

Mount Saint Vincent University
Department of Women and Gender Studies

“Making Women Mad”

by

Courtney MacDonald

A Thesis

Submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Women and Gender Studies

September 2019

Halifax, Nova Scotia

© Courtney MacDonald, 2019

ACKNOWLEDGEMENTS

The completion of this thesis could not have been possible without the involvement and assistance of so many people whose names may not all be mentioned here. Their contributions are genuinely appreciated and acknowledged with gratefulness.

To my Thesis Supervisor, Dr. Randi Warne for providing support, encouragement, and the scholarly basis for my graduate studies. Ultimately, for her insistence on my success, I am forever thankful. To my Second Reader, Dr. Meredith Ralston for offering thorough suggestions and encouragement throughout the thesis revision process. To my External Examiner, Dr. Valda Leighteizer for her thought provoking questions during my thesis defense. To Phoebe Smith, Administrative Assistant, for her bright smile and continued encouragement along the way.

To the library staff of Mount Saint Vincent University. Your skills and assistance has been so important to the production of my thesis.

To the donors of the John Ardenne Memorial Endowed Scholarship for Women who have helped me pay my tuition through two generous financial donations within the course of my graduate degree.

To Registered Nurse, Steve Kelly for encouraging me to go on to graduate studies, and providing support during my university and professional work.

To some of my coworkers, and especially “The Ladies” who I have had the pleasure of supporting over the last decade. They are true psychiatric survivors, and a great inspiration to me.

To all of my family, especially my spouse, Craig O’Leary for his understanding and encouragement. To my parents, Paula and Weldon MacDonald, who have always supported me and my education, and have helped with my tuition. To my brother, Matthew, my sister in-law, Amanda, and my amazing nephew, Christopher who was born during the completion of this degree, and who has continued to be a source of happiness in my life.

To my closest friends, Laurel Walker, Ashley Gosse, Sarah Hornsby, Danielle Goyetche, Angela Hendsbee, Linda Bent, and my classmate, Terri Roberts who have been with me since day one of this journey, I cannot thank you enough for standing beside me and cheering me on even though you have faced your own struggles. You are all strong, determined, and hardworking women who inspire me daily.

To my grandmothers, Lucinda (Lucy) Griffiths and Joan Daigle, my cousin, Ryan Kidson, and my aunts, Gail Griffiths and Charleen Kidson who have since passed away, I thank you for your love, and the important roles you have played in my life.

I sincerely thank all of you.

ABSTRACT

“Making Women Mad”

In this thesis, I look at the complicated business of “Making Women Mad” through a feminist and gender aware lens, with an interdisciplinary approach to examining women’s narratives of psychological oppression and resistance in an autobiographical short story and one book. I draw on women’s written experiences from the Victorian Era of Charlotte Perkins Gilman’s “The Yellow Wallpaper,” and her personal treatment by Silas Weir Mitchell’s “The Rest Cure,” Kate Millett’s personal narrative as told in her book having taken place in the 1970s and 1980s, *The Loony-Bin Trip* where she chronicled her struggle with navigating the social and healthcare system which was concerned with “madness,” and my experiences in the 21st century, living and working within the mental healthcare system with those charged with real mental illness and the social and cultural construct of “madness.” I base this on the theory of the “misbegotten man” and Aristotelian views that women possess innate flaws directly due to their defective biology from the moment of conception. These flaws and defects occur at every stage of women’s naturally occurring stages of biology, therefore their whole being has been pathologized. The new and emerging field of “Mad Studies” will be paid attention to, along with issues of violence and stigma. In conclusion, I present my personal remarks and a path forward as a way to provide information based upon experience and hope for the future of women’s healthcare and mental and physical well-being as a means of resistance, the restoration of agency, and empowerment.

Table of Contents

Chapter 1: “Making Women Mad”	1
Introduction	1
My Experience Early on	3
The Relevance of Experience- Mad Studies	6
Chapter 2: Gender Ideologies	8
Women as the Embodiment of Pathology: Defective, Dangerous, Necessary	8
Life Cycle Applications: 19th Century Diseases of the Woman's Natural, Developing Body..	10
Girlhood- “Green Sickness”	11
Puberty and the Emergence of Hysteria	12
Pregnancy and Reproduction	18
Menopause	19
Chapter 3: Charlotte Perkins Gilman and “The Yellow Wallpaper”	22
Enforcement of the Separate Spheres Ideology- Seclusion and Silencing	26
“The West Cure” for Men.....	28
Chapter 4: Kate Millett and The Loony-Bin Trip Brilliance, Craziiness, Mess; Feminist Solidarity has its Limits.....	31
Reading “Madness”- the Issue of Contrary Narratives	34
Chapter 5: Personal and Professional Experiences	44
Lithium- a Case in Point	45
Violence and Stigma.....	50

Chapter 6: Conclusion.....	53
Conclusion	53
Personal Remarks and a Path Forward	54
Bibliography	59

Chapter 1: "Making Women Mad"

Introduction

The title of this thesis is "Making Women Mad." The term "mad" has two main meanings, both relevant to this thesis. In the common sense, to "make someone mad" means to make them angry. People "lose their temper, " "fly off the handle," even "flip out." Anger is associated with intense emotion, something apparently particularly dangerous in women, as we shall see, as women have no rational core to focus that anger and ground it in something real and meaningful. "Madness" is also another term for insanity - not sane, not rational, not self-controlled. This thesis is going to explore how cultural assumptions about female mental instability have played out in relation to two significant feminist thinkers and actors, both of whom were diagnosed with a form of "madness", and both of them subject to strategies of silencing. Cultural control of women continues to be a key site of feminist analysis for good reason. The context and strategies of containment may change from era to era, but the practical effect remains.

"Madness" must also be understood as a social construct. Social anthropologist Clifford Geertz provides a useful set of tools for understanding the persistence of this plural construction of "mad" women. His influential articles on cultural systems illustrate how concepts are instantiated within complex social systems as myths and symbols, and then ritualized in common human practice. Gender can be viewed as a cultural system as well, with its own, myths, symbols, rituals, and ethics and values (Warne: 2001). "Madness" is thus a value-laden description grounded in social assumptions and practice.

The thesis will undertake the analysis of the making of madness in women in three historical "moments". The term "moment" implies a context that is era-specific in many of its

elements, but is overall representative of a common assumption that "women" are inherently flawed, even dangerous. The first moment considers the late Victorian practice of "The Rest Cure", an enforced regime of immobility designed to resolve the malaise or despair of intelligent women, some of whom were experiencing post-partum depression. Charlotte Perkins Gilman's "The Yellow Wallpaper" is one account of that treatment. The second moment addresses the multiply conflicted experience of a once-revered feminist writer of the 1970s, whose *Sexual Politics* (1970) influenced a whole generation of feminist activists, but whose later mental instability (bipolar disorder) and bisexuality were unsettling to the "dress-for-success" iteration of "woman power" in the affluent 1980s. The third moment is contemporary. The late 20th and early 21st century have heard an explosion of voices from the margins. One late and welcome voice in this mix is found in the emerging field of "Madness Studies." Located materially in Canada, at Ryerson University, a whole school of inquiry is challenging conventional wisdom about "madness", "the mad" and who can and ought to speak as representatives of that world. Like women through much of history, "the mad" have been silenced, and/or spoken about by others. In Madness Studies, "the mad" speak for themselves.

The thesis concludes with a prescription, a "Path Forward. " It is based both on the scholarship here, and on my lived experiences working in multiple professional locations, and as a woman subject to Canadian medical practices of early 21st century. This final section of the thesis, "The Path Forward," envisions what needs to change to make mental health care less abusive and more humane.

Because this thesis is interdisciplinary, a strict discipline-based literature review is not possible. Rather, intellectual resources have been drawn from a range of sites across several disciplines. This is in keeping with the "cultural systems" model found in Geertz, and also with

feminist analysis overall. If the depiction, articulation, and justification of women's "difference" is undertaken across the board of a range of historical and cultural/intellectual sites, no one body of academic literature may be sufficient, especially when involving an emerging new field (here, "Madness Studies"). One caveat - issues of class and race are not foregrounded. Prescriptive literature about women in western culture invariably take the allegedly "highest specimen" as normative. Much as the male is the norm from which the female deviates, so too the white female has been seen as the norm for all women. Clearly, that should not be the case, as an intersectional approach asserts. Marginalized voices across a range of cultural sites are now being heard more fully, including in contemporary areas of study, of which Madness Studies is one.

My Experience Early on

My work as a Graduate Women and Gender student did not start when I was accepted into the program at Mount Saint Vincent University. In truth, the core of this work started eighteen years earlier, when I was an undergraduate student in the brand new (at the time) Cultural Studies Program. One of the courses that has been critical to my knowledge and interest today was Religious Studies 3308 Women Religion and Social Change taught by my now thesis supervisor, Dr. Randi Warne. My interest in the subjects covered, particularly in regard to gender ideologies and women's minds and bodies, has remained keen.

After completing my undergraduate degree, I have worked with girls and women in many capacities, including working in a family resource centre and a collection of small options homes for individuals with diagnoses of mental illness. In those roles I was required to handle many difficult situations. Over time, I concluded that I needed to return to school to build upon my experiences, acquire new insights, and to learn new approaches to working with girls and women

in marginalized positions. I enrolled in the joint Graduate Women and Gender Studies program at MSVU, taking stimulating core courses, like *The History of Feminist Thought*, and also directed studies like “*The Trouble with Normal*.” In that frame, my initial intent was to do a graduate thesis on Drag culture, but I soon realized that it was not a field of study in which I wanted to invest my efforts. I struggled with not being excited to do this research and writing, but did not know why. It then came to me to question what I wanted to change. My answer was “nothing.” I did not want to change a single thing about Drag Culture, nor did I feel I had any right to. I did not belong to the Drag community, I had no ties, no insights. I was not situated there. I was an unknowing outsider peering in at this subculture. After this realization, I was flooded with ideas and the realization that, after almost 15 years of experience working with marginalized girls and women, this was what I knew. I know the madness of which we will be speaking about throughout this thesis. I belong here due to my personal and professional experiences. I have “insider knowledge” that – handled carefully and respectfully – could be brought into conversation with academic analyses of women’s lived experience of marginalization due to their sex and mental status.

Then came “Madness Studies.” After most of my research and much of my writing was completed, I was made aware that a whole genre of academic inquiry was emerging. Based on the conviction that personal experience is intellectually and analytically significant (the old feminist claim that “the person is political”) others are now writing about what I’ve been experiencing and thinking for some time now. What others are saying, therefore, has bolstered what I have been saying. I truly did not have a direct plan for my thesis. It really took on its own shape from where I have been situated as a knower.

In terms of being situated as a knower, feminist standpoint theory must be mentioned at this time. From its beginnings in the 1970s to its rapid growth in the 1980s with influential feminist

thinkers such as Sandra Harding, Nancy Hartsock, Dorothy Smith, Patricia Hill Collins, and Susan Hekman producing critical texts leading up to 1997 with the collections of works in Hekman's *Truth and Method: Feminist Standpoint Theory Revisited*, the resulting dialogue coming from collective discussion of feminist standpoint theory has been extensive. Standpoint feminist theory is an interesting and fascinating theory and methodology due to its complexities, tensions, and debates. It has potential powers to gain critical insight into the material conditions of women's lives advancing theory and practice in ways that can be transformative in both locations. According to Caroline Ramazanoglu and Janet Holland, authors of *Feminist Methodology: Challenges and Choices*, "The notion that 'women speaking their truth' results in new knowledge of gendered social lives, grounded in women's experience, is a central theme of conceptions of a feminist standpoint, but that is not a simple or agreed notion" (Ramazanoglu & Holland: 2002, 64). If methodology is a theory and analysis of how research should proceed (Harding: 1987, 2) it makes sense that it should start from women's experiences given that feminism is a political movement for social change (Harding: 1987, 182). This thesis is based on women's experiences, including Charlotte Perkins Gilman, Kate Millett, and mine and the women I work with.

"Madness Studies" is where this thesis is also located. It is related to an earlier and essential focus of scholarship on "disability." Traditionally, "disability studies" focused on questions of "accommodation," specifically, how "dis"abled (rather than "differently abled") persons could more easily fit (or be fitted into) conventional social and material structures. The norm – the "normal" – remained the unquestioned centre, though greater attention was paid to ease of adaptation. In *Rethinking Normalcy*, (Titchkofsy and Michalko: 2000), that position was foundationally challenged. Numerous articles signal the shift: Kudlick, "Disability History: Why We Need Another 'Other'; and Titchkosky, "Disability Studies: the Old and the New; Garland-

Thompson, “Disability, Identity, and Representation: An Introduction” all draw attention to a new theoretical frame. Hansen and Philo’s “The Normality of Doing Things Differently” claims new political ground. Still others apply the new Disability Studies to the further marginalized within that community: on women (O’Toole); on Indian Feminism (Ghai); and on Queer subjects (McRuer).

