

Introduction

Depression and Narrative

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“I did not think such anguish possible,” William Styron writes of the depression that almost killed him.¹ It is likely each sufferer has had some version of this thought. Worldwide, at any time, millions upon millions are enduring depression.² From the contours of private anguish to psychiatric, cultural, and epidemiological accounts, there is an urge to give an account(ing) of depression. As a “cultural reference point,” especially with the surge in memoirs since the 1990s,³ depression is as ubiquitous an object of lay and professional interest now as melancholy was over the centuries.⁴ However, even with depression frequently in the media and with new books and memoirs on the subject appearing all the time,⁵ it is still associated with stigma—an anguish added to anguish.

Why another book on depression? I would say that there can never be enough visibility for this illness⁶ or condition whose stigma causes the sufferer to dissemble and “pass,” forgoing needed treatment, or to withdraw from others in shame—a condition misrepresented by myths and stereotypes that inevitably color, and cover, our understanding. Why, then, depression and *narrative*?² Certainly poets such as John Keats and Jane Kenyon have addressed melancholy in lyric, seeking to understand “the bile of desolation” that darkened their lives.⁷ As well, innumerable papers on depression and bipolar disorder appear each year in the psychiatric and psychopharmacological fields, discourses their authors would be loath to describe as narratives. So what does narrative add to the conversation—to our knowledge—about depression?

For some, this question does not need to be asked. Across a number of disciplines today, narrative is seen as central in the constitution of

identity and culture. Oliver Sacks has written that “each of us constructs and lives a ‘narrative’ and . . . this narrative is us, our identities.”⁸ According to this argument for the centrality of narrative in identity formation, one can know oneself as a self only within the context of a (life) narrative. A person who has had an episode of depression might construct the following story of himself or herself: I was a happy child, but as a teenager I began suffering from anxiety attacks and long periods of sadness, and then I had my first episode of clinical depression as a young adult. Or a chronic sufferer might tell this story: I was abused as a child and my mother died when I was twelve, and soon afterward I had my first breakdown, and depression has plagued me since then. The narrative of the self is a (re)telling or plotting—establishing relations, causes and effects—of events that, in reality, simply happen one after another.⁹ One cannot feel well one day, numb and oppressed the next, suicidal after a few months have elapsed, hyperenergetic and driven to talk and flirt and drive up one’s credit card after a few more months, then “normal” again one day, without seeking a narrative explanation—the cycle of bipolar disorder, for instance, or the Christian narrative of sin, repentance, and redemption—in order to make sense of it all, to trace a single self through all these changes.

Jerome Bruner argues that the self is a story, “a product of our telling and not some essence”; stories “impose a structure, a compelling reality on what we experience.”¹⁰ Narratives mend the “breach in . . . ordinariness” (the latter itself involving stories of what can be expected, day after day), the breach that occurs, say, when one falls seriously ill or loses a family member to suicide; according to Bruner, narratives help one “to cope with it, . . . get things back on a familiar track.”¹¹ In this view, narratives stitch up the wounds resulting from traumatic events or simply unexpected change. Such views on the omnipresence of narratives, shaping our experience and our sense of who we are, can be found across a number of disciplines today.¹² Families and cultures, too, are seen as products of stories told and retold—stories sometimes generative, sometimes stultifying or even destructive.

For some, however, the question “Why narrative?” *does* need to be asked. Philosopher Galen Strawson has recently questioned what he terms the “narrativist orthodoxy.” He suggests that while there are many people “who are indeed intensely narrative . . . in their sense of life and self,” there are others, “non-narrators,” whose lives develop more like poems, who are not given to “storying”; and there are “mixed cases” in between.¹³ This dissenting position has been acknowledged by James Phelan, editor of the journal *Narrative*, who concedes that such dissent offers a corrective to “narrative imperialism,” addressing the “blind spots” of those who make “unsustainable extravagant claims” of the centrality of narrative in understanding identity.¹⁴

