal life. In fact, she added herself to the cast of characters through Beneatha. She once stated during an interview on the
success of her play that “Beneatha is me, eight years ago.” In her autobiography, To Be Young, Gifted, and Black, she mentions that her parents raised her and her siblings to believe that they were better than no one else. Her father brought many influential scholars and artists of the time into her childhood, including W. E. B. Du Bois and Langston Hughes. She attended college at both the University of Wisconsin and Roosevelt University. She also traveled to Mexico, Uruguay, and New York.

Hansberry realized that it was her duty as a writer to interject her thoughts into this changing society targeting her race. A Raisin in the Sun served as her comment to combat negative opinions about African Americans. Based on her personal influence on the character Beneatha, one may conclude that Hansberry too wanted to enter the medical field since she projected herself onto the character. Due to World War II, women in the workforce no longer surprised the masses. However, gender norms limited job opportunities for women entering the medical field. Black women suffered especially, only being offered nursing positions at facilities in their own communities. When analyzing this play, most scholars focus on the main themes of economics, class and family. However, the theme of healing deserves equal attention. Beneatha provides Asagai and the audience with a personal reason why she wants to be a doctor. When she was a child, she witnesses a boy in a terrible head accident. The ambulance took him away and returned him patched up. At that moment, she decided she wanted to heal her people. Beneatha didn’t want to become a doctor simply to practice medicine; like her creator, healing her community became her main goal. Beneatha’s desire to obtain the highest position in the medical field stems from a necessity for a cure to societal stagnation in the African American community. This necessity results from the limited assistance within the community and the push for civil rights.

A NATIONAL QUARANTINE
During World War II, a large number of African Americans migrated to cities to take advantage of industrial job opportunities. This factor, plus the additional number of returning soldiers, lead to a suffocating housing market. African Americans returned to less-than-desirable conditions. American society forced black people into a state of stagnation and pessimism. It left citizens deficient in confidence, completely stricken of hope. Large cities, such as Chicago, suffered from overpopulation in African-American designated areas. Cities failed to regulate assistance and maintenance to these areas, leading to unlivable conditions. Landlords charged more for less quality and space. As with the Younger family, many apartment complexes only offered one bathroom per floor. Some buildings lacked proper heating systems. Such compacted spaces harbored infestation and deadly disease.
To escape overpopulation, Hansberry’s family and many others attempted to move to white suburbs. Angry white people used methods such as rises in rent, violence, and unfair laws to keep out the “contamination” spilling from the city. Eventually, the U.S. Supreme Court found these attempts unlawful.

Beneatha’s observation and decision to enter medicine supports the fact that motivation and change needed to come from within the community. She decides to follow the footsteps of women such as Mary Elizabeth Mahoney, the first black professional nurse in 1879, and Dr. Rebecca Lee Crumpler, the first African-American female to earn a medical degree in 1864. These women trailed behind a list of already accomplished Black men with medical experience. For years, black doctors and nurses struggled to find hospitals allowing them to practice their careers. Many establishments turned them down because of their race. Thanks to the Black Hospital Movement after the Civil War, Black people in the medical profession finally received spaces to practice. The purpose of this movement was to rectify the exclusion from white hospitals and the growing number of deteriorating health cases in black communities. The Black Hospital Movement began with Freedmen’s Hospital in Washington, D.C. Established and funded by Howard University in 1862, Freedmen’s hospital specifically treated slaves and freedmen post-Civil War. Nearly 25 years later, Saint Agnes Hospital, established in Raleigh, NC, in 1886, was titled “the most well-equipped Black hospital” in the entire nation at the time.

Beneatha’s most local opportunity to start working in the medical field, though, comes from the Provident Hospital and Training School for Nurses. This hospital was the first African-American owned and operated hospital, founded in 1891 by Dr. Daniel Hale Williams in Chicago. By 1944, African-American hospitals spread across the country, totaling to more than 120 hospitals servicing only black people. Though the Provident Hospital would limit Beneatha’s opportunities to run the full gauntlet to doctor status, it would provide a springboard to get acquainted with the field. Perhaps attending the New England Female Medical College, the same school Dr. Crumpler attended for her medical degree, would sufficiently grant Beneatha’s wishes. Initially, the school offered a two-year program for women of different ethnicities. Previous schooling, including OBGYN training, was a requirement. Prior to the school’s opening, midwives and nurses handled women’s health, and many referred to these women as the “Doctresses of Medicine.” Dr. Crumpler, the first African-American female to earn a degree there, cared for 10,000 slaves, aided in pregnancies, and treated typhus and malaria. Since she found no support from other hospitals or druggists, the college supplied her medicine and bandages. In 1870, the college declared bankruptcy after benefactors fell into financial trouble.
Boston University soon bought the school, took on the debt, and turned it into a co-educational college in 1872. It became the third such medical school, accepting women and people of color.

HANSBERRY’S ALTERNATIVE CURES
Malcolm X’s memorable public influence occurred during the heart of the Civil Rights era—years after the play’s success. Though he neither condoned nor denied violence, X believed in getting results by any means necessary. During one of his speeches, *The Ballot or the Bullet*, he expresses his discontent with his fellow black citizens. He argues that black people are too submissive in the nation and suggests building an economical and educational foundation to better compete with white business owners. He questions leaders in the government, more specifically what they promised black Americans about voting rights and obtaining public office. X notes that if black people don’t come together as one, then they will remain in a submissive state. His speech notes similar injustices that Walter finds in his society.

Walter’s anxiety about stability acts as a virus attacking him and his family. For example, he tries to talk about his dream of opening a liquor store with his friends, but Ruth interrupts his talk by demanding that he eat breakfast. While Ruth’s motivation is his health for the oncoming day, Walter sees this as suppression of his manhood. As the remaining man of the household, he realizes he has a responsibility to provide more. Mama hinders that responsibility and Ruth and Beneatha barely support him. He feels ignored, so the only way to gain a willing ear, in his mind, is to lash out. He believes that a woman’s less superior position under a man prevents them from understanding how the world works. Walter fails to realize the negative effects this “cure” promotes. Slavery attempted to strip away masculinity from black men through labor, torture, and public degradation. Then as black people merged into American society, stereotypes depicting them as animals and brutes only added toxins that poisoning minds. Walter is plagued with the idea that bribing the “higher ups” in business equals success. Instead of coming together as a community, Walter’s decision and attitude only promotes fierce competition and separation.

ASAGAI’S TRANSFER SUGGESTION
The Back to Africa Movement was a push for African Americans to return to Africa with the goal to self-govern. The movement began as an independent effort funded by white former slave owners in the Jim Crow era. Small groups funded the necessary travel cost to send less than 150,000 freed slaves to Africa. These departures contradicted with the reemerging necessity for black labor. The movement would continue its low-funded
trajectory until its revitalization under Marcus Garvey’s leadership in the 1920s. Garvey noticed some citizens felt that they had no true voice or control in American society. In response, he began building a small community of followers through his newsletter and his multiple speeches. Eventually, his message reached masses, prompting him to push further. Garvey created the Black Star Line, a shipping company attempting to fund a mass migration to Africa. Unlike X’s ideology, Garveyism pushed for a complete removal from American society. The company unfortunately faced serious financial issues, including inadequate funding across different departments. The business soon fizzled into nothing after bankruptcy and Garvey’s arrest.

Asagai fails to understand why Beneatha needs to stay in Chicago to achieve her dreams. A fraction of African Americans believed that Africa not only represented a stable history and culture ripped away from years of mistreatment and segregation, but also was a better option for more opportunities than America could even think to give. While the first part is somewhat correct, this fraction failed to understand how decades of American influences distances them from their homeland. To simplify, Africans faced their problems and African Americans faced different problems. Asagai and George, Beneatha’s two love interests, represent these differences in cultures. Asagai’s worldly view and racial freedom appeals to her search for individuality. He targets Beneatha’s desire to find her “identity.” She wants to be like him for the right and wrong reasons. She craves the personal understanding he projects but she jumps from one idea to another without grasping the full picture. Opposingly, George represents submitting to the vanity of American capitalism. He constantly criticizes Beneatha for exploring her individuality and expects her to fall into a stereotype. His wealth prevents him for sympathizing with Walter’s idea. He hints at the misinterpretation of Africa to some Americans: a giant group of savages instead of the sophisticated and complex mixing pot it is. Asagai posts a wonderful opportunity to Beneatha; however, if Garvey’s vision worked out its intended way, then it would appear as if black people were submitting to white supremacy. This isn’t the situation to run and hide.

THE “HOME REMEDY”
Beneatha clashes with Ruth and Mama while discussing domestic topics like marriage and keeping a home. She rejects the idea of quarantining herself in domestic life. For years, American society dictates the women to upkeep the home and care for the children while the men work hours to keep the lights on. Incidentally, African American women almost have an opposite history. In *This Disease Called Strength*, Trudier Harris points out that “Images of African women who trudge for miles with heavy loads of wood across their shoulders, or of regal women carrying huge pails of water
on their heads, or of warrior queens, or of women who cultivated their own fields, or of women who fought alongside their men during intertribal wars serve as ancestral inspiration for depictions of contemporary matriarchs and other strong black women [...] conveying the trap into which black women (by their selective approval of certain stereotypes) and black writers (by their desire to reject Anglo-American models) have been caught” (112-113). In Hansberry’s society, women and men share responsibility for keeping the lights on. Both Ruth and Mama work domestic jobs, such as cleaning homes and cooking in restaurants. These job positions remain in the domestic field, demanding physical strength and patience. Both women placed their dreams on the shelf so they can care for their families.

Mama’s apprehension to Beneatha’s doctor dream may stem from an apparent connection between female doctors and abortions. The world created the illusion that all women are naturally maternal, hence the domestic job market. Once Ruth discovers she’s pregnant, she considers taking the “treatment” to terminate her pregnancy in order to keep her family stable. The desire for black women to spare their children by killing them is nothing new to fiction. For example, Toni Morrison’s *Beloved* features the main character slaughtering her child to protect it from the horrors of slavery. In fact, African-American women faced steep hills compared to white women when faced with pregnancy and family planning. Rooted in slavery, black women were expected to continually birth new slaves for their masters. These women took big risks to spare their children, labeled as heretics, crazy, or unstable, or arrested and put to death. They faced hyper-invisibility until the Reproductive Rights movement of the 1960s. There was a myth that black women had no control or knowledge of reproductive health, and thus were incapable of making choices on the subject. Beneatha would rather prevent this stress and domestic rut women face by aiming higher.

*A Raisin in the Sun* distributes alternative perspectives to the issues plaguing the African-American communities. Each character represents a different cure. Beneatha pioneers with her push for innovation and evolution. Walter foreshadows the rising ideals of the 1960s and the masculine struggle. Asagai represents the idea of an appealing existence for African Americans in Africa. Ruth and Mama represent the desire to hold on to the safety of gender norms. African-American communities still struggle with settling on one response to racial issues. This play exemplifies how hard one voice must work to make an impact over a crowd of voices. In this case, the original production connected to a majority white audience without objectifying black people. Beneatha’s “cure” needs dedication and success because it’s the only one that benefits the entire community. It’s impossible for her to change the world by herself, but if others put forth that same determination she projects, then all the groups represented by the other characters
stand to benefit. Rejecting submission from the norm projects confidence internally and externally. Hansberry’s most popular work forever remains an example of overcoming pressures from society.

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was born into a world that is tormented for beauty. For as long as I can remember, I too, have been tormented—in subtle ways—for this thing called beauty.

And so began my first college writing assignment—a response to French philosopher Jean-Luc Nancy’s essay, “Beauty,” in which he argues that, “everyone knows what beauty is,” and defines it as something much greater than mortal, surface-level prettiness. Rather, he paints beauty as a hefty, abstract idea, like that of “hope” or “love.”

From those first lines I went on to write a too-brief essay about God, and how I thought that surely beauty could not be unanimously recognized by everyone—because if God is beautiful, then where would that place atheists and agnostics, those who deny the existence of God or God as a knowable being?

I realize now that my argument was flawed, but not for the reasons one might think.

In his work, Nancy also emphasized that “beauty can be unsettling.” I remember heartily agreeing with this. He said that “beautiful” does not necessarily equate to “pleasant.” I wrote that mere pleasantness disgusted me. Pleasantness was nothing more than mediocrity, and to quote educator Jaime Escalante, what is mediocre is useless.

It was my first attempt at freshman year, at the Savannah College of Art and Design, where I’d last only a month and a half.

THE DIVIDE
In Laurie Halse Anderson’s 2009 young adult novel, Wintergirls, the protagonist frequently illuminates her childhood through vivid flashbacks,
transitioning into each one with the phrase, “when I was a real girl . . . .” For me, the line between “real girl” and what I became afterwards remains hazy, illusory, but thick and splintering all the same.

In writing this, I keep trying to avoid using a particular metaphor, for risk of sounding like an angsty fifteen-year-old. But it’s difficult for me to conjure up the true feeling of my adolescent years without likening myself to an inanimate object—more specifically: a cheap, off-brand Barbie doll, sitting in a box on a shelf. The unnaturally colored hair that will never look normal. The faintly distorted face and body. The makeup painted on that tries to distract from these features. But this is all beside the point. The point is how long I spent, still and silent in the box, watching years and people race by in a blur. I got so accustomed to passive silence, that there was no longer any way out.

When I was ten, my family and I moved from Rhode Island to Georgia, because of my father’s new job. I walked into a new school full of strangers, already traumatized, though I didn’t realize it then. In some ways, the move was actually a saving grace, and I knew at least that much.

When I think about “the divide,” I’m reminded that ultimately my life was not severed quite as neatly as I once believed, its pieces conveniently labeled by location. Rather, my fading began more gradually.

One day in fourth grade, months before I’d move away from New England, my best friend, Hannah, and I were walking along the vast square of blacktop outside our elementary school, amid the shuffle of a weekday morning, before we were allowed to go inside. The cold, early spring air wrapped around us, and I noticed tiny pokes of yellow and violet crocuses writhing up from the hard ground.

There was a stagnant pause in our conversation. Hannah stared ahead and then suddenly spoke up.

“Last night I had a dream about you,” she said. “I was walking along and I heard your voice. And then I looked over, and you were in the ground, partly buried. I saw your head sticking out. And I was like, Megan! What are you doing? And you told me, I’m dying.”

I didn’t know how to respond. My words were already running out, and even Hannah knew.

To my dismay, Georgia wasn’t the new beginning I’d hoped for. I quickly got shuffled into silence and its resulting isolation. And when I think about it—the slipping, the shutdown—I spy an escape, a lapse where I could have crept through and perhaps chosen an alternate route. Had it even been possible?

I can picture it now, sitting in the dimly lit classroom, frozen when my teacher asks me a question. I paused too long, swallowed my words by accident. That’s all it took.
I barely spoke to another soul besides my parents and brother for a year. Muteness re-arranged my brain, my entire way of life. Thoughts and opinions scrolled across my mind like clouds. Silent, ever-moving.

My teachers instructed me to nod my head for yes, shake it for no. Soon I gathered more words—basic ones, like hi and bye and please and thank you—and those became programmed into my mind, safe and easy enough that I was able to spit them out when I had to.

It took me about two years to force myself to look people in the eye when they spoke to me. I cannot explain this, other than emphasizing how wildly unnatural it feels, even to this day. It took even longer for me to verbally respond How are you? back to people in greetings. Internally, I understood social expectations, and it’s not that I didn’t care. But when the words formed in my mind, they felt foreign in my mouth, and stuck there. I couldn’t choke them out before the moment passed. As the years have gone by, I’ve realized there are many different ways to be trapped by your own silence.

My friends back home in the North moved on. Eventually, I became convinced that I’d never interact with people in the ways that I used to. In this way, I had died. I grieved my old self, but like a ghost, she never left me.

It wasn’t a choice. And yet it all feels hinged on a single moment. In reality, it was a combination of different factors—all the way down to my DNA and murky origin—that lined up like dominoes and only needed the flick of a finger to fall.

DYSMORPHIA

I’m embarrassed to say that my initial “torment” by this thing called beauty did not begin after the divide, but rather, has festered inside me for nearly as long as I can remember.

The sides of my face don’t match. I’ve always felt that my left profile was passable, but the right side warped out of proportion, like a reflection bellowing in rippling water. In fifth grade I started to wonder if this was the result of some kind of birth defect. I was adopted as an infant, and knew little about my birthmother or her pregnancy. Was she on drugs? Did she have some sort of accident while I was in-utero? That would explain a lot. I’m painfully aware that all of this stems from self-absorption and vanity. I’m not proud of it. I wish I had an explanation. For years I wondered if everyone else had the same obsessive, consuming insecurities. Did anyone really know what he or she looked like?

In elementary school, I’d agonize over my hair, wondering why it fell frizzy and limp, like straw—like the dollar-store Barbie that I was—in comparison to seemingly every other girl I knew, with thick flowy hair that flounced around their heads when they moved.
Then whenever I wasn't obsessing over my hair, I'd zero in on another feature, some new hamartia of my outward appearance I hadn't noticed before. I remember thinking, *What will be next?* After I get over my nose or my skin or my hair, what's the next obsession to monopolize my thoughts, spin circles around me like a gnat?

I used to hide behind a curtain of my hair so people couldn't see the blotchy rosacea on my right cheek. I remember being nominated “the 3rd ugliest girl in class.” I wanted to claw out of my own skin.

Maybe the combination of my neurotic mind and privileged childhood allowed me such frivolous worries. Even admitting all of this now seems indulgent.

I still hide behind my hair, but I don't think about my appearance in quite the same obsessive way that I did in elementary school. However, I wonder if knowing one's biological relatives changes one's self-perception. Or are we all unreliable, shape-shifting reflections?

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In her book, *How to Disappear Completely: On Modern Anorexia*, writer Kelsey Osgood explores the baffling and contradictory nature of eating disorders—how these illnesses differ from other psychological disorders and addictions, and how sometimes anorexia narratives—works published in the very name of recovery—can actually perpetuate the disordered attitudes and behaviors they claim to caution against. Nowadays, while many mental-health advocates encourage the spread of “awareness,” the erasure of stigma, and the importance of honesty and authenticity about one’s struggles, the line between benefit and backfire has become thinner and more elusive. Additionally, with the increasing influence and power of internet culture in the past two decades, cult-like communities called “pro-anorexia” or “pro-ana” have arisen in the cyber world all over the globe. That said, in recent years, popular social media sites like Tumblr and Facebook have worked to ban blogs and posts that promote such material.

Regardless of whether these books, films, or online communities claim to be recovery-focused or not, for people prone to eating disorders, body dysmorphia, or simply low self-esteem, these avenues can pose a serious threat. The rhetoric permeating this subculture calls out to the vulnerable with a siren song. In her essay “Reading Disorders: Pro-Eating Disorder Rhetoric and Anorexia Life-Writing,” scholar Emma Seaber introduces the concept of “reading disorders,” a term she has coined to describe this very phenomenon. While she notes that eating-disorder memoirs, most notably Marya Hornbacher’s *Wasted*, do not directly cause eating disorders in
healthy individuals, Seaber points instead to an “interpretative gulf” that separates those who can walk away from books like these unchanged, and those who cannot. She elaborates: “Presented with a text, the (reading) disordered reader’s analysis will, thus, reflect only their reading of themselves. The reading disorder hypothesis resists and poses a direct challenge to the implicit conclusions of the visual interpretation of anorexia and thereby avoids the negative consequences of framing the illness as disorder of superficiality.” In Seaber’s view, then, one’s false perception of anorexia as an acceptable way of living—an aspiration, even—rather than a condemning act against the self, marks an already unhealthy mind sowing the seeds of sickness. As an example from someone with personal experience, Osgood describes her initial opinion on eating disorders as a teenager: “I didn’t think of anorexia as a disease, really, but rather as the most logical progression of self-control. It was dieting perfected, and perfection was always the goal” (22). Despite her skewed perception and subsequent decade-long struggle with anorexia, throughout her book, Osgood still questions the legitimacy of her own illness (and others’), wondering at which point one’s disorder becomes “real.” In a chapter entitled, “Blurry Lines,” Osgood ponders various friends and acquaintances she has encountered over the years, and their potential statuses as “real anorexic” or “wannarexic” (someone who desires the diagnosis). While Seaber takes a more empathetic stance on this overall cultural phenomenon, Osgood smartly criticizes herself and today’s eating disorder culture throughout her book, not only shedding light on the problem, but also de-romanticizing the disease for those prone to its strange allure.

Perhaps it’s a chicken or the egg situation. Which comes first? Was the disordered mindset regarding one’s self-worth and deep, internalized misogyny present to begin with? And what causes someone to take these beliefs to the point of starvation and potential self-destruction? Certainly, every eating-disordered person’s experience is different. In fact, an individual anorexic’s multiple relapses can vary dramatically from one another in their initial triggering, form, and level of severity. Given that anorexia and bulimia have psychological roots that manifest into superficial preoccupations and behaviors that contradict every natural, biological instinct of survival—why do these disorders seduce so many young women (and sometimes men), even when their consequences are described in such harrowing, cautionary detail? Is there a way to share one’s story in a responsible manner, and what’s the point, anyway? What if the stigmatization of mental health is not altogether dissolving, but instead being overturned and inverted?

*   *   *

Senior Seminar, Spring 2018   49
maligner: (intransitive verb) to pretend or exaggerate incapacity or illness (as to avoid duty or work) —Merriam Webster online

In fifth grade, anorexia was simply a name I couldn’t properly pronounce. I encountered “her” for the very first time in Seventeen magazine. My brother and I were over at our neighbor’s house while my parents met with the school psychologist, counselor, and my teachers, who’d had me tested, because they couldn’t figure out why I never spoke or did my schoolwork. The day I learned about anorexia was the day I got diagnosed with Selective Mutism.

This particular neighbor lived across the street from us. They had a boy my brother’s age, and a girl in the grade above me, Jenna. She hadn’t gotten home from middle school yet. Her mother offered me Jenna’s Seventeen magazine that had just arrived in the mail. I flipped through it, feeling too young to read such a publication, but indulged my interest nonetheless. Eventually I turned to an article on anorexia. Is this even a real thing? It seemed like malingering to me. Yet the crippling insecurity described throughout felt all too familiar, and I knew the truth, deep down.

Maybe someday I could do this, who knows, I’d thought, with a sense of flippancy that astonishes me now.

By middle school, my nagging fixations shifted to my body. One afternoon in sixth grade I sat in the back of the chorus room, waiting for class to start and probably brooding about my insecurities. I doodled myself on the inside of my binder. Giant alien head, my hair like a fistful of yarn, frayed and unraveling. Towering too tall for my age (I wouldn’t realize until eighth grade that everyone else had already caught up to me). With my pencil, I sketched my arms into languid wisps, made my body a popsicle stick. My collarbone jutted out like a wire hanger stretched taut underneath my skin.

Ironically, at the time I perceived myself as far too thin. Other girls could be much tinier and still look good—but not me. It wasn’t even my weight, but my shape that made me “abnormal.” In reality, I was thin back then, but not noticeably, and still well within the healthy weight range.

In retrospect, I probably agonized more over my falsely perceived thinness than I ever did over my chubbiness, years later. It hurt all the worse feeling like I was alone in this. Other girls worried about being too fat, other girls “got anorexic.” The phrase Real women have curves haunted me relentlessly, filled me with shame.

I deliberately, selfishly avoided subject matter related to body image and eating disorders. The fact that even in this—this basic feature of girlhood—I deviated, only confirmed my status as an abnormality, a sentient deformity.

Eventually, I gained weight—too much—and by eighth grade, I realized that I should lose some
THE BUTTERFLY EFFECT

In March 2009, my favorite author at the time, Laurie Halse Anderson, released her fifth young adult novel, Wintergirls, which chronicles the struggle of an eighteen-year-old girl caught in the throes of anorexia, psychosis, and the grief of losing a former friend to bulimia. Although still apprehensive about the subject of eating disorders, I bought the book the day it came out, and quickly devoured it.

Initially, for fifteen-year-old me, Wintergirls provided a sobering glimpse at what these “eating disorders” really were. I understood, then, how pain could be displaced onto food, how the punishment of one’s body could serve as a coping mechanism, and how these habits could snap in the mind, eventually commandeer all control. Any bitterness or skepticism I’d once felt towards the topic melted away while reading this book. Though many young adult novels seem to ring false or make a mockery of youth, Anderson gives validity to the teenage experience with her fresh, lyrical voice. As with her previous books, she cuts inside the protagonist’s tormented psyche and splays it open, all through the power of language alone. While literature certainly cannot redeem all suffering, it has its place. Art will never fully rub away the sting of trauma, but it honors the human experience as a whole, and serves as witness to those dark places inside us that no one would otherwise see. Obviously, adolescence can be extremely difficult, to the point where many kids develop a figurative tunnel vision, because they may not realize that their lives can actually improve in the future. In the meantime, literature helps.

Laurie Halse Anderson’s books convinced me to pursue creative writing seriously, and her work influenced my own writing style more than anyone else. She was my literary patron saint for years. My fairy godmother. That little angel on my shoulder, prompting me to punch in and get my words on paper. A ghost lingering in between the lines, giving me permission to use sentence fragments. She was a metronome of sorts, keeping me in rhythm with the language. From childhood, I’d always enjoyed a good story, but from Laurie I learned the lyricism of words. Eventually, I had to let her ghost go, as one does, but I still feel grateful for how she helped shape my voice.

Suffice it to say, her words have literally changed people’s lives. However, with writing that powerfully and psychologically entrenched inside the unreliable narrator’s perception, in the case of Wintergirls (as well as with other books and films depicting eating disorders), I see it as a catch-22. While reading Wintergirls, it’s impossible to peel the main character, Lia Overbrook, apart from her anorexic gaze. The strangers and acquaintances around her lose their identities and become their BMIs, their excesses, their rolls, their “padded hips.” In a school cafeteria scene, she denies her class-
mates’ names altogether and replaces them with what’s on their lunch trays. For example, a girl from the drama club becomes “cheesefingers.” Another student becomes “spaghetti,” and another, “lettuce&ketchup” (106). In addition, a calorie count accompanies most mentions of food items, and even the most seemingly insignificant of descriptions portray food as the enemy, and the surrender to it an act of grotesque gluttony and weakness. Take, for example, a scene in which Lia reluctantly joins her family at the dinner table:

[Dad] passes me the casserole dish filled with gravy and leftover turkey. I have to use both hands to hold it because it weighs more than everything on the table plus the table itself, plus the chandelier and the custom-built cabinet that holds Jennifer’s collection of glass figurines. I set the dish next to my plate. The triangle Dad-Emma-Jennifer locks in on my hand reaching for the fork. I pull out a full-fat slice of baked flesh, gravy-blooded (250), and let it fall onto my plate. Splat. (63)

We can see that, through her warped perception, a casserole might as well be a cartoon anvil falling from the sky. When sitting around the table, her family, while they try to help, actually forms the frontline of an opposing force in Lia’s mind. However, despite the disgust, animosity, and bitterness Lia projects towards food and to those who try to help her, from the beginning the reader can clearly see that Lia’s negativity towards others stems from the deep loathing she harbors for herself.

