Malevolent, Mad or Merely Human: Representations of the 'Psy' Professional in English, American and Irish Fiction

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I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

Signature……

Abstract

This work draws attention to the widespread, damaging, cultural depictions of psychiatrists and allied (or 'psy') professionals. I first explore the frequent presence of these specialists in such artefacts as horror fiction, literary novels, detective fiction, movies, comics with their related films and video games, asylum-based entertainments and cartoons. Close analysis of four representative novels will form the main body of this thesis, each fiction being set in a significant stage within the relevant historical treatment of the mad between 1946 and 2008. In this way, I shall demonstrate how fear and distrust of 'psy' professionals pervades anglophone fiction. I shall show how the overwhelming number of negative portrayals greatly outweighs positive depictions. I suggest this can lead to a problematic response to the 'psy' professions from prospective and current patients and the general population. Broad internet searches of patients' reactions will show that fear of seeing a psychiatrist is a common reaction. I shall consider the widespread concern, evidenced in scholarly journals, among 'psy' professionals about the negative perception of their role and work, noting that distrust and denigration of 'psy' practitioners is also apparent among medical colleagues and students, with a resulting problem of low recruitment to this specialty. I shall suggest that the roots of this suspicion lie in the pervasive cultural fear of madness, Anti-Semitism and the persistent notion that psychiatry and allied professions are pseudo-scientific, unlike other medical disciplines. Using historical examples, I shall demonstrate that the 'psy' professions are tainted by historical treatment failures and rogue professionals in ways that do not occur elsewhere in medicine. While 'psy' professionals are generally less transparent (for reasons including confidentiality) than other medical specialists, they face vociferous criticism from within their own ranks, especially on the internet. This thesis will promote an understanding of the injurious negative place 'psy' professionals hold in our culture.

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Preface

Identified as a psychiatric patient all my adult life, my experiences have shaped my academic interests as well as my day-to-day interactions. I have been incarcerated in county asylums while detained under the Mental Health Act. I have been subject to courses of electroconvulsive treatment and have spent weeks and months in various locked wards and open wards, as well as punishment time in a padded cell. I have been prescribed and have taken a vast range of medication, some of which was helpful although most was not. In addition, I lived for almost a year in a therapeutic community (TC) at Bethlem Royal Hospital in the mid 1970s. Twenty-three years of psychotherapy from the mid 1980s onwards made my continued existence possible. The anger and dismay - and also gratitude for good treatment - that these experiences aroused have prompted me to transform interesting experience into academic study.

It has been informative both to take advantage of the right to see one's own case notes and to consider how this access may be limited if deemed to be damaging to the patient (*Rethink Mental Illness*). Requesting my own case notes from my GP surgery produced an edited, seemingly random array of 278 papers dating back to 1973 (South Molton Medical Centre). These notes judgmentally describe me as "angry", "withdrawn" and "inadequate". Such qualities might usefully be compared with the limited judgment of "unable to write" applied to a patient with a broken wrist. Unfortunately, these qualitive judgments about my mental illness were used in a quantitative, actuarial way when I was refused life insurance after my husband's death, when I was the sole, unemployed carer for our 5-year-old child (South Molton Medical Centre, letter to GP from C, M & G Insurance). Along with my life-long difficulty in getting work, this insurance refusal is an example of the damaging financial consequences of having been treated for mental illness.

In the 1970s I started to read novels which presented the lives of mentally ill characters. I was, in part, searching for accounts of similar illnesses and treatments to my own. However, it became evident to me that psychiatric patients - who were silenced in the real world - could have powerful voices in fiction. In addition, I began to read some of the texts of psychiatry and anti-

psychiatry. This background has had a significant influence on my current research.

Fiction has a great deal to offer to the exploration of psychiatric illness, enabling patients' points of view to dominate texts. Indeed, even the silent and silenced catatonic can have a loud voice in fiction.[1] As a result, novels can provide alternative narratives to those versions of mental illness contained within the case notes, specialist journals and books which professionals use to communicate with each other about those of us who are ill. Importantly, fiction is available to us all, while case notes, until recently, remained largely closed to patients and general readers.[2] The primary focus of this thesis is the fictional representation of what I shall call the 'psy' professional.[3] This group includes the psychiatrist, psychoanalyst, psychologist and psychotherapist: in sum, those professionals on whom patients rely for help when in distress. If the mad patient has long been the subject of social stigma, it must be noted that the 'psy' professional is usually dealt with severely in fiction. The influence of fiction and other popular cultural artefacts on the relationships between psychiatric patients and professionals offering care is of considerable importance to all of us who are either patients or therapists. It is also significant that it is fiction that puts the reader in a similar position to that of therapist decoding the 'text' that is the patient's account of her problem. Psychotherapy guides and informs the reading of such novels.

I open this thesis with background information since I acknowledge in my approach the related work of autoethnographers who see value in "describ[ing] and systematically analyz[ing] personal experience in order to understand cultural experience" (Ellis *et al*, "Autoethnography" 273). Autoethnography allows researchers to work with "insider knowledge . . . [and] use *personal*

[1] See Paul Sayer's *The Comforts of Madness* (1985).
[2] While patients have the right of access to their own medical records, in practice little information may be revealed. According to advice from the British Medical Association, the Data Protection Act 2018 "prohibits the retention of personal data for longer than is necessary" (*British Medical Association*). My research has evidenced that most of my in-patient medical records have been destroyed.
[3] Throughout this thesis I use the term "'psy' professional" to denote the whole range of those whose work involves caring for the mentally ill. While I am fully aware that practitioners of various therapies are very careful about making distinctions between psychiatrist/psychologist/psychoanalyst/psychotherapist and the sub-groups therein, these divisions are often blurred in public perception. This makes a 'catch-all' term useful here.

experience to create nuanced and detailed . . . [descriptions] of *cultural* experience to facilitate understanding of those experiences" (Jones *et al* 33). Researcher and writer Carolyn Ellis describes how an autoethnographic approach can put the researcher in a vulnerable position so that "[it's] hard not to feel your life is being critiqued as well as your work" (Ellis, *Heartful* 672). Indeed, autoethnography has much in common with fiction, containing narratives that are acknowledged as always "partial, contingent, and constituted in and mediated by discourse" (Jones *et al* 26). Arthur Frank notes in *The Wounded Storyteller* (1995) the importance of reflecting on our stories of illness. Access to accounts of the illnesses of others may allow the reader to review, and even reshape, her own illness narrative. In autoethnography, a major part of the process is to "present an intentionally vulnerable subject. . . . Secrets are disclosed and histories are made *known*" (Jones *et al* 24). At the same time, attention is drawn to others who "endure in silence and shame" (Jones *et al* 24). This autoethnographic approach has influenced my choice of fiction discussed in this thesis: I have chosen works that illuminate my own experiences, as well as those of the wider constituency of the mad. At times, I shall also refer to texts I have put in the public domain, rejecting the shelter of pseudonym or anonymity.[4]

However, the discussion of my chosen texts is set firmly within the confines of literary analysis, and exploration of the historical settings of treatments and hospitals involved in these novels is limited to the scholarly. I see my personal links with the subject-matter of these texts as a means of bringing the literature of madness forward in order to shed light on the fictional portrayal of the 'psy' professional. It is also of considerable importance to me that the contents of these madness fictions be discussed openly, liberated from the secrecy that has often surrounded psychiatric conditions.[5] While mental

[4] Hopson, J, and J Holmes. "Through the Wasteland: Chronic Depression." Hopson, J. "Patients, Psychiatrists and Stigma"; "The Stigma of Mental Illness: Representations in Cultural Artefacts"; "First Person Narratives: One Good Year Part 1; and First Person Narratives, One Good Year, Part 2"; "Psychiatric Stigma," Exeter PGR Conference 2016; and "Not Dying: Scattered Episodes".

[5] Note how fictions were often published under pseudonyms. Sylvia Plath's *The Bell Jar* was originally published under the name Victoria Lucas in 1963, and Joanne Greenberg used the pen name Hannah Green in 1964 when *I Never Promised You a Rose Garden* was published. Madness narratives by former patients are often anonymous and offered as stories of recovery, the madness of these writers being placed firmly in the past (Hornstein, *Bibliography*). This suggests that shame surrounds confessing to mental illness.

illness may wound us, it does not need to attract the social shame that has usually surrounded it.

A note on selected vocabulary

The evasive spin on psychiatric illness contained in the common descriptor “mental health” is of interest. Discussing other conditions, we are much more likely to use plain direct terms, such as “stroke”, “diabetes” or “cancer”. In this thesis I shall frequently refer to mental illness as “madness”. The term “mad” is now usually rejected by those professionals who discuss patients. However, it is shorter, more deeply rooted in our vocabulary, widely understood and includes more verbal resonances than any of the awkwardly prevaricating terms such as “having mental health problems”. Additionally, a vast range of inventive vocabulary, too long to enumerate here, is used by members of the public to refer to the mad. Such epithets tend to be offensive. I do not believe it is helpful to use politically contrived language in discussion of fictions of madness: the works I shall discuss are not novels of “mental health”. It is of note that Nottingham University had an important project called “Madness and Literature”; that the new academic discipline of “Mad Studies” has found a place in some universities alongside disability studies; and that a significant critical psychiatry presence online is called “Mad in America”. If further justification of the term “mad” is needed, I ask the reader to substitute Shakespeare’s chilling words, spoken by King Lear, “Let me not be mad, sweet heaven, not mad!” (*Lr*, I.5.43-44) with the alternative and bathetic, “Let me not have mental health issues, sweet heaven, not mental health issues!”

CHAPTER ONE: Madness and Culture

SECTION 1: An introduction to the terrifying taboo of madness and the cultural fascination with insanity and its treatment

"King Lear and Fool in a Storm" (Dalziel 163)

"O let me not be mad, sweet heaven, not mad!"
(Shakespeare, *Lr*, I.5.43-44)

The loss of reason that is called madness is among the greatest of human fears. It is reason that has historically been considered the quality which dignifies humanity and separates us from beasts. The causes of insanity, its cultural perceptions and the social responses to the disordered mind have consistently intrigued and engaged writers of science, philosophy and literature.[6] Insanity has been seen as "medical, or moral, or religious, or, indeed, Satanic" (Porter *Madmen* 9). Historically, the treatment of the mad has been associated with magic, incarceration, moral management, psychoanalysis, warehouse-asylums, physical treatments (such as water treatments, electricity, germ therapies, insulin shock, organ removal and lobotomy), therapeutic communities, care in the community, big pharma, neuroscience, electronic apps (Nichols) and online regimens for patient use. This thesis will consider some of these treatments as it discusses the depictions of those who treat the mad: the mad-doctors, alienists and the modern range of 'psy' professionals in the twentieth and twenty-first centuries.

In this thesis, I aim to intervene in the scholarship on the public perception of the 'psy' professional. To do this, I consider fiction as a major source of the negative images of this figure. The scholarly writing that is currently published on this topic is overwhelmingly produced by the 'psy' professions themselves in specialist journals which are read by their peers. Such articles focus on serious concerns about what the professions might do to improve their public perception. However, the limited access to such journals means that this writing fails to contribute to popular cultural conceptions of the psychiatrist and his/her colleagues. This work intends to draw the attention of both readers and the professions to the much more accessible cultural artefacts of fiction, film and the media which inform the general public about how our society views the 'psy' professional. Moving this discussion into literary scholarship draws attention to the cultural impact of the 'psy' professional's frequent depiction in fiction as evil. My intention is to provoke wider discussion and critical thinking about the vilification of the 'psy' professional in widespread cultural representations.

[6] See Harris, *Mental Disorders in the Classical World* (2013) on works by Galen, Plato, Hippocrates and Aristotle. Later works of note include Erasmus' *The Praise of Folly* (1511) and Burton's *Anatomy of Melancholy* (1621).

Insanity has not only proved fascinating to intellectuals but has also provided enduring popular entertainment, from tourist visits to Bethlem Hospital (Routledge) to contemporary computer games set in mental asylums. The vast body of work by Sigmund Freud (1856-1839) has had great influence in the Western world on conceptions of the nature of the mind and its malfunctioning. Fiction - both literary and popular - with its ability to reorder time, change point of view, privilege material as significant for its narrative and present the inner world of characters, including those with mental disorders, has profited from the growing elaboration of theories of the mind. Indeed, the novel has much in common with psychoanalysis, in which relevant information is retrieved and structured to establish a meaningful narrative. Fiction, with its infinite variety of form, presents widely consumed, complex representations of human experience, including those of madness and its treatment.

The group of healers and carers who treat the mad has been culturally tainted, in part by its association with insanity. This thesis will consider how the 'psy' professional has been frequently demonised in fiction and will attempt to discover why this has happened. This is a matter of considerable importance to professionals and patients alike. If psychiatric care is to be readily sought and effectively offered and received, patients need to understand that psychiatrists and allied carers are there to help not punish. On the other hand, it is vital for the professionals to understand that fear is a common experience for the prospective 'psy' patient. This work will explore how the 'psy' professional has been depicted in cultural artefacts, with an emphasis on literary fiction. It will show how this group of healers - unlike those in any other medical field - has been vilified so that a 'psy' professional in a novel or film is frequently a cipher for evil.

Focusing on four representative novels, my analysis will be set in the context of the wider field of cultural representations of 'psy' professionals in literary and popular fiction, films, comics, cartoons, games and internet discussions explored in this introductory chapter. I shall show how a profoundly negative view pervades the majority of our cultural representations of this group, with the resulting fear of psychiatry and allied disciplines. Our cultural artefacts overwhelmingly tell us these professionals are manipulative abusers,

sometimes torturers or murderers and perpetrators of sexual exploitation. Often they are depicted as insane themselves or shown as charlatans, relieving patients of large sums of money in exchange for spurious, pseudo-scientific treatment which offers no alleviation from suffering. Unsurprisingly, the response to this is often a terror of psychiatrists.

My approach in this thesis is historicist, moving through specific English, American and Irish fictions concerning mental illness care from 1946 to 2008. It will become apparent that each historical setting - overcrowded warehouse asylums, therapeutic communities, hospitals for the criminally insane and the promises of decarceration - retains its largely negative view of the 'psy' professions. There will, however, be a glimmer of hope as I conclude this thesis for, while the obsession with the terrors of the screen asylum in horror movies remains strong (Langley), there are emerging portrayals of 'psy' professional help in a few television series in particular that show psychiatry working to help patients. I shall further note that journals which publish research on psy-related material are making tentative steps to become more open, so that specialised material published may be accessed by patients and no longer only reflects 'psy' professionals talking to other 'psy' professionals, protected from the gaze of the patient.[7] I shall further conclude that members of the 'psy' professions need to talk openly to the interested public and patients and not have exclusive interchanges of research and opinion among themselves.

In-depth analyses of four representative literary fictions from England, Ireland and the United States of America, published between 1946 and 2008, form the main body of this work. My selected texts are Mary Jane Ward's *The Snake Pit* (1946), Penelope Mortimer's *Long Distance* (1974), Patrick McGrath's *Asylum* (1997) and Sebastian Barry's *The Secret Scripture* (2008). I have chosen these fictions as each is set in a crucially significant time in the history of psychiatric treatment in England, America or Ireland. Ward's novel is

[7] *World Pscyhiatry*, *PsyArt Journal* and *General Pscyhiatry* are examples of journals with free access for all readers. Other publishers of research such as *Acta Psychiatrica Scandinavica, History of Pscyhiatry*, *Bulletin of the Menninger Clinic* and *British Journal of Psychotherapy* have no open access articles at all, while journals such as *Archives of Psychiatric Nursing, Mental Health Practice*, *JAMA Psychiatry* and *Issues in Mental Health Nursing* have 0.53%, 6.48% and 9.47% open access articles respectively (*Researcher*). The *BJPsych* has 31.95% open access, although patients may apply to read individual papers.

narrated by a confused, mad protagonist who moves to recovery in spite of her psychiatric treatment. This work covers the barbaric treatment frequently experienced by patients in the old, overcrowded asylums on the eve of reform when, in the USA, the National Mental Health Act of 1946 was passed and the National Institute of Mental Health was established to carry out research (79th US Congress; "National Institute of"). Ward's psychiatrists are cavalier and punitive. Mortimer's *Long Distance* reveals treatment within a UK therapeutic community (TC), the relatively short-lived, mid twentieth century experiment in patient care involving both inmates and staff and using all 24 hours of the day as material for therapy. While I adopt a non-standard reading of this fiction, arguing for its TC setting, I observe that it is narrated by an insane inmate who moves further into madness as the novel ends. *Long Distance* also shows the patient's confusion and inability to locate the psychiatrist and therefore find help within this less punitive but also much less structured setting. McGrath's *Asylum* is set during the period of change in UK law as the British Mental Health Act 1959 (Parliament of the UK 1959) introduces important ramifications for the criminally insane. This novel presents the reader with the task of deciding whose story is being presented, and by whom. McGrath's psychiatrist is a self-centred, manipulative, untrustworthy presenter of the stories of his patients, who are denied a voice. In *The Secret Scripture*, Barry presents two narratives. All information comes from the accounts of (sane) patient, Roseanne Clear, and (unbalanced) psychiatrist, Dr Grene. Set at the time of decarceration, when the large asylums were due to close and move patients to receive care within the community, the Irish setting, with its violent history, is essential to the novel. Roseanne's lifelong presence in an asylum is a result of the punitive social and religious attitude to women's sexuality, not insanity. Dr Grene is a confused, ineffectual psychiatrist whose own narrative is one of recovery from childhood trauma. Each novel will be presented in a framework of the relevant history of psychiatric treatment in the country in which it is set.

SECTION 2: How contemporary culture sees the 'psy' professional

Before discussing my four representative fictions, I shall explore the broad context of British, American and Irish culture to discover ways in which the 'psy' professional is portrayed. The figure of the mental health professional

has figured increasingly in modern fiction throughout the twentieth and twenty-first centuries. Library catalogue sources and best-seller lists provide information about this steadily growing field. I have extracted data from the WorldCat database, presented in Appendix 1, which provides the largest, searchable catalogue of books held by libraries worldwide, although it is a rather blunt tool.[8] In each decade of the twentieth century until the 1930s, only one or two novels containing 'psy' professionals as significant characters were listed as published in WorldCat data. In the decade from 2000-2009, a total of 1893 such fictions were entered; and the decade ended 31 December 2019 had a total of 5232 relevant publications. The 'psy' professional seems to have become a literary trope. This thesis will analyse the role of this figure in novels and explore the overwhelmingly negative qualities associated with these fictional characters, thereby extending the limited scholarly literature on the depiction of the 'psy' professional in novels. Within my discussion, I shall attempt to arrive at an explanation for the remarkable place held in fiction by this group of healers.

It is worth noting here the existence of historically real 'psy' professional villains, their place in medical scandals and the subsequent tainting of 'psy' professionals in actuality and in fiction. Notable among these are the American, Dr Henry Cotton, obsessed with focal sepsis as the cause of madness, who removed teeth and organs from large numbers of asylum patients (Scull, *Madhouse*); psychoanalyst Cornelia B Wilbur's joint fabrication, with her patient "Sybil" and a journalist, of multiple personality disorder (Nathan); the sexual abuse of many patients over more than twenty years revealed by the *Kerr/Haslam Inquiry* in 2005 (*Kerr*; Kennedy); and the considerable press coverage of 'false memory syndrome' in the 1990s (Merskey). All of these instances were damning of 'psy' professionals and went on to taint this group of therapists. However, if we consider the general practitioner Harold Shipman, who killed more than 200 patients in over 23 years, it is notable that he was

[8] This data does not offer a definitive list of works published in the categories which I used as key words, these being psychiatry, psychiatrist, psychologist, psychotherapy, psychotherapist, psychoanalysis and psychoanalyst. Entries may be duplicated, bypassed by key word searches or misplaced by error. For example, Virginia Woolf's *Mrs Dalloway* (1925) does not appear under any of my search categories in its year of publication, while best-sellers, such as Ward's *The Snake Pit* (1946) and Fitzgerald's *Tender is the Night* (1934), were obviously easily identified by cataloguers as novels of psychoanalysis and psychiatry.

generally considered a rogue doctor, not a representative of his profession ("Harold").

I have chosen to use literature to explore the depiction of the 'psy' professional as an adversary of mental health, although I shall briefly discuss the presence of this figure in a variety of other cultural artefacts in this chapter.[9] Fiction is an ideal medium for the exploration of mental illness and its treatment. This is because of the novel's ability to harness a variety of narrative techniques, especially what Erich Kahler called the "inward turn". Fictional narratives are able to communicate the inner monologues of characters, including the oppressed and silenced mad. These accounts offer a stark contrast to the external descriptions of insane patients which make up case note files. The novelist's ability to manipulate point of view is also a vital aspect of fiction, allowing consumers of texts to receive a range of versions in a much more nuanced way than is possible in, for example, film. The novelist may impart a number of "*believed* realities" (Kahler 10), leaving the reader to decide where she may establish her own assessment of the text's 'realities'. The omniscient narrator of fiction no longer dominates the text and guides the reader. American literary academic Wayne C Booth importantly drew attention to unreliable narrators in *The Rhetoric of Fiction* (1961), noting how, when the reader discovers the narrator's fallibility, "the total effect of the work he relays to us is transformed" (158). Unreliable narrators may lead readers in surprising directions, and perceptions from the distorted point of view of madness are of obvious interest in this context.

Critic Peter Brooks notes the way in which we seek coherence in narrative, reading different incidents as "promises and annunciations" of final coherence ("Freud's Masterplot" 283). In an apparently disordered madness narrative, the form of chaos itself provides ultimate meaning which may only be comprehended as madness at the end of the work. This mirrors the role of the therapist with her patient, holding multiple interpretative possibilities until meaning is securely identified. The poet John Keats called this approach, which is often present in literature "negative capability". It involves invoking the

[9] I shall not fully explore film, which is a major area deserving of its own study. However, I shall discuss Anatole Litvak's film of Ward's *The Snake Pit* in Chapter 2.

reader's capacity and willingness to be in "uncertainties, Mysteries, doubts, without any irritable reaching after fact & reason" ("Letter to his brothers"). I shall draw frequent attention to the way the reader functions as a version of the psychotherapist, interpreting information presented in a chaotic manner and sequence by the mad fictional patient. For the reader of madness fictions, this interpretive enterprise produces an enhanced reader experience of puzzle-solving, as in detective fiction. Since the reader's role is to find meaning in the presentation of madness, this involves the withdrawal of the authority of the fictional 'psy' professional, whose task the reader is called on to undertake. When withdrawn as potential providers of coherence, the 'psy' professional's role is open to significant change, including that of seemingly brutal abuse via psychiatric treatments. In this way, fiction has both drawn on the historical fear and distrust of the 'psy' professional and has also invited the reader to use methods similar to 'psy' techniques in creating order from apparent textual chaos. This parallel of therapy and the reading of fictional madness narratives will be followed throughout the analyses of my chosen fictions.

In addition, the novel can also concern itself with the unstable nature of the awareness of time and it will become apparent in this thesis that notions of the timing of fictional events are crucial to the analysis of my chosen texts. Time for the mad is a slippery quantity and, once more, the reader may be co-opted by the writer to assume a role similar to that of the therapist in listening to the narrator in attempts to untangle what happens when, and according to whom. I shall focus on the concepts of time, structure and the ownership of narrative in discussions of my four chosen texts.

Although its main focus is literary fiction, this thesis will also note the extraordinary proliferation in popular culture of the figure of the 'psy' professional. These characters appear in films, horror fiction, games and comics, and are overwhelmingly depicted as villains. Occasionally they are presented as useless charlatans, and only rarely as concerned and competent medical professionals. In spite of the lack of respect shown to the 'psy' professions, I shall note the attempts of many of their number to harness

literature as a very useful aid to understanding human experience,[10] along with trying to improve the image of 'psy' professionals in wider society and encouraging recruitment to the professions.[11] The value of literature in 'psy' education and recruitment difficulties are topics I return to below. I shall also note the significant number of 'psy' professionals who have written fictions. Surprisingly, such works frequently involve 'psy' professional characters behaving very badly.[12] Novels written by patients offer an additional perspective, including both bad and, infrequently, good 'psy' professionals. Within this context, I shall consider in some detail the role of madness in society and the nature of shared stigma that attaches to patients and carers in this field. My wider cultural exploration of social perceptions of madness and its treatment as a health issue will provide further context for the close readings of my four chosen texts.

There are some obvious reasons for the negative reputation of 'psy' professionals which may be deduced from cultural contexts. Firstly, a psychiatric disorder is the only medical condition which allows these doctors to incarcerate patients and treat them against their will (Parliament of the UK *Mental Health Act 1983* 3; *Mental Health Act 2007* chap 12 2). Further, the history of psychiatric medicine suggests that diseases are constructed according to the "rise and fall of the medical discourses" of the period in which the professional is working (Haggett 22) rather than relying on clear scientific diagnoses. Disease is also shaped by the development of new medications which require conditions for which they may be prescribed (Horwitz qtd in Hagget 130). The various versions of the *Diagnostic and Statistical Manual of*

[10] A number of 'psy' professionals and other scholars have written papers encouraging the use of literature in 'psy' training. Examples are Oyebode's "Literature and Psychiatry" (2002), Evans' "Roles for Literature in Medical Education" (2003), Shem's "Psychiatry and Literature: A Relational Perspective" (1991) and Holmes' *Between Art and Science: Essays in Psychotherapy and Psychiatry* (1993) and "Can Poetry Help Us Become Better Psychiatrists?" (1996). Additionally, US physician and academic Rita Charon has written in "Literature and Ethical Medicine: Five Cases from Common Practice" (1996) that "literary methods help doctors and patients to achieve contextual understandings of singular human experiences" (Charon *et al* 243).

[11] See, for example, Bhugra *et al* (2015), Forbes (2017), Rajagopal *et al* (2004) and Davidson (1986). Bingham's early article, "What the Public Thinks of Psychiatry" (1951), shows that the need to improve psychiatry's public perception is perennial.

[12] Keith Ablow, Henry Bladon, R L Jannaway, Jeremy Leven, Robert M Lindner, Dinah Miller, Raj Persaud, Paul Sayer, Samuel Shem, Arthur Smukler, Frank Tallis, Sally Vickers, Allen Wheelis and Irvin D Yalom are all 'psy' professional/novelists. Some, such as Miller and Persaud, are keen to present a positive image of the professions, while others (notably Sayer and Wheelis) depict 'psy' professionals causing extreme distress to their patients.

Mental Disorders (DSM)[13] define these conditions, giving them authoritative status for the duration of the relevant manual (American Psychiatric Association). In the longer term, there is much evidence that various, briefly acclaimed treatments for mental disorders have failed. Some of these have been brutal and barbaric. The promises of, for example, moral management,[14] hydrotherapy and shock treatments[15] were not fulfilled. General respect for advances in surgery led to the crude and now discredited practices of psychosurgery.[16] The development of germ theory encouraged such erroneous notions as madness being caused by focal sepsis.[17] The increasingly scientific nature of medicine has produced a desensitisation at odds with the person-focused, interpretative requirements of 'psy' treatments.

In addition, the 'psy' disciplines have attracted more scholarly dispute than any other specialty. Micale and Porter observe of psychiatry that "in no branch of the history of science or medicine has there been less interpretive consensus" (4). While welcoming the huge growth in psychiatric research beginning in the latter half of the twentieth century, Allan Beveridge wrote in 2014 of the problems arising from a revisionist view of the discipline's progress. Beveridge considered that historians, unfamiliar with psychiatry but newly engaged in its study, had a "glib and negligent attitude" to patients, often portraying 'psy' professionals as "agents of social control" ("The History of Psychiatry: Personal Reflections" 79). Beveridge also noted the late twentieth century view of psychiatry as "primarily a neuroscientific discipline" (84) while, like many other 'psy' professionals, he supported the inclusion of the humanities in psychiatric training.

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[13] The current version is DSM 5 (2013). While UK 'psy' professionals tend to use World Health Organisation's International Classification of Diseases (ICD), the DSM carries considerable influence worldwide and has ignited much debate (Gornall), including discussions on whether psychiatric conditions are actually treatable diseases (Warme).

[14] The moral management regime was instituted in England by William Tuke and sought to treat psychiatric patients with humanity and respect, banishing the brutalities of earlier treatments. See Porter (*Madness* 104).

[15] Water treatments, including immersion in a warm or icy bath, have been used over a long period (Scull *Madness in Civilization* 363; Foucault 166-172). Shock treatments have included infecting patients with malaria, inducing insulin coma and administering electroconvulsive therapy.

[16] American psychiatrist, Walter Freeman, carried out thousands of lobotomies and made a film about the process (Freeman). Antonió Egas Moniz won the Nobel Prize in 1949 for developing this technique (Nobel).

[17] Andrew Scull's *Madhouse: A Tragic Tale of Megalomania and Modern Medicine* tells the horrific story of Dr Henry Cotton's experiments his patients.

The many historical failures of barbaric 'psy' treatments in Britain, Ireland and the United States referred to above seem to have influenced the general public's distrust of the 'psy' professions and this is reflected in a wide range of fictions which show considerable suspicion of this figure. The ever-expanding popularity of such novels appears to indicate the general hunger for an understanding of the mind and the ways in which its malfunctioning might be influenced by psychiatry and allied specialties.[18] At the same time, the historical brutality of various failed 'cures' for insanity has resulted in the establishment of a strong connection between madness, its treatment, and the genre of horror. It seems that fiction and the 'psy' disciplines are inextricably linked. This thesis will explore the ways in which fiction portrays the 'psy' professional as the adversary of mental health and why fear, horror and the 'psy' professions are so frequently associated in novels.

In order to establish the nature of the broad cultural representation of 'psy' professionals, I shall first consider representative works from a range of cultural artefacts that depict this group. This introduction will then go on to address the critical literature that discusses such portrayals. I shall start with a discussion of typical fictions which show 'psy' professionals as competent and caring, malign and abusive, useless charlatans or themselves insane. My intention here is to indicate the prevalence of particular depictions of 'psy' professionals in texts, as well as noting why such stereotypes might exist. My subsequent chapters, with their in-depth analysis of my four chosen fictions, all contain largely negative representations of 'psy' professionals.

There is a small number of novels which present the competent and benign 'psy' professional, dedicated to the care and cure of his/her patients, just like the vast majority of medical experts in other specialties. These fictions appear to be at odds with the general trend of vilifying 'psy' professionals in novels. A representative of this group is Joanne Greenberg's 1964 novel, *I Never Promised You a Rose Garden.*[19] Published under the pseudonym,

[18] Lisa Appignanesi notes the perennial fascination with insanity and its treatment in *Mad, Bad and Sad,* her historical analysis of women's madness.

[19] Other examples of positive portrayals of competent 'psy' professionals are found in Pat Barker's *The Regeneration Trilogy* (1991-5), in which the historical figure of W H Rivers is shown as a caring and effective psychiatrist, dealing with shell-shocked patients. Mary McCarthy's *The Company She Keeps* (1942) ends with a chapter narrating an extended

Hannah Green, this novel follows deeply disturbed, schizophrenic Deborah through her rigorously demanding treatment with Dr Fried. Deborah finally begins to emerge from her constructed fantasy world. However, she is left in the difficult position of the mental patient who is never fully accepted back into society, retaining the stigma of madness. Dr Fried is shown almost exclusively within the therapeutic setting. This novel was an account of Greenberg's own illness and treatment with the eminent Frieda Fromm-Reichmann and is an example of a recovery story, these being patient-authored narratives which more often occur as non-fiction, frequently intended to encourage other sufferers.[20]

It appears that novelists who write about competent 'psy' professionals frequently have an interest in representing 'psy' therapies as serious elements of medical practice, aimed at helping patients. However, literary fiction also depicts non-standard 'psy' professionals who offer valuable psychiatric help from outside accepted medical practice. Canadian novelist Robertson Davies' healer, Dr Jonathan Huller in *The Cunning Man* (1994), uses holistic methods to treat patients, is informed by Native American wisdom, and defines himself as a listener and observer (Davies 230-1). John Barth's outsider healer, the Doctor in *The End of the Road* (1958), is a Black practitioner who offers treatments such as "Informational Therapy", "Mythotherapy" and reading Sartre in an organisation called the "Farm" (Barth 80, 83, 86). The Doctor and Jonathan Huller are diminished in status because of their non-standard, albeit useful, methods as outsiders.

Far more common in fiction than the helpful, supportive therapist is the malign 'psy' professional, often working within an abusive institution. Novels containing such characters are to be found in literary fiction, crime thrillers and horror stories. In the latter group, it is assumed the reader will recognise that

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treatment as Dr James works therapeutically with Meg Sargent, thus consolidating the earlier chapters of the novel and showing how good therapy can produce a coherent life story. Daniel Menaker's 1998 novel, *The Treatment*, shows a grotesque, comic therapist who nevertheless makes useful interpretations for his patient. Greenberg, McCarthy and Menaker each present the therapist almost exclusively through the eyes of the patient, while Barker's Rivers is a fuller human being.

[20] Clifford Beers' *A Mind That Found Itself* (1908) and Barbara Taylor's *The Last Asylum* (2014) are examples of such recovery stories.

asylums and madness automatically predict terror.[21] I describe below an example of a fiction (*The Dice Man*) in which a 'psy' professional appears as a wicked abuser.

The Dice Man was published by George Cockcroft under the pseudonym Luke Rhinehart in 1971. Rhinehart is also the name of the 'psy' professional at the centre of this fiction. At the beginning of the novel, the analyst rolls a die to determine whether he should or should not rape his neighbour. Rhinehart has been dissatisfied with the "non-directive" therapy he has been offering, seeing the therapist as "passive, compassionate, non-interpretive, non-directing. More precisely, he resembles a redundant moron" (29). Extending dice-throwing to his treatment of patients, Rhinehart finds that sometimes his approach works and sometimes it doesn't. This, he concludes, is completely in line with established therapies. What is more, dice-throwing allows him to express freely what he feels about his patients: "You can imagine the joy with which I responded to the dice letting me call my patients sadists, idiots, bastards, sluts, cowards and latent cretins" (90). Throwing a die, in this therapist's view, allows him to abdicate the moral responsibility of the healer and to treat his work as a game. *The Dice Man* is an entertaining comedy, farcically describing terrible behaviour. Cockcroft's book became a cult classic, sidestepping the reality of abuse by 'psy' professionals by moving into comedy. The use of a comedic tone to depict the brutalities of 'psy' treatments frequently appears in fiction and I shall return to this later.

Other noteworthy fictions, selected from a large range of novels with malign 'psy' professionals, include Victoria Glendinning's *Electricity* (1995), with perhaps the most chilling statement by a fictional therapist, the nineteenth century psychiatrist, Bullingdon:

> Those little mad girls, all slack-bodied and soft, great eyes, perfect skin. Examining them. . . . You can imagine. Sometimes they scream. There was this little one with long dark hair, bright eyes, she would not speak. . . . Never let anyone touch her, so they brought her

[21] A few typical examples of 'psy' horror fictions are: *Massacre in the State Hospital*, U C Poika (2013), *Nuthouse*, Rick Ryan (2014), *Terror Asylum*, S J Mountford (2013), *Psychosis: Tales of Horror*, Matt Dymerski (2012), and Madeleine Roux's *The Asylum Novellas: The Scarlets, The Bone Artists, & The Warden* (2016).

> to me. She let me touch her. But she was rigid. She knew I wanted to rip her open to fuck her warm little guts. . . . (176)

This lascivious boasting about a terrible assault on a child shows this psychiatrist as monstrously self-serving, with no thought of the care of his patient.

Such depictions of the 'psy' professional as sexual abuser arouse much concern. 'Psy' treatments are usually conducted in privacy, often occur over a long period of time, and involve, as a necessity of aspects of the 'talking cure', a certain amount of intimacy in the therapist/client relationship. The research on sexual abuse by 'psy' professionals and other medics is troubling. It also contains some problematic biases, including the self-reporting of abusive relationships, the under-reporting of incidents, and failures to take action. Psychiatrist and academic, Glenn O Gabbard, notes that Freud himself warned against the dangers of sexual intimacy, observes that Jung was "overinvolved with [patient] Sabina Spielrein" and that Ernest Jones' common-law wife had been his patient ("Patient-Therapist" n p). While guidelines were produced for the "investigation and evaluation" of this problem in the US in 2006 ("Addressing Sexual Boundaries"), damaging abuse is both deemed to be widespread by many scholars and "thought to be grossly underreported" (E Brooks *et al* 59). Information gathering on the subject of sexual abuse has been problematic, a 2017 US paper noting that "[m]ost patient-victims [in all medical specialties] do not report sexual violations" and complaints were usually logged as "not applicable" (DuBois *et al* 2). In the UK, general practitioners treated such complaints as "gossip" (Kerr/Haslam 272 etc; Kennedy 204). A 2003 US paper which reports that "the overall incidence of these events is relatively low" relied on self-reported data, so its conclusion is of dubious value (Lamb *et al* 106). While we may conclude that significant sexual abuse in the 'psy' professions is present in both the US and UK, the data are not entirely persuasive, thanks to general perceptions of under-reporting, self-reporting of therapist infringements and failures in taking action.

Other examples of various patient abuses in literary fiction are found in Marge Piercy's *Woman on the Edge of Time* (1976),[22] Paul Sayer's *The Comforts of Madness* (1988),[23] William Gresham's *Nightmare Alley* (1946),[24] Graham Greene's *The Ministry of Fear* (1943),[25] Irvin Yalom's *Lying on the Couch* (1996)[26] and A M Homes' *In a Country of Mothers* (1994).[27] Crime thrillers are another rich source of depictions of evil fictional 'psy' professionals, including Thomas Harris's *Silence of the Lambs* (1988), with the terrifying psychiatrist/murderer, Hannibal Lecter, further widely popularised by the film (Demme).[28] Keith Ablow, psychiatrist and adviser on all matters psychiatric to Fox News, has produced a series of novels with a forensic psychiatrist whose attributes include several that society considers morally dubious.[29] John Katzenbach's gripping thriller *The Analyst* (2002) has a fiendishly evil 'psy' professional.[30]

A number of novels reveal terrible patient experiences in the institutions ruled exclusively by the 'psy' professionals: the asylums. It is notable that nurses and other employees in these institutions may also be presented as

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[22] Manipulative psychiatrists use Mexican women mental patients for experimental psychosurgery. As with Jacqueline Roy's novel *The Fat Lady Sings* (2000), Piercy's fiction is concerned with the poor mental health treatment of ethnic minorities.

[23] In this novel psychiatric nurse/author Paul Sayer uses fiction to give voice to a catatonic patient as he is taken through a series of appalling treatments. This fictional inner monologue offers an excellent example of a novel producing a narrative that could not exist in any other form.

[24] Psychiatrist, Dr Lillith Ritter, seduces a carnival worker and together they are able to defraud Ritter's patients, using cheap fairground tricks.

[25] Greene's novel includes a minor 'psy' professional character who silences patients in a secret psychiatric ward, using psychiatry as a means of ensuring the disappearance of politically dangerous individuals.

[26] Eminent American psychiatrist, Irvin D Yalom, has written some 'teaching' novels which focus on abuses by members of his profession. Examples are *Lying on the Couch* (1997) and *Love's Executioner* (1991). These apparently work by showing 'psy' professionals how *not* to behave.

[27] Psychologist Claire Roth becomes obsessed with her patient, Jody, believing her to be her own daughter, given up for adoption. The patient's life is seriously damaged by the 'psy' professional.

[28] Harris's monstrous criminal psychiatrist, Hannibal Lecter, has stunning powers of deduction, and is a violent murderer who eats his victims. Lecter's name suggests a facility we fear 'psy' professionals may possess: mind-reading. Further films using Harris's character are *Manhunter* (1986), *Red Dragon* (2002) and *Hannibal Rising (*2007). The TV series *Hannibal* (2013-15) confirms the popular appeal of Lecter.

[29] Ablow's crime novels present deeply flawed forsensic psychiatrist, Frank Clevenger, a user of cocaine and prostitutes. Ablow continues the practice of 'psy' professional novelists using 'psy' professional characters. These vary from the disreputable to the downright evil. See *Denial* (1998), *Compulsion* (2003) and *Psychopath* (2004). Interestingly, Ablow has now lost his license to practice psychiatry, following a series of sexual abuse allegations from "vulnerable female patients" (Bellafante).

[30] Katzenbach uses a plot motif commonly found in crime stories involving 'psy' professionals: a good 'psy' professional uses his skills to catch a second, criminally minded 'psy' professional.

punitive. It must be remembered, however, that all carers are directed in the administration of patient treatment by the powerful 'psy' professionals. Maggie O'Farrell's, *The Vanishing Act of Esme Lennox* (2007),[31] Ken Kesey's *One Flew Over the Cuckoo's Nest* (1973),[32] Clare Allan's *Poppy Shakespeare* (2006)[33] and Howard Reiss's *A Family Institution* (2011)[34] are all within this category, as is Mary Jane Ward's 1946 novel, *The Snake Pit,* to which I devote a chapter.

The fictions indicated above, showing the 'psy' professional as evil, manipulative and experimental, with no real concern for patients, seem to point to a cultural fear of psychiatrists and their colleagues. I shall discuss below the notion of fear in this context and its negative impact on how 'psy' professionals are portrayed.

Fiction may also present the 'psy' professional as useless, with no substantive help to offer to patients. Jeremy Leven's 1981 novel, *Creator*, introduces scientist, Harry Wolper, grieving inconsolably for the death of his wife. Harry has little time for 'psy' professionals and his disdain produces one of the most entertaining descriptions in fiction of this group of healers:

> I rank the psychiatrist as a scientist somewhere between the beginning astrologist and the novice soothsayer. I equate his techniques with those of the divining rod, his approach with the sophistication of the handwriting analyst, the palm reader, and the phrenologist…. For me, talking to a psychiatrist is like nailing myself into my own coffin, with the doctor, on whom I've called for help, lounging back in his armchair and dispassionately handing me the nails. (39)

[31] In this novel of a stolen life, the narrator's aunt, Esme, raped, pregnant and committed to an asylum at 16, is only discovered by her niece as the asylum is due to close, 61 years later.
[32] Made into a successful film with Jack Nicholson in 1975, patient McMurphy is punished with a lobotomy for failing to be submissive in an oppressive institution.
[33] In a doubly unfortunate setting, Poppy is a patient in a mental institution in a dystopia, where there is no hope and no help in working through the bureaucratic hell in which the mad find themselves.
[34] Narrator, Ira, finds his "aunt", Eva Portnoy, when he traces her after discovering her gravestone. Eva was institutionalised, lobotomised, raped by hospital janitor, gave birth and died inside Pilgrim State Hospital. Eva was, in fact, Ira's mother and he also finds his rapist father, Fred, still working as janitor.

Leven here comically characterises the psychiatrist as an impassive witness to the patient's suffering.[35] Such derision of the psychiatrist and his/her colleagues is commonplace in fiction, the 'psy' professional not being seen as a serious scientist but, rather, as a purveyor of "[m]eaningless [h]ocus [p]ocus" (Posen "Psych in Lit*"* n p). These 'psy' professionals have no helpful treatment to offer their patients and do not elicit the respect of readers. Six examples of such novels are referenced in the footnote below.[36] This fictional trend seems to indicate the fear that 'psy' professionals have, in reality, nothing to offer to alleviate mental distress, which is terrifying for those with lived experience of madness as well as for those without such personal exposure.

Another kind of 'psy' professional frequently in evidence in novels is the therapist who is insane himself. I have already discussed Luke Rhinehart, the 'psy' professional in *The Dice Man*, who is represented using cultural codes that mark him out as evil and also insane. I shall discuss below the possible madness, as well as his malign effect on his patients, of McGrath's psychiatrist, Dr Cleave, in the chapter devoted to *Asylum*. Stephen Curran's 2012 novel, *Visitor in Lunacy,*[37] and Bill Scheft's *Shrink Thyself* (2014) [38] both present mad 'psy' specialists. Muriel Spark's *Aiding and Abetting* (2000) also suggests the madness of the 'psy' professional;[39] and in my chapter on Sebastian Barry's

[35] Humour appears to offer a way of dealing with the taboo subject of madness, allowing writers to present 'psy' professionals as figures of fun, thus undercutting our fear of such individuals.
[36] a) Joyce MacIver's *The Frog Pond* (1962) describes the narrator's terrifying distress as she turns successively to six incompetent 'psy' professionals.
b) In *Portnoy's Complaint* (1969), Philip Roth's narrator gives a rambling, hilarious account of his life, addressed to 'psy' professional, Dr Spielvogel, who only speaks once, at the end of the novel, providing its "PUNCH LINE" (274).
c) Iris Murdoch's *The Sacred and Profane Love Machine* (1974) presents an ineffectual, untrained 'psy' professional with a chaotic, harmful private life. Murdoch chooses the profession of psychotherapist for a weak and vacillating character.
d) *The Fat Lady Sings* (2000), by Jacqueline Roy, reveals another inadequate English psychiatric institution. Roy's novel addresses the issue of the psychiatric treatment of ethnic minorities.
e) Lillian Ross's *Vertical and Horizontal* (1963) satirises the incestuous, gossipy, self-absorbed nature of New York psychoanalysis.
f) William Gibson's *The Cobweb* (1954), shows the organisational structure of staff and patients falling apart, largely as a result of the weaknesses of the 'psy' professionals.
[37] An asylum director goes mad and is locked up in his own asylum.
[38] Bill Scheft's 'psy' professional, Dr Travis Waldman, is both useless and mad. Waldman's patient, narrator Charlie Traub, ends his expensive, fruitless work with Waldman, who then goes on to pursue his former patient.
[39] Spark's 'psy' professional, Hildegard Wolf, is 'really' called Beate Pappenheim, thus linking this analyst to Josef Breuer's famous patient, Anna O (pseudonym of Bertha Pappenheim), described in Breuer and Freud's *Studies on Hysteria.*

The Secret Scripture, I make the case for considering Dr Grene as mentally unbalanced as a result of childhood trauma.

The negative depiction of the 'psy' professional is not only apparent in fiction. The close association between horror, madness and the 'psy' professional as perpetrator of evil is also apparent in games currently on the market. The board game, *Lobotomy,* encourages players to experience the following, according to a game review site:

> Take the role of escaped mental patients. . . . Enter the abandoned mental hospital from your worst nightmares. . . . There is one goal: to escape. But it is not easy when you think that all the staff are evil monsters and the warden is the worst of them. ("Lobotomy")

This game communicates to players that patients are terrifying and do not command compassion; but also that 'psy' professionals are monstrous and offer punishments, not healing care.

Computer games involving mental asylums are a widely available and popular source of entertainment in the horror genre. These typically put the player in the role of a patient who attempts to escape from evil 'psy' professionals. Attendants and doctors are all portrayed as frightening monsters. This constantly growing market contains large numbers of such games which reinforce the picture of 'psy' professionals as adversaries, not carers, of the mad.[40]

In addition to games, there are attractions and entertainments on offer which take place in disused mental asylums and figure psychiatrists, their patients and colleagues. One such spectacle in Leeds, UK, is advertised as set in a "creepy Victorian lunatic asylum" and promises visitors "spooky sights including old photographs of tormented patients, strait-jackets, mouth traps and other strange devices" (Newton). Pennhurst Asylum, billed as "Pennsylvania's

[40] The *Haunted Halls* series is representative of this genre, as are *Batman: Arkham Asylum, The Inpatient, Fahrenheit, Twisted Lands: Insomniac* and *Outlast.* The horror theme of the mental asylum is a well-established trope in online games. In February 2020, Wikipedia listed 57 games set in asylums ("Games set in psychiatric institutions").

Most Terrifying Haunted Attraction!" is a similar attraction in the USA. Visitors in November 2017 were promised:

> fine detail and realism through a combination of high-tech animatronics, digital sound and highly trained actors. [You are invited to e]nter the world of the underground as your soul is led down the steps of the past to go back in time to a labyrinth of dilapidated cells, never ending halls, and be forced to confront a series of human experiments that have gone horribly and deadly wrong. This experience includes CGI special effects, illusions, attention to detail and ghosts that have never left the halls. (*Pennhurst Asylum*)

The website for Pennhurst Asylum's 2017 tour included a video in which you could see actors playing caged mad people, blood-spattered lunatics and terrifying attendants. Those visitors paying entrance fees would expect to be terrified by 'psy' professionals and their patients. However, this terror is limited by the presentation of these grotesque and frightening components as aspects of an entertainment. These asylum-based visits do not aim to produce compassion for the mad or respect for those responsible for their care and treatment. It is unlikely that any other medical specialty or illness would provide this kind of horror spectacle as entertainment for the healthy.

Concern has been noted about the negative presentation of mental illness by video game-makers in particular, and some developers have stressed the need to counter this. One games reviewer, Ryan Noble, reported on www.horrortalk.com about a challenge to move away from this depiction of madness and its treatment. The online games challenge, *Asylum Jam,* invited developers 'to make a horror game and explore the genre without negative mental health or medical stereotypes' (Noble). Subsequently, LKA's 2016 game, *The Town of Light,* attempted to arouse compassion in players for the patient, Renée, at the centre of this game set in the Ospedale de Psichiatrico di Volterra on the eve of the Basaglia Law of 1978, which closed the Italian asylums (Italian Parliament).[41] The importance of patient suffering in this game makes a welcome change to depictions of the mad as terrifying wild beasts. Nevertheless, the game offers yet another testament to the lasting perception of

[41] One review of the game *Town of Light* noted that such institutions as Volterra were "places where the most unspeakable violence was inflicted, where humanity was forgotten, giving way to an unexpected brutality" (Malgieri, 2017).

the barbarity of the 'psy' professional. Invited to identify with Renée, the game player is rewarded for exploring the horrors of the asylum, reviews noting that this does not produce an enjoyable experience (Walker).

Another range of consumer products that presents a strongly negative image of the 'psy' patient and 'psy' professional is that of fancy dress costumes. Various options advertised as suitable for Halloween celebrations have been available for purchase on the internet. The party-goer has been able to buy and wear a madman's outfit, with shackles and a mask,[42] or the blood-spattered scrubs of an asylum attendant, printed with "Dorothea Dix Psych Ward" (Koman; Reeves).[43] Protests have made these items harder, though not impossible, to purchase. In the UK, a "mental patient fancy dress costume" and "psycho ward" outfit were available at both Tesco and Asda, until withdrawn after protests from, among others, Mind, the mental health charity ("Asda and Tesco withdraw"). A costume that was still available in the UK in December 2019 was a "full frontal lobotomy scar" ("Zombie"), while the "Men's Circus Psycho Clown", showing a blood-stained, straightjacketed clown was available from Amazon.com in the US in December 2019 ("InCharacter").[44] It appears that protests have reduced the number of mad patient and evil psychiatrist costumes for sale.[45] However, Pinterest and YouTube (Sweatpants&Pumps) have a considerable amount of detailed and gory information on producing your own costume.

Seemingly unaware of the growing notion that such costumes which mock mental patients and 'psy' professionals is offensive, *Vogue* magazine publicised a surprising event in 2017. In order to celebrate Halloween, the Public Hotel in New York was transformed into what *Vogue* called a "terrifyingly cool asylum" (Ward). In a curious conflation of the mad and their carers,

[42] "Rubies-Costume-Co-Mens-Skitzo" was available from www.amazon.com. The Advertising Standards Authority banned this item in the UK in 2015 on the grounds that it implied schizophrenics were murderers (Ridley). It was still available from Amazon.com in the USA in 2018, though it now appears to have been withdrawn.

[43] This costume was also supposedly withdrawn, although shoppers reported being able to purchase the item after the ban. Dorothea Dix was a nineteenth century American campaigner for public asylums for the mad (Grob 78).

[44] This costume comprises a blood-covered straitjacket and a clown mask which clearly references a D C Comics character, the mad, evil Joker.

[45] Amazon.com still lists a "Fun World Masked Madman Costume", previously available for adults and children.

revellers were dressed as ‘psy’ doctors/patients and were pictured wearing white coats with blood spatters and head wound dressings.

In his posting on the Menninger Clinic Blog (2010), Cody Dolan wrote: “It had never occurred to me that so many comic book villains came from the world of mental health” (Dolan n p). It is indeed the case that there are large numbers of both patients and ‘psy’ professionals in the widely circulated DC Comics and Marvel Comics. Supervillains who are either ‘psy’ professionals or patients (or both) have a prominent presence in these publications and, while some superheroes exist among the ‘psy’ professionals in comics, they look as frightening as those who are supervillains (Lorendiac). Consider, for example, Brother Voodoo, with shrunken heads hanging from his waist (Tan). The patients, predictably, are all villains: there is no acknowledgement of suffering awarded to mad comic book characters.[46] Searches of the internet site, Pinterest, produce a great range of illustrations of these characters, including real people dressed as these villains. All the male characters are visually frightening, with little to discriminate between patient and ‘psy’ professional. As with literary depictions, there are fewer female villains. These women characters, whether patients or ‘psy’ professionals, are usually sexualised. In the case of Harley Quinn, this patient/’psy’ professional/villain is also infantilised, many versions of her showing a frilly skirt and hair in bunches, along with leather, shackles and an improbably large bust (“Harley Quinn”). This sexualisation of female comic book villains appears to suggest that the greatest evil that women characters exhibit is sexual temptation, and the reader is reminded of the biblical Eve, the supposed source of all sin (*Old Testament*, Gen 3.1-24).

Many of these comic book characters appear in the setting of the fictional Arkham Asylum. Pictures of this institution (“Batman: Arkham Asylum/Gallery”) show a disturbing similarity to those of real old asylums (“Ruined Asylums”), with image collections on the internet showing actual disused asylums as

[46] Notable DC/Marvel comic book patients include Poison Ivy, Mad Hatter, Clayface, Killer Croc, Riddler, Jeremiah Arkham, Amadeus Arkham, Two-Face, Scarecrow, the Joker and Harley Quinn. ‘Psy’ professionals are among these villainous patients. Arkham father and son were both heads of the terrifying comic book lunatic asylum, Arkham Asylum, before going mad and becoming patients in their own madhouse. Scarecrow, the Joker and Harley Quinn all trained as ‘psy’ professionals (*Marvel; DC Comics)*.

terrifying, dark and ruined, haunted by the ghosts of former mad inhabitants.[47] Comic book Arkham Asylum is very well-known. Indeed, best-seller and BAFTA winning, *Batman: Arkham Asylum,* has been described as "the best superhero video game ever".

These comics, related films and computer games have a huge and growing presence on the internet. This is a source of concern since, for many people, these representations of 'psy' professionals and their patients provide their first encounters with psychiatric disorders and their treatment. Supervillain and 'psy' professional Hugo Strange ("Hugo") is one of the oldest foes of superhero Batman. Arkham Asylum is the setting of much of Batman's activity, where the latter's "most dangerous enemy", the mad Joker, is a patient. The Joker has a considerable presence in the immensely popular DC/Marvel comic universe, appearing in 2,664 comic issues ("Joker"). 'Psy' professionals have protested (though infrequently) about the comic book representations of the mentally ill (Rogers). Additionally, Goodwin and Tajjudin (2016) consider the way the Joker stigmatises the mentally ill. On the other hand, Carol Tilley (2018) finds that doctors in comics now have a "more realistic and nuanced" presence (Tilley, Abstract), although Sharon Packer (2017) writes "no one disputes that negative images of mental illness abound in the Arkham universe" (Packer 253). Packer goes on to note

> [T]he Arkham franchise casts shadows on the current state of psychiatric hospitalisation, or, rather, on the lack of psychiatric hospitalisation, which has led to mass incarceration of persons with mental illness in jails and prisons rather than in treatment facilities. (255)

We need to be aware of these widespread, negative, cultural representations of the 'psy' professional and the mental patient, for they have considerable impact on the way our society treats the mad.

[47] See, for example, Tom Kirsch's 2016 photograph of Denbigh Asylum in Wales (Kirsch).

SECTION 3: Cultural representations of 'psy' professionals and the problems of stigma

The stigma that attaches to mental illness is much discussed by 'psy' professionals.[48] They see it both as a barrier to sufferers seeking treatment and also to medical students in choosing to specialise in the 'psy' professions. Patients have historically suffered from a stigma that is closely allied to shame. Insanity has been seen as socially unacceptable, causing subjects to hide information about their mental illness.[49] Families were considered to be tainted if they had a mentally ill member, so a mad relative might disappear entirely from family life and family history.[50] Sociologist Erving Goffman first published his important text, *Stigma: Notes on the Management of Spoiled Identity*, in 1963. Goffman saw stigma as a "deeply discrediting" attribute (*Stigma* 13) that reduced the bearer "in our minds from a whole and usual person to a tainted, discounted one" (12). Pryor *et al* (2012) noted Goffman's attribution of "courtesy stigma" or "stigma by association" (224) to any person seen as being in the same social group as the discredited individual. Goffman observes, "Thus, the loyal spouse of a mental patient, the daughter of an ex-con, the parent of the cripple, the friend of the blind, the family of the hangman, are all obliged to share some of the discredit of the stigmatised person to whom they are related" (*Stigma* 43). This "courtesy stigma" extends to 'psy' professionals who care for mental patients and is much reinforced by cultural depictions of professionals and patients. Fiction has long depicted the stain of stigma attaching to both 'psy' patient and 'psy' professional.

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[48] Among representative papers on stigma, Sickel *et al* (2016) note that scholarly writing concurs in the view that "[i]t is well established that mental illness has deleterious personal, social, and economic consequences for individuals, families, and society" (1). Sartorius *et al* (2010) stress the need for "an improvement of the image of psychiatry and psychiatrists in the eyes of health professionals, the general public, health decision makers and students of health professions" ("WPA Guidance" 131). Corrigan and Bink (2016) observe that stigma results from stereotypes, prejudice and discrimination" (230). As I note, such stereotypes are frequently the result of cultural representations of the 'psy' professions. Psychology professor Richard Bentall writes that representing insanity as brain disease "increase[s] stigma, diverts our attention away from other ways in which we can help patients, stops us from building a healthier world, and encourages in patients alienation, pessimism and a deep despair" (Bentall, "Mental Illness" n p).

[49] Patient Eric Levy (2016) discusses the need to "devote much energy" to hiding his bipolar condition from work colleagues to avoid the risk of being dismissed or ostracised. Peter Byrne (2000), concerned to identify ways of reducing stigma, noted "[t]he adaptive response to private and public shame is secrecy" ("Stigma of" 65).