The Relevance of Experience- Mad Studies

As the discussion above suggests, new stories need to be told not only *about* the marginalized, but also *by* the marginalized, about themselves. “Mad Studies” is a new way of thinking and giving voices to the oppressed coming out of the new initiative based at Ryerson University in Toronto, Canada. *Mad Matters: A Critical Reader in Canadian Mad Studies* (LeFrancois, Robert Menzies, and Geoffrey Reaume: 2013), is a collection of these stories and analyses. Historical legacy is important, as contributing author, Louise Tam writes: “The Mad movement and Mad Studies have arrived where they are today from more than five decades of resisting against ‘psy’ knowledge (destabilizing diagnostic categories, naming psychiatric violence, resisting pathologization, and creating countercultures)” (Tam: 2013, 12). The editors go on to say that “Mad Studies follows in the footsteps of various other classes of “studies” that have established themselves in recent decades- among them, labour studies, women’s studies/ gender studies, LGBTQ studies, equity studies, sexuality studies, black studies, disability studies...” (*Mad Matters*, 12).

Mel Starkman’s article elaborates the current initiative’s historical origins:

The mental patients’ liberation movement can trace its beginnings to several sources. Much of its emphasis on conscious-raising derived from the feminist movement. Particularly from the movement’s realization of the folly of medical treatment for so-called “neurotic” symptoms. For example, in Canada in the 1890s, a Dr. R.M Bucke, Medical Superintendent of London Psychiatric Hospital performed gynecological operations to relieve “hysterical” symptoms in women. He saw a close connection between gynecological deformities and

psychiatric conditions, and he was far from alone in this belief [...] in the 1960s, women began to reject such treatment, seeing it as harmful, oppressive, and sexist (Starkman: 2013, 27-28).

It makes sense that the feminist movement would have such influence. Women such as Charlotte Perkins Gilman and Kate Millett, both strong advocates for the physical and mental well-being for women were working on such issues of oppression and sexism well before and after 1960.

Even though Millett was being treated during the time of antipsychiatry backlash in the 1970s and 1980s signaled by R.D Laing and others, in practice, feminists were still not likely to be treated well in psychiatric contexts. This includes not being believed, not being understood, and being vulnerable to punitive measures from the past. Given all the other changes that had taken place since the mid-19th century, why was the treatment of women still so grounded in disrespectful constructions of their agency (or lack thereof)? One clue is given in the main definition of Mad Studies: “Mad Studies can be defined in general terms as a project of inquiry, knowledge production, and political action devoted to the critique and transcendence of psy-centred ways of thinking, behaving, relating, and being” (LeFrancois, Menzies, Reume: 2013, 13). The sole authority of the external judge (in this case the doctor or psychiatrist) needs to be challenged, and a broader view sought. This leads to another point that is critical to the understanding of madness as a complex system requiring viewing through multiple lenses, yielding a full and accurate picture of the issues at hand: “by its very nature Mad Studies is an interdisciplinary and multi-vocal praxis. From its beginnings, resistance against psychiatry has germinated in a multiplicity of sites, and it has involved people from every conceivable social position and walk of life” (LeFrancois, Menzies, Reume: 2013, 13). Religious Studies, Cultural Studies, Women’s Studies, and Women and Gender Studies all play integral roles here as interdisciplinarity allows.

Chapter 2: Gender Ideologies

Women as the Embodiment of Pathology: Defective, Dangerous, Necessary

Women exist but they have never been the norm for all humanity. They are always in a special category. There are two major forms this takes in western culture. *The Classical View* advanced by Aristotle and held to firmly throughout the many centuries of western Christian and non-Christian thought, claimed women and men are different in degree. Aristotle's theory confidently asserts that the male is the superior form of the human. Warne cites Lacquer's description of the "one sex/flesh" model of humanity in which "Women were essentially men in whom a lack of vital heat - of perfection - had resulted in the retention, inside of the structures that in the male are visible without...[thus] women are but men turned outside in"(Laqueur in Warne "Gender," *Guide to the Study of Religion*, p. 143). Women are thus deficient by definition, with the implication that any attempt to assert women's equality with men is, quite literally, insane. Tuana elaborates: "Because woman has less heat, she is smaller and weaker than man and far more influenced by the dictates of her passions and emotions" (Tuana: 1993. 18). Tuana continues: "Always emotionally volatile, she is more apt to scold and Strike. She is, furthermore more prone to despondency and less hopeful than the man, more void of shame, more false of speech, more deceptive, and of more retentive memory" (Tuana: 1993, 18-19). Clearly and firmly, woman has been viewed as an improper form of what a human "should" be. Taking this a step further, "Aristotle labeled her a "monstrosity," having defined a monstrosity as a "departure from type" (Tuana: 1993, 19). There was tremendous danger in that premise because when an archetype for "normal" was established, expected, and forcibly demanded, girls and women were made "Other"

and this perceived sense of difference was not one to be celebrated. Instead it was pathologized and treated (punished) following the thinking that it was “for her own good.”

In contrast, the second view, *Separate Spheres*, saw women as sufficient, within specific limits. This gender ideology emerged out of the social, economic, and scientific changes brought with “modernity.” This ran alongside the traditional Aristotelian, then Christian, notion of women’s deficiency and potential perversity. The ideology of “Separate Spheres” constructed men and women as different from one another, but in *kind* rather than degree. Both males and females were worthy, but only in their own natural and biologically determined areas of competence and responsibility.

Essentially, women were “internal” and men were “external.” Men dominated in the public sphere of politics, economics, the professions, indeed all forms of public decision making. They did so because they were Rational. Their rationality allowed them to be objective unburdened by personal feelings in what would be best for everyone. They were the authoritative speakers in the public sphere. Women too had a voice, in “The Home.” Women were rightly child bearers, nurturers, moral, spiritual, intuitive, gentle, and passive supports. They “ruled” by moral suasion, by appealing to men’s “better natures.” They did not, however, have direct power, not even over their own children.

It is important to note that, as with Aristotle, only the “ideal” versions of the human - the upper, “superior” class - enjoyed these distinctions. Where slaves were not truly human, in Aristotle's system, servants, working folk, and peasants were all relieved of the burden of the distinction of spheres, as they were expected to labor for their “betters” wherever they found themselves.

Life Cycle Applications: 19th Century Diseases of the Woman's Natural, Developing Body

Both gender ideologies are present within the developments of 19th century science that forms the foundation of contemporary psychiatry. It is useful to consider the normalization of the female body (and mind) as inevitably pathological. Pathology can be described as a scientific study of disease which is any abnormality that causes changes in the structure or function of the body. With women, there was no marked change because these abnormalities were considered innate; therefore, the only level of change resided in the stages of life. That is, women's lives were understood as a series of ongoing abnormalities. Women's "normalcy" was pathologized.

Due to these perceived weaknesses, women faced a special set of circumstances and were subjected to a wide variety of medical treatments, that in some cases were more harmful than helpful. While we now have the benefit of hindsight to fuel our investigation, and must keep in mind that theory, by nature, is ongoing, we also know that as scientific and medical theory changes, so do the implications for those involved. Randi Warne reminds us that "ascribing gender- the distinction of humans into "women" and "men"- is an ancient and ubiquitous practice. While there are cultures in which gender ascription is weak, there are no known cultures within which gender ascription is entirely absent. Gendering is thus a common and multifaceted human cultural strategy, with implications for, and imbrications within, human social institutions" (Warne 2001: 141). Because gender ascription within Victorian culture was so prominent, it makes sense to pay attention to the stark differences between female and male gender distinctions and the cultural manifestations of privilege and inequality.

It is also important when exploring treatments of girls and women within the context of nineteenth-century medical discourse to resist the notion that this population of people were strictly limited to the role of victim and did not assert their individual and collective power over such

forces. According to feminist epistemologist, Sandra Harding, “Victimologies have their limitations too. They tend to create false impressions that women have always been victims, that they have never successfully fought back, that they cannot be effective social agents on behalf of themselves or others [...] Women have always resisted male domination” (Harding: 1987, 85). Resistance requires considerable stamina, however, and it is undercut when one’s whole natural bodily life-cycle is pathologized.

Girlhood- “Green Sickness”

In a material sense, the preoccupation with the female body began in girlhood with an affliction known as green sickness, “the special anemia of young women”, or “the disease of virgins”. According to Helen King, “the earliest use of “green sickness” ...dates back to 1559, when the disease is explicitly called “a new disease” but is not yet linked to menstrual suppression, nor seen as a condition found only in young girls [...] but recommended remedies suggest that it is already seen as exclusive to women” (King: 1996, 376). Her findings suggest that this occurrence was less about illness and more about a social construction targeted at girls. Some of the symptoms included, but were not limited to, lack of energy, shortness of breath, dyspepsia, headaches, low appetite, and amenorrhea. Although some medical writers described patients visibly turning green in appearance, King suggests that “the English name “green sickness” may simply allude to the youth of the typical sufferer, rather than to a green hue” (King: 1996, 374). During this time of youth and transition, girls were warned of the evident physical and mental health risks they could be exposing themselves to. Early medical theory suggested that until a girl started menstruation, her humours built up in the womb festering and causing a whole host of health problems. In efforts to speed up the process of puberty, the use of herbs which stimulated blood flow in the pelvic area

and uterus were used to provoke menses. Herbal methods were so widely and frequently used that they were found in home recipe books.

According to King's research of the medical literature:

An excess of blood, due to “food and the growth of the body,” is unable to escape because “the mouth of exit” is closed. It therefore moves up the body, becoming stuck at the heart and diaphragm, where the internal channels through which it must pass are believed to be “at an angle.” It then exerts pressure on the heart, presented here at the seat of consciousness. This causes mental disturbances; in particular, seeing ghosts and desiring Death as a lover, sometimes resulting in suicide by hanging or drowning. Relief comes when there is no obstacle to the flowing of the blood; the recommended therapy is marriage, for if they become pregnant, they will be cured” (King: 1996, 379).

Girls and their virginity were thus pathologized. In Chleiner’s words, “Virginity is depicted not as a quality that elevates a woman, but one that makes her unnatural and diseased” (Chleiner: 2009, 666).

Puberty and the Emergence of Hysteria

The next stage of female life was also precarious: “At puberty, girls were advised to take a great deal of bed rest in order to help focus their strength on regulating their periods- though this might take years. Too much reading or intellectual stimulation in the fragile stage of adolescence could result in permanent damage to the reproductive organs, and sickly, irritable babies” (Ehrenreich & English: 1979, 127). Already, girls were being groomed for their “womanly duties”, advised to rest, and told to avoid intellectual stimulation as it would be to their own, and their future baby's detriment if they did not adhere to this advice. Taking it a step further, more advice was given to girls in terms of isolation and intellectual restrictions: “All heavy exercise should be omitted during the menstrual week... a girl should not only retire earlier at this time, but ought to stay out of school from one to three days as the case may be, resting the mind and taking extra

hours of rest and sleep” (Ehrenreich & English: 1979, 111). Even from an early age, girls were both discouraged from engaging in intellectual pursuits and groomed for pregnancy and motherhood as befitted their “proper sphere”.

After adolescence and the onset of menstruation, a diagnosis of hysteria in many cases was sure to follow. As Tuana has clarified, “The term hysteria as defined by classical medical theory is a disorder of woman caused by disturbances to the womb. The view is reflected in the etymology of the term, since its root is the Greek word *hysteria*, which means uterus” (Tuana: 1993, 93). Regarding hysteria, Ehrenreich and English stated that “Hysteria appeared, not only as fits and fainting, but in every other form: hysterical loss of voice, loss of appetite, hysterical coughing and sneezing, and, of course, hysterical screaming, laughing, and crying. The disease spread wildly, yet almost exclusively in a select clientele of urban middle- and upper- middle-class white women between the ages of fifteen and forty-five” (Ehrenreich & English: 1973, 40). Additional symptoms of hysteria not listed above included, but were not limited to: faintness, nervousness, excess of emotion, irritability, muscle spasm, lack of appetite, either sexual desire or lack of sexual desire, holding one's own opinions of prescribed gender roles, and speaking on behalf of one's own healthcare.

Just as there were herbal remedies used to treat the ailments of adolescent girls, there were also several herbs and remedies used to treat the symptoms of “hysteria” in women. Lavender and pennyroyal were given to women to calm “hysterical” fits. In addition, smelling salts were used to bring around women who had passed out. Valerian was given after “hysterical” women collapsed. This was given as soon as the woman was revived enough to swallow. Also, opium which was used by pharmacists and prescribed as over the counter medicine was sometimes used as a pain reliever for menstrual pain. Hysteria was a catch-all diagnosis in the sense that anything and

everything deemed “abnormal” (female) behavior constituted pathology and was grounds for treatment whether it was wanted or not.

