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Item Type	Essay
Authors	Donaldson, Elizabeth
Publisher	Centro de Publicaciones Académicas, Facultad de Artes y Ciencias, Universidad de Puerto Rico en Mayagüez
Download date	2025-01-17 18:12:02
Link to Item	<a href="https://hdl.handle.net/20.500.11801/3310">https://hdl.handle.net/20.500.11801/3310</a>

## THE PSYCHIATRIC GAZE: DEVIANCE AND DISABILITY IN FILM

Elizabeth Donaldson

“This is a true story.” Leaning against the seats in a seemingly empty theater, journalist Alistair Cooke stands in front of a blank screen and introduces the plot of *The Three Faces of Eve* (1957). Cooke functions as a surrogate spokesman for Drs. Thigpen and Cleckley, the two psychiatrists who originally authored this case study. Much of the film’s dialogue, Cooke reassures us, is taken directly from their clinical record, which has become a “classic of psychiatric literature.” Cooke’s preface is just as crucial as the narrative that follows: he helps to initiate the viewer’s complicity in a psychiatric gaze. *The Three Faces of Eve* promises the spectators a privileged glimpse into a rare medical case involving the multiple Eve White, who has “one more personality than Jekyll and Hyde,” Cooke notes. When Cooke conveniently drops the “Dr.” from Jekyll’s name, he does two things: he obscures the role Dr. Jekyll’s scientific background played in Robert Louis Stevenson’s original text, and he conceals the mutually constitutive exchange that exists at the permeable boundary of doctor and patient, of normal and abnormal. Except for the barely detectable cracks in Cooke’s Jekyll and Hyde analogy, the pathology of Eve White is safely specularized by this introduction.

Much has changed since the late 1950s. Eve White’s troublesome behavior as her alternate Eve Black—dancing with sailors and buying revealing clothing—would probably fail to shock today’s viewers and might even be judged as a justifiable feminist rebellion against her straitlaced husband. The trauma that ostensibly produces her multiple personalities—being forced as a young child to kiss the corpse of her grandmother—is even anticlimactic according to current conceptions of multiple personality, which would link severe childhood sexual abuse with Eve’s disorder.<sup>1</sup> Yet perhaps the most

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<sup>1</sup> For a thorough, albeit somewhat controversial, history of thinking about multiple personality (now called dissociative identity disorder) and the

important development in attitudes toward psychiatry and in film representations of mental illness since *Eve White's* day is the death of heroic narratives of psychiatry's power. In *The Three Faces of Eve*, the psychiatrists' attempt to integrate and normalize *Eve White's* three divergent personalities achieves success and produces a grateful ex-patient, Jane. In the stereotypically heteronormative ending of the film, Jane is newly reunited with the daughter she lost during her illness. As Jane drives away with her new husband, she expresses her gratitude for the insights her doctors helped her gain in psychotherapy. In contrast, in post-*One-Flew-Over-the-Cuckoo's-Nest* films, psychiatrists are commonly represented as corrupt, power hungry, or mad. Psychotherapy, moreover, is misguided and ineffectual, often failing in darkly comical ways. Psychiatric hospitals, the incarnations of psychiatric power, are almost exclusively portrayed as oppressive and unsalvageable institutions, more like prisons than true asylums for the ill.<sup>2</sup> This deep suspicion and anxiety about psychiatry, psychiatrists, and psychotherapy is especially thought provoking because it has developed and has been sustained in conjunction with a marked increase in Americans' identification with categories of mental illness. According to the National Institute of Mental Health, approximately 18.8 million adults (9.5% of the U.S. population) have a depressive disorder and, furthermore, these disorders seem to be appearing earlier, in younger patients, than in the past ("The Numbers Count"). As the popularity of Prozac and other antidepressants likewise suggests, more Americans have embraced the idea that they have impaired moods and mental conditions that should be treated by psychiatric medication. In other words, the psychiatric gaze is "schizophrenic," in the popular misunderstanding of the term: multiple and conflicted.

In *The Birth of the Clinic*, Michel Foucault describes the development of the "clinical eye" of medicine, the doctor's gaze on the body of the patient (120). Similarly, by psychiatric gaze, I want to suggest a gaze broadly structured by concepts of psychiatry and clinical psychology, but not exclusive to professionals in the mental health field. The psychiatric gaze may be the camera's critical stance toward psychiatry and psychiatrists, or the diagnosing vision assumed by a camera and the spectator's complicity in that vision, or the self-diagnosing dynamic created by antidepressant ads and

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controversies surrounding its diagnosis, see Ian Hacking's *Rewriting the Soul*. See also Ruth Ley's "The Real Miss Beauchamp" and Marta Caminero-Santangelo's *The Madwoman Can't Speak* for feminist criticism of these diagnoses.