[50] Reiss's novel, *A Family Institution* (2011) and O'Farrell's *The Vanishing Act of Esme Lennox* (2006), both discussed above, are fictional examples of mad relatives disappearing.

American sociologist, Bruce G Link *et al* note in a 1999 paper that, while there is optimism concerning attitudes to the mentally ill, a "strong stereotype of dangerousness and [a] desire for social distance persist" (1328). British psychiatrist Alison J Gray writes in 2002 that, while "[e]ffective treatment now allows recovery and reintegration . . . into society", employment and marriage prospects are still negatively impacted (74). A 2017 University of Basel report notes that "[p]eople with mental illnesses suffer from severe social stigma" and this can lead them to "avoid necessary treatment to escape the stigma" (University). There is also significant, negative, non-specialist discussion about mental illness. Concerning the influence of popular culture, Peter Byrne (2003) notes how "[m]any key debates in psychiatry - formerly the preserve of academic journals - take place in that amorphous public forum called the media" so that the media strongly influence the public perception of 'psy' professionals and patients ("Psychiatry and the Media" 135). Byrne is also optimistic that it will be the media that will challenge the negative stereotypes that surround insanity ("Stigma" 66). Australian psychiatrist Malcolm Forbes clearly identifies the negative contribution of popular culture. "The portrayal of psychiatry in popular culture is harmful and has been for decades. It stems from the wide dissemination of reports of early psychiatric practice, including harrowing institutionalisation, and a prominent and well-funded anti-psychiatry movement" (Forbes 436).

Writing in the *American Journal of Psychiatry* in 1964, when post-war interest in psychiatry was intense and the treatment of mental disorders had been prioritised by President Kennedy,[51] J Martin Myers noted the "tremendous growth of natural curiosity about the psychiatrist and what he does" (Myers 323). This proliferation of media interest has its negative aspect for, as Myers wrote, "Most of the people in our society have little contact with real, live psychiatrists. Therefore, if the image of the psychiatrist is distorted by these media, there is little chance of its being corrected by real life experiences" (323).

[51] In a new approach to mental illness and retardation, President Kennedy sought to improve community services and research with the 1963 Community Mental Health Act (88th United States Congress).

As well as the greater awareness of psychiatric disorders in the population, there is generally more widespread recognition of the lived realities of disabled people and the problems they have faced historically. Disability Studies have become a recognised area of study in academia, with many universities carrying out research and offering courses ("63 Postgraduate Courses"). Mad Studies are represented as a sub-set of Disability Studies, with a considerably smaller academic presence.[52] In comparison with other disabled people, the mad and their carers still attract significant stigma. In their book, *Cultural Locations of Disability* (2010), Snyder and Mitchell comment that

> we primarily come to know disabled people, both historically and in our own moment, through representations of their lives, experiences, and bodies that have been manufactured by those outside of the immediate disability experience. (19)

I have shown how this has largely been the case in the novels, games and entertainments discussed above, which overwhelmingly present disparaging depictions of 'psy' professionals and their patients.

SECTION 4: The response of scholars, 'psy' professionals and patients to negative cultural depictions

I have discussed above the 'psy' professional's substantial presence in fiction and various other forms of popular culture. Scholarly writing about this figure, however, is limited. I address below the small number of books and papers dedicated to exploring the role of the 'psy' professional in fiction. In considering these works, I draw attention to the different attitudes that apply peculiarly to the 'psy' disciplines in novels. The way novelists treat this specialist group is at variance with fictional approaches to other medical representatives. It appears that, in conjunction with fictions presenting mental illness and its treatment as terrifying, the fear of the unknown[53] and abuses of

[52] A handful of courses have been offered within the specific field of Mad Studies at, for example, Queen Margaret University, Edinburgh (Tweed). The field of Mad Studies is dominated by a few Canadian academics: see LeFrancois *et al*, 2013.

[53] The general public has been largely ignorant of the fate of the banished psychiatric patient, because of the abdication of social responsibility for the mad and the geographical remoteness of asylums. An insanity diagnosis was considered shameful, causing the distancing of families and friends. A consequence of this was the curtailing of general experience of psychiatry and its treatments. Andrew Scull notes that "security and isolation from society were among the

power play a large part in the derogatory depiction of 'psy' professionals in literature. I shall return to the question of fear later in this chapter. My discussion of the scholarly writing about the psychiatrist in fiction will largely focus on the three authors who, in my view, have taken the most comprehensive approach to the subject. They are Australian physician and literary critic, Solomon Posen, American psychologist, Charles Winick and American literary critic, Margaret E Grenander.

Dr Posen, specialist in general medicine and endocrinology, has written at some length on the roles of various medical specialists in fiction. In his 2009 paper, "The Psychiatrist in Literature", Posen observes that psychiatrists receive "the most negative treatment" of all fictional doctors. Novels, says Posen, frequently present psychiatrists whose "foreign accents and . . . eccentricities" mark them out from "'proper' doctors", this latter group seeing psychiatrists as inadequate medics who were unable to "make it in real medicine" (n p). Psychiatrists, as seen by Posen, are obsessed with sex and commonly "engage in inappropriate physical relationships on such a scale that sexual advances are almost taken for granted" (n p). Damningly, Posen further notes that fictional 'psy' professionals are singled out from other doctors in novels, the former group being "villains, lechers, sadists, acquisitive businessmen, or useless charlatans" who are "distrusted by the public and despised by other physicians" (n p). Overall, Posen regrets that these negative perceptions of fictional psychiatrists have been "responsible for some early negative career choices" (n p). As I discuss above with reference to stigma, psychiatrists suffer from their association with 'crazy' people.

Pointing to several important fictions which undermine the status of the 'psy' professional, Posen offers typical examples. He cites *Tender is the Night* (1934), in which Scott Fitzgerald notes, "The weakness of this profession is its attraction for the man a little crippled and broken" (Fitzgerald qtd in Posen, "Psych in Lit' n p). He quotes A J Cronin's *Shannon's Way* (1948), where the narrator comments that "asylum work . . . is an easy life and much medical flotsam drifts into it" (Cronin qtd in Posen n p). Discussing Joyce MacIver's

central advantages the madhouse offered its clientele - for patients' families and perhaps the local community more broadly, if not the patients themselves" (*Madness in Civilisation* 138).

immensely popular novel, *The Frog Pond* (1961), Posen observes of fictional 'psy' professionals, that:

> Psychiatrists are not only lunatics: they are outlandish lunatics from Vienna and other obscure parts of the globe. They have foreign names and they speak with an accent.

Walker Percy, Posen reports, notes with humour in *The Thanatos Syndrome* (1987) that

> In a small general hospital a psychiatrist is ranked somewhere between a clergyman and an undertaker. One is tolerated [but] one sees the patient only if the patient has nothing else to do. (Percy qtd in Posen n p)

Posen's wide-ranging paper paints a grim picture of the fictional 'psy' professional which he finds pervasive in novels. This figure, Posen observes, is wicked, badly behaved or mocked.

In his 2005 book, *The Doctor in Literature: Satisfaction or Resentment*?[54] in which he deals with doctors of all specialties, Posen goes on to note the perceived unscientific nature of psychiatry: "Psychiatrists deal with metaphors and imagery", while other doctors are "concerned with facts" (7). Posen's analysis produces a picture of the fictional 'psy' professional as a discredited, unscientific doctor who is seen by his medical colleagues as both a laughing-stock and a failure with a suspect sexual obsession. His analysis reveals a damning indictment of the 'psy' professions as depicted in novels.

As early as 1913, there was professional concern in the US about the quality of candidates entering the 'psy' professions. Neurologist Dr Charles W Burr[55] wrote in the 1913 issue of *The Journal of the American Medical Association*:

> First, I have never personally known a genius who devoted himself to teaching psychiatry. Second, psychiatry is the most backward of all

[54] Posen's work is, I believe, the most comprehensive on the presentation of medical specialties in literature.
[55] Burr also wrote in the *New York Times* in 1913, stressing the importance of the government's role in ensuring the nation's mental health (Burr "Government").

> the sciences fundamental to the art of medicine. Third, the time devoted to mental diseases in medical schools is too short to teach anything beyond the alphabet. (qtd in Grob 239)

This worry about the poor quality of entrants to the 'psy' professions and their inadequate training remained apparent throughout subsequent years and it became clear that fictional representations of 'psy' practitioners played an important part in this perception. In 1961, the American Psychological Association published *Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health* (Joint Commission).[56] This report was compiled in response to a mandate from Congress to carry out an extensive study of the care of the mentally ill in the United States, and to make recommendations for a way forward. In response to this report psychologist, sociologist and anthropologist, Charles Winick, published a paper in 1963 which "recommended that American psychiatrists should do something about the public 'image' of the psychiatrist" (43). Winick identified depictions of 'psy' professionals within novels as an important source of information regarding the public perception of the profession. His concern was that the fictional psychiatrist would "serve to extend and reinforce the image of his profession held by the public and indeed by psychiatrists" (43); and that these images were overwhelmingly negative. Psychiatrists in novels, noted Winick, showed frequent "naïveté" (53), were "weak" (44), "extraordinarily uninformed on psychiatric matters" (51), had a "lackluster ability to explain and predict other characters' behavior" (53), were "nihilistic" and "fool[s]" who were "less intelligent and far less attractive" than their patients (53). The only novel Winick cites as written by a member of the American Psychoanalytic Association, (*The Seeker*, by Allan Wheelis, published in 1961), "implicitly attacks the whole profession of psychiatry and analysis" (Winick 48).

Referencing a large number of texts, Winick's 1963 paper "The Psychiatrist in Fiction", offers a cumulative list of novels containing 'psy'

[56] The Commission was composed of thirty-six organisations and was the result of widespread concern that the needs of the mentally ill were not being met. Its report stated that "[t]he Commission's proposal is the first one in American history that attempts to encompass the total problem of public support of mental health services and to make minimum standards of adequate care financially possible" (*Joint Commission* "Overview").

professional characters.[57] Winick used "the contents of best-seller lists, magazines and literary reviews in America . . . for each year since 1910" (43). He aimed to include only those fictions which reached a wide audience in America and might, therefore, have had some influence on the public view of 'psy' professionals. He does, however, note the portrayal of the psychiatrist with an interest in psychoanalysis as the "bearer of light" as opposed to the "entrenched administrator" (often the head of an institution) who rejects innovation which might help patients (52-3). Winick compared poll data about public views of psychiatrists with the image of 'psy' professionals in best-selling fiction. Poll results showed the "public does not regard the psychiatrist as a 'real' specialist" (55) and that "persons who had feelings of an impending nervous breakdown ranked the psychiatrist as last among those they would seek for help" (55). Further, Winick deduced that "[o]nly a small proportion of fictional psychiatrists have the blandly positive qualities which emerge from some of the poll data" (56) and that "the American public may somehow relate the techniques used by psychiatrists to those of famous fictional characters who worked on the minds of others for sinister or evil purposes" (56). This was of great concern to the 'psy' professions in the early 1960s and it appears that, over fifty years after Winick's paper, little has changed to rectify that position.[58]

Another significant paper on the role of the 'psy' professional in fiction was published in 1978 by American Professor of English, Mary Grenander, under the title "Of Graver Import than History: Psychiatry in Fiction". Dealing with a substantial number of novels, this paper does more than merely draw attention to the frequency with which the 'psy' professional appears in fiction. Grenander highlights the abuse of power commonly found in fictions of madness. She observes that, while the 'psy' sciences had become increasingly important as literary themes, "[a]lmost without exception, studies of psychiatric

[57] Winick makes no claim to offer literary criticism but notes the overwhelmingly negative attitudes toward 'psy' professionals contained in the cited works.

[58] Many articles in 'psy' journals address the issue of the poor reputation of the 'psy' professions. Bhugra (1987) ("Pub Image of Psych" 105) references studies showing that 'psy' professionals "were seen as least advanced, least expanding and as having the lowest status in the profession"; Rajagopal *et al* (2004), point to the unpopularity of psychiatry as a career choice; Leicester (2013) draws attention to widely-held misconceptions about psychiatrists, including their ability to read minds: Stuart *et al* (2015), observe that surveyed medical students saw psychiatry as suitable only for those with poor quality medical skills. The date range of these papers makes clear that this is a continuing problem with a long history.

practice by the behavioural sciences adopt the viewpoint of those who are in a position to use them for social control" (29). This was a matter of considerable concern and added to the picture of the powerful and manipulative 'psy' professional. Grenander notes that fiction, on the other hand, is valuable in that it "also gives us an analysis of these practices from the point of view of those who are susceptible to such control" (29). The voice of the psychiatric patient may be heard in fiction, putting novelists in an important position since, as artists, it would appear that fiction writers "have no professional commitment to established psychiatric mores, [and] are paradoxically in a unique position to give us an objective analysis of their universal human significance" (29). This is in stark contrast to the silence of patient voices throughout most scholarly 'psy' professional writing.

Grenander addresses a further important question in her paper. Noting the growing significance of the theme of psychiatry in fiction, she considers how sanity/insanity might be defined, who allocates individuals to these categories and how particular social mores determine acceptable (sane) behaviour (30). Since those diagnosed mad are denied many human rights and may be forcibly medicated and incarcerated by psychiatrists who act as agents of democratic governments, this should be a matter of concern to us all.[59]

There is, as Grenander rightly points out, a small minority of 'psy' professionals in novels who act in the patients' best interests, noting that in these works patient and psychiatrist exhibit "no difference in humanity" (37).[60] However, the vast majority of fictional 'psy' professionals are described by Grenander as doctors who regard themselves "as the priesthood of their modern theocracy" who use "their prestige and a certain sense of private ownership of reality to separate themselves from their patients" (37). Such people are "[m]otivated by love of power" and "they advocate social engineering

[59] Grenander points to the fact that social control allows the incarceration of professional black men seen as threatening to white supremacy. Incarceration may be used to side-step legal processes.

[60] In this category, Grenander references Dr Fried in Greenberg's *I Never Promised You a Rose Garden* (1964) and Dr Marks in Brand's *Savage Sleep* (1969). It is important that these fictional 'psy' professionals are based on real practitioners, Dr Frieda Fromm-Reichmann and Dr Jon Rosen respectively.

as a laudable goal. Deceit and trickery are accompanied in their arsenal by physical restraint, chemotherapy, shock, and psychosurgery as they coerce their unhappy victims with pain and fear" (37). When diagnosed insane, "[d]eceit is used both to entice patients into the mental hospitals and to keep them docile once they are incarcerated" (38). Inside the hospital, patients are "induced to pretend an outward conformity to whatever they perceive as the demands made upon them" (38). This patient survival strategy of acting a part in order to achieve approval from those in authority within the institution will be discussed below in the chapters on Ward's *The Snake Pit* and Mortimer's *Long Distance.* The mental patient must appear to have responded to social engineering in order to progress through the system. Grenander thus identifies representations of the fictional 'psy' professionals as oppressors of 'psy' patients, punitive users of chemical and physical restraints, deceitful manipulators and powerful jailers of the mentally ill.

Overall, Grenander feels "the picture fiction paints of psychiatry is a grim one" (43). She sees psychiatry as "an instrument of social control unbridled in its arbitrary grasp of power . . . its fires stoked by society's yearning for scapegoats and man's lust for dominion over his fellows" (43). Writers of fiction have, in Grenander's well-substantiated view, dramatised psychiatry as "demonology, wearing the deceptive disguise of scientistic pseudo-humanitarianism" (44). Grenander's paper indeed explores a grave subject, pointing to the actions of powerful, fictional psychiatrists dominating powerless, fictional mental patients.

In addition to these three major papers, there is a small number of other noteworthy works on the 'psy' professions in novels. Jeffrey Berman, American literary critic, published a study of a small selection of fictions, *The Talking Cure: Literary Representations of Psychoanalysis*, in 1985. Berman made no general conclusions in his work about the overall view of fictional 'psy' professionals.

Borys Surawicz and Beverly Jacobson, American cardiologist and writer respectively, state their aim in writing *Doctors in Fiction: Lessons from Literature* (2009) is to give busy practitioners an overview of "how the medical profession

is viewed by prominent writers and how their writings may affect the judgment of the medical profession by readers" (ix). There is a chapter on psychiatrists.[61] This work is limited in scope and includes the authors' stated belief that doctors are too busy to read novels (ix).

The topic of doctors in fiction is dealt with summarily by other writers. UK psychiatrist Fiona Subotsky has produced a number of articles on 'psy' professionals in fiction in the *British Journal of Psychiatry*, offering brief plot outlines.[62] Subotsky's work is valuable in drawing attention to the ubiquity of the 'psy' professional in nineteenth century fiction. US psychiatrist Marjorie Meehan's 1964 paper lists 33 novels with 'psy' professional characters, categorizing them by type, such as "Unfeeling Scientists", "Magicians" and "Useless Nonentities" (Meehan 256-7).[63] Stephen McWilliams' 2012 book, *Fiction & Physicians* notes the public's "morbid fascination with fictional psychiatry" (173) but does little more than list and describe a selection of novels with professional characters. McWilliams, an Irish psychiatrist, does, however, make the important point that characters such as Hannibal Lecter entertain us by "scaring and seducing us simultaneously" (197). This comment goes some way in explaining the general public's fascination with - and repulsion by - psychiatry in novels.[64] While offering little or no literary analysis, the books and papers mentioned above do draw attention to the fact that the 'psy' professional has a special role in fiction.

There are additional papers dealing with the representation of 'psy' professionals in fiction, cartoons and mass media.[65] Some of these will be

[61] Surawicz and Jacobson expect their work will entice medics to read some of the books they have chosen; or at least gain "pleasure from following interesting plots and enjoying tasteful prose" (x).
[62] See, for example, Subotsky's article on Wilkie Collins' 1866 novel, *Armadale.*
[63] Although Meehan includes some positive representations of 'psy' professionals, her examples are largely negative.
[64] The juxtaposition of seduction and fear encapsulated in Lecter's effect on readers is significant in further describing the public reaction to psychiatry. Since madness is a reality that society is unwilling to probe, the mad - and, by extension, their stigmatised carers, the 'psy' professionals - are moved into a space of fantasy.
[65] Femi Oyebode (2004), referencing Brontë's *Jane Eyre,* considers how the mad can be denied "the gift of speech" ("Fictional Narr and Psych" 140); Dempsey (1988) points out that, in many novels, the "central character suffers as much from the treatment as from the disorder" (516); Valentine, discussing Wallace's *Infinite Jest* (1996), observes this fiction shows how hallucinated torture becomes real experience as machines are used in treatment (Valentine 95-96); Mariam Cohen (2000) writes that fictional portrayals put 'psy' professionals "in serious

discussed as relevant in the following chapters of this thesis. The role of the 'psy' professional in film is a large subject which I do not intend to cover in any depth in this thesis.

My discussion above has outlined the largely negative public perception of the 'psy' specialties in cultural artefacts. This appears to have affected recruitment of suitable candidates to the 'psy' professions and has been much discussed in websites and scholarly journals. The Royal College of Psychiatrists had, by February 2020, published 289 short films on YouTube under the heading "Choose Psychiatry" to encourage psychiatry as a career choice (RCPsych). Subsequently, a steady stream of films has been added. Many papers have been published in specialist journals which acknowledge the adverse publicity given by fiction, films, television programmes, comics, games and cartoons.[66] These depictions, encouraging fear or contempt for 'psy' professionals, have had serious repercussions for medical students. Students are discouraged from entering 'psy' specialties, while prospective patients are afraid of consulting a 'psy' specialist. This is clearly damaging. The patient's fear of seeing a 'psy' professional will be dealt with in some detail below.

As already mentioned above, it is notable that, in marked contrast to the depiction of 'psy' professionals in fiction and other cultural artefacts, many 'psy' practitioners value literature highly and encourage its use in training in the 'psy' specialties. They see reading literature as a method of providing knowledge which enriches their understanding of humanity and the wide spectrum of human experience. Dr W M Tucker (1994) makes the following case:

> Fiction writers effectively dramatise psychological and developmental issues in a way that makes them real and memorable to psychiatric residents. Stories may be of particular value in illustrating the process of change and in exploring the topic of prognosis, which are often overlooked in more traditional teaching formats. (11)

trouble"(319); Rom (1965) notes how fictions such as Nabokov's *Lolita* (1955) frequently show the patient's "resistance" to psychiatrists" (Rom 70).

[66] A number of academics have directly addressed the way negative images of 'psy' professionals arise from cultural artefacts: Rom (1965), Hoffman (1972), Dempsey (1988), and Walter (1989 and 1992) are representative papers.

Fiction may thus acquaint trainee 'psy' professionals with a much wider variety of human experience than that encountered in personal interactions.

Psychiatrist and critic Femi Oyebode (2002) quotes D H Lawrence on the value of fiction as a means to enter otherwise closed spaces.

> Here lies the vast importance of the novel properly handled. It can inform and lead into new places the flow of our sympathetic consciousness. . . . Therefore the novel, properly handled, can reveal the secret places of life. (Lawrence qtd in Oyebode, "Literature and Psychiatry" 121)

Madness is generally dreaded but it is perhaps not personally experienced by many readers. Although it is estimated that one in three to four people experience mental ill-health during their lives, it seems to be the rarer conditions of psychosis and schizophrenia that are the embodiments of madness which are generally feared, rather than the more common states of anxiety and depression. Fiction is able to offer accessible insights into the consciousness of the psychotic and schizophrenic, otherwise only presented in the more specialised set of non-fiction madness narratives.[67] Taking into account the views of 'psy' professionals who value novels, it is clear that there is an imbalance in the way fiction and the 'psy' professions regard each other.

SECTION 5: Gender, the 'psy' professional, the patient and feminist critiques

All four of the texts I explore in depth in this thesis contain male 'psy' professionals and female patients.[68] This is the most common combination found in fiction.[69] This divide appears to reflect a patriarchy in which men's power oppresses women. A number of important writers offering feminist analyses of madness address this issue. It is helpful to consider the gender

[67] There are many madness narratives. Gail Hornstein has collected these in her online summary, "Bibliography of First-Person Narratives of Madness (5th Edition)" (2011).
[68] McGrath's *Asylum* has one female and one male patient.
[69] Notable exceptions of women 'psy' professionals in fiction include Dr Fried in Greenberg's *I Never Promised You a Rose Garden,* Dr Nolan in Plath's *The Bell Jar*, Lulu Shinefeld in Rossner's *August* and Dr Johanna von Haller in Davies' *The Manticore*, all of which offer positive depictions. There are also a number of negative representations of women as malign therapists, including Dr Lilith Ritter in Gresham's *Nightmare Alley* and Sonia Bolgar in Koestler's *Arrival and Departure* (1960).

balance, both in actual 'psy' treatments and in cultural representations of such treatments. The matter of gender roles and power *versus* powerlessness are of considerable significance in both areas.

Before considering fiction, it is pertinent to consider the reality of the gender divide between patients and 'psy' professionals. While the fictional 'psy' professional is most frequently male, this does not always reflect the situation in 'psy' care. An American Medical Association internet post noted in 2015 that women make up about 57% of residents in psychiatry in the US (Vassar). National Health Service (NHS) data in the UK in 2018 included the information that "[t]here are now more women doctors specialising in psychiatry (51 percent) than men (49 percent). In 2009, 45 percent of this specialty group were women" ("Narrowing of NHS gender divide"). In the field of psychology, increasing numbers of women are shown to be practising: "In 2005 . . . nearly 72 percent of new PhD and PsyDs entering psychology were women, according to the American Psychological Association (APA)'s Center for Psychology Workforce Analysis and Research" (Cynkar 46). A 2016 patient advice blog in the US compared the changing numbers in psychiatry according to gender, with 35% female and 65% male in 1980, changing to 52% female and 48% male in 2015 and 41% female and 59% male in 2016 (Hannah Levy). It appears that the male/female divide among qualified 'psy' professionals does not currently show male practitioners as an overwhelming majority.[70]

There are noteworthy, gender-specific differences which relate to mental illness in patients. Indeed, gender-related disorder differences and help-seeking patterns complicate the ways in which mental illness is viewed in women and in men. The World Health Organisation (WHO) states that "Overall rates of psychiatric disorder are almost identical for men and women but striking gender differences are found in the patterns of mental illness" (WHO "Department" 4). Men are more than twice as likely to suffer from alcohol dependence,[71] while women predominate in the areas of "depression anxiety

[70] However, Holmes and Lindley note that, while women are probably in the majority among patients and therapists, "senior positions, as in other professions, tend to be occupied by men" (*The Values of* 85).

[71] Ali Haggett notes that, in the UK, men frequently self-medicate with alcohol and present to healthcare with alcohol related disorders (Kindle loc 1922).

and somatic complaints" (2).[72] On the other hand, there are no marked gender differences in the rates of severe mental disorders such as schizophrenia and bipolar, diseases which are "rare" (2). It seems that women both present with and are diagnosed with different mental illnesses from men and make up the majority of patients.[73] However, suicide rates among men have grown into an alarming majority.[74]

In addition to the discussion of data relating to psychiatric patients of both genders, there are several major scholarly works which analyse the female role of madness in society and act as a balance to writings by male theorists. Australian Professor of Women's Health Psychology, Jane M Ussher (1991) points to madness acting "as a signifier, clearly positioning women as other" (11). This view, claims Ussher, has pushed women into the role of scapegoat, representing "that part of ourselves that we most fear" (140). She further notes that drugs and therapies such as electroconvulsive therapy (ECT) "can all be seen as a means of control, comparable to . . . Indian suttee, Chinese footbinding and clitoridectomy. . ." (7). Ussher claims that misogyny is at the root of this view of women, who have repeatedly been seen by male society as "perverse and sinful, lewd and lascivious" if they are not controlled by men (26), as well as being silenced when "positioned as mad" (246). Ussher worryingly finds that "[s]exual abuse of women and girls is endemic in our society" (265).

American literary critic Elaine Showalter's 1987 book, *The Female Malady*, maintains that there has been a **"**pervasive cultural association of women and madness" (4), positioning the mad woman in nineteenth century fiction as "a symbolic representation of the female author's anger against the

[72] Women are also much more likely to be "prescribed psychotropic drugs" (WHO "Department" 2).

[73] Piccinelli and Wilkinson (2000) note that "the prevalence, incidence and morbidity risk of depressive disorders are higher in females than in males", this being, in part, related to "sociocultural roles" (486). Marecek and Gavey (2013) state "psychiatric diagnoses . . . are connected to prevailing moralities and norms regarding gender, sexual expression, the gender order, and heteronormativity" (5). Jimenez (1997) observes that "[t]raditionally, psychiatric conceptions have served to regulate women's behavior according to prevailing social norms", while "[n]ew diagnostic categories that were introduced [between 1960 and 1994] reflect an enduring psychiatric orthodoxy that privileges dominant values controlling gender-role behavior in women" (154). It appears that the social and cultural conditions of women's lives lead to mental illness.

[74] Of the 6,233 suicides recorded in the UK for people aged 15 and over, 78% were male and 22% were female" ("Mental health statistics ").

rigidities of the patriarchal tradition" (4).[75] Showalter makes clear that theories of psychiatric disorders propounded by men fail to take into account the different ways men and women are viewed and treated. She observes that Foucault, exposing the confinement of those deemed irrational and different, "does not take account of sexual difference" (6); that Laing and the anti-psychiatrists failed to note that "the typical patient - the misunderstood, mislabeled 'schizophrenic' - was female" (231); that Kingsley Hall's star patient, Mary Barnes, produced a madness narrative that was mediated by her male therapist, Joseph Berke (Showalter 232); that Ken Loach's powerful 1971 film, *Family Life,* did not address gender issues, in spite of Janice, her pregnancy and psychotherapeutic treatment being at the heart of the movie (236); and that male dominated antipsychiatry was "unaware of its own sexism", which included psychiatrist David Cooper's "bed therapy" or sex with patients (*Psychiatry and Antipsychiatry* 247).[76] This blindness to the centrality of the mad woman in 'psy' theory is remarkable. It makes the use of fiction to give voice to the mad woman a vital counterpoint to this bias. Showalter's work gives prominence to the fictional female, subject to the treatment of the 'psy' professional.

British-Canadian novelist and scholar Lisa Appignanesi (*Mad, Bad and Sad,* 1987) explores the historical feminising of madness, noting how judgments of insanity have been made by men and have oppressed women at various times. Appignanesi comments on how, with the rise of the huge public asylums in the mid nineteenth century, women patients began to vastly outstrip numbers of men patients (53).[77] She also notes how, in the Victorian madhouse, women were often beaten and prostituted, while pregnant or recently-delivered women were "considered to be subject to wild and depraved whims" (89). It seemed that being female and bearing children ensured madness.

Charles Darwin, writes Appignanesi, "emphasised the difference between the sexes emphatically to woman's detriment and with little sense that

[75] Showalter indicates differences in the way the English malady of madness has been viewed when applied to men and women. For men, it has represented "the intellectual and economic pressures on highly civilised men" while women's madness, presenting similar symptoms, has been "associated with the sexuality and essential nature of women" (7).
[76] Cooper was R D Laing's colleague at Kingsley Hall, London's infamous therapeutic community.
[77] The York Retreat in 1845 had approximately 30% more male patients than female (Appignanesi 53).

the source of what he described might have something to do with his own time's cultural conditions" (109). I have noted above how Foucault and Laing continued to ignore the social gender constraints experienced by women.[78] It has been fiction that has explored in depth the oppression of women deemed mad.[79]

US psychotherapist Phyllis Chesler published her important study of psychiatry within a feminist framework in 1972, putting forward the thesis that "[m]adness and asylums generally function as mirror images of the female experience, and as penalties for being female, as well as for desiring or daring not to be" (16). She identifies "psychiatrically labelled" women as "deeply unhappy, self-destructive, economically powerless, and sexually impotent", these states being the natural social lot of women (25). Chesler finds that the asylum "closely approximates the female rather than the male experience of the family" (35). She refers to Goffman's view that asylum hospitalisation was "more destructive of the self than criminal incarceration" (35). Chesler's interviews of 24 women hospitalised between 1950 and 1970 reveal that all of them "received massive drug dosages (such as thorazine, chlorpromazine, stellazine, mellaril, and librium), and many received shock therapy and/or insulin coma therapy as a matter of routine, and often before they were psychiatrically 'interviewed'" (164).[80]

Chesler also undertook interviews of women she had identified as having had sexual relationships with their therapists.[81] This approach may seem

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[78] English philosopher John Stuart Mill believed that "proper psychological assessment . . . would show that the differences between men and women are only the differences of their education and indicate no inferiority given by nature" (Appignanesi 121). Freud is credited with listening to women (instead of applying the clinical gaze, as did Charcot). As a result, Freud "diagnosed the wrongs of his time's repressive sexual mores", in defiance of conventional belief (Appignanesi 213). However, Phyllis Chesler pertinently discusses Freud's case, *Dora: An Analysis of a Case of Hysteria*, (1905) in which Dora is described as "bait in a monstrous sexual bargain her father had concocted" (Leonard Simon's unpublished manuscript qtd in Chesler 80). It seems Freud was aware of Dora's position.

[79] Charlotte Perkins Gilman's 1892 story of a woman author confined and forbidden to write (*The Yellow Wallpaper*) provides a powerful example of the oppression of a male psychiatrist. Silas Weir Mitchell, who had prescribed this treatment for Gilman, writes about it in his *Lectures on Diseases of the Nervous System, Especially in Women* (1881).

[80] Further, "[m]any of the women were physically beaten. Their requests for contact with the outside world were denied. Their letters were censored or not mailed" (Chesler 166).

[81] It was noted that most of these sexual encounters took place "between middle-aged male therapists and younger female patients" (Chesler 140); that 7 out of 11 women involved continued paying for their therapy (143); and that 3 interviewees "refused to reveal their

obvious but I have noted elsewhere in this introductory chapter that a more usual line within the scholarly psychiatric establishment has been to survey therapists, who then report (honestly or otherwise) on their own sexual misdemeanours. Indeed, in considering the power of psychiatrists, Chesler notes it is this group who decides "both medically and legally . . . who is insane and why; what should be done to or for such people; and when and if they should be released from treatment" (62). In noting the gender imbalance within professionals in psychiatric practice, Chesler observes the huge dominance of men. She reports that, in 1970, 14,267 men were members of the American Psychiatric Association, compared with only 1,691 women (62). Chesler comments on these figures that "[i]t is obvious that a predominantly female psychiatric population in American has been diagnosed, psychoanalyzed, researched, and hospitalised by a predominantly male professional population" (65). It is impossible to ignore the power dynamic inherent in this situation. At the time of writing this thesis, male 'psy' professionals may no longer be in the majority. However, it is women's fiction that has historically addressed the cultural power imbalance, and continues to do so in exploring the experiences of racial minorities and the poor within the mental illness system.[82] Fiction is the place where the social problems of the oppression, experienced by women and outlined by Appignanesi, Chesler and Showalter, are revealed and explored.

SECTION 6: Fear as the response of 'psy' patients to cultural depictions of 'psy' professionals and theoretical explanations from psychoanalysis, social science and social psychology

My review of the largely negative cultural depictions of the 'psy' professional means that it is unsurprising that fear of the psychiatrist and allied colleagues is the culturally pervasive response. These representations are likely to have a significant impact on current and prospective patients. As a start to analysing this situation, considering what psychoanalytic theory tells us about fear may allow us to move towards an understanding of the negative

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therapists' names", not wishing to harm the professional reputations of the therapists concerned (145).

[82] See, for example, Jacqueline Roy's *The Fat Lady Sings* (2000) and Clare Allan's *Poppy Shakespeare* (2006).

position psychiatrists and their colleagues frequently occupy within the public imagination.

I shall begin my discussion of fear by considering the concept of anxiety which Freud considers in Lecture XXV of *Introductory Lectures in Psychoanalysis* (440-460).[83] In this lecture, he is primarily concerned with neurotic anxiety, and notes that fear ("Angst") is the major cause of distress for most sufferers of neurotic illness (Freud *Beyond* 6).[84] Freud highlights the complexity of anxiety in human experience as "a nodal point at which the most various and important questions converge, a riddle whose solution would be bound to throw a flood of light on our whole mental existence" (Freud *Introductory* tr Strachey 441). This is an intriguing statement which suggests that understanding fear is central to understanding mental life.[85]

Freud discusses his use of language, saying he will avoid close scrutiny of the differences between "'*Angst* [anxiety]', 'Furcht [fear]' and 'Schreck [fright]'" (Freud *Introductory* tr Strachey 443). He does, however, return to this linguistic distinction in *Beyond the Pleasure Principle,* stating "[f]right', 'fear' and 'anxiety' are improperly used as synonymous expressions; they are in fact capable of clear distinction in their relation to danger. 'Anxiety' describes a particular state of expecting the danger or preparing for it, even though it may be an unknown one. 'Fear' requires a definite object of which to be afraid. 'Fright', however, is the name we give to the state a person gets into when he has run into danger without being prepared for it; it emphasises the factor of surprise" (*Beyond* 6-7). Unfortunately, the issue remains confused in English versions, since there are varying translations for Freud's 'Angst', 'Furcht' and 'Schreck'.

Freud continues to discuss the differences between what he calls "realistic" anxiety compared with "neurotic" anxiety: "Realistic anxiety strikes us as something very rational and intelligible" (441). Such anxiety serves the

[83] I am using the Strachey translation, though it should be noted that Stanley Hall, in his 1920 translation, uses "fear" where Strachey uses "anxiety" (Freud *Introductory* tr Hall 212).
[84] Anxiety is that "which [most neurotics] describe as their worst suffering" (Freud *Introductory* tr Strachey 440).
[85] Robert Burton's 1621 work, *The Anatomy of Melancholy*, identifies melancholy as the onset of both "fear and sorrow" (Kindle location 294), thus indicating fear as a major element of mental distress in this early text.

purpose of self-preservation, triggering the flight reflex in the face of danger (441). Anxiety as a fundamental human response develops, according to Freud, from the experience of birth, where separation from the mother produces real, physical stress as the life support system of the foetus changes from total, biological, maternal support to independent breathing. Birth produces "the prototype of the effects of a mortal danger" (444). Freud additionally maintains that anxiety is related to the libido, although "[h]ow anxiety arises from libido is not at first discernible" (451). Neurotic anxiety, on the other hand, is "a general apprehensiveness, a kind of freely floating anxiety which is ready to attach itself to any idea that is in any way suitable" (446). There is also the "anxiety of the extremely multifarious and often very strange 'phobias'" (446).[86] In addition, Freud notes a third set of phobias which seem to beset people indiscriminately: these he called "animal phobias" (448).[87]

With reference to Freud's descriptions, it seems that that the fear of 'psy' professionals may be a neurotic, freely floating fear, but one which is held culturally, rather than merely personally. It contains elements of fear of a known source, if we consider cultural depictions encountered as among our known sources. It therefore seems to fit clearly into none of Freud's three types of fear but straddles his definitions. The prospective patient may fear being referred to a 'psy' professional. What appear to her to be rational worries, based on her acquaintance with the 'psy' professional in widespread cultural artefacts, have no basis in her own experience. The artefacts seem to reflect cultural stereotypes which may not offer reliable representations. The patient's fear is thus based on cultural fears that she perceives as known or 'real'.

A number of other 'psy' theorists have also commented on fear. Donald Winnicott notes the vital importance of locating the fear which is causing illness*: "there is no end [to the analysis] unless the bottom of the trough has been reached, unless the thing feared has been experienced"* (Winnicott 105). Melanie Klein writes, "The working of the death instinct within - which according

[86] Freud cites the following examples: "Darkness, open air, open spaces, cats, spiders, caterpillars, snakes, mice, thunderstorms, sharp points, blood, enclosed spaces, crowds, solitude, crossing bridges, sea voyages and railway journeys" (I*ntroductory* tr Strachey 446).
[87] For these fears, Freud gives the example of a woman terrified of mice, noting such fear cannot involve "an exaggeration of universal human antipathies" such as solitude or darkness (*Introductory* tr Strachey 448), since the mouse clearly offers no threat.

to Freud is directed against the organism - gives rise to the fear of annihilation, and this is the primordial cause of persecutory anxiety" (190). Klein writes further of the splitting off of bad parts of objects and putting them elsewhere. Greed causes the baby to wish to destroy the good breast and introject what is bad about the baby (including faeces) into the breast (181). The resulting "bad" breast, having absorbed hated attributes, is then seen as an attacker. The subsequent confusion about good and bad objects causes difficulty in separating love from hate (184). This theory may well have relevance to the ambiguity in attitudes to the 'psy' professional, for whom the patient may feel both love and need as well as hate as part of the transference process. Thus the therapist's methods may well inspire fear at the same time as s/he works to counter the patient's fear. This, in my view, applies to both fictional and real 'psy' professionals and their patients.

These psychoanalytical discussions of fear and anxiety contribute to the understanding of the presence of these states in the individual. The fear of 'psy' professionals appears to be a generally held cultural phenomenon and therefore requires wider exploration of fear in society. It would therefore seem that cultural fear is a notion that psychoanalytic theory does not directly address. However, what I propose is that this takes place on a large scale, the 'psy' professional being made to absorb much that is intolerable in society. This figure thus becomes the repository of feared and free-floating evil.

Jung's notion of cultural archetypes may appear to offer an explanation of the roots of cultural fear, but this is contradicted by scholars of memory studies who posit that cultural memory is not "a result of phylogenetic evolution, but rather [is] a result of socialisation and customs" (Assman and Czaplicka 125). Critic and psychoanalyst Julia Kristeva's notion of "abjection" may also be pertinent. Kristeva sees abjection as "an experience of unmatched primordial horror . . . [while] ultimately, certain modes of discourse have found a way of speaking that horror instead of repressing it" (Becker-Leckrone 20). Literature is one of those significant "modes of discourse" which is able to speak of such horror.

What is abundantly clear is that prospective patients fear 'psy' professionals and internet searches reveal that fear is a very commonly expressed prelude to the need of distressed individuals to consult professionals in the field (see Fader, Gladwell, *Mental Health Forum, Quora*, *Healthy Place*, *WebMD*, Louise and *Drugs.com*). The following examples, which echo negative fictional/cultural depictions, indicate common themes. Patients fear they will be committed to insane asylums against their will and will never be heard from again; they believe they will be forced to take medications or be compelled to receive physical treatments; they fear sexual and physical abuse while receiving psychiatric treatment; and they are concerned that they will be forever tainted with the stigma that judges mental patients as dangerous and violent. Of particular interest to this thesis is that people posting on the internet often note that films and popular culture inform their concepts of the punitive, dangerous 'psy' professional. Indeed, one contributor to a Huffington Post entry stated: "All I knew about psychiatrists was what I'd seen in the movies and on TV shows" (Fader). This appears to confirm that cultural notions of 'psy' professionals are based on representations of this group in cultural artefacts.

On a positive note, however, many posts by frightened patients are followed by considerable reassurance from fellow sufferers. Such replies acknowledge fear and confide that they have shared it. Almost universally, replies from those who have consulted 'psy' professionals offer expectations of good outcomes to projected consultations.[88] This suggests that those individuals who have experience of encounters with 'psy' professionals have had positive experiences which allow them to offer comfort to new 'psy' patients. This would seem to be in contradiction to the overwhelmingly negative representations of 'psy' professionals in cultural artefacts.

I have indicated above that the terror of radically altered states as a result of madness is widespread and that fearing 'psy' professionals pervades our culture, as is exemplified by our cultural artefacts. King Lear's tortured cry, quoted at the opening of this introduction, communicates the fear of insanity

[88] This, in part, mirrors the content of a number of 'psy' novels (not discussed in detail in this thesis) in which there are no significant 'psy' professionals: the major source of help to patients comes from other patients. See, for example, Jacqueline Roy's novel *The Fat Lady Sings.*

that is perhaps universally present. If madness deprives the sufferer of identity, access to reality and reason, must it also, of necessity, produce fear of the 'psy' professionals whose role is to help the insane? While psychoanalytic theory offers some explanations, we may need to look to other disciplines to extend our understanding of the fear that seems to be invoked both by madness and its treatment.

Social scientist Jon Elster quotes French Renaissance philosopher, Montaigne, who notes our reluctance to admit ignorance while at the same time being "required to accept anything which we cannot refute" (Elster 126). Because of the social distance from the public kept by many 'psy' professionals, including their unwillingness to appear in public forums on television, radio etc, most of us personally know little of them.[89] Since depictions of 'psy' professionals in cultural artefacts are widespread, the public is much more familiar with these representations, leading to frequent adoption of the negative majority views expressed in fiction, comics, cartoons and films. Belief in the conspiracy theory of the evil nature of 'psy' professionals - a view that depictions frequently suggest - is then confirmed by a lack of contrary evidence from personal experience. This is exacerbated by the fact that 'psy' professionals largely talk to each other in specialist conferences and in journals that are not readily available to the general public. Lack of easy social interaction with 'psy' professionals would appear to confirm Darwin's statement that "ignorance more frequently begets confidence than does knowledge" (as ignorance of the 'psy' professional produces confidence in their malign nature) and that "ignorance together with confidence is a good recipe for error" (Darwin qtd in Elster 127).

Social psychology also addresses the problem of scapegoating, a practice applicable to a number of groups. Social scientist Peter Glick (2002) sees scapegoating as the result of seeking "plausible causal explanations at a collective level" thus "[blaming] shared frustrations on a specific group" (4). Glick notes that "[p]erceptions of the target group's malice and power are exaggerated in scapegoat ideologies" (4). An explanation of the general fear of

[89] The exception to this is internet films on YouTube.com. However, these are likely to be specialist, rather than popular, contributions.

the mad as perpetrators of violent crime, often expressed in the media (Mead-Brewer 2), suggests the scapegoating of the psychiatric patient and, by extension of Goffman's theory of stigma by association, of the 'psy' professional. Glick observes that scapegoating is "irrational" (4) but may produce a "continuum of destruction" (Glick 5). In this respect, the scapegoating that is aimed at the 'psy' professional may be seen as an expression of the fear of madness.

Scapegoating, of course, also offers an explanation for the historical and seemingly ever-present concept of Jews wielding astonishing economic and social power. The linking of 'psy' professionals and Jewishness is often observable in cultural imagery, perhaps predicated on no more than the key position of Sigmund Freud in both groups. Thus, the extensive power to do evil found in representations of the 'psy' professional may contain something of the attitude to Jews, which I deal with next.

SECTION 7: Other significant factors affecting the 'psy' specialties: Anti-Semitism, attacks from within the 'psy' professions and patient support groups

Just as the Nazis decried Albert Einstein's work on relativity as "Jewish science" (Ball), the Jewish origins of psychoanalysis, a theory developed by Austrian Jew, Sigmund Freud, have been repeatedly stressed in order to denigrate the scientific standing of Freud's work. It appears from my discussions of fictional representations and scapegoating above that Jews and psychoanalysis are frequently linked.[90] Anti-Semitism is a perennial social prejudice, with the Jew repeatedly cast in the role of despised outsider.[91] At the inception of the International Psychoanalytical Association, Freud, whose

[90] 'Psy' professionals are frequently given perceived Jewish characteristics (foreign names and odd accents) in cultural artefacts. See also Posen's comment above. Appignanesi notes how Freud appears as the "Jewish swindler" to some (220); and Jung's patient-turned-analyst, Sabina Spielrein has been characterised as "a seductive and plotting 'Jewess'" (Appignanesi 236), thus transferring blame for Jung's philandering to his patient.

[91] Stephen Frosh draws attention to the damaging, constant presence of Anti-Semitism and the nature of the outsider: "Anti-Semitism is a fundamental element of Western culture and is so pervasive and resilient that every individual member of that culture is constructed around it. That is, the Jew, and more generally the figure of the 'other', is a constitutive feature of Western consciousness" (4).

lengthy, sympathetic relationship with Jung had led him to regard the younger man as his spiritual heir (E Jones 328), supported the Gentile Carl Jung as Chairman for Life in order to distance psychoanalysis from Vienna and, of course, Jewishness (Frosh 42; "History of the IPA").[92] The influential German psychoanalyst Karl Abraham was aware of Jung's Anti-Semitism, to which Freud turned a blind eye as he sought to establish the universality of psychoanalysis (Frosh 25). As many Jews, including psychoanalysts, fled Nazi Germany, Jung used his position to "promote his theory as a fully Aryan alternative to the Jewish psychology of Freud and his followers" (Frosh 94). Jung does seem to have embraced the Nazi ideology which accepted a new, non-Jewish psychoanalysis, founded on a non-Freudian, pro-Nazi and Anti-Semitic basis" (Frosh 112). Anti-Semitism generally remains a frequent social feature, encompassing hatred of 'the other'. Ironically, this provides a useful metaphor for an unwanted element of the psyche being projected on the potentially good figure of the 'psy' professional.[93]

The fear and hatred of Jews has much in common with the fear and negative views of 'psy' professionals. Jews have long been blamed for many evils in the world (see, eg, Sion on "Conspiracy Theories"), while lack of evidence for Jewish responsibility for horrors may also be interpreted as a sign of the devilishly clever nature of the Jewish race. The Jew is often seen as barely human yet, at the same time, hugely powerful in causing major historical changes (Sartre). The conflation of Jew with 'psy' professional thus produces a toxic combination. What is more, the Jewish history of psychoanalysis, combined with the Jew's status as perennial outsider,[94] combines conspiratorially in the role of 'psy' professional as malign observer with secret powers.

[92] The early, close relationship between Freud and Jung turned sour (E Jones 365-8). Subsequently, Jung's Anti-Semitism has been much discussed. There is an interesting accumulation of material to counteract this charge, assembled by those working very hard indeed to exonerate him (eg, Purrington).

[93] This may also involve Klein's object theory, transferring bad attributes onto the potentially 'good' 'psy' professional.

[94] Frosh further suggests that "marginality" and "seeing things from the sides" may well be a "necessary condition for the emergence and influence of psychoanalysis" (13). Freud saw this marginality as an intellectual strength (qtd in Frosh 23).

Anti-Semitism and frightening fictional cultural depictions are not the only negative elements that threaten the reputation of the 'psy' professions. Perhaps more than in any other medical specialty, highly visible attacks on the 'psy' professions come from members within its own ranks. Critical psychiatry and antipsychiatry have been, and remain, powerful influences on the general public's view of the 'psy' disciplines. These offshoots of 'psy' theory have produced useful criticism of 'psy' disciplines, particularly that relating to the supposed scientific basis of psychotropic medications, their widespread use and economic desirability to pharmaceutical companies. It is, of course, commendable to cast a critical eye on treatments which may have no scientific justification, but balanced discussion is required if patients are not to be alarmed without recourse to alternative sources of help. Those activists who propound such criticism have a high-profile presence on the internet and in the non-specialist press. It is difficult for the general reader (and 'psy' patient) to distinguish between reasonable and unreasonable criticism of current 'psy' practice. There is much evidence to suggest that the pharmaceutical industry is indeed profiting from 'psy' patients, possibly to the latter's detriment (Bentall, *Doctoring*; Moncrieff, *Bitterest*; Moncrieff *Straighttalking*) but there are also extreme responses to the perceived power of evil 'psy' professionals, of which US psychiatrist Peter Breggin's 1993 paper "Psychiatry's role in the Holocaust" is an example. Here, Breggin claims "medical observers from the United States and Germany at the Nuremberg trials concluded that the holocaust might not have taken place without psychiatry" (1). While those who have criticised psychiatry include practitioners and authors worthy of considerable respect, such as R D Laing, there is nevertheless a powerful element of scare-mongering from some established 'psy' professionals.[95] These negative views, easily found and freely available on the internet, may offer valid criticism, but are not counter-balanced by the responses of psychiatrists who disagree, the

[95] Examples of such publications include Breggin and Cohen's book, *Your Drug May Be Your Problem: How and Why to Stop Taking Psychiatric Medications* and Canadian psychotherapist Bonnie Burstow's blog post, "Antipsychiatry - Say What?" (2017), which claims that it has been "demonstrated repeatedly by hundreds of solid theorists . . . that [psychiatry] is a bogus branch of medicine, and that it overwhelmingly harms". US journalist Robert Whitaker's 2017 blog post, "Psychiatry Defends Its Antipsychotics: A Case Study of Institutional Corruption", claims proof of the existence of "corrupt behavior which c[an] be found in every corner of psychiatry", including the "biasing of clinical trials by design". A number of 'psy' professionals, such as Joanna Moncrieff, Duncan Double, David Healy and Richard Bentall, often (though not always) tread a more nuanced line, blogging on such online sites as *Mad in America*, rXisk and *Critical Psychiatry Network*, but also publishing in major scholarly journals.

research of the latter group being largely published in scholarly journals, made inaccessible by paywalls. This leaves patients in a vulnerable position, with the strident, negative voices of those critical professionals urging us to discontinue our medication having a strong impact. Patients may well respond by rejecting medication, while critical psychiatry offers no valid substitution treatments. It is interesting that the group of 'psy' professionals who publicly engage in criticizing psychiatry is so much more vociferous than the professionals who practice mainstream treatment. This is not a clear-cut issue since some highly respected psychiatric practitioners and academics voice reasonable concerns. However, what is in my view damaging to patients is the volume of negative information on the internet, largely unopposed by positive information from the 'psy' professions. I maintain that a balance is vital and currently blocked as the voices of mainstream psychiatry are largely hidden from patients/service users within specialist journals that cannot be consulted without expensive subscriptions. These barriers of accessibility mean that patients are most readily exposed to negative, often frightening, information about 'psy' treatments. In my view, mainstream psychiatry should ensure its voice is also widely heard so that informed public debate is possible.

During the 1960s and 1970s, growing importance was attached to patient autonomy and consumerism in health care. A number of elements were central to this. Of note was the emergence of bioethics and notion of 'informed consent'. Within this context, patient advocacy groups began to emerge such as the Patients Association in 1963 and the College of Health in 1983 (Mold 162, 175). These gradually prompted a move away both from the culture of secrecy within medicine and from the deference to the moral authority of medical professionals.

At present there are large numbers of patient support groups, many of which post online. They can be helpfully positive, providing support from other patients and even legal advice (see MIND and Rethink Mental Illness in the UK). However, the Psychiatric Survivors Movement (see the Mental Patients' Union in the UK [Steven][96] and the Mental Patients' Liberation Movement in the

[96] Andrew Roberts, founder member in 1973 of the UK Mental Patients' Union, has produced an invaluable, comprehensive, online catalogue of mental health treatments, legislation and other

USA [Ginsberg]) which has highlighted the abuses of 'psy' treatments, has potentially caused some alarm, in the same way as have 'psy' professionals who attack their colleagues. A balanced approach is needed so that patients may be informed of abuses and lack of evidence for certain treatments; but also encouraged by the option of positive treatments, such as psychotherapy.

There is currently a plethora of disease-specific patient organisations, ensuring better patient rights. However, mental patients remain at a disadvantage as consumers of health care since their right to view records can be vetoed by a doctor. Health historian Alex Mold notes, "[t]he [National Consumer] Council believed that there should be just one exception: if access to the records would cause 'actual harm to the mental health of a patient with a record of mental or psychiatric illness" (131). Again, the system allows the greater power of the 'psy' professionals to take precedence over the rights of their patients.[97]

I have surveyed above the field of artefacts containing depictions of 'psy' professionals and have drawn attention to the generally damaging representations of this category of healers. I shall now proceed to consider four novels in some detail in order to elucidate the ways in which fiction presents this group of carers. Each work is set within a significant time within the history of psychiatric practice and will thus offer, in detail and in context, negative representations of the 'psy' professional as the adversary of mental health. It is my intention to highlight the unbalanced view fiction offers readers of a whole class of healers whose help is vital to many of us.

information (A Roberts). His fact-based advocacy of the rights of mental patients has been welcomed by many of us.

[97] In *Contesting Psychiatry: Social Movements in Mental Health* (2006) Nick Crossley writes: "It seemed that almost every perspective in sociology had something to say about psychiatry and in most cases what they had to say centered upon issues of power and control. Much less, in fact scarcely anything at all, was written about resistance to this power and control" (1). The powerlessness of the patient versus the power of the 'psy' professional is an ever-present cultural theme.

CHAPTER TWO: The almost invisible oppressor: the psychiatrist within the state mental asylum in 1940s America as presented in Mary Jane Ward's *The Snake Pit* (1946)

a) Introduction to *The Snake Pit*

The Snake Pit is the earliest novel to be analysed in detail in this thesis. I have chosen this fiction because of its importance in a number of areas. Firstly, *The Snake Pit* is challenging in narrative form and its subject-matter of mental illness and asylum psychiatry was unusual in a popular fiction which immediately became a best-seller. Ward's work heralded several widely read, major studies into the terrible conditions in US asylums, as well as a *Reader's Digest* condensed version of the fiction ("The Snake Pit: A Condensation") and a major film of *The Snake Pit* (Litvak). The result was that Ward's novel reached a very wide audience and had a major social impact on attitudes to psychiatric care which I shall discuss below. Secondly, *The Snake Pit* was published just after World War II when attitudes to insanity were showing signs of change as a result, in part, of major mental health screening in the population on behalf of the US military. The results of this screening and the large numbers of neuropsychiatric cases among veterans returning from the war was a stimulus to the passing of the *National Mental Health Act, 1946* in the United States (79th US Congress). The 1946 Act made mental health a primary federal responsibility. Broad public attention was now brought to the increasing concern about the treatment of insanity and dissatisfaction with the overcrowded, underfunded asylums. The psychiatrists who were the asylum heads at the top of the hierarchy in this specialty were eager to make changes in their practice. Their aim was firstly to gain scientific status that would equal that of their colleagues in physical medicine who were achieving major treatment innovations; and secondly to distance themselves from the failing asylums.

In this chapter I shall discuss the way Ward's narrative functions and the demands it makes on the reader. Central to this will be the apparent invisibility of the 'psy' professional to the patient and therefore to the reader. This figure might be expected to exhibit a key position of authority within the novel's

asylum, Juniper Hill. However, 'psy' professional input into the patient's treatment is obscured by the confusion of the narrator/patient, Virginia, who has considerable difficulty in locating and identifying where she is, whom she is with and where she might find the psychiatrists who could be expected to offer care. This places Ward's reader in a demanding position which parallels the fiction reader's role with that of a therapist receiving information from a mentally ill patient. This narrative technique will be explored as I highlight the task of the reader to follow and interpret the account of the patient, Virginia, and reconstruct her time in the place she discovers is a lunatic asylum with its various wards, doctors, attendants and frightening tortures. The reader comes to identify these brutalities as psychiatric treatment. I shall consider in detail how Virginia experiences the 'psy' professionals she comes across in the asylum. It is significant that all information in the novel is presented from the point of view of Virginia as asylum patient. Confusions of time, place and identity are in the forefront of most of the novel's narration, until Virginia moves towards recovery. The psychiatrists do not identify themselves or their role in treatment. If they have given Virginia information, she has been too disturbed to understand or recall it. I shall analyse in detail how Virginia comes by information relating to the circumstances in which she suddenly finds herself. I shall show how patient and reader work together to decode the events in Juniper Hill, while the 'psy' professionals - the overlords of the asylum - have no narrative input. Their case notes are not revealed, nor are these doctors described except through the eyes of the mad patient.

In considering the impact of Ward's fiction, I shall also consider Anatole Litvak's 1948 film of *The Snake Pit* and the *Reader's Digest* condensed version of the novel, since both these artefacts brought Ward's work to an even greater audience than the best-selling novel. I shall point to the significance of differences in these versions of Ward's work, both in terms of critical analysis and in considering the depiction of the 'psy' professional and interpretation of his role. My starting point, however, will be the historical contextualisation of Ward's novel in regard to the contemporary state of US psychiatry and the asylum.

b) The historical setting of *The Snake Pit*: the American insane asylum and the development of American 'psy' professions

The history of the rise and fall of the American insane asylum is intrinsic to the changing nature of the role of the psychiatrist in the USA. The psychiatric institution and the 'psy' professional's role evolved in the US in a distinctive way that I shall I explore below.

Social historian David Rothman discusses the persistence of the lunatic asylum in the US long after this institution was clearly failing to cure and discharge patients (xvii-xix). By the 1940s asylum conditions were perhaps at their worst and *The Snake Pit* did much to help bring to the nation's consciousness the dreadful conditions in America's psychiatric hospitals. Describing the optimistic rise of all forms of asylum in America from colonial times to the twentieth century, Rothman observed that it was firmly believed the evils of madness, poverty and criminality could be banished from the USA, a new country which had opportunities for everyone. Failed citizens, including the insane, could be retrained by the asylum. The English Quaker William Tuke had instituted moral architecture and moral management in the York Retreat in 1796 and his work influenced American planning, as did that of the English psychiatrist Dr William Battie. The latter believed that madness was "as manageable as many other distempers, which are equally dreadful and obstinate, and yet are not looked upon as incurable" (Battie qtd in Grob 50). Before this confident US expansion in asylum building, the mad were often housed in appalling conditions in jails (Grob 75; Rothman 88). American public policy changed and reformers such as Dorothea Dix sought to establish public US asylums for the insane by the second half of the nineteenth century (Grob 84).