In another instance found early on in the novel, Lia describes her first experience at residential treatment for anorexia, recovering from starvation:

I was a good girl because I didn’t poke holes in my skin (scars noted) or write depressing poetry (journals checked while we were in session) and I ate and ate. They stuffed me like a pink little piggy ready for market. They killed me with mushy apples and pasta worms and little cakes that marched out of the oven and lay down to be frosted. I bit, chewed, swallowed day after day and lied, lied, lied. (Who wants to recover? It took me years to get that tiny. I wasn’t sick; I was strong.) But staying strong would keep me locked up. The only way out was to shove in food until I waddled. (28)

Clearly, the illness has corrupted her ideas of strength and health. These disturbed beliefs permeate at least ninety-five percent of the book, and can be misinterpreted by overly impressionable readers. Lia eventually goes on to describe her discharge from treatment, where at 107 pounds she’s
released, her new meal plan bound in a “slut-red” binder. Her idea of “waddling” means landing at a BMI calculation technically still underweight, and despite getting discharged from multiple treatment stays, her breakthrough does not come until the very end. Her perception of the world is so drunk with delusion and toxicity that “disordered readers” cannot help sinking into this intoxication themselves. Yet Lia’s story matters, because it reflects the misunderstood reality of many girls and women (and some men) in the United States as well as abroad. The ultimate outcome of Wintergirls encompasses hope, healing, and knowledge, as well as fear and uncertainty—much like turning points in real life. But how can one render this relevant, adolescent experience in ways that won’t harm vulnerable minds?

According to the National Eating Disorders Association, anorexia is the third most common chronic illness among young people—after asthma and Type 1 diabetes. Additionally, anorexia happens to have the highest mortality rate of any mental illness. In an image-obsessed world increasingly permeated by technology, particularly social media, it’s no surprise that this issue, and an alarming rhetoric I call “eating disorder culture,” has infected not only personal testimony and memoir, but also the online world. Unfortunately, the prevalence of this type of disorder increases along with more awareness of its existence. The National Eating Disorder Association (NEDA) elaborates on its website: “An ongoing study in Minnesota has found incidence of anorexia increasing over the last 50 years only in females aged 15 to 24. Incidence remained stable in other age groups and in males.” Almost equally alarming, according to NEDA, is this: “Eating disorder symptoms are beginning earlier in both males and females, which agrees with both formal research and clinical reports.” The problem continues to saturate our world with little reprieve, despite efforts to dispel myths and spread awareness. However, eating disorders constitute a vast part of many people’s realities, so why shouldn’t they find their way in literature, art, and pop culture, in some form or another? In addition to artistic rendering for artistic rendering’s sake, family and friends of those afflicted should have a way to more deeply glimpse into their loved one’s psychological struggle, and therefore legitimize it. However, in writing about eating disorders, I do think it’s important to balance the anorexic propaganda with post-recovery-enlightenment—i.e., the character’s realization of the truth and decision to pursue health. I don’t necessarily believe there’s a way to truly delve into the psychological realm of anorexia and bulimia without including some material considered “triggering” to those prone to these illnesses. But there are ways to cut down on the harmful material, such as neglecting to provide any numbers (like calories and weight), and choosing to portray the ugly parts of the disease—like how the longer the anorexia sinks its claws into someone, the more blinding
it becomes. The anorexic’s viewfinder shrinks, and the demands of their illness choke out the people surrounding them. It’s an incredibly toxic, isolating illness. In that vein, while it’s important to illustrate the sick person’s struggle, displaying the devastating effects on his or her family and friends should perhaps garner just as much attention.

Lia’s mother, a brilliant cardiac surgeon, cannot save her own daughter. She tries to support Lia’s recovery, but in the end, is rendered helpless. Or how about addressing the result of chronic, treatment resistant anorexia? Take a note from Kelsey Osgood, who opens her memoir with ugly, visceral images of starvation’s long-term effects, and much later ruminates on the lost stories of those who remain trapped in anorexia’s clutch, those “forever condemned to that pathetic diaspora of the aging patients who weep over scrambled eggs and tighter jeans, a ghost in [our] peripheral vision” (209). Those whose sad stories will never breathe the outside air. The more romantic, clichéd aspects of eating disorders downplay so much of the harsh reality, and it shouldn’t be that way.

*   *   *

The memories of my anorexia’s origin are shifty at best. Like colored shapes in a kaleidoscope that rearrange themselves in different patterns every time you tilt the lens. The pieces always fit, and yet, the truth remains more complicated than that.

On the inside, it’s all just a bunch of broken glass. And I am forged of chaos and contradiction.

In the beginning, I knew I was chubby and simply wanted to lose weight. As vapid as it sounds, I mostly just recall wanting to be as skinny as Miley Cyrus. I liked the idea of anorexia, but acquiring the illness was not my goal at first, because I never thought I really had the discipline for it. (From the very beginning I’d believed that anorexia consisted of far more discipline than it did delusion, and I think that startling attitude has actually permeated mainstream society now, as well.)

It wasn’t long before I began equating food with failure. And “healthy” weight loss was never going to be enough for me, anyway. As the grotesque creature that I believed I was—unworthy to take up space or sustain my existence—the only way to redeem myself was exceptional thinness.

To give in and eat would be taking the easy road out. It would be lazy, apathetic. It would be, once again, surrendering to the glassy-eyed, stock-still, dusty shelf-sitting life. Because I could not speak, because I felt incapable of being a real, sociable, likeable human being, because it’d been so long since I’d felt loved (or liked) for reasons that were genuine, I fought back against the inanimate shelf-sitting life in any way I thought I could.
And if that resistance looked like anorexia—all bones, self-denial, and discipline—then so be it.

*Wintergirls* haunted me. Like Narcissus staring too closely at his own face glittering in water, I leaned over the pool too far. Through the rippling of dark possibility, I saw what I was, what I had been, and what I could be. And I fell. Surprised myself with the shock of cold water, with the bottomless desire of starvation.

For the better and the worse, *Wintergirls* altered the course of my life.

Even when I re-read it now, nine years later, a spark goes off in my mind when I reach the scenes where Lia mentions her weight. I see the numbers printed on the page—low hundreds, nineties, eighties—and it still ignites this slight craving in me, triggers a montage of old images: smooth, empty belly upon waking, hipbones jutting out like bowls rolled sideways, ribs like the rungs of a shaky ladder.

But I know I will never, ever go back, not all the way.

* * *

Sometimes, when mental health awareness advocates try to promote their cause, they actually end up romanticizing mental illness. This seems to occur most often regarding eating disorders. On a surface level, people affected by eating disorders use this phenomenon as a coping mechanism. It’s the anorexic’s way of legitimizing her struggle, an illness otherwise rooted in deep denial. It might also serve as a way to redeem what may appear an unfair situation. However, many of the writers behind this supposedly “pro-recovery” rhetoric remain seduced by their illness, and this ultimately permeates the language. Readers can often sense inauthenticity in writing. Even those with truly valid motives behind publishing “triggering” material (such as genuinely trying to subvert certain societal beliefs about the issue) still pose a problem and unravel damage that’s not easy to undo.

For example, when scrolling through hash tags such as “anorexiarecovery,” “edrecovery,” “edwarrior,” or simply the name of the dreaded disease itself, I stumble upon seemingly endless accounts, many created in the name of recovery, filled with “before” and “after” photos, haunting images of girls at their very thinnest. I realize that some of these accounts only contain food pictures (therefore much less triggering), and are designed to help the users behind them stay accountable and document their progress towards health. But other profiles continually share scary pictures of rock bottom—with poetic captions dramatizing the individual’s problem and with little regard for how that may affect others vulnerable to the affliction. Even quality, popular young adult fiction—such as *Wintergirls*—can perpetuate this triggering rhetoric, as it sucks its readers into the dangerous (yet vital to under-
stand) anorexic psyche. As someone who has observed this phenomenon for almost nine years now, and as someone has been personally affected by it, I understand the issue from the perspective of an insider. However, despite my own intimate familiarity with it and its overt presence in today’s culture, I have only recently found the problem clearly articulated.

Anorexia’s competitive nature also contributes to this phenomenon. Many people with eating disorders believe that their illness (and the “strength” that supposedly enables them to starve and over-exercise) remains the only aspect of their identity that gives them worth. Some see—or want to see—their-selves as stronger, sharper, purer, and overall superior to other people who give into “carnal desires”—otherwise known as nourishment, a basic, vital element to survival. Obviously, most people can see the sick, warped toxicity of this false belief. In relation to that, living stuck inside the anorexic mindset, plus adding the element of competition, can form a deadly combination. However, despite this, hospital eating disorder units and residential treatment centers make up a large percentage of the recovery options available. Contrary to this mode of treatment, one way to cut down on the spread of anorexic propaganda is to actually separate the anorexics from one another and, obviously, monitor and remove harmful triggering material.

Osgood suggests that “if your child develops an eating disorder, encourage the sufferer to start therapy as soon as possible without rushing him or her into a hospital or group facility. Anorexics should be treated individually for as long as possible, or at least cared for by competent professionals in a general psych population as opposed to a strictly eating disorders unit” (231, 232). Although eating disorder units can benefit some people, I support Osgood’s opinion. Sadly, surrounding oneself with others who are just as seduced by the disease often serves to keep the delusions in place. I myself entered an inpatient psychiatric facility and then an outpatient program with a trauma-focused therapy group, where I was the only member currently recovering from an eating disorder. At that point, I’d already begun to address the root issues of my anorexia prior to hospitalization, and by the time I was admitted, other psychiatric symptoms had surfaced, taking a higher priority. However, I still struggled with my eating disorder, and finding a so-called “new normal” took me over a year. If I’d been surrounded by other anorexics in my vulnerable state, I think that the fight for physical wellness would have intensified. I knew as much at the time: throughout my recovery, I swore off almost all eating disorder-related films, articles, and books, with the exception of Jenni Schaefer’s Life Without Ed, for fear of relapse. Years later, I’m rooted enough in my health now and can face such material without worry.

On another note regarding treatment: unsurprisingly, many individuals afflicted with eating disorders (and behavioral issues of any kind, for that
matter) have suffered significant trauma, which, in part, triggered their disordered habits to begin with. Along with the importance of individual treatment for anorexia that strips the disease of any appealing quality, there’s another element of treatment I’d like to address. Just as trauma can strip its victim of speech, I think types of therapies that can pierce through the silence (such as sand tray therapy or art therapy) should be utilized until the words return. Trauma transcends language. The sublime and spiritual transcend language. In certain cases, therapy should too.

Ultimately, in post-recovery life, it’s important to evaluate one’s true state of mind and motives when considering whether or not to publically share one’s disordered experience. For example, is your intention to be an advocate or simply an artist? Or is it to garner attention? Any of those can, at the right time and place, be acceptable, but at least be honest with one’s self. Sometimes this requires serious introspection. Artists and writers have the impulse to dig deep and share dark truths with their audiences, sometimes even personal ones. I think most of us recognize this. But many of those who don’t categorize themselves that way will try to disguise their craving for memoir as some kind of humanitarian mental health awareness movement, when the motive is more egocentric instead. In that regard, at this moment in time, eating disorders have a higher prevalence in Western cultures, and with the continually increasing influence of westernization, studies show eating disorder rates shooting up globally (Anred.com). I suppose this doesn’t really come as a surprise in a world so heavily doused with celebrity culture, or in the United States specifically, a country riddled with dreams doubling as curses.

Along with considering motives, the writer should be honest about his or her true audience. As becomes clear in Osgood’s email correspondence with Marya Hornbacher, Pulitzer Prize nominated author of the notorious Wasted: A Memoir of Anorexia and Bulimia, Hornbacher “wondered if perhaps she was too young to have so publicly lamented her struggles” (248). She also admitted that she had written the book primarily for the loved ones of eating disorder sufferers, rather than the sufferers themselves, so that they could fully grasp the severity of the problem, and therefore “put them in the hospital.” True intentions will automatically alter one’s language, but still, seriously re-evaluating descriptions and word choice before posting or publishing proves another vital element in un-glamorizing anorexia. Osgood comments on this when she discusses the anthology Going Hungry: Writers on Desire, Self-Denial, and Overcoming Anorexia. She discusses how these writers—some quite renowned—describe their own anorexic tendencies:

For example, they could have spared the reader any in-depth description of the anorexic body, especially when it sounds lovely
and graceful. ‘[When I was anorexic,] my older brother’s friend took some photographs of me . . . My eyes look big and dreamy; my lips are full. I have a slender body, long legs,’ writes Francesca Lia Block. She uses the metaphor of ‘faeries’ throughout her piece, likening them to anorexia itself. ‘That perfect blend of angelic and demonic—the faerie. Ethereal, delicate, able to fly. Also dangerously seductive, beckoning us into worlds unknown.’ Beautiful writing; great advertising (241, 242).

On the contrary, Osgood opens her book with pages upon pages that describe the ugly reality of the disease. She documents the last years of a young woman permanently caught in the throes of anorexia’s effects, a thirty-something-turned-walking-cadaver, eventually gone too soon. In addition to the way Going Hungry’s talented writers literally advertise anorexia, the book’s very existence attests to the anorexia and identity issue. Many eating disorder sufferers believe they should cling to their disorder as means of self-improvement and strength, though the reality of anorexia actually proves the opposite. Still, Going Hungry seems to present a different idea: “By collecting eighteen writers, including a Pulitzer Prize winner and numerous Ivy League graduates, to write about their experiences, which they do beautifully, Taylor is perpetuating a big problem. She is supporting the idea that anorexia leads to a type of fame—or at least bragging rights—but she does a big disservice to readers by neglecting to include just one ‘civilian’ voice, such as a person without a Pulitzer, maybe, or someone whose life was essentially decimated by anorexia” (237, 238). Osgood goes on to explain her own personal worries and regret over how her years of illness actually stalled her intellectually, rather than enhancing her abilities. She also ponders the “perceived link between genius and madness,” and how the two are not automatically intertwined, though this belief continues to sink its roots deeper, especially within the subculture of eating disorders. Additionally, in that vein, I think the way society values more salacious, clawed-my-way-up-from-rock-bottom stories over slightly quieter stories works as another obstacle in the way of a solution as well. Osgood emphasizes that while recovery from an eating disorder is very difficult, it is not remarkable:

What would be really remarkable is remaining healthy in a world in which one is essentially handed opportunities or manuals for self-sabotage, a world in which acts of histrionic self-destruction are, in many cases and many ways, considered more extraordinary and worthy of attention than keeping your head above the surface of water . . . A memoir of a person who, in this era, made it to the
age of thirty without being diagnosed with a psychological disorder or struggling with an addiction: now that would be remarkable” (246).

Ultimately, killing the stigmatization of mental health problems presents quite the challenge, and fetishizing (and even sometimes overdramatizing) it can simply invert the problem rather than solve it.

**CATALYST**

Many people who have been afflicted by eating disorders have a catalyst. A specific moment in time when the spark was lit, the first domino fell. When we realized that we were too big, and that altering our bodies could serve as a remedy to our current lot in life. Or at the very least, a distraction. A place to pummel all of our misdirected ferocity.

Some of these situations are laughable in their simplicity. Take Osgood’s, for example:

I was thirteen years old, had just switched from public to private school, and was out to lunch with my old classmates. We went to an Italian restaurant, where they ordered salads and I ordered pizza. As we walked around the one street that comprised our suburb’s downtown area, my stomach churned with cheese and confusion. I felt suddenly that I didn’t belong anywhere, that I was strange and without purpose; inside flew about those typical teenage emotions that felt, to me, entirely new, potent, and completely debilitating. I looked down at my stomach. It protruded. I sucked it in, then let it out again. I jabbed at my belly with my pointer finger and announced to one of my friends, ‘I’m fat.’

“No, you’re not,” she said.

I didn’t think she was very fervid, so I tried again.

“My stomach is huge.”

“Just do some sit-ups,” Arianna said, tossing her thick brown hair over her shoulder. I didn’t think that reply was a negation. A train rumbled on the tracks nearby.

So that was it: I was fat, and I would get thin. (20)

Mine, too, is embarrassingly petty. It was mid-April, the second semester of freshman year, a month after I’d read Wintergirls for the first time. I sat in the passenger side of my mother’s car as she drove me home from high school. I noticed my face in the side mirror, as I had so many times before. Catching myself off-guard. Eyes dark and staring ahead, too serious, brow furrowed. Pouting unintentionally. That day, my head leaned back lazily
against the seat and I was struck by the size of my face, my double chin spilling out from under it. How had I not noticed this before? Why didn’t it bother me? I already knew I wasn’t skinny, but God, how’d I miss that thick roll framing my chin and jawline?

A tiny moment like that, when the insecurity wells up to drown out everything else. Then a succession of moments like that. Then the need to do away with yourself, to check off the days with steady discipline, punishing your body for its own existence.

I’d joke years later that my double chin was half the reason I’d ever been anorexic. I used to subtly reach up and trace beneath my chin with my fingers. At first, it served as motivation, a reminder: You do not need to eat. You’ve gone too far already and you have to correct it. Then it was a check-point, a mile-marker: one day I reached up and it was gone, all I’d felt was jawbone and skin, the curve of my chin down to my neck. Then it became yet another miniscule obsession, one of many places on my body I needed to check and re-check, to run my hands along, to feel the bone.

In between my first anorexic bout at age fifteen and my more serious encounter with it at age eighteen, I yo-yo dieted—restrict/restrict/binge/restrict/binge/restrict/binge. Then a temporary stretch of some type of middle ground—but it didn’t last, and even then I felt fat, like a failure.

Even now, when I consider myself fully recovered, my double chin is a source of insecurity, and when I pause to focus on it for too long, the old fear creeps out. Occasionally, I feel panic like pins and needles, little tiny jabs, like pricking your finger on a needle. I have to stop it before it pokes too deep. I have to bring myself back up to the surface again, to the rational, to the world where feelings, food, and fat are three separate things and one should not be allowed absolute power.

FAMILIAL THREAD
In addition to the importance of individualized therapy for anorexics, Osgood also propagates a family-centered approach called the Maudsley method. She elaborates: “Rather than send an anorexic off to break bread with other anorexics, the Maudsley method advocates that the sufferer eat all meals and snacks with his or her family. If the anorexic does not finish the prescribed amount of food, there are consequences that resemble traditional punishments given to children, such as revoking television or phone privileges, or not allowing the anorexic to go to a friend’s house or a party” (233). While I understand Osgood’s reasons for supporting this treatment approach, ultimately I disagree with such a family-centric method. Eating disorders result from a variety of different factors, and so it should come as no surprise that the anorexic’s family dynamic intertwines deeply with his or her illness. I don’t necessarily believe that the family unit inherently
causes the eating disorder, but for such an intensely psychological issue, how can it not form a piece of the equation, whether consciously or unconsciously? Because of this, I think that family members forcing the anorexic to eat would only light a greater fire beneath the eating-disordered motives. Additionally, this method would further associate food with guilt, shame, punishment, and anger—an outcome most undesirable for a recovering anorexic, someone who already has these elements correlated in his or her mind to begin with.

Anorexia obviously differs from other types of mental disorders, such as depression or bipolar disorder, and I think on the spectrum of behavioral issues, it certainly falls closer to addiction. I think anorexia should be treated in a similar way to alcoholism or drug abuse. Anorexia is not simply a shunning of food, it’s a twisted addiction to the idea of food, the shape and size of one’s body, and the suppression of hunger. An absurd, Wonderland-esque approach to rules, food preparation, and portion control. It’s wanting something, with everything you are, but restraining yourself because you’re scared that once you start, you won’t be able to stop. Sound like anything else?

Early on in my recovery, I read Overeaters Anonymous, one of the twelve-step books. While I’m not fond of the cringe-worthy, shame-inducing title, this book gently forced me to place my eating disorder under an unflattering light, and evaluate it for what it was: a type of addiction. At certain points, my whole life revolved around food. Perhaps it goes without saying: OA does not glamorize eating disorders. The book presents over thirty heart-breaking personal stories of individuals who have struggled with trauma and emotional problems that triggered binge eating and obesity, as well as a story from an anorexic, and another from a bulimic. While the twelve-step program isn’t perfect, it provides a tangible way for one to actively fight against one’s downfall, and work for a healthier, fuller life. The one-day-at-a-time approach also helps those struggling to narrow their focus when addressing such an otherwise overwhelming goal.

* * *

At fifteen, I realized to some extent that anger fueled my behaviors. I’ve often heard depression described as “anger turned inward,” and in my case, so was the eating disorder. I used to lay down on my bedroom floor doing crunches and sit-ups so often that I began accidentally waking myself up at night as I threw my body forward, trying to work out in my dreams. While this isn’t necessarily disordered behavior in and of itself, I pushed myself to the point of unnecessary punishment. The angrier I became, the harder I pushed, and the more determined I became to lose. *I’m losing but I’m really winning*, I thought.
In a way, anorexia was my way of raging against the machine. And I suppose one could look at my fifteen-year-old self and shrug it off as typical teenage behavior. But why are we so quick to shrug off “typical teenage behavior” as though it were not problematic, as though it does not sometimes stem from deeper, darker roots?

I don’t really have an explanation for this, but when I was very young I associated shame about food with a male family member. This person never, that I remember, made any negative comments about my appearance or what I ate. Yet I conflated the two.

If I step back and look at the bigger picture, at my struggles with eating disorders at age fifteen and then again from age eighteen to twenty, I can smooth away the sharp edges and shadows, and see the colossi I constructed in my mind. I can see that certain people in my life represented bigger ideas and issues that were far greater, and out of their control.

Everyone knows that eating disorders are more or less influenced by current popular ideals of beauty. Nowadays, social media (and the egotism of our culture) also takes part of the blame. While men certainly have many wrongful and unfair pressures enforced on them by society, when it comes to matters of outward appearance, women and girls bear the brunt of the abuse. While I’ve always known this and have always struggled with it personally, it’s difficult to recall now exactly how much I understood about sexism and misogyny when I was in my teens. I had proclaimed myself an “egalitarian” until about three years ago, when I finally saw the light and surrendered to the common sense of feminism, and realized that feminism and egalitarianism more or less fought for the same ideals.

Suffice it to say, I understand far more about the patriarchal world nowadays than I did at age twenty, let alone fifteen. But I still remember my anger, and the leagues of self-loathing that eventually led to my body’s rebellion. My heart’s misguided, stuttered protest against giving in.

THE SUBLIME

While the philosophical theories of the sublime consist of different arenas, the aesthetics branch is among the most well known, thanks to the works of eighteenth-century philosophers Immanuel Kant and Edmund Burke, as well as the ancient texts of Pseudo-Longinus (Holmvquist, Pluccienik). Know that when I discuss matters of the sublime here, I am referring to it in the realm of aesthetics: philosophy “dealing with the nature of beauty, art, and taste, and with the creation and appreciation of beauty” (Internet Encyclopedia of Philosophy). I’ll also be relying primarily on Kant’s version of the sublime. Burke and Kant both focused their theories around the dualism of beauty and the sublime, but they also differed in various ways, mainly in how, “Burke’s theory is, broadly speaking, directed toward
the aesthetics of such situations in which some elements are felt either as painful or as threatening” (Holmvquist, Pluccienik). Also, according to scholar Simon Josebury, Burke emphasized a “sensual pleasure” and physiological response to the sublime, whereas Kant focused instead on a “purely subjective mental realm” (Josebury). Despite the corporeal element of anorexia, I too will focus on the sublime in a psychological sense throughout my discussion.

Scholar Sheila Lintott’s essay “Sublime Hunger: A Consideration of Eating Disorders Beyond Beauty” explores the idea of deeper aesthetic concepts driving anorexic and bulimic behavior—namely, the Kantian sublime. After she details the prominence of eating disorders nowadays, she goes on to emphasize how the eating disorder “might begin as an attempt to embody the ever-elusive ideal of female perfection, but at some point in the progression of the disorder, that external goal becomes a side issue and eventually a non-issue. In other words, at some point current beauty ideals fail to motivate” (68). Lintott explains how beauty and sublime differ from each other, in how the sublime experience consists simultaneously of attraction and repulsion, unlike beauty, which is merely attraction without purpose. The pleasure of the sublime, according to Kant, arises indirectly and gradually. Additionally, the enjoyment of the sublime emerges not only from the object that triggers the experience itself, but also our own ability to “reflect on and respond positively to frustrating or frightening stimuli” (Lintott, 70). Lintott makes certain to clarify Kant’s two different versions of sublimity: mathematical and dynamic. She uses the sky as an example for the mathematically sublime, in its vastness. She comments on how its “formlessness” suggests infinity, and how, “of course, we cannot perceive infinity. Nor can we perceive the sky in its entirety, for much of it eludes our perception” (70). This realization triggers frustration at first—at how “we know that the sky continues, even though we cannot perceive that it continues” (69). But then this is where the sublime pleasure creeps in, as we realize that though we constitute small physical vessels in an indescribably large universe that we cannot fully perceive, our minds can at least conceive of it. Therefore, our mental capacities encompass the world (and so much more beyond it). In Kant’s own words: “The mind has a power surpassing any standard of sense” (1987, 250).

In contrast to the mathematically sublime’s size, the dynamically sublime’s wonder consists of massive power. Examples of this include various forces of nature. In short, dynamic sublime experiences, though they, like the mathematically sublime, remind us of our own minuteness in stature, still offer a pleasure and peace in acknowledging our own “strength of spirit” (71) and how ultimately the fact of our sentience and the presence of our inner souls reigns superior to these worldly forces that threaten to decimate
us. Though we can be destroyed physically, nothing can obliterate one’s soul from ever existing. Jumping ahead a bit, Lintott explains how “a person with an eating disorder turns her willpower inward in an attempt to verify that her existence transcends the physical aspects with which she is identified by others at every turn” (74). Eating disorders are only “about” weight to a certain extent. “When confronted by a desire for food, the eating-disordered individual rejects the dominance of nature over her physical self by refusing to eat or refusing to take in nutrients from the food. This domination of self over nature is the crusade of the anorectic and bulimic” (75). The body becomes an enemy that threatens one’s attempts at control. However, the anorexic does not just wage the fight against one’s body, but something much larger instead. I think perhaps one of Lintott’s most provocative and potent statements comments on the true nature of anorexia regarding popular beauty standards and the objectification of women:

Whereas the dieter, by equating thinness with worth, believes she must physically conform to externally prescribed ideals, the eating-disordered individual blatantly rejects these ideals by far surpassing them in her excessively thin body. The eating-disordered individual’s self-starvation is therefore a two-fold protest. First, she lays claim to that supersensible portion of humanity that Kant (and others) reserved primarily for men. Her protest is motivated by her refusal to embrace and enhance the physical aspects of herself to please others. By judging her primarily in terms of her physical appearance, the world around her is undervaluing, if not outright denying, that there is anything to her other than that appearance. Second, her eating disorder, the logical conclusion of the impossible and contradictory messages society sends her, provides her with the voice of protest against the ideals dictated to her. Her very existence—in all its boniness and weakness—testifies to the absurdity of the ideals championed by the world around her. She will not allow them to define her, especially in reference to her looks (79, 80).