<sup>2</sup> In fact, the recent film *Quills* portrays an asylum doctor as even more sadistic than de Sade.

web sites that encourage would-be consumers to screen themselves for mental illness.

This essay sketches out recurring themes in the representation of mental illness in films and the media in order to interrogate how this frequently contradictory psychiatric gaze functions. The first section, “Mad Science,” juxtaposes the mental illness classic, *The Snake Pit*, with several films that register the failure of psychotherapy (*Leaving Las Vegas*) and the mad, criminal genius of psychiatrists (*The Silence of the Lambs* and *Hannibal*). The second section, “Schizophrenic Subjects,” focuses on *Fight Club* and *A Beautiful Mind* and the cinematic conventions used to narrate psychosis. The third section, “Self/Diagnosis,” employs disability studies theory to read the discourses of normalcy in television ads marketing antidepressants and “bipolar awareness.” Though the anxiety surrounding psychiatrists and the severely mentally ill may seem to contradict the tendency of these campaigns to normalize mental illness, these processes, I will argue, are actually mutually reinforcing.

## I. Mad Science

The 1948 film adaptation of Mary Jane Ward’s novel, *The Snake Pit*, illustrates the earlier heroic narrative of psychoanalysis even more clearly than *The Three Faces of Eve* and contrasts well with the sentiment of current films that register the failures of psychotherapy. Audiences were well primed for this film—Ward’s novel had already appeared in condensed form in *Reader’s Digest* in 1946. Also, at the time of *The Snake Pit*’s cinematic release, the public’s attention had been awakened to the horrors of state psychiatric hospitals by Albert Deutsch’s influential exposé, *The Shame of the States* (1948). Even though *The Snake Pit* catered to the American public’s new interest in the previously hidden world of the asylum, the film was not a radical challenge to current psychiatric treatment. In this context, what is most noteworthy about the film version of *The Snake Pit* are the strategic departures from Ward’s original text, which relates the psychiatric hospitalization (or incarceration) of a writer, Virginia Cunningham, who has had a nervous breakdown. In the autobiographically-based novel, Mrs. Cunningham remembers very little about her therapeutic talk sessions with her psychiatrist, Dr. Kik. The narrator is disoriented and amnesiac during almost the entire novel, making the book a difficult and challenging read. Virginia moves from ward to ward, sometimes blacking out in one ward and regaining conscious memory in a new ward. The wards are numbered based on the patient’s level of function: Ward One is supposedly the last

step toward earning release, while the higher numbered wards are that much further from health and freedom. But Virginia's movements from ward to ward do not proceed in a linear sequential manner: she moves back and forth and then back again, from Three to One and, at her worst, to Thirty-three. In the end, her release from the mental hospital (from Ward Five) seems to happen by chance, with no culminating epiphany and no convincing evidence that she has been at all "cured," as her doctors candidly acknowledge in the novel. Actually, the most important factor determining her doctors' decision to release her is the fact that she and her husband will be moving out of state (and out of the jurisdiction and realm of responsibility of this particular state hospital).

But the film is quite different. Although the film does acknowledge Virginia Cunningham's disorientation and her amnesia from shock treatments, it imposes a much stronger sense of narrative continuity by adding scenes portraying her psychoanalytic sessions, which reconstruct and make sense of Virginia's past. During these sessions, a photograph of Sigmund Freud, strategically placed in between Dr. Kik and his patient, looms in the background, like the seeing eye atop a pyramid. In the film, Virginia actively participates in her therapy, remembers the content of these sessions, and agrees with Dr. Kik's final analysis, that her breakdown is the culmination of survivor guilt after the death of her fiancé many years ago. In the novel, on the other hand, Virginia and her husband openly mock this explanation (Ward 255-57). The film, therefore, presents us with a therapy experience which is the exact opposite of what Ward's autobiographical novel describes. The authority of the patient to tell her story has been literally usurped by the authority of the doctor and the successful psychotherapeutic narrative; likewise, the novel's chaotic pastiche of asylum experience has been restructured and regulated by the psychiatric gaze of the film.