Importantly, psychiatry as a specialty emerged in tandem with the rise of the state asylum. Psychiatrists were largely employed in public institutions, ensuring their link with the asylum at the same time as being offered financial security and a prestige rarely achieved by their medical colleagues in entrepreneurial general practice. The American medical superintendents (institutional asylum heads who were the early American psychiatrists) were

optimistic administrators who read and wrote widely on the treatment of the mad. They practiced curative methods that were largely associated with the administration of the asylum, including the design of the building, ordered programs of activities, nutritious food, exercise and useful employment (Rothman 133). They believed they had workable theories which would offer cures for insanity. In 1844, these energetic and dedicated US asylum superintendents founded the first organisation of medical specialists in America, the Association of Medical Superintendents of American Institutions for the Insane. They also published the *American Journal of Insanity* to represent the views of the Association, which was highly active in standardizing and collecting data on insanity.[98] American psychiatrists held an eminent place in medicine at this time. However, the realities of a growing and diverse patient group made moral treatment difficult to administer. While there was general agreement that asylums should remain small, the growing number of inmates meant inpatient populations increased rapidly.

Although the asylum persisted into the twentieth century and beyond in the USA, significant changes took place as these institutions became overcrowded and unable to fulfil their curative function by the end of the nineteenth century (Rothman xxxi). Keeping the peace, rather than curing mental illness, soon became the asylum's major task (Rothman 42-3). Nevertheless, American society was content to see asylums change their role to one of providing custodial care, since immigration, poverty and madness grew at the end of the nineteenth century and insane asylums were able to eliminate increasingly large numbers of pauper immigrants from the community. America was now using the insane asylum to remove undesirable members of society in a version of Foucault's "great confinement" (38). Developments in the view of the causes of insanity also played a large part in changes in asylum functions. Once firmly believed to lie in social malfunction and lack of discipline, madness was increasingly seen as somatic (McCandless 188) and heredity was now deemed a major factor (Rothman 250).

[98] Founded by Amariah Brigham and first published in 1844 (Grob 118).

This change in the status of the asylum, from a place where cure was expected to one where patients were warehoused and kept quiet, had a considerable impact on the role of the psychiatrist. Historian of psychiatry, Gerald Grob, in his meticulously detailed work on the treatment of insanity in the USA, *The Mad Among Us: A History of the Care of America's Mentally Ill,* charts the course of psychiatry and the changing role of the psychiatrist from asylum administrator to office-based medical expert, with a new, wide remit to treat all sorts of social problems by the early twentieth century. Grob points out the contradictions contained in American public policy towards the mad, noting that "psychiatrists have vacillated between emphasizing curability and chronicity . . . between a commitment to deal with the severely mentally ill and a search to find other kinds of patients" (Grob 21). Additionally, legislative changes to the insane asylum as a state-funded body meant that superintendents could no longer turn away patients sent to them by the courts (Rothman 269-70). The result of this was that the asylum heads had diminished control over admissions and so could not restrict patients to those that they predicted to be curable. What is more, the social policy of caring for the mad was not entirely successful at changing public prejudice towards the "filthy insane" (Grob 130).[99]. Economic restraints on asylum income usually meant that these institutions were "cheerless, dismal, and forbidding" (Grob 131).

Chronic mental illness remained central to US policy into the 1940s when Ward's novel was published, though psychiatrists focused largely on the more rewarding acute diseases. The psychiatric hospitals continued to grow as psychiatrists firmly opposed the asylum losing its prominent position at the centre of mental health management, in spite of the fact that they were largely unsuccessful in producing cures (Rothman xviii). *The State Care Act of 1890* changed the status of county asylums to those of poorhouses and the "distinction between chronic and acute cases was obliterated" (Grob 181; New York State Legislature). Each state was now responsible for its own insane population and a state tax was levied to support institutions. One result of this

[99] Grob observes that even psychiatrists voiced their prejudices. At the annual meetings of the AMSAII in 1857, one superintendent described foreigners as "more noisy, destructive, and troublesome," while another commented on the low curability rates of the Irish in particular. A few years later Ray noted that "'very ignorant, uncultivated people' often lacked insight into their delusions, a trait particularly prevalent 'among the lower class of the Irish'" (Grob 134).

was that the chronic and elderly mentally ill were of financial interest to insane asylums, further strengthening the gradual change from therapy to custodial care in the American insane asylum. This change diminished the medical prestige of the profession of psychiatry: asylum psychiatrists had become custodians of helpless and hopeless chronic patients who brought funding with them. Elsewhere, in physical medicine and particularly with progress in the germ theory of disease, science was making great advances in the early twentieth century (Grob 194). Psychiatry needed to review its image.

The requirements of the psychiatric profession to improve its scientific status meant that the specialty moved its interest away from asylums. Grob notes that psychiatrists responded to criticism by "identif[ying] new careers outside of institutions; articulat[ing] novel theories and therapies; expand[ing] jurisdictional boundaries to include not only mental disorders but the problems of everyday life; and defin[ing] a preventive role" (194). The aim of American psychiatrists was "the reintegration of psychiatry into medicine, which would permit them to share in the status and prestige enjoyed by the latter" (194). The psychiatrist and the asylum had begun their gradual disassociation.

Identifying cures for madness would bring the 'psy' professionals scientific respect. Scholar of psychiatry Andrew Scull notes the wide range of somatic 'cures' explored in the mid twentieth century, characterising this change in psychiatry as "a veritable orgy of therapeutic experimentation on the vulnerable bodies of those who had been certified as mad" (Scull *Madness: A Very Short Introduction* 78). However, it was still the case that the causes of severe mental illness remained largely unknown. Psychiatry was attempting to sever its ties to the asylum as the profession further sought to rebrand itself as a scientific discipline.

A change in attitudes to psychiatry and insanity was evident in World War II, which had seen the move of many psychiatrists to the military, where mass psychiatric screening had thrown up some uncomfortable results (Grob 282-3).[100] Twentieth century psychiatry was eager for scientific innovations that

[100] Grob notes that "more than 1,750,000 individuals" were rejected by the armed forces "for neuropsychiatry reasons (including mental deficiency)" (283).

would mean the end of the warehousing of the chronically insane in the old, overcrowded asylums of the kind present in *The Snake Pit*. As Grob details, "Even before 1940, fever therapy, insulin, metrazol and electric shock therapy, and lobotomy had begun to transform institutional practice and foster a long-absent spirit of optimism" (262). Psychiatric therapies had to match in efficacy those of general medicine if the prestige of psychiatry was to return. A Nobel Prize was awarded to Julius Wagner-Jauregg in 1927 for his work on malaria therapy, which seemed to offer a solution to the large numbers of asylum inmates suffering from neurosyphilis ("Nobel Prize 1927)". Then, in the 1930s, further "shock treatments" were introduced. Insulin therapy, developed by the Viennese Manfred Sakl, was now used on asylum patients (Grob 265), in spite of a complete lack of any evidence about its *modus operandi.* In the early twentieth century the theory of eugenics had briefly supported sterilisation of the mad and "feeble-minded".[101] Now psychiatry was ready to justify the experimentation of unfounded theories on asylum inmates. The Hungarian doctor, Ladislas von Meduna developed another shock therapy for schizophrenics, using metrazol to cause convulsions (Grob 267). Meduna's justification was founded solely on the observation that epileptics rarely became schizophrenic. The convulsions caused by metrazol mimicked the epileptic fit and the drug, therefore, was thought to prevent schizophrenia. Soon electroshock therapy was deemed to be safer. A 1946 psychiatric textbook claimed that shock treatments were now "indispensable tools of psychiatric therapy" (Grob 268). Perhaps the most intrusive therapy, however, was lobotomy, introduced in the 1930s and winning another Nobel Prize in 1949 for Portuguese neurologist Egas Moniz and Swiss physiologist Walter Rudolf Hess ("Nobel Prize 1949"). This procedure involved severing nerve connections in the brain's frontal lobes. The operation was enthusiastically adopted and widely practiced by US psychiatrists Walter Freeman and James W Watts (Freeman; *Lobotomy*). Outcomes were not always predictable and the operation was irreversible.[102] Freeman performed thousands of operations, often before

[101] Alison Bashford notes in her chapter, "Insanity and Immigration Restriction" that "the term 'feeble-minded' entered immigration law in . . . the United States in 1907 (Bashford). This is one of the many pejorative terms used for those destined for the insane asylum.
[102] It is well known that President Kennedy's sister, Rosemary, received this treatment which caused brain damage responsible for her subsequent lifelong dependency and institutionalisation ("The Lost Kennedy").

audiences.[103] While therapeutically suspect, lobotomy certainly made difficult patients easier to handle (Grob 273).[104] The problem was that none of these apparently brutal therapies had foundations in researched biology. Their widespread use was soon largely abandoned.

By the end of World War II, there was a major effort to transfer the care of the mad to the community. By the 1940s, the brutal treatments carried out in asylums were much discredited. The state psychiatric hospitals were in a parlous state, with overcrowding and shortage of funds making them the neglected, nightmare places that Mary Jane Ward wrote of 1946. The American 'psy' professionals, instead of winning scientific medical prestige, had largely become the keepers of the chronically mentally ill in neglected institutions.

American insane asylums were perhaps at their lowest ebb in 1946, the year of publication of Ward's *The Snake Pit*. At the same time, the psychological ravages of World War II had produced a more compassionate attitude towards the insane within the general public as well as in the profession of psychiatry.[105] Thanks to various sources of inside information, including *The Snake Pit*, Americans now became intensely interested in and concerned about conditions within the asylums. The public was not content with asylums that warehoused the mad in overcrowded, underfunded 'snake pits' (Grob 171; Ward 217).[106]

The *National Mental Health Act of 1946* (79th US Congress) reflected the fact that "[w]artime experiences had helped to create a model that emphasised the superiority of community-based over mental hospital systems" (Grob 220). The Act suggested the way forward lay outside the institutions which had so

[103] Freeman describes on film how this surgery is carried out in three to four minutes, using an icepick, hammer and electric shock as anaesthetic (Freeman). Freeman's film has been removed from YouTube but an America Public Broadcasting Service film evaluates this procedure and Freeman's enthusiastic promotion of it (*Lobotomy*).
[104] Grob notes that "lobotomised patients, previously regarded as highly disruptive or intractable, became more manageable and were able to adapt better to institutional life" (273). See also *One Flew Over the Cuckoo's Nest* in which McMurphy is lobotomised to prevent insubordinate behavior (Kesey 272).
[105] Investigations into asylum abuses by journalists such as Deutsch outraged the public.
[106] Virginia, Ward's protagonist, refers to this ancient practice of throwing a mad person into a snake pit to frighten them out of insanity.

degenerated. No longer firmly attached to the psychiatric hospitals, American psychiatrists would fill a radically changed role as the goals of mental health care were significantly altered in 1946. *The Snake Pit* spoke to the zeitgeist of the post-war period and the path which would lead to John F Kennedy's reforms, resulting in the *Community Care Act of 1963*, had begun (88th US Congress).

c) The impact of Mary Jane Ward's novel *The Snake Pit* on US attitudes to psychiatric care

The astonishing popular success of Ward's novel, *The Snake Pit,* not only highlighted the terrible conditions within US state asylums in the 1940s but also pioneered psychiatry as a new subject-matter for popular fiction. *The Snake Pit* immediately became a best-seller, earning its author more than $100,000 from the first month's sales (Hornstein "Narratives of Madness" 4). Publishers Random House chose Ward's novel as their Book of the Month and a condensed version was published in May 1946 by *Reader's Digest* ("The Snake Pit: A Condensation").[107] The film rights were soon bought by Twentieth Century Fox. The subsequent movie, directed by Anatole Litvak, was released in November 1948 and did much to publicise further the appalling conditions in America's state mental hospitals (Litvak).

So terrifying were the conditions and asylum regimes now reflected in Ward's fiction that *The Snake* Pit was viewed as a horror novel. Notably, the 2008 publication, *The Book of Lists: Horror: an All-new Collection* cites *The Snake Pit* as the number ten best-seller in the horror genre in 1946, calling it "The first big 'real-life' horror story" (Wallace *et al* 221). This media attention to patients within state asylums made it very clear indeed that these institutions, run by powerful psychiatrists, were terrifying places. *The Snake Pit* helped precipitate a campaign to improve US mental hospitals which included Albert Deutsch's investigative reports concerning US psychiatric asylums, published

[107] My references to the *Reader's Digest* condensed version are from a digital copy of the 1946 text provided by Megan Halsband at the Library of Congress. I was unable to locate a May 1946 copy of the magazine.

as “The Shame of the States”, for *PM*, a New York newspaper, and later as a book (Deutsch).

There were other significant exposés of American asylums in this period. On 6 May 1946, *Time* magazine ran a damning article about state psychiatric hospitals called, “Bedlam 1946: Most US Mental Hospitals are a Shame and a Disgrace” (Maisel). This article, containing graphic and alarming photographs, arose from reports of conscientious objectors sent to work in the asylums during the war. These workers were horrified by the appalling living conditions of patients. Maisel writes:

> Court and grand-jury records document scores of deaths of patients following beatings by attendants. . . . We feed thousands a starvation diet. . . . We jam-pack men, women and sometimes even children into hundred-year-old firetraps in wards so crowded that the floors cannot be seen between the rickety cots, while thousands more sleep on ticks, on blankets, or on the bare floors. . . . Hundreds . . . spend twenty-four hours a day in stark and filthy nakedness. (102)

The American people seemed hungry for information about the degraded state of these institutions and Ward’s novel reached huge numbers of readers.

Clearly, the newly aware public’s reaction to asylum conditions was unforeseen by US ‘psy’ professionals. American psychiatrist, Karl Menninger, wrote in relation to *The Snake Pit* that:

> [i]t was striking to note how shocked the public was regarding many things that some of us thought everyone knew about. We - some of us - thought everyone knew that public psychiatric hospitals were crowded, dark, dirty, and unsanitary places where there was little hopefulness. (145)

As well as confirming the terrible conditions in the state asylums, Menninger’s surprise at this general reaction seemed to confirm Ward’s presentation of the psychiatrist as distant, uncommunicative and out of touch with the public.

Litvak’s film of Ward’s novel added much fuel to the debate, additionally conveying to viewers that “ECT is a brutal, harmful, and abusive manoeuvre

with no therapeutic benefit" (Gharaibeh 318).[108] The public was becoming better informed about the brutality of the treatment of patients in the asylums. Indicative of the impact of Litvak's film of *The Snake Pit* is the fact that the *New York Times* reported in 1949 that, in Britain, psychiatric nurses attempted to have the film of *The Snake Pit* banned, concerned that the audience would "associate American treatment with British hospitals" ("British Nurses Seek Ban on 'The Snake Pit'"). Twentieth Century Fox felt British audiences should not be denied the chance to see the film and were quoted in the same *New York Times* article, arguing that "the whole American public has welcomed [the film] as a great stride toward breaking through the darkness that has clouded this theme." Ward's novel and Litvak's movie had attracted widespread attention to the American insane asylum, since novelist and director were aware of the public's ignorance of conditions in the asylums. Litvak certainly intended his movie to highlight an important, though little examined, social issue. Being sent to a psychiatric institution had always meant disappearing from the world of normal people, sometimes for good. In the USA, Olivia de Havilland - who played the novel's protagonist, Virginia, in the film - appeared in character on the cover of *Time* on 20 December 1948, another clear indication of the film's major impact ("Olivia De Havilland").

In his major survey of mental healthcare in the USA, Gerald Grob records the positive response to *The Snake Pit,* writing:

> The psychiatric reception of the book and film was highly laudatory, for Ward had placed primary responsibility for existing problems upon parsimonious governments that did not adequately support their mental hospitals. (302)

This, of course, suggested criticism of the whole psychiatric system, of which the punitive psychiatric overlord was only a part. Overcrowding and underfunding were major causes of poor patient treatment in the vast asylums (Grob 243-250).[109] As early as the 1850s, the psychiatric asylum had

[108] This article refers particularly to depictions of electroconvulsive therapy (ECT) in *The Snake Pit* and *One Flew Over the Cuckoo's Nest.*

[109] Grob notes that "In 1938, the average daily population of state hospitals exceeded capacity by 10.6%. In three states corresponding rates exceeded 40%, and in ten others the range was from 22% to 33%" (250). He also writes that "[T]he induction of physicians and staff into the

degenerated from “a reform to a custodial institution” (Rothman 263). This had resulted in a breakdown of illness classifications and the major use of “harsh and mechanical” discipline, including the use of “straitjackets, cuffs, sleeves, bed straps, and cribs” (Rothman 264).

In the mid twentieth century asylum, it was the case that the psychiatrists had enormous power to lock away patients and treat them forcibly. I have already noted above that this group of doctors used untested, experimental treatments on patients. Asylum inmates had no public voice from within patient lobbies to protest against their treatment and the causes and progress of their disorders had not been scientifically determined.[110] Ward’s fiction presents as protagonist a patient who is barely aware of the psychiatrist and his role in her treatment. In real American asylums as well as in Ward’s novel, these doctors did little to communicate with patients.[111] While it could be inferred by inmates that the psychiatrist was at the top of the asylum hierarchy, patients had minimal, uncertain and irregular access to him. He remained almost invisible to patients. His orders for terrifying and brutal treatments were usually carried out by attendants, with no explanation offered to patients (or, possibly, to the attendants either) of the purpose of treatments that felt like punishments (Lichtenberg). Ward’s Virginia experiences life at the Juniper Hill Asylum as a series of punishments, meted out by a string of personnel who do not identify themselves, for a crime she cannot determine. *The Snake Pit* was in the forefront of writing which brought about important changes in how America’s insane were treated (Hopson “When a Novel Changes a Social System”).

d) Psychiatry and the psychiatrist in Ward’s novel

Ward’s depiction of the psychiatrist, a doctor seldom portrayed in popular fiction, was innovative. Jacqueline Atkinson, writing generally about romantic heroes in the late twentieth century, makes broad comparison between psychiatry and other medical fictions, noting that:

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military created acute personnel problems. By the end of 1943 New York found that 31 percent of its medical positions and 32 percent of ward employee slots were vacant” (250).

[110] Kalinowski and Hoch write in 1946, “We are treating empirically disorders whose etiology is unknown, with treatments whose action is also shrouded in mystery” (Kalinowski 243).

[111] Patient/psychiatrist ratios must have had an influence on this. Grob notes that “[i]n 1941 there were perhaps fewer than three thousand psychiatrists in the entire nation” (Grob 282).

> Stories about psychiatry tend to do less well than those about other illnesses. . . . The reasons for this seem to be that there remains a generally negative public attitude to mental illness. . . . In films many psychiatrists remain faceless, even nameless . . . and we learn little of their personal lives. When we do, we usually discover problems; it is as though being a psychiatrist gets in the way of personal relationships. . . .
> (97-8)[112]

This comment draws attention to the negative public perception of psychiatrists and their perceived difference from other medical specialists. In Ward's novel, Dr Kik fits well into Atkinson's negative view of fictional psychiatrists.

The presentation of psychiatrists in *The Snake Pit* reflects the historical position of psychiatry in the mid twentieth century. A 1954 paper on the changing role of the psychiatrist in the US state hospital confirms that it was the norm for this specialist to be distant, inaccessible and even despotic at this time:

> In most state hospitals, it has been the custom to assign a psychiatrist to a ward or building with the total administrative and therapeutic responsibility for that area. In most cases, the physician used to function in his area as a sort of overlord who considered his task completed when, after making rounds or interviewing his patients, he gave orders for privileges, medicines or specific therapies to his chief nurse or attendant. He rarely attempted to alter the social milieu of the area and seldom worked directly with, or trained, his attendant personnel. His relationship with his personnel was generally that of a master who might or might not have been respected, but who was rarely accessible. (Lichtenberg 428)

Psychiatrist Lichtenberg goes on to describe successful changes he personally implements, bringing the psychiatrist into much closer contact with both nurses and patients, with resultant improvements in patient care. However, his statement above is important for highlighting the way psychiatric wards were run by distant, superior psychiatrists. Ward's Dr Kik, who has little communication with his patients, reflects Dr Lichtenberg's description of the *status quo* in the state asylum.

[112] This lack of personal information about the therapist is, of course, fundamental to psychoanalysis, the doctor being a blank slate available for the transference of the patient.

Sociologist and social psychologist Erving Goffman has written much that is relevant to Ward's Juniper Hill concerning the inaccessibility of the psychiatrist within the asylum. Goffman's important sociological study, *Asylums,* shows the workings of the institution in Ward's novel as typical of what he was to observe some years later. Although not published until 1961, *Asylums* remains perhaps the most significant study of the "total institution" that is the mental institution (*Asylums* 19). Goffman focussed on "the inmate's situation"[113] in his undercover study of St Elizabeth's hospital, Washington, DC (*Asylums* 11), and his investigation stresses the immense power of the psychiatrist. However, this dominant doctor, protected from patients by his staff, is almost invisible within Goffman's observations of patient/staff interactions.

Significant in relation to Ward's novel, Goffman observes that such "total institutions" have a binary character, with a clear distinction between patients and staff (19). Patients are defined as "not fully adults" (108) and have "offended somehow against propriety" (269). The institution demands information "about the inmate's social status and past behaviour - especially discreditable facts - [and these] are collected and recorded in a dossier available to staff" (32). In other words, the patient must confess to appropriate sins, first having to identify what the staff believe these may be. This confusion about apparent punishment for an unknown crime is noted below in Ward's novel when Virginia receives ECT (43). The psychiatric patient is in a different human category from the 'psy' professional.

Goffman refers to Ward's novel in *Asylums*, observing it is the norm for attendants to keep patients away from doctors. The asylum psychiatrist, according to Goffman, is "unique among servers, no other being accorded such power" (313). Generally, only bad behaviour on the part of the patient is noted by staff within "a disciplinarian system developed for the management by a small staff of a large number of involuntary inmates" (315). Obedient behaviour then leads to "promotion in the ward system" and "obstreperous, untidy behaviour to demotion" (315). The frequent ward moves in Ward's novel are

[113] The norm had been to present the psychiatric profession's view of insanity.

examples of such promotion and demotion. I note below how Virginia learns to play the conciliatory part of a well person who conforms to the norms she slowly and painfully discovers are required in the institution. Her knowledge is the result of her own growing observations and perceptions, unaided by information from any 'psy' professional. The mental hospital system, observed by Goffman, produces the following circumstances for the patient: "A crime must be uncovered that fits the punishment, and the character of the inmate must be reconstituted to fit the crime" (*Asylums* 334). I shall note how Virginia wonders what great crime she must have committed to produce so severe a punishment as electroconvulsive therapy (39). Ward's patient regains some autonomy by fighting the system she encounters in the asylum. To this end, she discovers what is expected of her and learns to conform to an artificial mode of behaviour which allows her to present an acceptable performance to the attendants and the all-powerful psychiatrist.

e) Virginia's perception of the psychiatrist within the asylum

Throughout the novel, Ward stresses psychiatrist Dr Kik's inaccessibility in the Juniper Hill Asylum. I shall consider in detail Virginia's interaction with Kik and the novel's other fictional 'psy' professionals. The remoteness of these doctors from their patients is repeatedly emphasised, as is the confusion they engender by failing to offer explanations of their identity or of the nature and purpose of the treatments they will impose.

The Snake Pit opens with an unidentified, hidden man asking the narrator, "Do you hear voices?" and the latter observing that there had been "days and days of incredibly naïve questions" (3). Narrator Virginia observes that this man speaks "gibberish" while she feels he is "testing" (4) her. She is entirely ignorant of his identity (4). It will be some time before the narrator and reader are able to identify the questioner as the psychiatrist, Dr Kik. For the present, the narrator finds him "something of a pest" (3) but indulges him as if he were "a fanciful child" (3). In a more sinister vein, the narrator also observes "she had suspected him of magic and now she knew" as the "pest" turns into a girl she soon discovers is called Grace (3). Confusion, apparent hallucination and fear grow as the narrator has no idea where she is but knows she is

"terribly, terribly afraid" (10). While Virginia tentatively identifies the place she is in as a prison, since an attendant treats the women as "criminals" (26), the references to keys and locks (26) and the narrator's confusion may well lead the reader to suspect the setting is a lunatic asylum. This is likely to be confirmed as Virginia notes that the girl she has been talking to "definitely needed a psychiatrist" (28). Observing what Virginia sees as this girl's oddness causes the reader to be aware of the narrator's disjointed memories and general confusion. The prevailing attitude to psychiatry is referenced as Virginia voices her opinion that "[p]eople go to a psychiatrist as secretly as they go to an abortionist" (28). Virginia recognises that to be identified as insane is shameful.

Ward's narrator again encounters the unidentified man as she is headed for "shock" (40). Still ignorant of his identity, Virginia now calls him the "Indefatigable Examiner", referring to his constant questions. Led by a "guard", it is now that Virginia partly recognizes "gold letters on a door" which seem "familiar" although she unable to make out any words (41). Considerably later Virginia's reliable and supportive husband, Robert, explains what these letters mean when he mentions "Dr Kik" to his wife (100). Robert reports that the doctor "sort of spits and gargles around but it boils down to being something like Kik" (103). Virginia wonders, "Could all of those letters shrink into one ridiculous little syllable" (100)? Not only is Dr Kik unidentified and inaccessible to patients, but his very name is hard to grasp.[114]

Knowing she is going for "shock", though not understanding what this might be, Virginia finds herself in a place "with the appearance of an operating room" (42). Here the "Indefatigable Examiner" is now "out from the bushes" and "wearing a white coat" (43). He addresses Virginia as "Jeannie" in a "heavy

[114] "Kik" is one of several aggressive-sounding names given to fictional psychiatrists, pointing to Ward's intention of characterising the fictional psychiatrist as experienced as hostile. See also "Dr Basch" (Shem *Mount Misery*), "Dr Cleave" (McGrath *Asylum*) and "Dr Lash" (Yalom *Lying on the Couch*). The name "Kik" may also be seen as implying "kike", an offensive word for a Jew. Ward's own doctor, Dr Gerard Chrzanowski, was a Jewish psychiatrist, known as Kik within his hospital (McCoubrey). Nevertheless, Ward chose to use this name in her novel and was surely aware of all the associations it contained. It cannot be ignored that psychoanalysis, which Kik practices, has the dubious distinction of being known as the 'Jewish science', a subject that I have discussed in the introductory chapter to this thesis, since the psychiatrist as Jew is a common motif, frequently with negative associations.

accent that you had never been able to place" (43) and he clearly knows her. As Virginia recognises the foreign accent, the reader understands that Virginia has had earlier, though forgotten, dealings with this man. Virginia anticipates a "local anesthetic" as she is forced into an "unnatural position" and realises "[t]hey were going to electrocute her, not operate upon her" (43). Although the operating table, anesthetic and the man's white coat all suggest a hospital, Virginia does not understand what she has done to deserve what she feels is a punishment rather than a medical treatment of some kind. Believing she cannot possibly "have killed anyone", she asks herself, "Dare they kill me without a trial" (43)? This is in line with Goffman's observations, noted above.

By this stage, Ward has presented a description of electroconvulsive therapy (ECT, or shock therapy); indicated the doctor by his white coat; and suggested by his foreign accent ("Jeannie" probably being a version of Ginny, for Virginia) and "hawkish nose" that he is a psychiatrist, the fictional 'psy' professional frequently being identified as foreign and Jewish, as I noted in chapter one. This information, along with Virginia's extreme confusion, memory lapses and references to the locks, keys and guards, all suggest to the reader that the narrator is being treated in a psychiatric institution. However, what Virginia experiences is torture at the hands of the "foreign devil": "Your hands tied down, your legs held down. Three against one and he one entangled in machinery" (44).

Later, in the dining room where there are "women who were far more wretched than criminals" Virginia recognises the insanity of her fellow patients, though the "terrible words" that might describe such a state are never used here, for the shamefulness of madness is not to be openly countenanced (51). Frightened and vulnerable, partially understanding where she is, Virginia feels she faces a prospect far worse than "blindness" or "cancer" (51). There will be exposure to more arcane rules, unexplained events and unpleasant punishments in this place before Virginia comes to a terrifying realisation:

> Here in this bare dormitory that had no door, here on the narrow cot, clothed in a numbered nightgown, she lay with women who were insane and she was one of them. (54)

Virginia has vague memories of distressing experiences in this strange place which she has had to identify for herself but has no recollection of any communication from a psychiatrist about why she is here and what is to happen to her.

The "Indefatigable Examiner" becomes the "Young Jailer" as Virginia narrates more apparent punishment. A new chapter abruptly begins in what appears to be the unfamiliar setting of a "rocky coast" where waves "strike against the wall of the prison" (169). Just before this sudden entry into a narration of torture and hallucination, Virginia has made a bid for freedom, hiding in a staff lavatory and refusing to come out until someone in authority fetches her husband Robert, the only person on whom the patient can rely. Attendants persuade Virginia to come out of the lavatory by lying about Robert's presence. Rushing out in search of her husband, Virginia is caught by attendants. "Someone tripped her and she fell. Instantly her head was encased in a sack and someone was sitting on her legs . . . she could not breathe" (168). This assault is followed by Virginia sinking more deeply into illness. The reader can assume this descent has been caused by her rough treatment at the hands of the asylum attendants.

The new torture suggests a 'psy' professional has ordered a different form of treatment. The patient, however, experiences terrifying imprisonment in a tower where she is tied up (169). Hallucination is now mixed with details which the reader may perceive as Virginia's reality, for "[s]he could wriggle her toes and her fingers, but otherwise she was tied down tightly in cold wet cloths. It was winter and the cloths would have frozen had they not been drenched with salt water" (169). The confusion between 'reality' and hallucination is indicated by the 'actual' restraints of "wet cloths" and the perception of "salt water" from the delusion of a storm at sea. Virginia seems to be subject to 'packing', a treatment involving tightly wrapping a patient in wet sheets so her movement is very limited. Still hallucinating, Virginia believes Robert is coming to save her from this terror. The psychiatrist, on the other hand, has no positive role that the patient has discerned. Seriously ill Virginia believes "[h]er share of the plan was to die" (170) as "this jailer . . . this man with the deceptively solicitous voice" (171) arrives. He and "the other jailer" (171) will throw dead Virginia into the

sea in her “dripping shroud” (171). The reader will recognise the jailer as one of Virginia’s perceptions of Dr Kik: the “Young Jailer”. This is a terrifying account of a hallucinatory experience in which the apparent ‘psy’ professionals play a persecutory role.

In another abrupt movement that the reader will have come to recognise as a result of the seriously ill patient’s incomplete perception of reality, narrator Virginia segues into a new hallucination, which appears to equate with a different psychiatric treatment. Textual indication is given to show that the patient has not lost complete touch with the reality of the institution as, in this new experience, Virginia is aware of the approach of the hospital’s ‘carers’. She notes, “Now they will be coming back down the hall with the canvas. . . . Under her closed lids she rolled her eyes high” (172). Virginia has briefly joined the reader in recognizing her hallucination. In the new misperception, Virginia hurtles down “Death Mountain” in a speeding car. She is then aware of being moved to a tub where she “thought she was going to be drowned” (176). A man who calls her “Jeannie” (the reader recognises Kik’s foreign accent) arrives to force-feed her. Virginia remembers that husband Robert has told her this man “means well” (179), although this is totally at odds with her experience: “[t]hey couldn’t be satisfied with electrocuting you and choking you; they had to bundle you up in icy wrappings and then torture you with food” (179). In this new, terrible assault from her psychiatrist, Virginia feels she is at “the bottom of a deep hole” with “quicksand seeping into [her] nostrils” (179). Recognising the torturer’s face, Virginia “shrank close to the bed. . . . It was the Young Jailer” (180). All methods chosen by the psychiatrist to treat Virginia are experienced by his confused patient as terrifying and painful physical assault. The largely unidentified mixing of hallucination and perception within Ward’s narrative conveys the nightmare jumble of Virginia’s illness and hospital experience. Ward requires the reader to assemble the confused information meaningfully while the fictional psychiatrist does nothing to help Virginia make sense of what is happening to her.

There is only one occasion in the novel when Ward depicts Kik in a totally positive way. Finding it impossible to gain access to her psychiatrist, Virginia feigns appendicitis so she can be sent to Dr Kik. In a rare gesture in

which the patient is accorded fully human status by the psychiatrist, Kik "held out his hand" (127). It has been very difficult for the patient to achieve an interview with the psychiatrist. This meeting, which proves helpful to the patient, has involved Virginia's initiative in acting a part since she judges she is not well enough to cope with her current ward and asks to be moved. Dr Kik would not otherwise have been aware of his patient's distress. Much more common in the text are the times when Kik seems to have withdrawn his help.

There are two important occasions when Dr Kik lets down his patient very badly without communicating with her. This occurs when Virginia attends "Staff", a procedure that is unexplained to patients and only referred to by this opaque shorthand title. In this daunting process the patient is interviewed by a panel of unidentified people the reader may assume are 'psy' professionals. Their aim seems to be to determine the patient's readiness for discharge from the asylum. Virginia's first attendance at "Staff" is made considerably more frightening than necessary by the total absence of explanation to patients of the event. The episode is presented entirely from within Virginia's fear and ignorance. Even the nurse who takes a selected group of women to wait for "Staff" "seemed uncertain about the procedure" (137). Ward's narration of this experience by bewildered, uninformed Virginia emphasises the confusion felt by patients, while at the same time conveying an event the purpose of which is clear to the reader. The accretion of information given by Virginia allows the reader to construct an overview of events which is unavailable to Ward's protagonist. Virginia meets an agitated patient who emerges from her own interview tells those waiting, "They don't tell you anything. They just write things down" (137). When Virginia is summoned to sit "facing the audience" (138) she finds Dr Kik is not there and his absence at this crucial event appears to his patient as abandonment. Virginia is asked a string of detailed questions about her life in New York by a man who does not identify himself. The reader may assume this is another psychiatrist. Virginia feels tricked into revealing she knows little of her husband's work or her current home address. She becomes both distressed and angry with the aggressive interlocutor who "was waggling a finger close to her nose" (141). There is no attempt by the psychiatrists to put the patient at ease in this difficult interview. No explanation is given of the purpose of the questions which Virginia understands as being attempts to trick

her (141). No one present is identified. No information is given to the patient about how well or badly she has performed. No one tells Virginia what will happen next. She finds herself moved to a new, strange ward and later discovers she had bitten the waggling finger.[115]

This consistent lack of explanation of events to Virginia from unidentified, authoritative men works to emphasise not only the lack of care on the part of the psychiatrists, but also their seemingly punitive role. The narrative stance of the confused observer, challenged by mental illness, repeatedly conveys her fear and bewilderment to the reader, who is better able than the patient to assemble the disjointed clues contained in Ward's narration. After "Staff", the sudden appearance of the angry but still unidentified "little man [who] shook his finger" in Virginia's new ward is very frightening. Only from husband Robert does Virginia discover he is Dr Curtis, head of Women's Reception (159). It seems he has never made his identity known to a patient who has been in Women's Reception for many months.[116] Curtis has shown no understanding or care for his patient; nor does he now communicate anything more than his anger with Virginia who is left to infer that she has failed "Staff". All this may be seen as cruelty on the part of the psychiatrists within the institution.

Although the second "Staff" meeting is a more familiar prospect to Virginia, she is again overwhelmed with fear. Dr Kik is again absent. By this time, the patient has made her recovery her own responsibility, for it has become very clear to Virginia that she must trust her own perceptions and expect nothing positive from the psychiatrists. Virginia has learnt to dissemble, for she discovers that acting well is a way of being treated as a well person, as I noted in my discussion of Goffman above. This pretence is very demanding for the patient who not only has to deal with her illness but must also construct a false relationship with the asylum staff. Virginia has invented her own "Thinking Therapy" (238) in an attempt to work at relearning how to think, a skill she feels

[115] This is one of several examples of Virginia's sense of humour which introduces an element of comedy into Juniper Hill, thus making the text less grim.
[116] If Dr Curtis had introduced himself at some point, now forgotten by Virginia, his lack of any reminder of who he is he demonstrates an absence of awareness of the confusion and disorientation commonly felt by patients.

she has lost during her illness.[117] She has made a dedicated effort to put on weight in order to indicate her increasing mental health (219). Reviewing Dr Kik's treatment of her earlier, Virginia has noted with more confidence to Robert that the doctor is "kind of young, isn't he" (257)? The Cunninghams have discussed their lack of faith in Kik, Robert having come to distrust this doctor to whom he earlier clung in desperate hope when his wife was seriously ill. Robert now says, "Of course I don't know a damn thing about psychology . . . but I'd stake my life on Kik being wrong" (255). Only at this point does Virginia discover from her husband that Kik has experimented with psychoanalysis on her "when he was hiding somewhere in the bushes and asking those silly questions. . ." (255-6). The reader will recall Virginia's experience at the beginning of the novel, asked ridiculous questions by an unidentified man (3).

Virginia joins a "terrified troop march[ing] to a building where [she] may or may not have been before" and has a prolonged wait in an ante-room before she is summoned in to "Staff" for the second time (261). Although the reader may feel the patient is wrong about the layout of the room being "part of a deep psychological plan" (262), it is yet again the case that no-one present explains what is happening. Virginia has learned to trust her own perceptions more now, so the reader can be certain that she has not been given any information about this process. This interview seems "much less formal" to the patient. She finds she has more faith in the direct, down-to-earth Dr Gifford. Even though he does not give Virginia any information, she is now well enough to make comparisons between Kik and Gifford. Mentally addressing the absent Dr Kik, the patient observes:

> . . . there is a sympathy in this other man that you lacked. You had pity and interest but this new one has an intuitive understanding and a willingness to admit that a problem is solved even when he does not understand what the problem was or how it was solved. (264)

In fact, it is clear that the deciding factor determining Virginia's discharge from Juniper Hill is the new psychiatrist's information that "her husband planned to take her home, out of the state" (263). Saving costs, not the condition of the

[117] To retrain her brain in the ability to think effectively, Virginia secretly works at remembering the plots of novels she has read and the talks of writers she has heard speak.

patient, is what causes Virginia to leave the terrifying asylum. It is notably Gifford's ignorance of the causes of Virginia's illness and self-directed progress that makes the patient feel this doctor is "sympathetic". Dr Gifford has not understood what has happened to Virginia and the reader will not consider him an exemplary 'psy' professional.

While Gifford's admission of ignorance is both appealing and unexpected, praise of this doctor from a Virginia gaining in confidence notably involves criticism of Kik. It seems a further act of psychiatric cruelty, taking the form of failure to communicate with the patient, that Virginia is not told, even by Gifford, that she has "passed" "Staff", although the reader is aware that Robert's promise to remove the financial burden of one patient from the overstretched Juniper Hill has been the deciding factor (255). The privately agreed symbol of Robert bringing Virginia's fur muff means it is her husband who informs Virginia she is to be released from the asylum (269). No psychiatrist gives her the good news. The 'overlord' status of the psychiatrist is again emphasised, too superior and uninvolved to communicate information the patient would find of great comfort.

Virginia has not thought beyond escape from Juniper Hill. Now facing welcome discharge from the asylum, the patient is offered no support to face the "[t]error of a world no longer familiar" (275). Frightening as the asylum has been, it has nevertheless offered the patient shelter. Though no 'psy' professional has helped Virginia, she is fortunate in having a trustworthy husband who "wasn't afraid" about her future (275).

Ward includes a final, subtle criticism of the Juniper Hill psychiatrists. A different, unnamed doctor who signs Virginia's release papers "absorbed a little time by tell them of his misery with sinus trouble" (276). It is up to the reader to compare this doctor's rather trivial complaint with the horrors that Virginia has experienced at Juniper Hill. Ward has shown that, from the patient's point of view, a long stay in a state asylum produces only punishment, torture and further confusion. Not only does Ward highlight the terrible shortages of everything but patients (277) and the absence of cures in the state asylum, she

has shown the psychiatrists as distant and so uncommunicative that any good they may have intended has been experienced by their patient as punishment.

The American asylum had perhaps arrived at its nadir by the mid twentieth century. Virginia has found Dr Kik inaccessible and uncommunicative and his treatment brutal. Ward's novel shows that the psychiatric profession was suffering from its association with terrible mental institutions.

f) Narrative strategy and the writing of *The Snake Pit*

I shall discuss in this section, and elsewhere in this thesis, the ways in which a fiction narrated by a mad person mirrors the way in which the therapist receives disordered and incomplete information from a disturbed patient. Such a text makes similar demands on the reader to those made by the patient on her therapist. In both cases the job of the reader or therapist is to assemble apparently chaotic material into a coherent story. In *The Snake Pit*, the reader receives limited information and support from her visiting husband; incomplete and occasionally unreliable information about the workings of the institution from her fellow patients; inexplicable details from her own perceptions and memory which she does not always trust; and no explanations at all from the novel's 'psy' professionals. I shall analyse below Ward's narrative strategy and the difficulties of presenting the account of a mad narrator.

The Snake Pit was not only important for drawing widespread attention to the terrible condition of America's state asylums and the apparently oppressive rule of the psychiatrist within those institutions. It was also significant as an early example of a fiction of recovery from mental illness, the great majority of other such accounts being autobiographical reports. It must be noted, however, that the latter also rarely contained praise for the 'psy' professional. Ward had been hospitalised in Rockland State Hospital, Orangeburg, New York, for eight months in 1941.[118] On the back of the dust jacket from the Random House book-of-the-month edition, the author describes her writing of the novel:

[118] A brief author biography is available online (Ksander).

> I wanted to do a factual book about a certain type of hospital, but before I'd gone more than two paragraphs, I realised I was writing about a place that existed only in the mind of my protagonist. The photographic possibilities were immediately ruined by the fact that this character could not be depended on for accuracy. The resulting story, then, is not true. . . . (Ward dust jacket)

This quotation is important for its insight into Ward's view of the status of her narrative of madness, its reliability and its tenuous connection to 'reality'. The author draws attention here to the extreme alteration in perceptions that accompany severe mental illness. The novel itself shows that recognising and accepting these distorted perceptions are vital to the patient. Ward's fiction demonstrates that the psychiatrist within the institution fails to recognise or acknowledge the patient's disturbed view of reality so the latter cannot perceive him as a healer. While the shortage of psychiatrists and their resultant limited time with individual patients may have exacerbated this problem, Lichtenberg's quotation above acknowledges that the distant psychiatrist within the state asylum fails to make helpful, productive contact with his patients and staff. Ward's fiction of madness vividly shows the patient's overwhelmingly negative experience of psychiatric care.

The addition of patient narratives, factual or expressed as fiction, is very important for our understanding of psychiatric illness. American psychologist Gail Hornstein writes, "Patient memoirs are a kind of protest literature, like slave narratives. . . . They retell the history of psychiatry as a story of patients struggling to escape doctors' despair" ("Narratives" 1). Relevant to *The Snake Pit* and Virginia's struggle to produce her own recovery in spite of the psychiatrist, Hornstein writes, "Again and again, patients talk of having to wrest control of their treatment or cure themselves after some physician had given up on them" ("Narratives" 1). I have already discussed in this chapter the way in which Virginia invents her own methods to achieve an improvement in her mental health. Patient narratives are vital in offering an alternative view of madness. They stand alongside the psychiatrists' case note versions,[119] and, as both fiction and history do, they broaden the reader's perception of events.

[119] Case notes are, of course, largely inaccessible to general readers.

This results in a multi-faceted view of madness which enriches the reader's understanding of the subject.

Literary critic Peter Brooks draws attention to the pervasive role of narrative within human activity.

> Narrative is one of the large categories or systems of understanding that we use in our negotiations with reality, specifically, in the case of narrative, with the problem of temporality: man's time-boundedness, his consciousness of existence within the limits of mortality. And plot is the principal ordering force of those meanings that we try to wrest from human temporality. (*Reading* xi)

Brooks emphasises that we look to plot to understand time. It is, of course, not unusual for novel writers to eschew linear time in their narratives, but some resolution is the norm in fiction. A mad narrator, however, might well give the reader difficulty in establishing what is happening, as well as where and in what order events take place.[120] Indeed, an insane narrator is likely to be deemed untrustworthy in her presentation of experience. Ward's Virginia is frequently aware of her problems as a psychiatric patient in accounting for time in Juniper Hill.

> Time was different here; sometimes it was long and sometimes it was short and sometimes - this was disconcerting - it was not at all. In real life you had been able to count on time; you might feel you hadn't enough of it, but it was always there, nicely parcelled out in seconds and minutes and hours. (93-4)

Attempts to understand time are part of Virginia's constant struggle in the novel.

The reader understandably questions the reliability of a mad narrator in fiction. Critic Louis Sass summarises society's long-standing view of the mad when he writes:

> It has been assumed that the madman's point of view is not simply idiosyncratic but actually incorrect, or otherwise inferior, according to some universal standard. (Sass 2)

[120] This conundrum for the reader is present in the other three novels discussed in this work.

Virginia's comments on time show her uneasiness at perceptions that she is aware are unreliable (93-4). Although ill, she does know that her ability to judge time has been distorted. Clearly, madness is terrifying in itself, even before it leads to unexplained shifts in time. Sass goes on to define how the madman's problems in constructing a narrative have been considered.

> Depending on how reason is understood, this lack has been viewed in somewhat different ways: as a diminished capacity for logical inference or correct sequencing of ideas; as incapacity for reflexive or introspective self-awareness; as inability to exercise freedom through independent volition; as loss of contemplative detachment from immediate sensory input and instinctual demands; or as failure of language and symbolic thought - to mention the most common. (3)

It is a difficult task to present a narrative which successfully communicates perceptions from a position of madness, particularly when it comes to representing distorted time. Readers need and expect what Roland Barthes calls "an implicit system of units and rules", while noting "[t]here is a world of difference between the most complex randomness and the most elementary combinatory scheme" (253). To focalise a fiction through the eyes of a mad narrator is likely to be challenging, although a disordered narrative also works as a signal to readers that they are dealing with an insane narrator. It has been noted that one of the problems for the psychiatric patient is her inability to narrate her own story coherently since she is likely to lack the secure attachment that is generally recognised as a feature of sanity. In shedding light on the traumatised, insecurely attached patient, Jeremy Holmes notes:

> Those who are securely attached . . . can: (a) distinguish between their own experience and that of others; (b) represent and so tell the story of their feelings; and (c) have the capacity to break up their stories and reform them so they are more in keeping with the flux of experience. (Roberts and Holmes *Healing Stories* 57)

When severely ill, Virginia lacks this ability to "break up . . . and reform" her disjointed experiences into a meaningful whole which tells the story of her madness, incarceration and treatment, followed by her eventual recovery. Her earlier difficulty in accepting her diagnosis and owning her story within the asylum is apparent as she repeatedly fails to own her narrative, addressing an imaginary "you" rather than using the personal pronoun (6, 16, 18, 27 etc).

Only on discharge does Virginia notice the labels on her clothing, where, "[u]nder the hospital's name was a long string of numbers. All but the 33 were crossed out" (277). These labels provide a concise metaphor for the patient's abrupt, bewildering and unexplained movements between a succession of wards in a totally confused span of time. Now, on discharge, Virginia recognises these "mementos" (277) and is able to allocate some organisation to her Juniper Hill experiences. Virginia's recovery instructs the reader in seeing that the disjointed narration from within madness has moved into ordered sanity.

The reader of any novel looks to the work itself to discover how to read the fiction. Indeed, Peter Brooks argues that "[m]ost viable works of literature tell us something about how they are to be read, guide us toward the conditions of their interpretation" (*Reading* xii). While the twenty-first century reader may recognise the category of the asylum novel when reading *The Snake Pit,* the novel's early appearance as a popular fiction in this genre, barely established in the 1940s, must have presented some difficulties for contemporary readers. It is a considerable tribute to Ward's achievement that the novel was so well received and gained such great popularity immediately on publication. However, the very fact that *The Snake Pit* is indeed a novel gives the reader guidance on how to treat the narrative. Causal links between apparently randomly selected events may be assumed, although they are not immediately apparent. Literary critic Brian Richardson observes that "[n]arrative is a representation of a causally related series of events" (170). Richardson's approach is enlightening if reading a fictional narrative with a mad narrator in which causal relations are not to the fore.[121] He points to "the representation of events in a time sequence as the defining feature of narrative", noting that "some causal connection, however oblique, between the events is essential". Richardson also states that "narrative is simply a way of reading a text, rather than a feature of essence found in a text" (169). Richardson's broad summary is applicable when considering fictions in which time and causal connection between events appear to be random, lacking Barthes' "implicit system of units and rules" (253). In *The Snake* Pit, the causal links - which are at first hard to

[121] This will also be of relevance in my chapter on Mortimer's *Long Distance.* Not being a recovery narrative, Mortimer's novel presents greater challenges to the reader.

make - become apparent as Virginia moves from madness to sanity. Virginia's confused and terrifying experiences can only be understood if the reader accepts the disorder of her perceptions which gradually move towards a discernible structure as sanity is approached.

Ward uses a narrative technique which obscures causality as the text jumps abruptly between scenes, following Virginia's conscious awareness. The result of this lack of linearity is that Ward's narration achieves vivid depiction not just of the different places in which Virginia finds herself, but also of Virginia's confusion and fear at these apparently disconnected experiences. Each scene is quite clearly presented, although what the reader, like Virginia, does not know is how the protagonist moves between these wards and treatment spaces. The reader receives an accumulation of unexplained facts. For meals, the women are locked in a chaotic dining room, where there is pitifully insufficient food. The lavatories have no doors and there is a "curious and humiliating procedure" of a nurse handing out toilet paper" (34). Clothing is kept on a numbered rack (36), removing the individuality of the women. There is enforced medication from a "guard" (38) for the "prisoners" (38). One morning Virginia wakes in a room that she experiences as "having been moved to the other end of the hall" (40).

The narrative makes it clear that much of Virginia's confusion comes from her illness itself. Her memory is dysfunctional. Trapped within her confusion, Virginia is certain of very little at the outset of the novel, knowing barely more than that her name is "Virginia Stuart Cunningham, Mrs Robert P Cunningham" and that she is a writer from Evanston, Illinois. Virginia's confusion contains clues for the reader about her situation which the narrator is not yet able to interpret. This place has a "smell of zoo"[122] (17) and there are "cages" (17). As discussed above, discovering her own identity as asylum patient is one that Virginia finds extremely hard to recognise and the absence of an identifiable psychiatrist makes this considerably more difficult for the patient, although the reader receives a steady stream of indications, not the least of which is Virginia's confusion itself. However, no-one within the asylum offers any explanation of treatment or ward change as far as the narrator is

[122] This references the widely used sedative, paraldehyde.

concerned. In the dining room, Virginia remembers, “They became vindictive if you did not eat. They mashed the food into a mush and pushed it up your nose. No, I have dreamed that. That could never happen” (47). The reader may surmise that force-feeding is another unexplained and unpleasant procedure ordered by the remote but powerful psychiatrist. Patients are aware of total physical control. The administration of paraldehyde for enforced sleep is mandated (92). Arcane rules have to be followed, such as, “We do not walk on our carpet. . . . Because we don’t” (201). The nurses often seem as ignorant as the patients of reasons for the peculiar way the hospital runs. The psychiatrists who rule the asylum are rarely in evidence and, even when present, seem to offer no explanations to patients or even to staff. Conveying Virginia’s experience as madness narrative demands that the reader, in the role usually taken by a therapist, makes the causal connections which allow her to assemble the confused scenes meaningfully.

By the time Virginia is moved to a new long-stay ward, she is beginning to make considerably more sense of her Juniper Hill experiences. Here, the patient is aware of even worse conditions, noting the women “had great red sores on their faces” (211) and that some inmates are barefoot, even in the snow, as they rush through the nightmare tunnel to the cafeteria (222). In spite of Virginia insisting that Kik is her doctor, she is assigned another psychiatrist, Dr Terry. She sees this man as a “young squirt” (222), this definition marking him out to the patient as much less dangerous than the “Indefatigable Examiner” or the “Young Jailer” who was among Kik’s embodiments. The reader, who has learnt to trust the narrator’s growing confidence in her ability to perceive conditions and events in the asylum, will observe that Virginia expects to receive no professional care from this new doctor.

Ward’s narrative of chaos, which has followed Virginia’s confused mental processes, is gradually resolved into order at the end of the novel. The patient now emerges from madness and, though still afraid, moves towards sanity. In her final interview with psychiatrist Dr Gifford, Virginia is able to take control of her answers and show working memory and even effective insight into the possible causes of her illness:

> And I suppose I was scared about money. It was my fault, really, that Robert gave up his nice job at home, and so I kept trying to write something that would make up for it. It's bad when a writer begins to think more about the check than the story. It makes you awfully nervous. And Robert was working such terrible hours. . . . (271-2)

This ordered speech is a new mode of expression for Virginia. In Ward's novel *dis*order is used as a narrative style to communicate the confused turmoil of madness. The narrative mode which highlights the inability of the asylum patient to perceive order in the timing of events, as well as movement within the spaces of the institution, have helped to produce the chaos which makes the psychiatrist so difficult to locate. Crucially, at no point in the narrative is the patient aware of the psychiatrist helping his patient find and use him.

At the end of the novel, Virginia insists to Dr Gifford that Dr Kik "was always so kind" and "remained a gentleman" (271). She makes these diplomatic statements recognising that, "[i]f Dr Gifford was waiting for Robert to fabricate white lies on the subject of Dr Kik he might as well settle back in his chair" (271). Virginia has taught herself to act the expected conciliatory part in order to produce the response required by those in authority. In her great need for help, the patient has shown a certain dependency on Kik throughout the novel, in spite of experiencing his treatments as brutal. She now exhibits highly competent social awareness of the right thing to say about Dr Gifford's colleague, while at the same time tentatively expressing her opinion that Kik was "mistaken" in some of his pronouncements about his patient (271). To the self-taught skills of acting an acceptable role as patient and the invention of "Thinking Therapy" to retrain her confused mind (238), the reader may also observe that the process of narrating experience has worked therapeutically for Virginia, in the absence of any psychiatrist able to offer the patient constructive help instead of inexplicably brutal treatments. Virginia's narrative has drawn the reader in to an understanding of the chaos of mental illness. The result of this is that the reader has considerably greater understanding of Virginia than any of the novel's 'psy' professionals.

g) The psychiatrist in Anatole Litvak's film of *The Snake Pit* (1948)

I shall consider in some detail Anatole Litvak's very successful film version of *The Snake Pit*, since the movie's relevance to Ward's work is significant. This is because of the great changes the film made to the representation of the psychiatrist, as well as alterations to the character of Virginia which make her receptive to Dr Kik's psychoanalysis. To highlight these major departures, I shall consider the salient differences between Litvak's film and Ward's novel and analyse Litvak's motives in producing a very different text from the fiction. While it is the case that both novelist and film-maker concentrated heavily on drawing attention to the appalling conditions in US state asylums, ensuring that both fiction and movie had a major impact on the general public's perception of the treatment within these institutions and the need for reform, nevertheless the two texts differ markedly in the depiction of Dr Kik and Virginia's response to him.

It is important to point out that Litvak's movie has introduced misperceptions among readers and critics who cite events from the film as if they took place in Ward's original novel. A *New York Times* critic, praising the film, notes in 1948 that "[t]hey followed the book with rare fidelity" (Crowther). Attentive reading of Ward's novel will show that this is far from the case with regard to both Dr Kik and Virginia. Litvak's Kik is a committed 'psy' professional, dedicated to the care of Virginia by the use of psychoanalysis, while employing all other forms of treatment only to improve the patient's ability to engage successfully in this analysis. The film version of Virginia is no longer an independent career woman but a much more malleable patient who finds constant comfort in Kik's care. Critic Michael Shortland points out that, "[s]et against the vivid realism of the rest of the film, the natural assumption was that Dr Kik was also a portrait drawn from life" (Shortland 429). Litvak's fidelity to Ward's depiction of hospital conditions has meant that many film goers have assumed that Dr Kik is presented identically by Ward and Litvak.

As soon as he saw the proofs of Ward's novel, movie director Anatole Litvak was immensely keen to make a film of *The Snake Pit*. Critic Leslie Fishbein writes of Litvak's great enthusiasm and determination:

> In May 1945, while *The Snake Pit* was still in galley form - long before it became the Book-of-the-Month Club selection in April 1946 and before it exceeded a million sales - Bennett Cerf allowed his friend Anatole Litvak, still an Army colonel, to read the proofs. Litvak not only decided instantaneously to film the book but also convinced Olivia de Havilland to play the title role. He then persuaded Daryl Zanuck, chief of Twentieth Century Fox, to buy the film rights from him. (646)

The lengthy article on the film in *Time* (which featured de Havilland as Virginia on its cover) also notes that Litvak used his own money to pay the $75,000 for the rights to film Ward's novel ("Shocker" 44). It was difficult to find a backer for the movie for some time, Zanuck finally paying $175,000 for the film rights and assigning Litvak, "together with veteran Fox Producer Robert Bassler" to make the film ("Shocker" 44). Litvak had taken a big financial risk and is quoted in *Time* as saying "They all thought I was as crazy as the girl in the book" ("Shocker" 44). The subject matter of terrible conditions in US lunatic asylums was perhaps unappealing as a financial risk for a film studio. Earlier films on the subject, such as director Robert Wiene's *The Cabinet of Dr Caligari* (1920) and Mark Robson's *Bedlam* (1946), starring Boris Karloff, could be designated as horror films which, as I discuss in my introductory chapter, was to become a major category for asylum films. *The Snake Pit*, in novel and film versions, offered social commentary.

