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The Vocabulary of Depression: Using Literature to Understand a Clinical Disease



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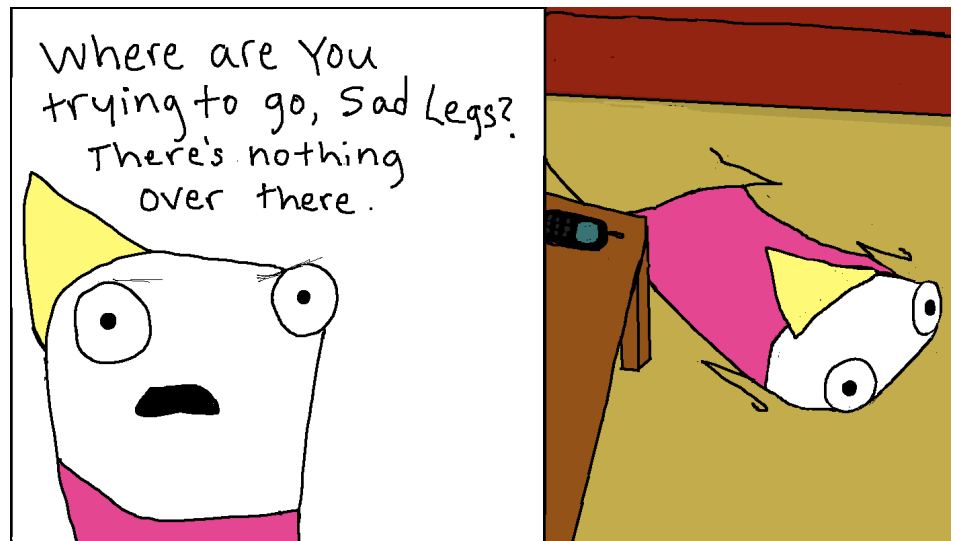


Figure 1. By Allie Brosch.

The image in Figure 1 above is a comic taken from *Hyperbole and a Half*, a blog created by Allie Brosch. The specific posting this comic was taken from, titled "Adventures in Depression," attempts to explain her mental disease. She discusses a variety of topics through comics, including conversations with her neighbors, battles with spiders, and the infuriating use of "alot." In Figure 1, the audience sees Allie discussing her depression by depicting herself twice – as her psychological actions and as her inner thoughts berating herself. The additional use of this avatar allows for readers to become more in touch with her perspective. By reading Allie's piece, the audience will discern a specific understanding of depression based on the perspective she has chosen to tell her story through. In order to fully comprehend the impact that literature can have on how we see depression, more than one source must be examined. In attempts to assist writers in their depiction of the disease, this study has examined the use of vocabulary surrounding depression within a small sample from clinical, fictional, and creative non-fiction sources. As merely one sample of an infinite amount of literature, this blog demonstrates some of the ways that literature can affect our understanding of depression.

The first assumption when looking to understand a medical disease would be to turn towards clinical sources.

Currently, the *Diagnostic and Statistical Manual (DSM)* is a major authority on depression due to its use in diagnosis by professionals. This source establishes the modern terminology surrounding mental illnesses. By standardizing vocabulary, it allows patients to receive congruent treatment between doctors or hospitals for their disease. In order to understand how this current perception of depression came to be, the historical significance of medical terminology must be addressed. By merely looking at the title of the earliest piece within this study, *The Anatomy of Melancholy* written by Robert Burton in 1621, the audience can see the way that terminology has changed over the years. Burton's work is a compilation of not only his theories of depression but also numerous other philosophers, dating back to Aristotle, discussing various aspects of "Melancholy," the original phrase for depression. For instance, concerning the origin of "Melancholy," the piece does not merely describe Burton's observations but lists a wide variety of them. A large portion of philosophers believed that depression came from a specific point of origin within the body. Burton explores this concept in "Parts Affected," explaining that "Melancholy" could be formed in the "Minde" or the heart – or in the Spleen, "Stomack," or Liver. Considering the symptoms of "Melancholy," such as emotional changes or inability to eat, there is a logical reasoning behind thinking these body parts are the cause of depression. Now, as medical knowledge has

advanced, the notion of a mental disease originating in the “Stomach” would appear unfathomable.

On the opposite end of the spectrum, Robert Burton also cites many philosophers that believed the cause of depression was “Imagination.” In *The Anatomy of Melancholy*, there are an equal amount of sources referring to a biological cause as there are those believing the disease is driven by human will. To support the idea of self-induced “Melancholy,” theorists will site symptoms of hallucinations and illusion. However, according to the current *Diagnostic and Statistical Manual*, such symptoms are currently defined as Schizophrenia. These conflicting ideas demonstrate the muddled understanding of numerous mental illnesses that has existed over many centuries. Even within *The Anatomy of Melancholy*, theorists will overtly muddle the lines between diagnoses. There are many instances where depression is defined by using other diseases with similar symptoms, such as “Folly” or “Madness.” Despite efforts to point out the differences, an association is created between “Melancholy” and insanity in the minds of the readers, leading to a stigma. The lack of knowledge at the time resulted in unrealistic biological explanations, a different diagnosis than current depression, as well as a connection to insanity that persisted from Aristotle in 322 BC past the release of *The Anatomy of Melancholy* in 1621. However, due to these original presumptions, all continuing studies were first based upon these earlier theories, whether it be that there is one body part to blame for depression or not. How the people during Burton’s time saw and depicted the disease would continue to affect future studies.

Similar indefinite hypotheses about depression can be observed within clinical sources even three centuries later with the publication of “Mourning and Melancholy” by Freud in 1914. The scant amount of advancement that the medical field had made between Freud and Burton’s times is quickly illuminated. A majority of Freud’s opening section is a form of disclaimer as he explains his small sampling size and the extensive amount of varieties between each individual case. Freud says he is “against any over-estimation of the value of our conclusions” (243) before he even begins his observational accounts. This depicts his lack of faith within his own results, despite his prominent work within his field. Such statements make the

incomprehensibility of the disease even two hundred years after Burton’s time quite clear. In attempts to understand it, Freud grounds the unfamiliar disease in something more relatable, similarly to *The Anatomy of Melancholy*. Both mourning and “Melancholy” are described as being the result of the loss of a “love object.” Just as someone in mourning loses a loved one to death, Freud states that Melancholy comes from someone feeling “justified in maintaining the belief that a loss of this kind has occurred” (245). The notion of “belief” in this context bears a similar resemblance to hallucinations or illusions, becoming synonymous with the “Imaginary” used by Burton as it demonstrates the continuation of depression as a voluntary disease.