While anorexia can be seen as submission to patriarchy, when examined in this light, it becomes almost a mockery of society’s beauty ideals—an ironic way of fighting back. I don’t think one can overestimate the depths of hurt and desperation that can accompany being valued or devalued by others based on one’s appearance, and the distances one will go to assuage or resist that pain. In this regard, I think Lintott’s view takes responsibility for girls turning to anorexia. The pain of degradation based on one’s appearance can stoke the fire of disordered behaviors. Rather than dwell on the pain, the anorexic exchanges it for a new type of pain: starvation and over-
exercise. Starvation is not simply the stuff of superficiality. Many people could not starve themselves for extended periods of time by sheer will, so in enduring this, anorexic women and girls not only feed their anger to a bombastic caricature of the pressure and scrutiny burdened on them, but also rise above an obstacle that not everyone could overcome.

When Lintott mentions “that portion of humanity that Kant reserved for men” she refers to the sublime and Kant’s (later retracted) comments about the how the sublime is for men and beauty is for women—how women possess “beautiful understanding,” while men’s understanding is a “deep understanding” that females supposedly cannot attain. However, if girls and women can stand up and face the sublime (which is far more powerful than men), then we certainly can stand up to toxic masculinity and corrupt ideals ingrained in society. At the risk of melodrama, the anorexic literally becomes a martyr in protest of female objectification and the pursuit of bodily perfection. The trick to recovery is realizing that, however potent these beliefs may be, they ultimately form the basis of psychological illness. In the end, inflicting harm on one’s body does not effectively “stick it to the man,” after all. At least ten percent of those with anorexia will end up casualties of their own war.

This theory of “sublime hunger” also extends to the dangerous nature of anorexia narratives—why people share their stories in potentially detrimental ways. They want more than bragging rights or validation of their experience—they want proof. If they can conjure up a dramatic story about how they succeeded in achieving a startlingly low weight, stared death in the face, and then returned to the land of the living (with photos of themselves looking like Holocaust victims), then they’ve transcended their bodies (by overcoming carnal desires) and have also transcended their individual, insignificant lives by constructing heroic epics out of themselves. We all just really want to follow Dante and take our readers on tours of the circles of Hell, don’t we? We want to show them how we clawed ourselves out. We want to show them the very grit under our nails. But perhaps most of all, we want to prove it to ourselves. We want to validate and forgive ourselves for the selfish, irrational, toxic things we’ve inflicted on others and ourselves, by pointing to our own personal hells. “In summary, then,” writes Lintott, “sublime experiences are those that begin with a moment of serious frustration or threat. Yet, rather than leaving us befuddled or running for safety, they allow us the opportunity to verify that there is something within ourselves that can deal with the frustration or stand up to the threat” (Lintott, 72). This desire for a wild story is really a desire for the sublime. And the sublime does not just live separately, outside of us, but within.

* * *
One day, a string of words arose seemingly out of nowhere, one at a time, and took up residence in my head. First: Control. Then Balance. Next Healing. They formed a mantra that floated in my thoughts so clearly, and I didn’t know what it meant, but it gave me a strange comfort, and so I clung to it. It offered some semblance of safety, amid fear and confusion. Control. Balance. Healing. Control balance healing. Control balance healing. Control balance healing. Control balance healing. Control balance healing.

Then another word: Trust. And then—though I did not possess any sentimentality or personal connection toward the name or the figure—Jesus. I decided that since I had nothing left to lose, I would just follow these words that the universe—or my subconscious mind, or ghosts in my head—had offered to me. I finally understood what people always said about hitting some form of rock bottom, where you’re finally willing to release and ride the wave, because otherwise you’ll surely drown. The name Jesus had just been a word to me, one that fell flat. One I’d seen as overused and frankly, meaningless. I’d believed in the existence of God, but what was Jesus? Nevertheless, my desperation gave me an excuse to hold onto it, to let it bob above the surface of water, to cling to it, to keep it like air.

While many details and precise chronology of this time period have fizzled out in my memory, I still recall the first time I looked in the mirror and peeled my former perception apart from the person I really was. Light shifted across the reflection, this new person. I smiled, and saw the seams split. Like a ghost oscillating between the living and the dead. The very first time we weren’t entirely eclipsed.

The “distorted perception” was a haunting, generated by the mind. And your mind could make you believe anything, I’d soon learn.

Before that moment, I’d honestly believed I could not smile. I never seemed to look normal in pictures. So I wasn’t allowed to smile, because I truly thought I didn’t have one. But suddenly, I felt worthy. Worthy to paint my lips with color again. I realized that color had not even been mine to reject in the first place. Color did not belong to me, but to someone, or something, higher. And that someone higher embraced me.

Soon I realized that control, balance, and healing were things I could gain not only in realizing my worth as a person, but also through a connection to something or someone bigger than I could imagine or even knew was possible.

PORCELAIN DOLLS
In high school, I wrote a one-act play for a Dramatic Literature elective. Never mind that I was seventeen and knew little about writing plays, or that I placed flowery, overly poetic monologues in the mouths of my characters—only a two-person cast, a pair of teenage girls whose relationship
I’d loosely based on Lia’s friendship with her dead, former bulimic friend, Cassie, from Wintergirls. But I also based them on different sides of myself.

The spring of my senior year, my school’s Thespian Society put on a “drama night,” in which my little play, “Porcelain Dolls,” debuted. The year prior, while writing it, I’d been obsessed with voiceover, ever since seeing it done in a performance of The Diary of Anne Frank. So, naturally, I had to weave the entire play together with dramatic voiceover. However, in rehearsal, it became apparent that the logistics of so much dramatic voiceover would not pan out.

Then one day, one of my actresses noticed two big wooden boxes lying idle in the black box theatre.

“What if we just stood on those, at the very back of the stage, when we recited the voiceover parts?” she asked.

And so my characters, “Jeny” and “Camille,” these pieces of myself, were shelved like the porcelain dolls they were. Trapped in their fragile shells.

The play revolved around their struggle with anorexia, their dysfunctional friendship, their disintegrating sanity, and the elusive outcome of Jeny’s health.

I’d always felt more like Camille—the sufferer in silence, the one in Jeny’s shadow, tied down to reality, the one who was sick but never sick enough.

Jeny was the enigma, the poet, this ghostly character who walked along the borders of the otherworldly, the girl who finally tried to get help for her issues.

I was Camille, and I believed I would always be Camille. The sufferer in silence. The one for whom nothing ever really changed for the better.

And hell, I didn’t even know what had happened to Jeny. I left her fate open-ended.

But at the end of the day, I shelved them both like dolls. Upstage, where the light could barely reach them.

After Control, balance, healing. Trust Jesus, a new mantra surfaced. Rewrite the script, it said. It was time. And yet, it wasn’t mine to write, but one that would be written for me as I went along. A script in which I’d have more lines, where I wouldn’t have to shelve myself into darkness anymore. Where the porcelain shell of silence would begin to crack.

Over a period of ten days, I took the wildest ride of my life. I glimpsed windows of stunning clarity. Each day, the wonder, beauty, joy, and presence of a higher power became stronger and stronger. But along with that, this force of darkness and evil got stronger and more terrifying. I had to truly, honest-to-god fight through it. I fought for my life. And every time, the higher power delivered me. Once the evil presence dissolved, the light that replaced it was brilliant, nearly blinding. Nothing else I have ever experienced compares. All the hyped-up sensations, the altered, sensual states of
mind that this existence has to offer fall short. I realized that I'd probably never experience the wonder and closeness of God like that again in my lifetime, and I accepted it, just as long as I could hope for it in another realm, someday. I even started eating a bit more. But ultimately, I was too distracted by everything I was experiencing to have much of an appetite—as I gradually slid from my depression into a manic episode.

*   *   *

Sublime experiences are such a personal matter, because we ourselves form such a vital piece of it. Our own intimate connection to and capacity for the sublime commands some of the wonder itself. In Lintott’s words, “[T]he true object of admiration and respect is not the object that occasions the experience of the sublime. Rather, it is that portion of us able to reflect on and respond positively to frustrating or frightening stimuli. The sublime makes salient our depth and power, and an awareness of our capacity for the sublime is intimately connected to self-admiration and respect” (70). Part of God’s sublimity and the experience of it is the fact that it no longer matters that everything isn’t about us. Suddenly, who we are suffices, even if we are just mere humans on a planet with billions of others. However, sublime experiences cannot all be encompassed by mere joy and awe. Some of the sublime can be evil and even threaten one’s life, such as the fight against dark spiritual forces (and the overcoming of these).

Fighting for your sanity and your life falls inside that category. God as a sublime experience can be classified as both “dynamically” and “mathematically” sublime—great in both size and power. The fact that we can “realize that although we cannot perceive the absolutely large, we can conceive of it” is part of what makes it so awe-inspiring. We cannot perceive of God, but we can conceive of him. This form of sublime experience, unlike anorexia, truly does overcome the physical self, in the sense that it promises the existence of much more beyond this physical earth, and it gives our beings so much more worth. And these experiences prove to ourselves our own worth—that even though we’re no match for God or for fierce, overpowering elements of nature, such as a hurricane or tornado, we ultimately “notice that there is some aspect of ourselves not threatened by [these] great force[s] of nature. We can acknowledge, therefore, that a part of ourselves is superior to nature and its laws” (Lintott, 71).

Anorexia does not provide a portal to the sublime. On the contrary, anorexia kept me chained to mundane reality, to my own anger and vain, self-absorbed desires. The sublime could not be farther from that. Lintott testifies that while a desire for the sublime serves as part of the eating dis-
orders behavior’s motivation, ultimately anorexia distorts the notion of the sublime in two ways: “There are two necessary ingredients to the sublime that are not present in the extreme behavior of the anorectic or bulimic. In Kant’s theory, the cause of the sublime state of mind is external to the agent and the agent is in a place of safety. But neither of these elements is present in the eating disordered behavior . . . This is because she refuses to satisfy her hunger—an internal force—and does so to such extremes that she finds herself in a seriously dangerous position” (81). When I experienced the sublime, I’d begun eating again. For some inexplicable reason or another, or maybe for no reason at all, I was held by my higher power, and safe enough, until I was no longer safe enough to function in the outside world, and got immediately admitted to Ridgeview Institute.

While part of the sublime experience does involve the inner self, it isn’t so consumed with the self to the point of ignoring the rest of the world. If a person sticks with their eating disorder long enough, it will turn them into a toxic and wholly self-absorbed person. While hitting some form of rock bottom (where “the breaking point that becomes your turning point”) indirectly led me to what I consider sublime experiences, these occurred once my eating disorder had already begun to die, after I’d decided to fight it. Anorexia wilts a person inward, but the sublime—at least in my case—made me discover that there’s so much more beyond ourselves (and this earthly reality) than what we could have ever imagined. I used to be afraid of language running dry—like, what if everything had already been written and there weren’t any more word combinations left? No more fresh images or phrases to spark? No more poetry. Until I glimpsed the vastness of sublime beauty—this beauty that, if experienced by everyone, would be universally acknowledged, undeniably—I had feared running out of words.

These experiences changed everything for me. What frustrates me now, however, is how it transcends language—how anything I could possibly say would be a travesty. I can’t put it into words. I always used to think that was a cop-out. But I know it’s true in this case. Kant articulated how the mind can conceive of sublime greatness but ultimately cannot fully perceive it, how the imagination fails to fully grasp all the wonder, and how this leads to pain, but in the end, the pure wonder overcomes it. The wonder of the sublime and the wonder at one’s own ability to experience it in the first place. While we won’t run out of words anytime soon, I confess that our craft still has its limitations, much as we stubbornly work to defy them. Madness can be described, packaged, labeled, diagnosed. But the spiritual sublime—which perhaps can be experienced on earth most fully when the edges of our sanity begin to crumble—transcends.
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Trauma and the Suppression of Critique in Dalton Trumbo’s *Johnny Got His Gun*

Jill Geyer

Although historians chose phrases such as “The Great War” and “The War to End All Wars” to describe World War One, soldiers who fought in the trenches used decidedly different terms. These men—who lost limbs, hearing, sight, mental function, and oftentimes, their lives—labeled the conflict “The Great Fuck-Up” and “The Sausage Machine.” The development of industrialized warfare churned out massive death tolls, with approximately thirteen million of the sixty-five million soldiers deployed losing their lives to bloodshed and disease. The slaughter shook the world unlike any other in history. Scholar Patricia McDonnell states, “Virtually an entire generation of male youth from Western European countries was sacrificed to the carnage” (43). The bulk of recruits (whether volunteers or draftees) were scarcely past adolescence. These “men” opposed their country’s enemies, often without realizing the horror of modern war and the disposability of their lives. These soldiers advanced into killing machines, while barely scratching the surface of their vital young lives outside of war. Although not utterly forfeited to combat, scads of veterans endured abhorrent wounds, and their disabled bodies struggled mightily in the post-war era. Additionally, all men (whether they returned home with permanent disabilities or not) clashed with their transition out of battle, often retreating into emotional shells, haunted by the devastation of war. The catastrophic toll of World War One opened jagged emotional wounds for soldiers, grieving families, and cultures at large. As a tool to cope with such tragic affliction, many people (of all impacted geographical locations) turned to the insights of war literature.

The themes of war literature—widely popular in the post-war era of 1919 to 1939—varied immensely in each of the countries involved in World War
One. Yet each nation created art that reflected upon the universal impacts of battle. From France, England, Belgium, Germany, the United States, and other nations came literary responses to war that served as permanent reminders of devastation and loss. In France, Roland Dorgelés’s *Les Croix de Bois* presented the harsh psychological havoc wreaked on veterans. German author Heinrich Wandt’s anti-war novel, *Etappe Gent*, met great opposition from its local readers. Described by David Budgen as “revealing German brutality in Belgium and the disparity between […] military high command [and] that of the ordinary soldier,” this work revealed an unpleasant truth internationally visible within the armed forces. *Etappe Gent* characterizes the ordinary soldier as “disposable,” and exemplifies this phenomenon through World War One—which ended masses of young men’s lives. British poets and writers such as Wilfred Owen, Issac Rosenberg, and Robert Graves also constructed probing literature in this revolutionary canon. As David Lundberg argues, “So overwhelming was the slaughter that survivors found it could not be described in conventional terms” (377). This innovative trend reached into American culture, as well, with Dalton Trumbo’s novel *Johnny Got His Gun* bringing into public view the disposable male body in wartime.

Trumbo’s protagonist, Joe Bonham, symbolizes the ruthless toll of war. Originally published in 1939, this text delves into Joe’s past and present as he strives to interpret his surroundings confined to a hospital bed. As physically disabled as a human body can be, all of Joe’s limbs have been amputated or lost from trauma. A hole stays open on the side of his body, draining an angry wound that refuses to heal. Furthermore, because of a crater-like wound to his skull, Joe can no longer taste, see, hear, or speak. In this radically impaired state, Joe can still think, but he initially has no means of communication with the medical personnel who tend to him. He characterizes himself as nothing more than “a side of beef” (109), and he blames the war machine. Drafted at the age of eighteen, with no choice but to go, Joe departs from his family and embarks for combat, as he recalls often throughout the novel. Although he undergoes years of hardship, the protagonist ultimately discovers ways to communicate and to interpret the world around him. But despite these victories, Trumbo’s hero suffers at the hands of the physicians responsible for “saving his life.”

Often labeled as glorious, fulfilling, and patriotic, war in fact cripples and desecrates those unfortunate enough to participate in its carnage. That war propaganda typically targets the young is equally disturbing. Dalton Trumbo’s anti-war novel utilizes Joe, unable to act for himself, as a martyr of war and a symbol of a type of death that does not so quickly decay. Despite Joe’s immeasurable injuries, he cognitively functions and cleverly uncovers a means of communication with his medical personnel. Joe dedicates his life to his country—conquering disease, shell shock and bullets—merely
to find himself imprisoned within his disabled body. The surgeons who try to save Joe merely sedate him into silence, dooming him to waste away until his demise. In a likeness to Joe, the suppression of *Johnny Got His Gun* muzzled Trumbo and his influential message at the onset of World War Two. This silencing poses an understudied curiosity about the text and the significance its past readers obtained from the novel’s critique. Classically known as an anti-war narrative, the text’s suppression history begs analysis. I suggest that the novel’s authority threatened the American public’s ignorance of the war machine by enacting modes of social change and awareness. Through the medium of Joe’s first person perspective off the battlefield and his journey in the hands of medical personnel, Trumbo suggests that the hospital and its staff represent a sophisticated symbol of oppression induced by the government and experienced by disabled veterans. By utilizing Joe’s medical care as an imprisonment, Trumbo shows how war is physically and emotionally engraved into the bodies and minds of veterans. Additionally, he examines the lack of options disabled individuals possess when returning from warfare.

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Joe’s unique situation places him in a circumstance with odds that he considers “ten million to one” (86). Even before obtaining knowledge of the full extent of his injuries, Joe believes that he might have been “a lot better off dead and buried” (24). As the medical team aims to mend Joe’s body, the hero’s mind continually weaves in and out of memories. Within these recollections, he recalls his childhood and his limited early adulthood before being shipped out to trench warfare. The American draft forced Joe’s participation in the war, as all men ages 18 to 45 were required to register. In addition, war propaganda targeted the younger generation, and this focus on youth reached far past U.S. borders. In a BBC radio report, Greg James notes that in Great Britain “250,000 boys ranging in age from 12 to 18 volunteered to serve while providing false information about their age” to support the demand for fighters. Convinced by the promise of glory and adventure, boys and young men discovered themselves caught in the malice of war, which often brought death or disfigurement. Reminiscing on his experience of being drafted at 18, Joe yearns to have possessed ample knowledge of the cost of his sacrifice. “Anybody who went out and got into the front line trenches to fight for liberty,” he recalls, “was a goddam fool and the guy who got him there was a liar” (110-111). Joe illustrates the loss of his own freedom and liberty (both internally and externally) and concludes, “Ending up dead or rotting before my life has even begun [. . .] Thank you mister. Go fight for liberty. Me I don’t care for some” (111).
Through flashbacks, recollections, and revelations, Trumbo depicts Joe in two ways—as a symbol of disabled veterans entrapped by corrupt political systems and as a reminder of those who lost their lives prematurely on the battlefield.

Joe recollects dying men victimized by battle and pleading for their mothers: “They died crying in their mind like babies . . . they died yearning for the voice of a mother” (117). Joe exhibits the same absence of maternal care when he discovers the extent of his disabilities. He remarks internally, “Mother where are you? Hurry mother and wake me up” (61). Not only do these quotations prove the psychological toll of war upon youth, but this plea also initiates Joe’s regression into a condition he refers to as “the womb.” Joe recalls this state by reporting, “It was like a full grown man suddenly being stuffed back into his mother’s body. [. . .] Somewhere sticking in his stomach was a tube they fed him through. That was exactly like the womb except a baby in its mother’s body could look forward to the time when it would live” (79). This fetus-like existence embodies a rebirth of his vitality from within his disabled body—however, this experience resulted not from Joe’s choice, but from his doctors. Joe never consented to his transformation into a “living dead man” (216). With no way to object, but still consciously aware, the protagonist conjures up the moment when his arms are amputated. Joe imagines the surgeons performing it for amusement. He envisions them bantering, “It takes a lot of money to fix up a guy’s arm. [. . .] To hell with it. Come on boys watch this [. . .] He’s down in bed and can’t say anything” (27). Under medical supervision, Joe exists as the prisoner of the medical personnel who have placed him inside a figurative womb. The physicians fashion him as “a slave” to their medical environment (181). They “mutilate and brand” him while trapping the hero inside his own skin (183).

Multiple physical and mental disabilities altered World War One’s veterans—however, loss of limbs and emotional trauma affected the men most prominently. According to historian Dr. Ryan Reft, “whether mental or physical, 200,000 [American] veterans would return home with a permanent disability.” As a result of the carnage, World War One advanced the medical field tremendously. With the discovery of blood transfusions and the advancement of pathological and laboratory medicine, many individuals survived grim injuries. Blood transfusions immensely improved survival odds of soldiers wounded in action. Advancements in pathology promoted reduced casualties as threat of disease stalked troops. As described in War and Medicine, “Until World War II, more deaths occurred among US troops from disease than on the battlefield.” Furthermore, Carol Byerly explores influenza among World War I American soldiers and how “at the height of AEF’s military offenses [. . .] more American soldiers died in army camp
beds than in the battlefields of France” (6). The inhalation of mustard gas also devastated the lives of many veterans, as they faced respiratory problems for the rest of their lives. With so much damage being done, hospitals existed on and off military bases with more than 80,000 nurses caring for soldiers. Registered nurses from prestigious hospitals such as Johns Hopkins volunteered through the Red Cross to be transferred into horrendous conditions in Europe to aid with a low supply of personnel to care for the ill, wounded and perishing.

Possessing no visual or auditory senses, Joe initially finds it impossible to differentiate between dreams and reality. This coincides with J. M. Winter’s description of veterans from whom, “looking back, it seemed like a dream” (249). During an incredibly grotesque flashback, Joe imagines rat chewing at his wound. Following this encounter, he recalls vermin eating a Prussian corpse in the trenches. He explains, “It didn’t matter whether the rat was gnawing on your buddy or a damned German it was all the same [. . .] when you saw it there fat and well fed chewing on something that might be why you went nuts” (91). Many veterans experienced similar repercussions of the post-war era, no matter what countries they risked their lives for. For example, discharged British disabled veterans returned home—not to parades and parties celebrating their sacrifice, as many public records claim—but to unforgiving conditions. Facing an inability to sustain themselves (in spite of the price they paid for peace and prosperity) soldiers possessed little option but to perish on the battlefront or return home to face homelessness and general unfair treatment. Deemed disposable and disowned by their countries, soldiers’ bodies became valuable—it seemed to authors like Trumbo—solely for medical advancement.

With new industrialized warfare, World War I guaranteed physicians the opportunity to perform procedures on soldiers without fear of the implications. Certainly, most physicians enacted these surgeries with the purpose of saving lives; yet, with so many bodies constantly cycling through these hospital facilities, they evolved into practice-cadavers. By 1920 in the United States and on American military bases “there were 113 special hospitals, with 18,603 beds, dealing with the most severely disabled and supplemented by 319 separate surgical clinics, thirty-six ear clinics, twenty-four eye clinics, nineteen heart centres and forty-eight special mental hospitals” (Winter 251). Additionally, physicians employed prosthesis limbs in mass quantities for the first time. Winter reports that “In the year 1928, new issues included 5,205 artificial legs . . . 1,106 artificial arms, and 4,574 eyes, for, as wounds worsened or failed to heal, so men came forth each year” (252). With the horde of casualties and disfigurements, it would not be unwarranted to suggest that some unnecessary experimental procedures occurred during wartime. Joe exists as the perfect candidate for such experimental trials,
since he possesses no facial expressions, no communicative abilities (verbal or non-verbal) and no family to defend him. The protagonist explores this question by pondering the medical need for advancement. Joe estimates, “The doctors were getting pretty smart especially now that they had three or four years in the army with plenty of raw material to experiment on” (82). Additionally, the disposability of soldiers and veterans—existing in and out of the medical realm—was prominent in the post-war era of World War I. James Ridgway (chief counsel for policy and procedure at the Board of Veterans’ Appeals) argues that American citizens expressed concern over the expansive cost of veterans’ benefits and began to oppose them, with “World War I veterans bearing the brunt of that attitude.” Likening their battles in the trenches to their fights for justice on the homefront, World War I veterans established the American Legion in 1919, a society designed to bring about fair veteran compensation and treatment.

The American Legion campaigns for veterans who suffer mental and physical disabilities, seeking financial compensation and healthcare. The American Legion reports that before its establishment, those suffering from shell shock (known today as PTSD) were “sent to hospitals for feebleminded children because there was no other space elsewhere, and they were forced to sit on infant chairs.” By revealing the adversity veterans endured at home, the organization presented the problems with medical care, as well as veteran unemployment, homelessness, and drug addiction. Great Britain followed suit, creating the British Legion in 1921 to combat the peril of World War I in their nation. According to J. M. Winter, “By 1917, one quarter of all men sent down the line in British forces were unfit because of psychological stress” (53). It wasn’t just mental and physical disabilities that rattled British veterans, however. Winter adds that “by January 1922 there were two million unemployed, and the British Legion reckoned that half a million of these were ex-service members” (239). Although measures toward compensation started in both America and Great Britain, the change was attained by the veterans themselves, as the public and government presented scant interest in the burden of their affairs. In America, the government deemed sub-branches of federal agencies responsible for veterans (including the Veterans Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers). However, the sporadic and ineffective method of these agencies proved unsuccessful and the veterans only continued to agonize. In 1930, nearly a decade before Johnny Got His Gun’s publication, the Veteran’s Affairs Department of the United States was formed. The V.A. represented a major political advancement for World War I veterans who had been anguished since the beginning of the American Legion’s founding. Yet, this victory neither aided nor relieved numerous individuals who already had experienced malicious and unforgiving conditions (affecting
their mental and physical health during those eleven years), especially with the onset of the Great Depression in 1929.

From struggling to survive in foreign lands to scuffling for aid on their own, veterans continued in their pursuit to alleviate financial devastation. During the summer of 1932, tens of thousands of veterans banded together to march from Oregon to Washington D.C., expecting to bring awareness of their ill treatment. However, violence erupted, as an order exclusively from President Herbert Hoover forcibly removed 3,500 veterans from the march. The police also burned down temporary makeshift homes that the men had constructed for their families. Instead of paying their original owed compensations, the V.A. forked over $76,712 to transport some 5,160 veterans back to their hometowns. Despite being deemed a failure, the march supplied awareness to the public of the veterans’ wretched treatment. In 1937 the Veterans Affairs Department compensated:

“2,414,000 men in receipt of a pension of some sort—40 percent of all serving soldiers. These ranged from 26,416 rheumatics and 1,907 flat feet through to 65,000 in mental hospitals for ‘shell shock’, the 9,074 men who had lost legs and arms, and the 40,000 partially blinded. All of these figures were, of course, conservative. Many with war injuries received less than they should have or even nothing.” (Winter 251-252)

The compensated celebrated their victory, but what of those who already wasted away, awaiting the foundation of the Veterans Affairs Department? What about the sixty percent of veterans who never beheld a single penny for their injuries and despair? Perhaps they (like Joe) anticipated a hopeful change yet attained nothing.

Despite minuscule pensions and the creation of the V.A., the bodies of disabled veterans possessed marks of the battles which left them permanently altered. Trumbo’s Joe Bonham exposes the grotesque climate of wartime, while existing as a symbol of disability. Winter suggests that disabled veterans’ bodies tell “the story of what he’s done,” and Joe exhibits this claim well (55). Disfigured and haunted by memories of battle, Joe cannot escape “the omnipresence of death and injury” which adds “a psychological dimension to the soldier’s complete involvement” to their enforced actions (237). Obliged to live the rest of his life nourished from tubes, Joe relies completely on his nurses and physicians. Similarly, the veterans returning from World War I lingered in entrapment—often by their own governments. By symbolizing Joe as the grotesque mark of war, and his caregivers as the oppressive government, Trumbo not only displays the visual lack of options available to veterans, and the risk of medical experimentation, but also the
figurative imprisonment of their surroundings. From the beginning to the end of Joe’s adult life, he resides in confinement. Drafted, wounded, and left to rot, Joe’s ultimate betrayal is established by those who championed his freedom. Uncaptured by historical record, Trumbo ventures to convey this hidden cost of freedom.