Litvak's personal background and interests, and the parallel developments of psychoanalysis and the movies - both of which developed through the first half of the twentieth century - do much to explain the pro-psychoanalytic stance of the film of *The Snake Pit.* Litvak became a US citizen in 1940 and worked as a contract director for Warner Brothers ("Anatole Litvak, Biography"). The cinema offered new narrative techniques and was able effectively to reproduce dream sequences and memory (accurate or distorted) in flash-back in a new and convincing way. Since the early twentieth century psychological states, such as those depicted in *The Cabinet of Dr Caligari*, had become recognisable tropes of the movies.[123] Litvak's use of flashback to

[123] Critic Stephen Heath, notes the intertwined, if one-sided, relationship between psychoanalysis and the movies (Heath 25). Heath writes of Freud's negative response to collaborating on a film about psychoanalysis, followed by the work of two of his followers, Karl Abraham and Hans Sachs, on what eventually became G W Pabst's movie, *Secrets of a Soul*, which premiered in Berlin in 1926 (*Secrets*), accompanied by an informative pamphlet on

provide a Freudian explanation of Virginia's illness - which informs viewers about Virginia's childhood - and the sudden scene shifts which mirror mad Virginia's confused perceptions as she is moved from ward to ward, are effects much suited to the medium of film. Litvak's direction clearly signals Dr Kik's theoretical allegiance to viewers: a picture of Sigmund Freud (not mentioned in the novel) is clearly visible in many of the interviews that take place in Kik's office, with Virginia and Kik often appearing on either side of the master's portrait. To reinforce the psychoanalytical setting of Kik's approach to Virginia's treatment, a new, altered back-story is added to the novel's content. Film-viewers see scenes from Virginia's childhood, showing her problematic relationship with her much-loved father. To this is added the death of her former fiancé, Gordon, in a car accident which Virginia survived.[124] These two deaths are identified by Litvak's Dr Kik as sources of guilt which have caused Virginia's illness. It would seem that Litvak wanted to present a clear psychoanalytical explanation for Virginia's severe mental illness, thereby showing that psychoanalysis can be a highly useful tool. This aim explains his major changes to the character of the psychiatrist in his film.

Interestingly, Litvak makes another change in Virginia's story. The Cunningham's unsettled, poverty-stricken living arrangements in a "co-operative" (56) and the Socialist and Russian friends of the young couple are omitted from the film, although "True Trotskyite" friend, Helene (20), features significantly in the novel as Virginia begins to remember her life before illness. Communism may have been too uncomfortable an association for Hollywood in a heroine with whom the audience was expected to sympathise. The spotlight shone on Hollywood by Senator Joseph R McCarthy in his search for subversive communist affiliations would have been dangerously unwelcome to Ukrainian-born Litvak. Ward's Virginia, engaged in contemporary politics, is

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psychoanalysis, "Enigma of the Unconscious" (qtd in Heath 27). At first, psychoanalysis showed a lack of general interest in cinema in the early years of the movie industry, displaying "intellectual and class disdain for the upstart popular entertainment" (Heath 26). However, soon "the trope of cinema as analogy of mental life had become commonplace" (Heath 30). Litvak, like other directors such as Hitchcock in his near contemporary film *Spellbound* (1945), capitalised on psychoanalysis's powerful notion of interpretation. While Freud saw cinema as "an inadequate mode of translation of psychoanalytic insights" because of its "reliance on a common sense of images" (Heath 41), Hollywood was generally happy to co-opt popular interest in psychoanalysis within its on-screen storytelling.

[124] Gordon dies of an unidentified, incurable illness in the novel and his death is considered by Virginia as irrelevant to her illness (257).

also at odds with Litvak's 'cured' Virginia happily accepting the domestic role of supportive wife, a matter to which I shall return.

Unlike Ward's foreign, uncommunicative and inaccessible Dr Kik, Litvak's handsome, charming, reassuringly British, pipe-smoking and avuncular Dr Kik moves to the centre of the film's content. This film version of Dr Kik pursues dedicated, constructive care of Virginia. He thoroughly probes her background to reconstruct the sources of her illness using psychoanalytic technique. He visits Virginia frequently in different parts of the hospital (including the dormitory at night) and even, extraordinarily, partners her at the patients' dance. None of these events appear in Ward's novel. This is most definitely not Ward's Dr Kik. At the end of the film, Virginia tells Dr Kik she has been in love with him, a motif that viewers may recognise as expected analytical transference, but one which does not feature in the novel. Ward's very different depiction of Dr Kik, which exhibits the negative presentation of the 'psy' professional which is so common in cultural artefacts, stands in clear contrast to Dr Kik in the film.

Litvak's enthusiasm to make a film of *The Snake Pit* was strongly motivated by the need to highlight the terrible conditions in state asylums, noted in various publications and mentioned above. Litvak was clearly aware of these critical publications and the scandalous state of patients' living conditions in the asylums. Along with his screen writers and lead actors, he dedicated much time and energy to researching mental institutions.

> Not only were the participants in the enterprise dedicated to achieving clinical accuracy on screen; they also set out to observe actual institutional life to guarantee authenticity. The writing of the screenplay was begun only after [screen-writers] Partos, Brand,[125] and Litvak had spent three months observing patients and hospital routine at public and private institutions in New York, New Jersey, and California. Heroine Olivia de Havilland[126] and Leo Genn, who portrayed her psychiatrist, spent several weeks simply visiting asylums and studying conditions. (Fishbein 653-4)

[125] Millen Brand had already published the sensational novel of mental breakdown and recovery, *The Outward Room*, in 1937 and was to go on to write *Savage Sleep* in 1968.
[126] Olivia de Havilland had previously portrayed screen madness, playing the good and evil twins in Robert Siodnak's *The Dark Mirror* (1946) alongside film psychiatrist Scott Elliott, played by Lew Ayres (*The Dark Mirror*).

Accuracy about mistreatment of mental patients was a high priority for Litvak in making this film of social commentary. However, Litvak's insistence on the message that psychoanalysis was a very useful tool was perhaps as important to the director as the exposé of the terrible conditions in asylums.

That the film of *The Snake Pit* clearly shows psychoanalysis in a positive light seems to reflect Hollywood's stance on this new method of dealing with psychiatric illness, a treatment which had been imported into America from Europe. Indeed, *Time* describes Litvak as "a strong believer in psychoanalysis [who] tells his story with great simplicity and sympathy" ("Shocker" 45). Anatole Litvak's experience makes this unsurprising. He had already worked in Soviet theatre and film, and in the movie-business in Berlin. While serving in the US military, Litvak made movies for the War Department ("Shocker" 44) and would have been well aware of the increased respect the psychiatric profession had earned from the armed forces. Noting this new trend in the cinema, Michael Shortland writes that during the war,

> the [psychiatric] profession itself was accorded a high profile: psychiatry, in effect, went public. It served the allied war effort by screening, testing, treating and then rehabilitating those who served in the armed forces, and this more visible presence was noticeable on screen. As we might expect, portrayals of the psychiatrist became more unified, or at least, more generally sympathetic. (Shortland 422)

Litvak took the depiction of psychoanalysis very seriously and his wish for accuracy was reflected in his research methods. "The case history was worked out in collaboration with three prominent psychiatrists and experts claim that it is accurate and typical" ("Shocker" 45).

At odds with Ward's novel, other treatments shown in the film are also presented in a more positive light, since they serve the aims of psychoanalysis. Litvak adds the technique of narcosynthesis to Virginia's treatment, as Kik injects his patient with an unidentified drug so that she recalls much of her past in a medicated state. The movie's Dr Kik is soothing and kind throughout this process. To a twenty-first century audience, this treatment suggests a strongly controlling, negative element in the patient/psychiatrist relationship. Litvak,

however, presents Kik's aim as benevolent. Even the ECT in the film is used by Kik in a limited way, merely to "make contact" with Virginia, and he withdraws her from this unpleasant treatment once she can effectively communicate with him and benefit from psychoanalysis. Discussing the film's ECT, film scholar Janet Walker refers to the "wise and paternal Dr Kik who prescribes shock treatment for Virginia in order 'to reach her' for psychoanalytic psychotherapy" (Brandell ed100). Ward's brutal treatments[127] are repeatedly tempered in the movie by Litvak's pro-psychoanalytic stance.

Litvak's Kik is not only supportively effective, rather than distant and casually experimental like Ward's psychiatrist, but the film of *The Snake Pit* also makes the psychiatrist constantly available when needed. Kik is no longer the elusive jailer of Ward's fiction. Notably, Litvak's Kik is present at both Staff meetings[128] and able to help Virginia. The novel, on the other hand, shows Kik crucially letting Virginia down by his absence from this vital ordeal that determines her future (138). Very different from Ward's Kik, who explains nothing, Litvak's Kik is always comfortingly informative. An early scene in the film (absent from the novel) shows Kik visiting the overcrowded women's dormitory where he first calms a distressed young mother who after says to him, "I always feel so much better after talking to you" (Litvak). The doctor moves on to visit Virginia's bedside where he reassures her that she is getting better. Another scene, which is radically at odds with Ward's novel, shows Dr Kik returning to the hospital after an absence and removing his snow-covered coat while he immediately asks another doctor, "How is she?" The film makes Virginia's treatment so central to Kik's concern that he does not even have to use her name here. In Ward's novel, however, Kik only appears when encountered by Virginia or discussed with her by Robert and, very occasionally, the nurses. This means that, unlike the film's presentation, Kik is never shown in an objective light as a professional or colleague. He is always seen from the point of view of Virginia, who finds him difficult to identify as well as punitive.

[127] Ward's Virginia describes what she experiences as assault when given ECT: "your hands tied down, your legs held down. Three against one and the one entangled in machinery." (44).
[128] This is an interview during which patients considered to be suitable for discharge are formally evaluated by a professional panel. Virginia attends Staff twice in both novel and film, Kik being present both times in the film and absent both times in the novel.

Later in the movie, when one of the frequent ward movements places Virginia in long-stay ward 33, Drs Kik and Terry visit her single cell where a straight-jacketed but calm Virginia is told by Kik that, although Dr Terry is now in charge of her care, he, Kik, will visit at any time should she need him. At this stage in the novel's text, Virginia feels abandoned by Kik, to whom she no longer has access when moved to the long-stay ward (222). Also completely incompatible with Ward's novel, Virginia tells the film's Dr Kik, "Everything you've said makes sense" after he has explained her precipitating guilt over her father's and Gordon's deaths and explained that, "husbands and fathers can't be the same thing" (Litvak). These film scenes have no basis in Ward's novel but work to show Dr Kik as a caring, heavily involved psychiatrist.

Again at variance with Ward's novel, Litvak's Kik shows a "self-effacing but authoritative manner" (Gabbard and Gabbard 61), which considerably aids Virginia's recovery. As film hero serving Litvak's purpose of social comment, Kik has much adversity to deal with in the asylum:

> Leo Genn's character may be the first cinematic psychiatrist to contend with the inadequacies in state institutions, including overcrowding, arbitrarily authoritarian nurses, and incompetent administrators, all of which were widely publicised in the late 1940s. (Gabbard and Gabbard 61)

While Gabbard and Gabbard note in their extensive study, *Psychiatry and the Cinema*, that Virginia is one of remarkably few mental patients in movies whose situation is improved after time in an institution, it is clear that Litvak's film is generally critical of asylum psychiatry, though emphatically positive about psychoanalysis. Gabbard and Gabbard even note that "[t]he seriousness of [Virginia's] sessions with Dr Kik could almost be part of an 'educational' documentary about psychoanalysis. The scenes in the ward, on the other hand, exploit the horrifying as well as the farcical aspects of mental institutions" (Gabbard and Gabbard 62). Litvak's film seems to have two major aims: to show state mental institutions as in appalling decline and to present psychoanalysis as a beacon of hope.

While Ward had experienced incarceration in a US insane asylum, Litvak had researched thoroughly to discover the harsh reality of in-patient conditions.

He retains much from the novel that shows these appalling conditions: the barbarity of ECT, the insufficiency of food, the extreme overcrowding and lack of beds or even mattresses on the floor, the poorly dressed, barefoot patients and the frequent images of locks, bars and cages. However, he erases all criticism of the psychiatrist which is central to Ward's novel. In part, this may be explained in Litvak's apparent support of the post-war return to the domestic role of the woman, discussed below. However, it is likely that cinema's great interest in the nature of psychoanalysis was reflected in Litvak's approach to film-making. Stephen Heath, in "Cinema and Psychoanalysis: Parallel Histories", points to the way the cinema seems to present "the surface on to which a dream appears to be projected" as well as noting that psychoanalytic film theory has "made much of the cinema screen as a mirror reflecting everything but the spectator" (Heath 32).

De Havilland's leading role as Virginia in Litvak's film is significant in its subtly different depiction of Ward's patient. Gabbard and Gabbard note that "De Havilland's performance itself may have been as important as any of many other elements in *The Snake Pit* for fulfilling Hollywood's goal of presenting a serious problem and then deflecting it towards a single sympathetic character" (Gabbard and Gabbard 63). Litvak thus does much to further publicise Ward's account of dreadful institutional conditions, while at the same time changing Kik's patient to offer a message that is absent from Ward's novel. It is important that Litvak's Virginia is susceptible to Kik's treatment, which aims at fitting her to resume her domestic role as wife. She has none of the determined rebellion against her treatment and social role that is a feature of Ward's Virginia.

Feminist scholars have criticised films such as *The Snake Pit* for displaying how "male psychiatrist characters 'cure' their women patients by reconciling them to gender-stereotypical roles" (Brandell 97). In marked contrast to Ward's character, who is certain of little else than her identity and achievements as a writer, the Virginia of the film denies she is married and can't remember her name is "Cunningham". Critic Janet Walker goes on to note of the movie, "It is Robert who delivers his wife into treatment with Dr Kik by narrating the story of their courtship, which becomes our first glimpse of Virginia's past. 'She needed me like a child needing protection', asserts Robert"

(Brandell 101). Even though Litvak's film presents psychoanalysis as a very effective treatment, it is difficult for a twenty-first century audience to ignore the gender oppression and infantilisation of women in Dr Kik's therapeutic stance.

Ward is more ambivalent about the causes of her protagonist's breakdown and emphasises Virginia's role as a published author with no particular difficulties in being a wife. For Ward, the Cunninghams' problems come largely from poverty. In the novel, Virginia needs Robert and values his letters and visits as her only source of help outside herself in the terrible asylum. Ward's Robert moves from total trust in Dr Kik, born of anxiety and desperation, to scepticism about his efficacy so that, as I have noted above, he is unable to make positive comments about Kik to Dr Gifford, leaving this to the now socially competent patient. Ward shows Virginia's own immense efforts, supported by husband Robert, as the source of her cure, achieved in spite of the oppressive psychiatric treatment in Juniper Hill.

In her perceptive article on the film of *The Snake Pit*, subtitled "The Sexist Nature of Sanity", American academic Leslie Fishbein eloquently argues that 1940s American society appeared to support women returning to the domestic sphere after the freedom of employment they had experienced during the war. Indeed, with relevance to Ward's published writer, Virginia, Fishbein notes that "[i]ntellectual and career women became the *bêtes noires* of popularisers of Freudianism in the late forties" (Fishbein 642). Litvak's changed content of Ward's novel supports the notion of a wife returning to the domesticity of marriage. Interestingly, this also apparently reflects the private life of actress, Olivia de Havilland. Fishbein refers to her recent marriage to Marcus Goodrich as "reflect[ing] the film's celebration of the values of marriage and domesticity" (654)

The message about women's domestic role in society, clearly supported by the *Time* article, "Shocker", appears to be at the heart of Litvak's interpretation and a major aim of Kik's treatment in the movie. This is further emphasised by de Havilland's physical appearance as Virginia. Ward's Virginia relies heavily on her spectacles to see through the fog of her experiences of insanity, while Litvak's heroine has perfect eyesight, without glasses to mar her

attractive appearance. Gabbard and Gabbard's extensive study, *Psychiatry and the Cinema,* reference the way "neuroses and even psychoses in women are frequently characterised by the woman's failure to attend to her physical appearance" (156). The "doctor/hero's cure . . . is presented as essentially a beautification of the women's body and face" (157). This is quite clearly the case in Litvak's film as thin, dishevelled Virginia appears without make-up until 'cured'. After her recovery, brought about by psychoanalysis, she is well-groomed, has expertly applied cosmetics and is smartly dressed. Litvak changes Virginia into a submissive, feminised patient who willingly responds to the treatment of the charming Dr Kik of the movie.

h) *The Reader's Digest* condensed version and the popular success of *The Snake Pit*

The challenging nature of the narrative form of Ward's novel did not appear to deter contemporary readers who quickly ensured the fiction became a best seller. It is of interest to note that the *Reader's Digest* condensed version came out in May 1946, one month after the novel was Book-of-the-Month at Random House. Then, in 1958 *The Snake Pit* was included in the one-off compilation, *The Reader's Digest New Twenty Book Treasury.* Obviously, many readers found Ward's original novel compelling. However, the condensed version brought *The Snake Pit* to a huge audience, the *Reader's Digest* having a circulation of nine million in 1946. The shortened version is a competent summary, retaining much of Virginia's confusion and significant information about the terrible conditions in the asylum. However, the condensed version does not contain the narrative techniques that delay the protagonist's and the reader's knowledge of what is happening to Virginia. Because of this, the shortened narrative is less frightening. It is also less opaque than the novel, as it contains plenty of signposting to help the reader. For example, a "blue-and-white creature" appears on the second page and is quickly identified as a "large woman dressed like a nurse" ("*The Snake Pit*: A Condensed" 131). Rather than obliquely referring to psychiatry during Virginia's interchange with fellow-patient, Grace, she thinks with clarity, "Grace definitely needed a psychiatrist" ("A Condensed" 132). Six short paragraphs in the condensed novel directly explain the stress of overwork, lack of sleep and

money which have caused Virginia's breakdown ("A Condensed" 135). Maintaining Ward's style, the short version often retains the exact words for such important moments as Virginia's shocking realisation of where she is: "Here on the narrow cots, clothed in numbered nightgowns, lay women who were insane and she was one of them" (54; "A Condensed" 135).

In the *Reader's Digest* condensation, memories of Kik and his odd questioning of Virginia at the opening of Ward's novel are removed. The novel, on the other hand, starts with this scene from what we later learn is Virginia's apparent psychoanalysis by the unidentified Kik, where his method invites questions which are not yet answered. The shortened version readily identifies Kik: "It was the Doctor, in a white coat" (*"*A Condensed" 136)**.** The reader is told in the condensed book that Virginia "[s]uddenly . . . remembered him" ("A Condensed" 136) and that she had "been in his consulting room many times" ("A Condensed" 137). Rather than presenting Virginia's confusion at her disjointed perception of time and place, as I have described above in my discussion of the novel, the condensation states clearly that "[they] were always changing things at Juniper" ("A Condensed" 151). In a further move to clarify - and shorten - Ward's text, the unalleviated hallucination of being bound up in a tower lapped by the raging sea is entirely omitted from the condensed version, although that of the speeding car is included since, at this time, Virginia is able to recognise nurses and Kik, who force-feeds her in the novel. Dr Kik is only marginally more sympathetic in the condensed narrative, for there is little information about him. Both texts include Virginia's quip, "I do not like thee, Dr Kik - now that I am not so sick" (257; "A Condensed" 164), and so the condensation retains Virginia's attitude to her psychiatrist. Kik's final interview with Virginia, crucially showing his cavalier treatment and lack of care of his patient as he denies she cannot remember past interviews, ("Come. . . . Of course you remember" [231]) is also omitted from the *Reader's Digest* version. In the shortened version, Kik is not praised as an exemplary doctor, as in Litvak's film, but neither is he presented as brutally oppressive in his seeming attempts to cause his patient to die. Virginia's hallucinations in the shortened version, although still terrifying, are narrated in much less detail than in Ward's novel. Only in Ward's novel is Kik called the "Young Jailer", the "Indefatigable Examiner" and the "Executioner" by Virginia. These variants seem to place the

condensed version part-way between Ward's novel and Litvak's film in terms of Kik's depiction. The film and condensed version have similarities in form, such as opening with Virginia and Grace on a park bench in the open air, but it is difficult to say which - if either - influenced the other. Certainly, Dr Kik's role is played down in the short version. He is not the elusive oppressor of Ward's novel but neither is he given any of the admirable qualities of Litvak's Dr Kik.

i) *The Snake Pit*: Conclusion

This chapter has drawn attention to the changing nature and status of the treatment of the mentally ill in the USA and the role of the state lunatic asylum in that country. I have noted the significant place of the asylum in public policy and the willingness of the 'psy' professions to experiment on asylum patients during the first part of the twentieth century. The mental institution's decline into a place of overcrowding, neglect and appalling conditions was brought emphatically to the American public's attention by Mary Jane Ward, while the unpalatable subject of madness and the insane asylum, tempered by narrator Virginia's humour, made her novel a surprising popular success. For the first time in the USA, mental illness became an acceptable topic for a popular, best-selling novel. The fiction succeeded as an accessible, compelling narrative even though it was told from within a disordered consciousness. Ward's novel remained hugely popular, although the more accessible *Reader's Digest* version was soon available. Litvak's film, of course, tapped into the great interest in the 'psy' disciplines in the cinema, noted by Michael Shortland among others:

> Psychoanalysts have resisted the cinematic popularisation of their work for a mass audience, but this has not stemmed the steady outpouring of motion pictures depicting psychoanalytic themes, ideas and figures From the earliest days of the cinema, the fascination with lunatics, asylums and psychiatrists has proved irresistible to directors and audiences alike. (Shortland 421)

The horror of Litvak's *The Snake Pit* was deemed in a 1948 review as "dynamite" and likely to make children "terrifically disturbed" (Crowther). It was considered so inflammatory that Twentieth Century Fox "began to get cold feet" as soon as the rights had been bought, causing Litvak to be asked "to 'tone

down' its message" (Shortland 424) and so frightening as to have been banned in several states in the USA (Shortland 425). Ward's novel and Litvak's film elevated the 'talking cure' of psychoanalysis to a major role in fictional psychiatry. We rarely see patients in movies helped by other methods, including effective medication, although pharmaceutical treatment is the current norm. Since the publication of Ward's novel and the release of Litvak's movie, the terrifying asylum has remained a popular film trope into the twenty-first century, particularly as a setting for horror stories (Langley). The much-feared asylum has retained a significant place in horror film and fiction well beyond its presence as part of actual psychiatric care. It is of note that Ward's novel and Litvak's film were instrumental in ending the dominance of the asylum in caring for the insane.

While it could be argued that Ward's Dr Kik was both well-intentioned and up to date in his use of psychoanalysis, this does not change the fact that the patient, Virginia, experienced him as a jailer and torturer. The novel drew attention to the fact that psychiatry was responsible for terrible neglect within American state institutions. It also emphasised a decidedly negative depiction of the psychiatrist. Litvak's film changed this view of the psychiatrist in such a persuasive way that its positive view of Dr Kik has permeated the perceptions of readers of Ward's novel, who often fail to note Virginia's negative experience of her psychiatrist.[129] The novel, *Reader's Digest* condensed version and the film all helped to shape public views of mental institutions so that, by 1946, many in American society were loudly demanding changes in the practice of psychiatry. As a result, American psychiatrists began to move away from asylums and into more lucrative, office-based, private care. This change in American psychiatry has not improved the fictional image of 'psy' professionals. It is interesting that, as well as the terrifying asylum remaining an established feature of horror stories, it is Ward's negative representation of the psychiatrist in what became the popular form of the asylum novel, rather than Litvak's highly persuasive and well-received depiction of an effective psychoanalyst, that gained prominence in the widespread cultural portrayals of the psychiatrist.

[129] See, for example, Bosley Crowther's *New York Times* review.

CHAPTER THREE: Seeking the elusive psychiatrist in an unresolved madness narrative: Penelope Mortimer's *Long Distance* (1974)

a) Introduction to *Long Distance*

My chapter on *The Snake Pit* showed how Mary Jane Ward produced a madness narrative which became a successful popular novel, thus acquainting a greater number of readers with the fictional presentation of a distorted reality observed from within mental illness. Ward's novel depicted the psychiatrist, Dr Kik, as elusive, remote and uncaring. His patient, Virginia, recovered in spite of the treatment offered within the US state psychiatric hospital. In this new chapter, I shall move forward some thirty years, change country and consider a different kind of institution.

Penelope Mortimer's *Long Distance* (1974) takes place in the UK and is located within another type of psychiatric establishment. This was the era of the therapeutic community, a much less rigid setting for care, but one which potentially presented the patient with new problems. In this chapter I will explore the patient's difficulty in finding the 'psy' professional within what I argue is the setting of a therapeutic community. Like Ward's Virginia, the unnamed narrator in Mortimer's fiction is unable to locate any 'psy' professional who might help her. Mortimer also had her own experience of psychiatric illness and interaction with 'psy' professionals. Her autobiographical writings, *About Time* (1979) and *About Time Too* (1993), contain much about her strange, unstable childhood, her unconventional, neglectful parents, her father's abuse of his daughter and her difficult marriage to John Mortimer. She gives details about a number of psychiatrists visited throughout her life, as well as information about two communities in which she spent time. These were Greenways, where Mortimer first had electroconvulsive therapy, and the Yaddo artists' colony, where Mortimer states she produced *Long Distance* with considerable ease (*Too* 192). I shall return to these topics below since, as with Mary Jane Ward's *The Snake Pit*, these autobiographical details inform Mortimer's fiction of the experience of madness. They also add support to my proposition that the mental institution in *Long Distance* is a therapeutic community.

b) *Long Distance*: the challenges of an unresolved madness narrative and the novel's critical reception

Mortimer's novel is complex and opaque in form, giving the account of an unnamed narrator addressing an unidentified "you", the latter not appearing to be the reader. The events and places experienced and narrated are as disjointed and unfathomable as those undergone by Ward's Virginia. However, *Long Distance* does not become a recovery narrative, there being no seeming escape from the narrator's madness. Nevertheless, there are plenty of clues which point to a health care setting and suggest mental illness in Mortimer's work. Of particular note is the clear introductory comment to the novel's publication in the *New Yorker* in 1974. This gives the following definitive guidance: "A woman at a sanatorium for mental patients tells her story" (Mortimer, *New Yorker*). The reader is nevertheless left with uncertainties that cannot be totally resolved, since the setting and identities of characters as patients or 'psy' professionals are never firmly defined. Contemporary reviewers noted these difficulties.

> There is no anchor or reality [in *Long Distance*]. The landscapes are created by the self, and are liable to sudden, treacherous change. The reader, swung from memory to mirage to urgent reporting, must make up his or her mind how the pieces are meant to be put together, and what they ultimately mean. (Tennant)

In the quotation above, British novelist and critic Emma Tennant points to some of the intriguing qualities of *Long Distance.* She observes that the reader has the task of creating meaning from apparently unfathomable, disjointed information. The task that faces Mortimer's reader is made more difficult as it becomes evident that the unnamed narrator is probably mad. Interpreting the novel therefore requires that the reader enters into the uncertainties of madness, where much is frightening and unexplained, as it was initially in Ward's fiction.

Uncertainty is also the state in which patient and therapist ideally enter psychotherapy, with an openness that allows for interpretation. Psychotherapist Jeremy Holmes, acknowledging the poet John Keats, references British psychiatrist and psychoanalyst Charles Rycroft's discussion of the necessity

within psychotherapy of "conditions under which imaginative activity is likely to flourish", including "negative capability", this being "the capacity to tolerate uncertainty . . . the capacity to play with ideas and feelings without knowing in advance what their outcome might be" (Holmes *Attachments* 208). Keats describes "negative capability" in a private letter to his brothers as the state in which "a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason" (Keats). Reading *Long Distance* requires this capacity. I have already referred to the parallel between reading fictions of madness and psychotherapy in Chapter One. This novel also makes demands on the reader to employ this approach.

I identify *Long Distance* as an 'unresolved' madness narrative since the narrator remains insane to the end of the novel. No part of the fiction is written from a recovered or sane standpoint. This is quite different from Ward's recovery narrative in which the uncertainties are resolved as both narrator and reader uncover the protagonist's temporary madness within an insane asylum, from which she is discharged by the end of the novel. Critics found Mortimer's narrative of deepening madness challenging and contemporary reviewers of *Long Distance* such as Emma Tennant found Mortimer's novel opaque. Another reviewer, David Bromwich, writing in the *New York Times Book Review* in 1974, merely dismissed the novel as: "not only bizarre but impossible." Peter Ackroyd, in the *Spectator,* was initially damning, seeing *Long Distance* as

> set in a place and in a mood which will be familiar to those accustomed to the nouveau Italian cinema: a well-appointed mansion which is both grandiose and eerie, a heroine who does not know whether she is coming or going but remains solemn[130] on all occasions, and absolutely no plot at all.[131] (Ackroyd)

Showing some willingness to engage with the text, Ackroyd also noted: "A sensitive and mysterious 'I' inhabits this book with a proprietorial air which events do not actually justify and . . . she . . . is escaping from an equally mysterious and oppressive 'you'." He also pointed to difficulties for the reader: "without the benefit of first-name terms, it becomes all too easy to get the

[130] I take issue with Ackroyd on the subject of Mortimer's solemnity, her humour often being apparent (32, 41, 43, 78,79, 112, 131).
[131] Ackroyd appears to be showing evidence of the "irritable reaching after fact and reason" that Keats suggests should be suppressed to allow "negative capability" (Keats)!

characters completely confused and to leave the novel feeling that you have been banging on closed doors in vain." However, Ackroyd went on to state, with some perspicacity: "This, of course, may well be the point", before dismissively giving up on the novel:

> The whole business is so resolutely mysterious that there must be an allegory somewhere. . . . But I cannot believe in a mystery which is so easily created: a positive fog of meaning and intention is imposed upon the narrative from the beginning. . . . Is the mansion a mental hospital? Are the characters real? Are they figments of a past life? Is Miss X here or there? Am I still reading this book or have I fallen asleep? None of these questions is satisfactorily answered. (Ackroyd)

Ackroyd has, in fact, pinpointed the difficulties a therapeutic community may present when a severely confused patient tries to identify the roles of other community members.

Even Tennant went on to criticise Mortimer for a "mishandling of fantasy", judging that "A fantastic landscape needs to be as convincing as a recognisable, realistic one". Such reviewers did not fully recognise *Long Distance* as a madness narrative. Insanity is able to conjure up a reality just as compelling to the psychiatric patient as any mental landscape produced by a sane person. In the context of the narration of a mental patient, the confusion of Mortimer's presentation has its own rationale. The reader must enter a fictional world where her bearings are frequently hard to establish. This confusion allows the frightening state of madness to be directly conveyed to the reader, without any of the explanation that might come from the final resolution of recovery.

There were also contemporary reviewers who had praise for *Long Distance.* Doris Grumbach wrote in *The New Republic* that she found the novel "original, distinguished" if "often puzzling". Unlike Tennant and Ackroyd, Grumbach seemed content to accept the novel as unresolved enigma:

> I have rarely read a more intriguing novel. It is a great puzzle, a Chinese box of a story inhabited by an unnamed woman. Where is she? Far from us, from anyone she has ever known (in one sense),

> unvisited, in a great white mansion. In a mental institution. . . ? (Grumbach)

In the second volume of her autobiography, *About Time Too,* Mortimer gave her personal experiences of the reception of *Long Distance.* "Harold [Pinter] rang to say he thought it a major work, comparable only with Beckett"; Jonathan Miller "pronounced it 'extraordinary' and told me I was like Isaac Newton, whose life apparently changed dramatically in middle age"; and playwright Sir Ronald Harwood "sent a succinct postcard: 'It's a masterpiece'" (*Too* 201). Reviews in what Mortimer calls "the posh papers" were, she found, polarised between those who thought the novel "enthralling, impressive, mysterious but precise, limpid but unfathomable. . . ." and those who "damned it as obscure, nutty as a fruitcake" (*Too* 202). Mortimer particularly noted the "outraged" Auberon Waugh, who ranted: "'Psychiatrists expect to be paid twelve guineas an hour for pretending to listen to this sort of ego-maniac drivel'" (*Too* 202).[132] Mortimer went on to say, "*Long Distance* crept on to the bestseller list with Solzhenitsyn and Len Deighton, slid rapidly off and disappeared" (*Too* 202). This was not a work of fiction that could be easily categorised and definitively judged. The highly appreciative reception among "connoisseurs" left Mortimer "doubtful" (*Too* 201), perhaps understandably, for derision and suspicion characterised the more general response to the novel.

Doubts about the merits of *Long Distance* were, in large part, a result of uncertainty about the novel's setting and the nature of the narrative. If judged as an account of the narrator's emotional distress, *Long Distance* may be placed within the familiar category of madness narrative. This reading of Mortimer's fiction is confirmed by a great deal of paratextual information from her autobiographical works which I discuss below. The challenge of Mortimer's narrative form requires detailed analysis and I shall show that such exploration offers rewards, even though uncertainty is what remains. I shall argue that *Long Distance'*s strange setting has significant and recognisable aspects of the therapeutic community. I shall discuss this psychiatric milieu, as well as the

[132] Waugh's comments indicate his low view of psychiatry. He does, however, recognise that the novel is a madness narrative.

ways in which this institution, particularly as conceived by R D Laing, was concerned with the relationship between madness and society.

My primary concern in this thesis, however, is to explore ways in which psychiatrists are represented in fiction. My study of *Long Distance* will attempt to identify Mortimer's elusive 'psy' professional. I do not intend to offer a definitive reading of *Long Distance,* but one which situates the novel within asylum fictions, madness narratives and texts in innovative fictional form. My analysis will posit that the 'psy' professional is potentially hard to find in the therapeutic community if the patient/narrator is severely disturbed. Unlike the traditional asylum, the therapeutic community is notable for its lack of hierarchy, with its absence of titles and uniforms and its inclusiveness of both staff and patients in therapy exercises.[133] Regarding *Long Distance* as madness narrative emphasises our mistrust of the narrator's perceptions. The reader is required to accept narrative confusion and uncertainty.

c) Mortimer's autobiographies: *Long Distance* as *roman à clef*

As well as nine novels, various short stories - many of which were published in the *New Yorker* - drama, screenplays and journalism, Mortimer published the two parts of an autobiography I have mentioned above. The first volume, *About Time* (1979), is a witty, highly engaging, carefully controlled account of her life until her 21st birthday. This entertaining narrative does, however, present such horrors as her father's sexual violence[134] and abuse[135] and Mortimer's grim childhood home, with a decidedly odd clergyman father who had lost his faith and a lonely mother who required much skill to keep the family in adequate funds. In the second volume of her autobiography, *About Time Too* (1993)*,* Mortimer describes her dependence on her strong but distant mother who "lacked every maternal quality except faith in regular meals" (*Too* 3). *About Time* was well received and won the 1979 Whitbread Prize. The second volume of her autobiography, *About Time Too*, covers the years 1940-

[133] My experience of the Charles Hood Unit TC at Royal Bethlem Hospital in the mid 1970s included staff participating in drama therapy and revealing personal experiences in the same way as did the patients.
[134] Mortimer recounts how her father "sat on the edge of her [mother's] bed and talked for hours about spiritual passion, and then he raped her" (*About* 27).
[135] Mortimer refers directly to her father sexually abusing her (*About* 73; 165).

1978 and is an informative, though less entertaining work, describing a life plagued by her interdependent but damaging relationship with her second husband, novelist John Mortimer. *About Time Too* gives an account of her celebrity-filled life with her successful writer husband, her many children, frequent travels and changes of home, and the devastation and subsequent depression she felt after Mortimer persuaded her to terminate her eighth pregnancy at the age of 42 and undergo a sterilisation (*Too* 80). Her marriage to John Mortimer appears in this volume as a source of frequent pain, as the infidelities of both partners are recounted. John Mortimer later largely abandoned his wife and, in 1972, married another, much younger woman.

In *About Time Too* Mortimer describes her writing and publishing career as well as ongoing psychiatric treatment. She reproduces parts of what seem to be a journal from a period in 1971, in the institution called Greenways where she spent about six months. Mortimer refers to this institution as the place where her son, Jeremy, was born, as well as being the scene of her first electroconvulsive treatment. The nature of this nursing home *cum* psychiatric clinic is not further clarified. In her second volume of autobiography, Mortimer directly refers to Greenways being the West Wing of *Long Distance,* the place where she is sent to be taught "how to conform" (*Too* 192). Throughout *About Time Too,* Mortimer recounts taking Mogadon, Triptozyls (sic), Valium, Optimax, Nembutal, methydrine, lithium, Ritalin, Mogadon and Mandrax. The Greenways journal contains information that is enlightening in relation to *Long Distance*: "April 27: *There's some terrible butchery going on, the nurses hustled me away. I am hemmed in by doctors, by a false and poisonous way of life*" (*Too* 158). This may be interpreted as the paranoia of an unbalanced mind; or the fact that 'psy' treatment in this community was experienced as brutal. The reader's task is to try to separate hallucination and misperception from actual experience.

Mortimer writes of consulting a number of psychiatrists in this second volume of autobiography. Dr Heinz Wollf, Dr Barrington Cooper, "[p]sychiatrist to the stars" ("Dr Barrington"), Dr Kraupl-Taylor (proponent of group therapy, as discussed by Meyer and Gelder in their 1963 paper), Dr A W Erskine and Dr Martha Friedman are all therapists mentioned in *About Time Too* (161, 200). Notably, Mortimer's most successful novel, *The Pumpkin Eater* (1962), was

published the year after her abortion (Cooke) and opens with an interchange between a mother of many children and a psychiatrist. Psychiatrists, mental illness and its treatment were clearly matters with which Mortimer had considerable acquaintance. They offer background which is often present in Mortimer's fiction and lead the reader to consider that *Long Distance* may indeed be a fictional madness narrative, informed by personal experience.

As Mary Jane Ward used her hospitalisation in a state asylum in her novel, Mortimer seems to have used episodes from her own life to address issues of mental illness in fiction. Terrible experiences which emerge from the confusion of a mad narrator are recast in an innovative, fictional form. The presence of a psychiatrist, a major and troubling figure in *Long Distance,* is repeatedly hinted at but never confirmed. As I present a reading of the novel as set in a therapeutic community (TC), I cast Basil Gondzik in the role of 'psy' professional. While this is a possible interpretation, it is one that I can amply substantiate. The setting of *Long Distance* in a TC means that the help of the 'psy' professional in this more liberal, less punitive institution is shown as equally hard to locate as Dr Kik's care was for Ward's narrator. Changes in the institution, from old asylum to TC, may improve the daily life of the patient but do not necessarily make psychiatric help more accessible or the mad patient less fearful.

d) The difficulties of complexity in *Long Distance*

The uncertainty that so troubled contemporary reviewers of *Long Distance* is in large part due to its complex structure, the novel's form and language making it impossible to firmly identify place, people and experience. The structure of the text, added to the suggested setting of a therapeutic community - a non-hierarchical treatment institution where a lack of distinctions between staff and patients is stressed - further complicate both the reader's and narrator/patient's search for the psychiatrist. The narrator is the only source of information in the novel and it becomes apparent that the reader can have no firm knowledge of the nature of the fictional events recounted. We cannot be certain if we are dealing with the narrator's memory, hallucination or observation of fictional action. The reader is left struggling to define setting and events, just

as the narrator struggles to do so through most of the text, before finally settling into her hallucinatory state. Being an unresolved madness narrative, it is necessary for the reader to follow the narrator, remaining in the uncertain 'reality' which is perceived from within insanity. However, the reader may then review the novel from her own standpoint of normality after finishing the text. These complexities, while making the novel daunting, contribute to the considerable accomplishment of the fiction. Remarkably, *Long Distance* was published in full in the *New Yorker* in 1974, an accolade to a fiction only previously accorded to J D Salinger's *Raise High the Roof Beam, Carpenters.*[136] While the *New Yorker* guides readers by definitively introducing Mortimer's work as the account of a mental patient (Mortimer *New Yorker*), it refers to Basil Gondzik as the narrator's "mentor", recognising his authority but leaving his role open to interpretation. It is my aim to justify why this novel should be considered a significant literary achievement, adding to the fictional representations of 'psy' professionals, within the genre of madness fiction.

The history of the TC, particularly in the UK, forms an important part of my discussion of this novel and I discuss this treatment model in some detail here, since it is a lesser known setting for psychiatric treatment than the asylums. Its comparative rarity in both fiction and scholarly, psychiatric writing is notable, particularly as TCs gave patients a considerably greater voice, inviting a comparison with novels of institutions. This highly innovative setting for the treatment of mental illness came to brief prominence in the UK from early post-war years until the 1970s. In the USA, it remains largely as a model for group therapy for addiction disorders (Campling 365). In Britain, where it was shown to be cost-effective and of great benefit to patients as a long-term aid to recovery (Bridger 86), the decline of the TC is as curious as is its near absence from fiction. I shall return to possible reasons for this decline and note the TC's very limited appearance in fiction later in this chapter. After discussing the history of the therapeutic community in the UK, I shall offer evidence for *Long Distance* being a madness narrative set in a TC where the patient cannot find the 'psy' professional.

[136] This reference to the *New Yorker* does not include Truman Capote's 'non-fiction novel', *In Cold Blood*, which was serialised in four parts, starting in September 1965.

e) The therapeutic community as setting for *Long Distance*

The vital figure of the 'psy' professional is never firmly recognised in *Long Distance.* I shall offer evidence to suggest that Basil Gondzik holds this role, though he is never given the title of 'doctor' or recognised as a therapist. However, the narrator frequently alludes to his power within the unidentified institution which seems to be a therapeutic community.

In addition to the TC, other kinds of 'communities' were in vogue when Mortimer's novel was published and the author seemed familiar with them. I have already discussed the Greenways community and referred to the Yaddo writers' community where Mortimer apparently produced *Long Distance* with astonishing ease (*Too* 192). Mortimer refers to writing her novel in Yaddo in her autobiography: "This real place, with its people, relationships, anxieties could expand to contain the past, even the future. The story would unravel minute by minute, each character and incident bringing with it the shadow of its own history. All I had to do was observe and report what happened" (*Too* 192). Arriving at Yaddo, Mortimer writes in *About Time Too* that "Mrs April opens the door" and she goes on to describe the narrator's room in *Long Distance.* These are the same words used in the opening of *Long Distance* (*Too* 192; *Long Distance* 11). It seems that Yaddo and Greenways offer possible models for the mansion and West Wing respectively. In the real world of psychiatric treatment, however, the TC was about to fall into general disrepute and I shall discuss the reasons for the abandonment of this treatment model, while also noting that Mortimer's use of a similar environment was not, in her fiction, of much use to the patient.

f) The rise of the British therapeutic community from its historical origins

Any discussion of the therapeutic community's history must include mention of the extraordinary and successful 700-year old tradition in Geel, Belgium, "an experience that has evolved into a system of treatment that successfully integrates psychosocial rehabilitation, hospital services, and drug treatment" (Goldstein and Godement 443). Academic, Eugeen Roosens, has written a detailed socio-anthropological study of Geel, a town where mental

patients live within the community, boarded out in host families. A psychiatric hospital is available for short stays when required because of acute distress. This very early TC model, involving the community of an entire town, provides a positive model for the growth of TCs in the post-war twentieth century. Geel remains active today. The TC in the UK was to develop much later.

The emergence of the therapeutic community in the UK resulted from an important advance in social psychiatry in World War II. The new TC used "all the relationships and activities of a residential psychiatric centre to aid the therapeutic task" (Bridger 68). A highly significant feature of this treatment was the move away from the authoritarian hospital model to one in which patients and staff shared power within the institution and all activities were monitored by both patients and staff as potentially useful in developing the inmates' abilities to function as successful social individuals within a group (Bridger 68). In the old asylums the distant but all-powerful psychiatrist had total authority over the powerless patient and the subservient nursing staff: my chapter on Ward's *The Snake Pit* explores the typical doctor/nurse/patient hierarchy of the traditional mental asylum. Both in the USA and Britain, the psychiatrist was firmly at the top of this institution, ordering physical and drug treatments for patients that were then usually carried out by nursing staff, who acted more as technicians than carers. Now, in the TC, the inclusion of the patient in his/her regimen became a significant component of treatment for mental disorders. In addition, nursing staff had a much greater part to play in patient care and were no longer limited to carrying out the orders of the often remote psychiatrist. The TC offered a radically new form of treatment for the seriously mentally ill, one which stressed communication, the inclusion of the patient's voice and the development of independence within the social setting of a community of patients and carers. The TC is therefore of considerable interest to this thesis which explores the role of the fictional 'psy' professional as he or she is presented in different types of historical treatment.

Although the TC survives in Britain today, it is not in the mainstream of psychiatric care for patients with severe mental illness and I shall discuss some of the reasons for this below. Britain has imported the more limited addiction therapy model of the TC from the USA (Winship 1-2), although there are

currently few British TCs treating serious psychiatric illness. Among those remaining UK TCs treating the seriously mentally ill are the houses of the registered charity of the Richmond Fellowship and the two residences of the Arbours Association.[137] In both organisations, the patients are fee-paying. Additionally, a number of TCs are listed by the Consortium for Therapeutic Communities, the majority of these being funded by the voluntary or private sectors. The Consortium lists the handful of remaining NHS-funded TCs which treat severe personality disorders, noting these "generally use a complex admission procedure" ("How do I get into a TC")?[138] I shall briefly explore below the rise and decline of the TC in British psychiatric treatment.

In wartime Britain, high-ranking military officers Maxwell Jones, Wilfred Bion and Tom Main were all important innovators of TCs, which initially developed within army psychiatry. Essential to this new form of treatment was psychotherapeutic group therapy, promoted by Bion, later outlined in his work, *Experiences in Groups*, first published in 1961. By 1942, Bion had established an experimental TC (the first Northfield Experiment) within the Northfield Military Hospital, its aim being to "re-engage . . . alienated individuals" (Bridger 68). The main aim of the project was to return servicemen to military duty. This experiment lasted only six weeks, in spite of the fact that Bion had "succeeded dramatically" (Bridger 73). The Military Hospital and the War Office ended the therapeutic community experiment because they were unable to tolerate what they saw as "anarchy and chaos" (Bridger 73). Psychoanalyst Harold Bridger went on to lead a second Northfield Experiment, initiated in 1944/5, with Bion taking on the "double role as officer commanding the TW (training wing) and as psychiatrist helping his men to face the working through of issues following their treatment and to make decisions about their immediate future" (Bridger 70). These two Northfield Experiments both took place under the aegis of the War Office and the projects were "conducted during WWII at a critical phase of the war as an integral part of army psychiatry" (Bridger 70). Bridger found that "Northfield showed that an unusually facilitating environment can lead to

[137] Psychiatrist Joseph Berke, who later worked at Kingsley Hall with R D Laing, was one of the founders of the Arbours Association in 1970.

[138] This is not a new phenomenon. I note in "First Person Narratives" that being accepted into the Charles Hood Unit at Bethlem "was harder than getting into university and felt to me like a greater achievement" (Hopson).

unusual maturation in adults" (Bridger 86). However, the success of the TC also produced an effect that surprised Bridger who noted: "They [TCs] pose a persisting threat to authoritarian institutions and the prevailing bureaucratic culture" (Bridger 86). I shall return below to this and other problems and criticisms of the TC movement, which ultimately limited its trajectory as a major form of treatment.

By the middle of the twentieth century, the long-established mental asylums had become unmanageably overcrowded and offered little effective treatment. In addition to having its roots in concern about the effects of the war on soldiers, the TC movement was, in large part, a reaction to what was seen as the failure of the vast psychiatric asylums (Manning 1). Treatment in the TC harnessed the recent, more positive attitude to the mentally ill which had developed as a result of World War II, when many servicemen suffered from psychiatric problems. In parallel to the Northfield Experiments, Maxwell Jones independently developed a TC in 1947 at the Belmont Hospital. This institution was designed to rehabilitate ex-servicemen for re-entry into civilian life immediately after World War II. As psychiatrist and head of the Industrial Neurosis Unit at Belmont, Jones commented on changing reactions to the mentally ill within British society: "the community is to-day assuming social responsibilities which would not have been contemplated a generation ago" (M Jones xiii). The post-war shortage of labour meant disabled servicemen were needed to fill jobs and this, along with more positive, societal responses to psychiatric casualties of war, prompted a change in attitude towards this large new group of psychiatric patients. The aim of Jones's unit was to combine treatment with a "serious attempt at resettlement" (M Jones xiv), much as Bion had initially attempted to rehabilitate servicemen for return to the front. (Bridger 68).[139] Jones offered patients sociotherapy rather than medication[140] ("Henderson Hospital") and worked with patients suffering from "war neuroses" and, later, with those "who had experienced extreme neglect or abuse in childhood" ("Henderson Hospital"). Jones worked closely with the Department for Work and Pensions in order to promote actively the progression of patients

[139] In the 1946 *Bulletin of the Menninger Clinic,* which was devoted to Northfield, Bion discussed the need to bridge the gulf between hospital treatment and life after discharge and also his institution of psychoanalytical groups ("Leaderless Group").
[140] Bion also focused on group dynamics rather than medication (Pick 121).

back into work (M Jones xiii). This was a great change from the custodial practice of the old asylums.

Psychiatrist Tom Main also led "war-time group experiments at Northfield Hospital in Birmingham, treating shell-shocked soldiers using methods of group and milieu-based approaches to therapy" (Russell n p). Main later pursued these methods as director of the Cassell Hospital, where he was joined by psychiatric nursing pioneer, Eileen Skellern. Main reorganised the Cassell as a TC, using psychoanalytic theory, believing that "[t]raditional hospital practice resulted in dependent patients, who thus needed resocialisation in addition to treatment of their illness" (Main 69). Importantly, Skellern developed the new field of "[p]sychological nursing" at the Cassell. In this model, nurses worked with patients "by engaging in day to day activities and problem-solving", while "[t]he key to this approach was the concept of the therapeutic 'use of self'" (Russell n p). Skellern went on to work at Belmont Hospital (later Henderson Hospital) and the Bethlem and Maudsley and was instrumental in opening the NHS Charles Hood Unit TC at Bethlem in 1971 (Hinshelwood and Manning 26).

London's Bethlem Hospital had two TCs. First, psychiatrist and psychotherapist Dr Bob Hobson opened Tyson West 2 (1960) (Andrews *et al* 686). When this failed, the Charles Hood Unit was opened and ran from 1971 to 1978 (Andrews *et al* 686). Dr Hobson has written an extraordinary, disillusioned, negative piece on his concerns about the TC in which he characterises the development of this model as "'the coming of the Messiah', 'the Enlightenment?' and 'the Catastrophe'" (Hinshelwood and Manning 232). He comments: "My main message is that we do harm. Much of what I have to say is about failure and damage" (Hinshelwood and Manning 232). It is important to balance Dr Hobson's view with accounts of patients. The short-lived Charles Hood Unit offered an excellent treatment programme and, as a former patient, I can attest to its success and major differences from the incarceration, physical treatments and heavy medication of the traditional asylum.[141] The old asylums were terrifying places but it was a pleasure to live

[141] During my time at the Charles Hood TC in 1974-5, no psychotropic medication was administered to most patients, treatment relying on group therapies of various kinds, plus individual psychotherapy once a week. I had previously been hospitalised in, among other places, Winterton Hospital in County Durham, where my experiences included a locked ward,

in the safe, stimulating, productive environment of the Charles Hood TC. I have written about my very positive experience as a TC patient in the Bethlem Blog (Hopson "First Person").[142] A handful of other TC patients have also described their experiences in other communities, offering insight into TC life. These include Nick Mahony's and Anne Crozier's accounts (Hinshelwood and Manning 76-87, 263-271).

In the 1960s, new ideas abounded in psychiatry and the significant work of Goffman and Foucault, published in that decade, is discussed elsewhere in this thesis.[143] In the mid twentieth century, the extensive criticisms of the traditional, failing asylum appeared to be giving way to the development of the TC. However, it is arguably the case that anti-psychiatry's newsworthy forays into TCs in the 1950s, '60s and '70s gave rise to popular misconceptions about this type of treatment. The founder of the much discussed and infamous Kingsley Hall TC, R D Laing,[144] was internationally known and achieved the popular status of a cult figure.[145] I shall return below to the TCs, Kingsley Hall and Villa 21, established by R D Laing and anti-psychiatrist David Cooper[146] respectively. It is clear, however, that, far from the TC having its roots in the developments of anti-psychiatry, the new TC started out as an establishment psychiatric treatment, developed in war time by the British Army. It was the British armed forces, the Tavistock Clinic[147] and the Ministries of Health, Labour and Pensions, not the anti-psychiatry lobby, which gave the impetus for the

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twice-weekly electroconvulsive therapy (ECT), incarceration in a padded cell and continuous heavy medication. Doctors were rarely encountered and occupational therapy was non-existent.

[142] However, I am aware from private correspondence, that at least one fellow patient had a negative response to her stay.

[143] Foucault's *Madness and Civilisation* was available in English by 1964.

[144] Novelist Clancy Sigal refers to Laing as the "celebrity shrink" in his Guardian article (Sigal, "A Trip to the Far Side of Madness") and notes that Kingsley Hall became "an international mecca for psycho-tourists".

[145] R D Laing began his work as an Army psychiatrist, joining up in 1951 (Laing *Wisdom* 88), and soon undertook psychotherapy training at the Tavistock Clinic (O'Hagan). Laing's ideas on observing and interacting with seriously mentally ill patients are clearly described as coming from his experience as a young army psychiatrist (Laing *Wisdom* 95).

[146] The term 'anti-psychiatry' was coined by psychiatrist David Cooper in his 1967 book *Psychiatry and Anti-psychiatry.* Cooper felt that recent psychiatry had "aligned itself far too closely with the alienated needs of the society within which it function[ed]" and had therefore committed "a well-intentioned act of betrayal of those members of society who ha[d] been ejected into the psychiatric situation as patients" (Cooper preface). Cooper was referring primarily to patients labeled 'schizophrenic'.

[147] Tavistock Clinic head, J R Rees, was appointed consulting psychiatrist to the army in 1939 (Manning 6-7).

development of the TC (M Jones xiv).[148] By the end of the war, it had seemed possible that the TC could be a mainstream model for future treatment.

In effect, several factors worked against the spread of the TC. There was resistance from the psychiatric profession (Bridger 86) and there were also various criticisms of the movement. I have already noted above the short life of the first Northfield Experiment, its apparent chaos making it intolerable to the hospital establishment. In David Cooper's early TC, Villa 21, "dirt and disorder" were so obvious that "senior nursing officers expressed their outrage at what they saw" ("Villa 21 at Shenley" 3). Oisin Wall writes that "windows were broken, rubbish accumulated . . . and plates went unwashed" (Wall 329). There were other stressors affecting nursing staff in TCs: "The real difficulty for staff is to confront themselves, to confront their own problems, disturbances, madness" (Cooper 83-104). Cooper also reports how, in his absence, the disaffected staff "decided to limit their function to controlling the drug cupboard as was legally required" (Cooper 93). While nurses at times found the new environment of the TC dauntingly unfamiliar, it was clear that more, better quality staff were required for this new treatment model, along with "more space with suitable facilities for work activities and group meetings" (Manning 194). Staff exhaustion was also a problem. While the "messianic spirit, excitement, and high morale" was inspirational at the beginning of the life of the TC, these elements could result in the undesired effect of staff tendency to "withdraw from the parent hospital unit" (Kernberg 340-341). In addition, Rapoport *et al* point out that psychiatrists, who had traditionally been at the top of the hierarchy in the mental hospital, found the democratisation of the TC difficult to handle. Here, the psychiatrist no longer had a white coat or a title. He (and more rarely she) was obliged to "give up many of the symbols and prerogatives of status that protected him by creating social distance as well as gratifying him personally" (Rapoport *Community* 114). He could be "asked direct and personal questions by his patients. His 'style' of work will be public and observed by all" (Rapoport *Community* 113). Tom Main wrote of the considerable demands placed on the psychiatrist in the 1946 *Bulletin of the*

[148] Academic Jennifer Walke, also quoting Brian Evans, notes that, in spite of Laing's counterculture prominence, his "views were in opposition to mainstream psychology and psychiatry, but, crucially, 'well within the limits of contemporary liberal thinking'" (264).

Menninger Clinic, noting that his role included "refus[ing] any platform offered to him, and abrogat[ing] his usual right to pass judgement" (Main 68). Importantly "he is an ordinary community member" (Main 67). It is clear that his actions in this role do not identify him as the 'psy' professional whose task is to provide help to patients. There is obviously a tension within the 'psy' professional's role if he is to fulfil the function of leader while, at the same time, he no longer "owns 'his' patients" but is "privileged and restricted only insofar as the community allow or demands" (Main 67). Further, he must "tolerate disorder and tension", facilitating its diffusion by acting as "a catalyst for social response and awareness", acting as "technician among, rather than a superintendent of his patients. . ." (Main 68). This is a new and highly demanding role for the psychiatrist. His/her lack of obvious power will be shown to have particular application to Mortimer's fictional depiction of a TC, in which Basil Gondzik may be seen as an example of this diminished status of the 'psy' professional and where psychiatric help is not clearly identifiable.

In practice, successful TCs often relied on a charismatic leader. Nick Manning discusses the importance of such leadership and quotes Rapoport who points to Maxwell Jones as "the archetypal charismatic innovator" (Manning 205). Obviously, a system that depends on the personality of its leader is not built to last. That fatigue and staff burn-out were possible results of this new, demanding treatment is evidenced in Bob Hobson's essay, cited above. The negative reactions of psychiatrists to this new form of treatment are of significance to this thesis. Of further note is the curious absence of the TC in fiction, with only a handful of novels dealing with this interesting social experiment.[149]

[149] Clancy Sigal's *Zone of the Interior* (1976) clearly identifies itself as a TC novel about Laing and Cooper's Kingsley Hall. Peter May's crime novel, *Runaway* (20) contains a section depicting a version of Kingsley Hall. Other novels, such as Patrick Gale's *A Place Called Winter* (2015), contain brief passages on TCs. Paul Sayer's *The Comforts of Madness* (1988) has a very sinister, coercive TC which is one of the places of treatment experienced by the catatonic narrator. Will Self's *Umbrella* (2012) also contains a TC.

g) The theories behind treatment in the therapeutic community: the changed role of the 'psy' professional

The new theoretical position of TCs was that "authoritarianism is anti-therapeutic" (Kernberg 332). No longer was the 'psy' professional to be firmly at the top, actively treating the passive patients at the bottom of the hierarchy. In support of this theory, Rapoport and Rapoport note that mental illness often derives from early "authority figures who are seen as rejecting or repressive" (130). In the TC, the "flattening of the hierarchy" and "blurring of the role structure", with an absence of authoritarianism, allow conditions where social relearning can flourish (Rapoport and Rapoport 130). Maxwell Jones notably established an environment at the Henderson Hospital in which it was considered that "those who had experienced similar traumas would be best placed to offer support to their peers" ("Henderson Hospital" n p). Now patients became "active participants in their own therapy and that of other patients" (M Jones 85-6). As Bion noted, this represented a change from meting out "punishment as the appropriate form of therapy" towards the practice of communal "hard thinking" ("Leaderless" 80).