The antipsychiatry movement of the 1960s and 70s would forever alter the authority of this vision in popular film. The asylum, Foucault suggested in his influential *Madness and Civilization*, was primarily a form of institutional control. Similarly, in his *Asylums: Essays on the Social Situation of Asylum Patients and Other Inmates*, Erving Goffman used his field work in the infamous St. Elizabeth's Hospital to argue that large institutions shaped and harmed psychiatric patients more than the illnesses that originally caused them to be hospitalized. Inspired by the work of Foucault and others, antipsychiatry flourished: R. D. Laing described the ways in which psychiatric labeling engendered illness (*The Politics of Experience*), and in *The Myth of Mental Illness*, psychiatrist Thomas Szasz argued that mental illness did not

exist (a belief he still maintains, quite vocally). The authority of psychiatrists and clinical psychologists was thereby widely challenged.

Perhaps no text reflects the influence of antipsychiatry and the American public's fear of psychiatric power more recognizably than the seminal film *One Flew Over the Cuckoo's Nest* (1975), based on Ken Kesey's novel of the same name. While the film is surely familiar territory to many readers, in the immediate context of my argument about the psychiatric gaze one aspect of the plot is worth recalling briefly.<sup>3</sup> In this film, convict Randall Patrick McMurphy feigns a mental illness in order to move from a work farm to a mental hospital. While a member of the ward, McMurphy attends group therapy sessions led by Nurse Ratched. These therapy sessions are more than simply ineffectual: they are portrayed as absurd exercises which infantilize and feminize the patients. Because of the structuring quality of the psychiatric gaze, the antipathy toward therapy in *One Flew Over the Cuckoo's Nest* is mixed in nature. Although the spectator is encouraged, through the perspective of McMurphy, to cast a cold eye on the group sessions' therapeutic effects, at the same time it is in these group therapy scenes that the problems of the characters are revealed to McMurphy. Although McMurphy contests Nurse Ratched's authority by attempting to seize control of the group session, he does not try to abolish the group: he primarily seeks to replace what he considers Ratched's feminized ideal of normative male behavior with an alternate, more active and rebellious, model of masculinity. The psychiatric gaze of McMurphy (and the spectator) corrects the flawed psychiatric gaze of Nurse Ratched: the regulatory power of the psychiatric gaze remains intact.

Similarly, although it is not a film about severe mental illness or psychiatric institutions, *Leaving Las Vegas* is, I would argue, a film about this same self-critical yet structuring quality of the psychiatric gaze: the film deploys the psychiatric gaze in order to challenge the efficacy of psychotherapy. In *Leaving Las Vegas*, the suspicion of

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<sup>3</sup> It is also worth noting in the context of the psychiatric gaze and disability studies theory several other pertinent issues in the film. For example, McMurphy's successful malingering calls into question the scientific legitimacy of a profession that cannot accurately diagnose illness. McMurphy's ability to "pass" as a patient also reinforces the public's belief that criminals habitually and successfully fake mental illness to avoid prison (a belief that makes advocacy for people disabled by mental illness even more difficult within the criminal justice system). Finally, as a result of his insubordination to Nurse Ratched, McMurphy is lobotomized as a form of punishment and control. His mercy killing by the Chief, and the film's valorization of this act as the proper, noble end for McMurphy, illustrates the public attitude that the chronically disabled are better off dead.

psychiatry or therapy is covert. The film portrays the romantic relationship that develops between a prostitute, Sera, and an alcoholic writer, Ben Sanderson, who comes to Las Vegas to drink himself to death. Early in the film, Sanderson says, “I can’t remember if I started drinking because my wife left me, or my wife left me because I started drinking, but fuck it anyway.” Ben’s self-assessment is not only circular, which may signal Ben’s confusion between disease and symptom; it is also a meaningless exercise (“fuck it anyway”), which reflects the treatment failures and diagnostic confusion concerning alcoholism (whether conceptualized as a disease or as a behavior disorder, treatments may be equally ineffective).<sup>4</sup> The inscrutable cause, or unresolved diagnosis, of Ben’s problem—why does Ben drink?—drives much of the film. Before he leaves Los Angeles, a bartender attempts to advise Ben: “It’s none of my business, but if you could see what I see, you wouldn’t be doing this to yourself.” The spectator does see what the bartender sees, and this dialogue illustrates the essentially powerless relationship that any witness has regarding Ben’s actions. Early in their relationship, Sera also searches for the cause of Ben’s drinking: “So why are you a drunk?” Although Ben’s answers are cryptic, she grasps his purpose: “Are you saying that your drinking is a way to kill yourself?” “Or killing myself is a way to drink,” he replies. By eliciting conjecture about the causes of Ben’s problem, the film encourages the spectator to adopt a psychiatric gaze. Yet, in the case of Ben, this diagnostic vision is never consummated: when Sera asks, Ben refuses to see a doctor. The film also never reveals the cause of his drinking, and perhaps as Ben’s dialogue suggests, to ask is a circular process, or an infinite regress of two mirrors touching.<sup>5</sup>