In an environment where they no longer correspond, veterans became “faced with this radical restructuring of a whole social personality, the need to make new friends, the need to go back to the beginning again” in which “some took refuge in despair” (Winter 242). Coupled with no desirable work experience or disability acting as an ailment, individuals withstood tremendous hardships blending back into the societal workforce. Winter reports that “Ex-servicemen continually came to the door selling bootlaces and asking for cast-off shoes and shirts. Many of them were unskilled with no trade” (241). These men, characterized as amateur and unable to locate a trade conducive to their financial needs, were exactly the type of individuals utilized by the draft. According to Gerald E. Shnek, “Draft officials called only those unmarried white men whose occupations they deemed inessential to the material needs of a nation during wartime” (151). Exploited for their inessentiaity to the demands of war, the government predetermined young males capable of becoming disposable bodies to feed the war machine from the frontlines and trenches.

Unable to shield himself from the rigid demands of his country, Joe’s body becomes property of the United States government. Even in his disabled state, Joe exists as a disposable body to the staff in charge of his medical care. Reflecting over his circumstances, Joe comprehends, “Somebody tapped you on the shoulder and said come along son we’re going to war [. . .] You’ve got no rights. You haven’t even got the right to say yes or no or I’ll think it over. There are plenty of laws to protect guys’ money but there’s nothing on the books that says a man’s life’s his own” (109-110). Likewise, young men seized by the draft lacked basic human rights to their own lives. Forced to risk their existence and bodies, the boys retreated home to face a new battle—one revolving around their living conditions and treatment. Joe responds to this by analyzing his own circumstances. He ponders, “He must never expect or hope for anything different. This was his way of life from now on every day and every hour and every minute of it” (81). In spite of his disabled dilemma, Joe feverishly attempts to master time and communication. Similarly, World War I veterans desperately endeavored to recover their conditions by establishing the Legions. Joe’s determination ends with success, but the medical personnel’s response leaves him devastated. Both parties only partially succeed. Joe’s catastrophe not only reveals a heartbreaking scenario, but also communicates to the circumstances of struggling veterans.
By interpreting sensory reactions from the warmth of the sun and the nurses’ schedules, Joe develops the ability to decipher time. For years, this venture holds Joe’s interest. On “New Year’s Eve,” or Joe’s one-year mark of analyzing time, a nurse discovers that by tracing letters on his chest, she can communicate to Joe with full sentences. This breakthrough chronicles the transformation of Joe’s isolation as he becomes radically obsessed with conversational discourse. He uncovers the dexterity to motion his head and neck against the bed to create Morse Code taps. The nurses interpret his frantic thumping as discomfort, often shifting his position or providing pain medication to quiet him. One nurse even endeavors to relieve Joe erotically to halt his annoying tapping. Despite sexual abuse and misunderstandings, Joe’s fixation with communication only intensifies. Finally, a new nurse comprehends the protagonist’s tapping, and fetches a doctor to translate. Ecstatic to have shattered the verbal barrier, Joe contemplates how credulous his caregivers must be towards him. He envisions the doctors inviting their friends to witness the ghastly nature of their patient’s body while saying “here is a man who lies in bed with only a cut of meat to hold him together and yet he thought of a way to talk” (214). Nevertheless, Joe’s wishful daydream cuts short when “a finger came out of the darkness [. . .] that shattered against his head like the crash of a pile driver” and taps “WHAT DO YOU WANT?” (217). Taken aback by the doctor’s question, he ponders his reply for a long time before answering. Eager to be of use, Joe suggests they display him for profit—to showcase the cruelties of war. The doctors meet Joe’s idea with disgust, before ultimately tranquilizing him. Tammy M. Proctor argues, “The disabled wanted simple acceptance [. . .] They might receive awe or horror” (253-254). Imprisoned by his government and healthcare professionals, Joe wastes away within his disabled body, baring the mark of war’s brutality.

On December 7th, 1941, two years after Johnny Got His Gun’s publication, the Japanese bombed Pearl Harbor—initiating the U.S. involvement in World War II. Shortly after, authorities suppressed Trumbo’s book, before it completely fell out of print for several years. Surprisingly, Trumbo agreed with the decision and even participated in the censorship of his novel. As James DeMuth attests, “Distressed by this political campaign for a negotiated conditional peace with Hitler, Trumbo worked quickly to forestall any new edition of his novel during the war” (331). Had the United States viewed Trumbo’s work as a threat to National Security, silencing him would have been an easy feat. To state it plainly, America possesses a long history of secrecy and deception. This covertness roots its existence within the beginning of America’s history. As Frederick A. O. Schwarz, Jr. argues, “Slavery in America was not itself a secret. Yet it was veiled in secrecy. Many Founders dealt with it evasively. So did the Constitution.” With slavery representing
one example of many surreptitious tactics and attitudes, there also exists an event silenced during the same era of the text’s suppression—the Manhattan Project.

Based in New York, the Manhattan Project commenced in 1942. This secretive government mission explored (and eventually tested) nuclear warfare. Hidden from the American public (but financially supported by the British and Canadian governments) President Franklin Delano Roosevelt’s classified scientific mission later revealed the extent of the new industrialized warfare when dropping the first atomic bomb in Hiroshima on August 6, 1945. For a government capable of engineering weapons of mass destruction with a past of violence and ill-treatment of its veteran citizens, muzzling a screenwriter and novelist like Trumbo would be straightforwardly accomplished, and that is exactly what the United States House of Representatives did with their House of Un-American Activities Committee. After vindicating Trumbo and his colleagues, the novelist refused to acknowledge the ludicrous questions of his antagonists. The opening statement of his interrogation reads, “Already the gentlemen of this Committee and others of like disposition have produced in this capital city a political atmosphere which is acrid with fear and repression; a community in which anti-Semitism finds safe refuge behind secret tests of loyalty; a city in which no union leader can trust his telephone; a city in which old friends hesitate to recognize one another in public places” (Palmer 67). The H.U.A.C. sentenced Trumbo (and nine others of “The Hollywood 10”) to prison for treason in 1951. Confronted by Trumbo’s persuasive anti-war artistic work, the presentation of young men as disposable bodies position the United States government as callous.

Although a century has passed since the start of World War I, the U.S. government continues to treat soldiers as disposable bodies. J. M. Winter clarifies, “The cemeteries are not closed. Newly found corpses are still placed in them” (260). Although the United States implemented the Department of Veterans Affairs, homelessness and lack of healthcare still plague veterans—especially the disabled. Homeless veterans beg for change on the streets in large cities, desperate to sustain themselves. These individuals are at risk of malnutrition, disease, and crime. Uncompensated for the ultimate prices paid for their country and left to rot on the streets, their comparability to Joe Bonham could not be more apparent. Sedated within a hospital bed, Joe symbolizes the dead and the living reminiscent of war. Trumbo’s usage of Joe as his protagonist and the hero’s caregivers as the antagonists must certainly signify an extreme critique of America’s treatment of World War I veterans, and also speaks for the lack of options provided to those returning alive from war. Today, the cycle of disposability and ignorance continues.
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“I think you guys are going to have to come up with a lot of wonderful new lies”: Literature as Medicine in Kurt Vonnegut’s *Slaughterhouse-Five*

Chyna Gowen

Bayonets aren’t much good against tanks . . .
—Kurt Vonnegut (in a letter home from a P.O.W. Repatriation Camp)

The inability of language to explain the atrocities of war permeates much of anti-war—specifically post-World War II—literature. With around 15 million battle casualties and over 45 million civilian deaths, World War II provides a daunting task for the writers of the late-modernist and post-modern period. Marina MacKay, in her introduction to *Literature of World War II*, concludes, “The major challenge facing [. . .] account[s] of World War II is how to convey [. . .] the crushing totality with which it managed to turn into a battleground everything it touched” (1). Part of this conveyance comes in the form of literary accounts. Post-war novels convey issues that the battlegrounds themselves fail to fully convey, which raises the question of literature as medicine. What could better succeed in articulating the “crushing totality” of war than the raw—often blisteringly true—stories of war themselves? War novels such as Norman Mailer’s *The Naked and the Dead* and Joseph Heller’s *Catch-22* create literary worlds that ironically provide spaces of healing. Even more so, Kurt Vonnegut’s *Slaughterhouse-Five* uses the language of war not as an arbitrary over-explanation of its tragedy but rather as an escape into a space where grieving—followed by adequate coping—is possible. Moreover, the novel offers a realistic, albeit wildly unconventional, view of combat and its after-effects. After Vonnegut served in the U.S. Army and fought in World War II, he wrote harrowing war stories masked by satire and a non-chronological structure. Through his fiction, he offers more than
just bayonets to fight the metaphorical tanks of emotional trauma that followed the soldiers home.

The concept of a literary world where fiction itself becomes a sort of treatment aids the depiction of post-traumatic stress disorder within World War II literature. This disorder, named PTSD in 1980—35 years after the end of World War II—remains the primary disorder used to identify the lasting effects of war. The Diagnostic and Statistical Manual of Mental Disorders, or DSM—also introduced post-World War II—originally defined PTSD in “a rather simpler definition than we now use,” according to Nigel C. Hunt. In his book, Memory, War and Trauma, Hunt says “if someone reacted due to combat stress, then they would be classified as having an ‘adjustment reaction of adult life’, which was ‘fear associated with military combat and manifested by trembling, running and hiding’” (Hunt 51). Currently, the DSM uses six criteria for diagnosing and treating PTSD with definitions including “recurrent and intrusive distressing recollections,” “feeling of detachment or estrangement from others,” “sense of a foreshortened future,” “difficulty in falling or staying asleep,” and “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (Hunt 52-53). While this list of definitions continues and provides a broader understanding of PTSD as a mental disorder, it was unavailable during World War II trauma.

For an anti-war novel like Slaughterhouse-Five, published in 1969, even the initial definition and diagnosis of post-traumatic stress disorder would have been nonexistent. The psychological means for understanding this post-war disorder would have evaded doctors treating Vonnegut’s protagonist, Billy Pilgrim. Even so, this ironic hero’s satirical account of World War II provides ample understanding of the realities of war. Hunt, while discussing literature and trauma, agrees with this inherent function of literature by explaining the relationship between psychologists and war novels:

Psychologists have traditionally ignored literature as a potential source of data [but], after all, the nature of psychological data can include all behaviours of people, including writing. Our understanding of the psychological effects of war benefits by a detailed consideration of literature published in the area [because] it provides an opportunity to explore responses to war trauma in other times and cultures (161).

Such psychological data within anti-war novels provides plenty of evidence of the after-effects of war. The approach of psychologists limits true and raw knowledge of the mental toll soldiers face after exposure to rigorous training, casual death, and forced re-association within society. War novels
provide greater gravity to this subject—something that pure methodology could never fully provide. An exploration into these effects underlies the life of Billy Pilgrim.

In war-filled narratives where grieving and coping seem nonexistent, the concept of literature as medicine may never cohere. How can an event so horrific be adequately conceptualized within the pages of a contemporary novel? James Dawes, in The Language of War, answers this question through two models of understanding: “the emancipatory model, which presents force and discourse as mutually exclusive, and the disciplinary model, which presents the two as mutually constitutive” (1).

About most war novels, I would argue that Dawes disciplinary model greatly succeeds over the emancipatory model. While language and violence seem unable to exist within the same sphere, literary language—in the form of anti-war fiction—seeks to provide a space of connection between death and its explanation. In light of this, Dawes asserts, “[The American war novel’s] philosophy is [. . .] existential [. . .] but it is just as often obtrusive and ham-fisted—a structural risk in war representation, it must be said, since the heart-sickening content demands at least some speculation about the meaning of recklessly shattered lives” (MacKay 57). While I believe war novels can be “ham-fisted” at times, they are less obtrusive as they are freeing. For authors such as Vonnegut, this paradoxical ability and inability of language to provide explanation highlights the need for war novels to react in the same way as antibiotics and vaccines work within the body. War novels must inject the reader with the disease—exposing them to perverted patriotism, flippant loss of life, and followed understanding of trauma—in order to cure them.

THE VACCINE
If the anti-war novel paradoxically plagues and cures the reader, how does literature exist as medicine? The use of satire and humor in recollections of war offers insight into this paradox. Vonnegut’s anti-war satire Slaughterhouse-Five offers a protagonist who is mentally plagued by the effects of war. Although Vonnegut survived the firebombing of Dresden, Germany, he never explicitly refers to himself within the novel: with a third person omniscient narrator, the structure focuses on Billy Pilgrim, a fictional soldier suffering from PTSD, who also survived the Dresden raids, hunkered in a slaughterhouse below the city. Vonnegut describes Billy as “a funny-looking child who became a funny-looking youth—tall and weak, and shaped like a bottle of Coca-Cola” (23). When assessing Billy, one of the Englishmen even says, “This isn’t a man. It’s a broken kite” (97). Instead of creating a brawny hero who survives the difficulties of war through his own strength, Vonnegut chooses an unconventional “tall and weak” character who exists...
as less of a hero and more of a medical case study—a malleable youth who survives war but mentally deteriorates, in a non-linear fashion. Herein lies the injection—the first sign that this humorous novel is also a vaccine.

Vonnegut’s refusal to write *Slaughterhouse-Five* chronologically highlights its satirical elements—the foremost being Billy’s obsession with science fiction and perverted healing on the fictional planet of Tralfamadore. Since Billy discovers the sci-fi novels of Kilgore Trout, a down-and-out fiction writer who fails to produce anything close to a literary masterpiece, he paradoxically discovers and prohibits forms of treatment. Ultimately, there exists no tangible treatment or medication for Billy Pilgrim. Even while experiencing a twisted type of healing in his own mind, Billy’s life within the novel ends scourged by trauma. Vonnegut experienced a similar trajectory—prompting him to write “[the] funny book at which you are not permitted to laugh, [the] sad book without tears.” With “people numbering 135,000, nearly all of them civilians” dying above his head in Dresden, Vonnegut lived through one of the largest massacres of WWII (Klinkowitz 11). John Somer, a foremost Vonnegut scholar, suggests that “the Dresden firebombing was the central and most deeply traumatic event of Kurt Vonnegut’s life—and that he would spend twenty years coming to terms with it, treating its horror in oblique ways through his first five novels before facing it directly in [. . .] his masterpiece” (Klinkowitz 12). Just as his famous protagonist struggles to understand the atrocities he sees, Vonnegut struggles—even after writing several war narratives—to piece together his own trauma. *Slaughterhouse-Five*, then, exists as humorous in multiple ways, but the novel also offers the clearest understanding of war that Vonnegut could imagine. Thinking about the novel as medicine, as a vaccine that introduces the body to the disease (which is the overtly and satirically displayed horrors of WWII), provides a deeper understanding of war-related trauma and PTSD.

**THE DISEASE AND DIAGNOSIS**

On about February 14\textsuperscript{th} the Americans came over, followed by the R.A.F. their combined labors killed 250,000 people in twenty-four hours and destroyed all of Dresden—possibly the world’s most beautiful city. But not me.

—Kurt Vonnegut (in a letter home from a P.O.W. Repatriation Camp)

Billy Pilgrim’s treatment within the novel shows the astounding lack of his or anyone else’s ability to see his madness for its medical significance. The fifth chapter of the novel logs his stays in hospitals and treatment facilities. This section shows the lack of medical knowledge about Billy’s PTSD and an inappropriate approach to handling mental instability. One instance happens while Billy is in Dresden watching a staging of *Cinderella* performed by
Englishmen dressed as women: “Billy found the couplet so comical that he not only laughed—he shrieked. He went on shrieking until he was carried out of the shed and into another, where the hospital was. It was a six-bed hospital. There weren’t any other patients in there. Billy was put to bed and tied down, and given a shot of morphine” (Vonnegut 98). This serves as a humorous foreshadowing of Billy’s self-admittance into a mental hospital after the war—two pages later. It abandons medical jargon and creates a realization of trauma through the appearance of men dressed as women. Vonnegut satirizes Billy’s first encounter with shell shock in Dresden by creating the moment out of performative literature. The comical aspect of the event becomes what sends Billy to the hospital, ultimately what initiates his diagnosis: following “[a] couplet so comical,” Billy’s instability strongly surfaces. This moment in the novel seems difficult to consider funny, but Vonnegut uses its humor to reveal Billy’s disease. After being “put to bed and tied down, and given a shot of morphine,” Billy rests in a shed without fellow patients. This highlights the earlier stated lack of medical knowledge about PTSD. Morphine being a drug administered to alleviate severe pain, the men who carry him out give Billy Pilgrim no hope of escaping an inward struggle that has less to do with physical pain and more to do with emotional trauma. The irony of this reaction, then, sets the stage for Billy’s scattered and disconcerting travel through time and space.

From this moment, the novel travels to Lake Placid, New York—three years after WWII ends. Billy has admitted himself into a hospital because of his mental issues:

He woke up with his head under a blanket in a ward for nonviolent mental patients in a veterans’ hospital [...] They were free to come and go as they pleased, to go home, even, if they liked—and so was Billy Pilgrim. They had come here voluntarily, alarmed by the outside world. Billy had committed himself in the middle of his final year at the Ilium School of Optometry. Nobody else suspected that he was going crazy. Everybody else thought he looked fine and was acting fine. Now he was in the hospital. The doctors agreed: He was going crazy. They didn’t think it had anything to do with the war. They were sure Billy was going to pieces because his father had thrown him into the deep end of the Y.M.C.A. swimming pool when he was a little boy, and had then taken him to the rim of the Grand Canyon. (99-100)

This introduces Billy’s status as a soon-to-be doctor. It also provides the first medical assurance that Billy is mentally unstable—“the doctors agreed: He was going crazy.” However, even when Billy and his doctors agree that
he suffers mentally, Billy receives little to no treatment and a lackluster explanation of his disease because “they didn’t think it had anything to do with the war.” Vonnegut himself was wary about the practice of psychiatry. According to his son, “he was very nervous and suspicious about psychiatry [. . .] he was afraid that therapy might make him normal and well adjusted, and that would be the end of his writing. I tried to reassure him that psychiatrists weren’t nearly that good” (Vonnegut Armageddon 3-4). Vonnegut writes the encounter between Billy and the doctors humorously but realistically. Mark Vonnegut was right, these “psychiatrists weren’t nearly that good.” Since doctors lacked an accurate description of PTSD during the time that Billy Pilgrim admits himself into the veteran’s hospital, his doctors would have been ignorant to its medical definition. However, they have pure sight—Billy’s trauma is overlooked and defined as past familial abuse not because the doctor’s lack the knowledge of PTSD but because the doctors ignore the fact that they all initially agree upon.

After this gross miscalculation of Billy’s suffering, Eliot Rosewater introduces him to a literary escape. Rosewater being a “former infantry captain” and “tired of being drunk all the time” exists as the opposite of what Billy needs to understand and cope with his disease. Nevertheless:

It was Rosewater who introduced Billy to science fiction [. . .] Rosewater was twice as smart as Billy, but he and Billy were dealing with similar crises in similar ways. They had both found life meaningless, partly because of what they had seen in war [. . .] So they were trying to reinvent themselves and their universe. Science fiction was a big help. (100-101)

Vonnegut introduces two different types of wartime trauma in the pairing of Billy and Rosewater: “Rosewater [. . .] had shot a fourteen-year-old fireman, mistaking him for a German soldier [. . .] And Billy had seen the greatest massacre in European history” (101). While Billy witnesses the slaughter of thousands of civilians, Rosewater kills one. Existing on a spectrum, both former soldiers cope with the scenes of a war-torn world by using science fiction. Vonnegut reinforces that both Billy and Rosewater seek to escape the current world in order to relieve the mental stress of years of war. This form of coping seems out of place within a mental ward post-WWII, but it continues Vonnegut’s use of humor and satire to drive literature as a form of medicine. Robert Scholes’s review of Slaughterhouse-Five supports its use of comedy to squelch the burned images of dead civilians within the eyes of mentally ruined soldiers. He writes, “The humor in Vonnegut’s fiction is what enables us to contemplate the horror that he finds in contemporary existence. It does not disguise the awful things perceived; it merely
strengthens and comforts us to the point where such perception is bearable. Comedy can look into depths which tragedy dares not acknowledge. The comic is the only mode which can allow itself to contemplate absurdity” (Merrill 38). A comedic obsession with science fiction after surviving one of the deadliest wars in history “looks into depths which tragedy dares not acknowledge.” Eliot Rosewater and Billy Pilgrim “contemplate absurdity” while realizing the depth of their emotional pain. Vonnegut sets this up within the novel’s plot: he introduces Rosewater as a perverted mentor to Billy Pilgrim, Billy accepts and adopts Rosewater’s obsession with sci-fi, Vonnegut casually introduces their roles within WWII, and their decision to “reinvent themselves and their universe [through] science fiction” becomes a workable solution.

This solution continues to manifest in the way that Billy and Rosewater interact and react within the hospital environment. In one instance, Billy remembers Rosewater’s flippant comment regarding the treatment of patients: “Billy heard Rosewater say to a psychiatrist, ‘I think you guys are going to have to come up with a lot of wonderful new lies, or people just aren’t going to want to go on living’” (101). Rosewater’s comment satirizes the symptoms of war. It results as a comical plea for more and better treatments for the mental instability that both patients suffer from, and it critiques the medical system through the view of an insane former captain, obsessed with science fiction. Robert Scholes concludes, “The truth of Vonnegut’s vision requires its fiction,” and Rosewater’s claim stands at the forefront of this vision (Merrill 39). Literature as medicine fixes the problem that Rosewater finds so aggravating within the psychiatric field. The inability of tangible medicine or treatment to positively affect or reach those with PTSD results in the need for “new lies.” However, literature—in Vonnegut’s case—exists ironically as a fictional account as well as a truth much more potent than history. Robert Merrill and Peter A. Scholl, in “Vonnegut’s Slaughterhouse-Five: The Requirements of Chaos,” suggest that “the need for supreme fictions is a very human trait [and] the need for such ‘lies’ [as Rosewater states] is almost universal in Slaughterhouse-Five” (Merrill 146). They offer the need for fiction as well as lies, but I would argue that Vonnegut provides a universal truth through the fiction that arises well after Billy leaves the hospital: the “lies” of classic fiction offer greater healing and treatment for wounded minds than psychiatry and medical definition does.

THE MEDICINE AND TREATMENT

Time travel is Billy’s therapy; his stories are his delusions.

—Todd F. Davis in Kurt Vonnegut’s Crusade
Throughout Billy’s interactions with Rosewater and his stay in different hospitals, literature exists as both a type of treatment and a relapse. At the beginning of the fifth chapter, the Tralfamadarians transmit him to their planet. On the way, he asks for a book, and the Tralfamadarians give him *Valley of the Dolls* by Jacqueline Susann. After reading the fictional romance novel set in the post-war world of Broadway and Hollywood, Billy decides “he [doesn’t] want to read about the same ups and downs over and over again [and] he ask[s] if there [isn’t], please, some other reading material around” (Vonnegut 87-88). This rejection of popular fiction begins the textual discussion of the proper medicine and treatment for Billy—which insinuates that a proper (and helpful) type of story exists. Billy asks about other literature on Tralfamadore, and the Tralfamadarians offer examples of their books. Billy describes them as “little things” with “clumps of symbols separated by stars,” but Tralfamadarians describe their literature differently: “the author has chosen [the messages] carefully, so that, when seen all at once, they produce an image of life that is beautiful and surprising and deep [. . .] What we love in our books are the depths of many marvelous moments seen all at one time” (88). This subtly mirrors Vonnegut’s novel. The images of Billy’s attempted healing “seen all at one time” produce an understanding of literature as a form of medicine and treatment—an image “that is beautiful and surprising and deep.”

Vonnegut also alludes to literature other than science fiction through the books that Edgar Derby reads in the Dresden hospital and the books not written by Kilgore Trout that Rosewater reads while in the veteran’s hospital. While Billy succumbs to the morphine pumped into him by the Englishmen, he notices Derby reading *The Red Badge of Courage* by Stephen Crane. A book set during the American Civil War centering around a cowardly private who runs from the battlefield, the plot echoes Billy’s own predicament and experience in World War II. Like Vonnegut’s Billy Pilgrim, Crane’s protagonist does not offer a brave and brawny hero, and Vonnegut’s allusion to this text is not coincidental within Billy’s trajectory. This allusion offers the first step during the treatment of PTSD: the acceptance of the disease. Vonnegut also offers another allusion to *The Brothers Karamazov* by Feodor Dostoevsky, which Rosewater discusses with Billy in the hospital at Lake Placid. This novel, unlike Kilgore Trout’s fiction, is highly acclaimed and delves into dynamic and universally relevant themes. Billy’s remembrance of this discussion comes in between scenes of Rosewater’s and his introduction in the hospital and Rosewater’s statement that psychiatry needs “new lies” for its patients. This memory reads, “[Rosewater] said that everything there was to know about life was in *The Brothers Karamazov* [. . .] ‘But that isn’t *enough* any more’” (Vonnegut 101). Rosewater’s assertion that a work of literary merit fails to be sufficient after supposedly knowing everything
about life offers an assumption that noteworthy literature once helped and healed Rosewater but, after his introduction to Kilgore Trout, seems inadequate. Vonnegut counters this by the plot summary of one of Trout’s books: “The book was *Maniacs in the Fourth Dimension* [. . .] It was about people whose mental diseases couldn’t be treated because the causes of the diseases were all in the fourth dimension, and three-dimensional Earthling doctors couldn’t see those causes at all, or even imagine them” (104). Both Rosewater and Billy are (metaphorically) maniacs in a different dimension because of the doctor’s lack of knowledge about the mental disease they suffer from, and Vonnegut uses the plot of a terrible novel to highlight the fact that people in different mental dimensions would of course fail to treat this disease properly. I would argue that Vonnegut also poses this as a metaphor for the literature that Billy and Rosewater read. Science fiction, or the types that these battle-sickened men deem worthy, is not sufficient medicine for a disease outside of its realm. Vonnegut shows this through the private library under Rosewater’s bed: “[He] had a tremendous collection of science-fiction paperbacks under his bed [. . .] Those beloved, frumpish books gave off a smell that permeated the ward—like flannel pajamas that hadn’t been changed for a month, or like Irish stew” (100). Vonnegut deems his collection inadequate medication through its permeating stench. The “flannel pajamas” need to be changed, and the “Irish stew” needs to be thrown out. Comparatively, if they suffer from a *Karamazov*-like disease, they need a *Karamazov*-like treatment.

**THE CURE**

The trip has simplified the war book for me. *Slaughterhouse-5*, since I have now seen with my own eyes what I was trying to remember.

—Kurt Vonnegut (in a letter to Sam Lawrence in October 1967)

An adequate treatment for the mental horrors that Billy faces throughout the remainder of Vonnegut’s novel is packaged within the novel itself. Just as the vaccine introduces the body to a weaker strain of the disease it prevents, *Slaughterhouse-Five* becomes the immune system that Billy needs. It, ironically, fights Billy’s PTSD through the reader’s exposure to his madness—a slow injection but a quick needle-breaking of the skin.