However, unlike his predecessor, Freud uses a rational and common emotional state in his metaphoric explanation of depression versus using “Madness,” a disease defined by insanity. “Mourning and Melancholy” compares the two, saying they have “the same painful frame of mind, the same loss of interest in the outside world, the same loss of capacity to adopt any new object of love” (244). These symptoms are the same ones listed in the DSM as well as by Burton; however, by comparing them to mourning it creates a sense of familiarity for readers. The implications of this change in comparisons from Burton’s time to Freud’s means that not only is the disease more relatable but it also appears less dangerous than when it is defined using madness. Despite its similarities, mourning also has a few specific traits that do not necessarily apply to depression. After a death there is a period for being “in mourning” before the grief caused by such loss shall naturally be overcome. Comparing the two thus gives the impression that after a certain time depression shall disappear, and remaining depressed past this time is inappropriate. The notion of “mourning period” also creates the assumption that someone should not require medical care to overcome it. Mourning is a logical and rational disease yet, in comparison, depression is illogical. This metaphor is an improvement from the concept of “madness” as it makes depression appear more familiar, yet it continues to aide in persisting misconceptions.

Since Freud’s work in 1914, clinical sources have advanced significantly in their approaches to mental illnesses, yet the mindsets created from works such as

Burton’s and Freud’s persist. A significant change in the medical field, in terms of mental illness, was the creation of the *Diagnostic and Statistical Manual*. Before this, during the time of World War II, the increased need for psychiatric care resulted in multiple manuals created specifically for veterans or soldiers. This led to three different, prominent sources being in general use, making the act of labeling mental illness to be “almost to the point of confusion” (vii). With many different sources supplying unique definitions of each disease, not even one of them could meet the international standard, making each one an individualized variation. The result was that not one diagnosis could be assured, making it a very difficult and dangerous time for those experiencing mental illness. It was not until the release of the *The Diagnostic and Statistical Manual* in 1952 that some of this confusion was allayed.

The first manual of the DSM helped to fulfill several main purposes that the medical field has: the need to diagnose and to treat. In order to understand and then cure a disease it must first be diagnosed. If medicine were an individualized science, every patient would receive a different diagnosis and treatment depending on where they sought help. Without a certain amount of cooperation and cohesiveness in the field, there would be no sense of advancement. When approaching nomenclature, doctors and scientists understood that a certain amount of individuality must be sacrificed in favor of overall progress. Due to this necessity, clinical sources began to slightly alter their approach. While Burton and Freud are able to discuss their individualized observation, they generalize their studies. However, as science expanded and medical professionals began to communicate more, the point of view changed its focus from an individualized narrator to emphasize a generalized summation of concepts. This is where the *Diagnostic and Statistical Manual* comes in as one of the earliest sources of standardization for mental disease.

The DSM-I is one of the most prominent medical sources in the early United States where mental illness begins to be defined by variations of the word “depression.” However, instead of being “depression” the disease is at first considered to be “manic depressive reactions” which at this point in history was an umbrella term. This phrase defined not only all forms of depression but also other mental illnesses such as

bipolar disorder, anxiety disorder, and even schizophrenia. In the 1950s, depression was described as including symptoms such as “illusions, delusions, and hallucinations” (25). Therefore, in the first standardization of depression, it continued Buton’s comparison to madness by including a multitude of symptoms and terminology that is normally assigned to the notion of being “insane.” Simultaneously, the view of depression in the eyes of the public was created from all of these symptoms. However, to be diagnosed a patient needed to only match a few of the requirements, not all of them. Therefore, being labeled as having “manic depressive reactions” meant that an individual would be attached to the stigma of the overall disease, leaving less room for their specific type of depression.

It was not until the release of DSM-IV in 1994 that hallucinations and illusions were no longer considered general symptoms for depression. After persisting this way for nearly fifty years, such symptoms became a subtype of depression instead of a defining factor in DSM-IV, known as “Severe with Psychotic Features” (377). Those who demonstrated these symptoms were therefore “psychotic,” despite the fact that a few years earlier they would have been considered “depressed.” Less than twenty years later, with the release of DSM-V in 2013, hallucinations and illusions were eliminated from depression altogether and instead became a necessary symptom for schizophrenia. Therefore, from before 1621 up until 2013, depression had symptoms associated with a completely separate disease. This created a lasting impression to those who used clinical sources as to what depression was supposed to look like, an impression that included symptoms labeled as “psychotic” and is incongruent with the current definition. Originally there may have been an understanding that variation was taking a back seat to categorization. However, as the DSM and other nomenclatures become more integrated into society, the idea of “one” depression becomes ever more prominent.

As the medical field searches for answers as to how to cure the disease, depression is seen as having a single answer – therefore one definition. However, even when simply exploring the clinical sources it becomes evident that there is not one definition for depression. Multiple sources including Burton and all versions of the DSM will approach the disease in terms of subgrouping – whether that be a subtype with psychotic features or levels of

severity. Also over the years it has expanded from the umbrella term of “depressive reaction” which included the symptoms of multiple other illnesses into a multitude of singular disease listed under the overall categorization of “depressive disorders.” Even as clinical sources standardize the disease there is a certain amount of allowance meant for variations within the disease, yet not enough to sufficiently account for the whole of the disease itself. In order to fully comprehend these variations, readers must look beyond the observational accounts of clinical sources and instead study the narrative works depicting the eclectic depression.

Andrew Solomon discusses the distinction of narrative within *The Noonday Demon: An Atlas on Depression*. He begins his novel with metaphoric language to establish a base definition for depression. Shortly following, he dismisses his own definition, adding metaphor after metaphor. He expands his examination of the disease from an impersonal general outline to include his own experiences, factual information, and others’ experiences. He cites similarities as well as differing experiences between individuals, exemplifying the sheer amount of variety within the disease. For instance, he describes the onset of depression as going “along the gradual path or the sudden trigger of emotion” (17). In some patients the disease could manifest slowly while in others it begins based upon a “trigger,” implying a specific event. Each option results in a different form of the disease with a different origin, each on opposite ends of the spectrum. The deeper Solomon delved into his studies of the disease as a whole, the more he discovered how varied the stories were. By the end of this first section alone, he has established numerous variations upon all aspects of depression and even by the end of his study there is not one exact “answer” to what depression is. He explains the depth of the variations of the disease while also depicting the miscommunications surrounding it. As there are many forms of depression, and just as many perceptions about what the disease is, there are also various amounts of ways individuals can react to it.