This debate between supporters of and dissenters against the narrative identity model might seem tangential to the concerns of a volume bearing the title *Depression and Narrative*. But it is an important context, I think, inasmuch as any reflection on depression and narrative—on narratives of depression, depression as a narrative—must engage with scholarship on life writing and particularly autopathography. Here, there is largely agreement on the centrality of narrative in (re)constructing a self and a life within or after illness. Writers such as Arthur Frank, David Karp, G. Thomas Couser, Anne Hunsaker Hawkins, Kathryn Montgomery, Arthur Kleinman, Hilde Lindemann Nelson¹⁵—working in and across the fields of sociology, social psychology, literary studies, medical humanities, anthropology, philosophy—all, in various ways, emphasize the preeminence of narratives (cultural, autobiographical) in shaping both the experience of illness and discourse about illness, indeed shaping professional understanding, medical knowledge itself. The same holds in the fields of disability studies and trauma studies, which, like illness studies, have burgeoned in the last twenty years or so¹⁶—all within a general trend in scholarship toward accepting the validity of personal narrative, both written and oral, as a source of knowledge. One can now read scholarship incorporating—indeed, building on—the author’s personal narrative of illness: for instance, Arthur Frank’s *At the Will of the Body* and David Karp’s *Speaking of Sadness* are exemplary scholarly works taking personal experience as a foundation for analyzing the narratives associated with cancer and depression, respectively. What is notable about the scholarship on narrative and illness up until now, however, is that it has largely addressed physical illnesses like cancer and AIDS;¹⁷ Karp and others who have written on mental illness, culture, and narrative are arguably in the minority,¹⁸ and this volume seeks to contribute to the redressing of this imbalance.

It is argued, then, that we should listen to personal narratives of illness and disability—really attending to them on their own merits, as opposed to using them in order to come to diagnoses and impose regimes of treatment—because such narratives give voice to the ill, the traumatized, and the disabled, those trying to make sense of catastrophic interruptions or shifts in their lives, and help them navigate the bewildering, impersonal context of medical diagnosis and treatment. As Hawkins puts it, the pathography “restores the person ignored or canceled out in the medical enterprise . . . places that person at the very center. . . [and] gives that ill person a voice.”¹⁹

From the perspective of the ill, disabled, and/or traumatized subject, then, taking up narrative is seen by many to be empowering, as it can be for cultures at traumatic junctures such as wars and natural disasters. However, there is an obverse side to this linking of narrative and identity: while telling one’s story, bearing witness, can be linked with enhanced agency,

it is also the case that the stories one tells are never entirely one's own. The poststructuralist view that identity and knowledge are socially constructed by dominant narratives can lead to the more skeptical conclusion that personal narratives—even the most heartfelt personal narratives of depression posted anonymously online—are always already ideological, shaped by myths and metaphors that, while they may vary from culture to culture and over time, have remarkable sticking power. Susan Sontag made this point about metaphorical constructions of tuberculosis, cancer and AIDS, arguing that these support “the excommunicating and stigmatizing of the ill”; in her view these constructions can and should be resisted, the ideal being “to detach [illness] from these meanings.”²⁰ Not so easy, however: in telling the story of cancer (in obituaries, for instance), one slips inevitably into battle mode, and every reader will understand. If one avoids the valiant battle, the story is no longer so readable or reassuring.

In telling the story of depression, other myths and metaphors prevail. Except in cases of suicide, depression is not fatal or only indirectly so: thus the teller will often draw on the quest or journey narrative, which organizes the real experience of depression (as it does that of other illnesses) into a story of trials, helpers, ogres, or sorcerers (often psychiatrists offering meds), and a return as a subdued but wiser person. These shaping myths are just about impossible to escape: as Fee puts it, “discourse is appropriated and lived out at intimate levels, [and] the deepest realms of somatic sensation and psychological suffering are intertwined with the technologies, knowledges, and stories of culture.”²¹ More than healing the self or bearing witness, these stories reproduce a dominant order that emphasizes certain identities (healthy, or physically ill) and marginalizes others (mentally ill). The experience of depression will be formulated by means of these stories unless the teller consciously “struggle[s] for rhetorical ownership of the illness.”²² It is doubtful whether this struggle can be won. In this view of narrative and illness identity, then, narratives can mystify; rather than empowering the self, they offer only the illusion of agency.