The slow injection may begin with Vonnegut’s many references to literature, both notable and terrible, but it continues with Billy’s own story of his time on Tralfamadore. Wayne D. McGinnis, in “The Arbitrary Cycle of *Slaughterhouse-Five*: A Relation of Form to Theme,” writes, “[Vonnegut’s novel] insists on both the world of fiction or fantasy (Tralfamadore) and the world of brutal fact (Dresden). [It] urges the primacy of the imagination in the very act of facing [history]” (Mustazza 113). Tralfamadore is, ultimately,
not just Billy’s fantasy but Vonnegut’s literary stitching up of the gaping holes that typical science fiction failed to sew together for Billy Pilgrim. This setting offers an escape from reality and provides Billy with an outlet to understand and cope with his trauma. Rosewater says, “Jesus—if Kilgore Trout could only write” to which the narrator adds, “[His] unpopularity was deserved. His prose was frightful. Only his ideas were good” (110). Vonnegut himself, in his early writing career, was dubbed a science-fiction writer—before critics started viewing his novels as black humor. However, in “Sci-fi and Vonnegut,” J. Michael Crichton assures, “There is [...] some business about a distant planet and flying saucers, but that doesn’t make the book science fiction, any more than flippers make a cat a penguin. In the final analysis the book is hideous, ghastly, murderous—and calm. There are just people, doing what people usually do to each other” (Mustazza 111).

Billy’s stay on Tralfamadore reveals the “calm” of the “hideous, ghastly, murderous” images of World War II.

After another scene in the Lake Placid hospital, Billy travels forward in time (now forty-four years old) to his fictional planet. They keep him in a zoo, which mirrors another hospital. The Tralfamadorians place Billy “on display under a geodesic dome,” “on a lounge chair,” “naked” (111). Billy’s location sounds similar to a perverted therapy session. Since “Earth [is] 446,120,000,000,000,000 miles away” from Tralfamadore, Billy enters a mental space where he can deal with the trauma and tragedy of war. “There were no walls in the dome, no place for Billy to hide,” which suggests the potential for genuine recovery (112). In fact, Tralfamadore becomes the only setting within the novel that Billy experiences any chance of full healing.

This healing comes when Billy introduces the Tralfamadorians to the atrocities of World War II. Being one of the only times he discusses these scenes verbally as opposed to inwardly, he praises their people for being so peaceful and says, “I am from a planet that has been engaged in senseless slaughter since the beginning of time. I myself have seen the bodies of school-girls who were boiled alive in a water tower by my own countrymen [...] I have lit my way in a prison at night with candles from the fat of human beings” (116). Billy admits the horrors he experiences, and this initiates his healing. It continues with a conversation between Billy and the Tralfamadorians, in which they explain the fundamental issue with Earthlings:

“So—” said Billy gropingly, “I suppose that the idea of preventing war on Earth is stupid, too.” “Of course.” “But you do have a peaceful planet here.” “Today we do. On other days we have wars as horrible as any you’ve ever seen or read about. There isn’t anything we can do about them, so [...] we spend eternity looking at pleasant moments [...] That’s one thing Earthlings might
learn to do, if they tried hard enough: Ignore the awful times, and concentrate on the good ones.” (117)

Through a fantasy experienced exclusively by Billy, which everyone else considers crazy, Vonnegut gives one of the best pieces of advice in the entire novel—the advice that would most help Billy and the advice that he so often subconsciously ignores. While Billy heals on Tralfamadore through talking about his trauma, the people offer a simple solution to continued healing: “concentrate on the good.” This cure, for Billy, comes in the form of his fantasy, while this cure, for Vonnegut, comes in the form of his fiction.

In the introduction to *Armageddon in Retrospect*, a book of unpublished work by Kurt Vonnegut, Mark Vonnegut says—concerning his father’s fiction:

> Reading and writing are in themselves subversive acts. What they subvert is the notion that things have to be the way they are, that you are alone, that no one has ever felt the way you have. What occurs to people when they read Kurt is that things are much more up for grabs than they thought they were. The world is a slightly different place just because they read a damn book. (6)

Vonnegut’s *Slaughterhouse-Five* makes the world of war trauma “a slightly different place.” He allows Billy to admit his trauma, therein admitting his own. In the world of mental disorders, these are “subversive acts.” They disrupt the system of blind participation in governmental structures, and they critique an entire era of inadequate medical diagnosis. Vonnegut brings to the surface the horrors not yet spoken in his way—those that other literature either ignores or champions. Wayne D. McGinnis concludes, “[*Slaughterhouse-Five*] is like the Tralfamadorian novel, a novel without beginning, middle, and end, without suspense and without a moral” (Mustazza 120). McGinnis argues that Vonnegut’s novel is itself a renewal—just like therapy. The novel must delve into the raw, untouched, still bleeding cuts. The novel must expose the atrocity to see the arrival of springtime. By the end of the novel, the reader does not feel certain that Billy reaches complete recovery, but that he copes with his issues. “World War Two in Europe was over [...] trees were leafing [...] birds were talking,” and Vonnegut ends the novel with a picture of renewal as well as dead bodies and corpse mines. He leaves the reader with a balance of horror and peace—a potential cure for the chronic illness of trauma.

**WORKS CITED**


Jeanette Winterson’s 1992 novel *Written on the Body* is an amalgamation of musings about death, insights on love, and poetic uses of medical jargon. Winterson rose to prominence as a quirky postmodernist voice in the waning years of the twentieth-century. She became known for composing unconventional novels with recurring themes of gender inequality, love, and sexuality. Winterson’s works have not shied away from embracing feminist ideologies and unwavering social critiques. However, when discussing *Written on the Body* scholars have seemingly overlooked the presence of medicine within the novel—even though it is the driving force of the narrative. This novel displays the originality of Winterson’s voice. Through her medically charged text, Winterson brings to the forefront not only how bodies—especially diseased bodies—are discussed but also how they are theorized. In this novel, the body is treated as text. It can be read, written on, and written about.

*Written on the Body* tells the story of an unnamed and ungendered narrator and lifelong philanderer who has fallen in love with the unhappily married Louise. The two begin an affair that encourages Louise to leave her workaholic husband Elgin. The narrator and Louise move in together and for several blissful months pursue a relationship. However, Elgin disrupts the romance by disclosing to the narrator Louise’s diagnosis of chronic lymphocytic leukemia. Elgin eventually proposes that the narrator break off the relationship, suggesting that the lovers were “both a bit too old for the romantic dream” (105). By leaving, the narrator would allow Louise to be treated at Elgin’s research lab in Switzerland. The narrator makes a regrettable sacrifice and goes away, foolishly believing that this action will save Louise’s
life. Within a novel that on the surface appears simply to depict the act of falling in love, Winterson brilliantly crafts a much more expansive critique.

Medicine and the presence of a doctor is very much secondary to the novel’s love story; however, its utilization frames a much larger discussion of the way a male-dominated society attempts to impose its will onto the female body. Michel Foucault claims that “the body is permanently inscribed by power relations seeping into everyday life in the form of disciplinary practices” (Lindenmeyer 49). Winterson explores how history is imprinted on the body as its surface is defaced by society. Initially, Louise is not allowed to make decisions concerning what she believes is best for her health. Her husband Elgin (and even her lover, the narrator) takes away her agency to choose. Elgin simply makes his own claim to Louise’s body by assuming that his treatment represents the best course of action. His selfishness is not truly about a remedy for his wife but instead has to do with his perceived ownership of Louise’s body. Scientific and medical discourses have a history of conveying sexist ideologies. In the novel, Winterson depicts medicine as a masculine practice that seeks to analyze and interpret the body. Winterson critiques androcentric medicine and the way that medical men like Elgin try to understand the female body by poking, prodding, or dissecting it. This consultation with a doctor who happens to be her husband creates a congested space that is occupied by numerous voices that are rarely her own. By giving the narrator an ultimatum, Elgin is proposing a sort of contest where the winner will ultimately claim Louise’s cancer-riddled body as their prize. These two characters somehow believe that by winning they will not only have ownership over her body but Louise’s illness, as well. The competition, then, turns to deciding who will be able to protect her.

Winterson situates Elgin in the novel to serve as the embodiment of a male-dominated institution that utterly disregards the female voice. The author makes use of Louise’s experiences within the text to point out the correlations between attitudes about bodies, specifically the female form, and prevailing thoughts towards women. In Written on the Body, Winterson utilizes the medium of medicine and its treatment of the female body to discuss and critique the larger implications of Louise’s subjection to the power of a patriarchal establishment. Cancer becomes a gendered representation of the toxic actions and individuals that occupy Louise’s life.

WHEN LOVE IS LOSS AND CANCER INVADES

Louise’s disease has a central role in Written on the Body and marks a turning point in the narrative. After bowing out to Elgin, the narrator escapes to Yorkshire, covering his/her tracks so that Louise can not follow. When separated from Louise, the narrator becomes consumed by the thought of her and attempts to recreate her body through the memories they once
shared. One day while transcribing Russian texts in the library, the narrator wanders over to the medical section. Believing that this will somehow help Louise or at least allow the narrator to reclaim the lost love s/he states,

“I became obsessed with anatomy. If I could not put Louise out of mind I would drown myself in her. Within the clinical language, through the dispassionate view of the sucking, sweating, greedy, defecating self, I found a love-poem to Louise. I would go on knowing her, more intimately than the skin, hair and voice that I craved. I would have her plasma, her spleen, her synovial fluid. I would recognize her even when her body had long since fallen away” (111).

Within this section, Winterson makes this interesting parallel between cancer and the way the loss of Louise affects the narrator. The narrator describes love as a visceral phenomenon that invades the body, similar to cancerous cells. The narrator finds comfort in this medical language, clinging on to the only remnants of Louise that s/he has left. However, Winterson employs the use of anatomy to highlight the underlying obsessive theme of this narration. This inventive use of language is attempting to convert the negative clinical view of Louise into a poetic evocation of the lover the narrator remembers. These words mark a structural change that takes place within the novel. As the story continues, the poetic prose that follows becomes the narrator’s way of reviving the dying Louise, with language as the cure.

On the novel’s first page, in its opening line, Winterson poses the question: “Why is the measure of love loss?” (9). The author has the narrator repeatedly attempt to answer this very question, hoping the narrative will offer a textual solution. In the latter half of the novel, Winterson leaves Louise, Elgin, and the narrator to contend with this loss in their own respective ways. Louise’s cancer does not seem to affect her body alone; its presence casts a wide net over the narrative, embedding itself in the lives of the other characters, as well. The illness is most intensely felt during the long period in which the narrator mourns the absence of Louise. The narrator’s frantic attempts to recall memories of Louise is interrupted “by a series of prose pieces that seem to be the narrator’s attempt to reclaim Louise’s body against the thought of its physical absence and inevitable decay” (Burns 295). This portion of the novel is divided into sections with headings such as “The Skeleton” and “The Cells, Tissues, Systems, and Cavities of the Body,” each covering various parts of human anatomy. The narrator attempts to understand and explain what is taking place within Louise’s body as the cancer spreads throughout her system. Each section begins with a small excerpt from a medical textbook that details various functions of the body. Within each of them, Winterson creates these various vignettes that com-
bine medical language with the narrator’s expressions of love. Critic Antje Lindenmeyer comments that the novel “echoes the postmodern claim that the body is discursively produced through language by introducing a narrator whose words bring the body of the beloved woman into existence, and who constantly attempts to recreate her absent body through evocative descriptions” (49-50).

Interestingly, Winterson does not permit the audience to explore or experience Louise’s journey of bodily pain. Louise’s story is told through the lens of the novel’s narrator. However, Louise’s illness does appear to disrupt the continuity of the narrative. It forcibly stops the novel’s focus on love and instead shifts to a meditation on death and loss. In her article “Expression in a Diffuse Landscape: Contexts for Jeanette Winterson’s Lyricism,” Susann Cokal explores the presence of cancer within the novel:

“Midway through the book, leukemia provides the context for a breakdown in style (however temporary, however partial). Cancer “is the body turning upon itself” (Written 105), says Louise’s doctor husband; with cancer the text also turns both upon and away from itself when Louise goes from lovesick to simply sick. We never see what cancer does to Louise, only how news of her imminent suffering affects her lover and the text. The very word “cancer” introduces mystery into the novel: the sexual story is planned out, scripted, early on, but with cancer the outcome of that story turns murky; it is as if, in trying to avoid clichéd scripts, Louise and the narrator invite disease. “Cancer” also reveals the origins of lyricism—which lie in the sense of loss, not of love; in the process of reading-in, translating, rather than in bare facts and plain English such as the lover finds in medical texts” (28).

Louise’s cancer permeates the second half of Written on the Body, and the novel itself has to adjust its style. The text moves away from the lyricism that was initially used to express falling in love in the first half, and instead, entirely new language is created. Leukemia is a cancer of the blood that spreads and essentially makes the entire body a potential enemy. While Louise’s illness is mentioned it is only ever defined by Elgin or the narrator. Louise’s body is a blank slate. What has been definitively written on it at this juncture in the narrative is disease. However, in an effort to fill Louise’s body with text the narrator applies clinical language to it.

THE MAN, THE MYTH, THE MEDICINE
What is Louise to do if she no longer has control over her body or decisions? Louise abruptly has to grapple with a certain dissociation with a body
she no longer controls or understands. Louise is not granted a moment of freedom, but rather the narrator writes on her body and cancer writes on her body. She is at times treated as an object and as such Louise's illness is not claimed as her own. This allows someone like Elgin, under the guise of medicine, to take advantage of Louise in her depleted state. These actions are also an attempt to eliminate Louise's own desires and foster a prolonged dependence on Elgin. As Mary Halas points out in “Sexism in Women's Medical Care,” “This dependence on all-powerful doctors and women's relinquishing of responsibility for their health to male doctors is the result of physician behavior that reduces the patient’s sense of autonomy” (12). Lack of information about her body, coupled with the dependent relationship with her physician husband, makes it difficult for Louise to find her best course of treatment. Sexism in the practice of medicine is rooted in the socialization of women to be passive recipients of care from authoritarian male doctors, plus the socialization of doctors who trivialize women's medical problems and foster attitudes that demean female patients.

Winterson depicts the medical field as lacking the ability to engage the body unmediated by historical relativity. Winterson openly criticizes the limiting and reductive nature of the medical gaze. Winterson also presents the novel’s only doctor as a flawed, manipulative figure. Louise's husband Elgin personifies the problematic nature of men within the field of medicine. Elgin attempts to leverage his wife's health in order to maintain his reputation as a prominent figure within the medical community. Cancer research and treatment is believed to be the pinnacle of medicine, often dominated by egotistical male doctors. During an earlier intimate encounter at her home, Louise confides in the narrator revealing the truth behind her husband's public facade. Louise admits that Elgin may not have become a doctor solely because he aspired to save lives. Cancer is a popular concentration that is often regarded as “very sexy medicine” (Winterson 66). Louise goes on to point out that “gene therapy is the frontier world where names and fortunes can be made” (66-67). Elgin was pursued by an American pharmaceutical company and was subsequently moved out of the hospital and into a research lab. Elgin no longer utilizes his bedside manner in the terminal care ward but instead spends his days staring at a computer screen. Winterson discloses this information to convey that Elgin's lack of interaction with patients signifies that he has become more concerned with personal accolades. Ultimately Elgin's obsession with carcinomas becomes more beneficial to his career than to any of his patients.

The unnamed narrator of Written on the Body seemingly lacks a described body. While Winterson refrains from disclosing the gender of the narrator there is an emphasis on the female body, specifically Louise's. As Louise's body is ravaged by cancer, it is simultaneously under attack from outside
forces. By having the gendered body belong to a woman, Winterson allows the socialization of the female body in society and history to shape the novel. Louise’s effect on the narrative is somewhat comparative to Helen’s role in the Trojan War. She may indeed be the scapegoat in all the conflict that takes place; however, her presence is symbolically linked to the larger implications of the novel’s narrative. Throughout Written on the Body, Louise is indeed a woman of few words. It does leave one to wonder why Winterson does not let Louise tell her own story? Louise “is generally described as a mere physical entity rather than a character with a specific personality, she is denied agency and choices are made on her behalf” (Maioli 149). Louise is continuously viewed through the lens of the narrator and her voice is even suppressed by the novel itself. Essentially, Louise is being brought to life by words and descriptions that are never her own. The problem with this is that the ungendered voice becomes synonymous with the prevailing—and, in this case, male—voice. The narrator becomes complicit in the same offensive rhetoric that the novel criticizes Elgin for spewing.

SOMETHING BORROWED, SOMETHING NEW
The narrator fragments Louise’s body into scientifically poetic language. The narrator’s fetishization of Louise’s body focuses on single parts instead of the body in its entirety. Louise is never depicted as a being whole. This process compares Winterson’s writing to the literary Renaissance practice of emblazoning. The narrator’s medical sections about Louise are similar to blazons, poems that catalog discreet parts of a woman’s body. The history of this literary practice aligns with the medical practice of dissection. What unites the narrator’s poetics with the “medical varieties of blazon is their shared representation of competitive ownership and their rendering of the female body as visible and quantifiable—to possess it, as it were, by seeing, measuring, and describing its regions” (Harvey 33).

This reference links to Winterson successfully connecting medicine and colonialism, as these two subjects frequently appeared in blazons. The narrator’s anatomical account charts parts of Louise in an attempt to draw a map of her dying body with descriptions. By doing this, the narrator emphasizes the inscription of power onto female flesh. The narrator weaves Louise’s body into the anatomy of the textbooks s/he finds in the library, associating her different parts with specific imagery. The narrator describes Louise’s cells as trying to pick a fight within her bloodstream. In that same section, the narrator inquires about Louise’s defenses proclaiming that “There’s no-one to fight but you Louise. You’re the foreign body now” (116). The narrator continues this metaphor of illness and war. Louise no longer possesses immunity against infection, and the cancer has become her body’s enemy. This interpretation of the anatomy textbook centers on issues of violence,
science, and death, which along with the narrator's language are all written on Louise’s body. Louise plays no active role in any of this, her body simply provides the surface for inscription. Louise is left to carry the narrative and these experiences on her own skin. This language does not provide a better understanding of Louise or her suffering. The narrator is simply applying a gaze that further connects colonization to that of anatomy and medicine by alluding to the violent nature of the cancer.

THE BODY AS TEXT
In the early modern age, anatomy was used to discover some truth about a specific issue. It was widely considered to solve the enigma of mortality and human existence. In the novel, the narrator turns to anatomizing Louise’s body to unveil its mysteries and discover a hidden truth about her. However, this proves to be an impossible task for the narrator. Winterson utilizes this approach as “a way of further strengthening the discourse on power and control over women’s bodies” (Maioli 149). Despite appearing healthy and full of life, the inside of Louise’s body becomes a fascinating yet frightening entity. The disease that is taking over her body adds to the narrative of Louise being weak. This positions Louise as needing to be defended from her own body—therefore, not allowing her to be independent in her decision making. Medicine tends to focus on the elimination of abnormalities rather than the actual patient. The sick individual thus becomes “reduced to and understood in terms of the disease that he or she suffered from” (Hughes 12). This methodology encourages the erasure of the person to concentrate on symptoms instead of suffering. As a result, Louise literally and figuratively disappears behind her disease. The narrator’s language moves away from the surface of Louise’s body and instead focuses on its interior, which is where the cancer is actively ravaging her from within. The text then begins cutting into the interior of Louise’s body, making sure no parts of her are left unexplored. The narrative shifts into a discourse of mastery and possession. Louise’s body is made to convey various meanings that are reflected in the text that is written on it. Like many other female characters in literature, Louise is not granted an autonomous self-identity. Instead, her body is relegated to being the property of patriarchal institutions.

Louise’s body is never a clearly defined entity within the novel. The narrator often constructs it as land that “is constantly in search of a proper definition and is fought upon by different competitors struggling for a colonial-like control over it” (Maioli 144). In talking about Louise, the narrator’s language depicts natural landscapes and expressions that refer to voyages of conquest. These descriptions suggest a colonial setting that ends up being identified with Louise’s body. This is emphasized by the
colonial language that the narrator employs in search for the right words to describe Louise, who appears as a body to be explored and discovered in a very ambiguous way. There are moments where the narrator becomes plagued by the same patriarchal discourse as Elgin, and this is depicted in his/her language. In an attempt at understanding Louise’s body, the narrator compares it to a voyage of discovery: “How could I cover this land? Did Columbus feel like this on sighting the Americas?” (52). In the mentioning of Columbus, Winterson evokes a colonizing metaphor of a woman’s body as uncharted land, passively waiting for the male conqueror to penetrate, explore, and exploit it.

Cancer invades the body, an intrusion similar to the narrator’s exploration of Louise. Both flourishing around the same period, anatomy and colonialism indeed have commonalities. The role of anatomy was to provide answers to the confusion that surrounded observations of the body. Similarly, colonialism was used to shine a light on continents such as Africa, and as a result, this insight directly correlates to the creation of western civilization. Therefore, one can suggest that “colonialism represents a geographical anatomy of the exterior world analogous to the pathological anatomy which sought to expose the structure of the inner world of bodies” (Turner 28). Both of these disciplines essentially sought to control and seize a specific person or object. Anatomy utilizes the inner workings of the body to fight diseases such as cancer. The geographical discoveries of colonialism made efforts to dominate the natives of these colonized areas. Louise’s body happens to be the object both practices. The novel initially describes her body as a colonial landscape that is fought over. Midway through the narrative, this same body becomes a similarly subjugated entity as it is anatomized. By denying Louise control the medical and colonial language appears intrinsically imperialistic. Within Written on the Body this discourse denies Louise her own distinct personality and ability to narrate her own story. By having Louise’s language limited, Winterson leaves her at the will of the narrator and the novel.

ERASING WHAT WAS WRITTEN
The narrator, while claiming to be celebratory of the female body, ends up creating language that comes off as a narration of colonization. Large portions of the narrative are sustained by actions that dominate the female body and suppresses the only feminine voice in the novel. The narrator may be genderless; however, the novel is riddled with the presence of patriarchal sentiments. The female body is described through the use of rich medical terminology and geographical imagery. Winterson uses the narrator’s language to recall the process of inscribing social norms onto female bodies in order to keep them under control. Written on the Body is based
on a discourse of colonization that “provides the main set of images used to talk about Louise’s body but at the same time it is a strong metaphor for the power dynamics at work in the story” (Maioli 144). The narrator is not simply a romantic protagonist narrating exploits in love. On the contrary, the narrator is revealed as having a dominating presence that is driven by naivete and control. It is common for most readers to identify with the narrator of the story. By allowing the novel to be entirely filtered through this problematic narrator, Winterson implicates her audience in the colonial enterprise of conquering a female body. This also applies to the competition between Elgin and the narrator, as both attempt to claim ownership over Louise’s body. Louise is a figure whose presence is minimized and at times is too elusive to identify with. Winterson appears to frame Louise in this way because such a tactic demonstrates how often women in literature are used as plot devices or sacrificed to benefit a man. Louise’s body is analyzed with textbook explanations that become a poetic lament of the beauty and tragedy of her failing body. The narrator’s illustrations question whether this deconstruction of Louise’s body is an adequate way to understand her. Simply categorizing Louise does not depict the full essence of her identity. In Written on the Body, Winterson turns her narrative lens towards society, reflecting the ways in which this negative treatment of women has seeped into media, literature, and even the laws and institutions that govern nations. In this novel, Winterson chooses the field of medicine as her symbolic stand-in. However, it is only one of the patriarchal establishments that should be scrutinized. Louise is not the sole diseased figure in the novel. Written on the Body explores how the cancerous mindset of men who are historically privileged undermines female agency, as they attempt to imprint women’s bodies with narratives of their own making.

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“Erroneous Deductions:” The Undermining of the Physician in *Sherlock Holmes*

Mary Lyndall Hunt

The Victorian detective series *Sherlock Holmes*, written by Sir Arthur Conan Doyle between the years of 1887 and 1927, contains within its canon fifty-six short stories and four novels and introduces one of literature’s most illustrious detectives—the intuitive, cunning, and sometimes downright frustrating Sherlock Holmes. His reasoning skills influenced the art of forensic investigation and still impact modern culture through film and television. Conflictingly, Holmes’s companion and biographer, Dr. John Watson, assumes the identity of the duped or misguided counterpart to the detective. Due to the portrayal of Watson as a dim-witted assistant in contemporary adaptations of the series dating back to the 1940s films starring Basil Rathbone and Nigel Bruce, Watson is frequently regarded as the entertaining and “endearing . . . buffoon” to Holmes’s genius (Reed 77). However, Watson’s intelligence is no small matter, and in fact, before working with Holmes, Watson graduated from the University of London as a Doctor of Medicine, the highest rank in the Victorian medical profession, and a short time later the British Army commissioned him as an army surgeon in India during the second Afghan War. While Watson’s medical knowledge and experience allows him to be a commendable confidante to the brilliant Holmes, his own deductions and conclusions of their numerous cases are oftentimes misguided. As Holmes puts it in *The Hound of the Baskervilles*, “I am afraid, my dear Watson, that most of your conclusions were erroneous. When I said that you stimulated me I meant, to be frank, that in noting your fallacies I was occasionally guided towards the truth.” Ironically, Holmes has no medical education and many scholars even debate whether he actually attended university or not, revealing a subversion
of the physician within the *Sherlock Holmes* stories, since a detective with no advanced degrees is able to outsmart highly trained physicians including Watson.

It comes as little surprise that the doctor figure occupies a large part of the series, considering Sir Arthur Conan Doyle’s own history with the medical field. In 1881, he graduated from University of Edinburgh with a degree in Bachelor of Medicine and Mastery of Surgery qualifications and continued his education in 1885 earning a Doctor of Medicine. While he was earning his degree, he was offered a job as a surgeon on the whaling ship *Hope*, which voyaged the Artic Seas for seven months. Once he graduated, Doyle opened his own practice, and it was during this time that he began writing detective stories featuring Sherlock Holmes, who takes inspiration from Joseph Bell, a doctor he studied under in medical school. Doyle describes Dr. Bell as a “very skillful surgeon, but his strong point was diagnosis, not only of disease, but of occupation and character,” and in a letter to Dr. Bell, Doyle writes, “Round the centre of deduction and inference and observation which I have heard you inculcate, I have tried to build up a man who pushed the thing as far as it would go—further occasionally.” On the contrary, though, Holmes’s confidante Dr. Watson has more of a “drab” creation, as Doyle admits in his memoir: “[Holmes] must have a commonplace comrade as a foil—an educated man of action who could both join in the exploits and narrate them. A drab, quiet name for this unostentatious man. Watson would do.” This reveals how Watson is oftentimes forgotten, overshadowed, or second best to his legendary friend.

Scholars often draw attention to Holmes’s embodiment of a new form of doctor and how his inductive reasoning can be applied to the medical field. Yet critics seem to discount Watson’s and, subsequently, the medical field’s importance in these stories. In “Sherlock Holmes and Medicine,” Douglas Guthrie chronicles the various medical aspects of and inspirations for Sherlock Holmes, and although he admits the “simple-minded Watson” is often duped by Holmes, he accounts for this by merely arguing that “Holmes is always in the centre of the picture, perhaps that is why Watson did not appear to advantage, and the other doctors made such temporary appearances” (999). Paula Reiter similarly argues that “Holmes’s brilliance [. . .] shines all the more brightly against a dull background. Watson often provides such a contrast. Watson and the client know less than Holmes, and the structure of the detective story highlights this gap in knowledge” (Reiter 79). What Guthrie, Reiter, and others seem to overlook is the significance of the medical profession—especially how it is situated in a detective series where a genius detective with no medical degree repeatedly outsmarts doctor figures. This begs the question: Why would Doyle include doctor figures in the *Holmes* canon that undermine his very own profession? Dr. Watson
and physician figures like Trevelyan and Roylott in “The Resident Patient” and “The Speckled Band” illustrate the incompetency and problematic hierarchy of dated medical practices of the nineteenth century, but also reveal the anxieties of late-century Victorians of the advancing scientific medical profession. Whereas Sherlock Holmes, who has no medical degrees, represents a new form of doctor emerging in late nineteenth and early twentieth century that is situated in scientific advancement and deductive reasoning.