As the topic of his book became public knowledge, Solomon himself was greeted with disbelief and accusations. In one specific instance, an editor from the *New Yorker* asked Solomon “What the hell do you have to be depressed about?” (366). From this statement, readers can see the

resentment that the editor feels towards Solomon. The audience can gather that the editor has a basic understanding of what depression is; however, his definition includes a “what” – a specific requirement or cause before it’s considered depression. Though the specificity is unclear, the editor believes there is a prerequisite that needs to be reached which Solomon does not seem to exhibit. While maintaining some form of knowledge, the editor’s comprehension does not extend beyond his own individual view of disease. Solomon’s account stresses the need to recognize varying, individual stories in order to understand the multiple sides of the diseases. However, these personal stories cannot be found solely in the observational analysis that is provided by clinical sources.

To understand a larger view of depression as a whole, studies of the disease must turn towards the narrative. For the purpose of this study, narrative shall be defined as fiction and creative non-fiction. In a comparison to medical works, the purpose of clinical sources is to create a unified definition of the disease. When looking upon patients, it is not a matter of “Werther” or “Ester” but of “they.” The study is upon the collective in order to understand the disease as a whole. The standardization that results enables clinical sources to diagnose, treat, and advance research within the disease. It is this method of study that advanced “Melancholy” past the umbrella term of “manic depressive reaction” into the modern day context of “depression.” The cost of this standardization is that individual accounts are sacrificed for the greater purpose of general understanding.

On the other hand, the primary goal of narrative sources is not to define the disease but instead to account specific experiences of it. Each source discusses how the characters are mentally ill, some going into detail of visiting hospitals and doctors and repeating the idea of “illness” or “madness.” Comparatively, others will give a clinical definition a passing glance while going in-depth onto how it is revealed within the specific person. However, not a single fictional source examined in this study presented readers with a specific diagnosis. Thus in narrative works, the patient is placed on a greater level of importance than the medical diagnosis, enabling the audience to see depression through a personal account rather than as a generalized definition.

However, even narrative relies on clinical sources, given that medical works establish the terminology defining depression at that time. How the disease is viewed will be based upon the medical definition, and thus will affect how the patients see themselves for having the illness. When Melancholy is defined by “Madness,” patients living in that era will likely define themselves in the same way. Believing that they are insane will affect how they value themselves, how they treat others, and their overall behavior. Studying the language depressed patients use to describe themselves and their disease becomes a way of understanding the consequences of misperceptions. It also creates a sympathetic understanding on the part of the audience. For instead of observing the symptoms with clinical sources, readers are given specific experiences from characters they are able to empathize with. The value of personal accounts is that it enables a shift from the use of only medical terminology to vocabulary surrounding identity – terminology used by patients to define themselves based upon the understanding of the disease at the time.

The Sorrows of Young Werther written by Johann Wolfgang von Goethe in 1787 is the earliest piece this study examines. From analyzing the vocabulary within this source, readers can come to understand what earlier misconceptions were formed and therefore how they prevailed through time. The story is a compilation of letters that Werther writes to his friend, the audience taking the place of said friend. In the beginning, he relates his adventures of moving to the countryside and meeting Charlotte, a woman who he instantly falls in love with. However, she is engaged, and his letters begin to be filled with laments for his misfortune. Werther becomes obsessed with Charlotte and readers can see his mental stability slowly deteriorate. From merely discussing the sorrows of his situation, he then defends others with mental illnesses, comes to hate himself for his own symptoms, and eventually considers aggressive acts of violence – such as killing himself or others. At the end of the novel, with Charlotte long married and flat out rejecting his overt confession of love, he finally does commit suicide, and the story is taken over by an “editor” who depicts the fall out.

This fictional story demonstrates numerous examples of the terminology surrounding “Melancholy” as it is defined in *The Anatomy of Melancholy* by Burton and

“Mourning and Melancholy” by Freud. The idea of “madness” either replaces the diagnosis of “Melancholy” or is consistently associated with the disease. In clinical sources, madness is a base point through which depression is compared, such as in Burton’s piece. He notes similar symptoms and supposed causes between the two diseases to make the overwhelming unknowns of “Melancholy” seem more manageable. The misconceptions around the similarities of the disease in ordinary folk are made evident through the use of the two labels within fiction. Those who would be diagnosed with “Melancholy” do not define themselves that way. In *The Sorrows of Young Werther* the two diseases are considered reciprocal. Werther refuses to label himself as having “Melancholy” because other men that were either violent or locked away for such diseases are his only understanding of it. At one point, when discussing how he knows Charlotte is engaged, he says “I have become accustomed to that thought, although it will drive me mad yet, it will kill me!” (106). Werther assumes that “madness” is the lowest point to which he can be driven: a near equivalent to death. At his worst he often depicts himself as being mad or insane despite the lack of any formal diagnosis. The term “Melancholy” will be used by the “editor,” or temporary third person narrator, to describe a specific mood or by Werther to describe others. However, being melancholic is not something Werther identifies with. Werther’s aversion to the term as well as the piece’s references to “Melancholy” in such extremes reveals how society’s understanding at the time favored “madness” instead of “Melancholy.”

Although Werther exhibits all necessary symptoms for a diagnosis of depression, neither the editor nor Werther consider “Melancholy” as they have already assigned the more common term of “madness.” In this instance, either the common use of madness by the patients in defining them has led to its comparison with “Melancholy” or the comparison of “Melancholy” with madness has led to the association within patients. As *The Sorrows of Young Werther* was released over 150 years after *The Anatomy of Melancholy*, the causal relationship becomes difficult to surmise. However, the association of language as a driving force for medical and personal understanding of depression is made extremely clear. There is also a significant leap between how each genre approaches this comparison. While Burton continuously insinuates that they are

“similar,” the fictional works implies that they are the same. No matter whether the personal accounts drove clinical sources or the other way around, personal accounts internalize the disease at a greater extreme while clinical sources can more clearly observe the differences. The genre change results in a different way of viewing the proximity between madness and “Melancholy” originally depicted within clinical sources.

The resulting varied view of a similar instance is revealed even further when comparing *The Sorrows of Young Werther* to Freudian theories. Werther’s story is based around the loss of a “love object,” reflecting the concept portrayed in “Mourning and Melancholy.” Werther cannot be with Charlotte, and therefore this rejection becomes similar to a death within his mind. His disease then becomes based around this instance. All of Werther’s actions surround Charlotte and how they interact defines which symptoms he exhibits at the time. Werther says, “when I feel like shooting a bullet into my head, she sings that air; the gloom and madness are dispersed” (38). One moment he is about to kill himself, but then he is allowed to see her and is placated. In this situation, Freud would define Charlotte as being the “love object” and her rejection of Werther as being his loss. Therefore Werther’s depression or “Melancholy” can be comparable to mourning under Freudian’s theories. As discussed previously, Freud also describes this overall metaphor using the idea that patients have a justified “belief” to their emotions. This implication of “belief” connects the disease with being “Imaginary,” insinuating that depression is something that can be controlled and is therefore voluntary.