As noted above, early scientific views held that the uterus had a powerful effect on women's bodies, and almost all ailments were believed to have originated from, or had been caused by the uterus. Physicians maintained that the uterus could become dislocated and move around the body causing a wide variety of problems. Often, intercourse and pregnancy were prescribed as cures because it was believed that a lack of intercourse could cause disruption to the uterus causing it to become cold and dry due to the lack of moisture from male seminal fluids. Greek philosopher and physician, Hippocrates claimed that “The womb, deprived of such fluids, would dry up and, especially when was “heated” from exertion, would go in search of such moisture within the woman's body; hence, a wandering womb” (Tuana: 1993, 93-94). This occurrence was considered dangerous, but once again, controllable by engaging in sexual intercourse and pregnancy.

Hysteria was also labeled a mental condition in the nineteenth-century. One theory stated that “The human body was a closed system containing a fixed quantity of energy. If energy in one part of the system was expended, there must be a corresponding depletion in another part” (Tuana: 1993, 98). This theory served to discourage women from engaging in all intellectual pursuits in favor of a life dedicated to focusing all energies on reproductive functions as this involved a great deal of care and concern because it was believed to be women's “purpose”. A widely held belief by physicians, according to Tuana was that “Woman's nature, her supposedly greater role in reproduction, makes her more vulnerable to insanity, but any attempt on her part to defy her “nature”, perhaps striving for an education equal to that of a man, would also bring about a mental breakdown” (Tuana: 1993, 100). Although reproduction and education were both believed to make

a woman unbalanced (or more unbalanced), reproduction was expected and even enforced by various means and methods while education was forbidden.

Women's sexuality was also considered problematic. Women were considered to be “too easily stimulated, leading to a loss of moral and mental capacities” (Tuana: 1993, 104). This thinking echoes firmly established ideas of the past that have claimed that women had a defective and less developed faculty of reason and were more prone to passion and emotion than men. Unharnessed sexual desires were said to have led to significant womanly health issues. The trouble was that the only religious and socially acceptable space for women's sexual outlet to take place was within heterosexual marriage; and even then, sex was less about pleasure, and more about human procreation. For physicians and husbands, “Their prescription was that woman should not deviate from her proper role of wife and mother in order to protect her mental well-being” (Tuana: 1993, 104).

One striking contradiction here was that even during a gynecological exam, there were concerns from men that women would enjoy the insertion of the speculum in a sexual manner, and that pleasure was equal to the moral deficiency of prostitutes (used as a derogatory term within this context). This is an obvious double standard given that men were able to seek outside pleasure from paid women and mistresses even within the confines of marriage. Also, it is possible that men could indulge in premarital sex with servants and women they paid for sex from while women were expected to remain pure and virginal until marriage. Men could have claimed what I will call “moral immunity” to indulge in their sexual pleasures in various ways while women did not have such privilege of choice without significant social punishment. It was “men’s nature” to be sexually “vigorous”, later explained in biological terms as “necessary” for the growth of the human race.

During this time and onward, surgery was recommended as treatment for women's supposed psychological pathologies and included such practices as the use of leaches on the vagina and inserted into the uterus, injection of poisonous liquids, clitoridectomy which was removal of the clitoris with the goal to destroy the nerves and deaden sexual desires, hysterectomy, and the removal of the ovaries. During this time, the ovaries were considered to be “the most powerful agents of woman's mental, moral, and physical qualities, and [male physicians] stressed the destruction they could cause when disordered [always in some form or context]” (Tuana: 1993, 105). Physicians went to great lengths to attempt to tame and control women's minds and bodies for the “good” of society.

Women also needed to be convinced that they were sick and in need of male care. The majority of treatments required women to have recovery time to recuperate from them. Working-class women did not have the ability to do so, so a good deal of treatments were not designed for them. As Ehrenreich and English point out:

Still, however sick or tired working women might have been, they certainly did not have the time or money to support a cult of invalidism. Employers gave no time off for pregnancy or recovery from childbirth, much less menstrual periods, though the wives of these same employers often retired to bed on these occasions. A day's absence from work could cost a woman her job, and at home there was no comfortable chaise lounge to collapse on while servants managed the household and doctors managed the illness (Ehrenreich & English: 1973, 46).

By necessity, working-class women proved that some women were often able to work or continue to work while menstruating, during pregnancy, directly following childbirth, and into menopause. This distinction makes a clear case that the collective actions of affluent Victorian women were indicative of a lifestyle rather than genuine pathology, and suggests that this behavior emerged out of strict Victorian ideals. It is important to note that white, elite women were seen as simply more “evolved” than lower class women of any colour.

What was considered to be “The Cult of Female Invalidism” provided the base for the cycle of women's reliance on, and obedience to husbands and physicians. In brief description, female invalidism stemmed from the deep-rooted beliefs that women were, by nature, weaker than men. This perceived weakness was seen as rendering women incapable of taking care of themselves without the help of men. Moving beyond the material conditions of these women's lives, we must also consider the message that was being accepted, proliferated, and the impact it had on women.

In short, and by no means complete, the message was reinforcing the belief that women were by nature, weak, frail, irrational, and diseased. Charlotte Perkins Gilman spoke to this when she claimed that “American men have bred a race of women weak enough to be handed out like invalids; or mentally weak enough to pretend they are- and to like it” (Gilman, in Ehrenreich & English: 1973, 19). This quote is significant and powerful given the implications and consequences it carried. In terms of consequence, “For the doctors, the myth of female frailty thus served two purposes. It helped them to disqualify women as healers, and, of course, it made women highly qualified as patients” (Ehrenreich & English: 1973, 22). By maintaining the myth of women's weakness as a deterrent to intellectual and educational pursuits, some women may have been convinced that their limited capabilities and chronic illness made escaping the sick role seem like an impossible task to accomplish.

Excluding women from the profession of medicine was consistent with separate spheres (women could nurture in the home, but not publicly), and also with the Aristotelian notion of women's innate inferiority. Women were simply not competent. Excluding women from medicine was necessary because they could not handle the intellectual demands necessary to becoming physicians, and it would be harmful to them if they tried. The case was made quite patronizingly that barring women from this opportunity was for women's own good. Positioning women as

patients as opposed to healers (as a rule), served to keep them in a position of docility, reliance and dependence upon male physicians.

Women resisted. For example, women's suffrage worker, "Mary Livermore spoke against the "monstrous assumption that woman is a natural invalid," and denounced the unclean army of gynecologists who seem desirous to convince women that they possess but one set of organs- and that they are always diseased"" (Livermore qt. in Ehrenreich & English: 1973, 25). Both Gilman and Livermore called attention to this issue, as a matter of ignorance and fear of losing control over women. Women were vulnerable to charges of hysteria the moment they hit puberty and forever after.

Pregnancy and Reproduction

By extension of heterosexual, sexual relations, pregnancy marked the beginning of another one of women's stages of life. During this time, women were said to be "indisposed," throughout the whole pregnancy. The medical theory of "prenatal impressions" required her to avoid all "shocking, painful or unbeautiful sights," intellectual stimulation, angry or lustful thoughts [...] Doctors stressed the pathological nature of childbirth itself- an argument which also was essential to their campaign against midwives. After delivery, they insisted on a protracted period of convalescence mirroring the "confinement" which preceded birth" (Ehrenreich & English: 1979, 111). Given that women were often seen as "indisposed" for other alleged womanly health issues, and in general, to some degree, everyday life, it makes sense that the importance and focus on rest during pregnancy be that much more significant. A reason for this may be that pregnancy was seen as women's duty and responsibility, and male physicians and husbands were extra cautious during this time.

Aside from the supposed natural pathology of pregnancy, women faced real and critical dangers of physical harm to themselves during pregnancy and after giving birth to their children. In regard to preventing pregnancies, “Without adequate, and usually without any, means of contraception, a married woman could expect to face the risk of childbirth repeatedly through her fertile years. After childbirth a woman might suffer any number of gynecological complications, such as prolapsed (slipped) uterus or irreversible pelvic tear, which could be with her for the rest of her life” (Ehrenreich & English: 1979, 112). There were times that women could employ the “sick role” to their advantage. As part of treatment for various “hysterical” ailments, physicians could prescribe abstinence, thus, eliminating the threat of unwanted pregnancy for some time. With this medical advice given to women and ultimately their husbands, it is reasonable that this method could be effective because, arguably, man to man, this would be accepted as truth.

Menopause

Even old age did not relieve women of the effects of their “misbegotten” biology. Menopause provided the occasion to control women’s bodies pharmaceutically. One cause for concern and subsequent treatment was women’s bowel functions, as constipation was thought to worsen the symptoms of menopause. One remedy used was compound colcyntin pills which were powerful laxatives to aid in the relief of constipation, which in turn was seen as helpful for such symptoms. Another remedy or drug were hexital tablets (phenobarbital and hexoestrol) used as sedatives to assist with what was known as the period of “mental orientation,” a time in which women were seen as readjusting to this stage of life.

Here, they become vulnerable to “melancholia,” a sadness not at all surprising given that women’s primary value and “responsibility” was no longer a possibility. Although it alludes to

this condition only briefly, it was helpful to consult *The Statistical Manual for The Use of Institutions for The Insane* that was produced by the American Psychiatry Association, National Committee for Mental Hygiene, Bureau of statistics in 1918. This resource was a predecessor to *The Diagnostic and Statistical Manual of Mental Disorders* (DSM) which made its first appearance in 1952. In the 1918 manual, there is a brief reference to melancholia under the category of Manic-Depressive Psychosis. The diagnosis of “Involution Melancholia” was characterized this way: “These depressions are probably related to the manic-depressive group; nevertheless, the symptoms and the course of the involution cases are sufficiently characteristic to justify us in keeping them apart as special forms of emotional reaction. To be included here are the slowly developing depressions of middle life and later years which come on with worry, insomnia, anxiety, and agitation, showing usually the unreality and sensory complex” (*The Statistical Manual for The Use of Institutions for The Insane*: 1918, 23). Although this entry does not explicitly attribute this diagnosis to menopause, the combination of references to menopause and melancholia combined with the manual stating this occurs during “middle life and later years” suggests that menopause fits within this context.

Because women have long been considered to be in a state of mental infirmity, a melancholia diagnosis could have been especially damaging to women, as it was listed under the section of Manic-Depressive Psychosis. That particular diagnosis is noted as an extreme mood disorder causing severe fluctuation in moods between depressive and manic episodes, and a significantly elevated presentation of mental disturbance. In fact, when exploring this diagnosis in greater detail, some of the noted symptoms mirror those of the ones attributed to hysteria.

While conducting research for this inquiry and thesis, a great deal of information was at times shocking, but it was not until the process of organizing this information that it became

apparent just how deep, complex, and tangled the material conditions of Victorian era culture really were. Trying to organize women's life stages in a linear fashion proved difficult as all of the above mentioned stages can mirror each other and overlap such as green sickness with menstruation, menstruation with hysteria and pregnancy, and hysteria with menopause. Also, symptoms of these stages could occur simultaneously or transcend the ages that girls and women were thought to have been given exclusive diagnoses such as mature women still facing the risk of a diagnosis of green sickness if they appeared weak and sickly. This discourse is foundationally evident in the tensions between inferiority and elevated status of motherhood, the pathologization of virgins despite expectations of purity, and a whole other host of mutually exclusive conditions.

The cultural system of women's pathology is thus multi-faceted. All of these things point to a complex cultural strategy to secure and maintain rigid gender roles. Very clearly, solidly, and pervasively, the entirety of what made one female was pathological. Pathology of women did not come from a change that occurred in the body to substantiate disease. The only changes that occurred were during each stage of female life. In the two chapters that follow, this thesis will illustrate how the category of hysterical femaleness/ women and madness played out in two specific historical cases.

Chapter 3: Charlotte Perkins Gilman and “The Yellow Wallpaper”

In her day, Charlotte Perkins Gilman (1860-1935) was a widely known feminist writer and social analyst, a representative of what has become known as "material feminism." Gilman has been described by Delores Hayden, author of *The Grand Domestic Revolution: A History of Feminist Designs for American Homes, Neighborhoods and Cities* (1981) as:

A slender, dark-haired woman, with a light, penetrating voice and great powers as a speaker, Charlotte Perkins Gilman (91) charmed audiences in the last decade of the century [...] Her most popular lectures discussed women, men and the home. Although her eyes flashed with anger or indignation when she spoke of women's oppression, she could quickly change pace, joking, prodding, ridiculing traditionalists who romanticized the Victorian home and women's place in it (Hayden: 1981, 9).