* * *

While Doyle includes a great number of allusions to medicine in the canon—including over 30 physicians, 32 medical terms, 68 diseases, and 6 hospitals—interestingly, there are quite a few stories that depict the doctor as a deceived figure. In the 1893 short story “The Adventure of the Resident Patient” the general practitioner Dr. Percy Trevelyan mistakenly treats a patient faking catalepsy, and Dr. Grimsby Roylott in “The Adventure of the Speckled Band” unintentionally murders himself after attempting to kill his step-daughter. While Holmes oftentimes acknowledges the “intelligence and nerve,” of doctor figures including Watson, he reveals that physicians have “very limited experience and mediocre qualifications” (2). When Holmes induces the symptoms of Tapanuli fever onto himself in “The Adventure of the Dying Detective,” in order to catch a murderer, he manipulates Watson into thinking that his education and experience in the medical field is useless. Holmes sardonically asks if he shall “demonstrate [Watson’s] ignorance” in whether Watson knows anything about the pathological condition of the disease (2). Interestingly, this critique towards the medical profession reveals the evolving medical practices of the nineteenth century. Until the mid to late 1800s, the medical world was largely based on a “tripartite structure composed of physicians, surgeons, and apothecaries” (Medical Living 29). The physicians had the most prestige in society, as they held the highest-ranking medical position, and their job consisted of dealing with diseases and diagnosing patients. They mainly would take detailed case studies of their patients and did not deal with any external injuries or surgeries. Surgeons, on the other hand, treated patients that needed operations externally and internally, and apothecaries prepared and prescribed medicines. But as science and medicine started advancing with the acceptance of germ theory and the notion that several diseases are caused by microorganisms, medical practices needed to advance with it. Doctors started seeing crossovers of each division of labor: physicians found it important to know about the anatomy of a patient; a surgeon needing to be knowledgeable about prescription drugs and medicines, and as apothecaries and surgeons saw many of the same patients, eventually the
apothecary trade was abandoned (Digby 29). By the end of the Victorian era, medicine evolved into the “science of medicine” as clinical research, technology, and new techniques of diagnosis facilitated the transition from the tripartite hierarchy of doctors to the modernized medical profession of the twentieth century (Carpenter 158).

THE DUPED DOCTOR
The undermining of Dr. Watson’s medical experience and intelligence in “The Dying Detective” critiques the Victorian medical profession’s problematic medical hierarchy. Watson and Holmes take on a doctor-patient relationship as Holmes manipulates Watson into believing that he is dying from a rare eastern disease and needs to be treated. When Holmes summons Watson into his apartment and he sees Holmes in a “deplorable” state, Watson admits that “all [of his] professional instincts were aroused,” but Holmes will not allow Watson to treat him, stating that he has “very limited experience and mediocre qualifications” (1, 2). Doyle critiques the problematic hierarchy of nineteenth-century medicine as the tripartite structure consisted of physicians, surgeons, or apothecaries. Within each concentration of medicine, doctors were limited in their ability to heal patients, as physicians dealt with medicine under “intellectual direction or management” (Digby 29), surgeons treated patients for which operational means was necessary, and apothecaries prepared and sold medicines and drugs to physicians, surgeons, and patients. With this structure, diagnosis relied heavily on a patient’s own description of their symptoms—more so than a physician’s observations, since the knowledge of anatomy and medicine were not in their specialty. This medical order limited doctors on the ability to effectively cure patients. However, as the century progressed, so too did scientific and technological advancements in the medical field. This created a more fluid structure of medicine, as doctors found themselves needing knowledge from the other medical fields to enable them to correctly diagnose and treat.

With this new shift in medicine, however, many doctors were slow to evolve and preferred the conventional ways of medical practice. In a sense, Watson represents the outdated structure of the medical profession. He insists on diagnosing Holmes himself, but when Holmes brilliantly argues that Watson’s “mediocre qualifications” and lack of knowledge of both Tapanuli fever and the black Formosa corruption, Watson is forced to listen to the patient, Holmes. This reveals the problematic ways in which the old medical structure limited a doctor’s abilities to correctly diagnose and heal a patient. As Watson’s knowledge of foreign disease is not something he would have learned as a general practitioner, he is unable to effectively treat Holmes. By listening to Holmes’s insults about the medical field, instead of
listening to his “professional instincts, Watson exposes one of the weakness of nineteenth-century medicine: doctors’ reliance on a patient’s own biased observations of the disease rather than their own conclusions. With the creation of the character Sherlock Holmes, who uses his own deductions and abilities to solve cases, juxtaposed with Watson who is unable to solve a case or in this case cure Holmes, Doyle comments on Victorian doctors’ dependence on their patient’s opinions rather than their own informed diagnoses. Rather than allowing Watson to diagnose him, Holmes uses Watson as a pawn and asks him to obtain Mr. Culverton Smith, who “is best versed in this disease [and] is not a medical man, but a planter” (3). Watson is a symbol for the outdated practice of medical hierarchy in which doctors are restricted to their given fields and do not have the ability to fully treat a patient. Conan Doyle uses the planter with no medical experience as a humorous attack on the Victorian medical profession, since Watson is forced to allow this farmer to “cure” his friend.

Doyle utilizes irony throughout “The Dying Detective” and “The Resident Patient” in order to critique general practitioners’ reliance on traditional medical practices and social structures. Both stories contain duped doctors whose patients are faking diseases. With the fluidity of the medical profession in the late nineteenth century, a new hierarchy of medicine formed—that of the consultant and specialist doctor. The term “consultant” refers to practitioners who chose to practice strictly as surgeons or physicians, while specialists focused on a specific concentration within surgery or general medicine. With the establishment of specialist hospitals during the 1860s, medicine had become more scientific with surgeries, research, and medical training all taking place within one hospital (Carpenter 164). Tensions between consultants and specialist doctors rose, as consultants relied heavily on traditional medical practices and were hesitant about scientific advancements, while specialists were thought to have embraced scientific progress (Digby 34). In both “The Dying Detective” and “The Resident Patient,” Watson and Dr. Trevelyan take on the role of the of a consultant, as they are both practicing physicians and employ traditional medical practices rather than adopt newer scientific techniques. These cases share a familiarity in that the “patient” in each story is faking their illness, but the doctor is unaware until the very end when Holmes, a man with no medical degree, “cures” them. Holmes assumes the identity of patient to Dr. Watson in “The Dying Detective” as he inflicts himself with “Tapanuli” disease in order to catch a murderer. Holmes says to Watson, “Shall I demonstrate your own ignorance? What do you know, pray, of Tapanuli fever? What do you know of the black Formosa corruption?” Watson replies: “I have never heard of either” (2), illustrating a lack of knowledge and inability to “cure” Holmes. Susan Harris argues that Watson’s ignorance “is the voice of the specialist
declaring that the ‘general practitioner’ is not competent to treat this kind of complaint. Disease has slipped out of the realm of medicine and into the province of the ‘medico-criminal’ expert” (Harris 447). Ironically, by faking an illness, Holmes mocks Watson’s profession and its inability to not only correctly diagnose, but also to cure patients. Doyle seems thus to be commenting on the ways in which general practitioners are failing patients because of their inability to evolve with scientific advancement. Such a critical intervention was important, because the 1860s and 1870s were statistically the unhealthiest years in Victorian England, according to the General Register Office, which documented a death-rate rise of 22.5 per thousand people (Carpenter 252).

While Doyle dupes Watson in order to illustrate the inability of general practitioners to correctly treat patients with traditional and outdated medical practices, he also critiques consultants’ adherence to a superficial social structure by deceiving Dr. Percy Trevelyan through one of his patients. When Trevelyan introduces himself, he establishes his educational accomplishments while also revealing social elitism: “[I occupied] a minor position in King’s College Hospital [. . .] I was fortunate enough to excite considerable interest by my research into the pathology of catalepsy [. . .] As you readily understand, a specialist who aims high is compelled to start in one of a dozen streets in the Cavendish Square quarter [. . .] and to hire a presentable carriage and horse” (2). While Trevelyan refers to himself as a specialist, his concern is not with the scientific advancement or revealing research on catalepsy; instead, he focuses on the prestige that he associates with a specialist, including office space and a “presentable carriage and horse.” The Victorian medical profession was perceived as high-status, but Doyle found this frivolous, as the focus turns from the medical to the social. Before Trevelyan appears in the text, Holmes notes to Watson, “A doctor—general practitioner” (1), illustrating Doyle’s subversion of Trevelyan’s superficial view of medicine by having Holmes denote his profession before the doctor is even introduced. As the medical profession advancing in the late nineteenth and early twentieth century, a new elite hierarchy of medicine formed between specialists and consultants.

With the help of medicalized hospitals and colleges such as Royal College of Physicians, both of these types of doctors could foster their education and research, but tensions between specialists and consultants persisted. Specialists had a greater appreciation of scientific advancements and evolving social structures in the medical profession and with this a rise in the social status of these types of doctors. Whereas consultants, or general practitioners, had more loyalty toward traditional medical practices and social statuses (Digby 33-34). By having Holmes identify Trevelyan as a general practitioner rather than a specialist, Conan Doyle undermines Trevelyan’s
claimed profession and critiques the superficiality of prestige and elitism in the medical field. When Trevelyon asks for Holmes and Watson’s help in explaining peculiar behavior of his resident patient, he reveals that his new patient suffers from catalepsy, the very disease that Trevelyon gained “considerable interest” at King’s College Hospital. Holmes quickly deduces that the patient with catalepsy was “a fraudulent imitation,” as it is a “very easy [disease] to imitate” and reveals that strange behavior of both Trevelyon’s resident patient and his patient with catalepsy had nothing to do with illness, but rather, an old bank heist. Holmes undermines the Trevelyon’s medical knowledge by not only revealing that the patient is faking the one disease that he claims to have researched on, but he humorously adds that it is an easy illness to imitate. This speaks to the superficiality of the medical profession, as Trevelyon seems to care more about his prestige in society rather than the disease, illustrated in the fact that he is unable to see that his patient was faking the symptoms. Conan Doyle is critiquing the outdated nineteenth century medical profession and its adherence to superficial social structures, which ultimately prevents the physician from correctly diagnosing and treating the patient.

THE DETECTIVE DOCTOR
If the “ignorance” of Watson and other doctor figures reveals outdated and stagnant medical structures of the nineteenth century, then Sherlock Holmes, who undermines those physicians, embodies a new type of doctor in Victorian England, one situated in scientific advancement and deductive reasoning. The end of the nineteenth century saw a shift in the medical field as “medicine had become the science of medicine,” and doctors had the ability to correctly diagnose and treat a patient due to new medical innovations including the x-ray machine and acceptance of scientific theories such as germ theory. With this new technology, “practitioners became like prophets, able to see things about the body that were not visible to the naked eye, and thereby to forecast the patient’s future” (Carpenter 162-63) and through this a new form of doctor appeared, the specialist, who unlike consultants were more accepting of new scientific innovations. While Watson and other physicians signify the traditional and outdated Victorian medical profession, Holmes embodies the persona of the specialist as his progressive techniques aid in solving cases. In “The Speckled Band,” Watson is unable to solve the case and turns to Holmes:

“You have evidently seen more in these rooms than was visible to me.”
“No, but I fancy that I may have deduced a little more. I imagine that you saw all that I did.”
“[. . .] You saw the ventilator, too?”

“Yes, but I do not think this is such a very unusual thing to have.”

“[. . .] Well, there is at least a curious coincidence of dates. A ventilator is made, a cord is hung, and a lady who sleeps in the bed dies. Does not that strike you?”

“Holmes,” I cried, “I seem to see dimly what you are hinting at. We are only just in time to prevent some subtle and horrible crime.” (9)

Holmes employs deductive reasoning in order to come up with his conclusion and ultimately solve the case. Guthrie states that “There is a close kinship between the work of the detective and that of the medical practitioner. The former looks for clues which will point the way to the criminal; the latter, for signs and symptoms which enable him to make a diagnosis (998). Therefore, Watson’s inability to piece together the information and solve the case signifies Watson’s ineptitude towards medicine and effectively diagnosing patients. Conan Doyle critiques the general practitioner’s reliance on traditional medical practices and their hesitancy towards scientific advancements, as Watson is unable to solve the case without a detective’s help. Holmes represents the physicians who embrace the developing medical techniques of the late nineteenth and early twentieth centuries, as he is able to use the information he gathers from the room and come to a conclusion about the case. Holmes admits to Watson that all he has done is “deduce a little more,” meaning that Holmes is able to make connections between the information that Watson deemed insignificant or “unusual.”

Scholar James Reed states that there are “parallels between detection and diagnosis,” so Holmes identity as detective relates to the progressive medical field of Victorian England which created better tools and techniques that allowed doctors to “become like prophets” and correctly diagnose a patient. Holmes then represents a specialist, who through focused research and emerging technology is able to find correctly diagnose and treat patients. With the emergence of scientific medicine, deductive reasoning became important to physicians. Doctors had so much information at their disposal from a patient’s temperature to their x-rays that they needed to learn to sift through the information and come to a sound conclusion. The creation of the diagnostic process, or deductive reasoning, helped doctors find the important information to correctly diagnose a patient. This process includes three components: history, examination, and investigations (Reed 78). Holmes is able to solve each case because he uses this type of deductive reasoning in order to find the most plausible solution. His process consists of hearing the “history” of the client, and he applies this knowledge to an examination of the scene of the events. Watson admits to Holmes that
“you have evidently seen more in these rooms than was visible to me,” but Watson is incorrect as Holmes just applies the knowledge he learns from the client to “examine” anything that seems unusual. Holmes connects the “curious coincidences” of “a ventilator is made, a cord is hung, and a lady who sleeps in the bed dies,” and arrives at a sound conclusion that the lady was murdered. Holmes also uses this deductive reasoning and other burgeoning medical methods in order to dupe Watson into believing he was sick in “The Dying Detective,” and also, figure out Doctor Trevelyan’s patient is faking a disease in “The Resident Patient.” Doyle is ultimately revealing the advantages of physicians who not only situates themselves in science but who use observations and deductive reasoning to help diagnose and treat.

THE VILLAINOUS DOCTOR
The wickedness of Dr. Grimesby Roylott in “The Speckled Band” highlights the growing anxieties Victorians had toward the scientifically advancing medical profession, but the demise of the doctor subverts these fears as Holmes, the embodiment of a new medicine, is the one to solve the case. When Holmes and Watson discover that Dr. Roylott is poisoning and killing his step-daughters, Holmes comments: “subtle enough and horrible enough. When a doctor does go wrong he is the first of criminals. He has nerve and he has knowledge. Palmer and Pritchard were among the heads of their profession. This man strikes even deeper” (10). By evoking William Palmer and Edward Pritchard as real-life examples of prestigious doctors who murdered their patients with poison, Doyle brings in the cultural anxieties of the late Victorian era, when doctoring became more scientific and impersonal. Palmer and Prichard became cultural symbols for potential abuses of power and medicine (Price 81). Holmes admits that doctors have “nerve and knowledge,” revealing that physicians hold a certain authority and power over patients, and Victorians had fears of being exploited. The late nineteenth century saw patients being treated as case studies and exhibits to be researched and demonstrated to in hospitals and classrooms.

Whereas patients were the first authorities on their bodies at the start of the century, now with advance medical practices they found themselves being defined by their symptoms and illnesses with hardly any personal connection with doctors. This heightened Victorian anxieties as they felt their authority over their body was being taken away (Carpenter 172). Holmes as a doctor figure symbolizes these changing dynamics of Victorian medicine, while Roylott signifies the fears that the English had of these advancements. By having Holmes evoke the sentiment “when a doctor does go wrong he is the first of criminals,” Doyle illustrates that the fears of the medical profession are justifiable, since there is ample evidence that
doctors do “go wrong.” However, the death of Dr. Roylott subverts these fears as his crimes can no longer continue. By having Holmes solve the case and reveal Roylott’s delinquencies, Doyle comments on the idea that advancements in medicine are helping more than hurting.

Conan Doyle’s undermining of the medical profession within his Sherlock Holmes detective stories reveals the radical changes of the nineteenth century as science, technology and medicine advanced at a rapid rate. With this rapid progress in medicine, many general practitioners held onto traditional methods and beliefs, but Doyle critiques the stagnation in the medical field by duping Watson and other doctor figures within his texts. As medicine became the “science of medicine,” late-century Victorians worried as doctors held more authority and knowledge of their bodies and diseases than ever before, but the creation of Sherlock Holmes remedies this fear as he symbolized heroic new doctors who situate themselves in science and deductive reasoning to solve crime. Ultimately Conan Doyle’s inclusion of medicine within a detective series illustrates the evolving culture of medicine during the Victorian era.

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Pedophilia begins, in its own sadly ironic way, in the earliest years of human civilization. Pederasty, the first known form of pedophilia, was a structured way of bonding generations of males. The term pedophilia itself was not coined until 1918, with Stedman’s 5th edition being the most noticeably significant contributor to this phenomenon’s awareness. Years before, in 1908, neuroanatomist Auguste Forel called the diagnosis “pederosis,” distinguishing between cases where the perpetrator had previous mental conditions and those who are thought to be “sane.” Pedophilia’s inclusion in the Diagnostic and Statistical Manual of Mental Disorder’s (DSM) first edition in 1952 cemented the term in the mind of both medical and psychiatric practitioners, eventually leading to a full evaluation of the term in 1980, and a list of potential diagnostic practices in 1987. Today, Merriam-Webster defines the term “as a psychiatric disorder in which an adult has sexual fantasies about or engages in sexual acts with a prepubescent child.” Classified as a paraphilia, or a condition in which a person’s sexual arousal and gratification depend on fantasizing about and engaging in sexual behavior that is atypical, pedophilia is even now considered a highly common case, though medical experts agree labeling certain acts or thought patterns as strictly pedophilic can be quite difficult.

Indeed, pedophilia stands as one of several, similarly sexual attraction classifications of paraphilia, others being ephebophilia (those attracted to late adolescents) and the 1955 term hebephilia, or the condition of being attracted to early adolescents, usually aged 11-14. All three of these notorious terms fall under ingrained societal taboos that rightly condemn those who would harm children with lewd acts. But it is important to note that
none of these definitions state that sexual acts themselves are inherent to the condition, merely the sexual attraction to their specific development stages. As Margo Kaplan states in “Taking Pedophilia Seriously,” “Moreover, the law takes an awkward and incoherent approach because it confronts the issues pedophilia raises only after it manifests in criminal behavior” (80). These terms have been increasingly misused, either through ignorance of classification or the desire to use the infamous associations with the term “pedophile” to draw attention. One such association arises with another word from 1955, serving as title to a novel by Vladimir Nabokov: Lolita. This novel, ranked by the Modern Library in 1988 as the fourth greatest English-language novel of the twentieth century, caused massive controversy due to the relationship between thirteen-year-old Dolores Haze, and her “caretaker” and stepfather, Humbert Humbert. After Humbert’s killing of Dolores’s mother, and subsequent kidnapping of the daughter, the two of them go on a road trip around America, where Humbert violates his “Lolita.”

Purely based on that description, it is easy to see how this novel raises questions about the narrator’s sanity. For the novel is constructed in such a way that Humbert confesses everything to the reader in beautiful prose serving to mask his heinous actions and thoughts. What many critics overlook, however, is the introduction to the novel proper, given to us by Dr. John Ray, Jr, a professional writer and lecturer, and satirical persona. This fictitious psychiatrist, who appears only in this foreword, announces that medical professionals seen in this novel will not be credible. For those familiar with Nabokov, and his history with psychiatry, Dr. Ray’s inclusion speaks to a larger system.

For Nabokov, the field of psychiatry was a farce, having been introduced to it shortly after World War II, in which his brother lost his life to the internment camps. During this time, many of the practicing “psychiatrists” at the time had very little knowledge with the subject, most being physicians who could not be deployed to the front lines during this time. As the soldiers viewed war atrocities and began exhibiting psychological traumas or breakdowns, psychiatrists of any level were needed to evaluate and “fix” these soldiers for redeployment, regardless of lasting repercussions. Freud may have made bounds within this field of study, yet the public considered the profession to be mostly useless, and medical students found the field to be unprofitable. This lack of psychiatrists led to physicians being press-ganged into the role where they, according to doctor John A. Talbott, “learned a combat psychiatry very different from the prevailing long-term psychoanalytic model found in civilian life”; in short, common practices were overturned for expedient patch-jobs rather than true solutions. In fact, it is not until the 1960s when psychiatry was being turned into a true profession worth pursuing, and the early ’70s when medical students truly
began to take an interest. Thus, it cannot simply be said that the mocking psychiatric preface hints at a degrading field of science during Nabokov’s time. Instead, Humbert exists a figure who blatantly utilizes the language of a field meant to “cure” him and manipulates it to gain power.

As an example, psychiatric facilities began appearing in the 1870s, serving those with mental illnesses with trained professionals and therapeutic consideration. Yet, the constant observation and evaluations cost exorbitant fees over time, and the move into the twentieth century saw a drastic increase in patient numbers into asylums only able to realistically hold half those numbers. The early 1900s saw a move towards more general and physical operations, such as lobotomies and electric shock therapies. Though Humbert enters such an institution on a “relapse,” he encounters none of these therapies, only clueless psychiatrists who evaluate him to be a homosexual and allow him to turn those opinions back onto these “professionals.” For it is during this time, when *Lolita* is published, that psychiatric institutions are failing both economically and morally, being ousted as either abusive or corrupt. With the introduction of the DSM in 1952—a date not so coincidentally found in Dr. Ray’s preface—and the Mental Hygiene Movement, a new system of psychiatric diagnosis and treatment, would slowly be introduced over the next few decades.

Nabokov, however, experienced psychiatry during this failing time, and expressed a concern that the “vulgar, shabby, and fundamentally medieval world of Freud” could be used by the patients being treated to further their own perverted or dangerous goals. So why, then, would Nabokov start off his novel with such a figure, even as a satirical device? Scholar Stewart Justman, whose article “Dr. Humbert” attempts to answer this very question. According to Justman, Humbert throughout the novel uses the language of tyranny to dominate his relationship with young Lolita, utilizing his “dabblings” in psychiatry to psychoanalyze his actions and thoughts to justify himself, to find a level of acceptance with his insanity, even if he cannot understand. For Humbert, “institution is his disease, not his cure,” by which Justman means the fact that Humbert can so readily utilize the language of those means to “cure him,” and not only turn Freud’s writings into a weapon against Lolita, but also into a means of justifying himself, only deepens the central problems of Humbert’s existence. He lacks both a source of understanding and assistance, and so becomes “therapist” of both Lolita and himself.

The field of psychiatry, then, in attempting to take simple words and standards of normality that cannot be applied to figures such as Humbert, and then having unspecialized personnel push those standards onto him without knowledge of what they are doing, serves as a satirical device to critique the evaluation methods and treatment of those with mental health
issues during Nabokov’s time, if we agree with Justman. But there exists a simultaneous parallel between Humbert and Ray that cannot be ignored. In introducing this psychiatrist in the form of an entry, much like how Humbert addresses himself to the reader in the style of a confessional, one could read the psychiatric aspects of the novel as revealing the potential dangers of psychiatry when used by those without training or knowledge. Humbert views himself almost as a mythic being between worlds, containing knowledge inaccessible to others and reading into events, or thoughts, to draw some form of conclusion exclusive to himself, much as how true psychiatrists are supposed to retain knowledge of their field and be able to break down a person’s actions or thoughts to reach a conclusion. But having these conclusions skewed, either by John Ray or Humbert, reveals that both figures manipulate their “tools” of psychiatry to reach their own goals. In examining the characters and their language when it comes to psychiatry, then, Lolita exhibits both the post-war notion of psychiatry as a field of failure and a modern fear of figures such as Humbert taking on their own self-analysis and healing.

John Ray’s preface to the text introduces the theme of satire, where Nabokov utilizes this persona to, on the surface, exonerate the novel through a psychiatrist that subtly subverts his own profession. Ray’s second paragraph, where he describes his editing work on the novel, should immediately stand as what Eudora Welty would call “a cautionary blinker to what lies on the road ahead”:

My task proved simpler than either of us had anticipated. Save for the correction of obvious solecisms and a careful suppression of a few tenacious details that despite “H.H.”’s own efforts still subsisted in his text as signposts and tombstones (indicative of places or persons that taste would conceal and compassion spare), this remarkable memoir is presented intact. (3)

For all of Ray’s guarantees, Lolita begins with an admission of revision and the usage of moral authority to achieve it. These themes arise often within post-war literature, where information is repressed to limit the impact of information, or else change what that information is meant to convey. Erin Mercer, when speaking on Jack Kerouac’s On the Road, states that “Its use of the confessional mode renders repressed material revised and controlled, and its use of the picaresque provides a comfortably familiar literary framework” (Mercer, 228). If one were to replace the name of Kerouac with Nabokov, the point would remain just as strong. The confessional mode of the novel draws readers in, even while they remain aware of the base, socially taboo nature of Humbert Humbert, particularly when the genre of our novel is so
contrastingly simple as a travel narrative. Though easy to understand why this novel would have to be censored, given its very foundation of underage sex and murder, Ray’s casual admittance to altering this “remarkable memoir” should remind us that psychiatry takes given information to apply societal norms. The word “solecism” itself is defined dually as a grammatical mistake, and a breach of good manners. Instead of simply editing the novel to remove the mistakes, Ray also invokes the idea of “correct” behavior and how these mistakes must be “suppressed,” in Freudian fashion.

Likewise, Ray’s suppression of the undesired suggests another question that arises within his preface, if the novel should have been published: “That had our demented diarist gone, in the fatal summer of 1947, to a competent psychopathologist, there would have been no disaster; but then, neither would there have been this book” (4-5). If compassion were truly to spare, it could be argued that Lolita should have been burned at the metaphorical stake, and had Humbert die as a martyr for his cause. Instead, this novel arises out of a failure on the side of psychiatry, for Humbert does in fact receive treatment from ‘professionals’ in the text, treatment that only exacerbates the fundamental issues he struggles with. Scholar Margot Henriksen states that postwar America “revealed two cultural personalities in conflict” (Henriksen, 85). Here, we see the dual personalities played out in Ray’s preface. On the surface, Ray defends the novel by stating its achievements justify the method of creation, or at least states that the achievements could never have taken place had the events been avoided. But beneath the objective phrases, the novel points out that the lack of competent psychiatric professionals is an underlying catalyst to Humbert’s actions. The calm of our preface writer is undercut by his own failings, not the least of which is ineptitude. For while Ray states he has “no intention to glorify H.H,” he goes on to glorify “how magically his singing violin can conjure up a tendresse, a compassion for Lolita that makes us entranced with the book while abhorring its author!” (5). What Ray says is true, that the prose draws us in, but having a psychiatrist with a puffed-up ego ramble about the beauties of a self-professed madman creates a clear atmosphere within the novel that will only continue as Humbert begins to take on the role of psychiatrist for himself.