“Belief” implies that it is the choice of the person, and something they have decided upon using their own will. In terms of “Melancholy,” that would mean patients are forcing the symptoms upon themselves. The concept creates the perception that if these patients simply stopped “believing” in their disease, then they would not be depressed. In this case, the “belief” that Werther feels is surrounding the specific loss of an individual. The fact that interactions with Charlotte are the trigger to Werther’s changes in emotions also leads to the assumption that depression is event-focused, which is true for some but not all depressions. His reactions therefore seem to be in his control, especially in the case of rejection, as it is an event that majority

of the population has experienced. The general populous could easily believe that for such an ordinary incident to push an individual to the point of extreme, it must be something Werther is doing wrong. Werther's depression is portrayed as being his reaction to a specific event, implying that it is temporary as well as within his control. However, through the examination of individual stories, it becomes extremely evident that this is a long-lasting misconception.

Written over a hundred years later, "Ward No. 6," a short story written by Anton Chekhov in 1892 continues to exemplify the persisting confusion around the disease in numerous matters. Instead of focusing on cause, the story revolves around how characters deal with the concept of madness in themselves or others specifically through hospitalization. Even in current contexts, hospitals have one or two purposes – to treat and to contain. In theory these are separate concepts, as not all patients require quarantine even if they need treatment. A social commentary on these interactions, Chekhov's piece reveals how society viewed hospitalization during his time.

Chekhov's work follows a specific psych ward in a small rural town. The ward is depicted as being physically as well as morally deteriorated. The hospital itself is covered in trash, it lacks necessary equipment, its warden beats the patients, and one of its doctors has created a harem out of the women around him. Instead of having specific diagnoses, all patients are grouped together and labeled under the umbrella term of "madness," which includes depression. The short story specifically follows two main characters. The first is patient Ivan Gromov. Originally an aristocrat and a student, his family comes to financial then social ruin that is insinuated to be the cause of his "Melancholy". The other main character is Dr. Andrey Ragin, as he descends into "madness."

The story mostly revolves around Dr. Ragin as he goes from being one of the main psychiatrists to becoming a patient who dies in the hospital. Although exemplifying the common symptoms of depression, such as inability to eat or sleep, the people around him are more focused on other aspects of his behavior. The first sign of his "Melancholy" for the general public is that he stops caring about the hospital. However, given his wish to help patients and the depiction of Ward No. 6 as being corrupt, this aversion seems almost logical.

However, the fact that he has strayed from what is considered to be "normal" and begins to question the rationality of the institutions around him is paramount to insanity to others. The true tipping point is when he decides to venture into the hospital out of curiosity and strikes up a philosophical conversation with Ivan. Though currently there is little to no harm in attempting to understand others' opinions, Chekhov criticizes his society by making this a critical error on Dr. Ragin's part. The other hospital workers deem that if Dr. Ragin is talking to a mad man, then he must be mad himself. The patients in the hospital have become pariahs, as though their disease were contagious. This insinuates the idea of a hospital being a "quarantine," that depressed people need to be kept away from others for the sake of society.

While Goethe's piece barely addresses hospitals, the few instances it does so bears similar implications to those presented in "Ward No. 6." The one mention Werther makes to mental institutions is when he describes another man as being "quite violent, and chained down in a madhouse" (101). This presents the idea that hospitals are more a cage to keep "mad" people that society does not want rather than a place of treatment. The same impression is given within "Ward No. 6." It quickly becomes clear that the doctors have no intention of releasing any of the patients, especially as Dr. Andrey Ragin grows irked by his position and shrinks from his duties. The only true purpose of the hospital seems to be keeping the patients away from the rest of society. Only one patient is allowed to leave the grounds and this is because he is "a quiet, harmless half-wit, a town fool" (172). This specific patient is confined less for the safety of others and more because the doctors believe he is a "half-wit" and cannot take care of himself. However, the rest are deprived of their freedom "without a trial" (219), as stated by Ivan. How the town deals with these patients becomes a reflection of how society's perception changes once someone is labeled as being "depressed," and the immediacy with which that comes.

Dr. Ragin specifically has a nearly instantaneous reaction by the town when dealing with his depression. In a very little amount of time they go from whispering about him, to questioning him, and finally to locking him in the hospital without his consent. The moment that he becomes depressed he is viewed differently. There

are no thoughts of treating him outside of the hospital or attempting to get his life back to the way it was, instead he is immediately considered to be an invalid. The town then takes away his practice, his status as a doctor, and even sells his house with the clear understanding that he will never be leaving the hospital. Both the immediacy of his admission and reasoning behind it imply that he needs to be kept away from society. Despite the "treatment" side of being hospitalized, the defining characteristic of a hospital as a confinement, especially during Chekhov's time, often overpowers the idea that patients are being treated for a mental disease. The misperception implies that depression leads to dangerous activities and that they must be isolated for the good of society. Chekhov attempts to criticize this notion through his work, depicting the prejudice and the obscurity in it.

This prejudice takes place not only within society, but also within the minds of the patients. While "Ward No. 6" depicts a more generalized, anecdotal commentary, other pieces dive more deeply into how the characters view themselves while dealing with the symptoms and stigma of being depressed. One piece specifically that delves internally is *The Bell Jar* written by Sylvia Plath. While focusing on one specific character, the book reveals how prejudice against depression exists not only in society's view but also how patients view themselves or even other patients. *The Bell Jar* is about Ester, a girl from a small town who is trying to make her way in the world. It begins with her having a prestigious scholarship to work in New York and feeling like she cannot make the most of it. Her depression has a gradual onset, with little concerns of love and more troubles with school, work, and her writing career. As her symptoms worsen, she determines to come home and seek treatment only to have a bad experience with shock therapy in the hospital. Turned against treatment, she attempts suicide before being readmitted into a different hospital. Ester is eventually depicted as being able to overcome her depression to an extent though in her final thoughts she is considering the possibility of the disease returning.

Despite the fact that *The Bell Jar* was published in 1963, nine years after the release of the first DSM, patients are not referred to as having "depressed reaction" but instead as being "crazy people." Upon arriving to her first hospital, Ester says

“everything about the house seemed normal, although I knew it must be chock-full of crazy people” (140). The hospital is a distinct deviation from “normal” in her mind and that is all that demands her attention. She does not make an attempt to differentiate between patients nor give validation to their illnesses. Despite her own depression, Ester simply lumps everyone together under the degrading term of “crazy.” Before her suicide attempt she also does not include herself as a part of this group. She describes the patients as being a “they,” making them a singular group that is a separate entity from her. Only after her suicide attempt does she make the transition from saying those who are depressed are a “they” to being a “we.” Only after she has reached an extreme act of self-violence and being locked away does she begin to call herself crazy as well. However, with both “they” and “we,” the focus remains on the fact that those with depression are considered to be social pariahs. At one point she explains how a random hospital worker “gawped at us with big, rolling eyes. I could tell we were his first crazy people” (180). The distinction of “us” creates a barrier between those who are depressed and those who are not. This speaks not only to the idea that those who are depressed cannot belong in society but also to the inability to understand the disease without experiencing it.