*Leaving Las Vegas* also employs the structuring psychiatric gaze, and depicts the failure of the therapeutic moment, in scenes that take Sera as their primary object. Though the camera usually adopts a third-person-close or first-person perspective involving either Ben or Sera, in several scenes Sera speaks directly to the camera. In these distinct scenes, no one speaks back to Sera, and the camera focuses so tightly on her face that little else has room to appear on

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<sup>4</sup> In *The Natural History of Alcoholism*, George Vaillant assesses the disease model (15-44) and the limits of contemporary treatments (285-94).

<sup>5</sup> On the one hand, Ben’s drinking does not seem to be an involuntary compulsion: he repeatedly expresses the desire to drink himself to death, and he does not want anyone to stop him. However, one could argue that Ben’s apparently voluntary drive is actually an irresistible or hopeless capitulation to his physical addiction to alcohol. In some ways though, the point is moot. Ben’s desire to kill himself using alcohol is never reduced to a simple explanation.

the screen. Despite this seeming lack of context, these scenes are clearly identifiable as therapy sessions, with the camera characterized as the therapist. Through this pivotal characterization of the camera, the film's spectators are likewise positioned as the therapist. Just as the film tempts the viewers to diagnose Ben, the camera even more forcefully positions the viewers to assume the role of Sera's seemingly understanding, though silent, therapist.

Later in the film, this very identification between the spectator and the camera's perspective is purposefully manipulated. As three young men in football jerseys beat and rape Sera, they film the assault using a portable camcorder. Segments of this scene (including, oddly, Sera's flashbacks of the event) appear to be shown through the lens of this home video. This conceit—the screen images of the film becoming the images of the video within the film—collapses the distinctions between the clinical gaze of the therapist and the criminal vision of the rapists, and furthermore suggests a parallel perspective of the spectator, complicit as both rapist and therapist.

This same association of criminal violence with psychotherapeutic perception is perhaps best illustrated by the mad doctor of the mad, Hannibal Lecter.<sup>6</sup> In *The Silence of the Lambs*, Lecter is the imprisoned psychiatrist who aids FBI agent Clarice Starling in her hunt for a serial killer. Because Lecter has moved from doctor to incarcerated patient, he is also an example of the all-too-permeable boundaries dividing the normal and the abnormal, health and illness, the sane and the insane, reason and delusion. Films and novels about asylums conventionally include such a figure—like the former nurse Miss Sommerville in Ward's *The Three Faces of Eve*—someone who once held the keys, but who now is under lock. These figures of transgression not only mark the disturbingly porous bounds of disability and the abnormal; they also figure mental illness as a contagion. Even if it is not true that mental illness is infectious, the figure of Hannibal, the former doctor turned patient, illustrates the contagious creep of stigma. The stigma of mental illness and disability becomes associated not only with the patient, but also with doctors, caregivers, family members, and anyone who has familiar contact with mental illness. Lecter helps Clarice's investigation using his abstract professional knowledge of mental illness, by giving her clues about what in general motivates a person to commit these sorts of crimes. But, more to the

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<sup>6</sup> Lecter is obviously not the first "mad" doctor. In the film *The Cabinet of Dr. Caligari* (1919), an asylum director uses hypnosis to compel a mental patient to commit murder, though the fact that the story is narrated by another mental patient, whom Dr. Caligari describes as deluded, renders the doctor's madness nicely ambiguous.



point, Lecter is an insider. He also has personal, first-hand knowledge of the murderer, having met him before.

Hannibal “The Cannibal” Lecter is dangerous on one level because of the sheer physical power of his jaw: he eats his victims. But this danger is also symbolic of Lecter’s power to manipulate people through conversation, and to divine, like any good analyst, the hidden vulnerabilities and motivations of others. Lecter’s methods of revenge and his interviews with Clarice illustrate this power. For example, on one occasion Lecter stays up all night talking with a fellow psychiatric inmate, Miggs, who has offended Clarice and angered Lecter. In the morning Miggs is dead, having swallowed his tongue evidently as a result of his nighttime conversation with Lecter. Likewise, during his conversations with Clarice, Lecter probes into her past childhood traumas. Even in scenes that clearly do not include Lecter, the camera reinforces this psychotherapeutic vision by revealing flashbacks to Clarice’s childhood and her close relationship with her father. Also, in the final climactic scene, Buffalo Bill, the former psychiatric patient turned serial killer, uses night-vision goggles to hunt Clarice.<sup>7</sup> These images of Clarice groping in the dark recall earlier scenes when the penetrating gaze of Lecter revealed her figurative, psychic groping for meaning in her past.