Pearce and Pickard note that a result of the egalitarianism of the TC is that "belongingness . . . appears to be uniquely prominent in the TC method" (639). This is very different from the 'us and them' situation of patients versus staff in the traditional asylum. The "presence of mutual concern" among TC members is necessary to create this "belongingness". Treatment in a TC "rarely takes less than a year" (Pearce and Packard 638) and the communities are usually residential.[150] Jones also stressed that treatment was "a continuous process operating throughout the entire waking life of the patient while in hospital" (M Jones 14-15). The TCs typically and innovatively offered a full time-table of treatment, including social activities such as art, music and drama ("Henderson Hospital" n p), group therapy, in which patients were active participants in the care of their fellows, and administrative meetings in which the patients also had a say in the running of the community. Jones was particularly

[150] Although this seems a lengthy period, it compares favourably with the often life-long stays of many patients in traditional asylums, as well as the frequent readmissions of many psychiatric patients.

concerned “to use the hospital community as an active force in treatment” (M Jones 157).[151]

Anthropologist Robert Rapoport’s extensive study, based on four years’ work at Maxwell Jones’s Social Rehabilitation Unit at Belmont, shows how the new treatment of the TC had moved dramatically away from the old hospital “where patients are classified and stored” and towards a community in which “everyone is expected to make some contribution” (Rapoport 10). This concept was based on Freud’s belief that the mentally ill did not have diseased organs or defective genes. Instead, mental illness was considered to have developed in “a whole personality which had been malformed partly as a product of early emotional development within the family” (Rapoport 16). Rapoport identified the central tenets of the TC as “’democratisation’, ‘permissiveness’, ‘communalism’ [and] ‘reality confrontation’” (Rapoport 54). These ideals were in line with the development of widespread counterculture values of the mid twentieth century. “Democratization” made it possible for “’constructive’ patients to function as effective surrogates of the staff” thereby using their own knowledge of trauma to help their peers (Rapoport 57). “Permissiveness” allowed a range of patient behaviour which would then be commented on by the community. “Communalism” meant the inclusion of patients in all aspects of the community’s life, including treatment and administration; while “reality confrontation” involved patients being “continuously presented with interpretations of their behaviour as it [was] seen by most others” (Rapoport 63). All of this meant that the hospital community bore an important resemblance to the patient’s non-hospital life. Social problems could be observed, discussed by patients and staff, and corrected. It was a huge change from the traditional asylum to use twenty-four hours each day therapeutically.[152] Indeed, Rapoport

[151] Mortimer’s narrator largely fails to interact positively with her fellow inmates or take part in any group activities. In this respect, Mortimer’s account differs from the established British TC (Hopson “First Person”). This is, of course, acceptable in a madness narrative.

[152] This certainly happened in the Charles Hood Unit, where I remember one patient protested at her 21st birthday celebrations (dinner at a restaurant in London) being turned into a therapeutic opportunity. Our weekly timetable included a large Friday meeting, with patients, nurses, doctors, occupational therapists and social workers, two hostel group meetings, three longer group therapy meetings, one full afternoon of art therapy, one of psychodrama, another of sport and one of “social skills” in the occupational therapy department. In addition, each of us had a weekly individual psychotherapy session. Social events and hostel problems were discussed in groups (Hopson, Private Notebook).

observed that, “every aspect of hospital life is regarded as relevant and potentially therapeutic” (Rapoport 270).

The TC model seemed to represent great progress in the psychiatric care of the seriously mentally ill. However, the treatment’s lifespan was drastically curtailed. The rise *in tandem* of anti-psychiatry and the contributions to the TC of Laing and Cooper were, I believe, damaging to the TC model of treatment. Jones, Main and Bion had developed the TC as an alternative, successful treatment for the mentally ill, moving away from the vast, overcrowded asylums. However, the considerable press coverage given to R D Laing’s Kingsley Hall meant that this was the community that was popularly perceived as a typical TC. Life at Kingsley Hall was frequently presented as anarchic chaos, with emphasis on the use of LSD, sexual freedom between patients and staff and an apparent lack of structure. I believe Laing’s solid, useful work, with his major attention to the lived experience of the patient, was unfortunately undermined by his cult status in the media.

h) R D Laing and Kingsley Hall: psychiatry and counterculture

It is arguable that the high media profile of R D Laing’s Kingsley Hall and David Cooper’s Villa 21, about which Clancy Sigal wrote in comically libellous vein in his cult novel, *Zone of the Interior* (1976),[153] did much to thwart development of the TC movement. Sigal was involved in both TC experiments, Kingsley Hall and Villa 21 and had been Laing’s patient. In his novel, he presented Kingsley Hall in London as a place of anarchical squalor, drug-taking and excessive sexual activity under the bullying leadership of Willie Last, a thinly disguised version of Laing. Sigal also referenced anti-psychiatrist David Cooper’s TC, Villa 21, and the novelist is critical of Cooper (Dr Dick Drummond in *Zone*) whom he portrays as self-serving and lazy. Sigal’s representation of Kingsley Hall did not reassure the reading public about TCs or the ‘psy’ professionals who ran them.

[153] Sigal’s *Zone of the Interior* was considered libelous and not published in the UK until 2005. The resulting ‘underground’ status of the fiction may well have increased its impact. Sigal’s 2005 *Guardian* article, written on *Zone*’s UK publication, reveals his view of Laing’s methods of treatment.

The prominence and influence of R D Laing at this period is hard to understate. Eminent British psychiatrist Dr Allan Beveridge calls him "the world's first media psychiatrist" and "the most famous psychiatrist in the world" in the 1960s and '70s, observing that Laing's books sold in the millions (Beveridge "R D Laing" 452). Laing's status as counterculture hero, along with his experiments with LSD and other eccentric behaviour, eventually drew disapproval from mainstream psychiatry. Controversy continuously surrounded Kingsley Hall, where "several patients and workers were given high-grade LSD . . . supposedly to release their inner demons or buried childhood traumas" (O'Hagan n p). There were also rumours of people throwing themselves off the roof (Paton n p). Few psychiatrists have ever attracted such broad popular interest as did Laing.[154] He brought a much greater popular focus to discussions of mental illness, but I believe his nonconformist stance damaged the concept of the TC in the public imagination. The TCs of Laing and Cooper were the institutions discussed in the popular press, not the establishments of Jones, Bion and Main. It was not surprising that this important new treatment was relegated to a brief phase in British psychiatry. I shall explore below the rise, fall and the more recent renewed interest in R D Laing. Laing gave the 'psy' professional social prominence as a much-discussed, often scandalous figure, and he certainly had impact on the public perception of this group of doctors.

Although he personally rejected the term, R D Laing was much involved in the anti-psychiatry movement which arose in the 1960s and '70s in Britain and elsewhere, and which criticised mainstream psychiatry. Most notably, anti-psychiatry was a revolt from within the psychiatric profession itself and it gave impetus to the increasingly significant user movement[155] as well as making the TC a well-known, perhaps infamous, setting for treatment. The anti-psychiatry movement was influential in bringing psychiatry into general public discussion. In view of this interest, the rarity of the appearance of the TC in novels is surprising and underlines the significance of *Long Distance.*

[154] Arguably, Laing's considerable press coverage makes it surprising that the setting in Mortimer's *Long Distance* was not more readily identified by contemporary reviewers as a TC.
[155] The Mental Patients Union was formed in 1973 (Crossley "R D Laing" 879). One of the founder members, Andrew Roberts, remains highly active in the survivor movement and his *Mental Health History Timeline* is an excellent online historical source.

After a standard psychiatric background, R D Laing rose to fame as "a charismatic counter-culture guru" (Crossley "R D Laing" 879). His appearances drew large crowds and his books, notable for their clarity of prose, were widely read among psychology texts. In his 1985 BBC Radio 4 interview of Laing, well-known psychiatrist, Anthony Clare, claimed that "Laing made an enormous impact upon me" (Clare, *Psychiatrist's Chair*); and *Psychopolitics* author, Peter Sedgwick, wrote: "virtually the entire left and an enormous proportion of the liberal-arts and social-studies reading public was convinced that R D Laing and his band of colleagues had produced novel and essentially accurate renderings of what psychotic experience truly signified" (Sedgwick 6).

Laing argued that families produced psychiatric conditions which mainstream treatment attempted to alter by "brainwashing" in order to "induc[e] behaviour that is adjusted by (preferably) non-injurious torture" (Laing qtd in Crossley 884). It was at Kingsley Hall (which was open between1965 and 1970) that Laing developed his ideas of the damage done by families (*The Divided Self*, 1959) and where he instituted a 24-hour programme of treatment by the community. This TC encapsulated the anti-family, anti-establishment and pro-commune ideas of the British New Left. Sociologist Nick Crossley noted that Kingsley Hall became a "show piece commune and a central site of counter-cultural activity" (Crossley "R D Laing" 885). Laing, himself, embraced the counterculture, visiting the USA and meeting with Beat Generation poet Allen Ginsberg and US psychologist and advocate for psychedelic drugs Timothy Leary (Crossley "R D Laing" 885). However, as well as being a "magnet for thrill-seekers and party animals" (Paton n p), Kingsley Hall had a positive contribution to make to the care of the mentally ill: it was set up "to challenge accepted ways of understanding and treating mental and emotional suffering, [and] key to that was, and still is, a commitment to conversation as a way of articulating what disturbs people" (Paton n p). Laing had always espoused communication with the mentally ill. In *Wisdom, Madness and Folly* (1985), the psychiatrist described how he spent time in a padded cell, drawn to it by "the ravings of a manic character" (95). Laing also describes how he took a very disturbed patient home to stay with his family for a week, in order to protect him from insulin treatment and ECT when Laing himself was on leave (*Wisdom* 98-99). Laing's compassion and readiness to listen to the mad was

very appealing, not least to those of us who were psychiatric patients in the mid twentieth century. He seemed to offer a new kind of 'psy' professional, far distant from the old, punitive, asylum doctors.

However, scandal dogged Laing and alcoholism was a continuing problem through his life. He became "increasingly less acceptable" within the psychiatric community (Crossley "R D Laing" 884). The wide publicity that surrounded this famous psychiatrist appealed to an audience in sympathy with the counterculture rather than those in the mainstream of psychiatry. The photographic essay on Laing in *LIFE*, though positive in tone, contained pictures of Laing standing on his head, wearing only underpants, and sitting barefoot in the branches of a tree (Haynes). Laing's early death, aged only 61, seemed to relegate him to the alternative society of the now obsolete mid twentieth century counterculture. It seems that in recent years, however, Laing is being reconsidered, with a 2015 drama (Marmion; Paton) and a 2017 film, *Mad to be Normal.* Media psychiatrist Anthony Clare saw Laing as a hero who "dragged psychiatric illness and those who suffered from it right on to the front cover of newspapers and magazines . . . and he gave the most powerful and eloquent voice to those who until then had been mute in their isolation" (Clare qtd in Beveridge "R D Laing" 452).

I contend that Laing's strong ties to the counterculture, as well as the publicity surrounding his unorthodox methods, his alcoholism, lifestyle and use of LSD, dealt a blow to the therapeutic community, with its new type of 'psy' professional. Thereafter, the TC was associated with its most infamous example, Kingsley Hall. This was damaging for patients and, arguably, for 'psy' professionals. The 1988 Griffiths Report introduced new mental health watchwords, 'care in the community' (Griffiths). This did not offer patients treatment within therapeutic communities: it meant deinstitutionalisation and the mentally ill being treated in their own homes within broader society, a community from which they have been largely excluded. The disappearance of the notably successful TC arguably returned patients to a greater isolation than even that of the old asylum.

i) *Long Distance:* a challenging madness narrative of the therapeutic community

There are many elements of *Long Distance* which justify placing the novel within the genre of madness narrative as well as in the setting of a TC, a reading which is substantiated by the paratextual information already given. These fictional constituents all lead the reader to participate in the search for the 'psy' professional within *Long Distance.*

Elements of the novel which point to the narrator's status as psychiatric patient include her frequent attempts to grasp the flow of time in this place where watches and clocks are forbidden (13), as well as her considerable difficulty in mapping her surroundings (18, 44). A substantial section of the novel takes place in what appears to be a conventional ward, with nurses, doctors, medication, physical examination and ECT (133). Many passages seem to describe hallucinatory experiences. In addition, the date of publication (1974) and the descriptions of the mansion are congruent with a TC setting. The perennial, inherent difficulties in a madness narrative which relate to time confusion, non-linearity and the narrator's avowed confusion concerning place and the nature of events are all present in *Long Distance*, as they were in Ward's *The Snake Pit.* Contemporary readers and reviewers seemed to have found this difficult to accept. To be left within the uncertainty of madness, with no clear explanations of the misapprehensions of the novel's mad narrator, to have no patient or 'psy' professional offering an interpretation of the narrator's madness, are very unsettling fictional attributes for the reader. The placing of Mortimer's novel within asylum novel/madness narrative is necessary if the reader is to locate meaning, even though this meaning is non-definitive and retains uncertainty. Once again, the reader is in the position of therapist, accepting doubt while attempting to construct a meaningful story from a range of information presented by the narrator/patient.

In their paper, "Representing Madness", US academics Alexandra L Adame and Gail A Hornstein note that madness narratives essentially are first person accounts of "subjective experience" (135). The reader should not expect to find objective reality within them. Such accounts focus on "meaning-

making processes and the ways people construct their life stories in relation to the social environments in which they dwell" and usually attempt to "organise the chaos of existence into a coherent story" (136). Considering *Long Distance* in relation to these definitions of madness narrative, it is clear that *Long Distance* seems to move away from Adame and Hornstein's stated position of distressed voice changing to that of a "post-distressed narrator" (141) as Mortimer's narrator apparently accepts madness and a life constricted by it. *Long Distance* does not conform to the "'healing' narrative" (149), a form which is often presented to offer hope to readers. There is no such promise of healing for Mortimer's reader: her protagonist sinks further into illness, a situation that is the lot of many patients, for not all states of madness are healed and mental health is not always restored. It is uncomfortable to realise that there may be no heroic 'psy' professional who, like Dr Kik in Litvak's film of *The Snake Pit*, can bring a mad character into the reassuringly normal world.

If Mortimer's narrator has a "post-distressed" position, it is one of calm which reflects her acceptance of madness, rather than recovery. I have noted above that the narrator struggles with time and events until finally settling into hallucination. She finally achieves peace, observing:

> You have politely vacated my dreams, leaving me in order. I live at a long distance from everything I knew, seeing it very clearly. (238-9)

In this journey to accepting madness, Mortimer presents the struggle of a narrator striving to understand what is happening in her unidentified environment. She moves into total hallucination, indicated by the obviously unmanageable disorder, in what she feels is a "terrible slum" (83).

> Through an open door I see children spread-eagled and curled in beds and cots, soaking in the warmth of saturated sheets. The chaos is indescribable . . . . I think of escape. (84)

Later in this section, as the children return to the unmanageable house, the narrator, like Ward's Virginia, expresses her terror:

> Whatever fear I have known until now seems no more than a little gasp in my sleep. . . . Now I really know fear. . . . They have arrived. (91)

In the house full of children to care for, the narrator grapples hard to take control of time:

> Unlike the other place,[156] every room in this house has a clock, though none of them tell the same time. . . . The first thing is to decide (or choose) what time it is, and then synchronise all the clocks. . . . Then I realise that if I go from room to room setting all the clocks at twenty-one minutes past nine, it will be at least a half past by the time I've finished. (86)

The baby, who offers the narrator rare satisfaction ("I feed it, and it is fed. I wash it, and it is clean. I show it affection, it is contented" [86]), grows up during this brief passage, which also seems to cover a long period: "The baby is growing older. That's nice. . . . Now he is taller than I am" (96). To the reader - though not the narrator - it appears that this nightmare slum episode condenses many years of stressful, demanding motherhood into a brief period, indicated by only a few pages of the novel. The chaos and lack of normal understanding of time show a narrator who has failed at "integrating his or her emotional distress into a continuous life narrative" (Adame and Hornstein 146). However, in a brief and extraordinary moment of clarity in this time of hallucination, the narrator notes to herself, "Maybe it's a lunatic asylum, but do I deserve this merely by weeping at a play" (84)? Clearly she remembers the entertainment she recounted attending earlier and her reaction to it; and notes that she may indeed be in a lunatic asylum. It seems she believes that the chaotic house, in which she must attempt to establish order, is a punishment for not behaving in an acceptable way in this place. In this episode of hallucination, there is no 'psy' professional that the narrator or reader can discern.

Having gone through many struggles to take charge of time and chaos, trying to decode and map her environment in the mansion and the West Wing, experiencing the hallucinatory, terrified state in the "terrible slum", the narrator finally gives up the battle. At the end of the novel a kind of resolution is reached

[156] This refers to the narrator's room in the mansion, where the novel starts.

in which the narrator accepts her view of the mansion and its members in recast, acceptable forms. The narrator has settled into madness, leaving the reader to review events from her own (possibly/probably saner) position, from where she may recognise the apparently permanent descent into madness of the narrator.

j) Time and structure within madness narrative

If we consider *Long Distance* as what French literary theorist Gérard Genette calls the "traditional fiction of a narrator who must appear more or less to discover the story at the same time that he tells it" (67), we shall find that difficulties arise. This is because Mortimer's madness narrative prompts the reader to discover more than the narrator is able to discern from her own account. Identifying the text as madness narrative allows the reader to see the narrator's difficulties with time and her accurate perception of reality/hallucination. The narrator is uncertain about the "retrospective character" (Genette 68) of her account. Until the final episode of the novel, she is continuously struggling to locate past, present and future time, unaided by any perceived psychiatrist. Genette notes in Proust that questions of time, order and duration of events are liberated by "the narrative's capacity to disengage its arrangement from all dependence, even inverse dependence, on the chronological sequence of the story it tells" (68). Genette defines "story" as events which the narrator reconstructs in her "narrative". In madness narratives, however, 'story' involves both the fictional action of a novel and hallucinatory perception, which offers an additional or alternative 'story'. The reader is presented with the "anachronies" (Genette 35-6) that exist in the two time-schemes of "story" and "narrative", but in madness narratives these are very difficult to decode and may have to be accepted by the reader as unfathomable. The arrangement of narrative discourse in Mortimer's fiction and the implied events of the "story" on which the narrator bases her account cannot be definitively linked. The reader, with the narrator, is taken further into madness and left there. This adds another layer to Genette's "story time" and "narrative time" (33) which we might call "hallucinated time".

Distinguishing between 'story' and 'hallucination' is a major task for both narrator and reader. The narrator invites the reader to follow her own struggles to decipher time and action through most of the text. After an interview with 'psy' professional Gondzik, the narrator feels herself "losing balance. I am not who I thought I was. I am literally no longer myself" (55-6). Statements such as this invite the reader's complicity in the narrator's near-constant, overwhelmingly difficult task of deciding where she is, with whom, what is happening and why. While, like Proust, Mortimer establishes "temporal and/or spatial break[s]" (Genette 89), we are warned that the narrator has no certainty about her memory or perceptions. The reader follows a narrator dedicated to finding meaning in her experiences within the narrative; but the narrator frequently reminds the reader of her uncertainty about producing accurate accounts. Indeed, she writes, "It must be perfectly clear by now that, for all my efforts, I am recounting many things which are over, or which seem to me to be over" (60). *Long Distance* plunges the reader into the narrator's bewilderment and the reader must follow her through her often-frightening perceptions of place and action.

In Genette's terms, *Long Distance* is entirely presented via "*internal focalisation"* (10). The narrator's account describes what she consciously struggles to perceive in puzzling and frightening geographical surroundings, among people whose identity is unstable, and at times which she is unable to fix, since clocks and watches are banned or uncontrollable. While never defining the 'you' to whom the narrator says she is addressing her narrative, it is this address which establishes what Genette calls the "narrating act" (26-7). In Mortimer's novel, this "narrating act" embodies the struggle to define the narrator's outer reality, and the reader is involved in this confusion which makes for an unsettling reading experience. In his introduction to Genette's *Narrative Discourse,* Jonathan Culler refers to former's discussion of "relationships between the time of the story or plot and the time of the narrative" (Genette 11), noting that events may "occur in one order but are narrated in another" (11). Culler further references Genette's concern with "pace or *duration* (the narrative may devote considerable space to a momentary experience and then may leap over or swiftly summarise a number of years), and *frequency* (the narrative may repeatedly recount an event that happened only once or may recount once

what happened frequently)" (11). These notions are relevant to *Long Distance.* The reader has only the "narrative discourse" available for analysis (Genette 27). In *Long Distance*, the discourse is itself an account of the narrator's struggle to understand her surroundings and the time and order in which 'events' take place. From this, the reader must attempt to assemble the different experiences contained in the narrative and produce a notional entity which, as a version of the narrator's account, has confusion of time, place and people at its heart.

I shall argue that an acceptance of the narrator's madness is the only way to place her apparently chaotic account, this being one of unexplained experience viewed through insanity. The author offers no statements which fix or link the narrator's experiences, so the reader must give herself up to the undefined sequence of events over an ephemeral period, among a changing cast of characters, all of which lead the narrator to "live at a long distance from everything I knew" (239). In addition, the reader has no information about the narrator's previous life The reader who asks, "What happened, when, why and who was involved?" will receive incomplete answers.

I have already noted above the confiscation of clocks and watches in the mansion and the narrator's problems in synchronizing clocks and identifying time span in the more obviously hallucinatory period in the "terrible slum", where the narrator is overwhelmed in her struggle to impose physical order. Another time problem is evidenced by abrupt jumps in the narration, which are similar to those experienced by Ward's Virginia in *The Snake Pit.* Mortimer's narrator also experiences an abrupt shift to "a change of scene" (79) after the puzzling outdoor entertainment, which leaves the narrator distraught. Like Ward's protagonist, she returns to awareness in a new setting.

> When it is light again I look around me, raising myself on my elbows to see where I am: in a large bed in a large room. The other side of the bed is still warm (but I didn't dream, that I can remember). A cupboard gapes open, showing piles of shoes and clothes hanging anyhow. Every chair is hidden under accumulated clothes. On top of the chest of drawers (dull with dust) a drift of old letters curling at the edges, used envelopes, yellowing newspapers. I can see myself (though dimly, behind a mist of dust) in the dressing-table mirrors, which are triple. The dressing-table is cluttered with unstoppered bottles, topless

> jars: when I examine it more closely I will find rubber bands, safety-pins, hairgrips, stained pieces of cotton wool, grimy tissues. . . . (83)

This vividly hallucinated and terrifying new setting contains no indication whatsoever of a source of help. No 'psy' professional intrudes into this scene, the narrator only wondering, in her distress, where her mother is, and how she could have allowed her daughter to be in this situation (88).

The disorder of the narrator's thought parallels the apparently disordered narrative form of the novel. Seemingly deep in hallucination, burdened by the many children in this place for whom the narrator must act as "judge, provider, oracle, scullery maid, scapegoat . . ." (94) she nevertheless makes some contact with reality when she notes:

> I am not entirely to blame for this chaos; to believe that I, alone, created it would be a kind of hubris; to believe that I, alone, must clean it up and restore order (which possibly was never there in the first place) is both arrogant and presumptuous. (94)

This acknowledgement that she is not totally to blame for the squalor shows recognition of the full responsibility for domestic chores faced by women in the 1970s[157] as well as eliciting questions concerning the responsibility for madness. I note this in my discussion of the therapeutic community and R D Laing, who posited that insanity was a sane response to an insane society.[158]

Culler notes that narrative repetition, which Genette calls the "iterative", is a "central technique in certain avant-garde novels", with "important functions" (Genette 11). In addition to Genette's discussion of time, story and narrating act, his analysis of repetition is also of significance to *Long Distance*. Genette

[157] This is a recurring theme in Mortimer's fiction. See especially *The Pumpkin Eater, The Home, The Handyman* and *Daddy's Gone A-Hunting. The Pumpkin Eater* (1962) was made into a high-profile, successful film, with a screenplay by Harold Pinter and starring Ann Bancroft, Peter Finch and James Mason in 1964 (Clayton). It was republished by Penguin Classics in 2015 and was also aired as a BBC Radio 4 drama in August 2015 and repeated on Radio 4 Extra in January 2020 (*The Pumpkin Eater*). Rachel Cooke observes in her 2015 article in the *Observer*, that Mortimer is now "hardly read at all". *Long Distance* remains out of print at the time of writing (Jan 2020).

[158] Laing is frequently referenced as defining insanity as "a perfectly rational adjustment to an insane world", though the origins of this quotation are disputed. However, Peter Sedgwick notes that Laing found the behavior of psychotics "actually appear[ed] to him as meaningful and appropriate rather than as odd or irrelevant" (*Laing and* 14).

notes that "*singulative* narrative" or "narrating once what happened once" is the narrative method most commonly used in fiction (114). In *Long Distance,* however, repetition is sign-posted as important by Mortimer's narrator. When she attempts to define the mansion, she states: "I now believe that the purpose of this place is to repeat experience until it is remembered: a gross over-simplification, no doubt" (101). For the reader, this may well evoke Freud's concept of repetition-compulsion, in which a person repeats an earlier trauma (Freud *Beyond* 30). The reader will remember that the narrator first occupied a room with four doors - one of them partly obscured, broken and jammed (18) - and three mirrors (18), a fourth dressing table having lost its mirror. This first room is echoed when the narrator awakes in the "terrible slum" which has three mirrors, through which the narrator can see her reflection, "though dimly, behind a mist of dust" (83). Seen from within a metaphor of madness, these suggest three possible ways out (or in), including a fourth, blocked exit/entry; and three reflections of different 'realities' (less clear in the hallucinatory passage) along with a fourth blank space on the dressing table which lacks a mirror and therefore gives no reflection (18). This points to the fact that repetition may occur with different elements so producing different meanings. For example, the recurrence of this information at the end of the novel, the broken door and absent mirror suggest that there may be no way out and no reflected reality. I shall analyse below one significant repetition in Mortimer's novel and show how the reiteration of an episode recasts near-identical information, with no indication of whether either is more accurate.

The narrative moves to a complex recall of memories in the presentation of an interchange between Gondzik and the narrator in what may be a therapeutic session. Suggestive of Gondzik's psychotherapeutic, interpretive role here are his "thoughts, theories, speculations, conclusions, premises, data, analyses and propositions" (51). The narrator's observation of Gondzik's "sweet messages" that change to "bit[ing] and gnaw[ing]" may describe how the gentle beginnings of therapy move on to painful probing (51). The narrator's suggestion that she is probably "incurable" and the fact that she has "used so many means, struggled so hard" (52) to achieve a "result that is not entirely contemptible" (52) seem to describe her private mental struggle for tolerable survival. In the interchange discussed below, it is not clear to whom the

memories belong or by whom they are voiced. The roles of narrator and Gondzik appear elided here and the reader has to decide who is speaking at different points. I have added, in brackets, the speaker who may be implied by the arrangement and content of the text, G representing Gondzik and N the narrator.

> (G): 'In winter there are very few people. They have wine at dinner.'
>
> His hand moves idly to the table lamp. . . .
>
> (N): 'You *have* been here in winter. You *have.*'
>
> He looks puzzled; almost hurt, if this present Gondzik can be hurt. 'Maybe.'
>
> (N): 'It was cold, very cold, your feet froze to the ground!'
>
> He bats the air for silence. . . .
>
> (N): 'The lake was frozen, you walked across it, she was skating cutting figures of eight, she was eight, wasn't she -'
>
> (N/G?): 'Her little skirt like daisy petals flung out from a yellow stem, she loves me, she loves me not - '
>
> (N): 'You plucked them, leaving her shivering.'
>
> (G): 'GOD DAMN YOU!'
>
> He will probably hit me; but he doesn't . . . he walks over to the papal chair. . . . (53)

It is the reader's task to decide here who is speaking. There are hints but no certainty contained in the text. The narrator queries whether the memory of the skating girl belongs to her or Gondzik:

> I have no idea what possessed me: no skating child in my experience, the lake has looked solid with slimy weed, but never frozen. He would have told me about it, surely, as we lay in bed or by the fire or in the meadow. I believe he told me everything, except what his analyst thought of me. Then perhaps the skating child who burst out of my mouth is part of *my* memory. (53-4)

The skating girl may be memory or hallucination. Indeed this whole episode, involving an exchange between the narrator and Gondzik, may be a figment of the narrator's unreliable perceptions. The suggestion that she has

lain “in bed” (53) with Gondzik, refuted as it is by her own comment that she had “almost given up hope . . . of his body” (51), may possibly be construed as the transference/sexual fantasy of a patient towards her therapist. The reference to Gondzik’s “papal chair” (53) suggests both psychiatric and clerical authority. The church motif is also present in relation to the gardener, when he sexually assaults the narrator and, at the end of the assault episode, “puts on the clerical collar, its black bib over the sweat-soaked shirt” (47). Paratextual material from Mortimer’s autobiographies suggests elision of both Gondzik and the gardener with Mortimer’s sexually abusive clergyman father. Although this fact does not form part of the novel, the clerical and sexual associations of Gondzik and the gardener are clearly present in the text.[159] However, textual interpretations, like the triple mirrors found in this place, must remain as multiple possibilities which cannot be fixed.

Later in the novel, the narrator returns to the skating girl. Now suggesting her certainty about the event belonging to Gondzik’s memory, the narrator, sketching a map, notes: “I also draw a rough circle for the lake, where Gondzik saw the skater” (111). However, uncertainty now extends to place: the reader cannot know if this lake is merely a fantasy location, since the only bodies of water frequently referred to in the novel are the pond and the swimming pool. Now the narrator talks of her attempts to map the “lie of the land” in order to facilitate her escape (111). The attempt at mapping is a recurring motif, frequently daunting as “the immensity of what isn’t there defeats me” (115); her efforts at map-making producing only an “unreliable map” (123) which was “useless” (236); and the narrator refers to leaving her “map “in the gardener’s hut” (182) so she can no longer refer to it.[160] This confusion about place and the narrator’s near constant struggle to map her confusing environment add to the uncertainty about reported memory. Significant changes are apparent in the repetition of the skating girl incident, casting even further doubt on the nature of the action involved (197). By this time, in an

[159] Indeed, we may see the gardener as the harmful ‘father’ and Gondzik as the caring ‘father’. Talking of her father’s abuse in *About Time*, Mortimer is generously able to say, “My Daddy: and I want to add the poor sod” (*About* 30).

[160] Geographer Dragos Simandan’s paper, “Making sense of place through multiple memory systems” is pertinent. Simandan considers the “relationship between memory and people’s subjective experience of place” (21), noting that “one of the hallmarks of depressed people is the inward focus of their attention . . . [which] severely limits the scope of their actual engagement with the places in which they find themselves” (22).

indication of descent to inescapable madness, the narrator has undergone "that imperceptible separation from myself which, when completed, will be permanent" (169) when 'she' (that separated part of the narrator's self which is not 'I') is called on to attend Hathaway (who appears to be the administrator of the mansion/institution) in the Office to receive instructions for work. She is to produce "transcripts of tapes" (187).[161] Adding a further layer to the unfathomable uncertainty of perception and events, Hathaway recounts how the tapes themselves remained "inaccessible" to the Board, while the "transcripts of tapes" were not (187). The narrator, now aware of herself as split into two, reports (amusingly), "I am incredulous. She is impressed" (188). The narrator (as 'I') understands Hathaway's instruction as meaning: "He's not only asking me to be a spy, he's asking me to be a dishonest spy. Oh repulsive Hathaway, who killed my dog and had me trapped by the gardener and encouraged all my vices for his own ends. I am sick with disgust and anger" (188). The part of the narrator that has split off from 'I' and has become 'she' responds to Hathaway: "'I'd be glad to help you', she says" (188). This acquiescence is in spite of the fact that the narrator (as 'I') is aware that "[t]he whole thing is absurd. Does he really believe those tapes will be honestly transcribed? Of course not. That's why he asked me here, that's where he made his mistake" (188). The confusion inherent in the text has deepened. The reader has even less certainty about what is happening and even less trust in the narrator's perceptions and presentations of her experiences.

Now Mortimer's reader has to consider that a mad narrator, who initially gave an account of a remembered interchange with Gondzik, is to give a new version that she declares will not be "honestly transcribed" (188) by the split off part of herself that is now called 'she'. If we consider what is commonly understood by 'reality', this account lacks it. It is important that Mortimer has used an exchange between the narrator/patient and the possible 'psy' professional to explore this lack of certainty. If the scene had its origins in a therapeutic session, it has engendered even more confusion for patient and reader. However, what the novel does produce is the terrifying account of how

[161] It was common practice to tape-record psychiatric sessions. During my time in the Charles Hood Unit at Bethlem Royal Hospital, our daily group therapy sessions were always taped (Hopson "First").

experiences, people and places appear to a narrator who is mad. This reality is that of madness, which requires different methods of decoding on the part of the reader. Confusion must be accepted, since the shifting nature of a mad reality itself is the subject being conveyed. Should the reader resist this reading, seeking for submerged meaning, she is likely to become lost in a convoluted imagining of yet another, implausible fictional reality. Mortimer's occlusion of the presentation of the narrator's experience firmly lead the reader to a view the world seen from within insanity, without the benefit of help from a 'psy' professional.

In a repeat of the events previously recounted, the narrator (as 'she', not 'I') proceeds to transcribe the tapes. What she hears is:

> 'You *have* been her in the winter. You *have . . .* It was cold, very cold, your feet froze to the ground! . . . the lake was frozen, you walked across it, she was skating cutting figures of eight, she was eight, wasn't she--'
>
> 'Her little skirt like daisy petals flung out from a yellow stem, she loves me, loves me not - '
>
> 'You plucked them, leaving her shivering.'
>
> 'GOD DAMN YOU!' (197)

This is almost identical to the version quoted above from page 53 of the novel, the earlier version having additionally given some indication of who was speaking as Gondzik answers the first question. Now, the narrator sees herself as two distinct people: as 'I', the narrator is "intrigued", while as 'she', she "sits stony-faced, occasionally scribbling something in neat handwriting" (197). The reader retains multiple - even increased - options about who is speaking, again reminiscent of the possibilities contained in the triple mirrors and three/four doors of the narrator's accommodation in the institution.

There follows a (taped? written?) long outpouring by "MYSELF", addressed at Gondzik. This has much that can be interpreted as a tirade from patient to psychiatrist and is worth quoting a lengthy extract in justification of this interpretation.

> My God, you're just like all the others! What's the matter with you in this place? . . . here your so-called freedom's like a bloody nursery! . . . You're safe, aren't you, because you're so fucking *smart . . .* you can kill other people and play awful games with other people, but if anyone tries to do the same with you, sitting up here monarch of all you survey with all that sex boiling round in your head. . . . You never did anything horrible to a little girl on the pond, did you? You didn't tear off her skirt like daisy petals or whatever awful phrase it was? You didn't set fire to the bloody Reichstag or shoot those students or . . . gas a single person of your own race, did you? . . . You play innocent . . . and you sit there mumbling that like the Talmud while just at the bottom of your garden the cattle trucks are rattling by. . . . So you're laughing. Of course, you have to. That's one of the most tedious things about you . . . if anyone tells you the truth. It's *your* job to tell the truth. No one else knows it, of course. It's your private possession. And you trick it out to look like fire and brimstone, your truth is so *significant,* not like anyone else's. . . . I'm so delighted to be entertaining you! God, that's what I'm for, isn't it" To entertain Gondzik?. . . You'd be *lost* without the system! . . . Damn you and your rules for freedom and your silly tricks with time and your cheating, cheating. . . . *Damn you!* (197-200)

This contains considerable anger. The apparent 'patient' rails that the putative 'psychiatrist' claims to offer freedom, seems to own truth, is constantly concerned with sex, is Jewish (albeit also carrying out the extermination of fellow Jews), tortures and abuses others, is part of an oppressive system and plays tricks.[162] This is the information that the narrator as 'she' has apparently transcribed, before returning to the exchange recounted earlier (53) with Gondzik stating: "There's no point in being here if you don't go along with it, obey the rules as you say. It's one of the few situations which one can quite validly call a waste of time. Why don't you leave?" (200). This exact repetition (ie, Genette's "iterative") with added text serves to recast the narrator's earlier experience of an interchange with Gondzik. Now, however, the narrator can voice her anger and scorn of the person I maintain is the psychiatrist. As it is the narrator as 'she' who writes this new version, we may deduce that the narrator as 'I' wants to leave all this frightening and frustrating matter of psychiatric cure behind and enter a new existence, accepting "the fact that I'm

[162] This echoes Melanie Klein's concept of the "splitting" of good and bad, giving rise to "the anxieties aroused by interpretations of hate and envy toward the primal object, and the feeling of persecution by the analyst whose work stirs up those emotions" (Klein 232). Bateman and Holmes offer an example of this behaviour in a case example: "She would at times launch into a vicious attack on the analyst, whom she saw as a superior, heartless treatment machine on whom she had become inextricably dependent, and whose sole purpose was to humiliate her" (Bateman and Holmes 240).

simple" (238) in her room "where I hope to live forever" (238). The rejection of treatment of course means the acceptance of a permanent state of a life limited by a form of madness perceived as tolerable in relation to the alternatives.

I have set out above my reasons for reading *Long Distance* as a madness narrative set within an institution which appears to be a TC. The narrator is unable to establish a chronological framework or recognisable setting for her experiences: "I have no past, but am doing everything for the first time. This is where I begin. Memory, if it ever existed, is irretrievably drowned" (56). If we consider this to be an attribute of a state of madness, then we need to seek a psychiatrist in the text, who may be able to establish order. As in Ward's *The Snake Pit*, the narrator has found it extremely difficult to find the psychiatrist, possibly her only source of help. The passage analysed above (197-200) suggests the mad narrator has been unable to identify the 'psy' professional as such or obtain his help, resulting in the narrator's submergence in permanent madness at the novel's end. The identification of Gondzik as psychiatrist is left to the reader.

k) Basil Gondzik as elusive psychiatrist

All the information about Basil Gondzik, as with everything in the novel, is conveyed solely by the narrator. She recounts her interactions with him, some of which are realistic (that is, they appear ordinary), and some of which seem to be hallucinatory. I shall first consider the ways in which Gondzik is set apart from the other inhabitants. To start with, he is the only person in the dining room who introduces himself to the narrator on her first day in the mansion. He is also the only character in the novel who has both a forename and a surname. The narrator's first impression of him is that "[h]e seems to be on tremendously amiable terms with everybody. I feel I am being invited into the fold" (24). This suggests Gondzik may be in the position of leader. From early in the novel, he is singled out as different from the other characters the narrator sees. Unlike them, he appears to have a certain authority. Arriving in the dining room, the narrator notices "the girl in front of [her]", who is "concave" and "seems to be in a state of deep depression" (23). By contrast, a "small, burly man smiles in his beard" and offers his hand, saying "'Zotkind', or something of the sort. . . 'Basil'"

(24). This lively person is quite unlike the colourless girl. In a curious muddle, the narrator fails to register Gondzik's name, referring to him variously as Zotkind, Gotzink, Basil, Gizdonk, Gidzink, Godzonk, Nozdik, Zidgonk, Gizdink, Dinzok, Godzik, Zinkot, Donzik and Nizdok (24-29). Finally, the narrator asks for his name again and he spells it out: "G-o-n-d-z-i-k" (31).

This difficulty with a 'psy' professional's name is paralleled in *The Snake Pit*, in which the protagonist Virginia finds it extremely difficult to establish the unusual name of the psychiatrist. In Ward's novel, Dr Kik does not identify himself or his role to his patient. In *Long Distance* I suggest that the lack of hierarchy of a therapeutic community makes the roles of those encountered but whose status is not delineated difficult to establish. If Gondzik is a psychiatrist, he, like Dr Kik, does not say so. It is necessary to look for other information in the text to move towards defining Gondzik's role. His demeanour, his possession of a first name and surname, the way he "continues to chatter, exuberant", his "small eyes glint[ing] behind gold-framed spectacles" (24) all point to the difference in his status, compared with the others present. The narrator now notes that her fellow diners include people whose first names she knows (25-26). As Gondzik addresses other inmates individually, speaking "quietly and forcefully", the narrator thinks she "begin[s] to recognise him" (26). Gondzik now appears to her to be "heavier, more rabbinical" (26). Gondzik's beard (47), spectacles (24) and "rabbinical" manner are attributes associated with Freud and Jewishness and are frequently given to fictional 'psy' professionals. The narrator notes Gondzik has "a white band on his wrist, where he must have quite recently worn a watch" (27). This access to time is unusual in a place where clocks are banned. Basil Gondzik appears confident, with an air of authority and the ability to make decisions. Aware of his seemingly special role, the narrator comments, "I have the impression that Gondzik's status is a little different from the others - something to do with his familiarity with the staff, perhaps, or the fact that I know that he often goes out after I have gone to bed" (36). In one of Mortimer's narrator's comic asides, she says, "Much of the time, to be truthful, I haven't the faintest idea what Gondzik is talking about. He can't answer a direct question, that's for sure" (37). This may be interpreted as comment on the arcane verbal communications of psychiatrists and their renowned propensity to deflect direct questions put to

them by patients. Further, Gondzik is "proprietary" towards the narrator (35) and also terrifying at times, in scenes the reader may consider hallucinatory: "Outside my room he kisses me good night. His lips and teeth have disappeared, he gnaws at me with open jaws. . ." (34). However, Gondzik appears to offer supportive strength as well as causing fear in the narrator. These are both attributes of the psychiatrist as seen by the patient: while his strength may allow the patient to explore in relative safety, the dark reaches of memory to be accessed with his help may also be very frightening.

There are scenes in which Gondzik plays an important role, further suggesting his identity as psychiatrist. Following the account of the gardener's sexual assault on the narrator, Gondzik appears, with seemingly supernatural powers, as the narrator's saviour. She rushes to the pool, "tearing off my smock on the way, out of my slippers and crash, smack on to the cold water. . . " (47).[163] Gondzik rescues the narrator as he "descends with hair flying, beard still apparently dry, grabs me by the ankle and hauls me to the surface" (47). This rescue allows the horror of the assault to recede as the narrator "lay[s] the memory to rest" (48). From "sinking fathom after fathom into darkness" the narrator becomes aware of floating "like a cork, rocking in the wake of Gondzik's energetic crawl" (48). Gondzik, it seems, has offered substantial help to the distressed narrator, bringing her out of submerged darkness. Even now, however, the narrator does not interpret this as therapeutic help.

From early in the novel, the narrator has been aware of Gondzik's "proprietary" attitude towards her (35). She also notices that he keeps his distance at times, perhaps suggesting the professional need of a psychiatrist not to get too close to the patient (35). On the other hand, the narrator recounts that Gondzik "always kisses me good night" and "when we are lying by the pool he strokes my bottom as though it were a cat" (35). This inclusion of sexuality may be interpreted as an aspect of transference, as the patient substitutes Gondzik as an object of desire. If this is not transference, it perhaps suggests

[163] This need to jump into (cleansing?) water after being assaulted echoes the difficulties of the bathroom in which the narrator fears she will "never be able to clean [her]self" (20). The pool is also referenced at the novel's opening, pointing to the significance of water and cleansing from the outset (14); and the pond is significant as a place of drowning for the infant, where the "folded lilies" recall the "folds of grey" from which the gardener's penis appears "as an unopened magnolia" (47). Water may offer cleansing but also contains threats.

the experience of further unwanted sexual advances. The narrator goes on to say that Gondzik "tells me of his sex life" which is "pornographic". That sex is the subject of psychiatric discussion is not surprising, Freud having stressed the centrality of sex to psychological development (*Three Essays*). The reader is aware of the lack of firm definition of Gondzik's role, though she may be able to recognise the many clues that point to Gondzik's different, authoritative and supportive role towards the narrator for much of the novel.

Chapter five (49-56) contains a scene which invites interpretation as a therapy session. Gondzik receives the narrator in his room where, as additional information regarding his superior status, "he gets his bed made every day . . . and has the confidence of a man with special privileges" (49). Although she has tried to avoid Gondzik, the narrator has found that "he stood patiently in my way and I have to get to know him very differently, without disturbing my memories" (49). This suggests both Gondzik's tenacity and the narrator's 'resistance' to psychotherapeutic probing of her memories. The narrator now notes that Gondzik has become "an athletic intellectual", having given up talk of sex. "Now he has so many thoughts, theories, speculations, conclusions, premises, data, analysis and propositions" (51). Further, "[he] no longer conveys sweet messages from mouth to mouth, but bites and gnaws", actions already noted which suggest the possible fear involved in painful psychotherapeutic exploration (34). The narrator also notes of Gondzik that "[h]e is, of course, equally hopeless about me, about my obsessions. He doubts whether I can be reclaimed. . . . He disapproves strongly (with all the ambivalent feelings of a father?) of my nightly dreams about you. . ." (51). The narrator observes: "I am probably incurable, and may well be visited by you for the rest of my life" (51). The narrator's resistance to change is apparent. Gondzik says the troublesome "you" could be "exorcise[d]" if only the narrator would abandon her "flabbiness, the apathy, the passive acceptance". However, she notes:

> I can't be bothered. I have used so many means, struggled so hard, and the result is not entirely contemptible. My waking hours are undisturbed so long as I keep to the straight and narrow path - see what happens immediately I leave it - and avoid heights, precipices, quicksand, swamps, cul-de-sacs. . . . (52)

The narrator's ambition is modest. She lacks the ambition of major improvement but hopes for calm acceptance. Not expecting to be cured from her suffering, she "can at least steer [herself] towards some tolerable tropic clime where the chances of contentment are slightly above average for the time of year". The narrator knows "that survival is a long, hard slog" at which she feels she has "not done too badly" (52). If we read this scene as an interview between therapist and patient, it seems the doctor is urging the painful process of change, while the patient/narrator here prefigures what I see as the final accommodation of her madness which takes place at the very end of the novel (238-9). Not all mental illness is curable and the acceptance of a limited, more tranquil existence may be considered as a reasonable response by a severely ill patient.

In this possible therapy session, the narrator first exhibits the anger and frustration often felt by a patient towards what she perceives to be the comfortable, superior, even amused, therapist, and observed above in my discussion of a later possible therapy session (197-200). This early outburst is described rather than quoted.

> I attack him with some tirade about sheepish obedience, accuse him of cowardice, of inertia, I venomously tell him that he bores me, is mediocre, an arse-licker, a good little boy, a conniver at fascism, a parasite, a sycophant . . . I am entertaining him, for God's sake. I throw myself down on the floor, drum the floor with my heels, twist and turn while some part of me quite calmly waits for the result. (54)

The angry narrator is aware of her childishness as she act out her rage by kicking the floor. Gondzik asks the narrator, "Why don't you leave" (54)? He suggests she go back to "[t]he obsessions. The loneliness you have described" (54). Interpreting this scene as taking place between patient and doctor in a therapeutic community, which is attended voluntarily by the patient, makes clear the expectation of hard, therapeutic work to be engaged in by the patient with the 'psy' professional's help. This is the only point of the patient's presence here. The reader is forewarned that the narrator is seeking an accommodation of her madness, a way to accept the horrors of the past without risking painful therapy in which she would have to excavate deep into her memories. Her solitary strategy is expressed thus: "In order to survive (I hope) with some sort

of sanity, I've learned to adapt myself to the chaos until such time (if ever) I can control it" (95). As with her attempts to map the place, the narrator rejects help from others, unsuccessfully trying to manage alone, without seeking the help of a 'psy' professional.[164]

Religious motifs proliferate in the first possible therapy session. Just as the gardener put on a clerical collar after his sexual assault on the narrator, the latter now describes Gondzik's room as "tricked out like a chapel" with a "white altar screen, white choir stalls, a white prie-dieu" (50). The narrator here refers to her fictional father as a "tormented man" who "sonorously" preaches from the pulpit each Sunday, a "terrible day" (41), clearly linking fictional and actual fathers, the former plainly a priest and the latter both priest and abuser. We may expect fathers to be protective of their daughters, although we know they can also be abusive. Gondzik also has something of a father's authority and normally accepted ability to protect. Indeed, after the narrator's tirade against Gondzik, she experiences the latter as supportive. "I don't feel at all foolish as I ask him how I am to get back to my room. He, not finding the question foolish, accompanies me" (56). After the emotional turmoil of this scene (just as in a psychotherapeutic session), the narrator finds "it is all (briefly) less confusing" as her "mind is blank" and she takes "a straightforward interest in the other residents of the mansion, even going so far as to memorise some of their names"(57). Now more at home in this strange place, the narrator is able to seek out Gondzik when she needs him. "I take the little book of directions that Gondzik has thoughtfully provided me with and go to his room" (59). It seems that Gondzik has encouraged the narrator to consider various theories about her distressing situation, has offered straight-talking criticism, humour and support. He even helps her find her way around this confusing place. He has provided tangible assistance of the sort expected from a 'psy' professional, though he remains largely unidentifiable as such to the narrator. The reader must struggle to identify Gondzik's role and may remain uncertain about his status to the novel's end.

[164] The narrator does enlist the help of a real or imagined dog which provides a mute source of comfort until she claims it is killed by administrator, Hathaway (188).

Further information in support of his leadership role is that Gondzik appears to have organisational authority in the mansion/institution. He arranges an outdoor entertainment which involves such therapeutically pertinent topics as Oedipus (eg 71, 73, 78), rape (75) and motherhood (71, 74). The event, which the narrator finds extremely distressing, ends with the abandonment of the central figure of the woman (79). (Of course, the entire production could also be the narrator's hallucination, containing material which applies to her particular mental suffering.) It also seems to the narrator that Gondzik has a role in organizing what may be considered as her treatment. He tells the narrator that she "was put through the ordeal of the house . . . in order to experience desolation" (103); she feels he has "become (according to his lights) properly parental" (103); she experiences him as "like a doctor" (104); and the narrator offers a possible definition of transference when she describes Gondzik as being aware "(without consciously knowing) that a successful lover is parent, sibling, child, not to mention the minor gods" (103). It is Gondzik who encourages the narrator to form new relationships and her attempts with the new character, George, (109) are carried out under Gondzik's direction. It is also Gondzik who takes the narrator to the West Wing. The events described may have been experienced or hallucinated or both. Their 'reality' or otherwise do not affect their representation of the narrator's understanding of her perception of what she undergoes. This applies equally to her experiences of Gondzik.

The new setting of the West Wing appears to be a much more conventional ward in a psychiatric institution. It also seems to be another section of the complex which contains the mansion/therapeutic community. Therapeutic communities have often existed within larger psychiatric hospitals. It is notable that Bethlem Royal Hospital did, during my stay, send a patient from the Charles Hood Unit to a more secure ward when her illness was deemed to have worsened (Hopson "First Person"). The earliest TC, the town of Geel in Belgium, has long had a hospital to treat patients when they are unable to cope with boarding in the community (Roosens). The narrator's experience of moving to a different 'ward' appears to suggest a similar situation. After an attempted escape from the mansion, the shadowy Director, Hathaway, tells Gondzik to take the narrator to the "West Wing". The narrator feels

Gondzik's caring now as she is "gathered up again, though this time in Gondzik's arms. Cradling me, he carries me a long distance" (126).[165] Here there are "nurses and doctors" and the narrator is given "an incredible and constantly changing quantity of drugs" (132) as well as "convuls[ing] me with many electric volts" (131). She confesses she "had never known such unhappiness or such exhaustion" (132). The West Wing is experienced by the narrator as a psychiatric ward and is likely to be recognised as such by the reader. As Gondzik carries the narrator "a long distance", we may understand he is caring for her as she moves into deeper madness, since the name of this new place, "Wing", suggests it is joined to the mansion and therefore not physically very distant. She later describes her total descent into madness as living "at a long distance from everything" (239), this repetition of the novel's title appearing to confirm that the narrator moves to a permanent state of just bearable insanity, far away from normality.

In spite of feeling his care for her, the narrator does not identify Gondzik as psychiatrist. He is, however, the butt of her anger. Parallels to this are apparent in real treatment: in addition to feeling overwhelmingly cared for, the psychiatric patient may well be infuriated by the psychiatrist, since the patient suffers pain at the necessary recall of trauma and the examination of her lack of success in living tolerably, both of which are part of her treatment. As the narrator moves further into madness in *Long Distance*, she imagines revenging herself on Gondzik: "As for Gondizik, I will kill him slowly, scalping his beard, submitting him to dreadful agony" (184). Moving further into (vengeful) delusion, the narrator presents a diminished Gondzik, treated as a lackey by the mysterious administrator, Hathaway. I have discussed the two versions of the narrator's harangue of Gondzik (one remembered - or misremembered - and the second [mis]transcribed). In the more vindictive tape transcription, the narrator calls Gondzik a "bully" who is kept going by "the system" (199). He is a "barking and braying" "tyrant" who has "no such thing as humility in [his] book", according to the narrator (199). If the reader doubts the role of Gondzik as both caring and punitive psychiatrist, his apparently unmediated voice on the end of

[165] As Gondzik here carries the narrator "a long distance", we may understand he is caring for her as she moves into deeper madness. She describes her total descent into madness as living "at a long distance from everything" (239). This repetition of the novel's title appears to confirm that the narrator moves to a permanent state of madness.

this tape is interesting, strongly resembling a psychiatric summing up: “she’s hopelessly misguided, of course, but shows spirit. I calmed her down. It will be interesting to note her progress from now on” (200). However, it is the narrator as ‘she’ who seems to use the tapes to damn Gondzik and allow this psychiatrist-figure to be demoted, to suffer the indignities of being “institutionalised” in the West Wing (219) and to re-emerge in the lowly position of gardener (237). This continues the conflation of gardener/father/psychiatrist that frequently occurs. Each personification is both harmful and caring to varying degrees.

I have argued that Basil Gondzik fulfils the role of ‘psy’ professional in *Long Distance.* The narrator does not find him useful as healer, in part because - like Ward’s Dr Kik - he never identifies himself or his therapeutic role. This lack of identification makes the use of his skills by the distressed narrator very difficult. There are other, equally useless, possible ‘psy’ professionals in the novel, none of whom identify themselves and, beyond being vaguely kind, offer no concrete help. After trying to escape from the mansion, the narrator is “haunted . . . by men”, who could be seen as doctors (120). The first “looks over my life a little, writing down salient points in a small notebook, very gentle and attentive. Then he kisses me good night with a long, thoughtful, exploratory kiss. . . . I never see him again” (120). The next man “strokes the back of my head, folds me in his arms” but “walks easily away. . . . I never see him again either” (120-1). Then they “search me out every day” and “the sweetness of the conversation and the kiss is too alluring. They promise me the pleasure of eternal peace, or the peace of eternal pleasure” (121). These men also offer false comfort: “They allow me to believe that they will stay, and I needn’t escape after all” (121). The narrator is not fooled by these unidentified, apparently caring figures: “To them I am simply a woman they meet and comfort, kissing me better before they continue on their way. They aren’t responsible” (121). By comparison with these useless comforters, “the idea of escaping to the gardener”, the narrator’s abuser, seems attractive (121). This is indeed damning of the supposedly caring doctor-like figures. If Gondzik and these men are psychiatrists, they are of minimal use to the distressed patient/narrator and appear to her as less helpful than her abuser. They may, of course, be various lovers and not doctors at all, although their note-taking

and presence in the West Wing make this less likely. Again, it is up to the reader to assign psychiatric roles to these men and to judge how real the narrator's experience of being kissed by these men might be.

I) *Long Distance*: a neglected literary achievement

It has been my aim in this chapter to consider the representation of a fictional psychiatrist within a therapeutic community. Basil Gondzik proves himself to be of only limited help to the patient, in part because of the setting of the TC, which makes his role as healer unclear to the significantly distressed patient/narrator. I have included substantial information about the development of the TC in the UK, since it is an important form of psychiatric treatment, often neglected by historians of psychiatry as well as by producers of fiction and film. I have noted above how few novels deal with the TC. I believe *Long Distance* is a rare achievement, giving an account of the experience of a patient within a TC. However, the narrator's permanent insanity makes a definitive reading impossible. The reader cannot be confident that the novel's setting is indeed a TC, or that Basil Gondzik is a 'psy' professional. This uncertainty is the salient feature of Mortimer's novel. I have discussed above how a willingness to receive information in uncertainty, without knowing the outcome that may develop, is a feature of both the psychotherapeutic and poetic processes. Both practices require an openness to interpretation. In deciphering the complex text of *Long Distance*, it is the reader's task to receive the narrator's material, although it is not clearly signalled as coming from a reality shared by narrator and reader. Like the 'psy' professional working with the disordered narrative of a psychiatric patient, the reader must search for meaning from which a life story may be assembled.

Long Distance is a work of formal experimentation, presenting the reader with a conundrum. It is this that makes the novel both difficult and rewarding. Uncertainty and openness to interpretation may be seen as embedded in the TC. I have discussed above the chaos that characterised the TC in the view of traditionalist 'psy' professionals. Such apparent chaos might also be viewed as institutional fluidity, rather than rigidity, signalling a greater range of possible outcomes. The TC was founded on the idea of a flattening of hierarchies as

discussed by Bridger, Rapoport, Main, Jones and Hinshelwood. In such an institution, it was intended that all voices had equal weight. Mortimer's innovative form gives a sense of some of the problems of the TC, in which there are no labels attaching to individuals, clearly defining their status. Who are the characters in *Long Distance*? What are their roles? What constitutes experience of treatment and what is hallucination or fantasy? Mortimer's formal experimentation, successfully presenting an unsettling representation of madness, allows the reader an intriguing and unusual view of the sufferings of an insane protagonist. At the same time, looking at the body of Mortimer's work, including her two volumes of autobiography, we can see in *Long Distance* an innovative use of personal experience turned into an important fiction of madness. The theorists and developers of the TC mentioned above rejected the traditional role of the psychiatrist as having exclusive authority within the institution. Mortimer's literary experimentation is thus linked with a wider social and political movement within the care of the mad. Both the theories behind the TC movement and the construction and contents of Mortimer's novel raise questions about what it would mean to erode the social structures by which we live and the literary forms with which we are familiar.