Based on the above description of Gilman as having attributes of a strong individual, it makes sense that her qualities and her passion about women's right have led to the claim that “On the basis of her economic, social, and architectural arguments for collective domestic life, she has been judged the most original feminist the United States has ever produced, and she has been described as representing “the full elaboration of the feminist impulse”” (Hayden: 1981, 9). Gilman has clearly left her mark in this social and academic terrain.

While "the Vote" was an end in itself for some feminists, many feminist women saw the vote as a tool to effect a much larger end, namely, social and economic parity and power for both women and men. Yet still others bypassed official governmental structures to focus directly on material realities. Gilman's *Women and Economics: A Study of the Economic Relation Between Men and Women as a Factor in Social Evolution* (1898) was one such text. Gilman also wrote and published her own magazine, *The Forerunner*, which included social commentary as well as fictional pieces meant to illustrate her points, and stimulate her readers' ability to imagine alternate perspectives. In Gilman's self-narrated autobiography, *The Living of Charlotte Perkins Gilman*,

Gilman states that “yes, I have written enough to make a set of twenty-five, including volumes of stories, plays, verse, and miscellany; besides no end of stuff not good enough to keep” (Gilman:1972, 100). Gilman’s written collection is quite extensive. Aside from writing, throughout her life, Gilman was a strong advocate and voice for women in terms of social standing and economics, and a bright example of women, agency, and resistance.

Gilman is still most widely recognized in current days as the author of “The Yellow Wallpaper,” (1892) a 6,000-word short story that chronicles a fictitious yet telling narrative of women’s experience of the Rest Cure mandated by her husband John, who subscribed to Dr. Silas Weir Mitchell’s way of “treatment”. This text provides a material and personal experience of the concepts and treatments touted as for women’s own good, as was a central theme for women during the Victorian Era and into the 20th century. This story was based on Gilman's personal experience of being subjected to S. Weir Mitchell's popular remedy for privileged women's perceived maladies, the infamous Rest Cure.

Gilman’s “The Yellow Wallpaper”, illustrates the power husbands could have over wives. As the heroine states: “John says if I don’t pick up faster he shall send me to Weir Mitchell’s in the fall. But I don’t want to go there at all. I had a friend who was in his hands once, and she says he is just like John and my brother, only more so!” (Gilman: 1892, 650). It was clear that if women did not perform to the expectations of these men, there would be consequences.

Negative psychological outcomes were also possible and or likely to occur. Gilman wrote about the rest and isolation imposed upon the woman subject of the story by John which caused her to be driven “mad” or more specifically, psychotic. This was made apparent as the character proclaimed at the end of her short story: “I don’t like to look out of the windows even- there are so many creeping women, and they creep so fast. I wonder if they all come out of the wallpaper as

I did. I've pulled off most of the wallpaper, so you can't put me back!" (Gilman: 1892, 656). These types of delusions are not uncommon after prolonged isolation and seclusion.

This story is significant in its vivid playing out of the gender assumptions of Separate Spheres ideology under the guise of Science. In "Writing Silence: "The Yellow Wallpaper"" Elizabeth Ammons claims that "Above all, "The Yellow Wallpaper" is about using paper to connect women, a theme doubly insisted upon in Gilman's story- on the wall, on the page- and repeatedly voiced and demonstrated in the work of women writers at the turn of the century" (Ammons, eds. Erskine & Richards: 1993, 271). Clearly Gilman's "The Yellow Wallpaper" stands on its own, but is part of a larger movement of women speaking out against men controlling women's minds and bodies. In terms of the larger movement of women's resistance efforts, here we can see a real life example of the ways that the control of women spans the various life stages as discussed at length, above: "The drama and patriarchal control in "The Yellow Wallpaper" is the same one that Charlotte Perkins Gilman felt as a child, saw in her mother's life, and then experienced again herself as a young wife and mother. The story is not limited to just one stage of life as a woman, but applies potentially to all stages, from childhood to old age" (Erskine & Richards: 1973, 271). These all enveloping constraints over women's changing biology and life stages are made clear once again.

In a real life, "The Rest Cure" was developed in the late 1800s by Dr. Silas Weir Mitchell to treat hysteria and neurasthenia. While hysteria was a woman's disease based on their reproductive organs as noted above, neurasthenia (nerve weakness) was a diagnosis that was mostly given to men of high social standing. The Rest Cure was gender specific; men were instead prescribed the active, invigorating "West Cure", discussed in more detail below. According to Gilman, "At the time the greatest nerve specialist in the country was Dr. S.W Mitchell of

Philadelphia [...] I went to him and took “the rest cure” [...] This eminent physician was well versed in two kinds of nervous prostration; that of the business man exhausted from too much work, and the society woman exhausted from too much play” (Gilman: 1972, 95). Here it is shown that women were not viewed as contributing to society outside of the home. “Women’s work” was described as mere “play”, even though they were maintaining households including babies and children. It was not considered that this was real work and that it would have been a natural response to be tired and or depressed, and possibly very angry about it.

Concurrent with the use of the Rest Cure, the medical approach to the treatment of hysteria was to intervene by performing invasive surgeries to alter or remove all reproductive organs such as the ovaries and uterus since most if not all perceived ailments were believed to stem from the biological specifics of being female. Contrary to the pain inflicted by these physical invasions, Mitchell's Rest Cure was proclaimed to be the new and painless advancement in the treatment of “women's issues”. The Rest Cure differed as it was an attempt to “directly force the brain's surrender” (Ehrenreich & English: 1973, 131). In terms of psychological intervention, this process was alleged to require close to total isolation paired with sensory deprivation; halted intellect because it allowed women to neither read nor write; involved isolation by strictly limiting human interaction to physicians and nurses; involved physical invasions such as forced feedings and muscle stimulation and massage to compensate for the patient lying flat on her back for at least six to eight weeks. One other possible consequence was ‘the force of the physician’s phallus’ (i.e. rape) to ensure compliance. Barbiturate drugs were also introduced at this time as a hypnotic (sedative), for “Sleep Cures”.

Mitchell was a published author as well as a physician in the public sphere. In *Fat And Blood: And How To Make Them* (1877), Mitchell illuminates the crucial fact that his notion of rest

was not to be on women's own terms. In relation to what quite clearly shows punishment, Mitchell stated that "I am rather given to insisting on rest, but the rest I like for them is not at all their notion of rest [...] When they are bidden to stay in bed a month, and neither to read, write, nor sew, and to have one nurse, - who is not a relative, - then rest becomes for some women a rather bitter medication" (Mitchell:1877, 40-41). Here, it is made plain that Mitchell was acutely aware that his treatment was abusive to women.

Enforcement of the Separate Spheres Ideology- Seclusion and Silencing

Seclusion was key to Mitchell's treatment. For women, Mitchell asserted that "Once separate the patient from the moral and physical surroundings which have become part of her sickness, and you will have made a change which will be in itself beneficial, and will enormously aid in the treatment to follow [...] but I am now speaking chiefly of the large and troublesome class of thin-blooded emotional women" (Mitchell: 1877, 34-35). The reason for the seclusion seems to be less about treating the woman patient and more about protecting society from her presumably unstable nature. Mitchell clarifies by stating that "A hysterical girl is [...] a vampire who sucks the blood of the healthy people about her; and I may add that pretty surely where there is one hysterical girl there will soon or later two sick women" (Mitchell: 1877, 35. Mitchell speaks of women as though they are contagious and breed pathology as a crime against society that only he, the male physician could remedy.

While nurses played a role here, above all else, the male physician was the only one considered to have had the power to cure. "The physician, according to Mitchell, could heal by the force of masculinity alone" and the prevailing belief was that "female doctors could not obtain the

needed control over those of their own sex” (Ehrenreich & English: 1973, 133). Additionally, women were already widely forbidden from becoming physicians within mainstream medicine.

Aside from the belief that only the male physician could heal women, women were to ask no questions, especially about her “care” of the physician which adhered to the design of the treatment that called for total submission to the physician's male medical authority. That submission could produce “Stockholm Syndrome” like consequences. Even after what could be considered horrible treatment, women sometimes held deep gratitude for these interactions and a promise of a “cure”. In some cases, physicians such as Mitchell were seen as saviors, deeply invested in the care of women. Although this conditioning is apparent, I caution this way of thinking as to not take up the notion that “those poor women didn't know any better”. Gilman did, and she wrote about and articulated it quite well in “The Yellow Wallpaper” cited in this thesis.

Even after the treatment had concluded, women were still encouraged to rest, seemingly as a way of life. For a woman to get better, she was cautioned by physicians that she must strive to become a better woman. This meant that she should strictly obey the gender roles as determined by class and race prescribed to her, and do so without resistance. Upon release, Gilman and other women were advised to “Live as domestic a life as possible” (Ehrenreich & English: 1973, 132). In addition to this advice, Gilman recounts Mitchell’s advice: “Have your child with you all the time [...] Lie down an hour after each meal. Have but two hours intellectual life a day. And never touch pen, brush or pencil as long as you live” (Gilman: 1972, 96). In other words, tend to the needs of your husband and children and avoid any and all independent thinking; personal, religious, political, or otherwise.

Arguably, and with good reason, it makes sense to assert that women could be, and were driven “mad” from a treatment touted as less invasive and more humane than previous treatments,

even though the psychological damage was in some cases, evident and real. Gilman's account of the impact of the Rest Cure states that "I went home, followed those directions rigidly for months, and came perilously near losing my mind. The mental agony grew so unbearable that I would sit blankly moving my head from side to side- to get out from under the pain. Not physical pain, not the least "headache" even just mental torment, and so heavy in its nightmare gloom that it seemed real enough to dodge" (Gilman: 1972, 96). In addition, Gilman tells the reader that "I made a rag baby, hung it on a doorknob and played with it, I would crawl into remote closets and under beds- to hide from the grinding pressure of that profound distress" (Gilman: 1972, 96). This profound abuse leading to extreme mental unwellness or even insanity, was not given important consideration. What counted in society and in the Victorian home was gender roles and the Home. Although women were driven "mad" in situations such as Gilman's, the heterosexual relationship between husband and wife prevailed.

In relation to the gender roles above, Tuana offers: "While philosophers stressed the proper relationships between husbands and wives, scientists emphasized domesticity as woman's natural lot. In his text on female diseases, Charles Meigs explained that woman's role in the private realm of family and her exclusion from the public are not arbitrary- that is, due to restrictions on educational and career opportunities. Rather, women's "lot is cast for them; men did not make it; God made it. They cannot, in the present state of the world, and probably never will, participate in the affairs of nations or municipalities, because, by their very nature of their moral and physical constitution, they are bound to the horns of the family altar" (Tuana & Meigs: 1993, 164). With these beliefs hard at work, the message was clear that women were expected to adhere to strict female gender roles within the family home.

"The West Cure" for Men

Where the "normal" woman was understood as passive, a "normal" man needed to be strong and assertive. Not all men met this standard, however, and a medical remedy was called for here as well, through the so-called "West Cure". For men, excessive anxiety and depression was seen not only as an illness, but as a direct response to the stresses of having a superior intellect and "citified" male professions (like banking, business, and government). The remedy, then, was physical activity. In the West Cure, men were sent "out west" to participate in extended periods of cattle roping, hunting, and male bonding. During this time, men were to engage in these physically vigorous activities, share their experiences with other men, and then return home to chronicle their experiences in a written account of their time spent in "treatment". It is worthy to note that Mitchell himself participated in the West Cure, possibly to strengthen his sense of innate masculinity which he then used to justify his ability to cure women. The West Cure was seen as a temporary time of rehabilitation before returning to business, academic, or political pursuits; a time to tap back into men's innate virility, and return to work in the public sphere stronger than before. It is reasonable to think that for men, this strengthened their gendered role in society and that was most likely empowering; but for women, the Rest Cure strengthened their gendered role within the home which could be considered to be disempowering given the circumstances.

Further, the West Cure was characterized by struggle, the ultimate triumph of masculinity, and professional advancement while the Rest Cure for women was characterized by the admission of feminine fragility and submission to reproductive function and domesticity. This has been exemplified by Theodore Roosevelt's personal involvement with the West Cure; after which he returned to politics, and Gilman and other women being instructed to confine themselves strictly within domesticity (and perhaps lingering psychosis) upon discharge. Distressing images come to mind here: men, who in large part already held privilege engaging in non-restrictive physical

activities with others for their betterment, while women lacking such privilege were most often held against their will in almost absolute solitary confinement, their strengths and abilities diminished, and arguably, a limited life to follow discharge although it is unfair to say that all women felt limited.