Yet, just as in *One Flew Over the Cuckoo’s Nest*, the violence of Lecter’s psychiatric gaze is not limited to the psychotherapeutic moment. For example, *Hannibal*, the sequel to *The Silence of the Lambs*, is remarkable primarily for its graphic ending, when Lecter cuts out part of an FBI agent’s brain and fries it up in a pan. While Lecter performs this surgery, he lectures as if he were in a teaching hospital: “You see, the brain itself feels no pain, Clarice, if that concerns you. For example, Paul won’t miss this little piece here, which is part of the prefrontal lobe, which they say is the seat of good manners.” The frontal lobe is indeed associated with behavior, social adjustment, impulse control and emotions. In addition to vividly portraying the particular “madness” of Lecter, this scene evokes the troubled history of psychosurgery as a medical treatment. When Dr. Lecter cuts out a section of the prefrontal lobe, cooks it, and feeds it to Paul, who seems to enjoy it, he parodies the most controversial of psychiatric surgeries, lobotomy (or “lobe cutting,” cutting the nerve fibers that connect the frontal and prefrontal cortex to the thalamus).

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<sup>7</sup> Buffalo Bill’s character is loosely based on convicted killer Eddie Gein, diagnosed with schizophrenia, who used the skins of corpses and murder victims in a similar fashion. Gein is also the inspiration for Norman Bates, the paradigmatic “psychokiller.”

Lobotomy was once heralded as a successful treatment for schizophrenia and certain behavioral disorders. In 1949, Dr. Antonio Egas Moniz won the Nobel Prize in Physiology and Medicine for developing the prefrontal leucotomy (lobotomy) procedure. In the United States, Walter Freeman, the chief popularizer of lobotomy, streamlined Moniz's procedure: instead of trepanning two sides of the brain, which he found too time consuming, Freeman used an ice pick which he inserted through the patient's eye socket. In this fashion, Freeman was able to perform the surgery more quickly and more often. According to one source, Freeman even kept a photograph of himself performing a lobotomy on his most famous patient, actress Frances Farmer (Youngson and Schott 255).<sup>8</sup> Despite the initial enthusiasm for lobotomy as a wonder-cure, critics of psychiatry were fairly quick to identify lobotomy as a technology of social control. For example, the film *Suddenly Last Summer* (1959) tells the story of a woman who is threatened with a lobotomy because she knows too much about a family member's death. Lobotomy today continues to represent one of the most frightening abuses of psychiatric power—seconded in the popular imagination perhaps only by electroconvulsive therapy (ECT) or involuntary committal to a mental institution.

The fact that Paul the FBI agent eats part of his own brain unwittingly illustrates the violence intrinsic to past involuntary psychiatric treatments like lobotomy. This feeding scene is also distasteful from a more contemporary perspective. People with mental illness undergoing psychiatric treatment used to be called "patients." Then, in an attempt to de-pathologize this relationship, they became "clients." The current label of choice in the clinical treatment of people with mental illness is "consumer." When he consumes his own brain, Paul becomes an involuntary consumer of Dr. Lecter's psychiatric treatment. Hannibal's cannibalism, furthermore, suggests psychiatry's circular nature and its ability to feed off of itself: remember that *The Silence of the Lambs* ends with one psychiatrist planning to eat another psychiatrist, with fava beans and a nice Chianti.<sup>9</sup>

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<sup>8</sup> See Jack D. Pressman's *The Last Resort: Psychosurgery and the Limits of Medicine* for the history of lobotomy. The film *Frances* portrays Farmer's life, including the lobotomy and other abuses she suffered while undergoing involuntary psychiatric treatment.

<sup>9</sup> Dr. Lecter plans to eat the psychiatrist who directed the state forensic hospital where he was incarcerated. This doctor harbored professional jealousies against Lecter and treated him unfairly.