Ray’s closing words once again expose a dual nature, but this time carry a dual critique often overlooked as this “work of art” reveals the true issue at play in the novel: “‘Lolita’ should make all of us—parents, social workers, educators—apply ourselves with still greater vigilance and vision to the task of bringing up a better generation in a safer world” (5). Looking beyond the clearly ironic words of a psychiatrist endorsing this novel, there is no little irony found in a psychiatrist stating that others need to apply themselves in bettering the future when it is the lack of competent
psychiatry, Ray included, in the text that leads to the disasters that unfold. Yet, many critics overlook this fact, dismissing the preface merely as a farce meant to introduce themes in the text, but the farce parallels the field of psychiatry during this time. Eric Goldman remarks on this phenomenon, stating “anxious not to internalize the wrong language, they often mark Ray’s as ‘alien’ and, hearing echoes of Nabokov in Humbert’s words, internalize Humbert’s closing words instead” (Goldman, 98). While Humbert may more closely carry the same thoughts as Nabokov, when it comes to psychiatry and its uses at least, the character of John Ray crystallizes those thoughts in a manner that Humbert cannot convey. How ironic, then, that the attempted psychoanalyses of a clearly mad Humbert are taken more seriously than the true psychiatrist. For Goldman, and myself, there is no “true” language to *Lolita*, as the morals of all characters involved are clearly not worthy of reproduction. Instead, the novel’s layered satirical devices all exhibit Nabokov’s “goal” in exposing postwar psychiatric hypocrisies and internalizing only half of the equation risks misunderstanding not only Ray’s usage, but that of Humbert as well.

As to Humbert, our protagonist is quickly established as a character out of place and time with those around him. The lack of true assistance from psychiatrists is foregrounded in Humbert’s growing insanity, where “psychoanalysts wooed [him] with pseudoliberations of pseudolibidoes” (19). Humbert is pained by the fact that he cannot understand his own amorous feelings, wracked by guilt and doubt because there are no institutions in which he can receive the proper aid. As evidenced by the time, the psychiatrists here to whom Humbert goes give him nothing but falsities, speaking around the issue rather than address the problem in any meaningful manner. Without the proper understanding of the condition, on either side, Humbert is left on his own to absorb the terms and phrases lobbed at him by these ‘pseudoanalysts.’

The result is that when Humbert faces a return to asylum, he comes prepared to subvert those phrases, having analyzed himself more than the professionals. Philip Rieff, a sociologist and longtime studier of Freud, remarked that often “the patient comes armed with Freud’s own jargon, and may even bring along his own diagnosis,” which is what enables Humbert throughout the novel to justify his own actions and confound those “true” practitioners of psychiatry:

> I discovered there was an endless source of robust enjoyment in trifling with psychiatrists: cunningly leading them on; never letting them see that you know all the tricks of the trade; inventing for them elaborate dreams, pure classics in style [...] never allowing them the slightest glimpse of one’s real sexual predicament. (36)
The widespread use of Freudian language and practices allow for anyone to attempt their own psychoanalysis, often leading to a self-manipulation. For though they may be able to follow the concepts of Freud, their own mind would not allow for an interpretation that places the burden on the self. Humbert’s constant need throughout the novel to address himself to “the jury” reads as an attempt to convince himself rather than any outside force, and here it becomes obvious that Humbert is attempting to hide the predicament from himself as well. The enjoyment in which he partakes covers the insanity roiling beneath his veneer, displacing the frustration of not understanding his own mind onto others. In his article “Sixty Years of Social Psychiatry 1945-2005,” David Clark notes that “for a first admission to a psychiatric hospital an admission ward was a shocking experience; there was little hope of discussing one’s situation or finding out what chance there was of improving things.” Humbert faces the same dilemma, in that he cannot speak seriously about his condition to anyone and expect assistance, and so leads these psychiatrists on a false trail. But even then, Humbert does not improve anything, and very soon again faces the ultimate object of his fascination without improvement, only the tools necessary to psychoanalyze his actions, if incompletely.

Humbert’s focus on himself, derived from the absence of professional assuaging, becomes a driving issue in his relationship with Dolores and his created Lolita:

What I had madly possessed was not she, but my own creation, another, fanciful Lolita—perhaps, more real than Lolita; overlapping, encasing her, floating between me and her, and having no will, no consciousness—indeed, no life of her own. (65)

Humbert’s lack of understanding his own mind, his own desires, imposes a construction upon his Lolita as something greater than any person ever could be. What Humbert sees in Dolores is not a culmination of his lust, or not simply that, but rather the object of his deranged mind. The young nymphet stands in as the nymphet for Humbert, an identity that surrounds her, trapping her in Humbert’s clutches while simultaneously trapping her away from Humbert. It is an image in Humbert’s mind that encapsulates Lolita, not a living thing, intangible to Humbert, a fancy in his mind. It is important to note here once more that Humbert being the sole narrator of the novel constructs the image of Lolita not only in his mind, but in the mind of the reader as well. His prose and thoughts are the only avenue we have into their story and is thus the only form of authority that we come to know. Much like in Ray’s preface, the process of revision and suppression comes again to the forefront, but unlike with Ray, there is not set of codes
dictating what we should know and why. Ray does his editing based on an arbitrary set of social standards for what is considered “acceptable,” but now we are placed into the hands of a madman who cannot differentiate his image of “Lolita” from the Lolita that stands in front of him. Frederick Heard states that the language of the text draws us in: “Humbert appeals to our well-developed artistic sensibilities to short-circuit our ethical reactions” (Heard, 155). Hiding his madness behind beautiful prose, Humbert provides us the image of a doll, rendered in our minds as something to be admired, while conveniently having us forget, until he chooses to remind us again, that he has made this doll out of the form of a fourteen-year-old girl, to whom he is the stepfather. Abhorrent as Humbert may be, the desire to learn his story, to understand his struggles, is still stronger than our disgust for him. That ability to displace the emotions, to “short-circuit” us, comes from his appropriating the language of psychiatry, in placing us in a state of suspension, but also revealing that this practice is available to anyone, a constant threat not only from the inexperienced, but also the professionals themselves.

This displacement occurs again when Humbert finally violates Lolita, where Humbert withholds the scene to which he had been building:

However, I shall not bore my learned readers with a detailed account of Lolita’s presumption. Suffice it to say that not a trace of modesty did I perceive in this beautiful hardly formed young girl home modern co-education, juvenile mores, the campfire racket and so forth had utterly and hopelessly depraved. (141-142)

Over the course of several pages, Humbert explains in meticulous detail how he had maneuvered everything in order to get to this exact moment yet denies the reader that very moment. Not only does this abrupt break throw off the reading pattern established in the novel, it also jars the reader back to reality. The language Humbert uses is meant to describe his actions in sexually consummating with Lolita, and we should be rightfully disgusted. Instead, the interest and suspension continue to rise, demonstrating that Humbert is the true power within the novel. After Humbert’s pleas that we not skip over the long build-up to the act between Humbert and Lolita, he suddenly reverses the situation and withholds the information that we had been involved in now, the climax (both physical and metaphorical) that we will not see because of Humbert. In parallel to Ray, Humbert suppresses and edits his own narrative for the sake of societal standards, but that very act also questions whether those standards are truly acceptable. If we, as ostensibly sane and normal members of society, are so easily taken into the narrative of a man who commits murder and statutory rape with his
stepdaughter, then are we not at fault for Humbert’s actions as well? Ray claims that society needs to educate our children and stay vigilant for the future, but Humbert claims that same education is in part to blame for what occurs between Lolita and himself. Nabokov utilizes this scene not only to raise those same questions, but also question whether we see what is occurring in this “sane” society around us even now.

Humbert’s tone throughout the latter half of the novel takes on a more guilty, resigned cast as he realizes the enormous consequence his actions have brought; not the criminal aspect, of course, but the loss of innocence experienced by his nymphet. Having been sullied by the “brute” Humbert, Lolita no longer retains the image he wanted to preserve. Only when the imposed identity is fully lost can Humbert begin appreciating his actions: “I thought I would use these notes in toto at my trial, to save not my head, of course, but my soul. In mid-composition, however, I realized that I could not parade living Lolita” (327). This living Lolita was rejected by Humbert because it is the lifeless image that he held dear, not the young girl. But Humbert nonetheless expresses his culpability in the outcome of his desires, as he does not shy away from losing his head (again, both physically and metaphorically), but the soul that defined his relationship to Lolita—“My sin, my soul” (9). In saving his soul, the essence of what has occurred in the novel, so too can Humbert save his Lolita from himself. But, as Heard weighs in once more, “Humbert retroactively fabricates a moral epiphany out of retrospective curiosity and tenderness, and his interest in Lolita’s suffering and her shattered childhood are too little and, more to the point, too late” (Heard, 155). The suppression of his feelings until the end fails to provide resolution for Humbert, whose words are not to be published until after he and Dolores have died. But in losing that image of Lolita, Humbert loses his psychoanalytic focus along with his identity, rendering any “moral” that he might fabricate moot. It is not just too late for Lolita or for Humbert, but for the field of psychiatry in allowing figures like Humbert to misinterpret their own madness. Stewart Justman most aptly summarizes Humbert’s relationship to himself, and the novel’s relationship to psychiatry: “Lolita is a monologue in which the therapeutic rituals of introspection and confession serve only to feed a moral autism” (Justman, 39).

Lolita’s characters of John Ray, Jr. and Humbert Humbert expose the postwar notion of psychiatric failure and the modernist fear of self-analysis. Even to this day, the terms associated with this novel fail to get the understanding they deserve, either due to their poor coverage in the past or the refusal to overcome ignorance. But steps are being taken to rectify, or at least address, some of the issues raised within this text. Sites such as “Virtuous Pedophiles” are dedicated to not only raising awareness of the psychiatric condition, but in correcting preconceived notions associated with all sub-
classifications of pedophilia and getting help to those who need it. There exists discourse on phenomenons such as the “lolita-complex” prevalent in Japanese manga and anime, with investigations into those have said conditions (lolicons, abbreviated). Both are just examples of continuing scientific and medical research into paraphilias, and psychiatry is no small part to that ongoing work. Modern acceptance of psychoanalysis, both in terms of the medical and literary, may have been the fear of the 1950s, but *Lolita*, and other novels great or small, have ushered in a new perspective on paraphilia, and the failed work surrounding them. By observing contextual relations for not only *Lolita*, but texts that come out even to this day focusing on medical dilemmas and problems, further steps can be taken to address the issues that arise, and perhaps even “bring up a better generation in a safer world.”

**WORKS CITED**


Miles away from London, a solitary maiden wanders through the dew-soaked garden, heart swollen with emotion as she scans the distant countryside, longing for her lost love. Ominous clouds stretch across April skies and threaten her twilight strolls, but are unsuccessful in deterring her roaming misery. Soon, she will be bedridden, suffering from a broken heart and a cold so violent that those around her feared she would never recover. This Gothic scene emerges surprisingly late in *Sense and Sensibility*, eight chapters before the conclusion and developing for half of the remaining length. In the most suspenseful portion of the text, Jane Austen prepares us for the potential death of Marianne Dashwood in the same vein of sentimental novels such as *Pamela* (1740) and *Clarissa* (1748) by Samuel Richardson as well as *Cecilia* (1782) by Frances Burney. Much like the heroines of those novels, Marianne is a victim of eighteenth-century fashions, so endowed with sensibility that she becomes vulnerable to male manipulation via John Willoughby, her love interest who unexpectedly, publicly rejects her by announcing his engagement with Miss Grey. Under the pressure of heartbreak, Marianne’s mind and body crumble, so overwhelmed from the trauma that she nearly perishes. While Austen is undoubtedly mimicking the sentimental novel when it comes to Marianne’s plot, she includes important divergences that suggest a societal shift in attitudes towards sensibility, which was previously celebrated as a sign of natural refinement. In the late-eighteenth and early-nineteenth centuries; however, sensibility was viewed as chaotic, irrational, even performative and inauthentic. But how does sensibility transform from a positive virtue to a negative one so quickly?
Austen began writing *Sense and Sensibility* around 1795 in epistolary form during the peak of the cult of sensibility and developed the novel until its publication in 1811 when sensibility was being heavily debated in popular and medical literature. For a majority of the eighteenth century, sensibility was considered a favorable trait to possess, especially in upper-class circles as it suggested a person’s enhanced ability to appreciate emotional, intellectual, and aesthetic complexities. Sentimental novels thrived off these complexities and aimed to represent them in literature, and, according to Inger Brodey, they are “shaped around the central idea of the vicarious experiences of tales of suffering and virtue, and the desire to make the feeling as direct as possible” (68). The novel essentially connected the greater population to sensibility by expanding its class reach and by modeling and evoking feeling via detailed descriptions of reactions to stimuli. Novels were thus praised for a time because possessing a superior capacity for emotion was a valued quality, but sensibility faced immediate criticism in political and medical realms when the prevalence of nervous complaints—negative reactions involving one’s hypersensitivity nerves—increased alongside the virtue’s popularity, resulting in what Erin Wilson terms, sensibility’s “pathological turn” (276). As more people possessed this heightened awareness, many of sensibility’s symptoms were categorized under the vague umbrella terms “nervous diseases” and “nervous temperament,” derived from a developing medical theory that attached bodily conditions to mental manifestations. As medical knowledge was much in its infancy, with much speculation still circulating, specific diagnoses were nearly impossible. Dr. William Cullen, a leading medical professor in the Scottish Enlightenment, grouped together a set of symptoms he related to nervous disorders, including “hysteria, hypochondriasis, and melancholia, alongside mania, frenzy, and epilepsy” (Shuttleton 272). Other physicians joined the ongoing conversation on nerves, including George Cheyne’s *The English Malady* in 1733 and Thomas Trotter’s *A View of the Nervous Temperament* in 1808. These doctors associated extreme emotional states with ill health, suggesting that even “passions of the mind” could lead to fatal “nervous fever[s]” and warned the population against psychological strain in their writings (qtd. in Wilson 280). A conversation of sorts was occurring between medical discourse and popular fiction that was merging notions of nineteenth-century hysteria with descriptions of sensibility in novels, and it is no wonder, then, that reading became a dubious activity that perpetuated dangerous idealizations of sensibility.

The sentimental novel, as a work of art intending to depict emotions so vivid as to allow the reader to live vicariously through the characters, might have accomplished its task too well. During the turn of the nineteenth century, novels “came to be associated with pathological excess of stimula-
tion linked to a variety of diseases” (Shuttleton 277-78). The logic followed that if someone engulfed themselves in the popular fiction of the time they would be at risk of second-hand overstimulation. Women were especially in danger, both within literature and while reading it, for it was asserted—by the likes of Trotter especially—that women possessed a greater tendency towards nervousness and excessive sensibility and would “inevitably suffer from nerves because of romantic disappointments or tragedies” (Wilson 277). As the supposedly “weaker” sex, women risked sensibility’s negative consequences far more often than men, though sensibility impacted both sexes. A contemporary and idol of Austen’s, Mary Wollstonecraft, in *A Vindication of the Rights of Woman* (1792), critiqued the culture of sensibility and its impact on women thusly:

> Their senses are inflamed, and their understandings neglected, consequently they become the prey of their senses, delicately termed sensibility, and are blown about by every momentary gust of feeling . . . All their thoughts turn on things calculated to excite emotion; and feeling, when they should reason, their conduct is unstable, and their opinions are wavering—not the wavering produced by deliberation or progressive views, but by contradictory emotions . . . The passions thus pampered, whilst the judgment is left unformed, what can be expected to ensue?—Undoubtedly, a mixture of madness and folly! (Wollstonecraft)

For Wollstonecraft, sensibility weakened an already vulnerable sex, and she strongly rebuked men and women equally for their perpetuation of such injury. English society stood at a crossroad, then, conflicted between an obsession with the dramatic tones of sentimental novels and the anxiety surrounding the prevalence of diseases linked with ideals of sensibility. In this ambivalent time, the press presented the debate to the public in the form of articles titled “Question: Sensibility to be Cherished or Repressed?” (Ahern 71). The mindset towards sensibility was beginning to shift, but ironically it first became stylish to display one’s nervous disorders, creating what we have now termed “fashionable illnesses.” Hysterical responses, fainting, turning pale, and expressing excessive despair or elation were all behaviors that demonstrated to the outside world one’s internal refinement, but the performativity of these fashionable symptoms raised more suspicions. For some, it was easy to assume illness in order to project a certain distinguished air, but from the 1770s onward, much of British literature centered around the distrust of sensibility due to the inauthenticity of fashionable illness, and “feigned invalids and fraudulent sensibility began to figure much more frequently in works of fiction, indicating that even the
genre of the novel, which had popularized the culture of nervous sensibility, was becoming more open to questioning the authenticity of fashionable debility” (Monaghan 388, 400). Jane Austen, born in 1775, was raised in the midst of this culture shift, and as an author utilized her writing to depict, question, and critique society around her, including and especially the cult of sensibility.

Jane Austen has engaged with sensibility from her earliest known writings, known as her juvenilia, where she parodies popular novels and includes excessive, nearly absurd plots with extreme sentimentalities. Throughout her youthful texts, there “is a pronounced thread of comment on and [willful] misreading of the literature of her day, showing how thoroughly and how early the activity of critical reading informed her character as a writer” (Sutherland). The same satirical lens continues in her more sophisticated, full-length novels, including in *Sense and Sensibility*, where Austen imitates the sentimental novel through the trials and tribulations of Marianne Dashwood, who acts as the personification of sensibility, opposed by her elder sister Elinor, who personifies sense. While the narrator introduces both girls as having equal abilities, Marianne is uniquely “eager in everything: her sorrows, her joys, could have no moderation,” and Mrs. Dashwood, the girls’ mother, values, encourages, and participates in this behavior: “They gave themselves up wholly to their sorrow, seeking increase of wretchedness in every reflection that could afford it, and resolved against ever admitting consolation in future” (Austen 8). Elinor, otherwise, had strong feelings as well, “but she knew how to govern them” (Austen 8). As the title suggests, a surface level examination of the text explores an inherent difference in the girls’ personalities, but more so, the sisters represent two developing and diverging ideologies at the turn of the nineteenth century. As Brodey similarly recognized, “the two sisters undergo very similar plot lines . . . They both fall in love, experience unexpected separation, are saddened by sudden departures, hear news of betrayal, and (after a few twists) experience eventual marriages” (76). They differ only in personality, which drastically impacts the way each character reacts to their relatively similar traumas, and Austen thus reflects the question raised by those periodicals about the repression or cherishment of sensibility via Marianne and Elinor’s struggle to understand each other.

*Sense and Sensibility* is more sophisticated from her juvenilia because she engages with a societal debate and presents a more didactic lesson rather than relying on pure parody, which can often go unrecognized by casual readers. The plot is divided in two, each centering on one of the two sisters as paralleled protagonists, and Jane Austen impersonates the sentimental novel in Marianne’s section in order to entice the popular readership and expose the negative consequences of sensibility. While Brodey argues that
Austen rehabilitates sensibility through Marianne’s survival (63), I argue that she rehabilitates the novel as a literary form and genre, healing it much like Elinor heals Marianne from her sickbed. While recognizing the well-founded suspicions towards the sentimental novel, she subverts the essentialist prognosis that novels are dangerous to one’s health through Marianne’s symbolic rebirth and self-actualization following her illness, demonstrating that novels can impart sense, as well.

Austen positions novels as important signifiers for Marianne early in the text to showcase their importance within the cult of sensibility. According to John Mullan, Austen’s early readers were expected to infer that Marianne’s sensibility was learned from her reading (226); this can be seen by how Marianne herself judges the virtue in others: through listening to them read. Initially, she dismisses Edward Ferrars because his “eyes want all that spirit, that fire, which at once announce virtue and intelligence”—that is, he lacks sensibility—and she anguishes over his reading style, complaining, “Oh! mama, how spiritless, how tame was Edward’s manner in reading to us last night!” (Austen 19). In lacking a specific passion and, arguably, performativity in his reading, Edward ironically agitates Marianne’s senses to the point that she can hardly listen to him and she ultimately deems him unworthy of her sister’s affection. She has strict guidelines for any suitor, asserting that she “could not be happy with a man whose taste did not in every point coincide with [her] own. He must enter into all [her] feeling; the same books, the same music must charm [them] both” (Austen 19). These artistic standards must be met in order to enter Marianne’s heart—if a man can entice or engage with the same source of her emotions, she feels equally connected with him, which is precisely how John Willoughby captures Marianne’s sensibilities for the rest of the novel. As the narrator informs us, Willoughby and Marianne’s “taste was strikingly alike. The same books, the same passages were idolized by each” and soon “they conversed with a familiarity of a long-established acquaintance” (Austen 49). Unlike Edward, Willoughby captures Marianne’s interest by being intelligent enough to recognize the value of similar texts, or, as Mullan notes, he is at least smart enough to “know that this beautiful girl rates such responsiveness very highly” (226). Whether or not Willoughby (or anyone) truly possesses this refined internal awareness for such aesthetic values, Marianne believes it and this leaves Marianne vulnerable to his mistreatment later. From his entrance into the novel, Marianne is blinded by his outward appearance and sensible expression, unable to think rationally or cautiously. And why would she feel the need to? Willoughby’s “person and air were equal to what her fancy had ever drawn for the hero of a favourite story” (Austen 44-45). By comparing him to a storybook hero, Austen reveals her hand, referencing character types that exist in sentimental novels. The two become
destined to fulfill the role of the tragic couple who suffer from their love, and Marianne is more than willing to be the heroine to match his heroism, though she is unaware of the danger awaiting her following his betrayal.

Little more than halfway through the novel, Marianne ardently searches for Willoughby, who has spent the last several chapters out of her reach in London until she and Elinor were given the opportunity to travel there with Mrs. Jennings. Elinor and Marianne undergo a similar crushing discovery in town, as both Edward and Willoughby are announced to be engaged to women other than the Dashwood sisters. But once again, despite their parallel plot points, they react very differently to the shock. Whereas Elinor internalizes and restricts her expression of despair and confusion, Marianne is unable and unwilling to do the same. When Willoughby initially shuns her in a party room in London, full of other witnesses, Marianne sinks into her chair, face “dreadfully white” and seemingly soon to faint. She has no concern for other’s concerns here, and though Elinor had begged her to “be composed . . . and do not betray what you feel to every body present,” she succumbs to her fraught emotions regardless (Austen 167). After receiving a letter of explanation and official rejection of their intimate arrangements, Marianne is all the more distraught and she tells Elinor, “I care not who knows that I am wretched. The triumph of seeing me so may be open to all the world” (Austen 179). Though certainly hurt, confused, and betrayed by her hero-turned-villain, Marianne seems to be aware that her misery is a commodity of voyeurism by the public, for the witnesses of her pain and suffering serve to validate it. A fashionable agony, if you will, that disrupts the entire household and forces attention on Marianne. Austen does not position Marianne’s pain in a manner that would raise suspicions in the same way at the fashionable illness I described earlier, but she does explore the fine line of authentic, public displays of emotion, which while exaggerated, do break society’s quiet, sophisticated mask of professionalize and guide our attention towards her literal cry for help that would otherwise go unnoticed or dismissed. For the sake of the sentimental, nineteenth-century reader, Marianne’s role as a victim is meant to evoke a vicarious experience; when Marianne entreats Elinor to hear, see, and feel her own agony, she is also convincing the reader. It is through the final scenes of the novel where Austen similarly tests our capacity to emphasize with Marianne, but Elinor’s presence ultimately asks us to sympathize, instead.

Austen does not allow Marianne’s suffering at the hands of Willoughby’s neglect to pass without very real consequences for her heroine’s well-being. Soon after the truth about Willoughby’s duty in London, Marianne feels an innate desire to escape the city and return home to the comforts of home in Barton Cottage. The city becomes tainted with her negative experience, as every location represents a unique emotional response for Marianne,
and in the hopes of restoring her senses in the comforts of home with her mother and younger sister, Margaret, Elinor is happy to leave. However, the Dashwood’s journey home is halted at a rest stop in the “cherished, or the prohibited country of Somerset” (Austen 283) mere hills away from Combe Magna, the estate of one John Willoughby and once-fancied future home of Mrs. Marianne Willoughby. From the mere knowledge of her close approximation to a once fiercely imagined home, Marianne is once again afflicted, unable to avoid her sensibilities for long, even when more distance is placed between her and the object of her suffering. The narrator describes Marianne’s aimless wanderings around her temporary estate, relishing in “precious, invaluable misery, [rejoicing] in tears of agony” (Austen 283-84). The paradoxical diction here—which oddly beautifies her pain—represents an internal and external expectation for her emotions. As a now tragic heroine, Marianne’s sensibilities are geared towards expressing her despair in Romantic solitude amongst the lush shrubbery. Unfortunately, Marianne is unable to merely express her pain for too long, as a storm foreshadows the lethal impact of her excessive performance.

The change in weather mimics Marianne’s change in constitution, and prepares the reader for an ominous climax to an ever-approaching conclusion. After a burst of heavy rain that prevents Marianne’s wanderings for a time, she engages in longer walks “all over the grounds, and especially in the most distant parts of them . . . where the trees were the oldest and the grass was the longest and wettest” and sits on the damp surface with wet stockings, which ultimately gives her a violent cold. (Austen 286). It is in the greenery of the gardens that Marianne is able to express true Romantic sensibilities that bring her closer to nature and the aesthetics she seems to be so in tune with her, but nature seems to turn against her in this scene—or does it? When she falls ill, Marianne suffers from a cough, fever, sore throat, and limb pain; the next morning, she is unable to move, unable to read, so overcome with illness that she has to rest, “lying, wearing and languid, on a sofa” (Austen 287). While this illness prevents some aspects of Marianne’s performative sensibilities, it emphasizes other stereotypes and threatens to transform her from a traditionally fainting maiden into an idyllic corpse, dying from a broken heart. Critical interpretation on Marianne’s declining health in relation to sensibility is divided, with many wondering if Austen is utilizing her illness to represent a physical manifestation of emotional trauma, a metaphor for nervous diseases, or if her illness is rationally explainable and not connected to her sensibility at all. In his novel, *Jane Austen and the Body*, John Wiltshire rejects the idea that Austen is working under the “premise that excessive sensibility, acting through the body’s heightened vulnerability, can of itself bring about destruction” (46). Wiltshire’s research and argument center around the awareness that Mari-
anne’s disease is not “hysterical” or “nervous” at all, but is instead entirely justified by scientific, medical detail (45). Erin Wilson disagrees with an equally compelling argument in her article, “The End of Sensibility: The Nervous Body in the Early Nineteenth Century,” where she explores how Austen purposefully pathologized Marianne’s sensibility, and posits that Marianne is suffering from a “chronic physiological problem” (Wilson 283) throughout the novel with her diction. Both scholars present valuable interpretations to a highly-analyzed text, and I do not disagree with either—in fact, I believe there are aspects of both arguments that Austen represents in her novel.