To claim that no men were negatively affected by the West Cure would be short sighted. Another function of the West Cure was for “effeminate” men to be sent away to regain their supposed inherent masculinity, and by extension, the heterosexuality men were expected to innately possess. This meant that these men were sent to be “corrected” of their deviant ways and be “cured” of homosexuality. To this end, “the regimen supposedly cured the young Teddy Roosevelt of his effeminate voice and foppish mannerisms in the 1880s (before this, TR was considered soft)” (Kean: 2014, 150). This point serves to reinforce both female and male gender roles. For the image of the heterosexual home and family to be protected, men must also adhere to these rules. While women were steered into their gender roles by various and numerous approaches, this was a method to ensure men's role and place. This bolsters, amplifies, and reinforces women's role as wife and mother, as the Victorian cultural ideal was contingent upon systemic adherence to feminine and masculine gender roles.

Charlotte Perkins Gilman's experience and the subsequent discussion of scientific and medical strategies to “cure” gender role dysfunction illustrate the degree to which ideology creates both perceived problems and their remedies. This insight is essential to keep in mind when considering 20th and 21st century examples of both making and managing “madness”. The next chapter will explore these ideas further when looking at Kate Millett in the mid-twentieth century.

Chapter 4: Kate Millett and The Loony-Bin Trip Brilliance, Craziness, Mess; Feminist

Solidarity has its Limits

The topic of this chapter is important to the study of women and "madness" because it incorporates both theory and activism. Theory on its own is important as a viable and thriving discipline, but activism is also of importance because it has the potential for positive social change. Theory also illustrates resistance to the harmful views and treatment of women, particularly women who have been diagnosed with a mental illness, whether they have accepted the diagnosis and subsequent label or not. The various methods used to control women are deep-rooted in a system that has always been persistent in denying women's agency, while also ignoring the material conditions that effect women's personal autonomy. For example, a large part of written work on women with mental illness focuses on women as victims, and does not account for women's agency and acts of resistance.

While it is crucial to critically explore and acknowledge injustices imposed (often forcibly) on women, it is also critical to recognize ways that women have and continue to assert their own power over such forces. This chapter will critically consider one feminist autobiography as a form of resistance, emphasizing how it can offer real life accounts of both injustice and resistance. Women writing about women's experiences, particularly women writing about their own experiences, provide women with a space to publicly expose such experiences, and provides stories that with combined application of theory can produce first hand insights and strong knowledge claims as well as contributions to theory and activism. These issues will be explored in relation to the reception and treatment of the autobiography of once prominent feminist and activist, Kate Millett.

Millett was once held in extremely high regard, was seen as making significant contributions to the women's movement with her book, *Sexual Politics* (1970). Fifty years later, there is barely mention of her anymore, and when she is mentioned, her once recognized widespread contributions and published works are limited to *Sexual Politics*. I explore this issue in regard to knowledge that can be gained from paying attention to what Millett has written about in *The Loony-Bin Trip* (1990). Millett's story provides a wealth of information about women and the charge of "madness".

According to the website Bronx Council on the Arts, Katherine Murray "Kate" Millett was born on September 14, 1934 in Saint Paul's, Minnesota, and died on September 6, 2017 in Paris France. Millett has been described by activists, scholars and the public as one of the most influential Americans of the 20th century. She was a feminist activist, writer, visual artist, educator, and human rights advocate. In 1970, Millett was awarded a Ph.D. with distinction for her dissertation which was then published as her book, *Sexual Politics*. Again, according to The Bronx Council On the Arts, Millett received numerous awards that include but are not limited to Yoko Ono's Courage Award for the Arts and the Lambda Pioneer Literary Award. She was inducted into the National Women's Hall of Fame in Seneca Falls, New York in 2013 for her significant contribution to feminist activism, education, and the arts. The National Women's Hall of Fame website (2019) says that Millett has been described as "one of the most influential Americans of the twentieth century". Like Charlotte Perkins Gilman who was honored by the National Women's Hall of Fame (1994), it is reasonable to think that Millett was recognized for her outstanding achievement and social influence as well.

A major point of concern and activism for Millett was the treatment of women who have been diagnosed with mental illness. Millett showed that feminism and psychiatry were deeply

intertwined with each other, and that feminism and feminist theory were perfectly suited to lift up and scrutinize issues of psychiatry that continue to harmfully affect women. Millett's work illustrates what can happen when one has cultural agency and privilege, but is forced to exercise it within the constraints of a diagnosis of madness.

One must first consider what it means to be agentic or have agency. Who has agency within the dominant discourse and otherwise and who does not? According to author Bronwyn Davies, "agency is synonymous with being a person. It is used interchangeably with such concepts as freedom, autonomy, rationality and moral authority" (Davies: 1991, 42). Davies continues: "Agency is never freedom from discursive constitution of self but the capacity to recognise that constitution and to resist, subvert and change the discourses themselves through which one is being constituted. It is the freedom to recognise multiple readings such that no discursive practice, or positioning within it by powerful others, can capture and control one's identity" (Davies: 1991, 51). It is about recognizing these injustices and working against them to create change for self and others.

Regarding resistance, author, Alisha Ali has stated that "According to Michel Foucault, power manifests itself at all levels of society and not simply at the level of elite groups. This implies that the workings of power/knowledge can be transformed even by the disempowered. However, disempowered individuals must work against the silencing of their subjugated forms of knowledge in order to counter the dominant modes of discourse that are supported by those in privileged positions" (Ali: 2002, 235). In this sense, not only those in powerful positions, such as the psychiatrists, will be producing what they believe to be true about women, but that women experiencing mental health issues, although sometimes disempowered, can challenge those dominate and harmful views, producing their own knowledge(s) and power. One of the ways that

women can produce their own knowledge claims and assert themselves is through feminist autobiography.

On feminist knowledge production and the value feminist autobiography can offer, author, Leah White holds that “Female autobiographical writings are extremely valuable to women's resistance efforts” (White: 2009, 6). White goes on to quote feminist author, H  l  ne Cixous as claiming “Woman must write herself; must write about women and bring women to writing... Women must put herself into the text- as into the world and into history- by her own movement” (White qt. Cixous: 2009, 6). By positioning oneself within the text on her own terms, what can be gained from that is that the account provided by a woman about her own experiences will not have androcentric, unrealistic, and harmful views of her that aim to place and keep her in a marginalized position. It is interesting to note that where Gilman’s personal story was told in fictional form, Millett’s account is brutally autobiographical.

Further “Through autobiographical texts, women are able to offer their own interpretations and reevaluations of power structures that seek to control and silence them” (White: 2009, 6). As noted previously, Millett, an established feminist, artist, activist, and author did just that. She illustrated this point with powerful conviction and honesty in her autobiographical memoir, *The Loony- Bin Trip* which she wrote between 1982 and 1985 and published in 1990.

Reading “Madness”- the Issue of Contrary Narratives

The charge of mental illness is often complex, and multiple narratives can exist. Author, Patricia Bishop has stated in reference to Millett that “At least two versions of this story are possible. The reader ponders a sad but predictable narrative of manic-depressive psychosis [...]. Alternatively, the narrative is a political thriller wherein a sane but wild and outrageous writer

attempts to escape confinement in a mental institution. She won a famous insanity trial in St. Paul's years before [...] but has to prove her sanity over and over" (Bishop: 1991, 89). Millett did have to prove her sanity over and over. She reported this in three parts of her book, *The Loony-Bin Trip*. The first part, "The Farm," addresses her refusal to start taking lithium again to treat what others considered to be an episode of mania where she narrowly escaped involuntary commitment. The second part, "Ireland", gives an account of Millett's involuntarily commitment for what officials claimed to be a manic episode. However, soon after, and with careful planning and application of professional legal knowledge, Millett and her friends managed to have her discharged. In her third part, "New York City" outlines how Millett sought help from a psychiatrist and additional clinicians for depression and officially decided to write and share her experiences and insights in *The Loony-Bin Trip*.

"The Farm" was Millett's personal property that she opened to women for a feminist art experience in exchange for work to be done as farm apprentices in the summer months. Millett experienced stress related to running the feminist art colony and tree farm, managing young apprentices, and her own personal work after making the decision to stop taking lithium which was prescribed for her diagnosed manic depression (now more commonly referred to as bipolar disorder). When those around her found out she had gone off of her prescribed medication, the focus was on trying to get her to start taking it again by frequently telling her to do so, trickery, and then an ambush in which Millett's relations hired a psychiatrist to force her in to treatment through involuntary commitment. Millett had told them repeatedly that she did not view her situation as problematic; in fact, Millett described that summer on the farm as "A summer full of making and doing, planting and beginning. A creative summer, manic in the innocent popular sense of elated and exuberant activity [...] happily disorganized at moments, euphoric, like kids

planning a clubhouse at one level but concentrated and adult at another” (Millett: 1990, 105). Millett acknowledged that the summer was filled with extraordinary excitement [possible evidence of a manic state], but also argued that she was able to maintain productivity despite her difficulty and distress at times.

Millett wrote about her concerns regarding the harmful effects of lithium: “Six years of diarrhea. Six years of hand tremors in public places, on podiums, at receptions, at the moment one is watched and observed. Six years of it in private while trying to draw [...] Six years of being on a drug that made one sluggish, the mind sedated, this suppressant. Rumors that it isn't good for you in the long run, the kidneys, the liver, maybe even the brain” (Millett: 1990, 31). Unfortunately, despite having experienced these effects there is a common misconception that “crazy” or “mad” people do not what is good for them and their resistance to take such drugs is taken as further proof of mental pathology. I will discuss this further when I discuss my personal work experiences. It is little wonder that Millett would refuse to take such a drug again; seeing no need and having experienced the negative side effects before and not willing to experience it again. The effects were far reaching and had an impact on her physically, mentally, socially, and professionally. Millett also experienced a loss of authority over her own body, just as in the Rest Cure.

Millett also acknowledged that this situation extended beyond her, and that many others were subjected to these effects as well. Millett challenged structures of power such as pharmaceutical companies producing such drugs and the psychiatrists prescribing and enforcing their use. Millett challenges this by asking “Do they know what it does to consciousness, perception, sensation, and logic and reasoning? [...] And even then, would they relinquish them? With all this money at stake? The vast multinational chemical firms?” (Millett :1990, 241) Aside

from the immediate effects, Millett also spoke to the long-term effects of psychiatric drugs, particularly lithium. Millett calls the Hippocratic Oath “One shall do no harm” in to question here. “Throughout the world millions of persons now suffer from tardive dyskinesia [...] Tardive dyskinesia is an irreversible condition, resulting in (among other injuries) involuntary spasms-physical disfigurements that stigmatize and often isolate the sufferers, minimizing social interaction and opportunity” (Millett: 1990, 212-213). Despite this personal and medical information in terms of short-term and long-term effects of lithium, Millett's refusal to take lithium was ignored by most of the people around her. This included the psychiatrist involved who first tried to get her to agree to voluntary hospitalization.

Millett’s attempts to escape involuntary commitment were strong and eventually effective. In one instance, Millett told her relations that she was planning to hire a taxi to get to the airport to travel to visit her mother and to other locations to give lectures and speaking engagements which were important to her and necessary for her career and means of financial income- her livelihood. She attempted to get a taxi to transport her, but drivers kept driving by without stopping to pick her up. Millett then noticed that her sister was making gestures at her and communicating to the drivers that Millett was crazy and to keep going. According to Millett, “It is somehow the cruelest thing anyone has ever done to me, the most insulting, the most maliciously dishonoring” (Millett: 1990, 163). This is further complicated because her relations and the psychiatrist called for an ambulance and police assistance to come to the scene to enforce their plan. When two ambulances and three police squad cars arrived, although upset, Millett resisted and was able to articulate that she did not require assistance and that what they were currently doing was wrong. Millett knew her legal rights on this matter, and convinced a police officer that this was a violation of her civil rights. In addition, she did not require assistance, and without her consent, no further action could

take place. Millett played an integral role in freeing herself from what could have been another involuntary commitment and further assault on her livelihood. This was a strong example of protest and resistance.

Millett further spoke to this incident when she recounts a conversation with the psychiatrist involved immediately following her escape. The psychiatrist reduced Millett's successful resistance efforts to luck and went on to patronize her and make light of what had taken place. The psychiatrist said: "You were more than lucky." "One thing I'll congratulate you on"- She [the psychiatrist] speaks as if it were only an exercise, a fire drill of civil rights, and she had never meant for it to be more, no one had- "You didn't decompose." "What on earth do you mean?" Is this some psychiatric in-joke? Decompose indeed. "I mean you kept your cool"" (Millett: 1990, 167). It seems absurd for a psychiatrist to speak to her this way, as if Millett's life were a game of sorts. The fact that a psychiatrist congratulated Millett on not "decomposing" under the circumstances acknowledged that Millett acted with reason and self-composure during such a trying situation of duress. If Millett at no point "lost her cool", it made little sense that those involved were willing to go to such extremes to confine her against her will.