Another way of approaching narrative is to emphasize its limits—even its failure—in truly conveying suffering, especially that associated with personal and historical trauma. Here Strawson's skepticism is helpful: not all experience can be formulated in narrative form. Further, at traumatic extremes experience can be narrated only through a kind of aesthetic violation. “Transforming is what art does,” Susan Sontag asserts of photography conveying the horrors of war,²³ and narrative also involves the aesthetic transformation of suffering. Claude Lanzmann has suggested that the drive to tell and make sense of the Shoah is in itself a form of traumatic violation.²⁴ That narrative has limits—should have limits—is an ethical issue, one that must be acknowledged, I think, in any book addressing the subject of depression and narrative.²⁵

There is also a limit to what the reader will take in. What Sontag says of war photographs can be said, as well, of mental illness and trauma narratives: the audience may be overwhelmed and turn away: "Compassion is an unstable emotion. . . . The question is what to do with the feelings that have been aroused, the knowledge that has been communicated."²⁶ Some narratives are almost unreadable: they risk repelling the reader, who fears, via a process of emotional contagion, going under in turn.²⁷

Despite these limits, the authors in this volume are very much concerned with the possibilities and the problems of narrative—its kinds, contexts, motives, strategies, effects—in representing and interpreting depression (or bipolar disorder, or "madness"). Like those who work on physical illness and narrative, the authors in this volume work within (and often across) a range of disciplines, including social work, education, psychology, cultural and media studies, gender studies, literary studies, rhetoric, and philosophy. Particular issues recur in the essays, issues that come up generally in discussions of depression: its contested causes; its gendering; the shifts, ruptures, and adjustments in identity that it entails; the problems of communication and representation, the associated stigma and shame. The essays in this volume are grouped around some of these issues, and draw variously upon the perspectives on narrative identified in the first part of this introduction.

The five chapters in the first part, "Negotiating Illness Identity and Stigma," in different ways address the fact that a diagnosis of depression confers a particular identity, one that is stigmatized to a greater or lesser degree. These essays look at some ways in which sufferers construct their identities and lives (past, present, and future) so as to defend themselves against stigma and shame. In "My Symptoms, Myself," Jennifer Radden looks at two ways in which narrators of first-person illness memoirs construct the relation between personal identity and disorienting symptoms (such as delusions). These strategies she terms "symptom alienating" and "symptom integrating": in the former, symptoms "are depicted as emanating from alien, sometimes diabolical, sources of agency outside the self," whereas in the latter, "narrators 'identify with' their symptoms," accepting them as part of their identity. Radden traces these two models, and the philosophical issues they raise, through a range of (Western) mental illness narratives from the fifteenth century to the present. In "The Language of Madness," Debra Beilke, like Radden, focuses on the manner in which the sufferer interprets disturbing symptoms that threaten the integrity of the self. Beilke identifies strategies similar to Radden's, but she draws different conclusions about them. Focusing on recent memoirs by Kay Redfield Jamison and Kate Millett, Beilke suggests that Jamison distinguishes between her symptoms and her core self, seeing her symptoms as

an “outside force” alien to this core, and so is able to live with the diagnosis of manic depression. On the other hand, Millett makes no such distinction between symptoms and self; thus she must refuse to accept the diagnosis of manic depression, because to do so would be to see her self as “inherently flawed.”

In “Winter Tales,” Brenda Dyer looks more directly at depression narratives as such, focusing on the myths by means of which one recounts depression and constructs an identity as a depressed person. Drawing on Northrop Frye’s categorization, in *Anatomy of Criticism*, of archetypal story-types—comedy, tragedy, romance, and satire/irony—Dyer explores the particular attraction that comic (recovery) and romance (quest) plots have for writers of recent depression memoirs. While the comic plot allows one to imagine a self restored to health, a “happy ending” without further symptoms, the romance plot is more realistic for those with chronic depression who must find ways of acknowledging and living with their condition.

Picking up on this issue of the narrative and interpretive strategies by which one constructs a mental illness identity, Frederick White and I examine further how sufferers manage the shame and stigma associated with such an identity. In “Repenting Prodigal,” I look at poet William Cowper’s eighteenth-century memoir of madness, particularly his use of a “comic” conversion plot that interprets his experience of delusions and suicidal despair as a necessary stage in a return to God. As Radden would say, he alienates his symptoms, seeing them as visited on him by Satan and God. In this way he seeks to flee the shame of madness. Similarly, White traces the interpretive strategies by which, in his early diaries of the 1890s, the Russian writer Leonid Andreev tries to make sense of his ongoing struggle with depression. Looking outward to failed romances and the meaninglessness of life, and inward to a flawed self, he constructs versions of his experience that serve as the basis for his literary works.