When Marianne’s illness does not pass quickly or react to any of the party’s home remedies, an apothecary is called to examine the patient. Here, Austen introduces medical discourse into the sentimental novel. An apothecary would “prescribe, prepare, and sell substances for medical purposes,” though their ability to diagnose was still tenuous and unregulated (Adkins 295). Mr. Harris, after looking over Marianne, declares that “her disorder [has] a putrid tendency” and uses the word “infection” to describe her state (Austen 287). By today’s standards, the illness could be understood as putrid fever, or typhus, or even a streptococcal infection, but as it is impossible to retroactively diagnose a fictional character, we also have to wonder if attempting to do so is beneficial—is Austen attempting to present an easily explained illness here, as Wiltshire claims? To some extent. Certainly, it is important for Austen to describe the details of her illness and attempts at healing. Within the next few days, various “cordials” are administered to Marianne, with little to moderate success. Though Mr. Harris remains confident in his patient’s recovery throughout his visitations, the lack of immediate results points to a disillusionment with the medical field attempting to administer healing. Perhaps she is unable to get better because her status as a novel’s heroine prevents her from doing so. Mrs. Jennings, from the moment of Marianne’s decline, “had determined . . . that Marianne would never get over it” (Austen 289), already too weak from Willoughby’s actions in London. The opposing reactions from the doctor and Mrs. Jennings reflect the ongoing conversation surrounding sensibility. As I explained previously, early nineteenth-century England was at a crossroads in understanding sensibility and various maladies that pervaded the population at the time. Medical knowledge was advancing, but it was slow, and physicians could only recognize symptoms rather than diagnose the causes of illness. And though society was becoming ever-so-quick to suspect the authenticity of sensibility, it was still claimed in much of the upper-class as a means to preserve status. Austen includes medical diction to describe Marianne’s “affliction” of sensibility long before her illness sets in, and the remedies used in attempt to heal her are much in line with the
medical capabilities at the time, so in this way, Wiltshire and Wilson are engaging with and explaining two sides of the rationale motivating the same text.

Throughout the entirety of Marianne’s illness, it is Elinor who remains by her side and keeps watch over her condition, behaving as the acting nurse when the doctor is away and the others rest, and it is ultimately Elinor’s influence that deviates Marianne’s fate from the likes of Clarissa’s. She is with Marianne when she experiences a turn for the worst with her illness, having just “carefully administer[ed] the cordials prescribed” and watched her fall into a length slumber before she “started hastily up, and, with feverish wildness, cried out” for her mother (Austen 290). Elinor utilizes her steadfast, calm demeanor and temperament to soothe Marianne for a time before she is able to leave her in the care of one of the true nurses so she can alert the doctor once more of Marianne’s dangerous shift. Her maturity and ability to take charge of the situation allow for Mr. Harris to be called and for Colonel Brandon to bring Mrs. Dashwood to them in the worst-case scenario. Elinor’s anxiety for her sister is pronounced throughout the scene, but because the perspective is focused on her activity with regards to Marianne, we are equally anticipating her recovery. Had Austen written the scene from a third-person focus through Marianne’s point of view, the attitude of the scene would change entirely. She does not want us to empathize, idealize, or relate to Marianne’s suffering here, and she thus does not allow us to see the inner workings of her delirious mind. Instead, we are asked to only sympathize with her state of ill-health and hope, alongside Elinor, Colonel Brandon, and Mrs. Jennings for her recovery. In this way, Austen diverges from the sentimental novel and forces the audience to take a step back to see the consequences of actions justified by sensibility. Not only does it place Marianne’s life at risk, it threatens the peace and security of the entire community with her. Elinor is especially concerned with the impact of Marianne’s death, for “she was calm, except when she thought of her mother; but she was almost hopeless; and in this state she continued till noon, scarcely stirring from her sister’s bed, her thoughts wandering from one image of grief, one suffering friend to another” (Austen 293). Elinor acts as a didactic figure for both Marianne—though she had ignored her before her illness took hold—and the audience, exposing the widespread threat the cult of sensibility poses for society. And it is only after we experience the true extent of the danger that Austen rewards us by allowing Marianne to survive.

When Marianne’s fever finally breaks and she “fix[es] her eyes on [Elinor] with a rational, though languid, gaze” (Austen 293), we are finally allowed to join the characters in breathing a sigh of relief. But Austen presents a cautious tone to the respite, once again through Elinor. Rather than expressing
an outward exclamation of gratefulness and Marianne herself might have had their positions been reversed, Marianne’s recovery “led to no outward demonstrations of joy, no words, no smiles. All within Elinor’s breast was satisfaction, silent and strong” (Austen 294). This is the reaction Austen positions Marianne to witness upon first waking up, and it becomes an important visual for the novel’s reconstruction of Marianne’s personality. After the near-death experience, Marianne emerges from the experience humbled, quiet and timid, the exact opposite of her manifested sensibilities previously, which ordered her loud proclamations of emotion. When she is well enough to return home, Marianne is continuously tested by the environment around her that would have urged her sensibilities to come forth before, but now they lay dormant. In Barton Cottage, the birthplace of her infatuation with Willoughby, Marianne “turn[s] her eyes around it with a look of resolute firmness” (Austen 319) and remains as Elinor does, silent and strong in response to the stimuli that once controlled her life. Her recovery from illness acted as a rebirth, from which Marianne emerged no longer taking after her mother’s sensibility, but of Elinor’s sense. Austen, though she may not believe sensibility causes illness alone, recognizes the metaphoric associations in her own literature and utilizes it in the final moments of the novel. Sensibility, symbolized through her delirious, hysterical cold, has been purged through Elinor’s healing presence, her vigilance, compassion, and calm, steady hope that she would gain (rather than regain) her senses.

On a walk with Elinor in one of the final chapters, Marianne displays her newfound senses by explaining her sudden shift in outlook:

My illness has made me think—It has given me leisure and calmness for serious recollection . . . I considered the past: I saw in my own behaviour, since the beginning of our acquaintance with him last autumn, nothing but a series of imprudence towards myself, and want of kindness to others. I saw that my own feelings had prepared my sufferings, and that my want of fortitude under them had almost led me to the grave. My illness, I well knew, had been entirely brought on by myself by such negligence of my own health, as I had felt even at the time to be wrong. Had I died,—it would have been self-destruction. I did not know my danger till the danger was removed; but with such feelings as these reflections gave me, I wonder at my recovery,—wonder that the very eagerness of my desire to live, to have time for atonement to my God, and to you all, did not kill me at once. Had I died,—in what peculiar misery should I have left you, my nurse, my friend, my sister! . . . Whenever I looked towards the past, I saw some duty
neglected, or some failing indulged. Every body seemed injured by me. (Austen 322-23)

Sensibility, for Austen, is not an active agent that attacks the body, rather, it is a dangerous state of mind that distracts the person for self and social-awareness. Through its celebration of hypersensitivity, it ultimately blinded the individual to the impacts of their own actions on themselves and others. Marianne’s illness forced her to face her death head on, to recognize how precarious her actions had become. It was under sensibility’s influence that she failed to recognize the warning signs against Willoughby as well as the literal dark clouds that foreshadowed her cold, so entrapped in her own emotions that she failed to listen to the advice of her friend and family, and especially her closest companion, Elinor. As she relates to Elinor, “Your example was before me; but to what avail?” (Austen 323); before her brush with death, Marianne was unable to take Elinor’s instruction seriously, but now she is willing and capable of doing so, and in the final moments of the chapter she transcends the capacity of the heroines of the sentimental novel and breaks free from her casket fate.

It is through Marianne Dashwood’s lengthy, reflective address that Jane Austen imparts her lesson in Sense and Sensibility, one for those both suspicious of and obsessed with the popular literature of the time. If Marianne, a near caricature for sensibility, can be reformed, so too can the literary body so intertwined with sensibility as to be stigmatized and ostracized for its association with the cult of sensibility. Rather than allowing the novel to fall by the wayside, Austen satirizes the sentimental novel to prove just how expansive and capable genre is. In the ongoing conversation surrounding the cult of sensibility and nervous diseases, Jane Austen includes her voice and perspective to the mix in ways that are still being debated two hundred years later, but without her ardent dedication to the powers of her literary form, who knows what the novel’s lifespan may have been? Much like Elinor rescues Marianne from the brink of death, so too does Austen rescue the novel, healing sensibility through sense and presenting society with a rationality it desperately lacked.

WORKS CITED


Exploring Health Care and Social Injustice in Toni Morrison’s *Song of Solomon*

Tamaya Williams

The lack of adequate health-care options and resources has plagued black communities throughout American history. Toni Morrison contributes to the critique of poor medical treatment within African-American cultures in her novel *Song of Solomon*. Morrison adds an element of confusion to her audience by having the only actual doctor in the entire novel dead. In all actuality, the lack of black doctors in the United States is extremely realistic. In 2015, there were reportedly only 11.8% black physicians and surgeons compared to the 74.6% white ones. Though over 40 years since this text was published, the racial divide within this profession is tremendous.

*Song of Solomon* was published in 1977. This was a time that was only 25 years after Brown v. Board of Education, and approximately 10 years after the Black Power movement began. As only one can imagine, the racial injustice, and tension within this time era was still extreme and affected the mass majority of Africans Americans causing their attempt to assimilate into American culture to be a struggle. The significance of the timeline of this novel, and when it was written is ideal to the thematic roots of the storyline. There is no doubt that the African American people who were just gaining basic civil rights constantly battled tension between their race and the predominately white world they lived in. The novel takes place in the 1930s, which thickens this tension even more. The history between then and when it was published is undeniably one of the most important aspects when analyzing the different ideas Morrison provides throughout the text. She uses the key era of history and the characters in *Song of Solomon* to exemplify forced self-care both physically and mentally within the black community due to a lack of doctors, medicine, and resources. While
focusing on the main character Milkman and his adventure to dig deeper within his family roots, the novel ultimately shows how the absence of doctors and medicine negatively impact the majority of the characters’ lives in both physical and mental manners.

* * *

Morrison opens up the text with what is arguably the most important scene in the novel by addressing three significant aspects that essentially sets up its entirety. The location, people present, and action that is all taking place at the beginning of Song of Solomon highlights important factors that will not only continuously affect the characters but also eventually assist with a conclusion on a theme. The history of the street that the opening chapter begins on is crucial to understanding the bigger picture Morrison is approaching. The start of the novel takes place in an unnamed town in Michigan at a hospital where a crowd forms around a man attempting to fly. Within the first few lines, the reader learns, “No Doctor Street” is legendary in this small town. “No Doctor Street, a name the post office did not recognize. Town maps registered the street as Mains Ave, but the only colored doctor in the city had lived and died on that street, and when he moved their 1869 his patients took to calling the street, Doctor Street ”(4). Immediately the audience is able to sense the tension between the different races, as well as the lack of black doctors within this area and era.

The books continue by explaining the amount of trouble caused due to the different references of this street. “And since they knew that only Southside residents kept it up, they had notices posted in the stores, barbershops, and restaurants in that part of the city saying that the avenue running parallel to and between Rutherford Avenue and Broadway, had and always been and would always be known as Mains Avenue and not Doctor Street” (6). The detailed history provided off the street indicates the amount of importance of the street withheld. The location and purpose of “Doctor Street” are emphasized directly which provides the reader with the first sense that there is a lack of doctors and medicine within the town. Laura Dubek emphasizes the importance of the street as well as the effect of the critical time in history. In “Pass it on! Legacy and the Freedom Struggle in Toni Morrison’s Song of Solomon,” she states, “By framing the novel’s opening scene—Robert Smith’s suicidal leap off the roof of Mercy Hospital in 1931 Detroit—with local history and geography, Morrison begins with the assertion that the promise of freedom for black Americans has gone unfulfilled. The narrator tells us that in 1896, the only colored doctor moved to the city. This means that Dr. Foster, the protagonist’s maternal grandfather, moved to Mains Avenue the year the Supreme Court issued its ‘separate but
equal’ ruling in Plessy v. Ferguson” (93). It is important to recognize that
the time period and political issues that were active in the setting are key
to fully grasping the issues Morrison is discussing. The social inequalities
contribute to the history of No Doctor Street.

Morrison sets the entire tone of the novel with the opening chapter by
immediately providing foreshadowing aspects that will later allow the read-
ers to arrive at the idea that the setting of the book’s opening is key to its
theme. Morrison is pushing for the reader to generate an understanding of
this specific location and people present, while also allowing speculations of
what is to come for these characters. What is not immediately clear is the
relevance of the lack of medical care within each character’s life, and how
this ultimately affects their growth both mentally and physically through-
out the novel. Because Morrison revolves the text around the adventures of
Milkman, and his attempt to learn more about his family tree, she also uses
this opportunity to platform their contrasting disabilities that ultimately
highlights their need for not only medical care but the medical care of
someone of their own race.

Milkman’s mother, Ruth Foster Dead, screams for mental help through-
out the entire novel, as she acts as the ultimate unliberated damsel in dis-
tress. As previously mentioned, Ruth’s favored father died very early on in
her life. She was sixteen when he passed, and lived a very privileged life.
As she grew older, she married Macon Jr., who was also able to take care of
her finically. Considering her extremely abusive relationship with her hus-
band, and her constant sadness due to her father’s death, it is easy to assume
that Ruth was suffering from one or many mental illnesses that she would
never be treated for. The reasons for Ruth troubled mental condition vary.
The close relationship Ruth shared with her father moved both Macon Jr.,
and even Dr. Foster to think otherwise. When describing the relationship
between the two, Morrison allows the mind to wonder if Ruth lusted for
the two to engage in a strange sexual relationship. “The good-night kiss
was itself a masterpiece of slow wittedness on her part and discomfort on
his. At sixteen, she still insisted on having him come to her at night, sit on
her bed exchange a few pleasantries, and plant a kiss on her lips. Perhaps
it was the loud silence of his dead wife, perhaps it was Ruth’s disturbing
resemblance to her mother. More probably it was the ecstasy that always
seemed to be shining in Ruth’s face when he bent to kiss her—an ecstacy
he felt inappropriate to the occasion” (23). The uncomfortably presented
by Dr. Foster in his relationship with his daughter causes the question of
why he allowed the frequent encounters to continue. Though Macon Jr.
was oblivious to these nights they spent together, he still withheld his own
speculations of what was happening between the two. Macon Jr. accused
Ruth of having an inappropriate relationship with her father that ultimately
led to his death. One night Milkman decided to follow his mother to his late grandfather’s grave and discovered her reasoning for being so attached to him. In explanation, Ruth states, “I didn’t think I’d ever need a friend because I had him. I was small, but he was big. The only person who ever cared if I lived or died” (124). Though Ruth finally has the chance to speak on why she shares the relationship she does, it still comes off sexual, and abnormal. Ruth portrays an abandonment issue while incorporating a sexual tension by her father. Not only do these actions lead to clear associates of mental illnesses, it is the first instances in which a character could have contributed from professional help, but didn’t have the opportunity or resources to do so.

Within the text, Guitar Bains serves as Milkman’s mentally unstable best friend that lacks any realization of the consequences of his actions causing his lack of accountability. Ironically enough, Guitar was one of the characters present at No Mercy Hospital when Mr. Smith flew off the building. As Ruth went into labor, the nurse sent him for help, “The stout women slid her eyes down the nurse’s finger and looked at the child she was pointing to. Guitar ma’am [. . .] Listen. Go around to the back of the hospital it will say admissions on the door. But the guard will be there. Tell him to get here on the double” (7). The presence of Guitar and the action he played in assisting the birth of Milkman instantly hints at the importance of their relationship, and the significant role Guitar plays within his future life. In the following chapter, Morrison emphasizes that importance by stating, “But if the future did not arrive, the present did not extend itself, and the uncomfortable little boy in the Packard went to school and at twelve met the boy who not only could liberate him, but could take him to the women who had as much to do with his future as she did his past” (36).

From childhood to mid-adult life, the readers grow up with Milkman and Guitars friendship though the two differ in interest. Milkman lacks any real concern on social issues or politics, whereas Guitar is depicted as a modern-day Black Lives Matter advocate. Guitar exemplifies pure anger when speaking of what was then the recent killing of Emmett Till, and craves retaliation, which shows Milkman the first instance that the two men’s interest are beginning to differ. Guitar had become so paranoid of white people, and the constant death of African Americans, he was triple locking his door at night. Still keeping his actions a secret, Milkman took matters into his own hands by following Guitar, then confronting him about his actions forcing Guitar to explain what he had been doing. “There is a society. It’s made up of a few men who are willing to take some risk. They don’t initiate anything; they don’t even choose. They are as indifferent as rain. But when a Negro child, Negro women, or Negro man is killed by whites and nothing is done about it, by their law, and their courts, thus
society selects a similar victim at random, and they execute him or her in a similar manner if they can. If the Negro was hanged, they hang; if a Negro was burnt, they burn; if a Negro was raped, they raped” (155). The actions presented by Guitar allow the assumption of multiple mental illnesses as a result of the many social injustices with the time period. As previously stated, the era in which this novel is set is a key factor to the themes present. The mentioning of Emmitt Till automatically exemplifies the type of racial issues that were at hand at the time the book was taking place. Recognizing that Morrison wrote this novel almost forty years after the time period, it takes place in significances the issues still being active. Morrison uses Guitar to enlighten readers that there where black people who were socially and politically aware of the differences within the injustice systems, and the continuous of mistreatment, and neglect forced them to participate in corrupt activities. The availability of a psychiatrist or psychologist for the black community was extremely rare during this period, and can be considered a primary cause of the action of Guitar. Reverting back to times after slaves were freed, they were forced to assimilate into American culture on their own with no assistance for educations, jobs, or caring for themselves. With the force of segregation, black people had no other choice than to learn on their own and do for themselves. African Americans had to figure the majority of their life out on their own. Guitar’s extreme concern with the mistreatment of black people can be categorized as normal, but what he did for revenge was far from it. With the help of someone to assist Guitar mentally, he could have led him to stray away from violence and revert his anger into education in order to make a more sufficient change within his community. Instead, he acted off what was an example for him.

Guitar’s actions at the end of the novel align his character to be characterized as mentally unstable. The majority of the plot of the text focuses on Milkman’s attempt in robbing his Aunt Pilate for the possible prize of gold, in which he promises to share with Guitar considering his introduction to her. Milkman and Guitar search for the gold continuously together, though the end they found nothing. The anxiety and paranoia of Guitar led to him losing his best friend in the worst way possible. Guitar stressed the importance of the gold to Milkman, in order to help the 7 Sons. Guitar became so obsessed with the secret society he accused Milkman of finding the gold and not sharing it. Because of his previous patterns of seeking revenge, it was no surprise Guitar wanted the same of Milkman. After various failed attempts in killing Milkman, the last scene of the novel results in a bullet that was intended for Milkman, killing Pilate. This action resulted in Milkman “flying” towards Guitar, with last words being, “You want my life? Here you got it” (337). In just about every way possible, Guitar represents a character with mentally ill characteristics as result of his environment.
The lack of professional help led him to self-medicate by using revenge and violence in order to improve his own feelings of himself and the world he lived. His anxieties and paranoia took complete control of his life and not only led to him being a murder but also losing one of the few people he could count on, Milkman. Morrison takes advantage of Guitar’s weakness and depicts him as the “crazy character,” but allows the question of “what if?” to be posed. Had Guitar had the option of mental help or expressing his worries in a different manner, his story may have been different.

Hagar is another character who suffers serious consequences due to self-medication. Hagar is Milkman’s predominate love interest in the novel. As the granddaughter of Pilate, she is also his cousin. Throughout the novel, the reader sees the constant on-and-off relationship between Hagar and Milkman. Though Milkman constantly informs Hagar that they will never be together due to her low social class, it is an odd love, and she refuses to let go. With the constant feeling of being rejected, Hagar takes matters into her own hands, similarly to Guitar. As a result of what seems to be depression, Hagar grows sad and also seeks revenge on Milkman by killing him. Her mental instability first appeared in her multiple attempts in killing Milkman, and then transitions to Guitar discovering her despondent and nude in his room, waiting for Milkman. As result of this, Pilate and Hagar’s mother Reba’s attempt to reverse the state Pilate is in by sending her on a shopping spree. This act of self-medication turns left as Hagar’s items are all ruined on her way home, and Hagar dies. Hager presented many symptoms of multiple mental diseases, considering her insistent love turned obsession and her death due to heartbreak. Both Guitar and Hager exemplify characters that would have ultimately benefited from the help of a doctor. In both instances, the consequences suffer due to this lack professional healing are extreme and result in death. Morrison uses both Guitar and Pilate to exemplify how the lack of health care in the black community can negatively impact those who live there. Seeking professional care was not an option, forcing the characters to medicate themselves. There was no positive outcome in any of these acts of self-medication. If anything, these characters and the people they loved suffered because of it. Reverting back to No Doctors Street, it is near impossible to not see the relevancy of the street, and the issues the characters are dealing with. Though the initial introduction emphasizes the importance of the street, the issues in which the name hints at are prevailed throughout the characters and ultimately exemplified through their actions.

Critical analysis often characterizes Pilate, Milkman’s aunt, and his father’s sister, as a main character throughout the novel due to the physical and mental differences that alienate her from being categorized with the other characters as well as the predominant role she plays in each
character’s life. Like Guitar, Pilate was also present on the day Milkman was born and assisted in his safe delivery. His birth date acts as the beginning of her lifelong journey of looking out for his overall wellbeing. In spite of Milkman’s father’s advice, Milkman was dependent on Pilate for many things, as most the people did in her life. In search for more history of the Dead family, Milkman reached out for advice and guidance from Pilate, which led to their overall strong relationship. Pilate acted as lovable, and selfless character throughout the novel regardless of the ridicule she endured due to her own physical mutation. Pilate was born without a navel, causing her to be bullied and alienated by her peers. Nevertheless, Pilate never let these things control her, but instead overcame them and presented herself as a strong black woman. Morrison uses Pilate, her characteristics of strength and long-lasting youthfulness, and her supernatural powers to represent the black women as a healing tool that stems from African American culture. Though Pilate uses what can be described as supernatural aspects, she still lacks the ability to be able to save Hagar, Milkman, or herself from death. Pilate’s character brings attention to the common ideology of self-medication and the normality pared with it in African American culture. But this also sheds lights on these fixes being extremely temporary. Vikki Visvis examines the use of song and language within this novel in her text titled, “Alternatives to the ‘Talking Cure’: Black Music as Traumatic Testimony in Toni Morrison’s Song of Solomon,” and states,

“Unlike her brother Macon Jr., Pilate deliberately uses song to take possession of her past, particularly her traumatic history. Pilate knows that ‘to be traumatized is precisely to be possessed by an image or event’” (Caruth, Trauma 5). As she tells Milkman, “the dead you kill is yours. They stay with you anyway, in your mind” (208). In an effort to allay the memory of both her father’s death and her role as an unwitting accomplice in the murder of a seemingly threatening white prospector, Pilate needs her father’s admonition to sing. After both instances and throughout her life, Macon Dead’s ghost returns to Pilate and “tells [her] things [she] need[s] to know” (141), advice that Pilate deems “real helpful,” such as the imperative to “Sing, Sing” (170). The reader later learns that Pilate misinterprets her father; in actuality, he calls out to his dead wife, who is named Sing. Nevertheless, the text implies that Pilate’s old blues song allows her to reintegrate traumatic memory, a gratifying psychological process that is repeated when she retrieves the with prospector’s bones. In an effort to alleviate not her conscience and the memory of her painful past, Pilate needs her
father’s response, “You just can’t fly off and leave a body” (208), interpreting his maxim as a directive to return to the bones of the man she and Macon Jr. left dead in the cave. We learn later that Macon’s moving refrain relates to his own trauma of paternal loss, for he was the body left when his father Solomon escaped slavery by flying back to Africa. Unaware that her father’s admonition is directed towards his own father, Pilate returns to the recesses of a dark cave in Montour County and unearths the bones of a man whose death she believes is partially her responsibility. Pilate carries the bones with her on her travels and ultimately hangs them in the center of her home, preferring to confront the anathemas of her past rather than having the memories haunt her. As she tells Milkman, it is “a more better thing to have die bones right there with you wherever you go” (208). Singing her old blues song figuratively replicates her return to the cave; it allows her to access her history from the dark recesses of her mind and bring it to the fore.” (Visvis 259-60)

As another tool or form of self-medication, Pilate resorts to singing in order to hide her own pain from her past. Many of these black people are forced to self-medicate, as a result of the lack of professionals available, and this exemplifies that though in many cases African American women are depicted to be superwomen, still there are some things that are out of their hands. Pilate acted as a doctor for Hagar, Milkman, and other characters that relied on her mentally, physically and emotionally but without any true medical education, she could have never fully healed them. She also shows that in her own way of attempting to heal herself, she fails due to misinterpretation.

*Song of Solomon* exemplifies the negative effects that overtake African American men and women with the lack of professional medical care both physically and mentally. Though the plot of the story strays from the issue at hand, the theme is repeated throughout many of the characters. The text beginning specifically at a hospital, on a street that was named after a former doctor, promotes the significance of both the street and what Morrison is trying to say medically. No Doctor Street acts as a first-hand representation of the equality issues faced by African Americans and the results inflicted on the people who have no choice but to deal with it. Though Dr. Foster is dead throughout the entire novel, it is critical to the bigger picture of the text to note the important role he played in the community. The history and the naming of No Doctor Street alone show the amount of respect the African Americans held for Dr. Foster and a great deal of attention they believed he deserved, regardless of whether he was alive or not. It is
also important to recognize that aside from Dr. Dead, there were no other options for black people in this town.

Along with racism and other civil issues, Morrison uses characters such as Guitar and Ruth to exemplify the actuality of what black people face when they are not granted basic human rights, such as health care. Throughout the black community it is common to strictly rely on a mother or grandmother figure, and home remedies in order to improve any health issue. This text shows that the act of self-medication is a habit within black community solely because it is forced, and the people have no other options. Morrison uses this text as an opportunity to educate readers on the constant battle of being of African American. In “Black Heritage Versus White Dominance in Song of Solomon,” Masha Khadivi states, “Significantly, her objective is to explore the complex interaction between the present and a past that as a frightening nightmare imposes itself between the present and a future of freedom and renewal. In this regard, Morrison’s novel undoubtedly has been a major contribution to the celebration of black identity and culture” (188). Overall, Morrison positively used her book in order to bring attention to the many issues African Americans are facing. This is a common deed of hers and with this specific text, she is using health care and doctors to gives readers the opportunity to become socially aware of issues that are both from the past and present while also recognizing the black culture plays a huge role in black people’s survival skills.

When topics like discrimination and inequality are discussed, certain privileges such as health care, tend to be overlooked. Not only do many African Americans lack the funds in order to contain basic health care, they also lack the ability to choose a doctor of color they would possibly feel more comfortable with due to the small ratio of African American physicians. Going into a doctor’s office of any sort and having the professional look like you is indeed a privilege. Being able to afford to go to a doctor, and having one available in your town, or nearby, is also a privilege. These privileges are often viewed as accessible, and that is untrue. Within this text, Morrison is able to bring attention to many issues involving healthcare in the past that are also present today. Revolving the entirety of the novel around No Doctor Street, while also eliminating the presence of an actual doctor, creates an actual representation of a black neighborhood and the primary resources it lacks. The physical and mental disabilities the characters deal with, based on self-diagnoses, also contributes to the constant act of self-medicating. Overall, this novel reveals the reality of health care in the black community. With its awareness of a very small number of doctors, little to no medical resources, and the state of being content with self-medication in black communities, Song of Solomon explores the unfair truth of proper health care for all.
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