Just as Mortimer used a radically innovative literary form, R D Laing, the most well-known advocate of TC treatment, did much to deconstruct the old systems within the asylum in order to reach the suffering individual incarcerated within. Importantly, Laing stressed that: "The sense of a human bond with [the] patient may well be absent in the psychiatrist who diagnoses the patient as incapable of any such bond with anyone" (*Wisdom* 8). Laing was not a Luddite in terms of the psychiatric system: "I could see the necessity for regimentation and routine, the way rules and roles have to be to make the system work. But I began to question the necessity of that sort of regime" (26). The TC offered a new system and, I believe, was misjudged and abandoned too quickly. Mortimer invites her reader to make the effort to reach across the gulf separating the (sane) reader from the mad narrator, within a setting which is not easily recognised. *Long Distance*, just like the TCs which I believe it represents, was hailed by perceptive critics as a fine achievement and then disappeared from sight. It is notable that only used copies of the novel are

available in 2020, these being the 1974 Allen Lane first edition, the 1977 Penguin paperback and the 1986 Hutchinson edition.

Mortimer believed *Long Distance* was her greatest fictional achievement. One obituary writer commented: “Almost audible between the lines of Mortimer’s sparely written novels about lonely women trapped in domestic nightmares were the trials and traumas of her own colourful life”, summing up that life as follows: “She was sexually abused by her father and had a remote mother. She had six children by four men, attempted suicide and had lung cancer” (Woo). Another obituary noted that her novels remained “[d]omestic” but contained “increasing aridity, sterility and hostility of a world elsewhere, beyond the homely hearth” (Gordon). *Long Distance* is a fiction but, as with her other novels, it uses material from a troubled life, which many will recognise as reflecting the oppressive, contemporary situation of women in the 1970s. Because this novel is an unresolved madness narrative, never moving to recovery, nothing revealed has any certainty. All is in doubt. The reader cannot, with confidence, distinguish between hospital and the outside world or between madness and sanity. *Long Distance* presents the troubling, ambiguous perceptions of experience viewed through major emotional distress. From within her illness, the narrator is unable at any point in the novel to recognise Gondzik as the ‘psy’ professional who may care for her. The reader may, however, justifiably assign him this identity.

CHAPTER FOUR: Patrick McGrath's *Asylum* (1996)*:* the psychiatrist steals the patient's story

a) Introduction to *Asylum*

> The catastrophic love affair characterised by sexual obsession has been a professional interest of mine for many years now. . . . Stella Raphael's story is one of the saddest I know. . . . I tried to help but she deflected me from the truth until it was too late. She had to. She couldn't afford to let me see it clearly, it would have been the ruin of the few flimsy psychic structures she had left. (1)

Patrick McGrath's *Asylum* subtly presents a misapprehension of fictional events, starting with the above warning from psychiatrist Dr Cleave. The reader is clearly told that Cleave only belatedly discovered the "truth" about his patient. The opening caveat that this "truth'" will only emerge late in the text must constantly be born in mind if the reader is to appreciate fully the ways in which the psychiatrist is an unreliable narrator. McGrath's reader has the task of selecting information and assessing its trustworthiness, just as she did with the novels of Ward and Mortimer. However, in *Asylum*, it is not the perception of the psychiatric patient that needs decoding but that of the authoritative psychiatrist. My analysis draws attention to the ways in which Cleave misleads the reader. I show how the psychiatrist repeatedly reveals his unreliability while, at the same time, lulling the reader into believing his version of events because of his confident style and his commanding position within the institution as 'psy' professional, not mad patient. As critic Robert Adams observes, failing to keep in mind this early admission of the psychiatrist's failure means that, on finishing the novel, the reader must recast the entire text, "turn[ing] back to the first page and beg[inning] to reread the fiction, bearing in mind that the whole novel is Dr Peter Cleave's version of events" (172). Almost at the very end of *Asylum*, Cleave cries, "Oh, I had been blind! . . . I at last realised the full extent to which I had allowed my judgement to be coloured by private concerns, and in the process lost my clinical objectivity" (246). While Cleave appears now to be aware of his mistakes, it is not only the psychiatrist who has been "deflected . . . from the truth". As apparent narrator, he has also repeatedly deflected the reader from understanding Stella's experience and state of mind. This fiction does not present "Stella Raphael's story" but Peter Cleave's, revealed by his

own account. Cleave is a 'psy' professional who has constructed his own story while malevolently silencing his patients for his own reasons. The psychiatrist remains deluded to the end, leaving the reader to understand his self-serving motives.

Asylum presents a fictional puzzle in a complex structure. Its major 'psy' professional, psychiatrist Dr Peter Cleave, is not difficult to locate within the facility for the criminally insane in which the novel is set. However, what is in question is his access to material about his patients and, therefore, the reliability of his account. The matter of who experiences or observes the fictional events of *Asylum*, when they occur and who is narrating whose story is largely obscured by McGrath's narrative technique. This novel is not a madness narrative that is told from an institution inmate's perspective, since patients, Edgar Stark and Stella Raphael, have almost no voice that is not interpreted and reported by the 'psy' professional. On the other hand, we may judge Cleave's account to show that he is deluded and unbalanced for, as I shall show, he does not move into full awareness of his methods and motives, his professional attitudes remaining suspect to the very end.

The events in *Asylum* appear to be recounted by an omniscient narrator, with Cleave occasionally presenting episodes in the first person. This form of narration is trusted by readers and it takes considerable effort to question and overcome this acceptance. I shall show how McGrath's narrative presentation is subtly and successfully misleading, so that the reader is repeatedly offered evidence for the psychiatrist's misinterpretation and is also alerted to his manipulation of patients for his own purposes. Consideration of who has the authority to speak for the mad is at the centre of this novel. As in the other chapters in this work, assessing the fictional narrator's authority, capability and motive is central to my discussion of *Asylum.* The reader's task, as in *Long Distance* and *The Snake Pit*, is to decide what 'really' happens in this novel. In *Asylum* the reader is again called upon to sift through information to come to a judgement about the experience of the patient. In this novel all such information is presented by the 'psy' professional narrator.

As with all the fictions analysed in detail in this work, *Asylum* is set at an important time in British psychiatric history. I shall first establish this context, since it is my intention to show in this thesis that historical setting does not affect the pervasive and overwhelmingly negative depiction of the fictional 'psy' professional. After detailing the historical background of the British institution for the criminally insane, I shall discuss McGrath's use of the Gothic within a fiction about insanity and psychiatry, and then move on to close textual analysis which will focus on the narrative devices and structure of *Asylum*. I shall concentrate on how events are presented and by whom. This will involve detailed consideration of the role of the psychiatrist, Peter Cleave, to discover the way he constructs a self-serving narrative.

b) *Asylum* and its setting in British psychiatric history

I referred in my introductory chapter to the isolation from society of the old mental asylum. McGrath's setting of the institution for the criminally insane is even further outside the experience of the general public, although *Asylum's* author was particularly well-placed to make use of this singular environment. Patrick McGrath grew up on the Broadmoor estate, where his father was appointed Medical Superintendent in 1957. In a 2012 article ("A Boy's Own Broadmoor") on his decidedly happy childhood spent in this unusual environment, McGrath remembers his "dreadful fascination" with the building "where the most disturbed male patients were housed" and from which he and his father heard "a scream of the most wretched misery" ("A Boy's Own" n p). McGrath was deeply impressed by his father's compassion and total absence of fear of such patients. McGrath goes on to refer to the historical event which produced the subject-matter for *Asylum* many years later.

> I remember once coming into a roomful of grown-ups, and silence suddenly descending. This is catnip to a curious boy. I never did get the whole story, but it seems a doctor's wife had been "compromised" by one of the men on a working party. The patient lost all his privileges; what happened to the wayward wife I don't know - the family moved away soon after. But I did know enough that when, years later, I was groping around for an idea for a book, I thought of it, and wrote a novel called "Asylum" on the basis of it, using my imagination to fill in the blanks. ("A Boy's Own" n p)

This direct experience of Broadmoor gave McGrath both inspiration for his novel and intimate detail of the workings of this setting. It is of interest that McGrath notes how he uses imagination about the bare bones of a real event to construct his novel. It will become apparent that conjecture, rather than fact, is an essential tool for *Asylum* psychiatrist, Dr Peter Cleave, as he constructs his patient's story.

Although published in 1996, *Asylum* is set historically in a year of significant legislation, the *Mental Health Act 1959* (Parliament 1959). In the lead-up to 1959, other important legislation was enacted which affected those offenders with diagnosed psychiatric conditions. The *Criminal Justice Act 1948* (Parliament 1948)[166] had decreed that psychiatric treatment for offenders should take place within the mental health, rather than the correctional, system. This resulted in Broadmoor being "vested in the Ministry of Health, managed by the Board of Control" (Parliament 1948). With reference to McGrath's novel, it is noteworthy that the admission and discharge of such offenders remained under the auspices of the Home Secretary, rather than of a psychiatrist. The *Homicide Act 1957* introduced the legal concept of "diminished responsibility" by reason of psychiatric illness (Parliament 1957 part 1 section 1). The *Mental Health Act 1959* gave a significant new power to the courts: in-patient offenders, including those legally designated as insane, could be ordered by the judicial system to be sent to a hospital rather than a prison. This meant that convicted criminals deemed psychiatrically ill could, with medical evidence, now be sent for treatment rather than punishment. Further, a restriction order could be imposed by the courts, so that the power to discharge an in-patient offender remained with the Home Secretary. The 1959 Act also required Broadmoor to take patients who had not been charged with any offence but who might exhibit "dangerous, violent or criminal propensities" (72). This Act was the topic of lively discussion in the psychiatric world during the time of the setting of *Asylum.*

There are several elements in the 1959 Act which are of particular interest in the discussion of *Asylum.* The Act states that sexual intercourse

[166] The Criminal Justice Act 1948, Part II, 62 (2) states: "The expression 'criminal lunatic' shall cease to be used; and there shall be substituted for it wherever it occurs in any enactment the expression 'Broadmoor patient.'"

between an officer at the hospital and a patient is a culpable offence, warranting a prison sentence of up to two years (88). This has potential fictional repercussions for staff wife Stella with respect to her affair with convicted murderer Edgar, and for Cleave in the light of his proposed marriage to Stella towards the end of the novel. As Stella moves from being a staff wife to institution inmate, another aspect of the 1959 Act is important: the removal of the category of sexual promiscuity as grounds for incarceration in a lunatic asylum. The Act states,

> Nothing in this section shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder . . . by reason only of promiscuity or other immoral conduct. (3)

In his version of Stella's actions, Cleave appears to identify Stella's promiscuity as a sign of her madness although the details of her "ravenous lust" (19), as I shall show, come from Cleave's conjecture rather than firm knowledge, as he constructs Stella's story. The novel notably takes place at a time before the sexual liberation of the 1960s and the extreme social disapproval of Stella's affair with Edgar, while contemporarily convincing, does not offer grounds for her hospitalisation. The suggestion of Cleave's homoerotic attraction to Edgar, which will be discussed below, further complicates this issue. The *Sexual Offences Act 1967* came into law in England after the time of the setting of the novel and Cleave would be unlikely to acknowledge his possibility homosexuality, perhaps even to himself, in 1959. On the other hand, his need to control and possess Stella to obtain information about her relationship with Edgar offers a self-justifying excuse to explore Edgar as sexual being. It is up to the reader to decide what grounds, if any, exist for Cleave's incarceration of Stella. She seems to have broken a social and ethical code but do love and adultery constitute madness? Further, is Stella implicated in her son's death by drowning on a school excursion? These are vital questions for a psychiatrist and reader to consider. It must be remembered that the death penalty was still available under British law in 1959, although the *Homicide Act 1957* had recently restricted its use with respect to "diminished responsibility" (i) as a result of mental illness. Aside from these interesting details which are relevant to the subject-matter of McGrath's novel, the *Mental Health Act 1959* was intended to protect the rights of patients, updating the

integration of mental health services into the wider healthcare system. From the standpoint of 2001, Dr Adrian Grounds describes the legislation.

> The . . . 1959 Mental Health Act was heralded as a great piece of liberalising legislation, but its reputation became tarnished by concern about failures of services and abuses of professional power. The Act was seen as being deficient in safeguarding the rights of detained patients. . . . (387)

McGrath clearly chose a year of much discussion about the treatment of in-patient offenders for the setting of his novel. While the *Mental Health Act* had been granted royal assent in 1959, it did not move officially into its commencement until 1960. The above quotation from Grounds indicates the failings of the Act, despite its intention to produce better treatment. Many patients were left completely isolated from society in overcrowded institutions where psychiatrists held seemingly absolute power. The latter were certainly "the most powerful official labelers" in a setting where "mental illness" came to be considered "a social status [rather] than a disease" (Scull, *Madness: A Very Short* 100). This deficiency in the Act may suggest repercussions for *Asylum'*s patients Stella and Edgar. The year 1959 was a time of flux between the old legal framework and the new, the latter being optimistic but, with hindsight, found to be wanting. McGrath publication of *Asylum* in 1996 indicates his choice to write about a time when the mental patient was subsequently seen as oppressed by psychiatric authority. Cleave's depiction as abusive psychiatrist is entirely appropriate in 1959.

With its anticipated changes, the legislative hierarchy concerning the status of the criminally insane is particularly important in discussion of this novel. Dr Patrick G McGrath, the novelist's father and the last medical superintendent of Broadmoor, notes that,

> The responsibility for the admission and discharge of Broadmoor patients rests, rightly, on the Home Secretary as the spokesman of the society which has been offended against and not on the medical expert. (P G McGrath 39)

Asylum, however, shows Dr Cleave acting high-handedly, according to his own wishes, only noting he is "thinking of writing to the Home Office about a release

date for Stella" (225) and observing that Stella "didn't ask me if I'd told the people at the Home Office about the impending marriage" (234).[167]

In 1959 the inmates of an institution for the criminally insane were kept in extreme seclusion from society. Protecting the public from mad offenders was deemed of great importance. This was a time when legislation also sought to defend patients' rights. However, this protection relied on the disposition of powerful psychiatrists, who alone had the power to detain or recommend the release of patients from a world cut off from the general public. I shall show how McGrath's novel depicts patients at the mercy of such abuses of professional power. This abuse, led by the obsessions of Peter Cleave, is at the centre of this novel. I shall explore how it is McGrath's handling of narrative authority and point of view which is central to my interpretation.

c) Patrick McGrath and Gothic tradition: the uncanny invoked by psychiatry

Critics Matt Foley and Rebecca Duncan note that, in *Asylum,* McGrath "draw[s] together modernist technique and concerns with images of gothic excess". This results in "a radical excess of affect that defies rationalisation and even socialisation" (103). McGrath also makes "the boundary between passion and delirium unstable" (Zlosnik qtd in Foley and Duncan 105). The Gothic excess of passion, along with instability of time, place and reason, are significant features of McGrath's novel, making the rational identification of fictional 'facts' harder to identify. The author has demonstrated a close affinity with Gothic throughout his career, both writing and editing short stories within the genre (McGrath "Blood Disease; McGrath and Morrow). Interviewed by Bradford Morrow (McGrath Interview), McGrath makes clear his esteem for the Gothic, saying, "As a writer I saw tremendous possibilities within the genre. It seems so rich in terms of psychological states, political ideas" (30). He goes on to elaborate his definition of the Gothic, with its particular association with insanity.

[167] It is notable that in the film of *Asylum* (MacKenzie), Cleave mentions actually consulting the Home Secretary.

> If we think our language is built of sets of oppositions, Gothic is that which always tends toward the darker side of any opposition one cares to throw up. So that Gothic would always be motivated more by insanity than sanity, disorder than order, ruin, rather than whole structure, disease rather than health, decadence rather than virtue . . . Gothic is that form of fiction which is fascinated with the transgression from that norm, always pushing from light to darkness, day to night, reality to dreams. (30)

Asylum fits firmly into this description of the Gothic, which underwent a "strong revival" in the 1990s (Luckhurst "Contemporary" 527). The setting of the huge, rambling, Victorian hospital, as well as the maze of ill-lit, ramshackle buildings in London where Edgar sets up his studio, establish a darkly Gothic disquiet, reflecting the "ruin" and "disorder" mentioned by McGrath in the interview quoted above. In addition, the motivation of "insanity rather than sanity . . . [and] disease rather than health" slant the novel's narrative towards immersion in that which is dark. In his introduction to the *Oxford Book of Gothic Tales*, Chris Baldick writes that, to achieve a Gothic effect, "a tale should combine a fearful sense of inheritance in time with a claustrophobic sense of enclosure in space, these two dimensions reinforcing one another to produce an impression of sickening descent into disintegration" (Baldick xix). This is an effect McGrath achieves in *Asylum.* One of the consequences of the shadowy chaos of the Gothic is that historical time becomes uncertain, this being an element I have also identified in earlier chapters concerning madness narratives. Cleave's narrative is thus released from strict chronology, so that McGrath leaves the reader unsure about when many events took place. Within a recognisably Gothic setting, Cleave is able both to evade clarity about the ordering of action within the text and to obscure the experiences of the novel's characters.

The figure of the psychiatrist has a significant place in this recent Gothic revival. Critic and psychotherapist Adam Phillips notes how a mental hospital may replace the traditional ruin as a Gothic setting (Phillips 358). Phillips describes the new role for the psychiatrist here, observing that the "ultimate parody, or apotheosis of the novelist - or indeed of the so-called omniscient narrator - must be, as McGrath intimates so artfully in *Asylum,* the modern psychiatrist " (A Phillips 358). This suggests the reader will see the psychiatrist as a guide in the frightening labyrinth that is the psychiatric institution. McGrath

takes advantage of this redefining of both novelist and omniscient narrator, making his narrator/psychiatrist, Peter Cleave, seem to hover between first person and omniscient narrator. This works to increase the reader's trust in the apparently all-knowing account of the guiding professional who will be considered to have an understanding of how the mind functions. This makes his unreliability as thief of his patients' stories so much harder to unravel. In his review of *Asylum,* Phillips says that the psychiatrist in Gothic texts is

> the person who gets people to keep the madness inside - inside language, inside themselves, inside mental hospitals. After all, if he doesn't speak from a position of sanity, from where does he speak? And what exactly makes his tales better than the patients'? Psychiatrists, and their poor relatives, psychoanalysts, have always been Gothic figures trying to escape from the genre in which the characters are always shady, and authority is simply melodrama. (259)

This is of great relevance to the uncertain authority and sanity of *Asylum's* narrator, whose recounting of events, as I shall argue, is apparently but misleadingly omniscient. It also highlights the ways in which the psychiatrist's "tales" are deemed "better than the patients" (259).

McGrath makes full use of the Gothic tradition in *Asylum* to establish uncertainty, the threat of violence, confused chronicity and claustrophobic space. As the editors of *The Routledge Companion to Gothic* point out, the Gothic is "one tool among many employed in the service of conjuring up interior terrors" (Spooner and McEvoy 8). Academic Hélène Machinal points clearly to *Asylum's* position within Gothic tradition as she compares it to Henry James's *The Turn of the Screw*. While she sees James's novella as involving "the uncanny and the fantastic", with its uncertain appearances of the dead in a near empty country house and grounds, in a move to highlight madness and the 'psy' professional within Gothic, Machinal sees *Asylum* as "encompass[ing] a shift from an emphasis on nature and architecture to an exploration of the recesses of the psyche" (Machinal 65). Further, Machinal comments on McGrath's use of "spaciality" and references to outer and inner worlds, so that the "dichotomy between outside and inside leads one to reflect on enclosure, imprisonment, and on public and private spheres" (65). McGrath evokes sinister, imprisoning spaces in the novel, the institution itself being a "desolate sort of place" (*Asylum*

2) in which the insane are also terrifyingly confined by their madness. Edgar's loft, a place of escape from the asylum, is nevertheless situated in a part of London where "[n]arrow streets ran between derelict houses built in the last century . . . little light . . . windows bricked up or smashed or thick with dust" (80). The Welsh house, another place of escape, is one in which Max "knew [Stella] was trapped" (162). The reader is prepared for frightening events to happen in these places beyond the institution. It is clear that nowhere in McGrath's novel offers any sort of asylum to anyone. The novel ends on a Gothic note as Cleave finally has Edgar locked up in one of the most isolated secure wards and Stella, after her death, has been turned into the "thin, beautiful, tiny anguished head" that is the diminished, tortured facsimile produced by Edgar and kept in Cleave's desk drawer (250). The two patients are finally and permanently trapped and possessed by their manipulator, the psychiatrist.

Critic David Punter (Punter qtd in Spooner and McEvoy 129) discusses the problem of what information can be known within the Gothic and his description is enlightening in relation to *Asylum.* Punter states that, in Gothic, "the barriers between the known and the unknown are teetering on the brink of collapse" (130). If we consider this statement in relation to Cleave's account, the divide between what the psychiatrist knows and what he cannot fully know appears blurred. Punter rightly sees psychiatry, within Gothic, as addressing that which is repressed or not fully remembered. McGrath's novel repeatedly makes the reader consider whether information is reliably known, and the institutional setting continuously evokes the psychiatric notion of the problematic nature of memory. In *The Uncanny*, British novelist and academic Nicholas Royle writes: "The uncanny involves feelings of uncertainty, in particular regarding the reality of who one is and what is being experienced" (1).[168] He goes on to say that it also indicates "an apprehension, however, fleeting, of something that should have remained secret and hidden but has come to light", although it is not "'out there', in any simple sense" (2). Such "com[ing] to light" of information without being "out there" may be applied to the

[168] The term 'uncanny', frequently employed in discussions of the Gothic, is the usual English translation of Freud's word, *unheimlich*, or 'unhomely', referring to that which is inexplicably strange (Freud "The Uncanny").

oblique nature of Cleave's narrative, as the instability which arises from the uncanny "suggests the uncontrollable nature of memory, of trauma, of haunting" (Punter qtd in Spooner and McEvoy 136). This works to persuade the reader to accept Cleave's version within the unstable Gothic setting of *Asylum*. McGrath's employment of Gothic and the uncanny point to the fact that all information presented in the novel must be questioned.

Placing his novel within the Gothic tradition, McGrath is able to present unreliable accounts and memories within terrifying and darkly claustrophobic spaces where linear time is abandoned. The deceptive nature of memory and the confusion inherent in the maze-like settings of the hospital and Edgar's London disorient the reader so that Cleave's certainty and authority appear to offer welcome guidance. For the purposes of this chapter, it is vital to discover the psychiatrist's role in providing the reader with accounts of the actions of others. I shall demonstrate how these accounts are misleading.

d) The narrative process in *Asylum*: why choose the unreliable psychiatrist?

In exploring how Cleave's narrative works, I shall argue that the choice of this psychiatrist as narrator makes this fiction highly complex and rewarding to readers who attempt to sort fictional reality from fictional fantasy. I shall indicate how author McGrath misleads readers via the deflections of the narrator, Cleave, while at the same time repeatedly letting the reader know that his narration is untrustworthy, even as Cleave's version is cloaked in psychiatric authority. McGrath himself has made significant declarations about Peter Cleave as narrator in *Asylum.* When asked in an interview why he chose Cleave to narrate Stella and Edgar's story, McGrath has said,

> The first draft of the novel was written entirely from Stella's point of view. It became a paean to romantic love and she justified everything she did in the name of this great love that she had. Then it occurred to me that if Peter Cleave were to tell the story I could get both Stella's interpretation of it as a story of romantic love and his interpretation of it as a sort of clinical breakdown at the same time. Then we'd have the two different interpretations jostling together in the narrative to make it a much more juicy job for the reader to sort out their own moral reactions. (McGrath "Q and A" n p)

McGrath thus sets out his task for the reader, who has much work to do to unravel the puzzle the novel presents. On the matter of how much the reader can trust Cleave's version of events, McGrath is firm that interpreting the psychiatrist's voice is very much part of this puzzle. Asked if the reader can trust Cleave, McGrath replies,

> Really this is the reader's responsibility, but my plan was to allow Peter to lull us into a sense of security. He is, on the face of it, a wise, compassionate older man and a psychiatrist, and I wanted that authority to be very gradually undermined - but undermined it is. (McGrath "Q and A" n p)

Adam Phillips is enlightening about *Asylum's* unsettling and misleading mode of narration, as he observes it is through "the plot's subtle reversals and doublings that we begin to resemble the psychiatrist-narrator, who gives us the gradual creeps" (360). Cleave's peculiarly slanted narration means that: "In an uncanny way we perform, in the reading of this book, just what it is showing us' (Phillips 360). As Matt Foley writes, McGrath always presents "an ego at work that the (implied) reader must judge for themselves and, in some senses, psychoanalyze" (Foley and Duncan 107). Cleave's status as 'psy' professional draws the reader's attention to a possible psychoanalytic way of regarding the narrative and this will cause the reader to approach Cleave's text as a therapist might a patient, attempting to draw out the hidden meaning of what lies behind the presentation of the account. Phillips suggests that, in this way, the reader becomes complicit in constructing the psychiatrist-narrator's (unreliable) version of events. McGrath makes this task a major part of the reading challenge, which greatly enhances the pleasure of decoding his novel.

In his 1997 *New York Times* review of *Asylum,* British academic Michael Wood draws attention to another novel with a notably unreliable narrator, Ford Madox Ford's *The Good Soldier* (Wood; Ford). Wood points out the similarities in the opening of Ford's and McGrath's novels: Cleave claims Stella's story "is one of the saddest I know"(1), while Ford's novel begins with its narrator claiming, "This is the saddest story I have ever heard" (2). Author Julian Barnes, in a review of a new edition of *The Good Soldier*, points out that this is "one of the most misleading first sentences in all fiction" (n p). For Wood, this parallel between the two novels alerts the reader to Cleave's "ignorance, his

failure to see beyond the comfortable categories of his trade" (n p). Like Cleave, Ford' s narrator, Dowell, does not fully understand the story he tells. Wood further notes that Cleave "cling[s] to his illusions as hard as anyone can" and sees McGrath's novel as presenting "dangers that can't be grasped, a departure into madness that is perfectly pictured but beyond analysis" (n p). Wood is left with many questions and this ambivalence about what is 'true' within Cleave's version of Stella's story is clearly a powerful force within the novel. Drawing attention to this uncertainty, McGrath offers a body of evidence that reinforces the unreliability of his narrator.

In comparison with *The Good Soldier,* one aspect of *Asylum's* narration is markedly different from Ford's. Dowell is always present in his narrative, leaving the reader in no doubt that we are reading a peculiarly personal slant on the events that comprise the novel. In *Asylum*, on the other hand, Cleave rarely uses the pronoun "I". As a result of omitting such reference to Cleave's presence and frequently using the style of an omniscient narrator, McGrath confers his novel's recounting with impartial narrative truth, as well as endowing the novel's entirety with the psychiatric authority of Cleave's profession. Adam Phillips draws our attention in *Asylum* to the narrator's "voice of patient, informed explanation - with its knowing lists, its confidence in narrative - [which] makes the reader feel that it's more than possible to have a grip on things" (359). While this style apparently has the impartial authority of the case history, the reader must remember that the voice throughout is Cleave's and he is far from disinterested. As McGrath intended, Cleave's voice "lull[s]" us into a sense of security"(McGrath "Q and A" n p) and provides the gradual and insidious undermining of his own narrative. Indeed, Phillips notes that "as the story unfolds, everyone loses their grip, and there is no way of regaining it, because all the available forms of competence and comprehension - from the theological and the medical, down to the police - are either ridiculed by events, or shown to be complicit with the horror" (Phillips 359). Uncertainty is at the heart of *Asylum.*

Wood is right that the novel leaves the reader with many questions, for we cannot be certain about Stella's experiences. In spite of being frequently narrated as reports of events using direct speech and much circumstantial

detail, Stella's actions and thoughts are all presented by her psychiatrist. While Wood notes that Cleave can tell us Stella's story "since she recounted most of it to him", the undermining of the narrative voice that is apparent with careful reading makes the reader ask when and where such recounting by Stella to Cleave took place. The novel has many clues that lead the reader to understand that Cleave's version of Stella's story contains much conjecture. The psychiatrist's narration is not constructed merely to provide information about Stella and Edgar: we know a great deal more about Cleave from the telling of this tale than we do about his patients for, as critic Machinal points out, theirs are "lost voices". Machinal notes that the narrative shows "a hierarchy, a class-divided society which is reproduced within the microcosm of the asylum"(65). The psychiatrist's version in this hierarchy is readily deemed more reliable than any voices of the mad. The reader must take a leap outside the apparent authority contained within this social structure to ask how Cleave has come by his information about the relationship between Stella and Edgar. Is not Stella's deception of her psychiatrist, alluded to in the very opening paragraph of the novel and clearly evidenced towards the novel's end, providing clear testimony that whatever she has chosen to tell Cleave cannot possibly be reliable? We have no firm knowledge of the experiences of Stella and Edgar. What we can infer with some confidence from the narrative is that Cleave is one of the many self-serving, manipulative psychiatrists that this thesis identifies as common in fiction. In the interview referenced above, McGrath says the novel

> is making a smaller point that psychiatrists do wield a great deal of social power. . . . The point is that the abuse of that power is horrific. That's not to say that all or even most psychiatrists abuse that power, but it can be abused and *this is what it would look like when it is.* (Q and A" n p; my italics)

McGrath leaves the reader in no doubt that this work exhibits psychiatric abuse. Notably, only a 'psy' professional as narrator could provide McGrath with the necessary and considerable physical mobility, power, influence and apparent authority in recounting events. Only a psychiatrist could have trustworthy access to patients, custodial and domestic staff, medical colleagues, relatives and the police. It is Cleave's position as psychiatrist that invokes the reader's trust in his version of events, in spite of the fact that we are repeatedly warned of his unreliability.

There is much in this novel that shows that Peter Cleave has considerable failings as a psychiatrist. He is grandiose, lacking in self-knowledge, ruthlessly ambitious (though he repeatedly makes claims to the contrary) and a cruel and proprietary manipulator of those patients who are of particular interest to him. He is observant of much that happens around him, but capable of significant misreading of what he sees. Further, he often refers to his assured predictions of the course of psychiatric conditions in preference to responding to clinical situations. He consistently and dedicatedly pursues his own obsessions, rather than attending to the care of his patients. There are many clues to Cleave's character in the oppositions apparent within his narration. He is observant yet wrongheaded, self-effacing but grandiose, self-deprecating but also highly ambitious. These binary oppositions are contained in his name, 'Cleave' suggesting both clinging (as he possessively holds on to Edgar and Stella and his notions of the predictable progression of psychiatric illnesses) and violently cutting apart, which suggests his cruel severing of Edgar and Stella's relationship.[169]

During his account of his patients' affair, Cleave unwittingly presents much detail about himself. Identifying himself early on as an observer of the actions of others, staff as well as patients, Cleave tells us he has a habit of, "return[ing] to my office to write up my observations" (7), which he does after the asylum ball at the beginning of the novel. While he is clearly able to observe, he tends to fit what he sees into his preconceived theories, such as being certain Stella has a "classic Medea complex" (208) and "one of the most florid and dramatic examples of morbid obsessional sexual compulsion I had encountered in many years of practice" (208). These statements seemingly reinforce his opening claim to professional expertise concerning sexual obsession (1). Again generalising about psychological states, Cleave notes that Edgar showed signs of a "childish need to elevate and idealise the love object" which is "not uncommon in artists" (43). Cleave goes on with these glib deductions about Edgar, pointing to typical "isolation", "public self-display", "the associated risk of rejection" all of which are bound, in Cleave's view, to be followed by "disillusion" and "betrayal" with potentially "pathological conviction of

[169] The dual meaning of Cleave's name has also been noted by Hélène Machinel (78).

the other's duplicity" (43). The psychiatrist sees his patients as following predictable paths of madness and this prevents him from closely observing them with an open mind. This repeatedly undermines his psychiatric expertise.

Cleave persistently *mis*uses his observational competence, which is undoubtedly keen, to forward his own ends. His arrogance causes him to observe what he wants to see, always pre-empting how psychiatric illnesses progress. Having made questionable deductions from his observations, Cleave pursues his own agenda of placing Edgar and Stella firmly within his power. When Stella becomes his patient, Cleave notes her "well-tempered demeanour . . . composed but not depressed, this she knew was what we wanted to see" (217). He is acutely aware of Stella's dilemma as a psychiatric patient, "never being certain whether we noticed how well she was doing" (217). When, as inmate, Stella reports terrifying dreams, Cleave claims, "it was what I'd been waiting for" (222) and goes on to state his preconceived notion of how this patient should progress: "What remained now was to work through the guilt. I was confident that . . . it would be straightforward and relatively quick" (222).

Cleave's unwavering confidence that mental illness follows set patterns, which prevents him from paying proper attention to his patients, has dire consequences which he fails to acknowledge stem from his own deficiencies as a psychiatrist. His overconfidence causes him to make incorrect inferences from what he sees. At the second asylum dance Cleave says: "My calm eye oversaw everything and missed nothing" (244). The reader is to discover that Cleave has, in fact, missed a great deal. However, realising he has been proven wrong about Stella, Cleave needs to prop up his own self-image as a highly experienced and competent psychiatrist. Now he says "I knew then what my psychiatric intuition was telling me, and why I'd been feeling so uneasy" (248). There has been no previous suggestion whatsoever of unease. On the penultimate page of the novel Cleave confirms this assertion of superiority over such people as Stella and Edgar, for he has much experience of "disordered souls . . . trapped in their private hells, each aching for the other (249)". He has seen such "destructive affairs" often enough to know that "they all come to this, or something like this, in the end" (249). He does not doubt his generalised predictions. The reader (though not Cleave himself) may decide that the

psychiatrist is also "trapped" in his own "private hell" as he pursues Edgar via Stella.

There is considerable evidence in the text for Cleave's immense arrogance. He refers to his own "patrician affability" (39) in his dealings with custodial staff. He imagines Stella sees his clever perception after Edgar has absconded: "it occurred to her that there was nothing in the least dreamy about the busy, intelligent mind behind [my] lazy eyes" (75). He sees himself (not Edgar) as of central importance to Stella: "She hadn't been expecting me, and at the sight of me she felt the first faint stirring of emotion she'd known for days" (199-200). This is Cleave's assumption as he goes on to narrate, "'My poor dear girl', I said, and that was enough. The tears came" (200). Cleave now tells the reader confidently, "My visit became the central event of her day and made all the rest of it tolerable" (200). There is no external textual evidence for any of these self-important suppositions of Cleave's.

We discover that Cleave has become Medical Superintendent, after Jack Straffen's retirement and Max's apparent disgrace.[170] Cleave expresses great satisfaction at having his special patients within his own domain: "I always feel a rather proprietary pride when I gaze out over [the hospital's] orderly, well-tended paths and yards and terraces" (203). The ordered neatness of the institution acts as a metaphor for the orderly way in which Cleave firmly believes psychiatric disorders progress. On the following page of the novel, Stella learns from a nurse that Dr Cleave is now in charge. Not telling Stella himself has not been an oversight, for Cleave says he "thought it best" (204) for Stella to receive the news in this way. With typical over-confidence, Cleave claims: "When Jack retired they came to me, for no one knows the place better than I do. Reluctantly I agreed to take over" (204). It is difficult for the reader to miss Cleave's self-deprecating yet hugely confident disclaimers, particularly as he arrogantly projects his view of himself onto Stella: "It occurred to her to be grateful she was in so protected a place . . . and in wise, healing hands" (212). Having moved Stella to the downstairs ward, where conditions are much better,

[170] McGrath blurs the line between madness and sanity further by naming the novel's retiring medical superintendent Jack Straffen. John Straffen was a real patient who absconded from Broadmoor in 1952 and murdered a child. After this event, alarm sirens were installed. Such alarms are sounded in the novel when Edgar escapes (55; Slevin).

we see Cleave's inappropriate largesse, as he "waved away her gratitude", and his need to assert his importance in telling Stella, "Bloody meeting with the Ministry of Works" (219). He then grandiosely imagines Stella watching him as he leaves, "an elegant, elderly man with a sheaf of files under his arm and an institution on his shoulders" (219). Later, feeling that Stella must be delighted with his offer of marriage, Cleave imagines her "tell[ing] the ladies on the ward, just to see their reaction". He is "confident she would see marriage to me as her best course" (230). This last statement is interesting, for Cleave recognises Stella's trapped, powerless position as a psychiatric patient, but simultaneously feels entirely certain she will accept his proposal. His observations are often perceptive but his interpretations about what they mean and predictions about how people will subsequently behave will be shown to be terribly wrong. Cleave's comments repeatedly show his unwavering certainty that he is correct in his theories and dealings with patients and staff.

The occasion of the second asylum ball (the film version of *Asylum* plays the 1941 tune, *The Anniversary Waltz*, during both dances, drawing attention to the circularity of time in the plot [MacKenzie]) allows Cleave to express extreme confidence in his person and position. He is on the cusp of possessing everything he has worked for, with Edgar his securely confined patient, and Stella about to become his beautiful possession as wife. Cleave's inflated sense of self-worth reaches a crescendo towards the novel's end as he firmly believes "the propriety and order of the event [the dance] was a direct effect of my presence, my quiet authority and the deference I enjoyed from patients and staff alike" (245). He reports with self-assurance that he addressed the assembly with "a few benign words" and "a joke or two", for he confidently believes, "I am a popular medical superintendent" (245). Beyond Cleave's own claim, there is no textual justification for his supposed popularity. The psychiatrist is complacently certain of Stella's appreciation of his public address as he "conveyed that night my patrician ease, my warm wise humour" (245). Readers are unlikely to take at face value Cleave's amplified view of his own importance and capabilities.

All the information about Cleave's grandiosity and manipulative cruelty, such as his taunting of Stella and Edgar with the proximity and inaccessibility of

each other within the hospital, is given obliquely by Cleave the narrator. The psychiatrist seems unaware that he is making such revelations. However, there are two significant instances when Cleave reports the direct speech of others. These offer the only sources of information about Cleave that seem to escape his total narrative control, since they are apparently unmediated reports of the actual speech of other characters. Both statements come as abrupt intrusions of reality into Cleave's self-justifying, self-important narrative. Visiting Max in Wales to tell his former colleague about his plans to marry Stella, Max is reported as saying incisively, "It's Stark that you're after" (224). Shortly after, Cleave cruelly tells Edgar his plans for marrying Stella and Edgar responds saying, "The question is, what would she want with an old queen like you" (236)? In this way, the author draws attention to two significant facts - Cleave's central obsession with Edgar, and Cleave's otherwise undefined sexuality. I will examine these two stark facts within discussion of Cleave's inappropriate sexual behaviour, which surfaces subtly but often in the text.

e) Unreliable narration as a rewarding textual device: Peter Cleave as misleading narrator

I have already discussed above how the psychiatrist constructs his own version of events which he has observed, conjectured from partial evidence, or completely fantasised. I have signalled instances in which Cleave's account is inconsistent with other textual information so that he may be deemed unreliable. I shall now explore more fully the presence of the unreliable narrator and offer more evidence that we can apply this term to Peter Cleave. *The Snake Pit* and *Long Distance* have already been analysed in this work as examples of unreliable narration. They fit more clearly into this category as accounts of institution inmates who are deemed mad. McGrath's use of an unreliable narrator who is in the powerful role of 'psy' professional is quite different, since the reader might expect considerably greater trustworthiness from this supposed representative of the sane world.

The term "unreliable narrator" was first used by critic Wayne C Booth in *The Rhetoric of Fiction* (1961) (158-9), and has been much discussed

subsequently. Booth comments that, when considering different kinds of narration:

> the most important of these kinds of distance is that between the fallible or unreliable narrator and the implied author who carries the reader with him in judging the narrator. . . . *If he is discovered to be untrustworthy, then the total effect of the work he relays to us is transformed*." (158; my italics)

This gives a good indication of Peter Cleave's role in *Asylum.* His unreliability continuously recasts the text for the alert reader. The reader who fails to pick up the constant stream of clues to Cleave's fallibility may need to wait until the end of the novel, when Cleave clearly acknowledges he has been deceived by Stella, to question all the information previously presented with apparent authority. At this point, the reader may be reminded that the psychiatrist did, of course, recount that Stella "deflected [him] from the truth until it was too late" on the very first page of the novel (1). In *Asylum,* Cleave pushes the boundaries of unreliability. However, as stressed above, the psychiatrist continually draws the reader's attention to his unreliability. He reminds us again and again that there is no solid foundation to his version of events, and then goes on to lure us back in to his seemingly authoritative, highly detailed narrative from which his presence as mediator is almost completely removed.

The author, as described by Booth, invites the reader to work with him as the latter is "called on to infer the author's position through the semi-transparent screen erected by the narrator" (301-2). The nature of the fiction as complex enigma then also provides the additional reading pleasure of "[s]ecret communion, collusion and collaboration" as, "others are excluded" (304). I agree with Booth that this provides the reader with "a kind of collaboration which can be one of the most rewarding of reading experiences" and one which is indeed an, "exhilarating sport" (307). Greta Olson, in her 2003 paper "Reconsidering Unreliability: Fallible and Untrustworthy Narrators", expands on Booth's concept of how this pleasure is made available to the reader. The reader tries out "alternative interpretations" and then "makes a decision about the implied author's probable intentions, asking, 'how were these words meant to convey a message other than their intrinsic meaning'" (95)? In this way, the reader arrives at a "non-literal meaning", this being one that "sophisticated

readers . . . would agree upon and unsophisticated readers would not" (95). Consideration of this paradigm for enquiry into the nature of the unreliable narrator is essential to perceiving McGrath's psychiatrist as abusive. I have shown above how Cleave privileges his personal agenda over his patients' needs, appropriating and reshaping the life-narratives of Stella and Edgar to adapt them to his own obsessions. The distance between what Cleave imagines of Stella and Edgar's love affair and the unvoiced fictional reality, which neither reader nor narrator will ever know, leaves Stella dead and Edgar locked away in a secure ward, at the mercy of the abusive psychiatrist, Cleave. This hidden but implied story encompasses the fundamental uncertainty, presaged by the Gothic, that is at the heart of *Asylum.*

In order to further substantiate my view of Cleave as unreliable, I shall now explore the sources of the information presented in the novel, reiterating that all information is presented through the lens of Cleave's narration, even though the reader is repeatedly invited to forget this by the misleading use of apparently omniscient narration. In addition to conjecture and fantasy, I shall show how the psychiatrist also relies on gossip as the basis for events he goes on to describe in minute, imagined detail. It is highly significant that Cleave states right at the beginning of the novel, "Oddly enough I only saw [Edgar] with Stella once, and that was at a hospital dance" (3). This is a bald statement which the reader must hold on to when Cleave moves into narrating many other meetings between the lovers *at which he was not present.* Consider, for example, the following:

> Panes of glass were stacked against the wall. Edgar was on his knees chipping away at the crumbling mortar on the brickwork at the base of the conservatory. Shading his eyes with his hand he squatted on his heels and gazed up at Stella where she'd stopped some yards back along the path. He said nothing, just gazed at her, waiting, unsmiling, his hair hanging over his forehead and his expression one of deadly seriousness. (18)

This is authoritative narration of an encounter, exhibiting easy movement into omniscient narration. Its considerable detail leads the reader to believe this meeting actually happened. It is interesting to note how, at odds with the novel's text, MacKenzie's film of *Asylum* puts Cleave observing this meeting

from behind the shrubbery in order to present a version of events which has currency. The nature of film dictates that the director is obliged to take a stance on whether or not events occurred in the 'reality' of the fiction. If a meeting is part of the film's visual text, its details of place, weather, personal appearance etc are, of necessity, present. It is much harder convincingly to present, in film, events the novel points to as unreliably imagined. After this description of Edgar at work in McGrath's fiction, Cleave moves into Stella's supposed consciousness, a major narrative device which he uses throughout the novel.

> Picking her way back along the path in the sunlight she could imagine the glances being exchanged between the two men behind her back. She'd felt excitement when she saw him squinting mutely up at her, but she had resisted it, she had no further wish to be sympathetic. He is a crafty, unpleasant fellow, she thought, and he believes he has me at a disadvantage because I let him get away with that thing at the dance. (18-19)

This free, indirect style of the presentation of Stella's thoughts is beguiling and Cleave is a master at presenting convincing information from inside Stella's consciousness, without any real explanation of how he came by it. The reader might see this entering of Stella's consciousness as playing on the commonly held fear that psychiatrists know our inner thoughts and read our minds (Leicester n p).[171] Of course, presenting the inner thoughts of characters is also what novels do, so it is useful here to be reminded of Adam Phillips' statement that the reader's approach to this fiction is guided by McGrath's method of writing it (Phillips 360). Very soon, Cleave tells his reader quite openly of the source of information about this lovers' meeting which he has not witnessed: "John Archer reported to me, and he had sharp eyes and a devious mind, every bit as devious as Edgar's; he soon let me know about this budding friendship" (29). Archer is one of the "custodial staff" members who, according to the psychiatrist, appreciate the latter's "patrician affability" (39). The reader now knows that Cleave has fully imagined a scene the existence of which has been

[171] Liz Leicester, writing of common misconceptions about psychiatrists, notes "[a] striking 46% of medical students and 60% of the public thought that psychiatrists 'know what people are thinking'". It is of interest that Cleave's account shows Stella giving this mind-reading attribute to 'psy' professional husband, referring to Max, described as "*reading my mind …* like a book, finding it written in fragments of behaviour, fleeting nuances of expression, certain absences of response of which I would not be aware" (24). I suggest the paranoia here is Cleave's, not Stella's. This forewarns us of the narrative device of conjecture from seemingly irrelevant detail that I discuss below.

brought to his attention by a "devious" informer who reports gossip. Cleave's unreliability could not be made clearer. It is an extraordinary narrative achievement on McGrath's part that the reader's trust in Cleave's version of event is repeatedly renewed.

Cleave openly enlightens the reader about another event he did not witness but which was reported to him, this time at third hand. The reader is told how Edgar brings Stella's son Charlie into his parents' house after the child has fallen in the garden. This event was witnessed not by the psychiatrist, but by Stella's domestic help, Mrs Bain, who reported it to her husband, Alec, who, in his turn, informed Cleave of the incident. The psychiatrist expands his account of this event at which he was not present with much imagined detail: "Stella crouched and took his hands, [Charlie] fell into her arms and kissed her on the lips. She glanced up and caught the look that Brenda shot Max, the lift of a thin plucked eyebrow" (150). Yet again, the psychiatrist is exhibiting a writerly creativity. Cleave unashamedly reports "it was he [Bain] who told me later of his wife's reaction to a patient who came into the house without knocking, shouting for Mrs Raphael and using her first name" (29). From these two events, reported by "custodial staff", it is clear that Cleave uses his position to elicit what may be construed at worst as gossip and at best as hearsay evidence.

There are other clear indications of Cleave gaining questionable information via gossip. Max's mother, Brenda, provides Cleave with much informal chatter about Edgar, Stella and Max. Again exhibiting his frequent self-importance, Cleave openly attracts the reader's attention to his source by saying, "[Brenda] and I often spoke on the telephone. . . . She relied on me for reports about her son" (36-7). Cleave is present at a dinner at the Straffens' house to welcome Brenda. A chance remark of Brenda's, that Stella looks "in the pink", gets Cleave's attention. He now thinks,

> In the pink. I rather whimsically reflected that it sounded like a euphemism, something to do with sex; and it was then that it occurred to me that something *was* happening to Stella, sexually. I regarded her with care. (38)

Notably, this dinner and Cleave's statement above occurred after Bain and Archer had made their reports to Cleave about Stella and Edgar. Did Cleave, then, initially doubt their accounts? The psychiatrist now goes on to refer to his "intuition" that something is happening between Edgar and Stella (43-4). This is already at odds with the authoritative way in which Cleave has previously reported on meetings between Edgar and Stella, now putting the details of those encounters in further doubt for the reader. Later, it suits Cleave to give credence to the accounts of the lovers meeting in the garden, noting "John Archer had kept me fully abreast of all that" (96). This will not satisfy the alert reader.

There is also an admission by Cleave to meddling on the occasion of this dinner for Brenda, when the psychiatrist has used gossip from the custodial staff. Jack Straffen challenges Stella, saying, "It's been suggested . . . that your relationship with Edgar Stark went beyond what's proper for a doctor's wife" (60). Cleave now narrates, "I'd been there for the last hour, *bringing them up to date*" (61; my italics). While information about the lovers might be construed as gossip from another source, Cleave's authority as psychiatrist clearly has weight with Straffen, his superior.

Brenda later visits Max and Stella in Wales, where Max has moved to a posting that is, in Cleave's eyes, inferior. This follows the disgrace caused by Stella's misdemeanour with Edgar. Cleave tells us Brenda's motive for the Welsh visit is to rid Max of Stella. The reader may have some confidence of this being Brenda's motive, since Cleave reports that "Brenda took me into her confidence over this" (185). Cleave's descriptions of the "fiasco" of the dinner in Wales, the separate "sleeping arrangements" of Stella and Max Raphael and the "horror at how they lived" are all gained via gossip from Brenda (186-7). Indeed, it appears that Brenda has discussed her proposed visit with Cleave as he says, "I myself was adamantly opposed to this projected visit, but Brenda's mind was like a piece of forged steel, once she'd made it up" (184). This hearsay information, provided by Brenda, forms the basis of Cleave's knowledge about the Raphaels' life in Wales. It is then augmented with further observed detail about the place and its people when Cleave himself visits Max to tell him of his plan to marry Stella, the latter now being Cleave's patient in the

hospital. The psychiatrist's narrative thus mixes hearsay information with observation in order to produce an authoritative, albeit fantasised, account. Archer, Bain and Brenda are openly acknowledged sources of Cleave's detailed information about the affair of a couple he saw together only once.

There is other textual evidence to show that Cleave has worked hard to unearth information. When Edgar appears to telephone Stella at her house, Cleave notes that this would have been difficult for Edgar and states, "How he found the means of using this telephone *I have never been able to establish*" (19-20; my italics). Cleave has obviously tried to solve this problem. After Edgar has absconded from the institution, the psychiatrist tells us he attempted to get information from "everyone I knew" (73). Cleave uses his senior psychiatric position with the police to gain access to explore the loft in Horsey Street, London, where Edgar and Stella appeared to live for a time. He also has little difficulty in persuading the police to give him Edgar's drawings of Stella and the sculpture of her head. This is concrete information about his sources that Cleave includes in his narration. In addition to this, however, I shall now turn to the many clues in Cleave's vocabulary to show how he has constructed, by conjecture, a narrative which fills the gaps in his knowledge of Edgar and Stella.

f) Conjecture as the basis for unreliable narration in McGrath's fiction

McGrath makes frequent use of inference and speculation to explore events in his fiction. Two earlier novels, *The Grotesque* (1989) and *Spider* (1990), both make central use of this device, with narrators who present conjectured events as though told by an omniscient narrator. In both these earlier novels, this narrative device is clearly signposted. Conjecture is also present in *Asylum,* though it is harder to pin down here since its narrator is neither physically nor mentally disabled, as in *The Grotesque* and *Spider,* but holds the authoritative position of a senior psychiatrist. However, I shall show how close reading reveals that conjecture has a prominent place in Cleave's version of events.

The Grotesque is narrated by mute, paralysed Sir Hugo who admits at the novel's opening to having "reconstructed" the story of his wife's infidelity with his butler "since being confined to a wheelchair" (*Grotesque* 11). The reader therefore knows that the events described are a *post hoc* construct. Sir Hugo confesses that the highly detailed activities which he narrates are the result of "solitude" which "permits the imagination to picture, in detail, that which perhaps should never be articulated" (*Grotesque* 77). Describing the start of his wife's affair with the butler, Sir Hugo notes: "I saw it all beginning in the larder, for some reason" (*Grotesque* 77) and goes on to confide: "this is all conjectural, you must remember, but it hardly strains credibility" (*Grotesque* 77). Because novels are able to voice the inner thoughts of the voiceless, this account, in conjunction with the familiarity of omniscient narration in fiction, is readily accepted by the reader, in spite of the Sir Hugo's claim that he owes much to his imagination. McGrath's *Spider* contains the narrative of a schizophrenic man who commits his story to a journal which he keeps hidden in his lodgings. Much of Spider's tale concerns events which he is most unlikely to have witnessed. After one lengthy reconstruction of his father's supposed life, Spider himself feels "drained by my effort of memory and conjecture" (*Spider* 29). At another time, Spider is aware of the difficulty of narrating events since he was "moving forward in the darkness, with little to guide me but my intuition" (*Spider* 28).[172] No difficulty, however, prevents Spider from describing in great detail sexual encounters between the supposed prostitute, Hilda Wilkinson, and his father. Asking rhetorically, "How do I know anything about *any* of this?" Spider confides in his reader: "All acquired overseas, during the long, uneventful years I spent in Canada" (*Spider* 91). The reader is to discover that "Canada" equates to Spider's many years spent in a secure unit for psychiatric offenders in the UK where "[a]lmost all I know about what happened . . . I worked out during that period." This constructed story was formed by Spider from "a jumble of partial impressions: scenes viewed from my bedroom window, scraps of talk

[172] This difficulty of imagining events involving other people is echoed in *Asylum* (112), when Cleave finds it hard to describe Stella's life in London: "The problem was that the further she moved away from the hospital the harder I found *it to reconstruct her experience, to mould it into something with a shape and a meaning I could recognise*" (my italics). Later, Stella returns to the hospital when the police have come to London for Edgar and now Cleave notes (142): "With this dramatic development Stella swings back into my field of vision, she comes into focus once more, and the account is again grounded in my own observations." It seems that Cleave cannot distinguish between "reconstruction" and "observations".

overheard" (*Spider* 147). Moreover, Spider is a psychiatric patient, readily accepted by a reader as unreliable.

Put in the same category as Sir Hugo and Spider as conjecturing narrators, psychiatrist Cleave is a much more slippery source since he carries the authority of his profession with him. He does, however, point to his own creativity and I shall argue that this is applied to his construction of the lovers' story. After possessively referring to Edgar, Cleave makes his claim to artistry: "I have always been fascinated by the artistic personality, I think because the creative impulse is so vital a quality in psychiatry, certainly it is in my own work" (3).[173] Cleave uses "imagine" three times in describing the conjectured, first, sexual encounter between the lovers (23). He refers to his "intuition" (43) that there is a sexual link between Edgar and Stella. Cleave's statement that "I am satisfied this is the truth" is very close to an admission of fantasizing after he has recounted Stella's inner thoughts in great detail as she lies awake after Edgar absconds (65).[174] On another occasion, Cleave states "I allowed her to think of my life, my handsome house" but follows this with: "All this I *sensed* going through her mind" (95; my italics). I have already referred to a further statement which comes very close to an admission of conjecture about Stella and Edgar when the lovers are away from the hospital. Here Cleave now admits: "The problem was that the further she moved away from the hospital the harder I found it to reconstruct her experience, to mould it into something with a shape and meaning I could recognise" (112). On occasion Cleave uses, "I think" instead of his usual claim of "she told me" or "she said" (132). As the police arrive at Horsey Street, Cleave confesses: "With this dramatic development Stella swings back into my field of vision, she comes into focus once more, and *the account is again grounded in my own observations*" (142; my italics). This draws further attention to the fact that there is much in Cleave's narrative which has no such grounding.

[173] There is some truth in this statement about the method of therapy which I have discussed above with reference to the poet Keats' "negative capability" . However, the proper use of such creativity should involve confirmation by the patient of the congruency of her perception with the therapist's interpretation (Roberts and Holmes 57). This is certainly not how Cleave works.
[174] Cleave here narrates Stella's experiences in omniscient style. His patient is unlikely to have reported her actions in such detail long after the incident described (65).

Cleave makes increasing use of conjecture as the novel proceeds. After Stella is brought back to the institution, Cleave now tells us what is going on in Max's mind.

> He could not quite believe that she wasn't crawling about on her hands and knees, weeping and tearing her hair out and begging his forgiveness. He was aghast with a sort of furtive pleasure that she didn't behave with shame, which made her in his eyes more shameful still, and so compounded his sick delight in the whole sordid performance. (147)

At no time does Cleave make claims to any intimacy with Max. This passage can only be contrived by Cleave's imagination in order to fit his expectations of how Stella's husband would behave in the circumstances. This speculation contrasts with the psychiatrist's account of Straffen giving Max a farewell glass of sherry before his exile to Wales. At this point, Cleave reports his presence: "I was there; they murmured platitudes to one another" (159). Cleave then makes reference to his behind-the-scenes meddling as he indicates his part in the gossip about Max's poor judgment: "Could he be *sound?* I tried to keep an open mind, and encouraged others to do the same" (159). The latter part of this statement suggests the opposite of what it says, coming from this self-interested narrator.

According to Cleave's account, Stella apathetically falls into a sexual relationship with her Welsh landlord and neighbour, Trevor Williams. The narrative no longer claims the veracity of Stella's reported words, for Cleave has stopped saying "she said". Unlike Stella's first sexual encounter with Edgar, when Cleave repeatedly uses "I imagine" in describing the scene (23), Cleave now crudely details supposed encounters with Williams. When Williams is outside the house, Cleave recounts that Stella "was sure he couldn't see her clearly through the kitchen window, but he put his hand on his groin and rubbed, and she couldn't help smiling" (179). This event, told with salacious detail, supposedly occurs as Stella is talking to her son in the kitchen. Earlier, Stella is reported to have invited Trevor upstairs where "she knelt on the bed holding the headboard and pushed against his thrusts with her eyes closed and her mind empty" (169). In the unlikely event that Stella has provided this information, these accounts - like others in the novel referred to above - are at

odds with Cleave's much earlier statement about Stella's "distaste" concerning "explicit" talk of sex (22). This version of events, told by a seemingly omniscient narrator, appears to serve the function of demeaning Stella who, according to Cleave, has now grown fat, is careless of her appearance, reads magazines instead of novels and drinks too much (167-8).

As the novel moves to the crucial episode of Charlie's drowning, Cleave makes no attempt to justify his omniscient-style narrative. The horror is presented with all the apparent authority of truth.

> Charlie was trying to catch something in the shallows but it evaded him. She [Stella] watched him mutely and passively and smoked her cigarette as he grabbed at it, whatever it was, and lost his balance. (197)

The narrative states that Charlie's teacher, Hugh Griffin, "went crashing into the water" (197). Griffin, according to this account, pulls Charlie out and attempts to revive him. The narrator gives no authority for this sequence of events although what we already know of Cleave suggests he is most likely to have searched out information about what happened, and he will probably have fitted what he has been told into the pattern of behaviour that he has decided is Stella's. If the psychiatrist has, indeed, sought out details of what happened as Charlie drowns, the reader has already learnt he is likely to have accepted the general gossip surrounding this horror. Cleave goes on to report the loss of general sympathy felt for Stella after Charlie's death.