This issue of how one interprets and constructs mental illness identities in narrative is taken up, in one form or another, in most of the essays in this volume. However, the chapters in the second part, “Gender and Depression,” focus more on the uses of narrative for depressed women, and particularly the ways in which certain gendered narratives shape the therapeutic culture. In “Storying Sadness,” Suzanne England, Carol Ganzer, and Carol Tosone suggest that one must examine women’s own accounts of depression if one is to see beyond “the grand medical-psychiatric narrative” and recognize the sufferer’s experience. The authors focus on common issues in women’s depression—body image, the father-and-daughter relationship, the imbalance of power in marriage—in the work of poets Sylvia Plath and Louise Glück, and memoirist Tracy Thompson. The authors assume, rightly I think, that a poetic oeuvre traces a life narrative as much as a memoir does.

Women's depression and addiction have different cultural meanings, argues Joanne Muzak in her essay "'Addiction got me what I needed': the female addict is taken more seriously, is seen as having a "real" and treatable disease, whereas the depressed woman "occupies a more ambiguous position." In the memoirs of Elizabeth Wurtzel, Muzak shows how addiction comes to "subsume" depression, presumably because addiction allows her to interpret and present her chronic suffering as a "real" problem. Wurtzel's personal narratives, like many others, demonstrate the impact of conflicting cultural narratives. Kimberly Emmons shows this conflict, too, in "Narrating the Emotional Woman," arguing that the gendered commonplace of the "emotional woman" shapes not only official discourse on depression but also the stories women offer to each other in exploring their common suffering. In mental health pamphlets on women and depression, Emmons traces the commonplace of feminine emotional excess and instability; and listening to depressed women, she concludes that such ideas are taken up by women in interpreting their own experiences of depression. In "Fact Sheets as Gendered Narratives of Depression," Linda McMullen does a similar exercise in a Canadian context, analyzing online "fact sheets" on postpartum depression and indicating the narratives of individual responsibility (that is, maternal blame) that underwrite the "facts." Looking in turn at personal narratives by women, McMullen concludes that, left to themselves, women see their suffering as brought about by social factors such as the isolation of new mothers and lack of family support. Interestingly, while Emmons sees women's personal narratives as ultimately incorporating cultural ones, McMullen sees the former as (at least potentially) resisting and correcting the latter.

What happens when narratives of depression fill internet blogs and discussion boards, and draw audiences to Hollywood movies and to TV? The authors in the third part, "Depression across the Media," look at what the different media bring to these stories. In "A Dark Web," Kiki Benzon suggests that internet publication can convey "the cognitive shifts and fissures" of depressive and manic thinking in a way that print publication cannot. On the internet, everyone can be an author; while the narratives vary wildly in quality, the "multitudinous narrative of depression" that goes on from day to day is an organic "cultural narrative" that, while it incorporates official constructions of causes, therapies, and so on, is much more than these. In a similar manner, in her essay "A Meditation on Depression, Time, and Narrative Peregrination in the Film *The Hours*," Diane Wiener sees the particular medium of film—with its possibilities for cutting and layering and interweaving different stories—as realizing the special temporality of depression, whose narrative is not linear but interrupted and wandering. The film *The Hours*, Wiener argues, offers a layered narrative of three women's experiences of depression that "complicates" linear narratives of cure and the regaining of one's former life.

In “Therapy Culture and TV,” Deborah Staines takes on the depressed mobster Tony Soprano, showing how the serial medium of the TV drama, in *The Sopranos*, can convey the seriality of psychiatric therapy itself, a complex “episodic narrative—a story about the experience of depression—over time.” After Freud, therapy has become so much a part of the Western cultural narrative that audiences watching *The Sopranos* are already, in their “psychologized and medicalized” existence, attuned to Tony Soprano’s serial depression and therapy.