## II. Schizophrenic Subjects

The term “schizophrenic” often appears as a metaphor in a variety of non-clinical contexts. For example, a CNBC reporter says the stock market is “schizophrenic” when it is volatile. An English professor says a text is “schizophrenic” when it has two seemingly disparate purposes. Schizophrenia is also often confused with multiple personality disorder (or dissociative identity disorder): one can enter a gift shop and buy a shirt or coffee mug that reads “I’m schizophrenic. And so am I.” This confusion surrounding the meaning of schizophrenia is, unfortunately, not limited to the sphere of popular public discourse. Schizophrenia is arguably one of the most contested psychiatric diagnoses; it has a fraught past and will, more than likely, have an equally fraught future.<sup>10</sup> Even though medical definitions of schizophrenia have been to a certain extent historically mutable, many consider schizophrenia the most serious of the major mental illnesses. Affecting approximately 1% of the world’s population, schizophrenia is an incurable, but treatable, mental illness of undetermined etiology.<sup>11</sup> The illness itself can be as mysterious as its causes: schizophrenia can be severe, chronic, and disabling to various degrees. The diagnostic bible of psychiatry, the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R)*, describes both positive and negative symptoms of schizophrenia. Negative symptoms include blunted affect, social withdrawal, and apathy. Positive symptoms include those commonly associated with active psychotic states: disordered thinking, delusional beliefs, and visual and auditory hallucinations, such as the hallmark of schizophrenia, hearing voices.

A person with these symptoms presents an interpretive dilemma for the psychiatric gaze. As historian S.P. Fullinwider notes, “Certain

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<sup>10</sup> In part because there is currently no physical, biological test for schizophrenia, its “realness” is contested by Szasz and others. Keeping these critiques in mind, in the context of the “psychiatric gaze” I work with the assumption and the belief that schizophrenia is a neurobiological disorder. This theory of schizophrenia is widely accepted by psychiatrists, physicians, and advocacy groups such as NAMI (National Alliance of the Mentally Ill), an organization composed primarily of family members of people diagnosed with mental illness, of which I am a member. (I have two close family members who have been diagnosed with schizophrenia.)

<sup>11</sup> The development of schizophrenia has been linked to genetic predisposition and environmental stressors. Research involving identical, monozygotic twins indicates a 50% discordancy rate for identical twins: if one twin has schizophrenia, the second twin has an approximately 50% chance of also developing schizophrenia. The rate of schizophrenia in the offspring of discordant identical twins is exactly the same, 13%: even if the twin is unaffected by schizophrenia the genetic liability passed on to the children remains the same (Gottesman 124).

sorts of people—those the profession learned to call schizophrenics—place an almost unbearable perceptual strain on the psychiatrist. As the doctor confronts the patient he feels his world break apart. He begins to lose perceptual control over his environment” (quoted in Prendergast 58). Both *Fight Club* and *A Beautiful Mind* are films about schizophrenic subjects: by narrating the experience of psychosis they imitate this loss of perceptual control and then, to various degrees, they restore order to the narrative through a psychiatric gaze.

Although *Fight Club* does not take place in an asylum, and the main character is never officially diagnosed, *Fight Club* is a film about the experience of mental illness, among other things. The film begins, literally and figuratively, in the narrator’s brain, at the level of the neuron. Careening among soma, dendrites, and the myelin sheaths of axons, the camera speeds across the interior nerves of the brain as if it were following the path of neurotransmitters through synapses. The camera eventually pierces through the scalp and runs out along the barrel of a gun stuffed into Jack’s, the narrator’s, mouth. The interior landscape of the brain is a fitting place for the film to begin because Tyler Durden, the man holding the gun, is the narrator’s hallucination, though this fact is not revealed until much later in the film.

*Fight Club* relentlessly parodies medical practices and the roles of patient and consumer. Like *One Flew Over the Cuckoo’s Nest*, *Fight Club* also offers an alternate, hypermasculine version of group therapy. Jack, who hasn’t slept in six months, suffers from an undiagnosed dis-ease. When he seeks treatment for his insomnia, his doctor tells him to “lighten up” and chew valerian root. Jack, who clearly wants medication, presses the issue and complains of his pain, but the doctor replies: “You want to see pain? Swing by the First Methodists Tuesday nights. See the guys with testicular cancer. That’s pain.” Jack follows his prescription and attends “Remaining Men Together,” a support group for men with testicular cancer. There he meets “Bitch Tit Bob,” a former “juicer” (steroid-taking bodybuilder) whose body has responded to his testosterone treatment by manufacturing more estrogen, which causes him to develop breasts. During this group therapy, Jack buries his head between Bob’s breasts and cries like a baby. Later that night he sleeps like a baby, for the first time in six months. Jack immediately becomes addicted to support group meetings: he “passes” as a patient, attending meetings with names like “Free and Clear,” “Seize the Day,” and “Hope,” for conditions such as bowel cancer, blood parasites, brain parasites, lymphoma, tuberculosis, sickle-cell anemia, and organic brain dementia. Jack is addicted to these sessions because they allow him a cathartic release. Although Jack temporarily assumes the identity of a patient in

“Remaining Men,” once each group therapy session ends, his association with the illness ends. He moves securely back to the “normal,” non-diseased, non-disabled self that he wishes to be.