> [W]hat horrified them was that she had made no noise and hadn't moved. When they properly understood this it all changed, because then she was a mother who'd watched her child drown and done nothing to save him. It was unnatural, they said. It was evil. They couldn't understand it; she has no feelings, they said, she isn't human, she's a monster. Or perhaps she's mad. (199)

Yet again, the psychiatrist appears to be giving hearsay the status of fact, as he listens to how Stella is judged by gossiping non-experts. Stella finds her way back into Cleave's domain after being arrested for manslaughter and locked in a cell and now Cleave states, "How could you explain it, unless she was mad" (199)? Suggesting and accepting madness as the generally perceived label for

Stella puts her in Cleave's hands, at his mercy. The plausibility of Dr Cleave's malevolent account is readily accepted by colleagues and readers alike.

Only after Stella has been seized and questioned by the police in London, and taken back to the institution by Max before the Raphaels leave for their exile in Wales, does Cleave firmly report a time and place for a conversation with her: "She and I talked one morning in late October. . . . We walked through the vegetable garden, where it had all begun" (144). This statement, of necessity referring to a time before Stella is a patient, is unusual, since Cleave's reported interchanges with Stella are rarely given a definite location or time. The complex time scheme within Cleave's narrative has repeatedly called into question when the psychiatrist received the information he claims to have acquired. The attentive reader may note this lack of sequential certainty as a recognisable feature of Gothic. Only by adherence to continuous, close, textual analysis is Cleave's duplicity made clear.

Considering narrated conversations between Stella and her psychiatrist, most of which are given no chronological setting, it becomes apparent that Cleave's slant on the contents of these exchanges is as questionable as their timing. For example, when Cleave visits Stella in her garden, he reports: "My intrusion alarmed her" (94). However, Stella's reported words are: "Peter, what a nice surprise. Sit down. I was just enjoying the last of the summer" (94). Without Cleave's introductory comment, this would suggest that Stella receives Peter as a courteous hostess, with no indication of alarm or, indeed, friendly intimacy. After the psychiatrist has made what are clearly assumptions about Stella's thoughts during this meeting ("All this I sensed going through her mind" [95]), he asks her if she is still seeing Edgar. Stella replies in a "calm tone; not straining after outrage" with, "However did I give you that impression" (96)? While Cleave pursues his agenda concerning Edgar, he graphically and perhaps cruelly describes to Stella the way in which Edgar murdered and mutilated his wife. When Cleave then states: "She told me later she ran straight upstairs and fell on her bed and wept" (97) he fails to inform the reader when and where this confidence took place. Towards the end of the novel, Cleave reports many conversations with Stella when she is his patient. He now sees her as childlike, with Cleave taking control of the shape and content of their

encounters, as I have discussed above. Now, there is much, "she said" and "she told me" (200). However, Cleave continues his narrative habit of recounting Stella's inner thoughts, as if he has full access to her consciousness. Cleave reports that Stella "combed her hair and mentally apologised to me for so dismally failing to meet my own high standards" (209). This appears to be the deduction of a narcissist, whose theories are guided by personal agenda rather than objective observation.

g) Cleave, Edgar, Stella and male sexual jealousy

While Stella is viewed by Cleave as a beautiful possession to add to the artefacts in his home, it is Edgar as creative artist and sexual being who is Cleave's ultimate goal. Cleave introduces Edgar into his narrative as "one of mine" (3) and goes on to refer to "my Edgar" (39, 71), indicating the proprietorial nature of the psychiatrist's attitude to this patient. He reads his relationship with Edgar as "warmly combative . . . I wanted him to feel he had a special relationship with his doctor" (3). Cleave confesses that Edgar "intrigued me . . . he was possessed of considerable charm" (3). The reader may well infer that a homosexual attraction to Edgar lies at the root of his obsession with this patient. Cleave gives away very little of the conversations he has had with Edgar, the psychiatrist accurately noting to himself that, "Edgar *had* no voice" (47). It is, of course, narrator Cleave who is responsible for Edgar's lack of voice, since it is he who has excised his patient's words from his account. Edgar is presented via Cleave and the importance the psychiatrist attributes to his relationship with this patient. The greater amount of information about Edgar, however, comes from material Cleave claims to have received from Stella. This pursuing of Edgar by means of engaging with Stella starts right at the beginning of the novel, at the first asylum ball. Cleave is present, "watch[ing] the proceedings from the shadow of a pillar at the rear of the hall" (4), and from here he sees Edgar ask Stella to dance. Cleave claims that Stella confides in him that "she became aware that what was pressing against her groin, through [Edgar's] trousers, was, in fact, his penis, and it was getting hard" (16). Cleave's disingenuous response is that he was "surprised and annoyed" that Edgar "would put in jeopardy *our* work together, his and mine, in such a cavalier fashion" (17). I shall demonstrate that Cleave sees Edgar as his property, a

patient in whom he is interested both sexually and for his artistic creativity. In Cleave's view, Stella cannot compete with his own intimacy with Edgar as "[s]he had never regularly listened to him spinning out his morbid delusions, as I had done" (21). Cleave's reference to his joint work with Edgar shows signs of homoerotic jealousy which he attempts to deal with by 'owning' Edgar's lover, Stella.

There is just one therapeutic session between Cleave and Edgar that is described at some length in the novel (40-42). Cleave says he tape-recorded it, thus suggesting that the words reported have a basis in fictional reality, although still selected by the doctor's account. From this session, we discover Edgar's "Morbid jealousy. The delusion of infidelity" (42). Edgar bludgeoned his wife to death, believing her to have been unfaithful with "hundreds" of men. Cleave notes Edgar's "manufactured evidence", found in "such signals and traces from incidents as banal as her opening a window just as a motorbike was going past in the street below, and from phenomena as insignificant as a crease in a pillow or a stain on a skirt" (41). This passage is very important. It draws attention both to sexual jealousy as central to this novel and also to ways in which narratives may be fantasised from stray, arbitrary evidence.

Cleave observes Edgar's method of constructing a delusional narrative, an approach which the reader will increasingly observe in the psychiatrist's own account. The doctor notes,

> what particularly impressed me in Edgar was this retroactive adjustment of memory, so as to bring the early years of the marriage into line with the delusions that so tragically dominated it at the end. . . . (43)

This also describes the way in which Cleave contrives a delusional account which, in the end, leads to Stella's suicide. I argue that Cleave, like Edgar, is consumed by sexual jealousy which, in the psychiatrist's case, centres on Edgar. The doctor, just like his deluded patient, fantasises a narrative that feeds such jealousy by reconstruing observed events. Indeed, the psychiatrist's theorising at the end of this session with Edgar includes this telling reference to Freud:

> Morbid jealousy. The delusion of infidelity. Freud thought it a form of acidulated homosexuality, the projection of repressed homosexual desire on to the partner: *I* don't love him, *she* does. (42-43)

Cleave's sexual interest relates to Edgar, although frequently expressed by claiming the allure of Stella's beauty. In this way Cleave attempts to mislead the reader and credibly exhibits his inability personally to own his homoerotic feelings for Edgar.

Initially Cleave sees Edgar's affair with Stella as a hindrance to the former's treatment. "But this affair with Stella, this would set *us* back months; for in deceiving me he blocked the flow of candid confidences essential to *our* reaching *our* goal" (43). (My italics show an example of how Cleave repeatedly couples himself with Edgar.) Later Cleave goes on to use Stella's relationship with Edgar as a means to discover more about Edgar's sexuality. Cleave regrets he and Stella cannot "talk about it, about Edgar's sexuality" (44) at the point where he is suspicious that Stella and Edgar are clandestinely involved. This apparently new "intuition" about the relationship between his patients (43-4) belies the psychiatrist's claim to knowledge of Stella experiencing Edgar's erection at the ball (16). Cleave goes part of the way to seeing a connection between himself and Stella in their sexual interest in Edgar.

> In an odd way my own intense preoccupation with Edgar's whereabouts and welfare was mirrored in Stella: her sexual and romantic infatuation with him I later saw as a reflection, primitive and distorted, yes, but a reflection all the same, of my own solicitude for the sick man going untreated in what must have been a situation of great tension and uncertainty. (74)

Cleave seeks to distinguish his "solicitude" for Edgar from Stella's "romantic infatuation", while the psychiatrist is aware of the parallels in their "intense preoccupation" with Edgar. Cleave's "solicitude" may, of course, be a cover for his own "romantic infatuation" and obsession with his male patient.

I argue that Cleave behaves in a most unprofessional way when he comes to treat Stella as his patient in the institution. Diverging from common professional practice, it is Cleave, not his patient, who introduces the topic of therapeutic sessions. After Cleave has subdued Stella by making it clear she is

totally in his power in the hospital, he asks his patient “to tell [him] what had happened, from the beginning”. When Stella asks what the beginning is, Cleave declares his own obsession: “Edgar” (208)? Cleave wants details of sexual acts between Stella and Edgar, asking her of the sex, “Did it live up to your expectations” (210)? The psychiatrist goes on: “Describe Edgar physically” (213). That Cleave, not Stella, is determining the agenda of their discussion is clear as the former writes: “I encouraged her when she faltered, and somehow she found the words” (213). It is also obvious that Edgar not Stella is the patient of psychiatric and probably erotic interest to the psychiatrist.

While it is left unclear in the novel when and where earlier reported conversations between Cleave and Stella took place, the psychiatrist appears to start his patient’s psychotherapy proper with regular sessions after Stella has been moved to the upstairs ward. Here she has greater freedom than in the locked cell in the female wing where she was isolated in the institution after her son, Charlie, drowned. Given the trauma of the child’s recent drowning, it is decidedly odd and uncaring that Cleave opens Stella’s first session with: “Let’s talk about Edgar. Tell me about the first time you seriously entertained the idea of having sex with him” (210)? The ascendancy of Cleave’s own need for particular information is obvious as he asks Stella, “This love . . . this feeling over which you had no control. What is it exactly?” This psychiatrist, using his patient for his own purposes, is seemingly ignorant of the nature of love. He aims vicariously to explore Stella’s love affair with Edgar, for Edgar is the focus of the psychiatrist’s real obsession. Cleave disingenuously justifies his talk of sex to Stella with, “I’m sorry my dear, I don’t embarrass you for my own pleasure”. However, he immediately follows this with the question, “Was Max really so unsatisfactory” (211)? Cleave may wish here to establish Max’s inferiority; or to discover more about the sexual act of which, as with love, he perhaps has limited experience. The psychiatrist’s unprofessional methods, which serve his own twisted agenda, are presented quite frankly. The reader moves between utterly believing the authoritative narration of the novel and reminding herself that it is the unreliable Cleave who provides this authority, from which he subtly excludes his own person. The text contains mounting information about Cleave’s means of constructing and following a perverse personal agenda. These two narrative strands of authority and unreliability are

seamlessly interwoven. The novel is a constant enigma, a blend of what seems completely reliable narration with what is marked as dangerously biased, as Cleave's inappropriately personal agenda is pursued at the expense of his patients' well-being.

The text repeatedly makes it clear that Cleave is obsessed with knowing intimate details about the sexual relationship between his two patients. Early in the novel, the psychiatrist reflects in his account, "I imagine it [the sex] was urgent and primitive, a thing of hunger and instinct. I imagine he took her at once, without finesse" (23). The repeated use of "imagine" in this statement leaves the reader in no doubt that it is the doctor's fantasy that provides him with this information. This reading is reinforced as Cleave later claims Stella has found it difficult to talk to him about sex, for "[s]he has found it distasteful to be explicit" (22), and "all she would say about the sex is that it was effortless, and mutually intense" (34). This information, at odds with Cleave's claim to knowledge, through Stella, of Edgar pressing his erect penis into Stella at the dance, highlights for the reader the unreliability of Cleave's claim that Stella has earlier told him further intimate details, before she is in his power as a patient. "The sex, she said, was rather painful now. Her menstrual rhythm was disturbed. . . . I asked her if she wanted medical attention but she said no, she was fine" (122). No time or place is given in the text for this conversation. The psychiatrist's account suggests this discussion took place while Stella was living in London with Edgar, though there is no evidence in the text that she spoke to Cleave during this period. In fact, the psychiatrist claims that Stella was outside his range of knowledge at this time (112). This interchange between psychiatrist and patient indicates the movement of the narration outside chronological time. It seems to take place within a therapeutic session between doctor and patient, but Stella's psychotherapy only starts after Charlie's drowning, when she has no contact with Edgar. The reader will consider whether this material is in fact the product of Cleave's conjecture rather than a report of an interchange with his patient.

As Cleave prepares to leave the hospital for his new life with Stella, he again notes his "real concern" is for Edgar (234). The latter is in the psychiatrist's cruel control "in a room on the top ward of the Refractory Block, by

himself" (235). After Edgar is readmitted into Cleave's care, the psychiatrist reports that his patient has "consistently refused to speak to me" (235). Cleave's understated claim that this "was frankly a nuisance" (235) is belied by his further cruelty to Edgar, when, telling Edgar of his engagement to Stella, "I was blunt, and I was aggressive. I wanted a reaction" (236). Stella is repeatedly used by Cleave as a means of pursuing his own, frequently denied obsession with Edgar as sexual being and creative artist.

h) Solving the narrative puzzle of *Asylum*

To unravel the narrative puzzle of *Asylum*, it is necessary to recognise the text as offering much information about Cleave's deceptions, and very little reliable information about any other character. We cannot know if Stella has been deluded, if she has lied or told the truth, if she is mad or sane. Similarly, we can know almost nothing from the novel about Edgar's state of mind and intentions, Cleave having reported Edgar's lack of voice (47) and excised details of the many therapy sessions (40-1) he has, from his account, had with this patient. Of the two patients, we know that Stella is dead and Edgar in a secure ward by the end of the novel. The text does, however, contain overt and frequent indications of Cleave's self-deception, narcissism and grandiosity as well as his failings both as a psychiatrist and as a man. Along with all these traits, his obsession with Edgar and Stella makes his sanity questionable. He is a psychiatrist who makes life-changing judgments about patients on the basis of gossip, hearsay and conjectured fantasy and who ruthlessly follows his own need for power at the expense of patients and colleagues. Peter Cleave is a 'psy' professional who has pursued his own ends to the detriment of those in his care. At the close of the novel, he possesses the "thin, beautiful, tiny, anguished head" which is the sculpted piece Edgar made of Stella. This causes him to maintain he has been successful: "So you see, I do have my Stella after all. And I still, of course, have him" (250). The reader knows, however, that Stella and Edgar have eluded Dr Peter Cleave. Now dead, Stella can offer no conduit to Edgar. Locked firmly away and silenced, Edgar will never be possessed by Cleave.

I have argued how the novel's narrative structure, owing much to the Gothic, has seductively appeared to offer a reliable account of events. Cleave's position as a figure of authority and a powerful senior psychiatrist has made his version of the events that seemingly took place between Stella and Edgar highly seductive to the reader. However, the psychiatrist/narrator has repeatedly and frequently reminded the reader that the sources of his information have been conjecture, fantasy, gossip and hearsay. At the same time, his persistent use of authoritative, detailed, third-person narration has repeatedly lured the reader into accepting Cleave's narrative of conjecture. Right from *Asylum's* beginning, the psychiatrist has puts himself - a knowledgeable expert - at the centre of his tale. Stella and Edgar, who are designated mad (and therefore more likely to be deemed untrustworthy), have had almost no voice in this novel that is not filtered through the imaginings of Peter Cleave. I have shown how the psychiatrist's conjecture about his two patients has misleadingly included much intimate detail, of the kind usually associated with omniscient, third-person narration.

Throughout this thesis I note that, in the absence of a competent psychiatrist, the reader is frequently tasked with identifying with and decoding the patients' accounts. I have noted above Adam Phillips' comment on the way the reader is invited to perform what the text shows us, by accepting Cleave's versions of events (Phillips 360). It is also true that, outside fiction, the task of retrieving, assembling and incorporating disparate information into a meaningful whole is central to the process of psychotherapy, in which a real therapist and a real patient work together to construct a relevant life-narrative which is of use to the patient. Reading *Asylum* involves much that mirrors that psychotherapeutic process. It is the reader's job continuously to analyse the information presented by Cleave and judge if it is congruent with what may firmly be known of the story being told of Edgar and Stella's affair. My analysis has shown that such congruency is in doubt. This constant evaluation of the material presented makes reading the fiction a rewarding process, particularly since the reader is able to see through the words of a powerful psychiatrist whose position normally attracts trust. From the initial recognition of the misleading nature of Cleave's account, our attention is drawn to the way readers construct narratives. The reader's reward may be delayed if her awareness of Cleave's narrative

manipulation comes late in the novel. However, subsequent careful rereading from the beginning of *Asylum* brings acute observation of the openly expressed clues which have so readily been obscured by this psychiatrist's authority and confident tone.

McGrath's psychiatrist, Peter Cleave, has declared himself a sensitive, observant and highly skilled professional healer while, at the same time, obliquely revealing himself as destructive. A number of reviewers and scholars have omitted proper consideration of Cleave's role as unreliable narrator, believing that the narrative presents an objective view of events (Leeswammes;[175] Natalie;[176] Ylä-Kapee[177]). Another online reviewer ("Asylum", Kirkus),[178] and critic Robert Adams[179] both successfully identify Cleave's unreliability and the way this recasts the entire narrative. Cleave's realisation at the end of *Asylum*, makes this perfectly clear.

> Oh, I had been blind! It was not for us, that dress . . . it was for *him. . .* I at last realised the full extent to which I had allowed my judgement to be coloured by private concerns, and in the process lost my clinical objectivity. Classic counter-transference. (246)

This is confirmatory, not new, information for the alert reader. Even this recognition by Cleave of his failure of judgment is followed by a generalisation in this psychiatrist's usual vein. The alert reader will note with perceptive satisfaction that Cleave assesses his own counter-transference as "[c]lassic".

The overall aim of this thesis is to explore the representations of 'psy' professionals in fiction within the context of psychiatric history. I also consider the varying, modern, cultural perceptions of insanity and its treatment within the

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[175] This popular review states that the entire story is told by Cleave, "and he obviously has the whole story straight from Stella."
[176] The author of this online review believes it is the "insight" of "the older and wiser Dr Cleave" that provides a key to the novel.
[177] This scholar has trust in Cleave as "a proper analyst . . . aware of . . . the dangers of counter-transference" (178). However, the novel clearly points to Cleave only recognizing his counter-transference at the very end of the fiction (246).
[178] This reviewer observes the conspicuous nature of Cleave's narrative duplicity: "The unreliability of the narrator, the intense psychological layerings of the narrative, and the fevered interpretations of McGrath's characters make for a truly complex (but never obscure) novel."
[179] Adams shows how well McGrath dupes the reader and writes that only at the end of the novel does he notice Cleave's "brilliance", so that now Adams must reread the novel from the beginning (172).

Western world. In this context, *Asylum* is a very important fiction. Within our society, the psychiatric patient is frequently voiceless or, if heard, deemed untrustworthy as insane, although novels such as Joanne Greenberg's *I Never Promised You a Rose Garden* (1964) or Paul Sayer's *The Comforts of Madness* (1988) can offer astonishing and unsettling insight into the inner world of the silenced mad, untainted by the conjecture of the kind of malign 'psy' professional we have seen in McGrath's novel. *Asylum*, however, forcefully illustrates how a psychiatrist can dangerously misrepresent the experience of mental illness and negatively mediate between the mad and society. In choosing Peter Cleave to narrate his novel, Patrick McGrath has drawn attention to the way in which patients' stories may be lost as the psychiatrist appropriates their narratives by speaking for them. This loss is noted in my introductory chapter in discussion of doctors' case notes as frequently the only presentation of the condition of a psychiatric patient. *Asylum* has shown a malign psychiatrist in the person of narrator, Dr Peter Cleave, for it is Cleave's narrative construct and his own destructive power, not the love affair between Stella and Edgar, that is at the centre of this novel. Psychiatric mediation like Cleave's is self-serving and the psychiatrist is abusive in not primarily addressing the care of his patients. Such a narrative causes the mad to lose ownership of their own stories.

CHAPTER FIVE: The damaged psychiatrist: trauma and memory in the Irish asylum in Sebastian Barry's *The Secret Scripture* (2008)

a) Introduction to *The Secret Scripture*

> All the time I might have helped [Roseanne], all those years she was here, I had more or less left her alone. . . . I did not believe that I had ever been a good psychiatrist. (309)

Dr Grene, the psychiatrist in Sebastian Barry's novel, *The Secret Scripture*, is the last 'psy' professional to be discussed in detail in this work. Unlike the largely demonised 'psy' professionals in the other three novels which I have examined, Grene does not have malign intent. Indeed, he feels considerable empathy for his patients and particular concern for long-term, ancient asylum resident, Roseanne. His professional failure is not mistreatment but unwitting, unacknowledged negligence. In this respect, however, he is a grossly incompetent doctor. I shall show how this psychiatrist appears to have no faith in his discipline and, by his own admission, offers his asylum patients nothing more than a decaying hospital in which to exist.

This chapter will explore the negative presentation of Dr William Grene, and chart his progress from damaged individual, showing signs of major trauma, to a considerably more able human being with greater analytical ability, as he uncovers Roseanne's history and understands how it is linked with his own. I shall also note how these lives are shaped by particularly Irish experiences, this country being central to Barry's fictional concerns. It will be observed that the damning information about Grene's lack of competent professional action, as well as his personal failings, come almost entirely from his own account in his "Commonplace Book", which is the novel's second written narrative. Additional and limited external information about the psychiatrist is confided to the reader by the patient, Roseanne, whose traumatic life is laid before the reader in the patient's own, well considered words. It is the norm for a mental patient's voice to be silenced in society, although it may be heard in fiction, which allows the communication of internal monologue. Although it appears initially that "Roseanne's Testimony" is the secret scripture of the title, what becomes increasingly apparent in novel is that the

psychiatrist's second written account has a major presence in the fiction. I shall discuss how these two narratives work together and inform each other to achieve the overall revelation of the lives and traumas of psychiatrist and patient.

I shall draw attention to the ways in which life accounts are affected by trauma and memory, noting that Roseanne's Testimony is an ordered narrative in which her strivings after accuracy are evident. In contrast, Dr Grene's writing in his Commonplace Book is avoidant and circular and shows his lack of self-knowledge as well as his professional negligence. These attributes of the two major narrative accounts reveal the psychiatrist to have the apparently impaired memory of a victim of trauma, while Roseanne's recall is almost complete and set out in an orderly fashion, even as it communicates the terrible events of her traumatic life. Having told her story, Roseanne moves quietly towards a calm death at the novel's end, while Grene makes considerable progress in analytic understanding and shows a willingness to recover and confront his early trauma which has damaged his life up until the time of his retirement.

I shall consider the way in which the reader, who is privy to Roseanne's narrative well before her psychiatrist receives it, progresses through the novel in advance of Grene, a doctor who is astonishingly ignorant about his patients. I shall discuss how a briefer account, the "deposition" of the controlling, punitive Roman Catholic priest, Fr Gaunt, tells an apparently authoritative version of Roseanne's history and adds vital information to Grene's and Roseanne's narratives. I shall observe how the extraordinary life-long interventions in Roseanne's life of the seemingly minor character, hospital orderly John Kane/Sean Keane/Seanín Keane Lavelle, has offered the patient perhaps the greatest care, in addition to playing a surprising major part in directing Grene's career and bringing him to join Roseanne in Roscommon Asylum. I shall also note the way the deathbed letter of Roseanne's brother-in-law, Jack McNulty provides informative background information about the McNulty family, whose lifelong punishment of Roseanne has been shaped by particularly Irish forms of social and religious bigotry.

Details about the care of the insane in Ireland at the time of decarceration will be discussed. This treatment change contributes the impetus for the novel's action as Dr Grene is tasked with identifying the continuing care that will be needed for his patients as Roscommon Asylum is to close. His patients, who are paradoxically both cared for and neglected, are to have their lives changed radically by the legal introduction of care in the community. The faltering steps of Irish legislation will be discussed. This information, which is elaborated on in Appendix 2, will provide background to Dr Grene's role in the asylum under his authority which is in a state of near social abandonment.

Throughout my analysis, I shall draw attention to the ways in which the reader's work is to assess the information presented continuously in order to assemble an overall narrative of psychiatrist and patient within Irish society at a particular time in history. I shall evidence the way in which Grene and Roseanne appear to have exchanged roles, their secret narratives showing the doctor as damaged by trauma and the patient as having absorbed her terrible experiences in such a way that she is able to relate her life story competently in her Testimony.

b) The historical setting of *The Secret Scripture:* decarceration in the Western world

As was the case with the novels discussed in earlier chapters, *The Secret Scripture* is set at an important time in the history of psychiatric treatment which adds significant background information about the state of psychiatric care as presented in Barry's novel. Dr Grene is tasked with assessing his patients for discharge or transferral, since Roscommon Asylum is to close and suitable patients are to be returned to the community in the process known as decarceration. Indeed, it is this task that changes Dr Grene's fatalistic, negligent approach to his patients into one of actively seeking out of Roseanne's history. Decarceration had begun in the Western world in the mid-twentieth century, making Ireland rather late in following this trend. This radical change in the treatment of the mentally ill was intended to drastically reduce - or even eliminate - the inpatient populations of the old lunatic asylums. These institutions were considered to have outlived their usefulness, offering little

beyond providing a place for what was often the long-term detention of the mentally ill. Care in the community was to replace institutionalisation of the mad.

In his 1976 paper, "Decarceration of the Mentally Ill: A Critical View", historian of psychiatry Andrew Scull quotes John Arlidge's statement that "a giant asylum is a gigantic evil, and figuratively speaking, a manufactory of chronic insanity" (Arlidge qtd in Scull 173). Scull further reports in 1984 that,

> In recent years, a state sponsored effort to deinstitutionalise deviant populations ha[s] become a central element in the social control practices of a number of advanced capitalist societies. (*Decarceration* 3)

Seen as now damagingly oppressive, the role of the asylum in caring for the mentally ill was considered to be in need of a major overhaul. Mental health historian Gerald Grob notes that the American "concerted attempt" to move the care of the insane into the community began as early as 1945 (Grob 280). Scull points out that, in the United States, decarceration "was driven far more by fiscal concerns" than by ideology, for the costs of the traditional institutions for the mentally ill were huge (Scull *Madness: A Very Short Intro* 116). The prospect of decarceration resulted in a split between psychiatrists who supported asylum therapies and others who favoured "psychodynamic and psychoanalytic concepts" and felt that community care was the way forward (Grob 294). Additionally, there were major developments worldwide in the specialties of clinical psychology, psychiatric nursing and social work, all aimed at supporting patients in the community, while psychiatric wards were to be established in general hospitals. Outpatient clinics for the mentally ill began to be provided in the USA in the 1950s (Grob 313). Presidents Kennedy and Johnson optimistically pursued community psychiatry, stressing the social nature of psychiatric illness, the role of preventive treatment and the negatively controlling nature of the old institutional care (Grob 361). However, the asylums were not so easily replaced and their closure in the USA and the UK happened slowly and unevenly (Scull *Madness: A Very Short* 112). President Reagan's administration in the 1980s expressed an eagerness to close the old asylums in California (Scull *Madness: A Very Short* 113); and British Minister of Health, Enoch Powell, wanted to "set the torch to the [mental hospital's] funeral pyre" in

the United Kingdom (qtd in Rivett n p). Subsequent American and British administrations would gradually pursue the change to community care.

In Europe, a highly influential move away from the huge asylums began in Italy. This change had its roots in the antipsychiatry movement (Crossley "R D Laing" 878). The prominent Italian psychiatrist Franco Basaglia, like R D Laing in England, adopted an approach that was radically different from that of traditional 'psy' professionals (Foot 38-9). In the Gorizia Asylum, "psychiatrists under Basaglia were present in the hospital all the time, discussing and talking with patients" while "[b]efore Basaglia, doctors were notable only by their absence" (Foot 39). Basaglia was among leading psychiatrists who "called for the abolition or closure of *all* asylums . . . while at the same time working *within* asylums in order to reform or humanise them, or to display them either as examples of living hells or 'working utopias'" (Foot 44). Italy was at the forefront of this change and Italian national policy was strongly linked to the demands of critical psychiatrists (52), with the result that asylum closure took place here much more rapidly than elsewhere.

In the United Kingdom, deinstitutionalisation was a slow process. A King's Fund publication of 2015 notes that, although closing the asylums was first mooted in the 1960s, the first closure did not take place until 1986 (King's Fund) and continued gradually over the following thirty years. The outcome was that all institutions in the UK were closed by the early twenty-first century. A 2002 paper, "Mental health service provision in England", notes that only at this late date, the "[c]losure of the large asylums has largely been accomplished" with provision for the mentally ill having "been characterised not by the single-stage introduction of a wide-ranging policy of reform but by continuous development towards more community-based care over half a century" (Johnson *et al* Conclusion and Introduction). A 1989 paper on deinstitutionalisation reported that outcomes for patients treated outside asylums were "at least as favourable as for traditional long-term hospital care", although such treatment was no cheaper (Thornicroft and Bebbington 739).

The community-based care which was intended to follow decarceration was considered a more humane method of treatment of the mad. It was

thought it would end the isolation and social exile caused by asylum treatment. However, care in the community was not to be without its own problems. As Gerald Grob points out, the community policy enacted in the USA in 1963 had assumed that mental patients had homes and families prepared to support and shelter them (Grob 37). What is more, there were considerable social concerns since many in the community felt their lives were endangered by the presence of the mad on the streets, this being exacerbated by homelessness and frequent substance abuse (Grob 441). Scull notes how decarceration resulted in the mentally ill being

> left to rot and decay, physically and otherwise, in broken down welfare hotels. . . . For thousands of younger psychotics discharged into the streets, it has meant a nightmare existence in the blighted centers of our cities180 . . . [where] they eke out a precarious existence, supported by welfare checks they may not even know how to cash. (Decarceration 1-2)

Nevertheless, care in the community had begun to be the widely preferred treatment of choice in many countries, including Ireland.

Indicating the particular place of Ireland in the history of psychiatric illness and its treatment, social historian Ian Miller writes in 2013, that,

> In many ways, Ireland has been understood historically as a space of madness: as a geographical region where, in the late nineteenth century, incidences of insanity perpetually rose despite constantly declining population levels. In the mid-twentieth century - a period when decarceration was in fashion elsewhere - Ireland maintained the highest asylum institutionalisation levels worldwide. (581)

In 1961, Ireland was indeed notable in having the highest proportion of inpatients in mental asylums in the Western world, according in information provided by the World Health Organisation (qtd in O'Sullivan and O'Donnell *Coercive* 96). Irish patient numbers were swollen by the so-called 'feeble-

[180] The Mental Health Foundation found in 2014 that "80% of homeless people in England reported that they had mental health issues, with 45% having been diagnosed with a mental health condition" ("Mental health . . . homelessness").

minded',[181] epileptics,[182] the aged[183] and homosexuals.[184] These groups were, of course, also present in asylums in many other countries. However, Ireland additionally had a disproportionate number of single mothers, condemned to long years of slave labour in mental hospitals. Poverty and famine were rife in unindustrialised Ireland and large numbers of paupers were placed in asylums by relatives. Being poor was seen as a cause of insanity (Kelly *Hearing* 209). It was also particularly difficult to obtain discharge from an asylum in Ireland, a letter from a responsible family member being required, offering assurance that the lodging and care of a one-time patient would be met upon release.[185] Another specifically Irish factor in the size of the country's asylum inpatient population was that these institutions were very important for the part they played in the economy, providing work for large numbers of people, particularly in rural areas. Many asylum employees were unqualified, being former agricultural workers (Kelly *Hearing* 220). The asylums were a highly valued economic element in Irish society. Hopelessness about the worth of psychiatry to asylum inmates is Dr Grene's response to this complex Irish situation that he inherits in Barry's fiction.

Closing the asylums in Ireland and replacing them with community care was seen as a "gargantuan task" (Kelly *Hearing* 211). Decarceration was to be a very slow process, driven in the end by the country's need to comply with international regulations regarding human rights, a matter which was finally promoted by the United Nations in the 1990s.[186] I briefly outline the halting

[181] *The UK Mental Deficiency Act (1913)* was not applied in Ireland, so these patients remained in asylums. Significant changes in care in the community for this group were seen in Ireland in 1981 and 1991 (Kelly *Hearing* 163), though as late as 2008 concern remained about the number of people with an intellectual disability inappropriately placed in psychiatric hospitals (Kelly *Hearing* 164).

[182] Epileptics were routinely incarcerated in mental institutions, though not psychiatrically ill. Epilepsy was (and remains) incurable, so indefinite stays in madhouses meant that many epileptics died in asylums after lives of hopelessness.

[183] The elderly were often detained in Irish asylums without any psychiatric diagnosis, there being inadequate provision for them in county homes. Writing in 1971, journalist Michael Viney found the over-65s made up one quarter of the Irish asylum population.

[184] Homosexuality was removed in 1973 from the American handbook of psychiatric disorders (APA). The WHO removed homosexuality from its list of mental disorders only in 1990.

[185] Hanna Greally's 20-year asylum stay was the result of her mother's death shortly after Greally's hospital admission (Greally).

[186] The mentally ill were not mentioned in the 1948 United Nations Universal Declaration of Human Rights. In 1991 the UN introduced "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" (Office of the United Nations 188). WHO "Guidelines for the Promotion of Human Rights of Persons with Mental Disorders" were

progress of Irish decarceration that resulted in inpatient numbers decreasing from 21,075 in 1958 to 4,256 in 2001 (Kelly *Hearing* 193) in Appendix 2. This table shows how the resolve to improve care, though frequently repeated, was slow and uneven, with much faltering and occasional U-turns. There were many reports and commissions which made repeated recommendations for improvements in the Irish mental health system but the resolve to change care was constantly beset by difficulties. Lack of funding seems to have been a continuous problem, while the establishing of day hospitals was hampered by the huge task of identifying and acquiring suitable premises. As already mentioned, there was also anxiety in communities and among asylum staff about the loss of employment that would follow asylum closure.

The last years of the twentieth century continued to see inadequate mental health care in Ireland. The closed asylums were replaced by community services that were "commonly insufficient, inappropriate or inaccessible to those who need[ed] them most" (Kelly *Hearing* 243). Psychiatrist and major scholar of Irish psychiatric history, Brendan Kelly, writes in 2016 that Ireland's problems were not related to the higher incidence of mental illness suggested by the WHO data noted above. In Professor Kelly's view,

> The more substantive roots of the disproportionately large Irish asylums, like the roots of other troubled institutions in Irish life (orphanages, industrial schools, laundries, prisons), are fundamentally located in the nature of Irish society itself. . . . (Kelly *Hearing* 296)

This leads me to consideration of Barry's choice of setting in *The Secret Scripture.*

c) The decaying Irish asylum: *The Secret Scripture* as a novel of Ireland

Barry uses the familiar trope of the neglected and underfunded asylum, led by a seriously ineffective and unbalanced head psychiatrist who offers no healing care to his patients in *The Secret Scripture*. However, I believe Barry's use of this setting serves a purpose that relates particularly to the novel's

established in 1996. The WHO "European Pact for Mental Health and Well-being" was published in 2008.

concern with Irish history. He is not primarily interested in recounting the iniquities of the asylum system but is fundamentally concerned with collective and personal Irish trauma. As will be seen in Roseanne's case, the exile of the mad and the politically and socially inconvenient included unmarried mothers, whose harsh treatment by the Roman Catholic church is well known.[187] In addition, the asylum setting for the recall of the very Irish traumas of Roseanne and Dr Grene moves the novel's action beyond the active turbulence of Irish society, for the asylum is outside the ordinary community. Roseanne, of course, has been forcibly removed from Irish society, having spent most of her life in the total institution of the mental asylum. Her exile allows her a potentially useful perspective from which to write of her experiences. We gradually discover that Grene has removed himself from participation in *all* society, including the usual demands of his marriage to his semi-estranged wife Bet, his family and profession. He has done this for self-protection from his unacknowledged trauma. However, active involvement in Roseanne's case allows the psychiatrist to re-engage with Irish life as the institution is emptied of patients and the doctor, like his charges, moves back into the community. Roscommon has offered partial, inadequate asylum to patient and doctor alike and decarceration is a fitting metaphor for the emergence from the asylum of both Roseanne and Dr Grene at the end of the novel, although it has come very late for them both.

Roscommon Asylum provides the fictional scene of social near abandonment which is essential to Barry's depiction of the almost forgotten ancient patient, Roseanne, in the crumbling asylum. The institution also provides an analogy for the damaged life of asylum psychiatrist, Dr Grene, allowing Barry to explore the ways in which specifically Irish politics and religion have impacted on Ireland's citizens and its care of the mad. Indeed, Kelly observes that *The Secret Scripture,* "provide[s] a rare, insightful portrayal of a psychiatrist as the era of Ireland's large public asylums finally drew to a close" (*Hearing* 275). Barry's use of the lunatic asylum - a place unfamiliar to many

[187] One possible result of the powerful stigma associated with unmarried motherhood was the large number of women in Ireland charged with infanticide. Of the 70 women inmates in the Central Criminal Lunatic Asylum in Dundrum, Dublin, between 1868 and 1908 - who comprised 54% of the institution's population - 70% were charged with child killing (Kelly *Hearing* 77). Further, 27% of those women "committed following infanticide or child murder between 1850 and 2000" died in this asylum (Kelly *Hearing* 80).

readers, since the care of the mentally ill has historically taken place behind closed doors - allows a particular focus on Irish society from the curious, distant and circumscribed position of a hospital for those deemed mad by their society. The dilapidated, isolated asylum provides a metaphor for society's outcast and forgotten mad.

Critic Leszek Drong notes in his 2013 paper on Sebastian Barry that "[i]n Irish literature the national issues have always been in the limelight" (167), while literary scholar Terry Phillips notes how Barry draws attention in his fiction to the individual marginalised by the "dominant narrative of Irish history" (T Phillips 235). Phillips also observes that Barry uses his own family's experiences to take him into the "neglected byways of Ireland's hidden history" (T Phillips 235). Indeed, journalist Mick Heaney noted in the *Irish Times* that "*The Secret Scripture* . . . was inspired by a distant relative who had been confined in a mental hospital, and threw light on women who [were] similarly incarcerated for falling foul of the mores of Catholic Ireland" (Heaney). This far from uncommon Irish experience is at the heart of Barry's fiction and the peculiarly Irish situation relating to the confining of citizens in mental asylums is central to *The Secret Scripture.* Considering the psychiatrist this context, it is important to note how Dr Grene repeatedly attempts to distance himself from Irish history, presenting himself as an English Roman Catholic and, as such, not acceptable to his Irish wife's parents (122). It is only when Grene solves the mystery of Rosanne's personal history that he takes ownership of his own Irish heritage. Understanding that this was his history too allows Dr Grene to achieve some peace, albeit very late in his life. Barry's setting invites the reader to recall the horrors of Irish history over the centuries. This country's violent past has often cast it in the role of the abject 'other' as a nation. Its citizens have been frequently vilified, the Irish having long been the butt of racist English jokes (Judd) while Irish immigrants to America were often abusively called "white niggers" (Amour). Ireland's history and politics have repeatedly played a great part in the life experiences of its citizens and William Grene/Clear, as well as Roseanne Clear, are among these radically affected Irish citizens.

Although there is no broad focus on the institution except as a place of decay, *The Secret Scripture* considers the ways in which the asylum was

specifically used in Ireland as a method of social and political control. The novel's setting at the time of the decarceration of psychiatric patients sheds light on the discredited Irish asylum system. Barry presents the horrors of twentieth-century Irish life from within the largely isolated and secluded setting that is the Irish lunatic asylum. In this context, the psychiatrist and his patient, both adversely affected by particularly Irish events, become representatives of the disturbances of Irish history, with its pervasive trauma.

d) Roscommon Asylum and psychiatric treatment: Dr Grene's neglected professional responsibilities

In contrast to the other 'psy' professionals I have discussed in this thesis, Dr Grene repeatedly invites the reader's sympathy, in spite of failing to observe that the poor state of his institution is his responsibility or acknowledging the fact that he knows little about his patients. He frankly deplores the poor conditions in Roscommon Asylum while at the same time exhibiting genuine anxiety about the wellbeing of his patients. Grene communicates his concerns through his writings in his Commonplace Book. It is only on reflection that a paradox emerges as it becomes apparent to the reader that the neglect of both buildings and patients is largely the sympathetic Dr Grene's own responsibility. Funds may have been short and legislation unhelpful, but I shall show how Grene confesses in his private account that he lacks faith in psychiatry and has avoided his demanding professional duties.

For a large part of the novel, Grene's writings reveal that Roscommon has offered a form of asylum to its chief psychiatrist. He has used its geographical remoteness to shield him from the outside world, including the political and social intricacies of society, managing to shut out Irish affairs from his consciousness in an attempt to conceal his personal suffering from himself. Roscommon has offered asylum to its chief psychiatrist who "need[ed] this place more and more" (46). At the same time, Roscommon has been a prison for Roseanne, where she has received no 'psy' professional help. In addition, Dr Grene shows disdain for his chosen profession of psychiatry. He sees it as steeped in "effrontery" and "deviousness" and is aware of the "horrible depreciation in the states of those that linger [in the asylum]" (46). At the same

time, he does nothing to alleviate the worsening of his patients' conditions. His negative view of psychiatry appears at odds with his real concern for his patients and also calls into question why he has spent his life working as a psychiatrist. Only an exploration of his late-discovered personal traumas will offer answers to these problems and reveal why Grene's attitude contains these contradictions.

Dr Grene starts his first Commonplace Book entry with the information that a survey has revealed that his asylum is "in a terrible condition" and "on the verge of collapse", its advanced decay being even worse than he had feared (15). At the same time as acknowledging asylum deterioration since the hopeful period of nineteenth century building, when Roscommon was erected "as a charitable institution for the 'healthful asylum and superior correction of wounded seats of thought'" (15), Grene refers to the worsening of treatment of patients in the early twentieth century in Ireland, with its "clitoridectomies, immersions and injections" (15). This latter period is the one Grene claims as "'my' century", in this way partially owning his share in responsibility for the deterioration of patient care. However, it is his unacknowledged, career-long neglect of his patients in Roscommon Asylum that is Grene's real failure, not the violent and abusive treatments of the early twentieth century. Dr Grene feels genuine yet vague guilt for the general state of psychiatric treatment, although does not yet understand how he is implicated in the lack of care in Roscommon. Towards the end of the novel he continues to describe his hospital as a "deathtrap", a place that "has been scandalously ignored and never funded, and what could have been maintained has been let go to hell" (255). As I shall show, Barry's psychiatrist may grow in awareness during the novel but he never fully recognises his own responsibility for the present state of the asylum. That is the reader's task, whose understanding is likely to be ahead of the psychiatrist throughout the fiction.

The time of decarceration offers Grene some difficulty. He feels the removal of fifty ancient women as "a sort of violation" (16). These patients (who remain hidden from the reader, their plight not explored) have obviously suffered from neglect as the psychiatrist describes them as "bedridden and encrusted with sores" and "so old that age has become something eternal,

continuous" (16). Grene suggests the state of these patients is inevitable, outside his control, not acknowledging that it is largely his own responsibility that they are in this condition of neglected stasis. These patients are never directly presented in the novel and their invisibility to the reader is a further signal of Grene's neglect. The doctor's response to the deplorable conditions in Roscommon is among the many instances of his fatalism about what happens in the asylum, since Grene fails to make the link between his duties and the results of his professional laxity which are apparent to the reader. Described as having become "as much part of the building as the bats in the roof and the rats in the cellars", the staff under Grene's command are equally dismissed as relics of the past, firmly attached to the decaying asylum, a cavernous ruin where one can hear the "moaning of the wind in the corridors, even on still days" (17). Apart from the orderly, John Kane/Sean Keane, the staff are also invisible and silent in the novel. Grene shows his awareness that many of the elderly male patients in his care do not really belong in a lunatic asylum. He describes them as "poor old boys . . . who are not so much mad as homeless and ancient" (17). The psychiatrist fears for his patients after decarceration, seeing them as "creatures . . . long kennelled and confined" (17). Grene is fully aware of the appalling neglect of his patients and staff, without acknowledging that their care has been his own, completely neglected duty. In fact, it appears that it is only at this time of mandatory decarceration that the psychiatrist turns his attention to the state of affairs in his hospital. Grene's "weird reluctance . . . to see anyone go" (17) from Roscommon indicates the immutable, inevitable and necessary element in the psychiatrist's life that the decaying asylum has offered to its chief.

Referring to Roseanne, Grene notes that he is "always aware of her", that she "has been a fixture, and not only represents the institution, but also, in a curious way, my own life" (17). This is an intimation of the climactic revelation that the psychiatrist is Roseanne's son, neither patient nor psychiatrist being aware of this fact until the novel's end. In spite of his acknowledged interest in Roseanne, Grene admits he has "never delved into her life" (18). He confesses that his hospital's case notes are unusable as he tells Roseanne that "a great swathe of our archive in the basement has been used . . . by generations of mice for bedding, and it is all quite ruined and unreadable" (27). However,

Grene says to his patient, “Of course, I know you very well. We have talked so often over the years”, in spite of admitting to himself that he knows little of Roseanne and wishes he had made more notes, aware that he is “a reluctant taker of notes” and that this quality is “perhaps not admirable in my job” (27). At the end of the novel, Grene acknowledges in his Commonplace Book that he has “barely been aware of [Roseanne] for years” (301). This psychiatrist, heading a large asylum, is extraordinary in his inaction, in his ignorance of his patients and staff, and in his carelessness in record-keeping. Dr Grene has been content to preside over his institution while making little contact with his patients, in spite of his concern for them. He has been neither malevolent nor cavalier, but his negligence has not yet caused him to admit to any anxiety. Indeed, the doctor’s major concerns repeatedly return to his “marriage troubles with poor Bet” (18), so that attempts to focus on Roseanne’s future in his Commonplace Book time and again move to worries about his neglectful treatment of his dying wife. I shall discuss later how this obsessional return to his wife as he attempts to address Roseanne’s situation in his writing offers evidence of his avoidant, circular style which points to his own trauma.

Grene offers another metaphor for his asylum as “a sort of site of marriage, where I can be sinless, unaccused, even . . . redeemed” (46). This comparison encompasses his professional negligence, turning it into a positive act of doing nothing harmful as he drifts through his long years as asylum head. It also elicits Grene’s acknowledgement that it is he who has a deep need for the asylum. This otherwise likeable psychiatrist thus invites comparison with McGrath’s evil Dr Cleave, for neither of them offer care to their patients. However, the reader’s sympathy for Grene, which starts with his genuine concern for his nevertheless neglected patients, grows as he rediscovers his own Irish trauma and links it with Roseanne’s life story. Empathy with the psychiatrist as he makes his discoveries is necessary as the reader uncovers what is trustworthy in the fiction’s narrative. I shall return to this in my discussion of trauma, memory and narrative form.

Another extraordinary admission by Dr Grene concerning his lack of curiosity relates to his employment at Roscommon Asylum and the part played in his appointment there by its former head, Amurdat Singh, who had

"summoned" Grene for interview (309). Indicative of his drifting through life, Grene had never questioned why Singh had written to him "out of the blue" (124), sending for him "mysteriously" (125). Dr Grene fatalistically judges his appointment at Roscommon as "accident, mere accident" (124), although it later emerges that the damaged, unskilled orderly John Kane/Sean Keane was behind this crucial summoning as part of Keane's extraordinary life-long care of Roseanne (305) which stands in stark contrast to the 'psy' professional's neglect. Indeed, the psychiatrist comments when discussing his move to this "backwater" that "[t]he Arabs say that everything is already written in the book of life, and our job is merely to fulfil the narrative already there" (124). Grene has been consistently inactive and fatalistic in directing his life and career and in performing his professional duties.

In contradiction to Grene's professed views on the uselessness of psychiatry, he writes that, under Singh, the hospital had been a "true haven", his predecessor having had "radical and exciting views" (125). This confirms that Grene has indeed seen psychiatry working effectively, and the reader will wonder why he has not emulated the admired Dr Singh. What is also very strange is Grene's comment on Singh, made in passing, that "[s]adly he died a relatively young man, possibly even took his own life" (125). This absence of curiosity about a potential suicide is remarkable in a psychiatrist. When the reader knows more about Grene's childhood she is likely to understand his failure to pursue this painful information. As his quest for Roseanne's history advances and Grene becomes able to confront his own past, he confesses to the considerable trauma of his adoptive mother's suicide after the death of her biological son in a road accident for which Grene feels responsible (189). While Grene admits that it was this that "inspired" him to read psychiatry at university (188), there is much evidence in the novel that traumatic damage has impeded his effective practice of his chosen profession.

Dr Grene's writing shows his lack of self-esteem, and an awareness of his professional inadequacies, although, at the opening of the novel, he has not actively sought out the reasons for his failings. Attempting to deal with the decarceration of his patients, he observes that "[i]t would be a very good thing if occasionally I knew what I was doing" (45). He fears he is acting as a bad

parent, interviewing his patients for “expulsion” and “exile in that blessed ‘community’” (46). He feels (perhaps inappropriately) that he is “stupid” to feel “fatherly” towards his patients, seeing his compassion as a “weakness” which he must resist (46). Making investigations into his patients’ lives, Grene worries he is a “perpetual invader” (93) rather than a healer, suggestive of the “effrontery” he has previously considered to be part of his specialty and of which he has disapproved (46). The psychiatrist exhibits a problematic sense of his own worth, observing how he feels a “rather miserable sense of my own slightness as a person, as a soul” (93). He finds it “difficult to live” (120) and notes how lacking he has been in self-awareness, not having “*looked* at [him]self” until his wife dies. He has engaged in a meaningless infidelity (185-6) and has also neglected his wife, showing “scant interest” in her activities (122), only discovering by reading another secret scripture (Bet’s private diary) that his wife was refusing medical help. Utterly surprising in a psychiatrist, it is only after Bet’s death that Grene realises he has previously “listened blithely and with professional distance” to patients who have also suffered bereavement (120). The painful knowledge that he must “never again underestimate [death’s] acidic force in others” is a much overdue discovery for a psychiatrist about to retire (157). Additionally, Grene feels no contentment as a “healthy person” might as he considers his own aging and imminent retirement (123). Writing for his “own sanity”, he is aware of his “little sins of omission that loom large now” and observes, “You could go mad” (122). After receiving the doctor’s own words, the reader is likely to have little faith in Grene either as a psychiatrist or as a well-balanced human being, though she is likely to feel sympathy for this troubled man and will seek evidence of traumatic damage in his history.

As noted above, the psychiatrist’s dealings with Roseanne show him as surprisingly ignorant of the circumstances of this patient in whom he has professed a particular interest. The doctor records the extraordinarily sparse information in his possession: he had “spoken with [Roseanne] now and then for as many as two dozen years”, he knows she was “called once Mrs McNulty” and had “no known relatives” still in touch, and that “no one had visited her ever in the hospital”. Noting that he could “find out nothing about her” from the inadequate records in Roscommon, Grene has “a vague sense that she had

been transferred here from Sligo, but maybe forty years ago or more" (125). Much later he discovers the significant information that Roseanne's "severely deranged" mother was incarcerated in the asylum in Sligo and died there (282). This lack of important knowledge about his patient appears to be highly irresponsible on the psychiatrist's part. Only at this late stage, assessing her for transferral or discharge, does Grene finally send to Sligo for documents relating to Roseanne, now receiving papers which he finds of great interest (141). This is the first time he appears to have made contact with an old friend and colleague at another asylum, Percy Quinn, Grene seemingly having existed in Roscommon as if it were cut off from the rest of Ireland's mental health system. The newly unearthed documents deal with Roseanne's marriage, its later annulment and the patient's "sectioning" (141). This new-found information not only arouses Grene's interest: the psychiatrist also becomes aware that the written word must be critically assessed. He observes, "I must be very wary" since writing "assumes authority but it may not have it" (141). In addition to being a signal to the reader to consider these secret scriptures with care, this is an important step forward for this professional who has previously drifted through his life and his work, allowing events to take their course without questioning, interpreting or influencing them. He belatedly understands the need to appraise written information in order to judge its reliability. Grene is now acutely aware of the nature of Roseanne's life which he is able to see as the "living death that being her really is" (142). He has colluded in this situation for many years.

e) How the patient views the psychiatrist

Most of the information about the psychiatrist within the novel comes from Dr Grene's own writings in his Commonplace Book. The patient's view of the 'psy' professional is one the reader might have come to expect in madness narratives. While *The Secret Scripture* is not a typical madness narrative or recovery story, it does contain information about Dr Grene provided in his patient Roseanne's Testimony. Considering Roseanne's few direct comments about her psychiatrist in her writings offers commentary on Grene's view of himself and his failings. It allows the reader to see the psychiatrist from the vantage point of a patient, as in Ward's *The Snake Pit* and Mortimer's *Long*

Distance. Such depictions usually show the asylum inmate's fear of the 'psy' professional. Roseanne's view is particularly helpful as her own writings, describing the early, traumatic events of her life, confirm her sanity. I shall discuss below how the nature of Roseanne's writing makes her rationality unquestionable.[188] This gives credence to her observations of her psychiatrist.

The patient's first comment on the psychiatrist is that she is "not afraid of him" (4). It is significant that this is an unusual response on the part of a patient. Recording his small act of kindness in giving Roseanne "a beautiful biro full of blue ink . . . because I said I liked its colour", Roseanne refers to Grene as "my friend the doctor" and observes he "is not a bad man, in truth" (4). These are weighty remarks, set against the many negative fictional views of 'psy' professionals I have discussed in this thesis. Roseanne later writes, "I do not consider Dr Grene an evil man" (25). Her frequent use of negatives in her statements about the doctor hardly make for fulsome praise. However, Roseanne's perspective comes from a trustworthy patient whose views, as I shall explore, appear objective and sane. This objectivity is confirmed as the patient clear-sightedly observes, "The beauty of Dr Grene is that he is entirely humourless, which makes him actually quite humorous. Believe me, this is a quality to be treasured in this place" (26). Roseanne makes this comment as Grene has obliviously responded solemnly to her small joke (26). Her ability to see this quality in her doctor is further evidence of Roseanne's mental balance and astute perception. In Roseanne's room, assessing his patient for the task of emptying the hospital, Grene groans instead of talking to Roseanne. The percipient patient observes, "In that groan was all the years he had spent in this institution, all the mornings of his life here, all the useless talk of mice and cures and age" (26). Like her doctor, Roseanne does not respect psychiatry and silently agrees with Grene that his thirty years at the asylum have been wasted. The reader will recognise that psychiatry, in Grene's hands, has totally failed Roseanne. In spite of the doctor's blandishment that he hopes Roseanne has been happy at Roscommon, his patient observes the "certain elegance" of Grene's more honest outcry, "God knows . . . no one could be happy here" (28).

[188] Other critics have ignored the competence of Roseanne's Testimony and see it as proof of her disordered narrative ability. See, for example, Tara Harney-Mahajan, who considers that "Roseanne reveals her narrative slowly and unreliably (55); and Karen A McCarthy, who sees the psychiatrist's account as "legitimate" and the patient's as "less powerful" (1-2).

This forthright exclamation also implies that his thirty years at Roscommon have not been happy ones for the psychiatrist. Roseanne has a much clearer view of the doctor than he has of his patient or, indeed, himself. However, Grene is right in likening his patients to zoo animals who will not prosper if he frees them (17). Roseanne sees the prison of the asylum as her place of safety in a world that has been extremely harsh to her. Certainly commanding the reader's compassion, she silently appeals to the psychiatrist, "Do not prise my fingers from the bars, Dr Grene, I beg you" (36). The complete absence of good psychiatric care has not prevented Roscommon from offering a form of asylum to Roseanne. The society from which she has been removed was a crueller one than the prison of the institution.

As Dr Grene grows in narrative and analytical competence, acknowledging his unexplained need to discover Roseanne's story, the patient shows a parallel growing warmth towards her psychiatrist. She longs to tell her doctor of her happy memories of the early days of her love for her husband, Tom McNulty, believing Grene would be "interested" and pleased. However, she quickly returns to the usual stance of a fictional (and experienced) patient faced with a psychiatrist as she fears he would "read something into it. He interprets things, which is dangerous, extremely" (150). It is up to the reader to imagine the good work Grene could have done with Roseanne, had he not been arrested by his own trauma. Roseanne does, nevertheless, move closer to imagining Dr Grene as the recipient of her confession concerning the birth of her child. She writes, "Dear Reader, God, Dr Grene, whoever you may be" (257). It seems that Roseanne's objective view of her psychiatrist has moved unwittingly into one of trust as he gradually becomes worthy of her confidence when he discovers their related life stories. This, of course, does not make Grene a good psychiatrist, although he is changing into a caring son, his improved relationship being with Roseanne only and not his other patients. These latter asylum inmates, the reader may hope, will move on to better lives once they leave Roscommon and pass into more adequate psychiatric care than Dr Grene has offered them. However, the psychiatric patient ejected from the asylum into care in the community is not the primary fictional concern for Barry.

f) Theories of trauma and memory

Before discussing how Barry deals with of trauma and memory and the way these central elements shape the narrative accounts of psychiatrist and patient in *The Secret Scripture*, I offer below some background to this subject-matter, including the representation of trauma in literary fiction. Post-Traumatic Stress Disorder (PTSD) was included in America's Diagnostic and Statistical Manual *(DSM-III)* in 1980 (American Psychiatric Association). It was recognised that memory could be significantly disrupted by trauma and that major harmful events could be completely expunged from the subject's recall. This newly recognised disorder, which was observed in many Vietnam veterans, found its way into a large number of published narratives. Critic Roger Luckhurst notes in his essay "Traumaculture" in 2003 that a "new kind of articulation of subjectivity emerged in the 1990s organised around the concept of trauma" (Luckhurst "Traumaculture" 28). In this essay, Luckhurst defines trauma as "that which cannot be processed by the psyche yet lodges within the self as a foreign body, dictating its processes and behaviours in opaque and alarming ways" (28). This results in a lack of cohesion in the subject's narrative, which contains significant lacunae. This is also referenced by psychiatrist Jeremy Holmes in his discussion of the lack "narrative competence" in the disturbed patient ("Narrative in Psychiatry" 92).