In part 4, “Literary Therapies,” Andrew Schonebaum and Mark Clark take up the issue of therapeutic effect touched upon by earlier essays, here particularly focusing on therapy for the reader. In “For the Relief of Melancholy,” Schonebaum explains how the early Chinese novel presented itself as preventing melancholy in the reader, or mitigating symptoms, by representing melancholy characters, particularly frail young women, as models of an emotional excess to be avoided. As with any medicine, the dose has to be just right: ingesting too much of this literary antidepressant could make the reader even more ill; yet to be capable of healing, the novel must be potentially contagious. In Clark’s “Manic-Depressive Narration,” Coleridge’s *The Rime of the Ancient Mariner* is likewise presented as a kind of medicine for the reader—a devastating medicine. Clark argues that when the Wedding Guest is forced to listen to the Mariner’s tale, he is caught up in the dynamics of manic-depressive thinking; through this process he sees his own world, its social hierarchies and rituals, from the Mariner’s scorching perspective. Further, like the Wedding Guest, the reader of Coleridge’s poem cannot remain detached but is manipulated into a “deeply empathic” understanding of the perspective of the manic other.

This volume comes to a close, in part 5, “Depression and the Limits of Narrative,” with two chapters that treat the connection between trauma and depression, and how these manifest themselves in narrative symptoms of fragmentation, ambiguous perspective and temporality, altered syntax, and so on. In Geoffrey Hartman’s view, figurative language itself exemplifies the “perpetual troping of [a traumatic event] by the bypassed or severely split (dissociated) psyche.”²⁸ It seems that there is a limit to what narrative can tell—or tell via conventional means—about traumatized suffering. Yet the need to tell persists. In “Writing Self/Delusion,” Sophie Blanch looks at Emily Holmes Coleman’s *The Shutter of Snow*, her fictionalized memoir of postpartum depression, as an example of “scriptotherapy”:²⁹ an attempt to write herself free of the horrors of her hospitalization for postpartum depression. However, the wounds do not heal so much as insist in the form and language of the narrative. This insistence of suffering in narrative form itself is also the subject of the final chapter, Eluned Summers-Bremner’s “Depressing Books,” on W. G. Sebald’s haunting novels, particularly *The Rings of Saturn*. The author shows how its “circular, accretive structure”—

accompanying a mood of deep melancholy without an obvious or single cause—suggests the insistence of a traumatic past, a suffering both personal and historical. Like Clark on the reader of Coleridge’s *Rime*, Summers-Bremner argues that the reader of Sebald comes to “inhabit” the narrator’s melancholy perspective and gains new insight into the “defect in the human program,” the trauma at the heart of human subjectivity and history. Narrative can convey this wound—indirectly, and marked by the strain—but it cannot heal it. Ethically, in the context of human suffering, narrative is most authentic as it approaches, or reaches, its limits.

Notes

1. Styron, *Darkness Visible*, 63. Styron died of old age in November 2006.
2. See World Health Organization, *Investing in Mental Health* (2003): “Today, about 450 million people suffer from a mental or behavioural disorder. According to WHO’s Global Burden of Disease 2001, 33% of the years lived with disability (YLD) are due to neuropsychiatric disorders. . . . Unipolar depressive disorders alone lead to 12.15% of years lived with disability, and rank as the third leading contributor to the global burden of diseases. Four of the six leading causes of years lived with disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia and bipolar disorder)” (8). The Executive Summary points out that “those suffering from mental illnesses are also victims of human rights violations, stigma and discrimination, both inside and outside psychiatric institutions” (4).
3. Fee, “The Broken Dialogue,” in *Pathology and the Postmodern*, 12–13.
4. See Roy Porter, *Social History of Madness* (London: Weidenfeld and Nicolson, 1987).
5. On July 22, 2006, a quick check at Amazon.com (under “mental depression,” to exclude economic depression) yielded 8,182 results; ten months later, on May 17, 2007, a similar check yielded 9,157 results. The majority of these books appear to be self-help volumes (offering help in “wrestling with,” “beating,” “overcoming,” and “conquering” depression), the rest being memoirs and professional volumes. One can even find a *Depression for Dummies* (2003) and a *Postpartum Depression for Dummies* (2007).
6. For the most part, contributors to this volume assume there *is* such a thing as mental illness, that people experience mental illnesses just as they experience physical illnesses, and that they try to make sense of their experience and their suffering. It is also assumed that illness is not the same as disease. In *The Illness Narratives*, Arthur Kleinman defines illness as the “innately human experience of symptoms and suffering.” This experience is at the core of our understanding of illness, which is “always culturally shaped.” Disease is what the medical profession sees, “the problem from the practitioner’s perspective . . . an alteration in biological structure or functioning” (3–6).
7. Jane Kenyon, “Having It Out with Melancholy” (1993), line 5. See also John Keats’s “Ode to Melancholy” and “Ode to a Nightingale” (1819), and Charles Baudelaire’s “Spleen” (1857).