Despite the fact that Ester establishes a community of “crazy” people within her mind, for the majority of the piece it is still not an inclusive state for her. Calling herself “crazy” signifies an acceptance in her disease and the point in time where she agrees to treatment. However, this mental progress is deterred as within the “we” of the patients she begins to define her “I” as having a lower status. When admitted to the hospital she desperately wants to hide her suicide attempt from other patients, saying she didn’t want them to “know how really bad I was” (190). Ester feels as though she does not belong with them, though instead of feeling she is better than depressed patients she believes she is worse. She considers herself to be on the lower end of the crazy scale and while this may make her a part of the “we” that is different from normal; she is simultaneously excluding herself from the community.

The scale on which she defines herself also becomes the forum through which she judges the other depressed patients around her, excluding certain people accordingly. At one point, at a hospital where patients

are considered to be further along in their treatment, she observes them doing leisurely activities such as badminton. She then says “They mustn’t be really sick at all, to do that” (188). The idea of “really” implies there are other forms of depression that are “sort of” or “somewhat” and her judgment upon their illness shows her belief that she is at a lower end of the spectrum. Ester has a specific idea in her mind of what depression should look like, and she will judge herself and other patients according to this preconceived notion. *The Bell Jar* does not merely depict depression as the two extremes of being “normal” or “crazy” but instead defines a scale of how depressed a patient can be. Not only does this create a prejudice against the other depressed patients, but this misconception also results in an internalized stigma that leads to self-loathing.

The idea of self-loathing is prevalent throughout literature on depression. Freud and Burton will both site the patients they observe as being self-degrading. Similarly, Werther and Ester believe themselves to be terrible people and berate themselves often. One novel that especially demonstrates this theme within depressed patients is *Norwegian Wood*. Originally written in Japanese in 1987, it was translated into English a few years later. It follows Toru Watanabe, starting with the suicide of his best friend in high school and continuing through college as he, as well as many others around him, battle with some form of depression. His love interest, Naoko, is reeling from the suicide of her first love, Toru’s best friend, throughout the novel. In her attempts to overcome it she clings to Toru, has romantic relations with him, is disturbed by these relations, and then comes to stay in a long-term mental facility. Throughout this time Toru is simultaneously dealing with his own mental illness, though he will not seek treatment or give himself a diagnosis, as he is preoccupied with attempting to help Naoko. Both characters come to meet Reiko when Naoko is hospitalized, a slightly older woman who has been dealing with her depression for far longer than either of them. Things begin to improve once Naoko is hospitalized. Toru begins to find love elsewhere and is improving with his studies while Naoko makes steady progress towards recovery, even being moved to a less permanent mental facility. Reiko describes Naoko as being happier than she had been in a long time. It is only then that Naoko commits suicide,

consequently sending Toru into despair. Readers follow his spiral as well as his climb out of it to a healthier state, though the novel ends ambiguously as Toru’s final words depict him in a better place but still lost and isolated.

By the time this novel was released in America, DSM-III-R had been published for several years, and the impact the change in diagnosis had is evident within *Norwegian Wood*. In this copy of the DSM, “depressive reaction” had been adjusted to “depression,” relieving some of the perception that as a “reaction” depression can be controlled. Within *Norwegian Wood*, depressed patients are no longer referring to themselves as being insane but instead the focus is that they are “sick” or “not normal.” The depression is still a prominent portion of their lives, even more so than characters such as Werther who never accepts a diagnosis or Ester who is constantly battling with her diagnosis. Instead, the people in *Norwegian Wood* have a certain amount of acceptance for the disease as an illness that the other fictitious pieces in this study do not.

In all other fictional pieces examined thus far, being depressed was the dramatic point or the main climax of the story. Werther is only of interest to the readers because his story is about “the sorrows of” his life. Without his depression he would be of little to no consequence to the story, merely blending in with the rest of the characters. The same can be said for Ester from *The Bell Jar* as well as Dr. Ragin from “Ward No. 6.” *The Bell Jar* is solely focused on Ester’s depression with the other portions of her life acting as supporting scenes. The climax and all main events surround her disease or the illnesses of those around her. For Dr. Ragin, he becomes the focus of the social commentary because he is a doctor who is also depressed. Without his depression his character would no longer bear the significance it does for the piece. These characters’ depressions are the highlight of their stories, the specific draw that requires the readers’ attention. However, in *Norwegian Wood*, the sheer abundance of depressed characters make the disease seem nearly commonplace. Out of the first three characters readers meet – Naoko, Toru, and Toru’s best friend – two commit suicide, and the final outcome of depression for Toru is left unknown though not optimistic. As the story continues, it is revealed that nearly all of the main characters are experiencing depression or another mental illness. Several of these

characters are then hospitalized including Naoko. It is depicted as a part of everyday life and is no longer taboo but talked about freely. Comparatively, the other works of fiction take much longer for the main characters to reveal their disease and even longer for them to accept it, if they ever do. While the other pieces are resistant, *Norwegian Wood* opens by depicting Naoko in an episode of her depression, having lost weight, lacking in interest, and demonstrating a depressed, hopeless mood. The story does not experience the same sense of forbidding as the others do, making the disease seem to be a much more natural and common occurrence.

Even with the prominence of the disease within this novel, characters are still not given a specific diagnosis for depression or any other form of mental illness. *Norwegian Wood*, in fact, is the first piece where doctors play a significant role in the story yet are never depicted to the audience. While Ester in *The Bell Jar* will be seen in the middle of having conversations with doctors, Naoko will instead relay to Toru what the doctor has said. The information that Naoko relays is being retold, straying from clinical terminology and instead focusing on identity language. Therefore, what readers learn from the doctors is shaped through Naoko's opinions and understanding. How she views depression, for instance, shapes how she speaks about herself, other patients, and the doctors. This view then shapes what the audience hears. Specifically, Naoko will not use words such as "Melancholy" or "depression" but instead discusses her treatment through her own labels of "sick" or "not normal." Because Toru is telling the story, the audience can only receive this information secondhand, as that is how it is given to him. Readers will never meet doctors, because Toru never meets them. The story is told in first-person point of view, that is, the use of "I" by Toru, therefore what readers are allowed to know is filtered through his interpretations and perceptions of reality.