The Secret Scripture was produced during a period in the late twentieth century when trauma was the focus of much writing, both in fiction and in memoir. Such fictional writing employed techniques of disrupted time and circularity in narrative as a way of presenting the unspeakable. Critic Cathy Caruth notes that trauma had "become a central characteristic of the survivor experience of our time", involving a failure of normal recall of experiences that are traumatic, since a violent event is paradoxically characterised by the "absolute inability to know it" (Caruth qtd in Luckhurst *The Trauma Question* 4). Much of this theory stems from what Theodor Adorno called the "ruination of Western philosophy by the traumatic facts of Nazism", which drew attention to the need to find "ways of representing the unpresentable" (Luckhurst *The Trauma Q* 5). Luckhurst sees W G Sebald's novel *Austerlitz* (2001) as the culmination of such trauma fictions (*The Trauma Q* 111). In this novel, Sebald's

Jewish character Austerlitz spends a lifetime on the haunted peripheries of his suppressed memory of being torn from his family and subsequently followed by a perpetual circling of oblique clues to his background. Other contemporary novels focused on the narrative disruption of trauma relating to unspeakable memories. Significant among these are the presentation of slavery in the USA in Toni Morrison's *Beloved* (1987), childhood sexual abuse in Jane Smiley's *AThousand Acres* (1991) and the sustained brutal treatment of Native Americans in novels such as Louise Erdrich's *Tracks* (1988) and Leslie Marmom Silko's *Almanac of the Dead* (1991). Unlike other specialties, such as history, medicine or law, the logical disjunction in a narrative (called 'aporia' by philosopher Jacques Derrida) can be readily portrayed in novels, since the disruption of linearity, the circling repetition of events and thoughts and absence of obvious causation are familiar features of fiction. Critic Paul Ricoeur notes that a feature of narrative is that it "'grasps together' and integrates into one whole and complete story multiple and scattered events" (Ricoeur *Time* x). Literary theorist Gérard Genette also notes that anachrony is "one of the traditional resources of literary narration" (Genette 36). It must be noted that, as well as its presence in literary fiction, much popular writing similarly uses the terror of forgotten trauma in the types of horror fiction that I have referred to in my introductory chapter. The aim of such popular fiction is not to explore trauma but, from a safe distance, to produce the thrill and suspense of horror in the reader.

Unexpected aspects of the focus on the effect of trauma on narrative may be seen in Barry's *The Secret Scripture*. As alluded to above, it is not the psychiatric patient, Roseanne, who has disrupted memory following her traumas, but the supposedly sane psychiatrist, William Grene, whose Commonplace Book evidences the "delay and evasion" which leaves him "circling what [he] is defined by and cannot confront" (Luckhurst *The Trauma Q* 91) in his suppressed life history. Luckhurst observes that theorist Jean-François Lyotard specifically references Freud's work, speaking of the "paradoxically registered yet unregistered trauma [which] portray[s] modernity as something insistently haunted by what it had violently suppressed or forgotten" (Luckhurst *The Trauma Q* 5). It is literature that can produce the disruptions and repetitions that are characteristic of post-traumatic thinking and,

in Barry's novel, this narrative style is that of Dr Grene until he recalls and reviews his childhood events. It is fitting that a novel concerned with psychiatric illness, trauma and memory should evoke these ways of considering fictional narrative and that Barry's setting is Ireland, a country in which traumatic identity may be seen to be at the root of collective memory (Luckhurst *The Trauma Q* 2). Barry's novel causes the reader to consider that traumatic disruption may be experienced by those we might expect to be sane, such as the psychiatrist, while largely organised memory may be unexpectedly present in the psychiatric patient's narrative, as it is in Roseanne's Testimony.

Terry Phillips has observed that *The Secret Scripture* is concerned with the "process of remembering and the interaction of autobiographical memory with collective and social memory" (T Phillips 247). While this is not the place for an extended exploration of memory theory, it is nevertheless useful to consider here some scholarly writing on memory and its various forms. Scientist Steven Rose has written engagingly about the basic formation of memory, describing his experiments with chicks (Rose). His work allows us to understand how experience is recalled so that it reinforces future action. Social critic and philosopher Theodor Adorno writes of another type of memory and its communal dismissal, this being the social, collective forgetting of unacceptable social atrocities, such as the Holocaust (Adorno). Extending this discussion of cultural memory, other theorists have considered how the act of remembering "may be related to or dependent upon a particular place" (Connerton 10). We may consider this concept relevant to both Ireland and the lunatic asylum. Social anthropologist Paul Connerton points especially to modernity's "particular problem with *forgetting*" (1). He refers to critic and philosopher Fredric Jameson's argument that "our entire contemporary social system has little by little begun to lose its capacity to retain its own past" (Jameson qtd in Connerton 2); and notes Tony Judt's concern that, without the teaching of narrative history, "large parts of [our] common past will constitute something more akin to *lieux d'oubli . . .* or . . . realms of ignorance" (qtd in Connerton 3). There is much in Irish history that is and remains traumatic, with the attendant suppression of information which we have witnessed in Grene's narrative. The doctor has been unable to integrate these historical traumas, although he has noted his bedtime reading of Irish history in his Commonplace Book (121). He later

incongruously claims he knows very little of Ireland's past (117). Only when he discovers through Roseanne's history the part Ireland has played in his own story is he able to retrieve his knowledge. The gaps in recall left by his personal trauma have also hidden what he knew of his country's troubles. In addition to the widespread Irish suffering from long-standing political and religious unrest, the lunatic asylums in Ireland were sites of particular misery, as described elsewhere in this chapter. Barry's use of the trope of the socially and geographically isolated lunatic asylum underlines modes of forgetting in public and private spheres.

The way in which human memory deals with traumatic events is of great interest to psychology and psychiatry and therefore to this chapter on a novel containing the recollections of a troubled asylum psychiatrist and his patient. Freud wrote in "A Project for a Scientific Psychology" in 1895 that "[a] psychological theory deserving of any consideration must furnish an explanation of memory" (Freud *SE 1* 299). Freud's writing is much concerned with the repression of memory, which makes recollection of the past extremely difficult for the psychiatric patient. The forgetting of crucial events, asserts Freud, is a purposeful act on the part of the sufferer. It results from "the psyche's need to *not* remember something troubling" (Terdiman 95). Caruth notes how trauma involves memories that "are largely inaccessible to conscious recall and control" (*Trauma: Explorations* 151). Such trauma "in its unexpectedness or horror cannot be placed within the schemes of prior knowledge" (153). It "requires integration, both for the sake of testimony and for the sake of cure" (153). The unravelling of the meaning of trauma is vital to personal integrity, since it is not only a "record of the past" but, importantly, it "registers the force of an experience that is not yet fully owned" (151). Freud and Caruth here stress that traumatic memories, suppressed for reasons of personal survival, must be faced and assimilated into consciousness if the subject is to move towards mental health. This will appear to be of increasing relevance to Barry's reader as she receives the accounts of psychiatrist Dr Grene and patient Roseanne. *The Secret Scripture* shows a patient dealing with trauma effectively and a psychiatrist who is caught in a downward spiral of repression and avoidance.

The four types of memory discussed above (normal non-traumatic learning, personally traumatic, socially traumatic and place-dependent) all have bearing on *The Secret Scripture*. The recollections in the secret narratives of patient and psychiatrist may be considered in the light of each of these categories of memory. The "near impossibility of determining a reliable past" is addressed in this novel, as is the "compulsion to repeat a past we cannot shake off" (Terdiman 93). Recall always invites the criticism of bias or forgetting. With the addition of a first-person narrator who is potentially unreliable since she is assigned the label of lunatic asylum inmate, and a 'psy' professional whose account is severely affected by trauma, the task for the reader of Barry's novel is exceptionally difficult. However, the reader may well finally judge that no fact may be fully established as containing the sole truth. Barry's novel repeatedly exhibits the possible ambiguity of memory, while time and again suggesting that Roseanne's understanding of the workings of her own memory are markedly superior to those of her psychiatrist.

g) Barry's exploration of trauma and memory in the accounts of psychiatrist and patient

> It was a psychiatric gathering. Our topic as it happened was geriatric psychosis, dementia, all that. I was presenting a paper on versions of memory, the absolute fascist certainty of memory, the bullying oppression of memory. (185)

Dr Grene's reference to the conference paper he once gave invites the reader to consider him an expert on memory, while at the same time suggesting a dismissive attitude to the subject by his phrase "all that". Expertise concerning the workings of memory is to be expected of a psychiatrist. However, close analysis of the novel's text produces distinct contradictions and we shall see how Grene avoids "the absolute fascist certainty of memory, the bullying oppression of memory" as he presents an account which exhibits the avoidance and delay which are typical of post-traumatic stress disorder (PTSD). Grene's descriptions of memory as "fascist" and "bullying" further suggest he sees memory as negatively powerful, even something to be avoided. It is notable that it was this conference which provided Grene with his opportunity to engage in a brief affair (185-6), the recollection of this sorry event being what has remained with the psychiatrist after the conference. By way of comparison

with Grene's recall and ability to produce a clear written account, I also show below that his patient, Roseanne, displays considerably more narrative competence, this being a sign of her mental health. While Roseanne recalls much that is traumatic in her life, she also finds solace in good memories.

It is by means of considering the nature of each of the two major secret narratives in this fiction that it is possible to assess how trauma has impacted differently on the recall of both psychiatrist and patient. This consideration leads me to the judgement that the psychiatrist's disordered narrative indicates unacknowledged trauma for much of the novel, while his patient has confronted and accepted her traumas, allowing her to recall her past in a largely orderly fashion. It becomes clear as the novel proceeds that Dr Grene has memory deficits as a result of trauma. He has been unable to face or dealt with his personal horrors. It is only as the novel moves towards resolution that Dr Grene successfully recalls and integrates his early traumas into his narrative (188-9). The psychiatrist's narrative exhibits clear evidence that he is, for much of the novel, an unbalanced individual.

Comparing the two narratives, it is notable that the legal/religious word, "Testimony" used for Roseanne's narrative suggests a striving for accuracy and truth. Grene's "Commonplace Book", on the other hand, implies a more haphazard recording of random thoughts, such a book being a general repository for jottings on a range of unconnected topics which intermittently strike the writer as significant. A commonplace book does not attempt to construct a continuous narrative of cause and effect within a defined timeline. These two accounts make up almost the entire text of *The Secret Scripture.* There is very little comment on any of the novel's text, beyond Fr Gaunt's damaging deposition, the informative letters of Jack McNulty and John Kane and an official adoption record. I shall return to these below. It is clear to the reader that she is receiving a text largely made up from two individual sets of memories.[189]

[189] However, Mieke Bal notes a digression from this: "the narrator does not relate continually" for when "direct speech occurs" "it is as if the narrator temporarily yields this function to one of the actors" (Bal 9).

These two personal accounts point to a reversal of roles between patient and psychiatrist in much of *The Secret Scripture*. An incident which stresses this reversal is contained in Grene's account of how he breaks down and tells his patient of his wife's death. Roseanne then came "creeping over to me. But it was like being touched by a sort of benign lightning, something primitive, strange, and oddly clear" (126-7). It appears that patient has here turned healer, underlining Grene's professional inadequacies and Roseanne's competence in understanding. Though both Roseanne and Dr Grene have had traumatic pasts, the patient's memories are rationally available to her, while the psychiatrist's recollections are non-linear, avoidant, often forgotten and only gradually recovered with much effort as the novel progresses. Furthermore, Dr Grene suffers from occasional hallucinations, recounting an obviously deluded incident of being lovingly greeted by his wife (93). Roseanne, on the other hand, perceives what is, or has been, there. This is not to deny that, understandably, her recall is influenced by the vagaries of normal, long-term memory, especially taking her advanced age into account. The evidence of the workings of memory experienced by Dr Grene and Roseanne invites the reader to consider where sanity and madness may lie. As I have shown to be the case elsewhere in this thesis - particularly in relation to McGrath's *Asylum* - the reader may be seduced into believing one version of events while ignoring the fact that "telling otherwise" may offer a more reliable recall (Ricoeur 9). This can happen even though the person presenting information differently may, at first sight, appear to be unreliable. Such is the case in Barry's novel, with the most ordered, reliable recall presented by the putative mad-woman, Roseanne, and the muddled, avoidant, repetitive account being the narrative of the supposedly authoritative 'psy' professional. In this respect, my reading of the novel differs from that of scholar of Irish literature, Kathleen Costello-Sullivan. Costello-Sullivan sees Roseanne's narrative as indicative of trauma, in opposition to what she sees as the "authoritative" versions, written by Dr Grene and Fr Gaunt (Costello-Sullivan 73, 78, 81 etc). Apparently authoritative writing is powerfully compelling.

Psychiatric patient Roseanne has normal interest in, observation and recall of non-traumatic events, such as when flowers return to bloom outside her hospital window (253). She is able to remember clearly much of her past,

with some understandable and acknowledged confusion about childhood memories. She can competently insert her own remembered experiences into what she has gathered and lived through of Irish history during her one hundred years. Though her experience has contained much that is traumatic (her frightening interaction with the Free State rebels, her father's violent death, her mother's madness, Brady's attempted rape, her abandonment by her husband and the subsequent isolation forced on her by his family, the birth of her child alone on a storm-swept beach and the baby's subsequent removal, as well as her long incarceration in the asylum), Roseanne recalls and accepts all these experiences and includes them in all their horror in her life narrative, which she presents in a coherent way.

By contrast, her psychiatrist Dr Grene has considerably more problematic recall of the traumas that have formed major elements of his experience. His attempts to understand Roseanne's past are constantly interrupted by his repetitive, circular thoughts about his near-estranged and dying wife.[190] Freud notes in "Remembering, Repetition, and Working Through" that patients may repeat rather than remember so that, in such cases, repetition becomes an obstacle to memory (Freud *SE Vol 12* 145). This is what appears to be happening to Dr Grene as he avoids the "bullying oppression of memory" (185). Additionally, unlike Roseanne, he is unobservant of the natural world, with impaired memory of it. For example, Grene recounts his surprise at having wet hair, having come in from the rain (156). His traumatic memories (his brother's death and his mother's suicide) only emerge into his conscious mind with considerable effort and pain (188-90). His knowledge of his adoption is also banished from his consciousness, along with curiosity about his origins. Equally, Dr Grene appears to have retained almost nothing about Ireland and its troubles until his personal memories gradually return and show that he had absorbed historical information.[191] Paul Ricoeur observes that "[a] cure happens when one gets to the bottom of things, when the suffering subject

[190] The psychiatrist frequently turns to his anxiety about his wife, Bet, while attempting to focus on Roseanne (18,48-50, 73, 93,120-1, 126, 128, 156, 172, 173,175, 176, 184, 186, 191, 206). Late in the novel, when he is able to face his past traumas, Grene accepts Bet's death and is no longer obsessed by anxious memories of his wife (262-4).

[191] For example, when he achieves greater awareness of his personal troubles, Dr Grene feels compassion for de Valera and his enormous difficulties (236). Earlier, he had admitted to being "musty on that whole period". Grene refers to his reading of Irish history (121) but appears to have repressed his historical knowledge in the earlier part of the novel.

manages to remember and recount the whole story, or at least as much of it as is recoverable and utterable given the lapses of time between the events of trauma and the recalling of those events" (Ricoeur qtd in Kearney 21). The forward impetus that gradually emerges in Dr Grene's narrative as he remembers, acknowledges and faces his painful past is an example of the healing of memory that Ricoeur refers to as part of the role of narrative. Memory, forgetting, trauma and repression are all integral to the portrayal of the psychiatrist in this fiction.

If we consider the text's stance on the fallibility of memory, we can see that Barry shows Roseanne as aware of and concerned about memory's unreliability. The patient remarks, "no one has the monopoly on truth. Not even myself, and that is also a vexing and worrying thought" (134); and "I must admit there are 'memories' in my head that are curious even to me" (208). Life-writing scholar Sarah Herbe suggests this makes Roseanne an unreliable narrator (Herbe 28), while I suggest this shows Roseanne's perceptive awareness of the possible unreliability of recall. Dr Grene discovers almost at the novel's end that memory cannot accurately recall facts in their totality as he writes, "I am beginning to think there is no factual truth" (291). Herbe states that Dr Grene's records "started out as rather objective observations" and refers to the psychiatrist's conference paper as showing he is "acutely aware of the fallibility of memory" (Herbe 35). However, my argument concerning the nature of Grene's avoidant and randomly muddled Commonplace Book entries show that the patient's insight into the reliability of memory is much more developed than that of the psychiatrist. Grene's memories (which, as Herbe rightly points out, change after his wife's death) fit well with Roseanne's judgment that neglected memory "becomes like a box room, or a lumber room in an old house, the contents jumbled about" (208). It is Roseanne's very consciousness of the failings of memory that make her account more reliable than that of the 'psy' professional. Indeed, it is of great significance that Roseanne can exactly pinpoint her time of greatest suffering when she says, "Now memory stops. It is entirely absent. I don't even remember suffering, misery" (276). This occurs after she has given birth, alone on the stormy beach and understands that her baby has vanished, having been mysteriously taken from her. Only at this point does Roseanne evidence a trauma that has been banished from memory.

Because of this, Roseanne here moves into hallucination, experiencing the arrival of Eneas, come to take her and the baby from the asylum and away to safety. Writing much later in Roscommon about her life, Roseanne recognises this point of trauma and acknowledges the false hope of this hallucination, which is "[a] memory so clear, so wonderful, so beyond the bounds of possibility" (277). The aftermath of the birth does not lead to the reappearance of Eneas, but to further intervention from the priest. As the prisoner looks to his jailer, Roseanne has "looked for Fr Gaunt to help [her]", but instead Fr Gaunt has delivered her to "the two towers of the asylum" where Roseanne is "given forth to hell" (276). Roseanne's failure of recall is not the forgetting of avoidance, but forgetting as a means of survival, for Roseanne knows she has banished memory at this darkest of times. It is a traumatic gap, but an acknowledged one. This awareness of the functioning of her memory serves to reinforce the patient's narrative reliability.

By contrast to Roseanne's competent recollections, there are frequent signs of unconscious deflection in Grene's Commonplace Book, as he starts to write about one matter and is distracted, moving towards the details of another subject. While considering the pressing matter of the fate of his patients when Roscommon closes, the psychiatrist thoughts drift towards his silent wife, "not even playing the BBC World Service, as she usually does" (47). Later, thinking about his wife's death, Grene focuses on the fate of the captured Saddam Hussein, wondering who cared for his appearance in court, where his "jacket and shirt were always immaculate" (120). This can justifiably be read as an avoidant narrative style as the psychiatrist is unable to concentrate on the painful matter at hand. Dr Grene's reliability is in question throughout the novel until he unearths external evidence about Roseanne's baby, the McNulty family's part in exiling Roseanne while providing some provision for her child, and Sean Keane/John Kane's constant, caring role in Roseanne's welfare. Barry's novel moves towards the psychiatrist recovering the fact that he is Roseanne's son, put up for adoption as a baby to an English Roman Catholic family. This recovery (of information as well as mental balance) is facilitated by Grene belatedly following his patient's experience, eventually integrating her secret scripture into his private account. Unusually, Barry's fictional psychiatrist learns to develop narrative competence from his fictional patient. However, it is

up to the reader to perform the action of combining and assessing the novel's secret scriptures throughout the fiction.

h) Dr Grene's growth towards recall, understanding and competence

The psychiatrist learns greater competence in decoding written text as he reads the deposition written by Fr Gaunt, which Percy Quinn dismissively describes as "the very quaint account of that Fr Gaunt fella" (280). Dr Grene's growing awareness of the need to assess writing also works as a reminder to the reader to do the same and not take the written word at face value, even when coming from a seemingly authoritative person, such as a psychiatrist or priest. The reader knows from Roseanne's Testimony that Fr Gaunt has wielded considerable harsh power over Roseanne and her family. Reading the priest's words, Grene is aware that he "must make a judgement about the verities that are before me, not the verities that are only intimated, or that are suggested by own instincts" (160). This does not make the psychiatrist entirely objective, although he is aware of anomalies in Gaunt's writings. This is evidenced as Grene comments, "How Fr Gaunt knew all these details is not clear, and indeed as I read it over now I am puzzled by his omniscience" (159). Nevertheless, Grene attentively notes discrepancies in the priest's deposition in its discussion of Roseanne's supposedly guilty association with the rebels who come to her father's graveyard at night, asking for the burial of one of their number.[192] Gaunt claims the "newly cut name on the gravestone was Joseph Brady" while Grene notes, "no one of that name had died in the town" (159). The doctor also comments that "[u]nbelievably, the men had also buried with the guns notes of secret meetings, including, by some foolish miracle, various names and addresses, including certain individuals wanted for murder" (159). The psychiatrist clearly finds the existence of this evidence suspect but is hesitant to question the priest's account. This clemency towards Fr Gaunt perhaps indicates Grene's allegiance to Roman Catholicism and authority, so that the doctor is able to view this not entirely honest testimony as "the ambition

[192] The reader has already received Roseanne's different account of the activities that night, which involved the rebels request for Roseanne's father to bury Willie Lavelle (41). Thanks to the frankness and clarity of her writing, the reader is likely to believe her narrative, even before the further input of Fr Gaunt's inconsistencies, as his deposition is read by Dr Grene much later in the novel (160, 290).

of a priest in his time" (159), rather than detail deviously invented by Gaunt. However, the reader is likely to judge the priest a liar, since she has earlier received Roseanne's clear account of the night-time event at the graveyard. In addition, Joseph Brady has reappeared in Roseanne's Testimony both as a rapist and as the man to whom Fr Gaunt sought to marry her off (111). This information is corroborated by the orderly, Sean Keane/John Kane who, according to Percy Quinn, also complained of an orderly called Brady of "menacing and I fear molesting your patient over quite a long period" (282). It seems Grene has quickly forgotten the intelligence about Brady offered by Quinn, since the doctor curiously observes that Roseanne's account of Brady's attempted rape at the cemetery house "reads very 'strangely' to me" (289). The psychiatrist has, nevertheless, made a significant advance in carrying out his professional duties as he now both considers and assesses written information about his patient, albeit belatedly. The reader, however, is able to perceive more than the 'psy' professional, both by considering Grene's writing and combining it with Roseanne's much more competent Testimony, as well as by noting the frequent but apparently minor appearances of Kane/Keane. The reader and Dr Grene are to discover much later the loyal role played by Keane in protecting Roseanne during his work at Roscommon (305).

In spite of his lapses in attention as Grene weighs the evidence about Roseanne, the psychiatrist grows in analytic awareness as he wonders if he is using Roseanne as a means to deflect himself from his grief at his wife's death, since his patient is "someone I admire and yet at the same time have power over" (191). No longer drifting but now taking charge of his actions, Grene tells himself, "I must interrogate my own motives now in everything" (191). In a major change from his anxiety at intruding on his patients' privacy, he is now aware that psychiatrists "are like MI5 sometimes" since "[all] information becomes sensitive, worrying, and vulnerable" (206). In regard to Fr Gaunt's deposition, Grene wonders if "such all-knowing, stern-minded, and entirely unforgiving priests still exist" (236). He also considers that, in Fr Gaunt's "great desire to have [Roseanne] committed", the priest was "subject to a mere error of memory" (290). The reader may consider this overly generous on the psychiatrist's part in relation to Fr Gaunt's machinations, but this also shows Grene's enhanced understanding of memory and its failings.

While admiring Gaunt's priestly scholarship, as well as taking the forgiving attitude of a Roman Catholic towards the cleric's account with its possible errors, the psychiatrist is attentive to, but also respectful of, the priest's deposition. Being willing to accept Gaunt as necessarily authoritative as a priest, Grene states that "[t]he more I look at Fr Gaunt's deposition, the more I seem to believe it" (158). It is Gaunt's certainty, at odds with Roseanne's honest account, that highlights the tentative nature of Grene's writing. Gaunt's misleading authority reminds the reader that 'psy' professionals also represent authority and have considerable power over patients.

Putting aside being impressed by Fr Gaunt's "Latinate style", Dr Grene observes the priest seems to be "unburdening himself, as he might a sin" in "staunch", "fearless" and "conscientious" fashion (158). His mind apparently open to wrongdoing on the part of the priest, the doctor now appears to observe Fr Gaunt's possible confession of sin. As Grene exhibits his conflicted response to Fr Gaunt's account, the doctor's vocabulary in describing the priest's writing is full of paradoxes: Gaunt writes "conscientiously" and is "fearless", although his apparent "omniscience" is "puzzl[ing]" to the psychiatrist. Grene's attention to the deposition produces belief in the priest's words (158), although he finds it "unbelievable" and a "foolish miracle" that guns and "notes of secret meetings" were found in the grave marked "Joseph Brady", when no such person had died (159). Even more puzzling is that the grave was later found to contain the remains of the rebel, Willie Lavelle (160). Aware of these possible contradictions, Dr Grene, like Roseanne, states his aim for honesty, reminding himself he must judge what he sees and reads and supress his instinctive reactions (160). Though somewhat confused and misled by Fr Gaunt, the psychiatrist acknowledges the need for critical assessment of the written word. This does not, however, lead Grene to admit to his own sins of omission in failing to care for his patients. His move towards understanding remains limited and, in some respects, temporary: a little later, Grene describes Gaunt's deposition as a "remarkable piece of work, clerical, thorough, and convincing" (238). Once more, he is seduced by the priest's writing and religious authority. However, Grene does perceive that Fr Gaunt's writing has obliterated Roseanne "burning away all traces of her, traversing her narrative and turning everything to ashes and cinder" (238). For the reader, it is notable

that Grene's own neglect of Roseanne's care has also diminished her, for the patient has been silenced and excised from so-called authoritative accounts of her life and condition, communicating only with the reader by means of her hidden Testimony. Barry thus underlines for the reader the need to remain vigilant about accepting the authority of any presenter of the written word, as well as observing who is silenced.

Having earlier disregarded the ways in which Ireland's particular problems have affected everyone in that troubled country, Grene now brings his wider knowledge of Irish history to these writings about Roseanne and notes the "strange criminality" of recent Irish politicians, "not to mention" the abuse of children by priests (237). In this Irish context, Grene can now judge the "absolute power of such as Fr Gaunt leading as day does to night to absolute corruption" (237). The psychiatrist notes how "Fr Gaunt is almost clinical in his anatomising of Roseanne's sexuality" and is disturbed that it is "highly voyeuristic, morally questionable" to read the priest's writing, observing that "[Gaunt] betrays at every stroke an intense hatred if not of women, then of the sexuality of women, or sexuality in general" (238). Reflecting on the priest's writing, Grene now understands that Fr Gaunt considered it was Roseanne's beauty that "tempted all of male Sligo", making her "like a magnet to the lusts of Sligo" when exiled by the McNulty family and imprisoned in the tin shack by the beach (239). This recalls the heavy hand of the Roman Catholic church co-opting the lunatic asylum to imprison single mothers.[193] The psychiatrist acknowledges that, had he read the priest's deposition long ago, with the authority of the church behind it, he would have felt "obliged to commit [Roseanne]" (239). Dr Grene wavers between trust in and suspicion of Fr Gaunt in assessing the latter's deposition. However, the psychiatrist is honestly considering historical context, observing how Irish history has shaped all lives, a matter which runs through the entirety of this novel. Although his response to Gaunt's deposition vacillates between belief and condemnation, Grene shows

[193] Unmarried mothers were often transferred from Roman Catholic run "Rescue Homes" to lunatic asylums, where they provided years of slave labour (O'Sullivan *Coercive* 50). Indeed, merely being an unmarried mother often attracted longer confinement than criminal acts (O'Sullivan *Coercive* 26). Roseanne's committal to Roscommon Lunatic Asylum was arranged by Fr Gaunt on the grounds of "nymphomania" (231), the link between female sexuality and madness being contemporary medical orthodoxy, endorsed by such prominent psychiatrists as Henry Maudsley (qtd in Ussher 72).

himself able to make a fair judgement of how a psychiatrist might have behaved at an earlier time in history.

Fr Gaunt's most terrible lie about Roseanne is that she killed her baby, the child to whom she gave birth alone on the storm-battered beach, watched over at a safe distance by Keane. We discover near the novel's end that Keane is the son of the rebel John Lavelle, and nephew to the dead Willie Lavelle, brought to Joe Clear's graveyard for burial and helped by Joe and Roseanne. Keane's life's work has been one of "strange loyalty and protection" of Roseanne, tasked by his father to look after her (288). Grene is now aware of Keane's constant care, working as an orderly in hospitals where Roseanne has been a patient and, what is more, organising her son, Dr Grene's, employment at Roscommon. The damaged, seemingly powerless orderly has taken pivotal steps in real care for Roseanne and, indeed, for Dr Grene. It is notable that his crucial identity is partially veiled by his varying names,[194] thus obscuring even more this apparently minor character whose caring presence is nevertheless decisive. Dr Grene discovers that he was himself that child, rescued by Keane, put into the care in England of the nun who was Teasy McNulty, sister of both Roseanne's former husband, Tom, and the baby's father, Eneas. The child was put up for adoption and taken in by an English Catholic family. This information, tracked down by Grene at the novel's end, establishes Fr Gaunt's intent to punish Roseanne, which Grene begins to understand. Quinn concludes that Fr Gaunt must have meant "killed [the baby] spiritually" (281) rather than literally, this being according to the religious notion that the illegitimate child bears the sins of the parent and cannot therefore enter heaven. Grene, however, still entertains the idea that Roseanne physically killed her child, being "finally . . . parted from her wits" (285). Rather than blaming his patient, as did the unforgiving priest, Grene feels great sorrow at Roseanne's terrible suffering (285).

At this very late stage in the novel, Grene finds Roseanne's Testimony which, with his new textual competence, he reads "like a scholar of her life, making a mental concordance of facts and events" (288). The reader, of

[194] *Seanín Keane Lavelle* is the third version of John Kane/Sean Keane, given as signature to the note to Dr Grene (305).

course, has been privy to Roseanne's writing all along and has been able to compare and weigh information from different sources. This has allowed the reader to precede the psychiatrist in understanding, since Roseanne's Testimony, presented as an endeavour in serious recollection and honest recording, has provided much trustworthy information, as well as alerting the reader to the difficulties of accurate recall of distant events. Having written her Testimony, Roseanne recedes from the text, moving into what appears to be the approach of death. Now armed with the same information that has been available to the reader (biographical facts which an attentive 'psy' professional should certainly have known), the psychiatrist moves on to complete the story of his own traumatic background and its intersection with Roseanne's. Notably, for both of them it has perhaps come too late. Roseanne cannot expect to live much longer and Grene, about to retire, cannot now become a competent psychiatrist.

It is clear that a third party has intervened to ensure that Grene finds Roseanne's writings, as the doctor now discovers a "sheaf of papers in a large used envelope" which he remembers discarding (287). Grene "suspect[s]" that the orderly John Kane, now lying ill and also nearing the end of his life, is responsible (287). The reader is likely to concur that it is this loyal man who has brought this "freely" offered information to the psychiatrist (287). Like the reader, Grene now has Roseanne's account as well as Gaunt's deposition. The Roman Catholic psychiatrist is unwilling to see the priest as a liar and is also aware that his "own brain must have supplied [some] details" (289). He generously settles on the fact that "to a large degree, both Roseanne and Fr Gaunt were being as truthful as they could be, given the vagaries and tricks of the human mind" (290).[195] This leads Grene to believe that

> they have written not so much wrongful histories, or even competing histories, but both in their human way quite truthful, and that from both of them can be implied useful truths above and beyond the actual verity of the 'facts'. I am beginning to think there is no factual truth. . . . (291)

[195] Grene's generosity towards Gaunt possibly reflects his remaining Roman Catholic bias towards the priesthood.

It seems that what Dr Grene has learnt has been compassion. He has also discovered that "factual truth" is difficult to isolate with accuracy, it being dependent on the ability to transmit information unambiguously via the written word. Truth-telling also relies on competent memory. Even now, Dr Grene is unable to fully accept as largely 'true' the information from his mother's Testimony. His progress remains tentative.

Having grown in competence in many ways, the psychiatrist now understands that moral attitudes and behaviours are, as the nun to whom Grene speaks at Nazareth House states, dependent on their era.[196] What does appear as unarguably 'true' in this novel is the plain communication made in the document shown to Grene by Sr Miriam which states:

> The child's name was William Clear, born of Roseanne Clear, waitress. The father was given as Eneas McNulty, soldier. The child was given to Mr and Mrs Grene of Padstow, Cornwall, in 1945. (300)

Dr Grene's investigative action, perseverance, growing ability to recall his own past and to assess information have led him to the vital discovery that he is Roseanne's son and that the affinity he has long felt for her is justified. He is able to offer Roseanne, as she nears death, the comfort that she is "blameless. Wrongly committed" (303). He apologises to his mother and patient, taking full responsibility for her lack of care, saying

> I apologise on behalf of my profession. I apologise on behalf of myself, as someone who did not bestir himself and look into everything earlier. That it took the demolition of the hospital to do it. (303)

It is of note that, at the same time as the psychiatrist apologises for his own negligence in not pursuing Roseanne's case much earlier, he also apologises on behalf of his discipline of psychiatry. While owning his personal failings as a doctor, Grene's critical attitude towards his chosen profession remains, mirroring the views usually presented in fictions which concentrate on the mistreatment of asylum patients.

[196] Sr Miriam tells Grene that "things were very different in the forties, and personally I think it is impossible to travel back in time adequately to appreciate those differences" (300).

The psychiatrist's focus on himself and the special importance of his discoveries direct the reader to see this novel as a personal recovery narrative, in which the traumatised Dr Grene achieves his own return towards mental health and re-entry to the normal world. At the same time as the reader sees Grene emerge from his anxiety, confusion and grief, the doctor also believes that Roseanne has achieved her own 'cure'. He judges "she has helped herself, she has spoken to, and listened to herself. It is a victory" (309). In Grene's view, the patient has recovered without the aid of psychiatry. However, what is clear to the reader from Roseanne's ordered and competent narrative is that she was never insane. Certainly she has "helped herself" in facing terrible experiences which brought her to almost life-long incarceration in an asylum; but her writing shows she has faced her traumas, rather than avoiding whatever is difficult in her background, and can retrieve and narrate them effectively. Grene is now aware of his professional negligence, observing in the words with which I open this chapter, that "[a]ll the time I might have helped [Roseanne], all those years she was here, I had more or less left her alone" (309). He knows that "from a psychiatric point of view" he "had totally failed to 'help' [Roseanne], to prise open the locked lids of the past" (309). Dr Grene is a failed psychiatrist but a human being who has gained control over his own traumatic past. Discovering Roseanne's history has helped both Grene and his mother, although very late in their lives. At the same time, it must be borne in mind that the psychiatrist's long-term neglect of his many asylum patients remains indubitable.

i) *The Secret Scripture*: writing, secrets and truth

As the novel opens with Rosanne's writings, the reader may initially assume that hers is the secret scripture of the novel's title. The act of writing is of great importance for Roseanne. It is a way of both ordering her memories into a coherent narrative and also leaving a concrete account of her life after her death, even though she expects no readers. For the psychiatric patient, it is relevant that "silencing seems part of all traumatizing or abusing experience", while this silence of the "unspeakable" prevents healing (Roberts and Holmes 19). It is notable that Roseanne's surname, Clear, suggesting clarity of vision, comes from the Gaelic "O Cleirgh", meaning "clerk" or "cleric", with its obvious

associations with writing (*House of Names*). Roseanne's intention is to "imprison [her written story] under the floor-board, and then with joy enough . . . go to [her] own rest under the Roscommon sod" (5). This writing and hiding of a "brittle and honest-minded history" suggest that this is a truthful and vital endeavour, meant for no eyes but her own. Roseanne's straightforward style invites the reader's trust in her private version, in spite of her status as psychiatric patient. Very early in the novel we find another private account and it appears that the psychiatrist's writing will inform that of the patient, providing a second secret scripture. By contrast to Roseanne's Testimony, Dr Grene's confused and avoidant style suggests the reader should be aware of what is hidden in his account. Gradually, his active search for facts emerges in his Commonplace Book. The psychiatrist's movement into understanding and clarity, recorded in his writing, is echoed by his change of name from one suggesting the not-knowing of naïveté (Grene) to a second implying clarity of vision (Clear). Secrets are discovered and truths revealed.

There are three, additional, brief, written accounts by other characters which are quoted in the novel, these being Fr Gaunt's deposition and Jack McNulty's and John Kane's letters. These add plot information which the reader must consider, alongside Grene's reference to his dying wife's diary, which he reads without her permission, and the unquestionably solid information contained in the orphanage records concerning his adoption by Mr and Mrs Grene of Padstow. Each piece of the written evidence presented in the novel must be joined to the rest to achieve a more complete narrative. What the reader gradually discovers and must reassemble are the ways in which these narratives hide identities, contradictions and secrets. Roseanne Clear is also Mrs McNulty, rejected wife of Tom; Dr Grene is the psychiatrist and also William Clear, Roseanne's son; the orderly John Kane is also Sean Keane/Seanín Keane Lavelle, the son of the murdered Irish rebel, Willie Lavelle; Joseph Brady is the husband proposed by Fr Gaunt for Roseanne (98) as well as being the name falsely carved on a gravestone to hide Irish political secrets (159), the man who assaults Rosanne (111) and an abusive asylum orderly (282); old Mrs McNulty, the rigid Roman Catholic mother-in-law who destroys Roseanne's marriage to Tom, is also the illegitimate child of a Presbyterian mother, as revealed in Jack's letter (295); and the nun, Sister Declan of Nazareth House in

England, is also Teasy McNulty, sister-in-law to Roseanne and provider of care for baby William in spite of the McNulty family's cruelty to the child's mother. Barry thus draws the reader's attention to the ways in which people may be misled and roles obscured. Perhaps the most important deception, however, is that of the seeming authority of the written word, shaped by its source. The reader discovers that the psychiatric patient, not the psychiatrist or the priest, presents the most trustworthy attempt to recall events.

j) *The Secret Scripture*: conclusion

Barry's novel has presented a traumatically damaged 'psy' professional, whose childhood experiences have severely impeded his ability to live fully and to practice his chosen profession. I have shown how, at the time of writing of the novel, trauma and forgetting were at the forefront of much writing. *The Secret Scripture* emphasises the ways in which unacknowledged trauma may adversely affect an individual, who subsequently circles around the uncertainties in his life and may only move on if traumatic incidents are recalled and confronted. This is William Grene/Clear's position. The narrative of his patient Roseanne evidences how acknowledged trauma may allow the mental health of a person, even one who is imprisoned for most of her life in a lunatic asylum and unable to follow a normal existence. The reader is throughout called upon by the author to consider the authority of different written texts. As noted before in this thesis, the presence of an abusive, negligent or hidden 'psy' professional puts the reader in the position of a therapist who assesses and combines information to produce the most accurate version possible of the fiction's story.

The narratives of Dr Grene and Roseanne are each presented by writers who are both, in different ways, excluded from Irish society and the two sets of secret scriptures the novelist presents are written by social outsiders from within a place of social ostracism. This allows Barry an outsider perspective from which to view madness, sanity, social deviance, religion and politics, as the novel explores trauma and memory from the interior of the self-contained, idiosyncratic setting of the lunatic asylum, within the particular social structure that is Ireland. At the end of the novel, the psychiatrist is able to recognise that,

just as Roseanne “had always lived on the edges of our known world”, he “was born on the edges of things, and even now, as the guardian of the mentally ill, [he had] by instinct pitched [his] tent in a similar place” (310). Both Grene and Roseanne have been social exiles in need of asylum from Irish history. Decarceration - the reintegration of former psychiatric patients into the general community - may be seen as another metaphor used by Barry, illustrating acceptance of the previously exiled, along with compassion towards the formerly outcast.

I have argued in this chapter that Dr Grene is at the centre of Barry’s fictional concerns of recovering traumatic memories and absorbing them into a more balanced life narrative. Although the novel has exposed the terrible injustices wrought by Irish mental health practice, religion and Irish politics, the psychiatrist ends the novel with acceptance, rejecting blame and showing mercy to Ireland and all its citizens mired in its terrible history. Though unable to voice his thoughts to his psychiatric colleague, Percy Quinn, Dr Grene is able to confide his compassion to the reader, from within his secret scripture. The psychiatrist calmly acknowledges and forgives his own failings, recognising that he is “a ridiculous, sober, ageing, confused English Irishman” (307). Finally, he celebrates humanity as he writes of his mother.

> I thought it wasn’t so much a question of whether she had written the truth about herself, or told the truth, or believed what she wrote and said was true, or even whether they were true things in themselves. The important thing seemed to me that the person who wrote and spoke was admirable, living, and complete. (309)

In *The Secret Scripture* Barry has presented a psychiatrist who lacks faith in his professional discipline, who has consistently neglected his duties towards his asylum patients, while exhibiting signs of considerable personal trauma. Dr Grene is certainly not an evil man. He has no malevolence towards his patients, rather viewing them all with compassion throughout the novel. His attention to the long-term plight of his ancient mother improves her last days, when she sees herself as “back from the dead, apparently” (302), although earlier action on his part could have helped Roseanne many years before. In reclaiming his identity as William Clear, Roseanne’s son, Dr Grene saves himself. He is the only disturbed individual who achieves recovery in this novel.

I have shown that Roseanne, though having lived through great trauma, has not shown signs of insanity in her narrative, her incarceration in the asylum having been a result of both political events and the Roman Catholic Church's horror of female sexuality. Rather than Grene caring for Roseanne during her long stay in the asylum, the patient has shown helpful concern for her psychiatrist. By inviting this interpretation of a reversal of roles between psychiatrist and patient, Barry encourages his reader to reconsider sanity and madness and how they may be assigned to individuals. The focus of the reader's compassion is thus questioned, shifted and shared to include patient and 'psy' professional. However, while Grene's personal agonies attract the reader's sympathy, he remains another incompetent fictional psychiatrist. Although Dr Grene does not actively harm his patients, his many years of neglect have allowed his asylum to remain a site of fear and imprisonment. In this respect, he deserves a place alongside the other fictional 'psy' professionals discussed in this thesis. He has, however, offered a compassionate narrative encompassing the forgiveness of psychiatry, which has not always adopted humane approaches, as well as showing greater tolerance of Irish society for all that has been painful within its history. It is entirely possible that the reader of Barry's novel will also consider a compassionate stance towards the frequently vilified psychiatrists of fictions who may, after all, be subject to trauma and failings in the just same way as other human beings.

THESIS CONCLUSION

This work has considered the ways in which the 'psy' professional is depicted in cultural artefacts in general and in four literary fictions in particular. It has shown that such representations are overwhelmingly negative with the resultant problems of fear of 'psy' professionals from prospective patients, as well as professional recruitment difficulties. My introductory chapter has covered wide-ranging examples of the power of abusive (and often criminal) 'psy' professionals in popular cultural artefacts. The four subsequent chapters explore representative novels showing distant professionals who fail to communicate with patients in the old asylums (*The Snake Pit*); the difficulty of locating sources of professional help within the non-hierarchical therapeutic community (*Long Distance*); the dangers of the extreme silencing of patients' voices when their treatment is in the hands of a malevolent and manipulative psychiatrist (*Asylum*); and, finally, the negligent treatment of patients by a 'psy' professional who has his own difficulties in living (*The Secret Scripture)*. The historical contexts of psychiatric treatment have shown that problems have always been present, though they may change with the times. The exploration of the role of the 'psy' professional in my four chosen fictions has identified the novels as each offering a narrative challenge. Each work requires the reader to navigate through uncertainty about what has happened in the novel and to judge the kind of reality presented: that of the mad or that generally accepted as sane. A willingness to accept the reality of mad perception is demanded of the reader, who may then decide where narrative authority lies. This involves evaluating the trustworthiness of narrators as well as decoding the novels' time-schemes. Fiction remains the place where the silenced mad can have a substantial voice and where uncertainties may be explored.

The power of the 'psy' professional is at the forefront of much of the fear of the professions. Not only does the specialist have the legal power to lock up those deemed mad but, once confined, the patient judged as psychiatrically ill may well be evaluated as having unsound perceptions of reality. This imbalance of power between the patient and the 'psy' professional means there will always be an element of fear and mistrust on the patient's part. The mental patient is thus frequently exiled from society. In relation to the distrust of this group of

patients towards the 'psy' professionals who treat them, Gail Hornstein's comment is salutary.

> Patient memoirs are a kind of protest literature, like slave narratives or witness testimonies. They retell the history of psychiatry as a story of patients struggling to escape doctors' despair. Again and again, patients talk of having to wrest control of their treatment or cure themselves after some physician had given up on them. It isn't surprising that psychiatrists ignore this literature; physicians in every branch of medicine discredit patient accounts, and madness, by definition, further calls into question what patients say. But that attitude terribly limits our understanding of mental illness, and blinds us to the many contributions that mental patients have made to art, science, and literature. (Hornstein "Narratives")

Clearly, patient narratives can add much to our understanding of the experience of mental illness and the ways in which 'psy' professionals are perceived as working. However, they rely on considerable competence on the part of patient/narrators and I have used *The Snake Pit* and *Long Distance* as examples of fictional narratives written by authors who were also patients. Such works add much to the largely inaccessible case notes of the professionals if the reading public is to understand the realities of mental illness. It is fiction that is able to present the perspective of the largely powerless patient and their unchronicled experiences.

There have been a number of television and radio dramas presenting 'psy' therapies in recent years. Significantly, they are often comedies, such as the American *Web Therapy* and BBC Radio 4 series, *How Does That Make You Feel* (Stephenson)*?* Neither of these shows contain patients with very serious problems. In the first, it is largely comic actor Lisa Kudrow's character of the therapist that is the source of comedy. The BBC drama, by comparison, is very understated, containing much humour in the therapist's silence. On the other hand, HBO's drama series, *In Treatment*, which was initially an Israeli production, attempts to show a realistic version of therapy, via a drama that takes place within the consulting room. A voice-over of the therapist explaining his methods and rationale is a significant part of this long-running series. A *Guardian* article of 2011 (Barnett) shows a positive response to *In Treatment* from a number of British psychotherapists. More recently, another BBC Radio 4 drama, available as a podcast called *This Thing of Darkness* (2020), involves

'psy' professional, Alex, leading group therapy in a prison with a number of male inmates imprisoned for violent crime. Alex is presented as a sympathetic and effective therapist within the drama, gaining the trust and co-operation of her patients within the group. As in HBO's *In Treatment*, Alex competently addresses explanations of treatment to listeners. While the interest in various aspects of 'psy' treatment remains popular and is sometimes presented seriously in dramas, nevertheless, the trope of the abusive 'psy' professional remains a staple of horror movies, games and popular novels.

There is one television drama, based on a confessional book (Earl), which is significant enough, in my view, to comment on in greater detail. This is E4's *My Mad Fat Diary* (2013-2015). This successful production, aimed at a teen audience, won Best Drama Actress in 2015 for its heroine, played by Sharon Rooney. Within an engaging comedy, mental illness is presented without hyperbole, though with an awareness of the associated stigma as, for example, Rae feels ashamed of her cutting being revealed to her friends at a swimming party. The psychiatrist, Dr Kester, who treats Rae is shown as likeable, competent, trustworthy and caring, as well as having his own relationship problems of which Rae becomes aware. Kester is shown to be deeply affected by the suicide of Rae's best friend and fellow patient, Tix, sincerely telling Rae he is "devastated" when she accuses him of having no feelings. This is a comedy, but at no-one's expense. Kester responds to Rae, a patient asking difficult questions about his role, with irony: "I torture people. That's what I do" (Series 1, Episode 5). The viewer will have observed that Kester's aim is to help his patients. When Rae finds the divorcing Kester in a bad way in his flat, she notes, "I like it that you're a mess. It makes you human" (Series 1, Episode 6). In the second series of *My Mad Fat Diary*, we see Kester at work, both with Rae individually and with other patients. The 'psy' professional is particularly shown as leading group therapy with sensitivity. In addition, the viewer is aware that that there is a mutual liking between Kester and Rae, with no suspiciously sexual or coercive overtones of any kind. Scenes within the 'psy' hospital ward show highly empathic staff, and patients are given a powerful voice. There is one 'psy' professional who is presented at some distance from Rae in the first series. This is the handsome Dr Nick Kassar on whom Rae has a crush. He is not, however, involved directly in her

treatment, this role being left to the unglamorous Kester. It is interesting that Dr Kassar is seen only from Rae's glamorised point of view and the audience receives no information of this doctor's view of his patient. Such presentation is very different from the distant 'psy' doctor as torturer which I have shown as a frequent motif in fiction. Significantly, *My Mad Fat Diary* is aimed at a teen audience, presenting a serious yet approachable representation of psychiatric illness and its treatment to younger viewers, possibly before they have experience of the negative presentations of 'psy' professionals that appear in much literary fiction. Of course, this same group of younger consumers may be very familiar with the asylum/madness tropes in horror films, popular fiction, games and comics. It is to be hoped that the sympathetic approach of dramas such as *My Mad Fat Diary* will serve to counteract these negative stereotypes.

Comedy has always been apparent in many representations of 'psy' treatments. Often overlooked among the terror of madness and the horrors of patient experiences, is the humour expressed by sufferers, both real and fictional. I have noted how Ward's Virginia, Mortimer's unnamed narrator and Barry's patient, Roseanne, all exhibit their amusing reactions in dreadful circumstances. Bethlem inmate and poet, Nathaniel Lee's often-quoted quip is pertinent here: "They said I was mad; and I said they were mad; damn them, they outvoted me" (qtd in Porter *Madmen* 14). Lee's words, I believe, are important not only in showing the alternative perception of the 'psy' patient but also because of the wit they contain. The mad may be aware of a different reality but they remain human and sometimes even aware of the comedy inherent in their situation. My personal experience in therapy has shown that humour has an important part to play in the relationship between 'psy' professional and patient, providing a mutually felt experience of amusement. This can only happen if a social bond of trust is created between patient and therapist. Any trend which moves towards the humanising of both patient and, importantly, 'psy' professional, will be of social benefit.

APPENDIX 1: Novels with 'psy' professionals

DATA FROM WORLDCAT LIBRARY

Decade Ending	Psy-chiatry	Psy-chiatrist	Psycho-logist	Psycho-therapist	Psycho-therapy	Psycho-analysis	Psycho-analyst	DecadeTotal
1909	0	0	0	0	1	0	0	1
1919	0	0	2	0	0	0	0	2
1929	0	0	1	0	0	0	0	1
1939	0	3	9	0	1	1	1	15
1949	1	6	12	0	4	6	1	30
1959	4	10	13	1	1	10	4	43
1969	10	20	13	5	6	11	7	72
1079	11	35	30	8	13	11	7	115
1989	17	51	71	17	32	25	13	226
1999	34	159	289	46	59	43	22	652
2009	54	359	945	157	233	94	42	1893
2019	88	697	1408	174	249	95	86	2797
Totals	**219**	**1340**	**2802**	**408**	**599**	**296**	**183**	**5847**

APPENDIX 2: Selected events in the history of Irish psychiatric care

1821 *Lunacy (Ireland) Act* resulted in establishment of district asylums (Kelly "Mental" 50-51).

1893 Report of Inspector of Lunatics (Ireland) observed the continued inadequacy of Irish District Asylums, noting: "We have again to repeat the statement made in former reports that the overcrowding is rapidly increasing, and that the necessity for further accommodation is becoming more and more urgent (Kelly "Mental" 52).

1945 *Mental Treatment Act, 1945* introduced and "aimed to address legislative deficiencies in mental health law and to strengthen the delivery of appropriate care to individuals with mental illness" (Kelly "Mental" 55). The Act introduced legislation for voluntary admission to asylums, mandated an inspectorate of mental hospitals and divided the country into mental hospital districts (Kelly "Mental" 57-8). The duty of the hospitals was defined as providing "'treatment, maintenance, advice and services'" to individuals within a district, along with the provision of suitable accommodation to carry out the functions of a mental hospital (Kelly "Mental" 57). In addition, persons charged with an "indictable offence" were to be transferred to Dundrum Central Criminal Lunatic Asylum (Kelly "Mental" 60).

1961 The Commission of Inquiry on Mental Illness established. It was concerned with "the size of the inpatient population" (Prior 86) and noted that "it will be clear that, in Ireland, mental illness poses a health problem of the first magnitude" and that there was "inadequate facility" and a "lack [of] purposeful activity and therapeutic atmosphere" (Prior 86). The Commission recommended "radical and widespread changes" to include a "combination of community services and short-time and long-term hospital care" (Prior 87). This Commission did not report until 1966 (see below).

1961 *The Mental Treatment Act, 1961* (Electronic Irish Statute Book) "simply amended some of the outdated language and procedures of the 1945 Act" (Prior 292).

1966 The Commission of Inquiry on Mental Illness reported in 1966 with recommendations for improvement “but very little happened as a result of this Inquiry” (Prior 293).

1973 The National Psychiatric Inpatient Reporting System was established, with the aim of publishing “detailed annual reports on admissions, discharges and deaths”. Unfortunately, inadequate funding was provided for the efficient carrying out of this task (Prior 94).

1981 The *Health (Mental Services) Act 1981* was passed but never came into force as it was thought “logistically too difficult to implement” (Electronic; Prior 90).

1984 *The Psychiatric Services - Planning for the Future* was published (Department). In spite of efforts to improve community care, this report found that the large institutions remained the main providers of psychiatric treatment, and often housed permanent residents who were in conditions that were “less than adequate because of overcrowding and underfunding”. The report also noted that “community facilities [were] relatively undeveloped”. An increase in community care was recommended (Prior 90).

1987 The Irish Minister for Health made a “shock and largely unexpected” announcement of plan to close two mental hospitals. Local communities and staff greeted this plan with “anger and outrage”, the result being that both hospitals remained open (Prior 91).

1992 *The Green Paper on Mental Health* (Department) was published, echoing much of 1984 *Planning for the Future.* Although in-patient numbers were reduced, it was noted that Irish “services [were] still heavily reliant on hospital beds” and the “Irish rates of hospital residence were twice those of France, Denmark, England and Wales”. There were fewer referrals in Ireland but patients were retained for long periods once they entered the asylums (Prior 94).

1995 The White Paper, *A New Mental Health Act*, was published (Department), acknowledging that the current legislation (*Mental Treatment Act 1945*) was not compliant with international law (Kelly "Hearing" 219). This White Paper included the formal presentation of the main issues of the 1992 Green Paper but omitted any mention of community treatment orders (Prior 95).

1999 *The Mental Health Bill 1999* (enacted 2001) was published. This predated the 2000 case taken to the European Court (see below). This appeal was decided in the applicant's favour and initiated the move to greater compliance in Irish mental health law (Kelly *Hearing* 245).

1999 The Irish Law Society published a "remarkably hard-hitting" report, *Mental Health: The Case for Reform.* This drew attention to basic problems in the *Mental Treatment Act 1945*, noting that changes were required to ensure compliance with the European Convention on Human Rights and the United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (Kelly *Hearing* 244).

2000 A landmark case in the European Court of Human Rights was brought by patient in Ireland claiming the absence of "automatic, independent review" (Kelly *Hearing* 245). A "friendly settlement" was agreed and the patient was compensated financially.

2001 *The Mental Health Act, 2001* was formally enacted, to be implemented in a phased fashion (Electronic Irish Statute Book). The Act being underfunded, the final elements of legislation were not implemented until Nov 2006 (Kelly *Hearing* 248). The Act emphasised freedom and human rights (Prior 292-3).

2001 In the international sphere, the WHO devoted its annual report to psychiatric treatment: *Mental Health: New Understanding, New Hope* (WHO 2001; Kelly *Hearing* 234).

2003 Amnesty International noted some progress in mental health care in Ireland, though commented that "both inpatient and outpatient care were inadequate, inconsistent and severely under-resourced" (Kelly *Hearing* 249-50).

2003 The last report of Inspector of Mental Hospitals noted 3,701 persons remained in inpatient care in Ireland, 55% of them being long-stay patients (Prior 101).

2003 The Mental Health Commission (established in 2001) started to operate, "protecting and safeguarding the civil rights of persons coming in contact with mental health services" and reviewing detention of involuntary patients (Prior 101).

2005 The WHO published a *Resource Book on Mental Health, Human Rights and Legislation.* By 2006, Ireland had made progress but was still not fully compliant with WHO standards (Kelly "Hearing" 280).

2006 *A Vision for Change: Report of the Expert Group on Mental Health Policy* (DHC *Vision*) was published, repeating much of the 1966 Commission of Inquiry and 1984 *Planning for the Future* (Department *Planning*). The 2006 report put greater emphasis on the "administrative and organisational structures" required to bring about change (Prior 103), these matters being absent from the two earlier reports. Community mental health was prioritised in this new report (Kelly *Hearing* 253). Implementation of the report's contents were "commonly criticised as being too slow", lack of resources being again a major impediment. A Monitoring Group was set up to oversee change, which was "highly critical of the failure of the health service to advance any of *Vision's* recommendations" (Prior 103).

2009 The College of Psychiatry of Ireland was established. It was renamed the College of Psychiatrists of Ireland in 2013 (Kelly *Hearing* 256). (Irish psychiatrists had previously been affiliated to the Royal College of Psychiatrists in UK and were reluctant to break these ties [Prior 97-98]).

2010 By this year, the "majority of admissions to inpatient care in the public sector were to general hospital units" not nineteenth century institutions (Prior 92). Long-stay homeless patients were slowly being transferred to residential accommodation in small units in the community (Prior 92). Prior notes there were 2,812 residents in Irish psychiatric hospitals and units, adding that "some

1,500 long-stay patients languish in the remnants of those large, older mental hospitals that have not yet closed and [which] in some cases . . . still admit acute patients to surroundings that are no longer fit for purposes" (Prior 105). Further, "it [would] take up to 2030 before all [long-stay patients] [were] discharged and the last of the nineteenth century public hospitals could close" (Prior 105).

2012 The Independent Monitoring Group noted that the implementation of *Vision* remained "slow and inconsistent" while "[e]xisting community mental health teams [were] poorly populated with an estimated 1,500 vacant posts" (Kelly *Hearing* 261). However, there was "evidence of many local and regional initiatives being developed in line with [*A Vision for Change*] (Kelly *Hearing* 261).

2015 The *Report of the Expert Group on the Review of Mental Health Act 2001* was published in March 2015 (Department). This review focused on "dignity" and "least restrictive care", in an attempt to bring Ireland into line with European, United Nations and WHO directives (Kelly *Hearing* 271).

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