8. Sacks, *The Man Who Mistook His Wife for a Hat*, 121.
9. This recalls the narratological distinction between story and plot, where the story is the events as they occurred, and the plot is the (re)arrangement of these events.
10. Bruner, *Making Stories*, 85, 89.
11. *Ibid.*, 89.
12. Galen Strawson notes in his review "Tales of the Unexpected" the dominance of this narrative perspective in the humanities and social sciences, in "psychology, anthropology, philosophy, sociology, political theory, literary studies, religious studies and psychotherapy."
13. Strawson, "Tales of the Unexpected."
14. Phelan, "Editor's Column," 210.
15. See Frank, *The Wounded Storyteller*; Karp, *Speaking of Sadness*; Couser, *Recovering Bodies*; Hawkins, *Reconstructing Illness*; Montgomery, *Doctors' Stories*; Kleinman, *The Illness Narratives*; Nelson, *Damaged Identities, Narrative Repair*.
16. See Caruth, *Trauma*, and also Dori Laub and Shoshana Felman, *Testimony: Crises of Witnessing in Literature, Psychoanalysis, and History* (New York: Routledge, 1992). On disability and narrative, see Sharon L. Snyder et al., *Disability Studies: Enabling the Humanities* (New York: Modern Language Association, 2002).
17. Of course, the boundary between physical and mental is contested: the body and mind are interrelated in health, disease, and the experience of illness. However, for convenience I am using the common distinction between diseases such as cancer and AIDS, which affect the body and its systems (though often accompanied by psychological suffering), and conditions such as depression and bipolar disorder, not to mention schizophrenia, which affect moods and cognition (though often accompanied by physical suffering).
18. See also Dwight Fee, *Pathology and the Postmodern*; Ann Hudson Jones, "Literature and Medicine: Narratives of Mental Illness," *Lancet* 350.9074 (1997): 359–61; Roland Littlewood, *Pathologies of the West: An Anthropology of Mental Illness in Europe and America* (Ithaca: Cornell University Press, 2002); Arthur Kleinman and Byron Good, eds., *Culture and Depression* (Berkeley: University of California Press, 1985). David Morris writes on culture and depression in *Illness and Culture in the Postmodern Age* (Berkeley: University of California Press, 1998); Emily Martin writes on culture, depression and bipolar disorder in *Bipolar Expeditions: Mania and Depression in American Culture* (Princeton: Princeton University Press, 2007).
19. Hawkins, 12.
20. Sontag, *Illness as Metaphor*, 182.
21. Fee, 2.
22. Sontag, *Illness as Metaphor*, 181.
23. Sontag, *Regarding the Pain of Others*, 76.
24. Lanzmann, "The Obscenity of Understanding."
25. However, some authors in this volume might disagree with me on this point.
26. Sontag, *Regarding the Pain of Others*, 101.
27. See Hatfield, Cacioppo, and Rapson, *Emotional Contagion*, for a discussion of the phenomenon of emotional contagion in general. In teaching a course on women, depression, and writing, I have found depression narratives to be very

contagious: usually one or two students will become depressed enough to seek or reenter therapy. The instructor is not always immune, either. Two depression narratives that I have found to be particularly unreadable (in the sense of contagious) are John Bentley Mays's *In the Jaws of the Black Dogs: A Memoir of Depression* (Toronto: Penguin, 1995) and Marie Cardinal's *The Words to Say It*, trans. Pat Goodheart (Cambridge, MA: Van Vactor & Goodheart, 1983).

28. Hartman, "On Traumatic Knowledge and Literary Studies," 537.

29. "Scriptotherapy" is a term Suzette Henke uses in her book on women's trauma narratives, *Shattered Subjects: Trauma and Testimony in Women's Life-Writing* (New York: St. Martin's Press, 1998).

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