In the second part of her autobiography, Millett describes another incidence of psychiatric control. While staying in Ireland, Millett was taken by force to an insane asylum in southeast Ireland by police officers when she was considered to be acting erratically and agitated. When the psychiatrist came in to assess her, he concluded that she was "high as a kite" which is still true for today, slang for an episode of mania. When Millett asks why she had been taken there even though she did not do anything to warrant being arrested and brought there, the psychiatrist responded "Ha. Well, you are here for your own good. Now I want you to explain to me how you got here" (Millett: 1990, 194). Millett explained that she had left her camera in the trunk of a rental car after

switching cars and was waiting until that car was returned so she could get her camera. She was questioned as to why she switched cars in the first place, and answered that she wanted a car that was less expensive and less conspicuous. The psychiatrist asked if she felt she was being followed, and Millett answered honestly, saying she thought it was possible. Millett's answer was taken to be one of paranoia even though she did have reason to believe she may have been followed. During her stay at a hotel she was forced out by the hotel manager who told her she must leave. Even though Millett did not object to these orders, police officers escorted her out after someone in the hotel lobby saw her reading a book and she was accused of spreading political propaganda throughout the hotel. Millett was then asked "Why did you stop taking lithium? We have a report that you went off lithium in July" (Millett: 1990, 195). After further discussion, Millett was forcibly hospitalized.

While hospitalized, Millett noted that the ward held thirty-five other women and that "it is horrible to see women in their thirties here, but for me it is the older women who hurt the most. Having no hope, likely to die here" (Millett: 1990, 197). Millett saw this place as an institution for women who had been marginalized and confined for the rest of their days, and feared the same could happen to her too. Millett had good reason for her concern as one author noted, "Millett is drugged against her will with powerful overdoses of lithium, Thorazine and Prolixin. She is denied writing paper [like women during The Rest Cure] and not even permitted one phone call. She fears that she could be housed there, forgotten, for the rest of her life" (Bishop: 1991, 89). Although it seemed reasonable to believe that she might suffer the same fate as the other women, Millett managed to make contact with Irish women friends whom located her and together they figured out how to get her transferred to an institution in Dublin, knowing that her chances of being freed

were greater there. Their plan was successful as a Dublin psychiatrist certified Millett sane right away and she was released and went back to New York City (Bishop: 1991, 89).

After returning to New York City, Millett's personal relationships were strained, she had no money, and was unable to write despite her best efforts, as a result. She fell into a deep depression, one she feared she could not return from on her own without lithium. (As an aside, it is important to clarify that often in a manic state, the individual most often does not want psychiatric drugs as they might feel in control of the situation- elated, even. However, in a state of depression, it is more commonly noted that individuals seek medical intervention and psychiatric drugs to deal with depression). She made the decision to see a psychiatrist and stated "I am going to Dr. Foreman's office for myself alone, to save my life" (Millett: 1990, 258). This statement is quite powerful because she identified what was problematic in her own life and made the decision to seek help including starting lithium on her own terms even though she was familiar with the negative effects of the drug. When Millett requested lithium, the psychiatrist told her she must quit drinking. Millett told him that she did not drink to the extent he was suggesting; to which he responded "You were drinking plenty last summer, don't tell me you weren't" (Millett: 1990, 266). He did not take her seriously. It is important to consider the power dynamics here.

Arguably, Millett was an alcoholic. As such, her denials about drinking were not unusual. He could still have been belligerent and/ or condescending as he declared, "Maybe it is part of your life, but you cannot, you absolutely cannot, continue if you want to take lithium. Not if you're going to be my patient" (Millett: 1990, 267). The psychiatrist claimed the effects of alcohol while on lithium would do damage to the kidneys (entirely possible); however, this had never been considered or questioned by a psychiatrist before. Previously, during what psychiatrists diagnosed as an episode of mania, she had to be treated as quickly and as aggressively as possible, but not so

much now. According to Millett: “it is mania that really interests the doctors, that must be stamped out. Depression is your own problem; get out of it however you can [...] Your life does not belong to you but the doctors, the relatives, the state: the social circle” (Millett 1990, 259). At that point in time when Millett was requesting what she believed to help her, she was denied on his, the psychiatrist's, terms.

After persevering and acquiring a prescription for lithium, Millett began taking it and also engaged in psychotherapy to complement the effects of lithium. Some months passed and Millett's depression lifted, but author Patricia Bishop withholds judgement as to whether it was the lithium that helped or if something else had influenced the change in her mental well-being. “As she learns more about the patients' rights movement and its criticism of psychiatry as a political tool and a means of social control, Millett decides to forswear lithium again [...] She [Millett] weans herself off lithium gradually, with support from fellow ex-psychiatric patients” (Bishop: 1991, 90). Millett did not tell anyone outside of her fellow ex-psychiatric patients until she was off lithium completely for one year. The year went by without incident and when she finally did tell others, they were understandably quite surprised. The power of naming/labeling and the perceived safety (for the individual taking the drug(s), and those around them) that medication is thought to bring is highly suggestive and continues in present time to have great implications for how one lives their life and how others view them.

Millett spoke to the power that a psychiatric diagnosis and involuntary commitment had over an individual when she wrote: “Because when you come right down to it, whether you were even crazy or not, guilty or innocent, manic or sane as a bedbug- you've been jailed for madness and that doesn't go away. It hangs around in everybody's eyes; it's in the talk you don't hear and in the tones you do. And the shame doesn't go away” (Millett: 1990, 79). What Millett has illustrated

here is the notion of stigma, which can produce even greater harm than the effects of the alleged illness itself. Although Millett underwent terrible conditions imposed on her, she shared her story in such a bold manner that challenged stigma itself. She questioned, “Why should one of the thousands and hundreds of thousands who have known the pit and betrayal- the fear of madness or madness itself- not tell of it? Break the taboo of respectability which has been broken so seldom” (Millett: 1990, 313). Millett wrote these words almost four decades ago; and this question remains crucial as one worth questioning moving forward.

It is clear that women have experienced injustices imposed upon them in the name of psychiatry, but that women have resisted these powers as well. One of the ways we can gain insight in to these discourses is to meaningfully consider feminist autobiography and stories such as “The Yellow Wallpaper” as valuable tools of resistance. Real life accounts of women's experiences written by women themselves in a way that exposes injustices have the potential to tell and retell stories in a corrective manner that accounts for causality and takes in to consideration the material conditions of women's lives. They also validate and celebrate women's resistance efforts and successes. Feminist autobiography can produce women's first hand insights, strong knowledge claims in to cultural, social, and political discourses, and make significant contributions to theory. Millett has done so in *The Loony-Bin Trip* wherein she boldly exposed her personal experiences with psychiatry through a feminist lens and shed light on such powerful systems at large.

Of remaining concern is why Millett's works have been seemingly dismissed from feminist theory. Shouldn't women be allies in this? The first possibility to consider here is that she did not fit the ideal feminist image and was not saleable like some of her peers. [The 1970s found the conventional attractiveness of Ms. magazine founder Gloria Steinem more palatable and less frightening than "fat, angry dykes" like Andrea Dworkin. But even Dworkin was more

comprehensible to the popular imagination than the literary, artistic, "unstable", bisexual, "alcoholic" Millett. Part of that could be that she was labeled "crazy" and or "mad" and that stigma imposed on her further dislocated her from being perceived as able to occupy acceptable practices and behaviors. Further silencing women's voices by discrediting, exclusion, and dismissal is not conducive to honoring stories of women's embodied experiences as they themselves tell them. However, feminism and feminist theory is well-positioned to explore and analyze such occurrences and stands much to gain in both theory and practice.

Chapter 5: Personal and Professional Experiences

Personal experiences and narratives have a large, crucial role in this thesis. It is the material conditions of women's lives that we have been talking about all along throughout this thesis. At this point, I will discuss my personal and professional experiences with the psycho-medical community. Due to confidentiality and respect to persons to whom I have played a support role, I will be speaking in very general terms, and at times will not make the differentiation between workplaces. The two workplaces I will talk about are in general terms, a community non-profit outreach ministry within a Christian United Church and a series of small options homes as Primary Support Staff specializing in supporting those with mental illnesses and at times, dual diagnoses, i.e., mental illness and "developmental issues". It is important to make clear that the majority of persons I have worked with on a professional level were and are middle-aged- women who have navigated the mental healthcare system since the onset of their traumas (childhood and beyond) and/or mental illnesses (since onset and one or more formal diagnoses).

The current system, now, much as it has in previous years is more of an issue of management of disease and not a means to achieving a cure or resolution of traumas that occurred in one's life. The system names the patient as the problem, and aims to manage their behavior and affect. If they protest, they are told, as were Millett and the heroine of "The Yellow Wallpaper," that in their state of infirmity, they do not know what is best for themselves. This is not to say that mental illness and or "madness" does not occur, but rather, that it is often mistaken for a natural reaction to an unnatural situation in life caused by society within any given set of cultural circumstances. As the lengthy description of the 19th century medical pathologization of the natural cycles of girls' and women's bodies illustrates all too well, women are constructed as flawed from

the outset. Any further destabilization, though physical illness, social circumstances, abuse, and/or other injustices is easily read as congenital and irremediable.

Lithium- a Case in Point

One of the most common drugs used as a mood stabilizer, for Millett and still today, is lithium. It is extremely potent, and works in such a way that routine blood tests are needed to check for toxicity. Although blood tests are carried out semi-regularly (usually every six months), toxic levels of the drug can build up in one's blood if, for example, not enough liquid is consumed in as short a period as one or two days. The effects Kate Millett outlined are all still ones that I observe today in my professional work, as lithium is still on the market, still prescribed, and people still take it. It is important to note that some women do take this drug and report positive reactions and mental wellness, where the benefit of the drugs' mood stabilization properties outweighs its other dangers. I have worked with, and continue to work with women whom in some ways are vulnerable to being controlled "for their own good" and also "the good of society," and this is sometimes warranted. However, it often comes at the expense of a woman's well-being, autonomy, and sense of agency. This "care" also works to silence and oppress women within the healthcare system.

My experience over the years involves a woman who was taking lithium for decades. She was having her regularly scheduled blood tests and following up with her doctors, yet she still reported feeling unwell. Staff noted an increased level of lethargy and sedation and a sense of confusion. This immediately registered as a problem, and an ambulance was called to assess the woman. At this point, it was very clear that the woman needed to go to the hospital for emergency medical care. After their assessment and blood levels were checked, it was confirmed that lithium toxicity had occurred - a serious and potentially fatal health condition. This particular woman was

admitted to hospital for a couple of weeks to clear her system of the extra toxins (levels above what the physicians deemed a therapeutic level of lithium). She remained on the drug at a lowered dose for quite some time. I cannot stress enough how serious this could have been. If staff did not recognize the signs of toxicity, this woman more than likely would have died. It was pointed out that the resident did not consume enough liquids to make the drug safe in her system. Although this may be the case, the woman as patient was blamed, and the drug's reputation amongst hospital staff remained untarnished.

Unfortunately, this was not the last of her concerns with lithium use. One day on shift, staff noted early symptoms of lithium toxicity, and called for an ambulance. When the male Emergency Medical Technicians arrived at the house, they asked what was wrong, I and another staff on duty explained that we recognized the signs of lithium toxicity and stated the woman must be brought to hospital immediately. They argued with us, stating that we did not know her levels were toxic without blood levels being tested. They were prepared to not transport her to hospital even though we stated our concerns, pointing out each visual presentation exhibited by the resident. They stated that they did not see what we were noting, therefore there was no cause for concern at this point because her vitals were "fine". Although our professional skills and experience were downgraded and challenged, the EMTs begrudgingly prepared the resident for transport to the hospital. At the hospital, a blood test revealed that toxic levels of lithium were apparent. If not treated, the woman would have become more ill, which happens very quickly. At this time, the doctor on duty instructed staff to hold off on the bedtime dosage of lithium and decrease it in the days to come. At each routine psychiatry appointment on an out-patient basis, staff and resident would advocate for the cessation of the drug. Over time, the resident was weaned off the drug completely. In the days, months, and even years that followed the freedom from lithium, the resident flourished. She

told staff she finally had the will to live after decades on the drug. Aside from these feelings of wellness and the end of her hand tremors, what she also experienced was an influx of strong emotions and memories that were suppressed by continued lithium drugging. In my judgement as a professional Residential Support Worker, I see this as part of the journey in her recovery from lithium.