The use of first-person narration or limited third person point of view means that the audience will be enveloped within a specific character's experiences. While first-person will use the pronoun "I," third person will use names and pronouns but will similarly only describe the inner thoughts of one character. In this case the narrator's knowledge of the overall situation is being "limited" to that specific character. By placing an audience in the

pinnacle of a character's emotions, it allows readers to experience a character's actions, thoughts, and emotions with great clarity. Specifically with depression, this means that the audience is drowning in the same symptoms as the depressed patient. It is not that a reader is hearing about the lives of Naoko, or similarly, Werther, Ester, and Dr. Ragin. Instead, the chosen point of view forces readers to travel with the characters as though they were the main character themselves. This gives the audience a greater sense of intimacy with the characters and therefore the disease.

Fiction as a genre creates a different understanding of the disease as a whole due to the need to evoke sympathy in readers. All decisions are based upon the fact that as the story is not true as the author needs to work to make readers care for the characters and events. Clinical sources use indistinct pronouns and describe the disease as a generality, allowing clinicians to understand depression through the multitude of variations in order to treat it. Comparatively, creating a close proximity to specific, characterized individuals is more likely to make an audience invest in a story. This proximity to a few specific instances of the disease will result in numerous changes to how the depiction of depression is approached. The change from clinical terminology to identity language means that readers receive accounts from those experiencing depression. This in turn will give a different view of the clinical understanding of the disease. Even though *The Sorrows of Young Werther* came to several of the same conclusions as Burton or Freud, it did so with an amount of personalization. "Madness" was taken from being a comparable illness to being substituted for the idea of "Melancholy" in Werther's mind and therefore for readers as well. Therefore, other concepts such as the disease being a voluntary "belief" or event are also internalized, allowing the audience to see the resulting impact. Werther deems himself to be "crazy" yet is still resistant to saying that he has "Melancholy," as though that were a worse state. Readers see depression less as a disease and more as a toxin, something they should resist admitting to.

This resistance is similarly depicted through other works as the stigma around depression is revealed. The stigma around depression is something that becomes easier to understand in fictional works than in clinical sources. Clinicians will focus on the disease as a whole and therefore

reveal how society would see the disease, whether in terms of "madness" or in being a "depressive reaction." However, an aspect it does not explore is how this established stigma affects the lives of depressed patients personally. The need to evoke sympathy requires that instead of giving a broad generalization, fiction uses focused characters or events as representational for larger ideas. By detailing specific narratives, such as "Ward No. 6," fiction as a genre can demonstrate how society views depression and therefore how they will treat depressed patients because of this. Similarly, Ester in *The Bell Jar*, reveals how this stigma affects patients' view of themselves and of each other. As a multitude of depressive symptoms are psychosomatic, understanding how a depressed person views the severity of their disease becomes vital. For the longest time Ester is resistant to saying that she is depressed, then even when she begins to accept her illness she sees the people around her in terms of a scale. When she considers her depression to be worse than others, she views herself in a certain way and the audience becomes privy to this viewpoint. Ester's baseline within this scale is dictated by her preconceived notion of depression and readers are given the same understanding as all information they receive comes from Ester. Simultaneously, as with *Norwegian Wood*, this fictitious illustration from the mind of a depressed patient helps readers to become intimately familiar with how patients stigmatize themselves or other patients.

While there are numerous advantages to how fiction approaches depression, there are also several drawbacks. Unlike clinical sources, it does not give a distinct definition of the disease nor ever strictly defines its symptoms. Therefore, that explanation is formed completely through interpretation. While the terminology used in clinical sources can affect readers' understanding, there is still a set of symptoms or causes that can be referred back to as being strictly "depression." In fictional sources, there are no such guidelines. Audiences must define the disease for themselves and each reader will have a different idea for symptoms, causes, and other normally objective aspects. How the reader understands depression is depicted by the genre's demands for the illness's presentation. The defining features of how fiction portrays the disease become increasingly clear when compared to the depiction of depression within the genre of creative non-fiction.

In its most basic definition, creative non-fiction is considered to be factual narrative. Clinical sources bear true information and their main purpose is to convey facts as unbiasedly as possible. Fiction is set apart due to its use of fictitious people and events. Creative non-fiction differs because, while based on true events, conveying factual information is not the main goal. In comparison to fiction, the personal accounts given are true events. For creative non-fiction, the narrator and the author are often the same being, as any use of the word "I" is the author discussing *their* experience, which actually occurred. As fictitious characters are not real, authors need to work to make their audience care about things that have never occurred. In comparison, there is a sense of automatic sympathy that results from personal accounts that have really occurred. It is much easier to invest in something that actually happened than something that did not. Therefore, the goal does not become creating sympathy in general but to evoke a certain amount or type for specific things. How authors write their piece will then be based upon manipulating the sympathy and not generating it.

Consider how the genres deal with time differently. Fiction's need to work for sympathy results in stricter demands on how the story is portrayed. Often, writers will attempt to mimic reality in order to create an easier connection between the audience and characters. While creating imaginary events, having them being formatted in a timeline that is unnatural only creates a greater strain. Therefore, fictional authors will often use an organic timeline, a cause and effect way of dealing with time that is driven by character. This means that the decisions made by a character at event A will cause event B, and so on. Such events are also normally presented in chronological order. The character is the driving force as it is his or her decisions leading the story, such as the infamous *Romeo and Juliet*. How the characters chose to behave, have a cause and effect reaction that leads to the next event. For instance, when Juliet's cousin kills Romeo's dear friend, Romeo makes the choice to kill her cousin. This would be event A, an event that was driven by the character's decision. Event B is what happens because of this decision. In *Romeo and Juliet*, event B is that Romeo is banished from the kingdom and Juliet's family means to marry her off to another. Her decision at this point, either to marry another or to remain loyal to Romeo,

then lead to the next event. Event C is her decision to fake her death. These events, driven by the character's decisions, then lead to the eventual death of both Romeo and Juliet.

In contrast, creative non-fiction requires less work to establish an interest in their characters, resulting in more flexibility in terms of the rules of time. Therefore, in creative nonfiction, it is not necessarily the chronology of the events that bears importance but the events themselves. Over a period of time the author may choose any scene that works towards the main purpose, often including things such as general factual information, other people's accounts, and their own experiences. This is an episodic timeline. The piece does not need to include all information or be told in order; instead events A, B, and C need not build upon one another nor be given in order. This way of dealing with time is also dictated by the events acting upon the character, versus the character driving the events. So, in *Romeo and Juliet*, consider if there were an earthquake that had separated the lovers instead of Romeo's actions. An event beyond their control would be acting upon them. At this point, their separation being event B in the previous example, there was no event A causing this to happen. No decision either character could have made would have caused or prevented an earthquake from occurring. How they respond to the earthquake will then become the personal account depicted. One simple way to establish the difference between organic and episodic is to ask the following question: "Do the events create the character or does the character cause the events?" In terms of this study, however, the event is clinical depression and therefore the question becomes "Does the depression create the character or does the character cause the depression?" The answer to this question will depend in part upon the genre in which the author is writing. Then the difference between these two answers defines one of the major debates surrounding depression – if it is voluntary or involuntary.