This feeling of catharsis ends when Marla Singer, a woman who is probably another one of Jack’s hallucinations, starts attending “Remaining Men.” Marla eventually drives Jack away from these group sessions and he becomes increasingly dependent on “Fight Club,” a network of secret meetings organized by Tyler Durden. With Jack’s encouragement, even Bitch Tit Bob becomes a member. “Fight Club,” where men meet in order to fight each other, is a spontaneous grassroots group therapy for masculinity in crisis, in the tradition of Randall Patrick McMurphy.

The most noteworthy aspect of *Fight Club* as a mental illness film, however, is the revelation that Tyler Durden is not “real.” Tyler is a character in an elaborate delusional world that Jack has created.<sup>12</sup> Tyler is *Fight Club*’s equivalent to *A Beautiful Mind*’s Charles Herman, one of the hallucinated characters that director Ron Howard uses to personify or embody John Nash’s delusional thinking. Both films hinge on the same plot twist: the vision of the main character, previously accepted as an accurate perception of reality, is revealed to be false, or at least not always accurate. In *Fight Club*, Jack suddenly realizes that Tyler doesn’t exist and flashes back to the scene of their first fight: this time Jack sees himself from a distance, fighting alone. The accuracy of Jack’s second sight is reinforced in a later scene when Jack confronts Tyler in a parking garage. Although Jack can see Tyler at this moment, a glimpse from an observing security camera reveals Jack alone, fighting only himself. The objective view of the surveillance camera reorients the spectator. Similarly, in *A Beautiful Mind*, a significant element of the plot is Nash’s clandestine work as an intelligence agent for William Archer.<sup>13</sup> At Archer’s urging, Nash reads newspapers and magazines voraciously in search of secret codes. Late at night Nash delivers the results of this work to a private drop-off box. However, once Nash’s wife suspects that something may be wrong with her husband, she visits this drop-off point during

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<sup>12</sup> *I Never Promised You a Rose Garden* (1977) depicts the rich and frightening interior world of a young schizophrenic woman in a somewhat similar fashion. In this film the interior schizophrenic world is, however, more clearly distinct from the exterior world of “normal” life.

<sup>13</sup> There is no William Archer in Sylvia Nasar’s biography of Nash, upon which this film is supposedly based. The fictional delusional characters William Archer, Marcy, and Charles Herman are devices the film employs to simplify the representation of Nash’s very real and complex delusional thinking.

the day and finds an abandoned building instead of the embassy-like mansion that the spectator has seen during Nash's nighttime visits. Nash's deviant psychotic vision, which has earlier seemed nothing more than a reflection of a collective Cold War paranoia, is thereby corrected through the eyes of his "normal" wife. Similarly, *Fight Club's* surveillance cameras remedied Jack's psychotic vision. At these moments, the psychiatric gaze of the camera restores for the spectator what the schizophrenic subject threatens to destroy: reliable perception.

### **III. Self/Diagnosis**

In addition to healing the wounds of spectators who witness severe mental illness, the psychiatric gaze is also marketed as a technology of normalcy. A recent Bipolar Disorder Awareness advertisement, funded by Lilly pharmaceuticals, contrasts the depressed self the doctor sees with the manic self who frantically shops, dances all night, or, when not painting the town red, literally re-paints her apartment red. The depressed self the doctor sees has been medicated, but the hidden manic self goes untreated. This manic self has somewhat devilishly escaped the panoptic medical gaze, and the targeted audience, who are people already taking medicine for depression, is urged to reveal this intransigent self to their doctors.

This bipolar ad builds off of imagery already familiar to the public via several ad campaigns for depression medications, though the specific bifurcation of the bipolar self (into medicated depressed self and unmedicated manic self) is unique. Most depressants are marketed as instruments to regain a lost self. For example, Zoloft ads, which cleverly encourage consumers to self-diagnose, state: "You know when you don't feel quite yourself." Meanwhile a sad bubble bumps despondently, until its serotonin-reuptake receptors are properly balanced by Zoloft. Then the bubble bounces back to a happy face. Zoloft helps you feel like "yourself"--an original healthy self is regained and a natural balance is restored, albeit synthetically. Though Paxil ads rely far less on self-examination and much more on peer pressure, these ads employ a similar language and narrative strategy. In one widely and regularly broadcast Paxil ad, concerned family members and friends speak directly into the camera and ask: "Honey, why are you so tense?" "Daddy, are you mad at me?" The spectator is interpellated by pharmaceuticals, hailed into a world in which the self is vigorously monitored, mediated, and medicated. After treatment with Paxil, the ad concludes with an exuberant, "I remember you!" Yes, one might respond, "I'm back to being me."