This case study illustrates a common reality, namely, there is an extraordinary amount of prejudice and discrimination against those deemed “mentally ill”. Part of this prejudice and discrimination is due to the belief that mentally ill individuals do not occupy spaces of “sane” and “reliable” knowers, and there is danger in these beliefs. According to Maria Liegghio, author of “A Denial of Being: Psychiatrization as Epistemic Violence,” “For an individual to be disqualified as a legitimate knower, certain constructions become necessary in order to justify the disqualification. For psychiatrized people, being constructed as “incompetent” and “dangerous” becomes a powerful mechanism leading to their disqualification as legitimate knowers” (Liegghio: 2013, 125). If one is not considered to be a legitimate knower, their voice can often be discouraged or silenced, because they cannot possibly know what is “good for them”. I have seen this countless times in my professional work with women. When they try to advocate for themselves, physicians dismiss what they are telling them. For instance, I have seen women tell their psychiatrists that they feel bad due to a drug, and their illness is blamed- they are named as the problem. Another complication is that there can be tensions between what the physician says about the drug(s) and what the pharmacist says about the drug(s). Staff seek professional advice from the pharmacists and then take that information to advocate with, and or, on behalf of the “patient. As in the case of lithium toxicity, it was a combination of sources of information, with serious consideration given

to what the individual taking the drug was saying about her own health that led to the discontinuation of the detrimental drug in her treatment.

Another example of denying a mentally ill person's agency as a legitimate knower, could be when a woman diagnosed as schizophrenic confides in her psychiatrist that she is a lesbian and he questions her closely, asking her leading questions, insinuating that this was a delusion, an interruption of identity of sorts caused by her primary diagnosis. While it is reasonable that a physician with earned credentials should query patients who present significant knowledge after many years of silence, there remains the fact that the "authority" needs to exhibit gentle care in the event that the information is accurate. Being doubted may be extremely hurtful to this woman whom has known she was a lesbian since her teenaged years, but never in her life felt safe and comfortable to tell those around her. Perhaps being a part of a supportive environment of women allowed for this reclamation of self. If in the end, the psychiatrist remained skeptical of her claim, but no changes or increases were made to her daily drugs, given the history of drugging people into heteronormativity, this would be a small victory.

In terms of the support staff provide individuals in resource centres and care facilities, advocacy is always available. To someone living on their own or someone not "in the system", the mental healthcare system can be difficult, if not impossible to navigate with positive result. According to Irit Shimrat, author of "The Tragic Farce of "Community Mental Healthcare," "One of the ways in which mental health professionals judge patients' progress or lack thereof, is by determining their degree of "insight"- which seems to be defined as willingness to agree with the practitioner's assessment of, and prescription for, the problem" (Shimrat: 2013, 148). Shimrat elaborates on this concept by providing an example of this summation made by a mental health professional about the patient in question: "She has clearly stated that she does not wish to follow-

up with us [...] she is both delusional and without insight” (Shimrat: 2013, 148). Here, it is assumed that this person does not know of their situation and has no rational clue as to how to go about life without the guidance of the mental health professional. In Shimrat’s own experience:

Too many times, I have been apprehended by armed and uniformed officers who transported me, in handcuffs, to the nearest hospital for psychiatric care. Upon arrival, I’ve been stripped naked, shot up with a neuroleptic, tied to a bed, and redundantly, locked in an isolation cell. (This procedure has not changed at all between 1978, when it first happened to me, and the present.) So I emphasize with the woman of whom the Care team notes, “patient appeared to have little insight into her illness and stated, ‘I am not ill. I was kidnapped by the police and sent to the hospital’ (Shimrat: 2013, 150).

This is chilling, and strongly echoes what Kate Millett wrote about regarding her experiences with the confinement and abuse of psychiatry. Also, this notion of isolation and vulnerability is so pervasive just as it was with the Rest Cure and other related punishments.

In relation to vulnerability, Shimrat writes about psychiatry in relation to elderly women: “Psychiatry is often used particularly harshly against older women. More women than men are electroshocked, and most of these women are old. The routine abuse that takes place on geriatric psychiatry wards includes tying people into chairs all day to keep them from “wandering,” and quieting them with massive doses of neuroleptics and, if all else fails, ECT” (Shimrat: 2013, 150). In my professional work, I have worked with both women and men. It is in my experience that a far greater number of women have had ECT done on them than men. Individuals have told me about the brutality of this “treatment” when they experienced it in their young adult years multiple decades ago. For these women, the feelings of abuse and trauma has stuck with them- the feeling of having no control and being so violently violated all in the name of “treatment” has been a strong assault on their personhood. In the past, both women and “the insane” have been categorized as less than human, and those views still inhabit the psychiatric context to this day.

Children are another vulnerable sector of the population. They are also not safe from the systemic labeling, stigma, and drugging. Just as we have seen with the first moment of the thesis, all life stages of girls and women are pathologized. Once more, Shimrat offers this point:

The psychiatric drugging of children and even infants is increasingly exponentially as more and more childhood behaviors are pathologized. [For example, children diagnosed with attention deficit hyperactivity disorder or ADHD, and children being diagnosed with bipolar disorder and schizophrenia]. Consequently, CMH and other practitioners are inflicting more and more physical damage on growing brains and bodies, in the process crushing young minds, spirits, and personalities before they can fully develop (Shimrat: 2013, 151).

This is why it is critical for questions to be asked and protests to be made to advocate for self and others, particularly in the case of girlhood and guardians in this case, as girls face particular challenges that really have not completely gone away that we have outlined in previous sections of this thesis.

Violence and Stigma

In *Madness, Violence, And Power: A Critical Collection* (2019) edited by Andrea Daley, Lucy Costa, and Peter Beresford, chapter 1 “The Risk of Violence” by Anonymous Female states from personal experience that “The association between “mental illness” and violence is seared into public consciousness, and a generalized “fear of the mentally ill” is invoked and amplified; this has the potential, by association, to affect all mental health service users/survivors, even though the vast majority of people with “mental illness” diagnoses are never violent towards others” (Anonymous Female: 2019, 31). This stigma is hurtful and damaging to people with mental illness(es), and it is an incorrect assumption to believe that just because someone has mental health issues, they will harm you in some way.

Speaking to this point, The Canadian Mental Health Association website lays out common misconceptions in their section “Myths About Mental Illness” (June 4, 2019):

Myth #5 People with mental illness are violent and dangerous

Fact: Some people try to predict violence so they know what to avoid. However, the causes of violence are complicated. Researchers agree that mental illnesses are not a good predictor of violence. In fact, if we look at mental illnesses on their own, people who experience mental illness are no more violent than people without a mental illness. Excluding people from communities *is* linked to violence. And people with mental illnesses are often among those who are excluded. It’s also important to note that people who experience mental illnesses are much more likely to be victims of violence than to be violent (CMHA website: June 4, 2019).

Although research has found that guaranteed violence based on mental illness(es) is a myth, these thoughts and expectations are still prevalent in mainstream popular culture and arguably in the healthcare system by professionals themselves. Later, in the final chapter of this thesis I will discuss stigma as it relates to mental illness and violence during emergency care in what is referred to as “The Mental Health Suite”.

One more point on violence, according to Anonymous Female: “The process of sharing experiences of “Othering as mentally ill” may engender empathy and closeness; but when experiences of “Othering as potentially violent” are disclosed, empathy and closeness will likely be lost, with obvious impact on our “selves” and our humanity” (Anonymous Female: 2019, 32). By naming someone as violent, it removes them from being able to receive care and support from those around them. When we lose empathy for those around us, we are at risk for treating others unfairly, and possibly inflicting abuse upon them. In my professional work, I have worked with and provided support to individuals who had reputations for being violent against others. Some staff were nervous of the perceived potential threat, while others got to know said individuals and realized the threat of violence on their person was extremely unlikely.

In relation to “Othering” leading to abuse, I was once asked by a Department of Community Services worker when she was conducting a home inspection if staff lock residents in their bedrooms. I was personally offended by this question but what is so disturbing about this question is the fact that they must ask this question in the first place. Clearly, this abuse happens in some small options homes when some staff feel the need to contain mentally ill individuals.

Chapter 6: Conclusion

Conclusion

The purpose of this thesis has been to outline and to challenge the multifaceted project of “making women mad.” Its foundational assumption has been that “madness” – the assertion of insanity – is neither inevitable or natural, but has been particularly constructed regarding women. It finds its roots in venerable ancient philosopher, Aristotle, who asserted that women were deficient by definition, lacking authority, full intellectual agency, and rightly denied power. Various iterations of women’s “wrongness” appeared through the ages, a view so persistent that even a gender construction that claimed space for women in their own “Separate Sphere” denied women’s rational agency and psychological stability. These strategies have indeed made women “mad” – “crazy” in rejecting their constructions and conditions, but also rightly angry – even furious (*vide* The Furies) – as mythic memory testifies.

Two case studies were presented, one from the 19th century and one from more recent times (Kate Millett died during the writing of this thesis, and it is fitting that it stand in part as a memorial to her struggles). In both, intelligent, unconventional, intellectual, feminist, “writing” women were constrained, contained and for a while at least, had their voices silenced. The work of both these women lives on, but not without taint even today – and both suffered significantly during their lifetimes from prejudice and stigma. These case studies were put in context by a contemporary reflection on and analysis of “madness” as a social and institutional construct. My experience as a mental health professional provided additional information about what emergent scholarship is bringing to the fore of academic study. The field is fresh, vigorous, and seeks to bring about practical change, something that is both needed and long overdue.

Personal Remarks and a Path Forward

As we have seen in this thesis, drug toxicity can be quite severe and damaging to people's physical and mental well-being. At the time of prescription, the "side-effects" seem to be glossed over, with some of the most dangerous and unlikely ones not cautioned to the patient. Because of the often unwavering trust in the pharmaceutical companies (how else would they bring in billions of dollars annually?!), people are willing to accept the physicians' authority and take these drugs. In this section, I will speak directly to those most affected by the pharmaceutical industry and give my advice to them. What can be done is to ask questions and decide what you think is best for you. If you are not sure, speak with your pharmacist and read the pamphlet they usually print out with the filled prescription. Also, trust in yourself. If what the physician is prescribing to you does not seem right to you, or seems dangerous, discuss other options with loved ones, friends, and your physician. I must note that this can be a confusing process, but awareness is key here.

Blending in with the last point, there must also be a skepticism toward uninterrogated medical authority. Just because a physician has a medical degree does not give them the right to control your or your child's mind and body. They can offer their assessment, offer their advice, but you must remain in charge. One must always be ready to modify and or resist direction from physicians. Sure, there are good physicians who do what is right by you, and you may have built trust over years, but keep asking the questions.

Another point is that all health professionals, (particularly in reference to this thesis, gynecologists and psychiatrists) must listen to what women are saying and take it seriously. Women know their own bodies, and know when pain for instance is troubling. This notion of "oh, that's just a bad period", can be lethal to women. For years women can go without a proper

diagnosis to remedy their health conditions. In some cases, it is too late because that “bad period” was actually uterine cancer, almost killing women and/or leaving them no possibility of producing children if that is their goal after gynecological surgery(ies). Not being taken seriously or believed can also produce feelings of self-doubt, post-traumatic stress disorder, depression, and sadly, sometimes death as a woman knows something is wrong, but someone with the authority says she is “fine”.

Based on my own experience, this can also be true today for when women and other individuals go to the emergency department in psychological crisis stating that they are suicidal. Individuals can be sent home without any resources after going through triage and registration. In my work experience, staff have figured out that if we accompany someone to the emergency room, they are sent home even though they are experiencing a psychiatric crisis. Every time we have made arrangements for a person to go to the emergency room alone, they were admitted to the hospital for treatment. On one occasion, I accompanied someone to the emergency room and the psychiatrist on duty sent an email to the primary psychiatrist (outpatient physician for routine appointments) stating that I was “belligerent” even though I was calm and polite when requesting a safety plan and a crisis follow-up appointment for the next day with the person’s psychiatrist which is reasonable to do upon discharge from the hospital. This is a double bind because staff want the appropriate care and treatment for the individual, but do not want the individual to be alone and afraid at the hospital because of the circumstances I will talk about below.