From Burton's "Imagination" overpowering the sense to Freudian's "belief" causing their symptoms the notion that depression is the fault of the patient has been consistently brought up throughout the clinical literature of depression. However, neither source explicitly states that this is the only and direct cause, leaving much ambiguity around the origin of the disease. The debate around the cause of depression

continues today as even the DSM is meant specifically for diagnostic purposes only, it does not discuss causes. The first manual even labeled depression or "depressive response" at that time, as being one of the many "Disorders of psychogenic origin or without clearly defined physical cause or structural change in the brain" (24). This overall heading tells readers that there is no clear cause for depression; however, by the very nature of disease this becomes a difficult concept to accept. A patient has three main questions on his or her mind when presented with an illness: what is it, how do I cure it, and *how did I get it?* As society understands illness, in order to exist there must be a logical explanation as to how it came into existence. However, debates upon depression throughout history have made it clear that while the symptoms may be objective, the cause has numerous possibilities. Without this portion of the cause and effects of the disease, not a single medical authority can pinpoint a complete definition of depression. Therefore to the general population, who is looking to find a reason for an increasingly common disease, there is no cause. In the face of a lack of cause, the only way to answer the question of causality is to assign blame – if there is nothing making these patients depressed then they must be doing it to themselves.

The way other literary sources present depression may unintentionally lead the audience to one supposed cause over another. However, the demands of each genre lead authors to make certain decisions that can affect the outcome of this impression. In determining whether to use an organic or an episodic timeline, authors may unintentionally give the impression of the disease as being involuntary or voluntary. With the case of *Romeo and Juliet*, the use of an organic timeline means that Romeo's decision to kill Juliet's cousin is what separated them. In this timeline, it can be inferred that it is Romeo's fault that they cannot be together and therefore that they both die. An audience can read this story and point fingers. In an episodic timeline, where an earthquake separated Romeo and Juliet, the characters are not to blame for this separation; instead it was something beyond their control affecting them. Therefore, imagine if the event in question were not two characters being separated but one character being depressed. An organic timeline implies it is the characters fault while an episodic one does not. In fiction, the demand to sustain the audience's interest means

that authors often attempt to mimic reality. Depression, as a disease without a cause, is not a familiar concept to most readers. To make it more comprehensible, authors present it in terms audiences can understand – such as a rejection or a series of stresses in the character's life. Werther's depression is a valid disease that allows the author to discuss many things such as love and suicide. However, in the story his symptoms are based upon his obsession with, and rejection by, a woman named Charlotte. Similarly, Ester is met with a series of failures such as dropping out of school and not being accepted to a writing course she had wanted. Dr. Ragin also becomes disillusioned with his job before being met with serious life questions. From these fictional stories it can be interpreted that these specific events evoked a reaction in the form of depression; therefore, the organic timeline implies that their depression is a voluntary disease.

Creative non-fiction in comparison is able to jump around within the timeline and does not require an organic reasoning behind each event. *Darkness Visible* by William Styron, for instance is an example of how the author will manipulate the timeline. The piece begins at a point farther along in Styron's depression but quickly opens up to a broader discussion on the disease as a whole, bringing in the voices of other authors and people within his life. The rest of Styron's work continues in this manner, jumping between the author's personal narrative to instances described to him by other people, to factual information, and to other sources. Readers cannot pinpoint a specific event that leads to his depression, as the author cannot do so either. To Styron, the events he chooses to depict are those most important to his work. For instance, when Styron discusses the topic of suicide he uses examples of others barely in relation to him, such as an acquaintance or the public figure Randall Jarrell, instead of his own experiences. If working through a chronological timeline, suicide would have only been brought up when Styron had experiences with it in his own life and then would exclude the factual information. Information on its own is not a portion of the cause and effect organic timeline; instead it stands on its own separately. Therefore, a statement such as "clinical manifestation takes upward of twenty percent of its victims by way of suicide" (35) would not be included. However, without this percentage, the relationship between depression and suicide becomes less clear. If he worked merely

within his own narrative, Styron would not have been aware of these facts; only by using an episodic timeline is he able to give the audience a wider view of the disease.

Styron uses a multitude of information gathered beyond his narrative. While a portion of the story is about his experiences, the inclusion of factual information and others' accounts greatly alters the story. There is a significant amount of time between when Styron is going through his depression and when he is able to write about it, resulting in many alterations to the story. One way to understand these changes is to compare the genre with fiction. The focus in fiction is within the moment of a specific character, drawing the readers into an account as though they were living in the moment. The audience is enveloped in the emotions and thoughts of one individual. Memory, meaning, and overall impressions presented in the story are therefore clouded by the biased created from the character at the height of their emotions. For a depressed character, this means the psychosomatic symptoms such as sadness, emptiness, hopelessness, worthlessness, guilt, diminished ability to think, and others are affecting the story that they tell. With the character's ability to think clearly or function properly being compromised, so is their ability to relay his or her stories. Instead it shall be filtered through the lens of their emotions and readers will assuredly receive a biased point of view, preventing a clear, complete picture of the disease.

Consider how the symptom of self-loathing will affect patients' ability to clearly discuss their disease with the audience. Self-hatred is common throughout all pieces of this study, whether experienced by the narrator or other characters with depression. In *Norwegian Wood*, Naoko once compares herself to her roommate and says "I sometimes hate myself when I'm watching her. I haven't got one single thing I'm really good at!" (235). Here the narrator is Toru and he can assert to readers whether this statement is true or merely a figment of Naoko's depression. He will praise Naoko's kindness, her beauty, and other aspects that she, in her self-hate, could never properly relay. However, including *Norwegian Wood*, the fictional sources examined in this study are all told by a character that is depressed. For instance, the depression Dr. Ragin from "Ward No. 6," experiences combined with his disgust in the hospital leads him to state, "I serve a harmful cause, and I receive a salary from the people I deceive. I

am dishonest. But by myself I'm nothing" (190). As the story is told within the height of such symptom fueled emotions, the characters are unable to separate themselves from their episode of depression. Therefore, the demands of fiction as a genre limit the audience's view of depression