The true, original self is restored.

In *Listening to Prozac*, Peter Kramer struggles with the very fact that in practice antidepressants do not conform to this narrative. Prozac seems not to restore, but to alter the self. Although Prozac patients sometimes say, "I'm back to being me." Kramer, the psychiatrist, often seems to think, "You're the you you never were." In her best-selling *Prozac Diary*, Lauren Slater describes her experiences with depression and Prozac similarly. Although Prozac alleviates her depressed feelings, it does not "restore" her self. She tells her doctor, "I don't feel like me . . . I mean, I feel more like me in some ways and less like me in others" (Slater 48). Slater, furthermore, experiences the loss of her original self and alienation from her Prozac-induced self: "I was thinking of stopping Prozac altogether, torn between my desire for my old self and my enthusiasm for the new. I was concerned that Prozac, and the health it spawned, could take away not only my creativity but my very identity. . . . I was a different person now, both more and less like me, fulfilling one possibility while swerving from another" (49). Kramer's clinical observations and Slater's first-person account suggest that, at least in some cases, an antidepressant functions not as a method to restore health but as technology of normalcy, a key concept in disability studies theory.

"The concept of a norm," Lennard Davis writes, "implies that the majority of the population must or should somehow be a part of the norm. The norm pins down that majority of the population that falls under the arch of the standard bell-shaped curve" (13). Depressive states are depicted in antidepressant ads as uncharacteristic of the normal self. Yet, as Davis points out, for the majority of the population this norm is a hypothetical state, not a former condition that can be regained.

The current strategies of marketing antidepressants help transform psychiatric diagnosis into self-diagnosis. In so doing, psychiatric categories become occasions for educated consumers to exercise their (limited) freedom to choose what services and medications they receive from their health-care providers. Websites devoted to specific brand name antidepressants, such as Prozac and Celexa, include interactive self-assessment tools to encourage consumers' interest in their product. Infomercial web sites, like WebMD, also include self-assessment tests and likewise reinforce this dynamic. This marketing strategy serves to further decentralize and expand the psychiatric gaze's power.

Perhaps it is ironic that psychiatrists and psychiatry as a discipline cannot control this development. As one critic of psychiatric research

notes, “primary care physicians write about 80 percent of the prescriptions for antidepressants, and they prescribe significantly more psychotherapeutic drugs, in general, than any other medical group, including psychiatrists. Primary care physicians care for about 70 percent of the people who have mental disorders” (Valenstein 183). The ability to write prescriptions for psychiatric medication may even one day be extended to psychologists. In March 2002, Nevada passed House Bill 170, a program designed to create “prescribing psychologists.” This type of legislation helps to achieve the mission of the American Society for the Advancement of Pharmacotherapy, a division of the American Psychological Association. A healthy fear of Hannibal Lecter, therefore, does not prevent one from seeking and obtaining psychiatric medications; there are plenty of other non-psychiatrist doctors to take his place. Furthermore, a pervasive anxiety about psychiatry and psychiatrists will not preclude, and may even foster, the increased use of psychiatric medications.

While few may lament the decentralization of psychiatric power, this decentralization seems inextricably bound to the expansion of the psychiatric gaze, and while consumers may in some cases benefit from this development, it seems more likely that pharmaceutical companies are positioned to become the primary beneficiaries. Currently, would-be consumers are assimilated to a psychiatric gaze that reinforces a hegemony of normalcy at the expense of people disabled by severe psychiatric disorders. Although *A Beautiful Mind*<sup>14</sup> may suggest that a person with schizophrenia can find acceptance—especially if that person is a genius, or if the person “recovers” from mental illness, or, better yet, if both occur—the psychiatric gaze reinforces the hegemony of normalcy in popular attitudes toward mental illness. There are no television ads for schizophrenia medications, and no schizophrenia self-assessment tests on drug websites. The schizophrenic subject remains deviant, the abject element that categories of normalcy and mental health are positioned against. Whatever its future incarnations may be, the psychiatric gaze cannot become truly therapeutic while people disabled by schizophrenia remain the abject that sustain our concepts of the normal.

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<sup>14</sup> The film, *The Caveman’s Valentine*, and the television series, *Monk*, also depict men of exceptional talents who are disabled, but not destroyed, by mental illness.



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