Regarding violence discussed previously in this thesis, in my work experience, I have also seen what it looks like when the emergency department staff take possible psychiatry patients behind the sliding doors into what they call “The Mental Health Suite” in the QE11 Hospital in Halifax, Nova Scotia. This room is used to contain individuals until they can be assessed by a

mental health care professional. This “suite” is smaller than a small bathroom, with only enough room for a small round table and 2 chairs which are all connected by a thick metal wire and secured with a large and daunting looking metal padlock. The walls are drab grey or drab, pale green, the lighting is horrible and flickers. The noise in the small room is unbearable to someone experiencing a mental health crisis. One woman told me that the sounds made her paranoia worse. She also became more anxious the longer we sat waiting for the psychiatrist. Just outside the door sits security guards with a direct view of the “suite”. This is an issue of entrapment, fear and control. The security guard and the windowless door suggest the person in the room is dangerous and must be kept away from the other patients and the hospital staff. I can attest that every time I have accompanied a woman here, they were docile and terrified. They were not a threat to anyone, yet they were treated like monsters and made to feel worse. The personal memory of this does not just go away; it adds to the trauma one has already endured in their lives.

It would be best if individuals seeking medical care were taken to a quiet, comfortable room where they and their support person/people can be as comfortable as they possibly can be. In our current healthcare crisis, rooms are short already, but importance must be placed on women’s mental health. This is also true for gynecological concerns as well. Neither a woman experiencing a mental health crisis or a gynecological emergency should either be left in the waiting room to bleed profusely and suffer or be held prisoner in the “Mental Health Suite”. The emergency department can be a very trauma producing place to be- trauma that often stays with a person throughout their lives until, or even after, proper care is given.

In “The Opposite of Violence”, Carlyn Zwarenstein, discusses empathy. According to Zwarenstein:

Despite the substantial literature devoted to various forms of person-centred, humanistic, holistic, empowering psychotherapy, the most basic modelling of empathy- not skills, like

rote reflective listening, but genuine recognition that as humans we all possess the same needs and the same essential value- seems largely absent from both undergraduate medical and psychiatric specialist education, and so that moment of seeking comfort and the peaceful place to rebuild remain largely absent from the mental health emergency rooms, psychiatrist offices, group meeting rooms, and psychiatric wards they inhabit (Zwarenstein eds. Daley, Costa, Beresford: 2019, 51).

Until professionals collectively understand the difference between empathy and skills, kindness will not be forthcoming. All too often, professionals rely on their medical training and book smarts to do their jobs. The trouble is, people are individuals who require empathy and most importantly, understanding, and kindness when experiencing mental or physical health crises.

I agree with Zwarenstein about a very possible remedy to this problem when she says that “A major step that could be taken to address this would be getting psychiatric survivors into medical education classrooms to speak directly to residents and medical students about their experience, and having Mad Studies’ perspective inform compulsory courses in psychiatric medicine and nursing” (Zwarenstein eds. Daley, Costa, Beresford: 2019, 51). It seems very likely and reasonable to believe that this sharing of situated knowledges would be meaningful and create real changes in the healthcare system. It would also be a very real and potentially powerful way to reclaim one’s agency and voice.

We must also work with, for, and alongside women experiencing marginalization, not to rescue them necessarily, but to support and offer knowledge and strength. In my professional work, one of staff’s main goals is to support women to restore and maintain their agency by deconstructing abusive narratives that mentally ill women are told about themselves. This is crucial to one’s sense of self. Staff make conscious efforts to do their best to combat pre-existing and ongoing oppression that women experience by being a solid ally and providing reassurance. One of the clearest examples of this is when I was at work within the last decade and asked the group of women about voting. One of them told me she was “not allowed” to vote because she had a

mental illness. Truthfully, this both crushed me and woke me up to the extent of the problem against women. This woman reached middle-age believing she was not allowed to vote- to be part of her community- to make important decisions for herself and others. After our discussion, staff supported all of the women in the voting process. Everyone became informed and, as a group, we voted that year. I will never forget how visibly proud and elated this woman was. It was a true instance of reclaiming one's voice. This is the type of thing that needs to be done over and over again in any number of ways. We must always be looking for ways to use our voices.

It is also important to make the connection between restoring a person's epistemic existence by means of telling women's stories through story and feminist autobiography. Charlotte Perkins Gilman and Kate Millett have shown us that telling one's own story (or fictionalized story in Gilman's case in "The Yellow Wallpaper") in one's own words is a powerful act of resistance. What is troublesome is that this practice of restoration is so necessary as means of daily survival, and remains critical to personal autonomy and agency. This is because the problem runs so deeply, and is ingrained in many aspects of society – that women's normal functions are pathological and defective from men's. This has been the theme of the thesis. Its purpose is to show the multiple ways in which women were treated as "other", punished, and "treated" "for their own good".

Although this narrative must be exposed and or unpacked differently in the way this thesis set out to do, we must also take time to consider and appreciate the incredible work done by women for women. Charlotte Perkins Gilman, Kate Millett, and the girls and women I have made professional reference to are stunning examples of brave women engaged in social activism, social change, and resistance. Charlotte Perkins Gilman and Kate Millett have written down their narratives, published them, and shared them with us, if we only take the time to see what they have told us throughout these time periods. Both women have left us their legacy to be proud of as

women and carry on their work in ways that are practical to us in all aspects of the social and political.

What is clear is that “Mad Studies is part of a wider revolutionary project dedicated to the restructuring of the “mental health” industry” (LeFrancois, Menzies, Reume: 2013, 17). Madness Studies is perfectly suited with other activist efforts outlined above to create real and meaningful social change. The treatment of girls’ and women’s minds’ and bodies is not something to take lightly. The narrative needs to change, and the work being done by scholars and those outside of academia all need to view this as a movement- theory and methodology being fluid through time and place - with Madness Studies being part of feminist intersectional theory. This is and has always been political with true opportunity to change the ways we experience life. I personally, have decided to immerse myself within this culture as means to be an advocate for girls and women. It is my hope that my writing will inspire thought and action, and that some form of positive social change will occur. This information cannot remain solely in universities, and needs to be available to everyone. We must go beyond the books. This is about letting girls and women know that they are worth far more than the function of their biology, and that what they experience whether mentally or physically is real and true to their story. This has been a long time coming historically, and we do not have time to see this as anything other than a feminist movement with attention paid to gender that must be engaged and acted upon immediately.

Bibliography

Ammons, Elizabeth. *“The Yellow Wallpaper”*: Charlotte Perkins Gilman (New Jersey: Rutgers University Press, 1993).

Ali, Alisha, “The Convergence of Foucault and Feminist Psychiatry: Exploring Emancipatory Knowledge Building”. *Journal of Gender Studies*, vol.11, no. 3. 2002.

- American Psychiatric Association National Committee for Mental Hygiene Bureau of Statistics, *Statistical Manual for the use of Institutions for the Insane Primary Source Edition* (South Carolina: Nabu Press, 2014).
- Barbara Ehrenreich and Deidre English, *Complaints and Disorders: The Sexual Politics of Sickness* (New York: The Feminist Press, 1973).
- Barbara Ehrenreich and Deidre English, *For Her Own Good: 150 Years of the Experts' Advice to Women* (New York: Anchor Books, 1979).
- Bederman, Gail, *Manliness & Civilization: A Cultural History of Gender and Race in the United States, 1880-1917* (Chicago: The University of Chicago Press, 1995).
- Bishop, Patricia, "The Loony-Bin Trip". *Canadian Woman Studies/ Les Cahiers De La Femme*, vol. 11, no.4. 1991.
- Busfield, Joan, *Men, Woman and Madness: Understanding Gender and Mental Disorder* (New York: New York University Press, 1996).
- The Bronx Council on the Arts. "Kate Millett." <https://www.bronxarts.org/KateMillett.asp> (Accessed January, 2019).
- The Canadian Mental Health Association "Myths About Mental Illness." <https://cmha.ca/documents/myths-about-mental-illness> (Accessed June, 2019).
- Daley, Costa, and Beresford, *Madness, Violence, and Power: A Critical Collection* (Toronto: University of Toronto Press, 2019).
- Davies, Bronwyn, "The Concept of Agency: A Feminist Poststructuralist Analysis". *Social Analysis*, 30. 1991.
- Dock, Bates Julie ed., *Charlotte Perkins Gilman's "The Yellow Wall-paper" and the History of its Publication and Reception: A Critical Edition and Documentary Casebook* (Pennsylvania: The Pennsylvania State University Press, 1998).
- Erskine and Richards eds., *"The Yellow Wallpaper": Charlotte Perkins Gilman* (New Jersey: Rutgers University Press, 1993).
- Female, Anonymous, "The Risk of Violence". *Madness, Violence, and Power: A Critical Collection* (Toronto: University of Toronto Press, 2019).
- Foucault, Michel, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Vintage Books, 1965).
- Gilman, Perkins Charlotte, *The Forerunner* (New York: Charlton Co., 1909).
- Gilman, Perkins Charlotte, *Herland* (United States: Pantheon Books, 1979).

- Gilman, Perkins Charlotte, *The Living of Charlotte Perkins Gilman: An Autobiography* (New York: Arno Press, 1972).
- Gilman, Perkins Charlotte, *Women and Economics: A Study of the Economic Relation Between Men and Women as a Factor in Social Evolution* (United States: Small, Maynard and Company, et al, 1898).
- Harding, Sandra, *Feminism and Methodologies* (Indianapolis: Indiana University Press, 1987).
- Hayden, Delores, *The Grand Domestic Revolution: A History of Feminist Designs for American Homes, Neighborhoods, and Cities* (Cambridge: The Massachusetts Institute of Technology, 1981).
- Kean, Sam, *The Tale of Dueling Neurosurgeons: The History of the Human Brain as Revealed by True Stories of Trauma, Madness, and Recovery* (New York: Back Bay Books, 2014).
- King, Helen, "Early Modern Green Sickness: Hippocrates, Galen and the "Disease of Virgins"". *International Journal of the Classical Tradition*, 1996.
- LeFrancois, Menzies, and Reume eds., *Mad Matters: A Critical Reader in Canadian Mad Studies* (Toronto: Canadian Scholars' Press Inc., 2013).
- Liegghio, Maria, "A Denial of Being: Psychiatrization as Epistemic Violence". *Mad Matters: A Critical Reader in Canadian Mad Studies* (Toronto: Canadian Scholars' Press Inc., 2013).
- Maudsley, Henry, *Body and Mind: An Inquiry into their Connection and Mutual Influence, Specially in Reference to Mental Disorders* (New York: D Appleton and Company, 1871).
- Millett, Kate, *The Loony-Bin Trip* (New York: Simon and Schuster, 1990).
- Millett, Kate, *Sexual Politics* (United Kingdom: Rupert Hart-Davis, 1970).
- Mitchell, S. Weir, *Fat and Blood: And How to Make Them* (Philadelphia: J.B Lippincott & Co., 1877).
- Mumm, Susan ed., *The Greenwood Encyclopedia of Love, Courtship & Sexuality Through History, volume 5: The 19th Century* (London: Greenwood Press, 2008).
- The National Women's Hall of Fame "Charlotte Perkins Gilman." <https://www.womenofthehall.org/inductee/charlotte-perkins-gilman/> (Accessed May, 2019).
- The National Women's Hall of Fame "Kate Millett." <https://www.womenofthehall.org/inductee/kate-millett/> (Accessed May, 2019).
- Ramazanoglu and Holland, *Feminist Methodologies: Challenges and Choices* (London: SAGE Publications Ltd., 2002).
- Russell, Denise, *Woman, Madness & Medicine* (Cambridge, MA: Blackwell Publishers, 1995).

- Shimrat, Irit, “The Tragic farce of “Community Mental Health Care””. *Mad Matters: A Critical Reader in Canadian Mad Studies* (Toronto: Canadian Scholars’ Press Inc., 2013).
- Starkman, Mel, “The Movement”. *Mad Matters: A Critical Reader in Canadian Mad Studies* (Toronto: Canadian Scholars’ Press Inc., 2013).
- Stetson, Charlotte Perkins, “The Yellow Wallpaper. A Story” (United States: The New England Magazine, 1892).
- Titchkosky and Michalko eds., *Rethinking Normalcy: A Disability Studies Reader* (Toronto: Canadian Scholars’ Press Inc., 2009). Forward by Geoffrey Reaume.
- Tuana, Nancy, *The Less Noble Sex: Scientific, Religious, and Philosophical Conceptions of Woman’s Nature* (Indianapolis: Indiana University Press, 1993).
- Warne, Randi, “Introduction: Gender and the Study of Religion”. *Method & Theory in the Study of Religion* 13, no. 2. (2001).
- Warne, Randi, *Literature as Pulpit: The Christian Social Activism of Nellie L. McClung* (Waterloo, ON: Wilfrid Laurier University Press, 1993).
- White, Leah, “Narratives of Mental Illness: The Autobiographical Manifestos of Kate Millett, Susanna Kaysen, and Kay Redfield Jamison”. *Women & Language*, 31, no. 1, 2009.
- Zwarenstein, Carlyn, “The Opposite of Violence”. *Madness, Violence, and Power: A Critical Collection* (Toronto: University of Toronto Press, 2019).