In comparison, creative non-fiction by nature requires that time passes between these episodes and writing the piece. Styron specifically uses this time to research his topic, bringing in others' accounts and factual information; however, even without drawing in other sources the piece changes purely through reflection. As the author is no longer within the height of emotion, he or she can see the events that have passed more clearly, resulting in the reflective "I." *The Prison of My Mind* is a first person account by Benzinger who uses this reflective "I" to tell her piece. Throughout her work, she is often looking ahead or behind her in terms of how that affects her in the present moment she is describing. The result is that her emotions become more nonsensical while simultaneously being more understandable. In her opening chapter, giving a generalized view of her questions and thoughts on the disease, she wonders "what kind of factors in my life had pushed me this far?" (8). Readers are then given portions of childhood as evidence that she had gathered calmly after her episode had finished. She is able to give the audience a tangible start to her depression in a way she could not have done while experiencing her depressive symptoms. However, she still cannot justify specific episodes in the way she can explain her overall disease. Therefore, she still describes those feelings as being illogical and out of place. Her confusion becomes even more evident after she is able to look back upon her disease. In the midst of an episode, reasoning behind the emotions is a lesser concern for the patient than is the cure. On the other hand, when at a slightly more manageable state between episodes where Benzinger actually wrote her piece, she was able to look back upon her actions and recognize the obscurity and lack of knowledge in the entire situation.

In *Darkness Visible* by William Styron the effects of point of view becomes increasingly evident as readers can see the distinction between vocabulary of depression and how fictional characters discuss the same topics. Styron discusses his own experiences through additional factual information and third party accounts. One prominent aspect of

identity vocabulary practiced in fictional sources is the use of extremes such as “always” and “never.” In the midst of her depression, Naoko from *Norwegian Wood* says she “might never recover” (146) from her disease. Here, the symptoms of hopelessness and worthlessness become overwhelming, resulting in a warped sense of time. Characters are unable to pinpoint a beginning to their disease and in their despair cannot fathom an end. However, Styron’s work is characterized by nearly excessive variations of “seem” or “mostly.” Once beyond his episode of depression, he no longer assumes that there is no end to the disease and can look upon the events of his episode with a clear mind. Instead of everything guaranteed, which is an unrealistic concept in and of itself, there is a sense of ambiguity or uncertainty that Styron must account for in order to maintain his credibility as a creative non-fiction writer. In these instances, the point of view may still be first person; however, the narrator has a greater sense of clarity of their situation. The additional information they have gathered affects not only their understanding of the disease as a whole, but how they see their own experiences now that they are past their episodes.

In *Darkness Visible*, the ability to reflect upon the events that have passed gives Styron greater clarity of his work. He does not describe things in extremes of the moment but instead focuses on the larger picture, one that encompasses more than just his own story. By using an episodic timeline, Styron is able to choose the events he deems the most important to his piece rather than being focused on the cause and effect aspects of his specific experiences. *The Prison of My Mind* also works in a similar fashion, with the reflective “I” and the episodic timeline having a significant effect on what the readers will see. Due to the genre demands of creative non-fiction, the audience is able to gain a larger view of the overall picture. However, the use of such tools also results in a certain amount of loss. For instance, consider *The Prison of My Mind*. When Benzinger is discussing her stay in the hospital she brings up the fact that her husband had left her alone. Near this point, the audience is also made aware that her husband will soon become her ex-husband. The fore-knowledge of this event takes away the strain that the actual separation must have had on Benzinger to begin with. The ability to reflect upon her life has lessened some of the immediacy of her problem. Similarly, when characters are consistently using identity language such as

“always” or “never,” the situation becomes much more extreme. As Styron is able to reflect upon the events he experienced while not in the height of his depression, the extremity is lessened in his descriptions and therefore in the minds of readers.

While presenting a larger picture of the disease, creative non-fiction authors will lose an amount of tension around their description of depression. In a similar fashion, fiction writers are better able to communicate the intensity of the disease but lose a portion of the picture through the need to focus on a more individualized account. In contrast to both of these genres, clinical sources are able to give a more objective, wider view of the disease through a generalized perspective. To do this, there is a lack of specialization that prevents the readers from becoming closely connected to the disease through personal accounts. As a piece that skirts the line between genres, *The Noonday Demon* is one piece that can assist in demonstrating the differences between them. The work is largely based on factual information, discussing things such as history and politics while backing up major points with statistics. In this way, the design of the document is similar to clinical sources. Unlike the DSM, it is not based on strictly facts. Instead there is the inclusion of narrative as Styron depicts his own accounts as well as others’ personal experiences. This makes the piece greatly align with the demands of being a creative non-fiction piece.

The result is that the book is labeled as creative non-fiction, though this nomenclature does not necessarily encompass all aspects of Styron’s works. In classifying the story as only being one or the other, the novel automatically loses something that it would have had if it were labeled different. Becoming a clinical source would mean that *The Noonday Demon* would have more authority on the disease, but it would likely eliminate the usage of first person accounts. Being defined as fiction would provide intensity to his descriptions, and in order to produce this Styron would be forced to remove a majority of his factual information in order to stay in the moment. It would also completely eliminate the validity of his source, being that everything in his novel would be considered fictitious if even just one part of it were untrue. The result of the final label being creative non-fiction means that Styron is able to include all portions of his final manuscript. In the end, the loss

of validity or intensity was an acceptable trade for him to make in his personal piece. If he had picked a different genre in which to publish, Styron’s depiction of depression would have been greatly altered, and so would readers’ perception of the disease.

If we return to the blog, *Hyperbole and a Half*, readers will see the effectiveness of this piece within its genre. Not only does it discuss many differing but prominent aspects within the disease, but the additional use of imagery adds a significant amount of empathy to the work. The audience is a face to which they can assign these specific events to, where in even other creative non-fiction source they will merely be given a name. The inclusion of comics increases the emotional intimacy created from narrative. Simultaneously, Allie Brosch effectively uses the episodic timeline to best manipulate her time to better express her depression. However, even within this piece readers are only receiving one view of the disease. Without the objective study of the disease as presented within clinical sources readers will not fully understand the terminology surrounding depression. Also, the nature of creative non-fiction to allow Allie to reflect upon the events that have occurred also allows for a greater emotional distance between the disease and readers than would appear in a fictitious piece.

Each individual genre has its limitations. Though able to depict depression with a greater understanding in one aspect, defining a disease based upon one genre will only allow one perspective. Depending on which genre the author writes in, it will change how depression is depicted. Point of view is constantly in flux between genres and authors, allowing for the reader to receive a different perspective each time. It is only by understanding the effect of this depiction as well as studying all genres consecutively that readers and writers would be able to understand depression as a whole.

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